A personal reflection on suicide-related behaviour

The term ‘suicide-related behaviour’ is a very general term and is used in this book in the belief that it includes all self-inflicted life-threatening behaviours in which a person intended either to harm or kill him or herself and which could, whether intentional or not, result in the person’s death. For example, most practitioners will easily place attempted suicide within the concept of suicide-related behaviour. However, there might be differences of opinion as to the inclusion of self-harm within the concept of suicide-related behaviour. In even a brief analysis of the literature, readers will find that while some authors suggest that attempted suicide and self-harm are the same, other authors believe that they are different entities. In this book both self-harm and attempted suicide will be considered as separate entities and differences between both behaviours will be explored and discussed. In addition, having some understanding of the differences between self-harm and attempted suicide will be useful when caring responses and therapeutic approaches to care are considered later on in this book.

This chapter focuses specifically on my own personal reflections on tragic events that on some occasions ended in suicide. The events described are in the form of brief case vignettes, most of which are based on real people and to whom I feel privileged that they allowed me to share their innermost thoughts. Suicide-related behaviour is multi-faceted and the case vignettes outlined here offer only a brief insight into the different ways that the phenomenon of suicide-related behaviour presents itself. For me, each case vignette represents a person’s experience of events that have caused distress in them. Each of these people has helped me to focus my professional and academic studies towards people in crisis who have exhibited suicide-related behaviour in one form or another.
Experiencing suicide – a shattered innocence

During adolescence I was involved with two different groups of teenagers. One group was from an urban area and the other was from a rural area. Both groups consisted of teenagers from varying social backgrounds. While both groups mixed well together on many occasions, in general we were most loyal to our primary group. My recollection of that time was that we were a gregarious bunch of young teenagers. Friendships that were formed at that time in our lives have remained since.

However, in our late teens and early twenties on separate occasions three of our friends killed themselves. Each of these suicides shocked us all in both our groups. For all of us these were our first encounters with suicide. Those of us who had heard of the term suicide assumed that it was linked only with mental illness. Others within both groups had never heard of the term until they met it head on. We all knew that each of our friends had no history of mental illness. Each of them had achieved well in college, was in steady employment and each was expected to do well in the future. Then why should they have killed themselves? We came to the conclusion that they had killed themselves as a direct result of ongoing relationship difficulties at the time. We found it hard to believe that they could not find other options to their difficulties other than to take their own lives. The impact of their suicides still remains with me to this day.

Case vignette 1

While I was a newly qualified staff nurse in a busy acute admission ward in a psychiatric hospital, I met and cared for a young person called ‘Pat’. On admission to the ward, Pat was detained under the then Mental Health Act for Northern Ireland (1972). Pat was in his late teens and he had a recent history of cutting his wrists. During the handover report on the ward, we were told that Pat was suicidal. As a result of this the joint nursing-medical care plan specified that he be cared for in an open single room and that nursing staff were to observe him every fifteen minutes. Initially, Pat did not communicate nor was he willing to communicate with any of the ward staff. On my turn for observations I found this lack of communication quite difficult to deal with. Nonetheless, I ensured, through a very one-sided form of communication, that he knew that I was there and interested in him.

However, one day another nurse informed me that Pat had somehow managed to obtain a razor blade and had succeeded in cutting his wrists before staff could intervene to stop him. He used half the razor blade, which was removed. Pat’s wounds were dressed and efforts were made to find out why he had cut his wrists.
Pat did not offer any explanation. In fact he was very annoyed that he was ‘caught in the act’. I recall a member of staff saying that he must have been only ‘seeking attention’. Another member of staff commented that the cuts were only scratches, were not life-threatening and if a ‘fuss’ was made of Pat, it might encourage him to do the same in the future. Regardless of these thoughts, I remember thinking at that time that there were easier and less painful ways of gaining attention from other people.

A search of Pat’s room did not reveal where the other half of the razor blade was. Pat was subsequently put on ‘Special Observation’, which entailed a nurse being with him 24 hours per day. Nurses were instructed to engage Pat in conversation. One aim of this was to find the second half of the razor blade and the second aim was to elicit why Pat cut his wrists. From my own point of view, I found it much easier to communicate with Pat on this occasion as we had the wrist-cutting incident to refer to. This close encounter combined with verbal engagement enabled the nursing staff to break through the communication barrier. On the third day of continuous observation, Pat revealed where the second half of the razor blade was.

Following this incident, Pat and I had a number of discussions and I found that he had quite a few personal difficulties in his life, of which physical abuse, relationship difficulties within his immediate family and alcohol misuse were prominent. However, while he had social and relationship difficulties, he had no history of mental illness and he did not receive a diagnostic label. In our conversations he told me that the first time he had cut himself, his intention had been to die. However, he did not die and he got a feeling of relief after cutting himself. Since then he has never at any time considered suicide as an option. The fact that Pat would willingly cut his wrists but have no wish to die made me curious about the way the human mind thinks and the way we as humans can behave when experiencing psychological pain. It is relevant at this point to mention that Shneidman (1993, p. 51) wrote that ‘suicide is caused by psychache’ and he also defined psychache as ‘psychological pain, in the mind’. However, some 15 years earlier than Shneidman’s (1993) book, it had already occurred to me that in some way Pat was using what is now known as self-harm as a method of dealing or coping with his own psychache or emotional despair.

Case vignette 2

Although Marie had several admissions to hospital, I never met her there. She came to my attention through my interactions with professional colleagues working in non-statutory (voluntary) services. Marie had six-year history of self-harm. She had numerous cuts on different parts of her body but her arms bore the bulk of the physical scarring. From the first time that I met her, I found her
very pleasant and easy to relate and talk to. At times she was angry at the way some practitioners had treated her in the past but she countered that by saying that on occasion she met well-intentioned practitioners as well. Marie had a horrendous story to tell of sexual, physical and emotional abuse from early childhood until her teenage years. While she was being abused, she believed that the abuse was brought on by herself and that she was responsible for it. Also, she felt that she was alone, trapped and that help was unavailable.

Her initial response to these difficulties in her life was a vague attempt to die. At that time she did not know whether she wanted to live or die. When she was 13 years of age she found the psychological pain of it all too hard to bear. In a frenzy she found a bottle, broke it and used it to cut her arms. At that time she recalled thinking that she did not care whether she lived or died. On this first behavioural response to the abuse, she thought that it was probably a lack of anatomical knowledge that saved her life. However, she did observe that while she felt very tense prior to cutting herself, she felt immense relief once she had done so. In a very similar way this resembled Pat’s thinking. Marie began to use self-harm as a way of relieving her psychache.

Marie told me that when her parents realized that she was cutting herself, they took her to her general practitioner (GP) who then had her admitted to hospital. She was the youngest person on the ward and found it difficult to relate to anyone. While in hospital she was diagnosed as having a personality disorder, but did not find this out until later. However, she attributed the way she was treated in hospital to this diagnosis having been attached to her. She did not think that she had a disorder in her personality. She knew that she had difficulties in her life but did not know how to cope with them. She did not know who to trust or who she could talk to. The only effective relief she had until that point was her self-harming behaviour and while in hospital she was deprived of that. She felt that rather than helping her, hospitalization was abusing her all over again. Also, she felt that the establishment of any trusting relationships with those practitioners who seemed helpful was waylaid by the negative attitudes and actions of practitioners who she felt were less than helpful.

On discharge from hospital Marie started to cut her upper body and arms in an effort to hide her self-harming behaviour. Nonetheless, being young she was eventually found out. Over the course of several admissions, Marie’s self-harming behaviour did not decrease as she obtained much needed comfort from cutting herself. In her view most practitioners seemed more interested in her self-harming behaviour rather than in her as a person. Also, she felt that no one wanted to address the psychache she was experiencing or the reasons behind it. After several admissions Marie got the impression that most staff did not take her seriously, viewed her as an attention-seeker or as manipulative. At one point she felt that others thought she was a lost cause.
In her teens, the abuse stopped. She felt that this was because she was now older, able to verbalize her complaints and that the perpetrator feared legal action. However, the memories of the abuse remained with her and she still found emotional relief from cutting herself. Thus, her self-harming behaviour continued. In her late teens she met a practitioner who did not diagnose her, was non-judgemental, was interested in her as a person and who helped her unravel and come to terms with the emotions she was experiencing. Currently, Marie lives with a partner; they have two children and she has commenced studies for mature students. In the future she wants to become a counsellor and to help others who have histories of suicide-related behaviour.

**Case vignette 3**

Sarah was in her late forties when I first met her. She and I met as a direct result of research that I was involved with. Sarah was married and had several teenage children. She had a history of suicide-related behaviour, which resulted in over ten admissions to hospital. Her case notes revealed that she had a diagnosis of borderline personality disorder, a long history of alcohol abuse and – as mentioned in her case notes – deliberate self-harm by overdosing on prescribed medication. On this occasion, Sarah had been admitted to a casualty department following another overdose of prescribed medication. Subsequently, she was transferred to the local psychiatric hospital. The medical opinion was that Sarah had low self-esteem as a result of alcohol abuse and that she was in danger of harming or killing herself.

The medical opinion did not tell the whole of Sarah’s story. In general, Sarah, although impulsive in her behaviour at times, was really quite shy. I mentioned this to other staff but they were of the view that Sarah used this shyness to manipulate other people and that that would include me. Nonetheless, I found her open about her past history and I took an empathic non-judgemental approach when communicating with her. Sarah told me about her relationship with her husband. From what she told me it was a brutal and violent marriage in which she was much abused over many years. She was quite graphic in her details of the abuse. She felt trapped in that she felt that she could not leave home as the children were too young and she did not know where to go. In addition, Sarah feared that her husband would have followed her and that this could have disastrous consequences for her and the children. I asked her about her harming herself through overdosing. She told me that initially and on some occasions she had thought of killing herself but most times her intention was to get some sleep, obtain rest and to get away from the abuse. I also asked her about her alcohol abuse. She admitted to having a problem with alcohol but she felt that alcohol was a coping measure and a great release to her. It numbed the psychological pain of the
distress she was experiencing. In addition, she felt that if the abuse was resolved, then she would be able to deal with the alcohol problem. Sarah made one statement that has always remained with me and that was ‘My doctor doesn’t understand why I drink.’

Although I was not directly involved in Sarah’s care programme, I did ask her permission to share what she told me with practitioners who had responsibility for her care. This she agreed to on condition that I passed the information on to specific practitioners who she thought were helpful and could be trusted. This I was very happy to do. These practitioners, in agreement with Sarah, adjusted her care programme to involve specific therapy that would address negative aspects in her life such as the physical and sexual abuse she had experienced in the past.

Case vignette 4

Stephen was admitted to a casualty department after being found unconscious at his home. He smelt of alcohol and the person who found him felt that he may also have taken an overdose as an empty bottle of paracetamol was found beside him. Whilst in casualty he was given an emetic to induce vomiting and the remains of the paracetamol tablets were found in the regurgitated gastric contents. In our opinion he was very lucky to be alive.

Stephen and his partner Joan had been living together for three years. Both had decided to settle in Joan’s home town. This resulted in Stephen having to move several hundred miles from his home town. They had invested in a new home, which took all of Stephen’s monthly income and almost half of Joan’s monthly income to meet the mortgage repayments. Such a financial burden led to both partners working as much overtime as possible. Unfortunately, this arrangement played havoc on the amount of time they spent in each other’s company. Over several months, both Stephen and Joan had a number of disagreements, all of which seem to revolve around financial matters and how much time they spent together. Stephen still loved Joan but did not know how to resolve the financial and other pressures that they were facing.

One evening Stephen came home early from work and he found Joan in a compromising position with another man. An argument ensued, during which she said that she wanted to end the relationship and that he could keep both the house and the mortgage. She then moved out to live with this man. In Stephen’s evaluation he had been deserted by the person he loved, was left with a substantial financial burden and he felt isolated as his family lived 200 miles away. He did not know what to do. On opening a cupboard in the kitchen he found a bottle of whisky and beside it a bottle containing paracetamol tablets. He took both bottles and sat down on the settee in the living room. His thinking at that moment was to die and he felt that if he drank enough whisky it would dull the pain of
swallowing the tablets. In effect, Stephen’s suicidal thinking was a direct result of a breakdown in the relationship with his girlfriend.

Fortunately for Stephen a neighbour had seen his partner leave in a hurry and with a stranger and assumed that there had been an argument. This neighbour noticed no movement about the house and decided to call over just to see how Stephen was. When he received no answer after ringing the doorbell, he began looking in the windows. On seeing Stephen in a collapsed state he tried to waken Stephen by knocking on the window. On being unable to waken Stephen, the neighbour called the police and an ambulance.

In casualty the next morning, we met Stephen and we found that he felt embarrassed about the whole incident. Initially he was very reluctant to talk, but he eventually began to describe the events that lead up to his taking an overdose. At the time he took the tablets, his intention was to die. In fact he scored very high on the items in the Suicide Intent Scale as described by Beck, Schuyler and Herman (1974). However, at this moment he no longer felt that way and was glad to be alive. Stephen was offered crisis counselling rather than admission to hospital. After several sessions he felt well enough to deal with the aftermath of the break up of the relationship and to get on with his life. Following the sale of his house, Stephen moved back to his home town, his family, old friends and a new job.

**Case vignette 5**

Elizabeth was a married lady in her early seventies. During their lives together, she and her husband had got on very well. They had two daughters and several grandchildren. While in her sixties, Elizabeth had been treated by her GP for depression and had made a good recovery. Recently, she had been suffering from tiredness and she also had an arthritic pain in her left hip. One Saturday afternoon she was feeling poorly and she took some of her prescribed analgesia and went to bed. She suggested to her husband that he should go and visit the family of Jean, their oldest daughter. However, when the husband arrived at Jean’s house, Jean suggested that they all go to visit their mother and grandmother. On arrival at her mother’s house Jean found her mother in a collapsed state in the bath with a serious laceration to her left wrist. Elizabeth had used a bread knife to inflict the wound, which was so severe that it necessitated her being rushed to theatre for surgery to repair the Ulnar Artery and to have tendon and nerves repaired.

Early the next morning, my mentor telephoned me and asked me to meet her in the casualty department to assess Elizabeth. When we met Elizabeth she was not pleased to see us and she made this very clear when she said that she wanted to meet St Peter rather than us. She wanted to be dead and had no wish to meet her husband, daughter or any other member of her family. She blamed the knife
and said that it must have been blunt. We allowed Elizabeth to express her emotions and eventually she reluctantly began to tell what happened. In our assessment we found that although she was treated for depression by her GP eight years earlier, she had had no contact with the mental health services since. She had a very successful life, had a loving family and was very secure in her elderly years. Why did Elizabeth want to die? She did not relish the thought of getting old and wanted to die at a time that suited her. She did not want to become a burden on her family nor on anyone else. She had made her peace with God and believed that St Peter would understand her motives. It took most of the day for us to convince Elizabeth to talk to her immediate family. They, while being shocked at her attempted suicide, encouraged her to seek voluntary admission to hospital. Elizabeth agreed to this. During her time in hospital, Elizabeth took part in Cognitive Behavioural Therapy. Meanwhile, her husband and daughters sought advice on aftercare following discharge. After several weeks of in-hospital care, Elizabeth was discharged home with follow-up support from a Cognitive Behavioural Psychotherapist.

**Case vignette 6**

When I first met John he was withdrawn, spoke very little, looked very sad and very lethargic. John had been admitted to hospital on several previous occasions. John was in his late forties and was a successful businessman. Also, he had a loving wife and several grown-up children who were now adults. His family were very concerned about him and they visited him regularly. John had been diagnosed as suffering from clinical depression. On this occasion he was very depressed and had expressed suicide-related ideation. His GP and his immediate family were concerned that John might have killed himself. For these reasons, John was admitted to the ward.

Communicating or connecting with John was very difficult. However, we had no choice but to ensure that John knew that we were available and willing to listen to him. We did this because we were concerned about the possibility of his killing himself. Even though John had no previous history of suicide-related behaviour, the fact that he had previously expressed it to his GP meant that it must be explored. However, he denied any such thoughts about harming or killing himself. In addition, the nursing interactions with John and the observations made on his behaviour and his interactions with others did not suggest any suicidal thoughts. In fact, during his time in hospital, at no time did John ever express any intention of suicide and subsequently he was considered at low risk of suicide.

During the course of his in-hospital treatment, John’s medication was reviewed and the consultant ordered a course of Electro Convulsive Therapy. In time John
became more active, took more interest in his surroundings and in himself and he began to communicate more with staff. On one occasion when his mood was showing improvement he was asked about his depression. However, he was unable to give an explanation as to why he felt the way he did. He knew all about the good and positive things in his life but these did not connect with him nor did they ease his depressive feelings. For some reason unknown to himself and indeed to others, he just could not be bothered about anything during the time he felt so depressed. However, John made steady progress, his mood improved and his interactions and relationships with his family also improved. Weekend leave was encouraged and John also began to take an interest in his business again. Eventually, John was discharged into the care of his GP and the Community Psychiatric Team. Approximately four months later, we heard that John had killed himself. All of the staff on the ward were shocked and we never found out why he had done so.

Summary

I have deliberately begun this book with a personal reflection of these case vignettes because each of them has created in me powerful emotions that made me aware of myself first as a human being and secondly as a professional. Each of the suicides created an apprehension in me at the time and they still do today as I reflect on these past events. Similarly, a curiosity was created in me regarding the care required by people in psychological crisis. In addition, I became very curious about trying to understand the relationship between self-harm and suicide. No matter which way one views each case vignette, in each there is the potential, whether intentional or not, for death by one’s own hand. In addition, in my professional journey to date I have met numerous people who have been bereaved by suicide. To this day, while many have managed to come to terms and accept what has happened, none has recovered fully from the loss. It remains my belief that suicide provokes powerful emotions in all those who have come to experience it through the loss of family or friends and that these emotions are long-lasting.

As a direct result of my experiences and in trying to understand the human mind and why humans behave the way they do when under duress, I began to study psychology. The combination of mental health nursing and psychology created in me a lifelong interest in trying to understand and care for people in psychological crisis who harm or try to kill themselves.