High Risk Family Assessment and Health Promotion:

Families with Suicidal Ideation

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Many people believe only mentally ill or cognitively impaired people have suicidal ideations. In fact, most suicidal acts are taken by people who do not have psychotic conditions and most suicidal behaviors do not occur before the individual exhibits multiple obvious or subtle signs that suicidal acts may occur (Chen, Wu, & Bond, 2009, p. 133). Suicide completion is preceded by suicidal ideation. Individuals with suicidal ideation have the desire to commit suicide, but have not made the attempt to complete suicide. Both individuals with mental health disorders and individuals with no underlying mental health disorder suffer from suicidal ideation (Chen, Wu, & Bond, 2009). Family problems contribute to youth suicide and include lack of cohesion, negative family climate, increased family disputes, and lack of good communication between the generations are among the factors that contribute to suicide and suicidal ideation (Chen, Wu, & Bond, 2009).

Suicidal Ideation in Adolescents

Low self-esteem, high stress level, depression, and anomie have been linked to suicidal ideation in adolescents. These conditions are the result of parental behaviors that are over controlling and that negatively affect adolescent personality development. These types of parental behaviors have an intrusive or manipulative effect on the psychological development of children (van Renen & Wild, 2008). Parental behaviors that are intrusive or manipulative include inducing guilt, being inconsistent, and personal insults. This places the adolescent at risk of developmental problems due to their insufficient control over their own behavior. Non-fatal adolescent suicide attempts have been associated with families that are “often inflexible and characterized by over-controlling parenting styles, rigid problem-solving behavior,

patriarchal leadership and intolerance for developmental changes. Parents also tend to be over-protective of their children, intrusive and over-involved in their lives, which allows no room for individuation and normal developmental" (van Renen & Wild, 2008, p. 111).

When parents fail to provide support to adolescents create an environment in which suicidal ideation can occur due to depression, anxiety, feelings of hopelessness, and low self-esteem. Girls who experience increased family conflicts develop feelings of hopelessness which lead to depression and suicidal ideation. Boys develop these feelings when they perceive that the family has low cohesion. As a result, boys also develop depression that leads to suicidal ideation. Family relationships were found to be "a universal predictor of adolescent suicidal ideation, whereas psychological factors are mediators" (Sun & Hui, 2007, p. 775). Depression most immediately mediates suicidal ideation. Self-esteem and feelings of hopelessness are also strong mediators. Negative family factors can lead to suicidal ideation; however, peer and school factors can also mediate it (Sun & Hui, 2007).

Supportive parent-child relationships are characterized by a strong, close connection. This enables adolescents to freely go to their parents for support and information. Adolescents who have warm and supportive parents have healthier psychological well-being. This sense of well-being is protective against suicidal behavior in influence adolescents to have a poor sense of psychological well-being, which can include suicidal behavior and depression (van Renen & Wild, 2008). Adolescents who perceive lack of parental involvement and caring can also have impaired communication with their parents. They therefore turn to peers with their problems instead of turning to parents. This can lead to compromised behavioral and emotional health in the adolescent, including suicidal behaviors (van Renen & Wild, 2008). Lack of support and nurturing behaviors from parents is also associated with suicidal behaviors. Low levels of self-

esteem in regard to family relationships is associated with adolescent suicidal ideation and suicide attempts (van Renen & Wild, 2008).

It has been further found that a low level of connection of both boys and girls to fathers is a very important predictor for occurrence of suicidal ideation, despite the idea that fathers are more peripheral to the lives of children than mothers. "Closeness to fathers contributes to happiness, life satisfaction and reduced psychological distress in both sons and daughters independently of closeness to mothers" (van Renen & Wild, 2008, p. 118). Conversely, negative relationship with the father "is a significant risk factor for suicidal behavior in adolescents" (van Renen & Wild, 2008, p. 118).

Family Conflict

Higher levels of conflict are evident in families of adolescents who exhibit suicidal behaviors. Hostile expressions of inter-parental conflict are associated with both internalized and externalized adolescent problems. The suicidal behavior of the adolescent may be a sign of the adolescent's lack of ability to continue to function in the conflict-ridden family environment. The adolescent may have increased feelings of hopelessness and poor problem-solving skills due to the poor conflict resolution experienced in the family environment (van Renen & Wild, 2008).

Family stability and loyalty provide the adolescent with support and resources. When major changes to the family take place through separation, death, or divorce, needed support to vulnerable family members may diminish or cease. Fatal and non-fatal suicide behaviors and self-harm behaviors are significantly related to divorce. Parental death has an even stronger effect than divorce on the occurrence of fatal suicides (van Renen & Wild, 2008).

"Lower levels of connection and regulation and greater psychological control in the parent-adolescent relationship, higher levels of family conflict and parental divorce, would be

associated with suicidal ideation or behavior in adolescents" (van Renen & Wild, 2008, p. 114). Families characterized by conflict, aggression, cold relationships, lack of support and neglect create risk for children to experience various emotional and behavioral issues. While these behaviors within the parent-adolescent relationship are not uniquely related to suicidal ideations and suicidal behaviors, they do increase the likelihood that children will experience various physical and mental health problems (van Renen & Wild, 2008).

Assessment of the Suicidal Ideation Family

Assessment of the suicidal ideation family would first include a family health history to identify problems and risks specific to the family. The nurse would gain an understanding of the current family group as well as the families of origin of the parents. Evidence of genetic and environmental diseases and psychosocial diseases would also be gathered during the assessment (Friedman, Bowden, & Jones, 2003). The data for the assessment is gathered from various sources, including interviews with the family and family members, subjective appraisals of experiences related by family members, written and oral information relayed by agencies and healthcare team members who are working with the family (Friedman, Bowden, & Jones, 2003).

It is preferable that the nurse interview the entire family initially to give all family members the opportunity to discuss their perceptions and allows the nurse the opportunity to observe the interaction of the family members. This should be a focused interview, but structure will vary depending upon the purpose. The nurse may at times interview individuals, but must keep the family focus by asking the individual questions about the family. The nurse must also be both an active participant and an observer, being able to observe the situations and interactions that exist in the home between family members. (Friedman, Bowden, & Jones, 2003). The genogram and the ecomap are family systems tools used for information gathering

during a family interview. The Friedman Family Assessment Tool can also be used to provide structure and focus to the family interview, as can checklists, questionnaires, and inventories (Friedman, Bowden, & Jones, 2003). When the nurse assesses the family's socialization patterns, the nurse must keep in mind the diversity of sociocultural backgrounds that he or she might encounter. It is also important that the nurse be aware of his or her own biases and expectations based on his or her own upbringing. Child-rearing styles vary between social classes, with a more strict authoritarian style more common with lower class families and a more democratic style more common with middle class families (Friedman, Bowden & Jones, 2003).

After gathering the family data, the nurse will identify actual and potential family problems and arrive at a family nursing diagnosis. There are problems that are beyond the nurse's scope of practice. In these cases, the nurse will discuss the problems with the family, gain consensus with the family that the problem or need exists, and refer the family to other professional resources. For problems within the nurse's scope of practice, he or she will develop a plan or care with the family and apply appropriate nursing interventions to the family's problems (Friedman, Bowden, & Jones, 2003). In the case of the suicidal ideation family, the nurse might choose nursing diagnoses of Risk for Hopelessness, Ineffective Individual Coping, Ineffective Family Coping, and Risk for Violence: Self-Directed (NANDA Nursing Diagnosis List, 2014).

Nursing Intervention Strategies

The health belief model is the most widely tested of the models and is very useful in the analysis of personal health behaviors. It is predictive of varied health activities, such as utilization of preventive health action, utilization of medical care, delays in seeking medical care, and compliance with prescribed medical regimens (Friedman, Bowden, & Jones, 2003).

This theory utilizes Lewin's theories that states that the perceiver's world influences what he or she will ultimately do, not the physical environment, except as the individual views it. Based on Lewin's theories, the individual will avoid areas of life that hare viewed as negative and will seek out the areas of life that they view as positive. Preventive health actions are viewed as positive because they help the individual to avoid the negatives of illness and disease (Friedman, Bowden, & Jones, 2003).

Pender's Health Promotion Model is built on earlier health belief models. The Health Promotion Model "theorizes about the relationships among individual characterisics and experiences, behavior-specific cognitions and affect, and behavioral outcomes" (Friedman, Bowden, & Jones, 2003, p. 432). Pender's Health Promotion Model includes influences of past related behaviors and factors on the sociocultural, biological, and psychological levels of the individual. The primary motivators of patient behavior are the patient's behavior-specific thoughts and affect, which nurses are able to influence through nursing interventions. There are six of these that are considered to have significance to motivate patients to utilize health-promotion behaviors: "perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affect, interpersonal influence, and situational influences" (Friedman, Bowden, & Jones, 2003, p. 432). Behavior-specific thoughts and affect that are related to engaging in "health-promoting actions include positive perceptions of the anticipated expected outcome, minimal barriers to actions, feeling efficacious and skilled, positive feelings about the health behavior, presence of family and peer social support, positive role models, and availability of environmental contexts that are compatible, safe, and interesting" (Friedman, Bowden, & Jones, 2003, p. 432).

Nursing Intervention Strategy: Family Counseling of Families in Crisis

The family crisis intervention model applies problem-solving techniques in a systematic was. It is based on crisis theory and is designed to help the patient to process the crisis as quickly and painlessly as possible. The major goals of this strategy is to decrease the immediate stress felt by the family members and the entire family and to encourage the family to cope in more adaptive ways (Friedman, Bowden, and Jones, 2003). This involves reframing the family's view of the family's problems. It is often also used to help them to find alternatives to their "behavioral, cognitive, and affective responses to their problems" (Friedman, Bowden, & Jones, 2003, p. 196).

The nurse's role in using this strategy is to quickly provide the family with access to services that are needed to address their problem(s) after initially addressing and helping to reduce their stress level and to assist the family and family members with coping and problem solving. The nurse works to assist the family to attain homeostatis and hopefully, to move on to a higher, more healthy level of functioning. Helping the family to come up with their own solutions to problems is a powerful counseling intervention because it empowers the family by applying a self-care approach to the therapy (Friedman, Bowden, & Jones, 2003).

Role of Advanced Practice Nurse as Case Manager

Case management has long been part of public health nursing. It has more recently become prominent in acute care nursing. The growth of case management has been driven by managed care, which emphasized cost control and efficiency of care while patient satisfaction and quality of care must be maintained. All of this has influenced the manner in which case management has developed (Friedman, Bowden, & Jones, 2003).

"Case management is seen as a system, a clinical decision-making process, a technology, a role, and a service" (Friedman, Bowden, & Jones, 2003, p. 197). Throughout the literature there is agreement that the process of case management "involves five essential steps: client assessment, planning, linking (referring, coordinating, and advocacy), monitoring, and evaluating" (Friedman, Bowden, & Jones, 2003). Throughout the process, quality care outcomes are balanced with efficient use of resources. Case management is holistic, emphasizes client participation and client self-care and determination, and coordinates and efficiently uses a broad range of human services (Friedman, Bowden, & Jones, 2003).

Case management and the nursing process have much in common. The main difference is that the case management assessment is much broader in scope regarding psychosocial, environmental, and health variables. It also differs in the increased scope of planning and identification with clients and the service network and involves a greater degree of service coordination (Friedman, Bowden, & Jones, 2003). Assuming the role of case manager adds responsibilities in addition to the nursing role. The nurse case manager has more authority to coordinate services, more accountability for favorable outcomes clinically and financially, and must make a greater time commitment. The nurse case manager must sequence and organize multidisciplinary services across multiple settings. The management of transitions from hospital to clinic to home to hospice is a crucial case management role (Friedman, Bowden & Jones, 2003).

The nurse case manager is also a client advocate and this is a major component of the role. In addition to speaking for and on behalf of a client, the nurse case manager must be a defender or intercessor at times, much like an attorney. He or she must expose inadequacies and injustices, disrupt the status quo, and expose the incompetence of agencies and caregivers

(Friedman, Bowden, & Jones, 2003). Advocacy can be defined in many ways, but ethical principles are at the foundation. The principles of "self-determination (autonomy), justice (fairness and equality), beneficence (doing good), and nonmaleficence (doing no harm)…guide each of the varied definitions of advocacy. Some nurses see advocacy as the philosophical foundation of nursing" (Friedman, Bowden, & Jones, 2003).

Healthy People 2020 Objectives for Suicidal Ideation Families

There are several Healthy People 2020 objectives for mental health and mental disorders. The following four objectives, include suicide rates and suicide attempt rates, as well as rates of depression among adolescents and the percentage of children with mental health problems who receive treatment. MHMD-1, MHMD-2, and MHMD-3 fall under the objective category of Mental Health Status Improvement. MHMD-6 falls under the category of Treatment Expansion:

MHMD-1 Reduce the suicide rate (Leading Health Indicator). The baseline for this objective is a suicide rate of 11.3 suicides per 100,000 population, which occurred in 2007. The target is 10.2 suicides per 100,000 population by 2020, which is a 10% improvement.

MHMD-2 Reduce suicide attempts by adolescents. The baseline for this objective is 1.9 suicide attempts per 100 population, which occurred in 2009. The target for 2020 is 1.7 suicide attempts per 100 population, which is a 10% improvement.

MHMD-4.1 Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs) (Leading Health Indicator). Baseline: 8/3 percent of adolescents aged 12 to 17 years experienced a major depressive episode in 2008. Target: 7/4 percent. Target-Setting Method: 10 percent improvement.

MHMD-6 Increase the proportion of children with mental health problems who receive treatment. Baseline: 68/9 percent of children with mental health problems received treatment in 2008. Target: 75.8 percent. Target-Setting Method: 10 percent improvement (HealthyPeople, 2014).

Conclusion

The family whose member is experiencing suicidal ideation has complex family dynamics. The dysfunctional nature of the parent(s) places the child at risk of suicide and other self-harming behaviors. The family nurse can intercede in these family dynamics and help these

families by assessing them, by coordinating the care that they need to develop healthy family dynamics, and by advocating for their most vulnerable members.

References

Chen, S., Wu, W. H., & Bond, M. (2009). Linking family dysfunction to suicidal ideation: Mediating roles of self-views and world-views. *Asian Journal of Social Psychology*, 12(2), 133-144. doi:10.1111/j.1467-839X.2009.01280.x

Friedman, M., Bowden, V., & Jones, E. (2003). *Family nursing: Research, theory, & practice* (5th ed.) Upper Saddle River, NJ: Prentice Hall.

Healthy People. (2014). *Mental health and mental disorders, objectives, mental health status improvement.* Retrieved from: http://www.healthypeople.gov

NANDA Nursing Diagnosis List. (2014). *NANDA nursing diagnosis list: risk factors and characteristics.* Retrieved from: www.nandanursingdiagnosislist.org.

Sun, R., & Hui, E. (2007). Psychosocial factors contributing to adolescent suicidal ideation. *Journal of Youth and Adolescence, 36*(6), 775-786. doi:http://dx.doi.org/10.1007/s10964-006-9139-1

van Renen, L. J., & Wild, L. G. (2008). Family functioning and suicidal ideation/behaviour in adolescents: a pilot study. *Journal of Child & Adolescent Mental Health*, *20*(2), 111-121. doi:10.2989/JCAMH.2008.20.2.7.690