EFFECTS OF THE INTERPERSONAL NEED PROGRAM ON SUICIDAL IDEATION AND SUICIDAL ATTEMPT IN MENTALLY ILL PATIENTS

Miss Tantawan Yamboonruang

บทคัดย่อและแฟ้มข้อมูลฉบับเต็มของวิทยานิพนธ์ตั้งแต่ปีการศึกษา 2554 ที่ให้บริการในคลังปัญญาจุฬาฯ (CUIR)
เป็นแฟ้มข้อมูลของนิสิตเจ้าของวิทยานิพนธ์ ที่ส่งผ่านทางบัณฑิตวิทยาลัย
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are the thesis authors' files submitted through the University Graduate School.

A Dissertation Submitted in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy Program in Nursing Science
Faculty of Nursing
Chulalongkorn University
Academic Year 2015
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ผลของโปรแกรมความต้องการระหว่างบุคคลต่อความคิดฆ่าตัวตายและการพยายามฆ่าตัวตายใน
ผู้ป่วยโรคจิต

นางสาวทานตะวัน แย้มบุญเรือง

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาพยาบาลศาสตรดุษฎีบัณฑิต
สาขาวิชาพยาบาลศาสตร์
คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย
ปีการศึกษา 2558
ลิขสิทธิ์ของจุฬาลงกรณ์มหาวิทยาลัย

Thesis Title	EFFECTS OF THE INTERPERSONAL NEED PROGRAM ON SUICIDAL IDEATION AND SUICIDAL ATTEMPT IN MENTALLY ILL PATIENTS
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Field of Study	Nursing Science
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ทานตะวัน แย้มบุญเรือง : ผลของโปรแกรมความต้องการระหว่างบุคคลต่อความคิดฆ่าตัวตายและการพยายามฆ่าตัวตายในผู้ป่วยโรคจิต (EFFECTS OF THE INTERPERSONAL NEED PROGRAM ON SUICIDAL IDEATION AND SUICIDAL ATTEMPT IN MENTALLY ILL PATIENTS) อ.ที่ปรึกษาวิทยานิพนธ์หลัก: รศ. ดร.จินตนา ยูนิพันธุ์, 160 หน้า.

การวิจัยนี้มีวัตถุประสงค์เพื่อศึกษาประสิทธิผลของโปรแกรมความต้องการระหว่างบุคคลที่มีต่อความคิดฆ่าตัวตายและการพยายามฆ่าตัวตายในผู้ป่วยโรคจิต การวิจัยครั้งนี้เป็นการทดลองแบบสุ่มสองกลุ่มวัดก่อนและหลังการทดลอง กลุ่มตัวอย่างในการวิจัยเป็นผู้ป่วยโรคจิตที่เข้ารับการรักษาในโรงพยาบาลจิตเวชจำนวน 33 ราย และผู้ดูแลของผู้ป่วยจำนวน 33 ราย สุ่มเข้ากลุ่มทดลอง 17 คู่ และสุ่มเข้ากลุ่มควบคุม 16 คู่ โดยกลุ่มทดลองได้รับการพยาบาลตามโปรแกรมความต้องการระหว่างบุคคลที่ผู้วิจัยพัฒนาขึ้นตามทฤษฎีระหว่างบุคคลกับการฆ่าตัวตาย (The interpersonal theory of suicide; Van Orden et al., 2010) ส่วนกลุ่มควบคุมได้รับการพยาบาลตามปกติ ซึ่งโปรแกรมความต้องการระหว่างบุคคลประกอบด้วยการบำบัดทางการพยาบาลจำนวน 4 ส่วน คือ การสร้างสัมพันธภาพเพื่อการดูแล การเสริมสร้างการได้รับการยอมรับ การลดการรับรู้ว่าตนเองเป็นภาระ และการขจัดความสามารถในการฆ่าตัวตาย โปรแกรมนี้ใช้เวลา 2 สัปดาห์ในระยะฟื้นฟูสมรรถภาพทางจิตในโรงพยาบาล และ 1 สัปดาห์หลังจำหน่าย เครื่องมือที่ใช้ในการเก็บรวบรวมข้อมูลได้แก่ แบบประเมินความคิดฆ่าตัวตาย (SSI-Thai version 2014) และแบบบันทึกการพยายามฆ่าตัวตาย โดยเก็บข้อมูลในวันแรกที่เข้าร่วมการทดลองและ 2 สัปดาห์หลังจำหน่าย

ผลการศึกษาพบว่า กลุ่มที่ได้รับการพยาบาลตามโปรแกรมความต้องการระหว่างบุคคลมีค่าเฉลี่ยของความคิดฆ่าตัวตายลดน้อยลงกว่ากลุ่มควบคุมอย่างมีนัยสำคัญทางสถิติที่ระดับ 0.05 โดยไม่พบความแตกต่างกันของการพยายามฆ่าตัวตายในผู้ป่วยทั้งสองกลุ่ม ผลการศึกษาครั้งนี้แสดงให้เห็นถึงประสิทธิผลของโปรแกรมความต้องการระหว่างบุคคลที่สามารถลดความคิดฆ่าตัวตายของผู้ป่วยโรคจิตลงได้

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สาขาวิชา พยาบาลศาสตร์	ลายมือชื่อนิสิต ....
ปีการศึกษา 2558	ลายมือชื่อ อ.ที่ปรึกษาหลัก ....

5377972436 : MAJOR NURSING SCIENCE
KEYWORDS: THE INTERPERSONAL NEED PROGRAM / SUICIDAL IDEATION / SUICIDAL ATTEMPT / MENTALLY ILL PATIENT

TANTAWAN YAMBOONRUANG: EFFECTS OF THE INTERPERSONAL NEED PROGRAM ON SUICIDAL IDEATION AND SUICIDAL ATTEMPT IN MENTALLY ILL PATIENTS. ADVISOR: ASSOC. PROF. JINTANA YUNIBHAND, Ph.D., APN, 160 pp.

The purpose of this study was to examine effects of the interpersonal need program on suicidal ideation and suicidal attempt in mentally ill patients. This study was a randomized control trial design. The participants were sixty-six people comprising of thirty-three mentally ill patients who hospitalized at psychiatric hospital and thirty-three of their caregivers. The experimental group received the interpersonal need program which developed by researcher based on the interpersonal theory of suicide (Van Orden et al., 2010), whereas the control group obtained the usual care. This program composed of four parts: establishing caring relationship, promoting sense of belongingness, reducing perceived burdensomeness, and disabling capability for suicide. It was conducted within two weeks of rehabilitative phase of hospitalization and first week after discharge. The participants were assessed using Thai version of the scale for suicidal ideation (SSI-Thai version 2014) and the suicidal attempt record on the recruitment date and two weeks after discharge.

The Result revealed that the experiment group significantly demonstrated more reduction of suicidal ideation ($p < 0.05$) than the control group. There was no significant difference of suicidal attempt between two groups. The interpersonal need program demonstrates effects on reduction of suicidal ideation in mentally ill patients.

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Field of Study: Nursing Science	Student's Signature ....
Academic Year: 2015	Advisor's Signature ....

ACKNOWLEDGEMENTS

An accomplishment of this dissertation was made by great support from my advisor, Assoc. Prof. Dr. Jintana Yunibhand. This was my beneficial experience to participate in Ph.D. course. I would like to express deep appreciation to all committees of Ph.D. program, Faculty of Nursing, Chulalongkorn University.

I would also like to thank my dissertation committees who shared their experience and encouraged me to learn and improve my dissertation.

I would like to thank all participants, research assistants, and coordinators at Suansaranrom hospital who supported me during data collection.

I would like to thank all my experts and validators. And I would also like to thank Dr. Wipawee Phaokuntarakorn, who supported me at the arduous process of my study.

I would like to thank my doctoral classmate who shared experience and gave me a valuable support. In addition to my colleague at mental health and psychiatric nursing department, Boromarajonani College of Nursing Changwat Nonthaburi, they always support me to improve my ability to be a good nursing instructor.

Finally, I would like to express my greatly thankfulness to my beloved parents Ket and Siriphon Yamboonruang, my brother Piya Yamboonruang, and Miss Nittaya Chamnina who always give me their love and support.

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CHAPTER 1
INTRODUCTION

Background and significant of the study

In 2020, the number of people who choose to end their own life is estimated reach 1.5 million people (World health organization, 2009) whereas currently each year 1 million people worldwide die by suicide (Nock et al., 2008). As a matter of fact, patients with mental illness are at much risk for suicide, and in comparison with general population this risk for suicide is very significant. It is well established that suicide risk is substantially elevated in the context of psychiatric disorder (Windfuhr & Kapur, 2011). According to psychiatric diagnosis, it is the most reliable risk factor for suicide (Hawton & Van Heeringen, 2009). Approximately 90% of all suicides are committed by individuals with a diagnosable mental or substance abuse disorder.

Suicide is an enormous public health problem around the world (Nock et al., 2008). Suicidal behaviors affect millions of individuals worldwide, representing important public health problems (Joiner, Ribero, & Silva, 2012). In addition, suicide is usually a cause of great distress to victim, family, friends, and community and largely to the nation (Mekonnen & Kebede, 2011). When suicides were occurred, these were not effect only attempters or completers but also people around them. Losing a loved to suicide is one of life's most painful experiences. The feelings of loss, sadness, and loneliness experienced are often magnified in suicide survivors by feelings of guilt, confusion, rejection, shame, anger, and the effects of stigma and trauma. Furthermore, survivors of suicide loss are at higher risk of developing complicated grief, major depression, post-traumatic stress disorder, and suicidal

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behaviors (Tal Young et al., 2012). This seems to be multiple distresses to severe mentally ill patients and their caregivers who remain suffered from mental illness.

Suicidal behavior was classified into three categories: suicide-related ideation; suicide- related communication; and suicide-related behavior (Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007). Suicidal ideation is suicide-related ideation which individual has thoughts of taking their own lives; they may or may not go on to make a suicide attempt (Sun, 2011). On the other hands, suicidal attempt is suicide-related behavior which is defined as self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence of intent to die (Silverman et al., 2007). These two categories of suicidal behavior usually occurred with severe mentally ill patients. Interestingly, there were the studies found that the two highest-risk times for suicide are the first week after admission and shortly after discharge (Hawton & Van Heeringen, 2009; Knoll IV, 2012; Qin & Nordentoft, 2005). As a result, even patients obtained treatments, major risk factors for suicide in severe mentally ill patients are being confined to previous attempted suicide, and recent suicidal ideation (Hawton & Van Heeringen, 2009; McLean, Maxwell, Platt, Harris, & Jepson, 2008). However, these two suicidal behaviors are detectable and preventable.

Since last decade, approximately 60% to 70% of all suicides suffer from either major depression or bipolar illness (Bongar, 1998). It is estimated that, over a period of 10 to 15 years, 10% to 15% of all patients with depression, and schizophrenia will die by suicide (Keltner & Boschini, 2011). The most prevalent comorbidity in suicide for severe mentally ill patients were patients with mood disorders including major depressive disorder and bipolar disorder (Nock, Hwang, Sampson, & Kessler, 2010b),

and were patients with psychotic disorders including schizophrenia (Windfuhr & Kapur, 2011). The risk of suicide in patients with major depressive disorder is approximately 20% and in bipolar it is 15% (Gurney, 2009). Furthermore, there were the studies found that suicide is a major cause of death among patients with schizophrenia. There was a research indicates that at least 5–13% of schizophrenic patients die by committed suicide (Pompili et al., 2007).

According to mental health policy, gross national happiness and suicide rate are mental health indicators (Khon Kaen Rajanagarindra Psychiatric Hospital, 2012). There was the report expressed that Thailand was in second rank of happiness in ASEAN. However, Thailand was ranked number two of death from suicide in ASEAN while Singapore was ranked number one (Institute for Population and Social Research, 2014). Based on Ministry of Public Health data, Thailand was ranked number 71 in the world for the suicide problem (Thai health promotion Foundation, 2009). Moreover, there were data on the number of deaths and attempts from suicide occurring since 2011 until 2013 (Department of mental health, 2014). It was found that there were 3,873 deaths and 21,014 attempts, 3,985 deaths and 17,232 attempts, and 3,939 deaths and 39,560 attempts respectively. These data were shown increase in number of suicide attempt obviously. Even though mental health policy was proposed that suicide rate per 100,000 people have to be limited at ≤ 6.5 per year (Department of mental health, 2014), suicide rate in 2014 was increased from 6.07 to 6.31 in 2015 (National Centre for Suicide Prevention, 2015). In addition 41.89% of committed suicides are mentally ill patients (The National suicide prevention project of Thailand, 2011). There was a need for strategy to reduce suicide rate in this target group.

In Thailand, there was a depression surveillance system which one portion of this system was suicide prevention (Kongsuk et al., 2008). This prevention was used generally as suicide prevention for all health promotion hospital, general hospital, and also psychiatric hospital. In addition, this suicide prevention was not specified to severe mentally ill patients because the surveillance system was focus on general population who has depression. Even there were many strategies in the objective plans, those strategies were focused on depression reducing only. There also had the studies about caring for suicidal attempted patients protocol (Treyakul, Tapinta, & Wattanapong, 2008), cognitive behavioral therapy (Techanirattisai, 2008), and Satir's psychotherapy on suicide prevention (Inpun, 2008). However, these interventions were focus on depression, self care, and self-management. There was a few study focused on suicidal ideation and suicidal attempt. Moreover, there was a few study concentrated with severe mentally ill patients. Even there was a guideline for suicide prevention (Khon Kaen Rajanagarindra Psychiatric Hospital, 2012), there was mainly focused on suicide precaution in acute phase. In addition, this guideline was a multidisciplinary guideline which roughly displayed the overall image of prevention. There was a few confirmation of success in nursing implementation. Whereas nursing professional needs to strengthen nurse's role and potential according to theoretical framework which consistent with nursing task and responsibilities. Furthermore in rehabilitative phase, there was a few evident emphasized on reduction of suicidal ideation. As a result, there is a need for a systematic suicide prevention established for severe mentally ill patients that underlined on suicidal ideation and suicidal attempt reduction.

There are some models of suicide such as Beck et al (1974) has emerged hopelessness as a powerful and lethal factor in the context of clinical depression (Cutter, 1998). In addition Maris (1981), a sociologist, attempted to approach suicide with an integration of sociological, psychological, and psychiatric methods as well as existing knowledge(Cutter, 1998). Moreover, Ellis (1988) has reviewed prior efforts to define typologies and classification systems in dealing with the explanation of suicide(Cutter, 1998). However there is the current theory that attempts to address limitations of previous models by integrating theoretically meaningful and empirically supported aspects of other models.

In 2010, Van Orden and colleagues proposed the interpersonal theory of suicide. Briefly, this theory proposes that suicidal ideation is caused by two constructs that is the feeling that one does not belong to valued relationships or groups (Thwarted belongingness), combined with the perception that one is a burden on others (Perceived burdensomeness) (Van Orden et al., 2010). The theory also proposes that when acquired capability for suicide is occurred as the third construct, person will engage in suicidal attempt (Van Orden, Talbot, & King, 2012). This theory also emphasize on factors associated with each construct. Consequently, this theory was used as a theoretical framework of the interpersonal need program conducted base on risk factors for suicide in severe mentally ill patients and involved role of psychiatric mental health nurses.

From literature review, there are several risk factors for suicide in severe mentally ill patients. In this study the researcher focused on the risk factors associated with thwarted belongingness, perceived burdensomeness, and capability for suicide which are manageable and modifiable. Those factors are intimate partner conflict;

firearms in the home; legal charges or financial problems; incarceration; physical illness and functional impairment (Litts, Radke, & Silverman, 2008). Moreover, there are deteriorating health after a high level of premorbid functioning, recent loss or rejection, limited external support, and family stress or instability as risk factors for suicide in these patients as well (Pompili et al., 2007). In addition the other factors proposed in several studies are social isolation (Litts et al., 2008; Morrison, 2009; Pompili et al., 2007), unemployment (Morrison, 2009; Ruengorn, 2011), living in rural areas with access to guns or other lethal means, poverty (Morrison, 2009), self-hated and rejection (Murray & Upshall, 2009), the burden they perceived as having placed on others (Murray & Upshall, 2009), a few family support (Kim et al., 2010), deliberate self-harm (Pompili et al., 2007), and previous suicide attempt (Beautrais, Gibb, Faulkner, Fergusson, & Mulder, 2010; Kim et al., 2010; Litts et al., 2008; Ruengorn, 2011). In order to conduct the interpersonal need program, the researcher placed important on these factors and identify each factors into the constructs of the interpersonal theory of suicide. By this way we could handle these factors to reduce suicidal ideation and suicidal attempt efficiently.

Particularly in Thailand, average length of stay in psychiatric hospital was about four weeks (Department of mental health, 2015). Evidences were shown that the risk for suicide was extremely high in the first week after admission and particularly in the first week after discharge (Hawton & Van Heeringen, 2009; Qin & Nordentoft, 2005). After admitted in inpatient psychiatric hospital there was suicidal death 9 % within one day of discharge (Litts et al., 2008). In conclusion, first week after admission and first week after discharge are high risk for suicide. However, first week after admission was in acute phase, nursing care in this phase was focused on

assessment and precaution. While there was a study show that pre-discharge phase or maintenance phase is appropriate for rehabilitation including reattempt suicide prevention (Thowcharoen, Suttharangsee, & Inthanon, 2014). Consequently, the interpersonal need program was established within two weeks of rehabilitative phase in the hospital and required intervention within the first week after discharge. According to mental health and psychiatric nursing, it is an interaction with caring relationship. Psychiatric and mental health nurses are in a unique position to hear and to understand the client's unique patterning within the context of living with mental illness (Montgomery & Kirkpatrick, 2002). Consistent with these is the interpersonal need theory which developed from the interpersonal constructs. Consequently, the interpersonal need program was conducted bases on nurse's role in order to reduce suicidal ideation and suicidal attempt in severe mentally ill patients that would decrease suicide rate in this group and maintain their ability to live as well.

Research question

Does the interpersonal need program reduce suicidal ideation and suicidal attempt in severe mentally ill patients?

Research objectives

1. To compare the differences of suicidal ideation and suicidal attempt between severe mentally ill patients who receive the interpersonal need program and those who receive usual care.

2. To compare the differences of suicidal ideation and suicidal attempt among pre and post intervention in severe mentally ill patients who receive the interpersonal need program.

Theoretical framework

Theoretical framework of this program was derived from the interpersonal theory of suicide (Van Orden et al., 2010). This theory was developed from Joiner's interpersonal- psychological theory of suicide (Joiner, 2005). The interpersonal theory of suicide was proposed that suicidal ideation is caused by the feeling that one does not belong to valued relationships or groups (Thwarted belongingness) combined with the perception that one is a burden on others (Perceived burdensomeness). This theory is also described that not all who have suicidal ideation are capable of engaging in suicidal attempt; rather, individuals must acquire the capability for suicide by habituating to the fear and pain involved in self-harm, through the experience of physically painful or frightening experiences (Acquired capability for suicide) (Van Orden et al., 2012).

The interpersonal need program was designed to systematize nursing intervention in rehabilitative phase and after discharge phase for severe mentally ill patients with suicidal ideation or suicidal attempt. This group of patients may attempt or reattempt if risk factors were not changed or removed. Nursing activities in this program were aimed to reduce suicidal ideation and suicidal attempt by targeted to manage risk factors in these three constructs according to the interpersonal theory of suicide as followed.

1. **Thwarted belongingness** This first construct is comprised two components: the absence of reciprocally caring relationship, and loneliness. The absence of reciprocally caring relationships is conceptualized as ones in which individuals both feel cared about and demonstrate care of another. For relationships to meet the need to belong, they must be characterized by positive feeling and must

occur in a supportive context. In addition, loneliness is conceptualized as an affectively laden cognition that one has too few social connections (Van Orden et al., 2010). In severe mentally ill patients, the absence of reciprocally caring relationships risk factors are social isolation (Litts et al., 2008; Morrison, 2009; Pompili et al., 2007), and intimated partner conflict (Litts et al., 2008) . While the loneliness risk factors are a few family support; less than one family visitation to the hospital per month (Kim et al., 2010), family stress or instability, and limited external support (Pompili et al., 2007). To release thwarted belongingness in severe mentally ill patients, caring relationship could be established and loneliness could be decreased or modify. Moreover Social support could be set up by cooperation of family.

2. **Perceived burdensomeness** This construct is comprises of two components. The first component is affectively laden cognitions of self-hatred, and the second component is beliefs that the self is so flawed as to be a liability on others. The perception of burdensomeness in this construct is broader in that not only limited to family members but also on significant others (Hill & Pettit, 2014; Van Orden et al., 2010). The self hate risk factors are filled with self hated and rejection (Murray & Upshall, 2009). In addition the liability risk factors are: negative life events (being unemployed, recent loss or rejection, incarceration, legal charges or financial problem, physical illness, functional impairment, and deteriorating health) (Litts et al., 2008; Morrison, 2009; Pompili et al., 2007), and perceived the burden they having placed on other (Litts et al., 2008; Murray & Upshall, 2009). Self esteem could be occurred instead of self-hate or self rejection in order to decrease perceived burdensomeness. In addition severe mentally ill patients could have their strategies to deal with negative life events or feeling about those events.

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3. **Acquired capability for suicide** The last construct is composed of two components: increased physical pain tolerance, and reduced fear of death. Both components are occurred through repeated practice and exposure. Furthermore, the most direct route to acquiring the capability for suicide is by engaging in suicidal behavior, either through suicide attempts, aborted suicide attempts, or practicing and/or preparing for suicidal behavior (Van Orden et al., 2010). The risk factors for both components are easy access to lethal means; living in rural area with access to gun or other lethal means (Morrison, 2009); firearm in the home (Litts et al., 2008), Deliberate self-harm (Pompili et al., 2007), and previous suicide attempt (Beautrais et al., 2010; Kim et al., 2010; Litts et al., 2008; Ruengorn, 2011). There could be helping from family or caregiver in order to remove lethal means from environment surround severe mentally ill patients. Furthermore, they could have strategies to decrease their capability for suicide.

Research hypothesis and rationales

According to the interpersonal theory of suicide, suicidal ideation was related to interpersonal need which was defined as the fundamental need for connectedness as the need to belong combined with the need for social competence. Suicidal ideation was resulted from unmet interpersonal need: an unmet need to belong results in thwarted belongingness which is the feeling that one does not belong to valued relationships or groups, and an unmet need for social competence results in perceived burdensomeness which is the perception that one is a burden on others. Thwarted belongingness was caused by the absence of reciprocally caring relationship and loneliness which made the patients felt like they were not belonged to a valued relationship. In addition, perceived burdensomeness was resulted from self-hate and

liability especially negative life event which induced the patients perceived that they were a burden on other. Furthermore, suicidal attempt was resulted from acquired capability for suicide which was defined as a sense of fearlessness about pain and death, and an elevated tolerance for physical pain in order to be capable of suicide (Van Orden et al., 2012; Van Orden et al., 2010).

To reduce suicidal ideation and suicidal attempt, the interpersonal need program comprised of two phases; rehabilitative phase of hospitalization which was conducted within two weeks, and after discharge phase which was conducted within one week. There were four parts of each phase as followed.

Part one was establishing caring relationship which was involved with total nursing intervention in this program. In this part, a nurse-patient relationship was initiated. The activity of caring was established through the nurse-patient relationship, and was specified in the care plan with the nurse's interventions (Gamez, 2009). This caring relationship was continued from beginning to the end of the program. The patients recognized a caring relationship as a social support. In addition, from the patient's perspective, nurse-patient relationship was a sense of spiritual connection. The highest quality of this connection is the 'life-giving nurse–patient relationship' which is greatly empowering for the patient (Halldorsdottir, 2008). This caring relationship was resulted in fulfillment of need to belong

Part two was promoting sense of belongingness which comprised of cognitive behavioral approach for patient to reduce loneliness, and psycho-education for family to promote positive relationship with patient. According to loneliness, there were the studies of interventions to reduce loneliness. These interventions were centered on cognitive and behavioral techniques including identifying automatic negative

thoughts, and cognitive restructuring (Masi, Chen, Hawkley, & Cacioppo, 2011; Meltzer et al., 2013). In addition, there was a study found that caregivers should have optimal level of knowledge to avert negative attitude to patients in the forms of stigmatization, stereotypy, expressed emotions and social alienation (Bhattacharjee et al., 2011). The main focus of the psycho-education for caregiver is on how to manage while looking after the patient, understanding their situation and hardships, preventing any relapse and how to provide them with support(Virtual medical center, 2008). From this part patients modified their thought about relationship among themselves and their family especially the significant person. Companionship was made after caregiver received psycho-education. Moreover, patients realized their family as a social support which reduced feeling of loneliness.

Part three was reducing perceived burdensomeness which consisted of cognitive behavioral approach, empowerment, and individual counseling for conducting safety plan. There was recommendation that the patients should be guided to identify and confront their feelings of being a burden, and be able to reconsider to perceptions of burdensomeness should they arise in the future (Van Orden et al., 2012). Furthermore, cognitive restructuring is one of the interventions which may provide a useful means for reducing burdensome cognitions (Hill & Pettit, 2014). Consistent with this study, patients who report no current suicide planning, therapist may still consider enacting suicide preventative measures, such as creating a suicide safety plan for handling negative life events effectively (Van Orden et al., 2012). In addition, patient empowerment interventions can be helpful in reducing self stigma among people with mental illnesses (Girma et al., 2013). In this part the patients learned about their ability and power even they have been a psychiatric patient.

They learned to modify their daily life and improved a sense of pride on themselves which reduced self-hate. Even if negative life events occur again, they would know how to deal with it that helped them improve their perceived burdensomeness.

With three parts above, suicidal ideation would be reduced, however, capability for suicide would be considered. Therefore, part four was disabling capability for suicide which comprised of individual counseling to conduct safety plan. In addition psycho-education was provided for family in order to remove any lethal means from their home. Assessing the degree to which the patients may possess the acquired capability for suicide had to be done. Their level of acquired capability for suicide must be addressed and therapist might working with patients to remove the guns from their home(Van Orden et al., 2012). Similarly, there was a suggestion that acquired capability may serve as a point of psycho-education. Such education may include a form of a stimulus control intervention where patients identify specific behaviors and situations that would further facilitate acquired capability, and therefore, should be avoided (Smith, Cukrowicz, Poindexter, Hobson, & Cohen, 2010). Moreover, client should discuss his or her suicide plans with a significant other who can provide support or remove any weapons or medications involved in the suicide plan (Stellrecht et al., 2006). Patients created a safety plan which is a task near the end of the intervention. Also therapist asked patients what they could do if they started to feel overwhelmed and began thinking they would be better off dead (Van Orden et al., 2012). Before discharge caregiver adjusted the environment in their home by removing any weapons or medications. In addition, the patients had safety plans as the guide for finding strategies to ask for help when the overwhelming suicide thought occur. As a result, suicidal attempt was decreased.

Furthermore, there were interventions for after discharge phase. Within one week after discharge there were four times of telephone counseling. According to telephone counseling, it was efficient and filled the gap of home visit. Patients were able to receive care and support in the comfort of their own home at a time that was convenient (Ho et al., 2011; Tutty, Simon, & Ludman, 2000). In addition, first week after discharge was the high risk duration for suicide (Litts et al., 2008; Qin & Nordentoft, 2005; Ruengorn, 2011). Therefore, each time of telephone counseling was conducted to reduce suicidal ideation and suicidal attempt after patients discharge from psychiatric hospital. The aims of this intervention were to follow up on thought modification about loneliness, to follow up with family on disabling capability for suicide; to follow up on thought modification about self hate; and to follow up on safety plan respectively. In addition telephone counseling was made to confirm caring relationship and terminated when reached the end of the program.

In conclusion, the interpersonal need would be fulfilled and the acquired capability for suicide would be removed. As a result suicidal ideation and suicidal attempt would be reduced. The hypotheses of this study were as follow:

1. Suicidal ideation in severe mentally ill patients after received the interpersonal need program had significantly lower than before received the interpersonal need program.

2. Suicidal ideation in severe mentally ill patients who received the interpersonal need program had significantly lower than in those who received usual care.

3. Suicidal attempt in severe mentally ill patients after received the interpersonal need program had significantly lower than before received the interpersonal need program.

4. Suicidal attempt in severe mentally ill patients who received the interpersonal need program had significantly lower than in those who received usual care.

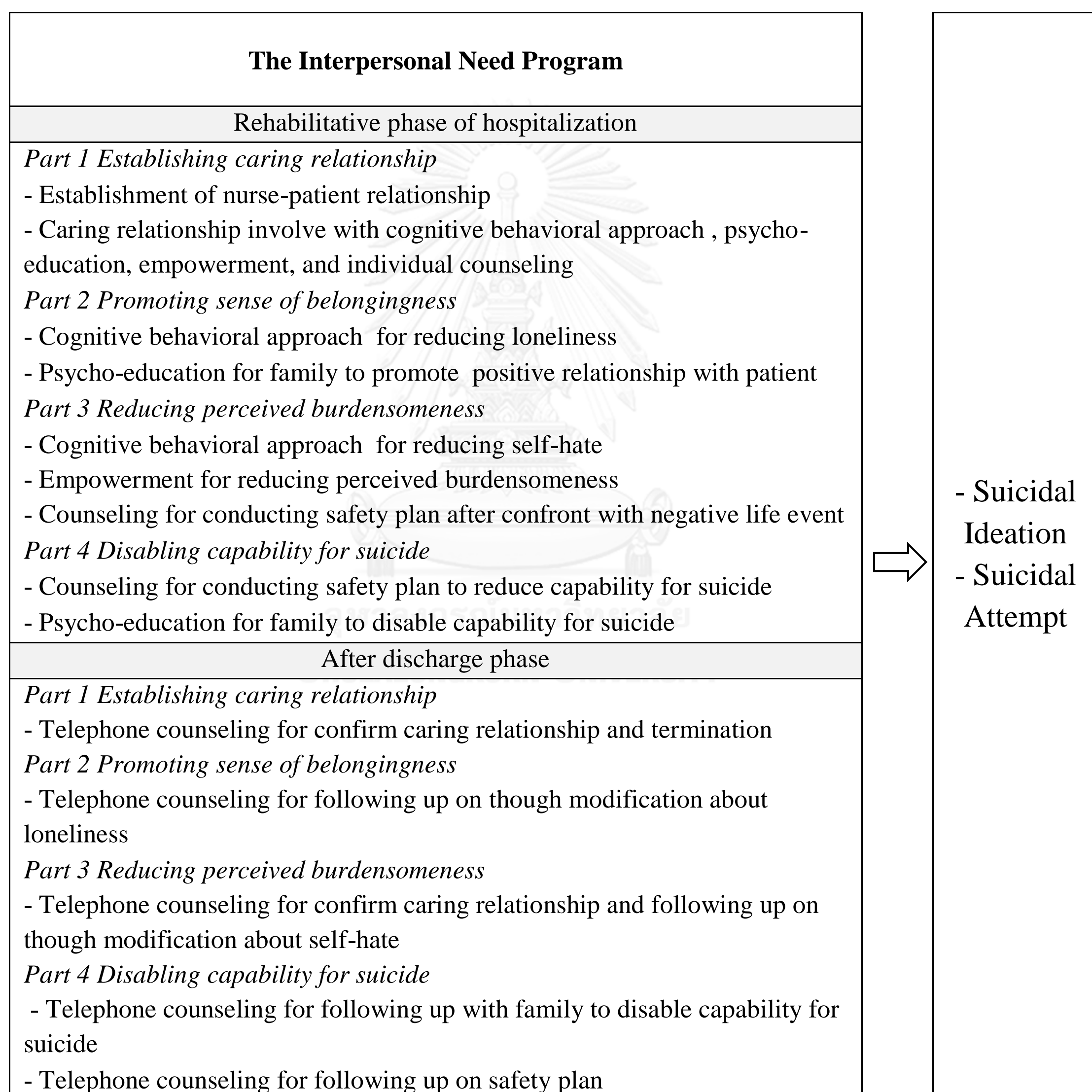

Figure 1 Conceptual framework of the study

Scope of the study

This study was a randomized control trial study using a pretest-posttest control group design (Shadish, Cook, & Campbell, 2002) that was established to evaluate effects of the interpersonal need program on suicidal ideation and suicidal attempt in severe mentally ill patients. Thus the independent variable of the study was the interpersonal need program whereas the dependent variables were suicidal ideation and suicidal attempt. The interpersonal theory of suicide (Van Orden et al., 2010) was used as a theoretical framework of the study. The populations of this study were Thai adult severe mentally ill patients who admitted at inpatient wards of psychiatric hospital in rehabilitative phase including their caregivers. The participants in the control group obtained usual care. On the other hand, the participants in the experimental group received the interpersonal need program

Operational definitions

1. **Suicidal ideation** was defined as a person's thought of taking their own lives including a plan regarding to end one's life. Suicidal ideation was measured by the scale for suicide ideation (SSI) (Beck, Brown, & Steer, 1997) which was translated into the Thai version of the scale for suicidal ideation (SSI-Thai version 2014) (Kittiteerasack & Muijeen, 2015). The intensity, duration, and specificity of psychiatric patient's plans and wishes to suicide were measured by this 19 items instrument.

2. **Suicidal attempt** was defined as a self-inflicted and potentially injurious behavior with the express purpose of ending one's life. The outcome of this behavior is non-lethal. Suicidal attempt depend on physician claims coding to identify.

The suicidal attempt record which developed by the researcher was used to record suicidal attempt according to psychiatrist diagnoses and suicidal attempt history.

3. **The interpersonal need program** was determined as the nursing intervention developed by using the interpersonal theory of suicide as theoretical framework. This program aimed to reduce suicidal ideation and suicidal attempt in severe mentally ill patients. The program consisted of four parts which conducted to manage risk factors in each component of three constructs. According to thwarted belongingness which was the first construct, part one was the establishing caring relationship which involved with other parts to manage the absence of reciprocally caring relationship. In addition, part two was the promoting sense of belongingness which conducted to manage loneliness by three times of cognitive behavioral approach, psycho-education for caregiver, and telephone counseling. In order to manage self-hate and liability in perceived burdensomeness construct, the reducing perceived burdensomeness was provided included three times of cognitive behavioral approach, empowerment, counseling and telephone counseling. For the last construct which was acquired capability for suicide, the disabling capability for suicide was produced to manage increased physical pain tolerance and reduced fear of death by counseling, psycho-education for caregiver, and telephone counseling. This interpersonal need program was conducted within two weeks of rehabilitative phase of hospitalization and one week of after discharge phase.

4. **Usual care** was referred to the nursing care which conducted by mental health and psychiatric nurses in rehabilitative phase of hospitalization. Usual care comprised of individual nursing care due to individual problem; discharge planning

which were group psycho-education; and psycho-education for family. The intensity of each activity was not specified.

Expected benefits

The interpersonal need program in this study could be used as a nursing practice guideline for psychiatric and mental health nurses to manage suicide prevention for severe mentally ill patients in order to reduce suicidal ideation and suicidal attempt in this group.

CHAPTER 2
LITERATURE REVIEW

The review describes the empirical finding related to the concept of suicide prevention on mentally ill patients. The review was divided into:

1. Severe mental illness
2. Suicide, suicidal ideation, suicidal attempt
3. Suicide in severe mentally ill patients
4. The interpersonal theory of suicide
5. Risk factors for suicidal ideation and suicidal attempt
6. Intervention for suicide prevention
7. Designing nursing intervention

1. Severe mental illness

Mental illness is the term that refers collectively to all diagnosable mental disorders whereas mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning (Goldman & Grob, 2006). In addition the American psychiatric association defines mental illness or mental disorder as an illness or syndrome with psychological or behavioral manifestations and/or impairment in functioning due to a social, psychological, genetic, physical/ chemical, or biological disturbance. The disorder is not limited to relationship between the person and society. The illness is characterized by symptoms and/ or impairment in function (American psychiatric association, 1994 cited in Shives, 2005).

Shives (Shives, 2005) describes characteristics of mental illness patient which including feels inadequate to self and others; has poor self-concept; is unable to cope

with stress; exhibits maladaptive behavior if temporarily disturbed; is unable to establish a meaningful relationship; displays poor judgment to make decision; is irresponsible or unable to accept responsibility for actions; is pessimistic; does not recognize limitations (abilities and deficiencies); exhibits dependency needs because of feelings of inadequacy; is unable to perceive reality; does not recognize potential and talents because of poor self-concept; avoids problems rather than coping with them or attempting to solve them; and desires or demands immediate gratification. In summary, mental illness reflects a person's inability to cope with stress, resulting in disruption, disorganization, inappropriate reactions, unacceptable behavior, and the inability to respond according to the person's expectations and the demands of society.

The current classification of mental illness is based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000). The most prevalent comorbidity in suicide were in patients with mood disorders including major depressive disorder and bipolar disorder (Nock, Hwang, Sampson, & Kessler, 2010a), and in patients with psychotic disorders including schizophrenia (Windfuhr & Kapur, 2011).

Severe mental illness is synonymous with both chronic mental illness and persistent mental illness. The term severe, chronic, and persistent, identify the gravity of the diagnosis. Chronic mental illness tends to last for a long time, if not a lifetime, and maybe characterized by periods of relapse or recurrence (Ballard, 2008). Severe mental illness presents a considerable challenge to clients and their families or significant others because it occurs over a long period, with accompanying and varying stages of grief and loss. All psychiatric disorders have the potential to persist

and become severe. However, schizophrenia, major depressive disorder, and bipolar disorder are the most prevalent of severe mental illness(Ballard, 2008).

1.1 Major depressive disorder

Major Depressive Disorder (MDD) is distinguished from everyday feelings of sadness by its duration and severity (Rodiguez, 2009). Depressive symptoms may range from mild, such as 'feeling blue', to very severe, where there is extraordinary sadness and dejection, and an inability to take pleasure in activities. The illness is described as major depressive disorder if the depressive symptoms are all-pervasive and deliberating in most areas of the client's existence (Athanasos, 2009).

Major depression is characterized by seven main features: low mood, lack of energy, lack of pleasure or interest in activities, negative thinking, disturbed sleep, difficulty concentrating and recurring thought of death and suicide (Athanasos, 2009). The classification of depressive disorders based on DSM-IV-TR (American Psychiatric Association, 2000) classified a major depressive episode as at least five of the following symptoms have been present during the same 2 weeks period and represent a change from previous functioning.

Those symptoms are: depressed mood most of the day, nearly every day, as indicated either by subjective report or observation made by others; markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day; significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day; insomnia or hypersomnia nearly every day; psychomotor agitation or retardation nearly every day; fatigue or loss of energy nearly every day; feelings of worthlessness or excessive or inappropriate guilt nearly every day; diminished ability to think or concentrate, or indecisiveness, nearly every day;

and recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide

1.2 Bipolar disorder

The occurrence of manic episodes with depressive disorder is called bipolar disorder (American Psychiatric Association, 2000; Athanasos, 2009). According to manic episode, mania is characterized by three main features: persistently elevated mood, which may be one of elation or irritability; increased activity; and poor quality of judgment. Although the name bipolar disorder suggests two categories of symptoms: depression, and mania, it does not require a depressive episode for the diagnosis to be made. There are individuals suffering from bipolar disorder who have never had a depressive episode. In general, the disorder is characterized by a cycling between depression and normal mood and mania. This may occur over periods of time from days to weeks to months (Athanasos, 2009).

The DSM-IV-TR (American Psychiatric Association, 2000) classified bipolar disorders as: Bipolar I Disorder that the essential feature of bipolar I disorder is a clinical course that is characterized by the occurrence of one or more manic episodes or mixed episodes. On the other hand, Bipolar II Disorder which the essential feature of bipolar II disorder is a clinical course that is characterized by the occurrence of one or more major depressive episodes accompanied by at least one hypomanic episode.

According to criteria for a manic episode, during the period of mood disturbance, three or more of the following symptoms have persisted and have been present to a significant degree: inflated self-esteem or grandiosity; decreased need for sleep; more talkative than usual or pressure to keep talking; flight of ideas or subjective experience that thoughts are racing; distractibility or psychomotor

agitation; excessive involvement in pleasurable activities that have a high potential for painful consequences. However, criteria for a mixed episode are met both for a manic episode and for a major depressive episode nearly every day during at least a 1-week period. In contrast, criteria for a hypomanic episode have a distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual non-depressed mood.

1.3 Schizophrenia

Schizophrenia is a disorder characterized by a major disturbance in thought, perception, cognition and psychosocial functioning and is one of the most severe mental disorders (Bardwell, 2009). American Psychiatric Association (2000) identified in The DSM-IV-TR that the essential features of schizophrenia are a mixture of characteristic signs and symptoms both positive and negative that have been present for a significant portion of time during a 1-month period, with some sign of the disorder persisting for at least 6 months (American Psychiatric Association, 2000).

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These signs and symptoms are associated with marked social or occupational dysfunction. The disturbance is not better accounted for by schizoaffective disorder or a mood disorder with psychotic features and is not due to the direct physiological effects of a substance or a general medical condition. In individuals with a previous diagnosis of autistic disorder, the additional diagnosis of schizophrenia is warranted only if prominent delusions or hallucinations are present for at least a month.

2. Suicide, suicidal ideation, and suicidal attempt

2.1 Suicide

Suicide is the deliberate and conscious attempt to kill oneself. May be either completed which results in death or attempted (Elder, Evans, & Nizette, 2012). It was Schneidman, founders of suicidology, said that suicide is associated with thwarted or unfulfilled needs, feeling of hopelessness and helplessness, ambivalent conflicts between survival and unbearable stress, a narrowing of perceived options, and a need to escape (Schneidman, 1966 cited in Shives, 2005). Moreover, for a client who feels suicidal, they may not be able to see a future and find it very difficult to imagine a way of resolving how they feel (Noonan, 2009).

Suicide is a complex bio-psychosocial phenomenon influenced by a person's cultural beliefs, values, and norms (Keltner & Boschini, 2011). This phenomenon includes the death of those who intended to kill themselves and individuals with patterns of self-harm who accidentally die as a result of their injuries. (Bongar, 2002 cited in Noonan, 2009). Terminology commonly used to describe the range of suicidal thoughts and behaviors referred to as "the suicidal lexicon" including (Badger, 1995 cited in Shives, 2005): suicidal ideation, which refers to vague, fleeting thoughts about wanting to die; suicidal intent, which refers to thoughts about a concrete plan to commit suicide; suicidal threat, which refers to the expression of a person's desire to end his or her life; suicide gesture, which refers to intentional self- destructive behavior that is clearly not life-threatening but does resemble an attempt suicide; and suicidal attempt, which refers to self-destructive behavior by which an individual responds to ambivalent feeling about living.

Nock and colleagues defined suicide as the act of intentionally ending one's own life. They divided suicide into fatal and non-fatal according to the outcome of behavior. Non-fatal suicidal thoughts and behaviors (hereafter called ''suicidal behaviors'') are classified more specifically into three categories: suicide ideation, which refers to thoughts of engaging in behavior intended to end one's life; suicide plan, which refers to the formulation of a specific method through which one intends to die; and suicide attempt, which refers to engagement in potentially self-injurious behavior in which there is at least some intent to die. Moreover, most researchers and clinicians distinguish suicidal behavior from non-suicidal self injury, which refers to self injury in which a person has no intent to die (Nock et al., 2008).

As Stuart (Stuart, 2009) stated that suicidal behavior is divided into four categories: Suicide ideation: the thought of self-inflicted death, either self-reported or report to other. In addition suicidal ideation may vary in seriousness. It can be passive, when there are only thoughts of suicide with no intent to act; or active, when there are plans or thoughts of causing one's own death; suicide threat: a warning, direct or indirect, verbal or nonverbal, that a person is planning to take one's own life. It may be subtle but usually occurs before overt suicide activity take places; Suicide attempt: any self-directed action taken by a person that will lead to death if not stopped. People who have previously attempted suicide are the most likely to successfully commit suicide; Committed suicide, or completed suicide, or simply suicide: death from self-inflicted injury, poisoning, or suffocation where there is evidence that the decedent intended to kill himself or herself. Completed suicide may take place after warning signs have been missed or ignored.

Moreover, Keltner & Boschini (Keltner & Boschini, 2011) described about suicide nomenclature that suicide ideation includes a person's thought regarding suicide, as well as suicidal gestures and treats. While suicidal gestures are a person's nonlethal self-injury acts, including cutting or burning of skin areas or ingesting small amounts of drugs. Others often see these gestures as attention-getting measures and do not consider them to be serious problems that might lead to a suicide attempt or completion. Moreover, suicidal threats are a person's verbal statements that might declare their intent to commit suicide. In addition suicidal attempt is the actual implementation of a self-injurious act with the express purpose of ending one's life.

In this study, the researcher was interested in suicidal ideation and suicidal attempt as the dependent variables. As the researcher considered definition of all term then found that suicidal ideation usually refers to thought that involved plan, while suicidal attempt usually refers to action.

2.2 Suicidal ideation

Shives (Shives, 2005) mentioned that suicidal ideation refers to vague, fleeting thoughts about wanting to die. Related to Nock and colleagues (Nock et al., 2008), suicide ideation refers to thoughts of engaging in behavior intended to end one's life. As same as Keltner & Boschini (Keltner & Boschini, 2011), suicide ideation includes a person's thought regarding suicide. In addition, Sturt (Stuart, 2009)explained that suicide ideation is the thought of self-inflicted death, either self-reported or report to other. Suicidal ideation may vary in seriousness. It can be passive, when there are only thoughts of suicide with no intent to act; or active, when there are plans or thoughts of causing one's own death. Moreover, suicidal ideation is defined as suicide-related ideation which individual has thoughts of taking their own lives;

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they may or may not go on to make a suicide attempt (Beck, Kovacs, & Weissman, 1979 cited in Sun, 2011).

In order to measure suicide ideation, the Scale for Suicide Ideation (Beck et al., 1997) was used to rate the severity of a patient's suicidal and plans. This scale consists of 19 items that are rated on a 3-point scale of suicidal intensity ranges from 0 to 2. The ratings are summed to yield a total score which can range from 0 to 38. This instrument was translated into the Thai version of the scale for suicidal ideation (SSI-Thai version 2014) (Kittiteerasack & Muijeen, 2015). The instrument testing showed the psychometric properties that SSI-Thai version 2014 had content validity index (CVI) of .89. In addition, the Cronbach's alpha coefficient was .81 and an index of item discrimination was more than 2 ($p < .001$) (Kittiteerasack & Muijeen, 2015).

2.3 Suicidal attempt

As we know that suicidal attempt is any act inflicted with self destructive intention, however vague and ambiguous (Stengel, 1965 cited in Noonan, 2009). An attempt to suicide is often reported by clients as reflecting their feeling of powerlessness or the experience of loss and disappointment, where they want freedom from the psychic pain they feel rather than actually wanting to die (Telseth, Jacobson, Norberg, 2001 cited in Elder et al., 2012).

Suicidal attempt refers to self-destructive behavior by which an individual responds to ambivalent feeling about living (Shives, 2005). It is any self-directed action taken by a person that will lead to death if not stopped (Stuart, 2009). Moreover, suicidal attempt was defined as suicide-related behavior which is defined as self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence of intent to die (Silverman et al., 2007). In addition, suicide attempt

refers to engagement in potentially self-injurious behavior in which there is at least some intent to die (Nock et al., 2008). This definition in consistent with Keltner & Boschini, Suicidal attempt is the actual implementation of a self-injurious act with the express purpose of ending one's life (Keltner & Boschini, 2011). In addition to strictly speaking, a "true" suicidal attempt should refer only to those who failed to die after having tried to kill themselves (De Leo, Bille-Brahe, Kerkhof, & Schmidt, 2004).

In order to record suicidal attempt, this term is defined as the presence of any of hospital abstracts or physician claims coding a suicide attempt using definitions derived from the hospital and/or the physician claims files (Martens, Fransoo, & McKeen, 2004). The suicidal attempt record which developed by the researcher was used to record suicidal attempt. This instrument had the first item with "had suicidal attempt" or "did not have suicidal attempt" which identified by physician. If the answer was "did not have suicidal attempt", previous suicidal attempt history was recorded. On the other hand if the answer was "had suicidal attempt", details were recorded including date, time, place, method, negative life events due to suicidal attempt, and previous suicidal attempt history

3. Suicide in severe mentally ill patients

Suicide might occur in children, adolescents, and adult (Keltner & Boschini, 2011). It occurs in all parts of our society and in all regions, affecting people of all ages. No group is immune but there are some groups at greater risk (Insel, 2012). Suicide is a serious risk in all kinds of depression because depression is associated with an increased risk of attempting and completing suicide (Athanasos, 2009). Therefore people who are seriously depressed or who express feelings of

worthlessness, guilt, anxiety, and anger, and display severe agitation and irritability, may be at risk of suicide (Morrison, 2009). As a result patients with mood disorders who have characterized by depressive episode are at greater risk of suicide.

However, not all suicides or attempted suicides are by individuals with a clinical diagnosis of depression. Stressful and negative life events can become triggers for suicidal ideation and attempts such as drug or alcohol abuse. Other mental illness, such as schizophrenia or bipolar disorder, can be prominent (Morrison, 2009). Nevertheless mood disorders are very common among individuals who commit suicide, with 36-70 percent of individuals having a mood disorder at the time of death (U.S department of health and human services, 2001). While some people commit suicide for reasons other than depression, of those people who lose their lives, approximately 40-60% has recently been in a depressive episode (Athanasos, 2009).

Moreover, depression represents the single most important cause of suicide among person with schizophrenia, just as it does among person without schizophrenia. The majority of patients will experience significant depression at some point during the course of their illness (Torrey, 2006). Consequently, depressive symptoms are frequently a part of the psychopathology of schizophrenia, with some studies suggesting that approximately 75% of schizophrenic patients experience depression (Keltner & Boschini, 2011).

The study by Keltner & Boschini found that when those with a “non-depression” background kill themselves, they are typically suffering through a period of depression (Keltner & Boschini, 2011). Specifically, a significant number of people (10%) with the diagnosis of schizophrenia end their own lives. Related to Torrey, suicide is the number one cause of premature death among schizophrenia, with 10 to

13 percent killing themselves, and a more recent estimate was five percent (Torrey, 2006). Among individuals in the general population, the suicide rate is approximately one percent.

Occasionally persons with schizophrenia will commit suicide accidentally in a stage of acute psychosis. Most suicides in schizophrenia are intended, however, and are often carefully planned by the person (Torrey, 2006). Furthermore, these symptoms can occur at any time during the illness, including years after the acute phase, but they do respond to antidepressants (Keltner & Boschini, 2011). However, it is ambivalence, where the persons want to escape from their feelings but retains an underlying desire to live, that nurses can try to understand and access when they work with the person who is suicidal (Elder et al., 2012).

The death by suicide of psychiatric patients is of particular importance to the nurse because of opportunities for assessment and intervention (Keltner & Boschini, 2011). The most important thing is to be alert for it, especially in an individual who is depressed and who has recently recovered from a relapse. Past suicide gestures or attempts are an important predictor of future attempts. Expression of guilt and worthlessness, hopelessness about the future, unwillingness to make plans for the future, and putting one's affairs in order are all red flags that may indicated serious suicidal intent (Torrey, 2006). The literature above indicates that suicide in severe mentally ill patients must be considered as the high prevalence of premature deaths.

4. The interpersonal theory of suicide

The interpersonal theory of suicide is a comprehensive theory that was developed from Joiner's interpersonal- psychological theory of suicide Joiner (2005)

by Van Orden, and colleagues. The theorist propose that the most dangerous form of suicidal desire is caused by the simultaneous presence of two interpersonal constructs: thwarted belongingness and perceived burdensomeness and further that the capability to engage in suicidal behavior is separate from the desire to engage in suicidal behavior (Van Orden et al., 2010).

4.1 Defining suicidal behavior

The primary focus in the current theoretical account is on near-lethal and lethal suicide attempts. The nomenclature states that suicide attempts possess the following qualities: (a) self-initiated, potentially injurious behavior; (b) presence of intent to die; and (c) nonfatal outcome. The term suicide is reserved for those cases in which a suicide attempt results in death. As this distinction is potentially confusing, whenever possible, this theory refer to nonlethal suicide attempts versus lethal suicide attempts, with the latter term synonymous with deaths by suicide. The definitional issues reviewed above regarding distinctions among ideations, attempts, and deaths highlight the multidimensional nature of suicide and suicide-related behaviors (Van Orden et al., 2010).

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4.2 Empirical and theoretical foundations

The theorists examine the literature on risk factors for suicidal behavior and follow it with a discussion of theoretical perspectives. The literature indicates the most consistent and robust support for the following as risk factors for suicide: mental disorders, previous suicide attempt, social isolation, family conflict, unemployment, physical Illness, and other Risk Factors such as agitation, hopelessness, sleep disturbances including nightmares, severely stressful life events (Van Orden et al., 2010).

4.3 Theoretical perspectives

The theorists propose that theories of suicide should be able to account for the diverse array of factors associated with lethal suicidal behavior. Their review of risk factors indicates the most robust support for associations with suicide and mental disorders, previous suicide attempts, social isolation, family conflict, unemployment, and physical illnesses. Thus, a theory of suicide should illuminate how these diverse factors are related to suicidal behavior (Van Orden et al., 2010).

4.4 Constructs of the Interpersonal Theory of Suicide

The foundation of the interpersonal theory of suicide is the assumption that people die by suicide because they can and because they want to. Within the framework of this theory, three constructs are central to suicidal behavior, two primarily related to suicidal desire: thwarted belongingness and perceived burdensomeness, and one primarily related to capability: acquired capability for suicide.

1. **Thwarted Belongingness**

Social isolation is one of the strongest and most reliable predictors of suicidal ideation, attempts, and lethal suicidal behavior across the lifespan. Social isolation can be conceptualized as measuring one facet of the higher order construct of social connectedness (or social integration), which can be measured at multiple levels (Berkman et al., 2000 cited in Van Orden et al., 2010). Thus, the interpersonal theory is consistent with past theoretical accounts of suicidal behavior through its proposal for a key role for social connectedness. Moreover, the interpersonal theory of suicide is proposed that thwarted belongingness is a multidimensional construct while

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an unmet "need to belong" is the specific interpersonal need involved in desire for suicide.

The theorists conceptualize the two dimensions of interpersonal functioning that are posited to compose thwarted belongingness as loneliness and the absence of reciprocally caring relationships. These constructs are depicted in Figure 2 as latent variables caused by the latent construct of thwarted belongingness.

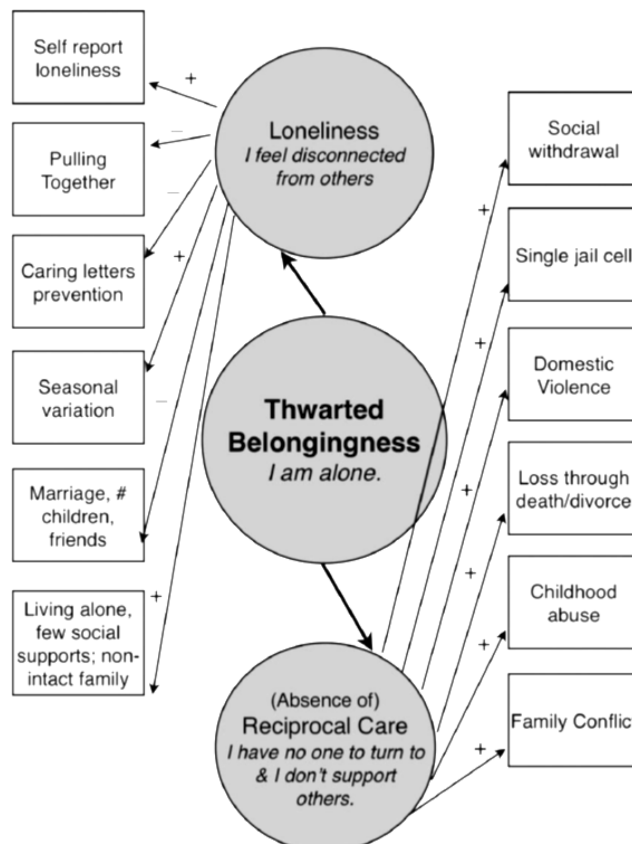

Figure 2 Dimensions and indicators of thwarted belongingness

(Van Orden et al., 2010)

A+ sign indicates a positive association; A - indicates a negative association

In addition to depicting the multidimensional nature of thwarted belongingness, Figure 1also further clarifies the definitions of these constructs by including observable indicators of the constructs of loneliness and reciprocally caring relationships. All of observable indicators are associated with elevated risk for lethal suicide attempts. The loneliness factor is posited to give rise to six observable risk factors for lethal suicidal behavior: self-report loneliness, pulling together effects, caring letters interventions (interventions designed to increase social contacts through long-term follow-ups, thereby decreasing loneliness and thus lowering risk for suicide), seasonal variation (reductions in social interactions that lead to increased feelings of loneliness have been posited as the mechanism whereby the spring peak in lethal suicidal behavior occurs), presence of marriage and number of children and friends, and living alone and reporting few to no social supports. The absence of reciprocally caring relationships factor is posited to give rise to six observable risk factors for lethal suicidal behavior: social withdrawal, low openness to experience, residing in a single jail cell, domestic violence, childhood abuse, and familial discord (Van Orden et al., 2010).

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2. Perceived Burdensomeness

The elevated likelihood of developing perceptions of burdensomeness on others is the common thread among family conflict, unemployment, and physical illness that can account for the associations with suicide. These three factors are all types of negative life events that are the most robust support for their association with suicide. In this theory, perceptions of burdensomeness on close others are not limited to only family members. This construct comprises of two dimensions of interpersonal

functioning: beliefs that the self is so flawed as to be a liability on others and affectively laden cognitions of self-hatred as in Figure 3 (Van Orden et al., 2010).

The liability factor is posited to give rise to six observable risk factors for lethal suicidal behavior: distress caused by unemployment, distress from incarceration, homelessness, serious physical illnesses, and direct statements in suicide notes or verbal communications that individuals perceive that they are expendable, unwanted, or burdens on others. It should be noted that in the vast majority of cases (if not all), these perceptions of liability are misperceptions amenable to therapeutic modification. The other dimension of perceived burdensomeness is the affectively laden construct of self-hate, with three corresponding observable indicators with empirically demonstrated associations with lethal suicidal behavior: low self-esteem, self-blame and shame, and mental state of agitation (in part, because it indicates that an individual may be experiencing a degree of self-hatred and anguish that is so elevated as to manifest physiologically) (Van Orden et al., 2010).

This theory is taken the former stance and proposed that when an individual holds perceptions of burdensomeness for all significant others in his or her life and the person endorses some degree of self-hate regarding those perceptions, a critical threshold is crossed and it is this severe level of perceptions of burdensomeness that is relevant to the theory. There are relations between thwarted belonging and perceived burdensomeness. The theory involves the proposal that other more distal risk factors exert their influence on desire for suicide by increasing levels of thwarted belongingness, perceived burdensomeness, or some combination of the two (Van Orden et al., 2010).

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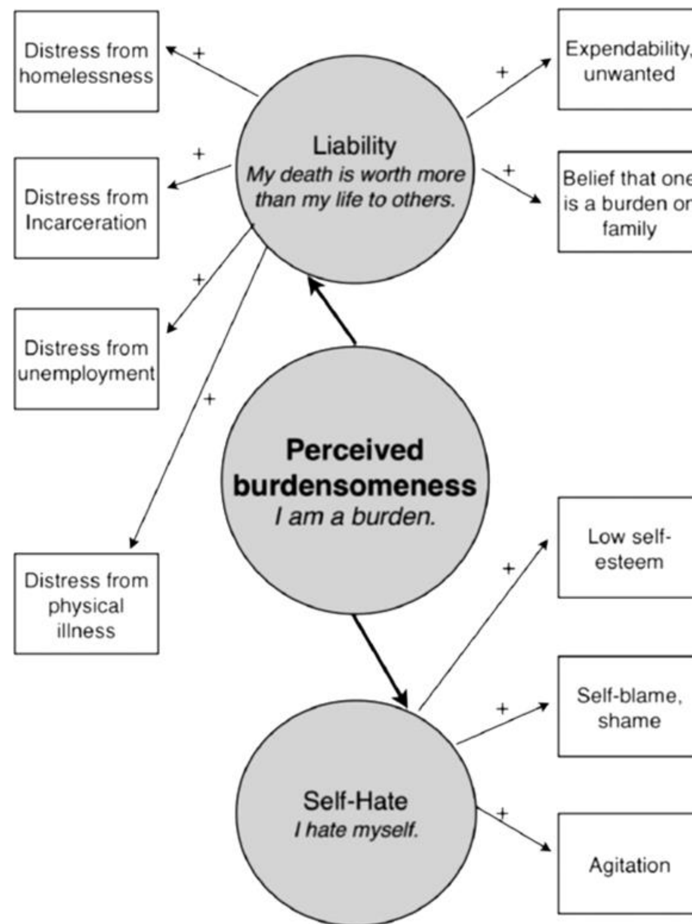

Figure 3 Dimensions and indicators of perceived burdensomeness

(Van Orden et al., 2010)

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A + sign indicates a positive association; A - sign indicates negative association

3. Acquired Capability for Suicide

The models of suicide assume that suicide is multi-factorial caused, such that suicidal ideation results from the fewest number of co-occurring risk factors, suicide attempts result from a greater number, and death by suicide results from the co-occurrence of the greatest number. These models also assume that risk for suicide is elevated due to greater risk for suicidal desire and, perhaps, increasingly severe forms of suicidal desire (Van Orden et al., 2010).

Despite desire to die by suicide is not sufficient for lethal suicidal behavior to result, because dying by suicide is not an easy thing to do. According to the theory, to die by suicide, individuals must lose some of the fear associated with suicidal behaviors, and it would be very uncommon (if not impossible) to find someone born with a level of fear low enough to engage in suicide. Hence the interpersonal theory draws on and extends evolutionary models of fear and anxiety by proposing that humans are biologically prepared to fear suicide because suicidal behavior involves exposure to stimuli and cues that have long been associated with threats to survival (Van Orden et al., 2010).

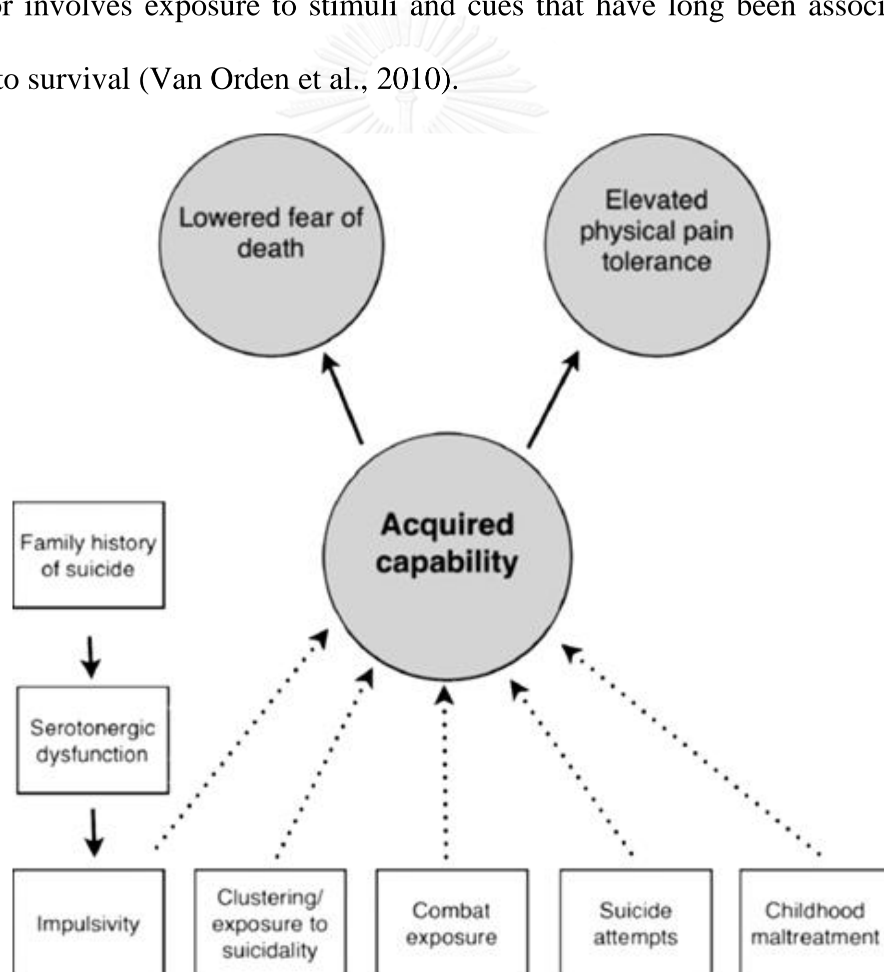

Figure 4 Dimensions and indicators of acquired capability for suicide

(Van Orden et al., 2010)

Dotted arrows represent habituation and strengthening of opponent process

According to Figure 4, it is possible to acquire the capability for suicide, which is composed of increased physical pain tolerance and reduced fear of death through habituation and activation of opponent processes in response to repeated exposure to physically painful and/or fear-inducing experiences. In other words, through repeated practice and exposure, an individual can habituate to the physically painful and fearful aspects of self-harm, making it possible for him or her to engage in increasingly painful, physically damaging, and lethal forms of self-harm. Further, acquired capability is presumed to be a multidimensional emergent latent variable that involves the dimensions of lowered fear of death and increased physical pain tolerance (Van Orden et al., 2010).

Fear of suicide is one category of reasons that individuals give when asked why they do not engage in suicidal behavior (Linehan et al., 1983 cited in Van Orden et al., 2010). These data suggest that suicidal desire must occur in the context of reduced fear of suicide. Fear of suicide is presumed to be a dimensional construct varying from very high levels to negligible levels of fear, and further, for active suicidal desire to progress toward more severe manifestations of suicide risk (i.e., intent for suicide), fear must be reduced to the point that individuals endorse a nonzero degree of fearlessness regarding suicidal actions (Van Orden et al., 2010).

Furthermore, dying by suicide is not only frightening, but physically painful. The latter finding indicates that elevated pain tolerance is likely specific to suicidal behavior rather than physical injury. In addition, more serious levels of suicidal ideation have been shown to predict higher levels of self-administered shock (Berman & Walley, 2003 cited in Van Orden et al., 2010). Pain tolerance is conceptualized as a dimensional phenomenon. What level of pain tolerance is

necessary to allow lethal (or near lethal) suicidal behavior to occur? First, this construct is likely highly method-specific, thus someone gaining the requisite pain tolerance to engage in cutting behaviors will not necessarily have gained the same tolerance for other methods, such as jumping. In this way, the theorists are able to provide an explanation for data indicating that method substitution does not typically occur. In addition, the type of actions involved must also be considered. This theory is proposed that both expectations about pain-to-be-experienced, physiological habituation to physical pain sensations, and cognitive appraisals of the tolerability of expected and/or experienced pain are key factors in determining individuals' tolerance for the pain involved in a specific suicide method (Van Orden et al., 2010).

The theory also includes a specification of the relations between these constructs in the form of four hypotheses and thereby includes a specification of a causal pathway for the development of the desire for suicide and the capability to engage in serious suicidal behavior (i.e., lethal or near-lethal attempts). As Figure 5, this theory is described both the theory's constructs and its hypotheses with a level of detail that opens it to possible falsification and invites tests of its hypotheses and comparisons with other theories of suicidal behavior (Van Orden et al., 2010).

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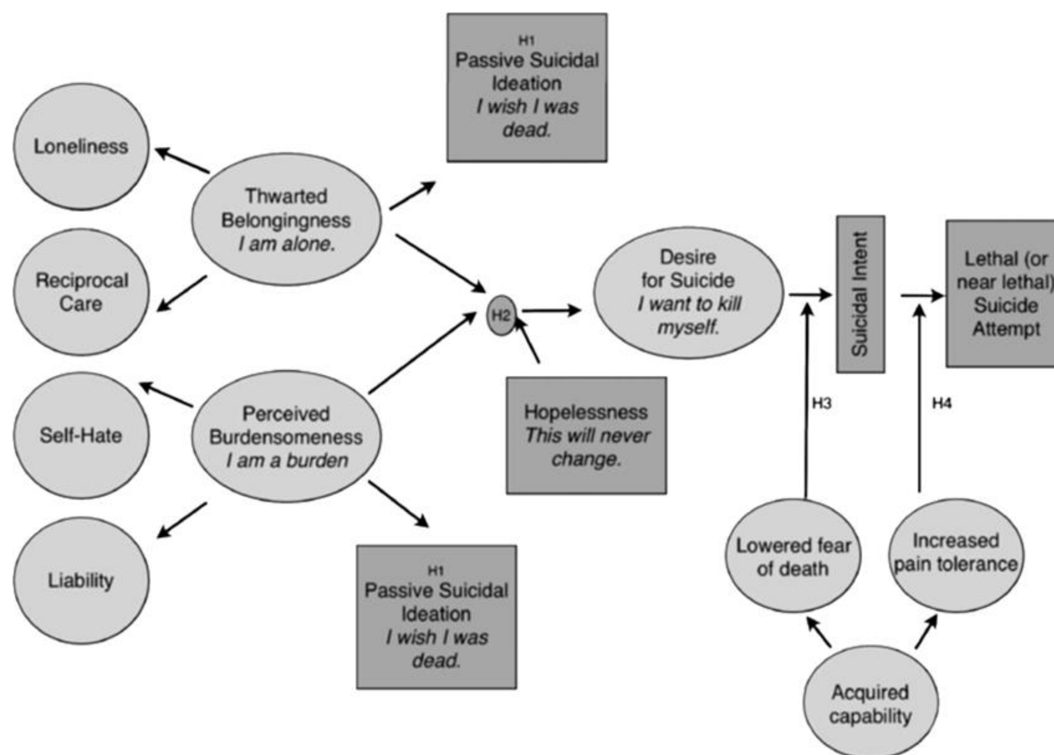

Figure 5 Casual pathways to lethal suicidal behavior (Van Orden et al., 2010)

5. Risk factors for suicide in severe mentally ill patients

Risk factors may be thought of as leading to or being associated with suicide; that is, people "possessing" the risk factor are at greater potential for suicidal behavior. In addition to the technical report on suicide prevention efforts for individuals with serious mental illness, there were the multiple risk factors acting together, rather than any single risk factor acting alone, and buffered by certain protective factors greatly influence the extent to which suicide attempts occur (Litts et al., 2008). The complex set of risk factors can interact and reinforce each other.

There were the categories of risk factors for suicide in mental illness patients that divided into general risk factors across all psychiatric disorders and risk factors associated with specific disorders. The most common risk factors across all psychiatric disorders include: prior suicide attempt; intimate partner conflict; social isolation; family history of suicide, mental disorder or substance abuse; family

violence including physical or sexual abuse; firearms in the home; legal charges or financial problems; incarceration; exposure to the suicidal behavior of others such as family members, peers, or media figures; and physical illness and functional impairment (Litts et al., 2008).

According to risk factors associated with specific disorders, mood disorders appear to carry the highest risk of suicide and suicide attempts. Moreover, the risk of suicide was higher for depressed individuals who feel hopelessness about the future, have just been discharged from a hospital, have a family history of suicide, or who have made a suicide attempt in the past (Beautrais et al., 2010). Furthermore, Pompili and colleagues stated that social isolation, hospitalization, deteriorating health after a high level of premorbid functioning, recent loss or rejection, limited external support, and family stress or instability are risk factors for suicide in patients with schizophrenia as well (Pompili et al., 2007). Moreover, there was the study determine factors associated with suicidal attempt in bipolar patients. The interesting results shown that being unemployed and having prior suicidal attempt are also risk factors in this group (Ruengorn, 2011).

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Although suicide is often a complication of psychiatric illness, it is usually accompanied by additional risk factors such as a genetic link with someone who has committed suicide, living in rural areas with access to guns or other lethal means, poverty, unemployment and social isolation (Morrison, 2009). In addition people with mentally ill who considering suicide is in so much pain that they feel they have no other option. The state of mind of someone considering suicidal behavior has been described as hopeless, helpless, powerless, and filled with self-hated and rejection (Murray & Upshall, 2009). As a way to release this pain and the burden they

perceived as having placed on others, in desperation, opt for death (Murray & Upshall, 2009).

In the study of Kim and colleagues, they observed that suicidal ideation was common (53.6%) in hospitalized patients with schizophrenia. In those patients there were risk factors for suicidal ideation and suicidal attempt which the researchers identified that depression is an important risk factor for suicide in both the general population and in schizophrenia patients. Moreover, the frequency of family visitations to the hospital during the admission period was used as a variable representing level of family support. The prevalence of suicidal ideation was significantly higher in patients with less than one family visit per month. In addition, family history of mental illness was also associated with increased suicidality of patients. A family history of suicide was significantly more frequent in patients with suicidal ideation than in those without. Previous attempted suicide in patients with schizophrenia was also an important clinical indicator for suicidal attempts. Finally, later age at onset of schizophrenia was independently associated with current suicidal ideation (Kim et al., 2010).

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Although there are some risk factors that cannot be changed such as a previous suicide attempt, they can alert others to the heightened risk of suicide during periods of the recurrence of a mental illness or following a significant stressful life event (U.S department of health and human services, 2001). Apart from this, there are some risk factors associated with interpersonal need and capability for suicide which are manageable. In order to conduct the interpersonal need program, the researcher will place important on modifiable and manageable factors. In this program we will handle those factors to reduce suicidal ideation and suicidal attempt. According to the

interpersonal theory of suicide, we can identify modifiable and manageable factors related to the theory as followed.

1. Risk factors related to thwarted belongingness composed of

1.1 Risk factors of absence of reciprocal care component: social isolation (Litts et al., 2008; Morrison, 2009; Pompili et al., 2007), and intimated partner conflict (Litts et al., 2008).

1.2 Risk factors of loneliness component: a few family support (Kim et al., 2010), family stress or instability, and limited external support (Pompili et al., 2007).

2. Risk factors related to perceived burdensomeness composed of

2.1 Risk factors of self hate component: filled with self hated and rejection (Murray & Upshall, 2009).

2.2 Risk factors of liability component: negative life events(being unemployed, recent loss or rejection, incarceration, legal charges or financial problem, physical illness, functional impairment, and deteriorating health) (Litts et al., 2008; Morrison, 2009; Pompili et al., 2007), perceived the burden they having placed on other (Murray & Upshall, 2009).

3. Risk factors related to acquired capability for suicide: easy access to lethal means (living in rural area with access to gun or other lethal means, firearm in the home) (Litts et al., 2008; Morrison, 2009), deliberate self-harm (Phillips & Van Ort, 1995), and previous suicide attempt (Beautrais et al., 2010; Kim et al., 2010; Litts et al., 2008; Ruengorn, 2011).

6. Intervention for suicide prevention

There was a study review showed the data showing examples of national suicide prevention programs around the world as followed. In Australia, there was The Australian Model, the best example of a comprehensive and successful suicide prevention program. The domain and principles of care and support are universal interventions; selective interventions; indicated interventions; symptom identification; early specialized care and support; standard specialized care & treatment ; longer-term treatment and support; individual, family and community growth and development; activities should be culturally appropriated; local suicide prevention activities must be sustainable to ensure continuity and consistency of service; and suicide prevention activities should first do no harm. The result was a decrease in the age standardized rate of suicide from a peak of 14.7 suicides per 100,000 people in 1997 to 8.9 in 2007 (Alonso-Betancourt, 2012).

In addition to suicide prevention in Thailand, there were the studies presented in suicide prevention national conference (2008), for instance, a study of nursing counseling emphasizing existentialist theory on depression and suicidal ideation of persons at risk for suicide, two studies of family counseling on suicidal ideation in suicidal attempters. There also had the studies of the effects of cognitive behavioral therapy (CBT) on suicide prevention in depressive patients (Techanirattisai, 2008), evaluation of implementing caring for suicidal attempted patients protocol (Treyakul et al., 2008), and Satir's psychotherapy for suicide attempters (Inpun, 2008). Although all studies had positive results, they were not used formally as prevention programs or strategies in mental department of Thailand. In addition they were not specified to severe mentally ill patients who have more various and complex risk factors than

those general populations. There still need prevention program especially well-organized nursing intervention for severe mentally ill patients.

There was a guideline for suicide prevention 2012 of Department of mental health developed by Khon Kaen Rajanagarindra Psychiatric Hospital (Khon Kaen Rajanagarindra Psychiatric Hospital, 2012). This guideline purposed that when suicide risk patients admitted to psychiatric hospital there were three steps of treatment. Firstly, nurses did mental and physical examination. If they found suicide risk after hospitalization, Sui-1 assessment and MINI-Suicide were used to identify level of that risk. Thai health of nation outcome scale (HoNOS) was also used on day one, day three, and every seventh day until the score was ≤ 2 or when symptoms were changed.

Secondly, there was multidisciplinary team for daily treatments. Psychiatrists ordered and reviewed treatment plan such as pharmacotherapy and electroconvulsive therapy according to each patient. On the other hands, nurses gave them group activity therapy and individual psychosocial therapy such as nurse-patient relationship, cognitive behavioral therapy (CBT), supportive psychotherapy, motivation interviewing (MI) for adherence, psychosocial therapy for patients with substance dependence, and psycho-education for patients and families. Other psychotherapy as Satir's therapy, family counseling, family therapy, Stress management, and problem solving skill practice were obtained by psychologists and social workers. Whereas occupational therapists set occupational therapy for patients, pharmacologists gave them knowledge about medication. All daily treatments including discharge plan with co-operation of patients and their families. Progress note, nurse's note, patient behavior record, and clinical patient profile data base were used to record these treatments.

Finally, there was an evaluation process which psychiatrists assessed clinical symptom, whereas nurses used MINI-Suicide and HoNOS to assess patients. If there was HoNOS > 2, psychiatrists reviewed treatment plan. When patients recovered, they were discharged and transferred to community mental health and psychiatric section to cooperate with community network for continuous care

In addition, there was precaution plan in acute phase. This plan was divided into three levels: severe suicide precaution, moderate suicide precaution, and mild suicide precaution. This plan included human resource plan, safety environment, and tool & arms. For severe suicide precaution, psychiatrists had to do symptoms assessment, mental examination, and progress note record within 24 hours after started plan. Closed observation was set during 24 hours by nurse team including closed-circuit television. Observer had to be 1:1 and could observe patients all the time. On day and night time, patients had to stay in limited area and had to be observed even they went to toilet. Container and spoon had to be checked before and after patients use. Belt, elastic pants, pants with strap, shoes with shoestring and any sharp objects were forbidden. Every shift nurses checked to remove harmful objects away from patients. Patient round had to be done every 15 minutes and at least 2 times per shift suicide risk had to be assessed. Activity was limited according to doctor order. In addition, yellow stickers with “H” letter were placed on patient document, name tag, and was written on board to show as a symbol of “High suicide precaution”. Nurses had to record place, activities, sign and symptom, mental health status, adherence, and interaction in nurse’s note. In case of symptom changed, nurses reported to psychiatrists within 24 hours. Furthermore, there were systematic incident analyses by multidisciplinary team in order to learn and share.

For moderate and mild suicide precaution, guideline was used in the same principle but different in details. For moderate suicide precaution, suicide risk had to be assessed at least 1 times per shift while mild suicide precaution, suicide risk had to be assessed 1 times per 24 hours. Patients with mild suicide precaution were allowed to do all activities inside and outside ward whereas patients with moderate suicide precaution could do only inside ward activities. Individual or group psychosocial therapy was set according to patient problem. In addition, there were differences of letters in stickers and on board which "M" letter was used to show as a symbol of "Moderate suicide precaution" while "L" letter was used to show as a symbol of "Low" in mild suicide precaution.

According to discharge preparation, there was guideline as following. Nurses assessed problems and needs before discharge which covered bio-psycho-social-spiritual aspects. Suicide risk assessment of patients in pre-discharge phase had to shown lower level without suicidal ideation or suicide plan. HoNos and MINI-Suicide was also shown mild or moderate level. Patients had to do daily life activities by themselves. Either individual or group psychotherapy were given in order to enhance hope and appropriate self concept for patients. Moreover, collaboration with community network was made for suicide prevention especially first three to six months after discharge.

There were roles of family or caregiver specified in this preparation guideline. All patients must have caregiver or family member who available to support for suicide prevention. Caregivers or family members were offered knowledge about how to look after patients, how to encourage patients express their thoughts and feelings, how to observe sign of suicide, and resources which they could ask for help. In

addition, there was supportive therapy for caregivers or family members to increase positive attitude and decrease stigma. Following up was emphasized including hotline information which patients and caregiver could call before appointed day.

Even there was a guideline for suicide prevention in psychiatric hospital, such guideline was a multidisciplinary guideline which roughly displayed the overall image of prevention. There was a few confirmation of success in nursing implementation. Whereas nursing professional needs to strengthen nurse's role and potential according to theoretical framework which consistent with nursing task and responsibilities.

In the same way, usual care by mental health and psychiatric nurses was conducted according to clinical nursing practice guideline (Suansaranrom hospital, 2015). This guideline composed of nursing care in acute phase, continuity phase, and rehabilitative (maintenance) phase. In acute phase, nurses assessed patients by HAM-D or 8Q continuously in 48 hours. Then in continuity phase nurses assessed patients by HAM-D or 8Q once a day continuously in seven days. The BPRS and ICF were used if patients were diagnosed as major depressive disorder. Finally, in rehabilitative phase, there was psychosocial intervention due to individual problem. There also had family psycho-education, included community and social planning.

The observations from this clinical nursing practice guideline were it was focused on only depressive patients who were diagnoses as F 32, F 33, F 34.1, F 38, and F 39. Furthermore, there were only checklists which declared only goal of nursing care. For example: goal for acute phase were "patient is safety", "patient accept and understand himself"; goal for continuity phase were "patient do not have suicidal ideation and suicidal attempt", "patient has problem solving skill", "Family or caregiver has knowledge and understanding about depression"; and goal for

rehabilitative phase were “patient has knowledge about depression and self care”, “patient is ready to go back home”, “Family or caregiver is ready to look after patient”.

Particularly, in acute and continuity phase, closed observation was conducted. Patients were assigned to stay in bed near nurse station in order to close observed through 24 hours. The environment in ward was rid of potentially harmful objects. Nurses were stick red sticker at the patient’s name tag, patient document, and board as a mark of suicide precaution. Nursing care in these two phases was focused on basic need while there was individual nursing care due to individual problem in rehabilitative phase. Nurses had interaction with patients due to individual problem which spent 15-30 minutes per time. The frequency of the interaction was depended on situation at that time.

For discharge planning, nurses conducted group psycho-education about depressive disorder and self care, stress management, and warning signs of relapse. In addition, family and caregiver obtained psycho-education about depressive disorder, medication, and following up. Nursing care after discharge was depended on patient habitat. Nurse in community mental health department collaborated with nurses in health promotion hospital or community hospital to visit the patients at their home for continuous care. The frequency of home visit is not specified. As same as guideline for suicide prevention, this clinical nursing practice guideline needs a designation of structure, content, detail, and intensity of each activity. As a consequence, there is a need for a systematic nursing intervention for suicide prevention which established for severe mentally ill patients that underlined on suicidal ideation and suicidal attempt reduction.

In order to design multifaceted intervention for this program, the evidence-based interventions for severe mentally ill patients were reviewed. According to the interpersonal need program, it was conducted to manage risk factors in each component of interpersonal need and capability for suicide. Then activities in this program were selected as in Table 1. There were six nursing interventions in the interpersonal need program: nurse-patient relationship, cognitive behavioral approach, psycho-education, empowerment, individual counseling, and telephone counseling.

According to nurse-patient relationship, The core characteristics of the nurse–patient relationship from the patient's perspective is that it is a dynamic lived reality characterized by a sense of spiritual connection which is experienced as a bond made of energy which some former patients have described as a bond of light. The highest quality of this connection is the 'life-giving nurse–patient relationship' which is greatly empowering for the patient (Halldorsdottir, 2008). The activity of caring is established through the nurse-patient relationship, and is specified in the care plan with the nurse's interventions (Gamez, 2009). The main features characterizing a caring relationship between two individuals have been identified as firstly, the manifestation of a commitment from the agent (or carer) to provide a sustained and continuous service until such time as it is no longer required. Secondly, as the possession of a sufficient level of knowledge and skills to ensure that the care being provided is adequate to meet the recipient's need for care. Thirdly, that the transaction is based on a premise which upholds the individual integrity of the recipient of care (Kitson, 2003).

The nurse-patient relationship is important for 10 reasons: to help patients make informal decisions; to avoid isolating and dehumanizing patients; to act as an

advocate for vulnerable patients and those unable to express their wishes; to nurture cooperation and understanding; to help in patient assessment and problem solving; to help patients cope with their problems; to help patients undertake, or carry out for them, activities of living and human needs; to care for dying patients and those with terminal illnesses and palliative care needs; to teach and promote health education and to learn about new ways of nursing and caring for people in a changing world (Castledine, 2004). In addition, the nurse patient relationship, as a helping relationship, provides nursing with an identity and differentiates it from other professions (Gamez, 2009). Therefore, the nurse-patient relationship was conducted as an introductory of the interpersonal need program to establish caring relationship.

Cognitive behavioral therapy (CBT) was developed to change an individual's thoughts, feelings, and behaviors that stem from dysfunctional cognitive patterns (ie, "I made a mistake and therefore I am a failure") as well as maladaptive behavioral patterns (ie, withdrawal, social isolation) (Hamill-Skoch, Hicks, & Prieto-Hicks, 2012). CBT was wildly used for severe mentally ill patients. For patients with depression, it is an evidence-based treatment used combined with antidepressant (Hamill-Skoch et al., 2012). In addition to schizophrenia patients, it was used with both first episode and chronic schizophrenia (Sirthemanun, Seeherunwong, & Au-Yeong, 2012). Moreover, it was aimed to increase self-esteem in bipolar patients (Hall & Tarrier, 2005).

Table 1 Constructs, components, risk factors, and nursing intervention of the interpersonal need program

Constructs and components	Risk factors	Nursing intervention
1. Thwarted belongingness		
1.1 Absence of reciprocally caring relationship	- Social isolation - Intimated partner conflict	**Establishing caring relationship** 1. Nurse-patient relationship (To set up caring relationship involve with cognitive behavioral approach , psycho-education, empowerment, individual counseling, and telephone counseling) 2. Telephone counseling (To confirm caring relationship and terminate relationship)
1.2 Loneliness	- A few family support - Less family visitation - Family stress or instability - Limited external support	**Promoting sense of belonging** 1. Cognitive behavioral approach (To decrease/modify loneliness) 2. Psycho-education for caregiver (To promote positive relationship) 3. Telephone counseling (To follow up on thought modification about loneliness)
2. Perceived burdensomeness		
2.1 Self-hated	- Filled with self hated and rejection	**Reducing perceived burdensomeness** 1. Cognitive behavioral approach (To decrease/modify self-hated) 2. Telephone counseling (To follow up on thought modification about self-hated)
2.2 Liability induced by negative life event	- Perceived the burden they placed on other - Negative life events	3. Empowerment (To reduce perceived burdensomeness) 4. Counseling (To realize strategies for dealing with negative life event)
3. Acquired capability for suicide		**Disabling capability for suicide**
3.1 Increased physical pain tolerance 3.2 Reduced fear of death	- Easy access to lethal means - Firearm in the home - Deliberate self-harm - Previous suicide attempt	1. Counseling (To realize strategies for decreasing capability for suicide 2. Psycho-education for caregiver (To encourage helping from family) 3. Telephone counseling for caregiver (To follow up on disable capability for suicide) 4. Telephone counseling (To follow up on safety plan)

Furthermore, there was a randomized controlled trial study found that patients who received cognitive–behavioral therapy in addition to treatment as usual had significantly greater reductions in self-harm, suicidal cognitions and symptoms of depression and anxiety, and significantly greater improvements in self-esteem and problem-solving ability, compared with the control group (Slee, Garnefski, van der Leeden, Arensman, & Spinhoven, 2008). These evidences showed that CBT was effective for this group of patients. According to risk factor for suicide in the constructs of the interpersonal theory of suicide, loneliness and self-hate were negative thought which need to be modified. Consequently, CBT approach was one of the multifaceted intervention in this program which conducted for modify both risk factors.

In addition, psycho-education was defined as an intervention involving interaction between information provider and service users or families, which has the primary aim of offering information about the condition; and service users or families may also be provided with support and management strategies. (National collaborating center for mental health, 2009) emphasized the importance of empowering patients with better information to enable a different quality of conversation between professionals and patients. Moreover, Smith and colleagues suggested that psycho-education about acquired capability for suicide should be served to form a stimulus control in order to avoid this capability (Smith et al., 2010). Thus, psycho-education is one of the best activities to improve knowledge and understanding of patients and their families about interpersonal needs and capability for suicide.

Empowerment can be defined as a social process of recognizing, promoting and enhancing people’s abilities to meet their own needs, solve their own problems and mobilize the necessary resources to feel in control of their own lives (Tveiten, Haukland, & Onstad, 2011). This intervention is especially important in societies that stigmatize persons with psychiatric disabilities (Marden, 2004). Coincide with concept of the interpersonal theory of suicide, empowerment is two-way nurse-patient relationship (partnership working) which is shift of power from nurses to individual patients (Piper, 2014). For severe mentally patients who had negative life event which induce their liability, empowerment was given to discover strategies to deal with those either negative life event or their thought and feeling. The impact of empowerment on the self is such that, despite societal stigma, empowered consumers endorse positive attitudes about themselves. They have good self-esteem, believe themselves to be self-efficacious and are optimistic about the future (Marden, 2004).

Because suicidal individuals often communicate their thoughts to someone, the therapeutic approach taken by a counselor is of tremendous importance (Paulson & Worth, 2002). Although patients with suicidal ideation and/or suicidal attempt realized their risk for suicide, they may attempt or reattempt because of overwhelming negative feeling that may occurred again. Safety plan to deal with this situation was exactly important. According to risk factors for suicide in the constructs of the interpersonal theory of suicide, negative life event and access to lethal means could be managed. Means-restriction counseling is a process which patients were educated about the risks associated with easy availability of means in order to limit the access to these means (Bryan, Stone, & Rudd, 2011). As a result, individual counseling was given to encourage patients conduct safety plans in this program.

Although the intervention after discharge usually has home visits, this activity is limited due to the patients' time. Then telephone counseling is another activity that might be filled this gap. It is the weekly phone call which needs only 15-30 minutes. There was the study about the effectiveness of telephone counseling for depressive patients (Tutty et al., 2000). The researchers noticed that patients were able to receive care and support in the comfort of their own home at a time that was convenient. This consistence with the study of Ho and colleagues which evaluated the suicide intervention program and found that home visits are limited, even so the number of persons contacted via telephone has increased (Ho et al., 2011). Therefore, this is the efficient activity for after discharge intervention.

7. Designing nursing intervention

A nursing intervention is any direct care treatment that a nurse performs on behalf of a client. These treatments include nurse-initiated treatments resulting from nursing diagnoses, physician-initiated treatments resulting from medical diagnoses, and performance of the daily essential functions for the client who cannot do these (McCloskey & Bulechek, 1996 cited in Aranda, 2008). Moreover interventions can be simply or complex. A simple intervention might consist of a single action by the nurse in response to common patient problem while a complex intervention would normally be in response to a complex problem and might be delivered over more than one interaction (Aranda, 2008).

Nurses and other health professionals need to demonstrate the benefits of the services they provide in direct relationship to patient outcomes. However, this relationship is complex and mediated by factors associated with the environment, the patient population and the model of care delivery (Aranda, 2008). In order to

create an effective nursing intervention in this study, the researcher has to know the characteristics of well-developed nursing interventions. There is the reflective framework to guide the design process as follow.

1. **Defining the patient problem** The design of a nursing intervention clearly depends on the nature of the patient problem. Thus the important starting point is a thorough analysis of the patient problem of interest. Defining the problem will also assist in clarifying the specific outcomes or patient problems that the intervention seeks to target.

The simple strategies to achieve the problem are focus group, and clinician and consumer describing. In addition, while a literature review is a major component of defining the patient problem, it is also useful to explore the nature of the problem in the local setting where the research is to be carried out (Aranda, 2008).

2. **Determining a conceptual framework** Careful consideration of the patient problem and the features that determine its prevalence in the patient population provides understanding of the dynamics of the problem in the local context. This will in turn assist with considering a relevant conceptual framework to guide the intervention elements (Aranda, 2008).Theories that make specific predictions are important for effective interventions. Theoretical frameworks that have received considerable empirical support are more likely to produce measurable differences in outcomes than theories with limited empirical support (Conn, Rantz, Wipke-Tevis, & Maas, 2001).

The intervention should definitively reflect the key constructs of interest specified in the conceptual framework (Heppner, Kivlighan & Wampold, 1999 cited in Conn et al., 2001). Careful conceptualization of an intervention is essential for

credible interpretation of the success or failure of a treatment (Sechrest et al., 1979 cited in Conn et al., 2001). Inadequate construct validity of an intervention leads to misinterpretation of findings (Cook & Campbell, 1979; Sechrest et al., 1979 cited in Conn et al., 2001).

The absence of a conceptual framework often is associated with weak intervention effects and with missing explanations of causal processes between the intervention and outcomes. Mediating variables specified in conceptual frameworks and measured with sound instruments provide possible explanations for findings regarding intervention effects (Goldenhar & Schulte, 1996).

3. **Defining the desired outcome** Significant work is being undertaken internationally to define those outcomes that are most sensitive to nursing interventions. As a result, defining the outcomes of interest is critical to ensuring you can adequately measure the impact of the intervention. This is important in nursing intervention research, as we need to be sure that the effects measured are not simply a product of the intervention nurse's personality but are a direct result of the intervention (Aranda, 2008). A nursing intervention might cover one or multiple patient outcomes. All outcomes have to be related with conceptual framework, measurements, and content of the intervention.

4. **Defining measures** Each chosen outcome will need a corresponding means of measurement. Selected instruments should be psychometrically valid and ideally previously demonstrated as suitable for use in the chosen population. Evidence of appropriateness for use includes the capacity of the instrument to distinguish between groups of participants and preferably evidence that the instrument will be sensitive to changes in the target outcome as a result of the intervention (Aranda, 2008).

5. **Defining the target population** Population-specific interventions are consistent with the attributes of the targeted persons. Developmentally appropriate and culturally sensitive interventions enhance the potential effects of the interventions (Stanton et al., 1996; Varricchio, 1995 cited in Conn et al., 2001).

Clarity regarding the intervention's target may include descriptions of individuals, dyads, families, components of organizations, or communities. Furthermore, the conceptual framework and problem determine the appropriate target(s) for interventions (Conn et al., 2001). For initial testing of the intervention the target population should be one in which the identified problem is a common or serious concern and where characteristics of interest are featured. Making the population too homogenous can result in difficulties in recruitment while being too inclusive can reduce the specificity of the intervention and reduce the likelihood of seeing an intervention effect (Aranda, 2008).

6. **Determining intervention content** The content of the intervention seeks to address the relationship between the patient problem and the desired changes in the related outcomes (Aranda, 2008). In addition, the content of the intervention is most often determined by the selected conceptual framework (Conn et al., 2001).

7. **Considering simple versus complex intervention** A simple intervention is one focused on a single outcome and utilizing a single intervention strategy, while a complex intervention may target one or more patient outcomes but the intervention will contain more than one intervention element (Aranda, 2008). It is probable that complex problems are more likely to require complex interventions to achieve desired outcomes. Some interventions are not easily separated into components, thus requiring treatment packages. In addition, it is possible that some interventions with

no detectable effect individually can be effective when grouped with other interventions.

Furthermore, the nature of the problem and the conceptual framework provide the justification for deciding whether to test simple interventions or complex interventions. Complex interventions should be used when the conceptual framework suggests multiple interventions, when complex problems are being treated, when it is practically impossible to separate components, when previous research has documented that simple interventions are ineffective or unsafe, or when efficacious interventions are sought for formidable problems. Simple interventions should be tested when the conceptual framework suggests solitary interventions or when the purpose of the research is to identify which components of interventions account for outcomes (Conn et al., 2001).

8. **Designing delivery method** Effective interventions are delivered by interventionists with carefully selected attributes. Most nursing interventions are probably best delivered by professional nurses who have received extensive preparation regarding the intervention. Some interventions are enacted entirely by research staff, whereas others require actions by persons who are not research-team members. At other times interventions are best delivered by individuals who have been selected for other important characteristics (Conn et al., 2001).

Interventions can be delivered in person or by phone, mail, printed materials, e-mail, or Internet (Conn et al., 2001). Most nursing interventions are delivered in face-to-face mode to individual patients. Programs of research would usefully focus on first assessing the impact of a face-to-face intervention and then assessing if

similar effects can be gained by changing the delivery mode. Mode changes fall into two main categories (Aranda, 2008):

1. Use of technology: developments in information technology provide very useful opportunities for interventions to be delivered by telephone, DVDs, websites, interactive CD-ROMS, Podcasts and more. As the population take up of technology is high the barriers against such interventions are rapidly reducing.

2. Alterations in patient numbers: group interventions may be a useful strategy to deliver nursing interventions, particularly when nursing resources are short and patients are easily recruited. A group easy to recruit might be patients about to start a particular treatment (e.g. those scheduled to have a knee replacement) while a difficult to recruit group would be those with infrequent contact with the health service (e.g. survivors of cancer who have returned to work).

Delivery methods should be carefully assessed during pilot work where factors such as feasibility of group recruitment can be tested and feedback from patients about the experience of the delivery can be assessed. Mode of delivery can also relate to the dose of intervention, with different methods being of potentially different strength despite similar content.

In addition, the setting of interventions may make them difficult to implement and can alter effectiveness (Phillips & Van Ort, 1995). It may be necessary to consider the setting as a dimension of the intervention. Moreover interventions often are delivered at a particular time in relationship to a specific event. The conceptual framework most often suggests the appropriate timing (Clark, 1996).

9. **Designing dose** The ability to achieve a clinically significant intervention effect requires an appropriate balance between the amount of intervention, the

severity of the problem and the burden on patients. Dose concepts include the amount, frequency and duration, and intensity of the intervention (Aranda, 2008). Amount is the actual time it takes for the delivery of the intervention. Frequency and duration refer to the number of intervention sessions and the time span over which they were delivered. In addition, the intensity of the intervention refers to a combination of these factors and is best understood as the amount of burden there is for the patient. More intense interventions usually require more time and more input (e.g. homework) by the patient. The goal with increasing the intensity is to increase the desired effect on outcomes but may also lead to increased attrition if patients judge the burden to be too high (Conn et al., 2001).

Duration of delivery over hours, days, or weeks is the other important dimension of dose. Increasing treatment dose is one way of constructing robust interventions. Increasing treatment dose to enhance the likelihood of achieving significant changes in outcomes must be balanced with the increased demand on the participants because of a more intense intervention. Interventions with high subject demand may be associated with increased attrition (Conn et al., 2001).

A content-appropriate intervention delivered in insufficient doses obscures the potential effectiveness of the intervention. In addition, important questions related to nursing interventions are those that seek to increase the dose of an intervention in ways that do not require more nursing time in the context of a workforce shortage. This is where the relationship between dose and method of delivery is important (Conn et al., 2001).

10. **Managing integrity** Intervention integrity refers to the extent to which the intervention is delivered as planned. It is important to ensure that outcomes of a study

can be formally linked to the intervention and to ensure that an absence of intervention effect is not caused by a failure of delivery (Aranda, 2008). Maintaining the integrity of an intervention across the life of an intervention study is a serious challenge. This is particularly critical where more than one nurse is involved in delivering a complex intervention. Strategies to enhance integrity need to be built into intervention design and include the following (Aranda, 2008):

1. Structured training of intervention nurses helps to ensure a common knowledge base and the attainment of a core set of skills required for the intervention delivery.

2. Evidence-based support materials to guide intervention nurses. In some cases these might be also developed as patient information brochures for use in the intervention.

3. An intervention manual that structures the responses given to each factor likely to be encountered. Such manuals can also provide quick access to the evidence behind particular responses as a memory aide.

4. Separation of intervention nurses from involvement in usual care conditions to prevent diffusion of the intervention into usual care. This is applicable where clinical nurses undertake the intervention but are part of the unit staff where the intervention is being delivered.

5. Pilot work can also assist in maintaining intervention integrity by allowing a closer scrutiny of what the intervention nurses are doing and allowing feedback and correction of actions that are outside of the intervention protocol. It can also be helpful to audiotape intervention sessions to allow an independent assessment of adherence to the intervention protocol and subsequent correction.

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CHAPTER 3
RESEARCH METHODOLOGY

In this chapter, the methodological aspects including research design, setting, population and sampling, research instruments, experimental procedure, ethical of the human right subjects, data collection procedure, and data analysis procedure were discussed.

Research design

This study was a randomized control trial study using a pretest-posttest control group design (Shadish et al., 2002). By this design, participants was randomly assigned (R) to experimental group and control group. All participants had pretest to measure suicidal ideation, and suicidal attempt after they are performed right and agree to participate in this study. The control groups was received usual care, whereas, the interpersonal need program (X) was given to those in the experimental group within two weeks in rehabilitative phase of hospitalization and continued to first week after discharge. The posttest of suicidal ideation, and suicidal attempt, were established at two weeks after discharge. This design was diagrammed as follow:

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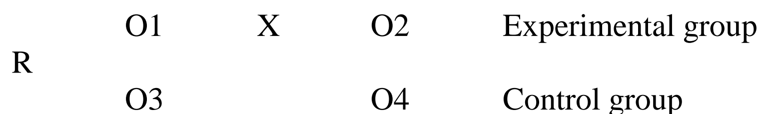

R= Random assignment in order to place samples into either experimental or control group

X= The interpersonal need program

O1= Suicidal ideation score and suicidal attempt score of the experimental group at the recruitment date

O2= Suicidal ideation score and suicidal attempt score of the experimental group at two weeks after discharge

O3= Suicidal ideation score and suicidal attempt score of the control group at the recruitment date

O4= Suicidal ideation score and suicidal attempt score of the control group at two weeks after discharge

Setting

The setting of this study was inpatient psychiatric ward at a large psychiatric hospital in southern part of Thailand. The mission of this psychiatric hospital was covered mental health situation of population in seven provinces of upper southern including Surat Thani, Nakhon Si Thammarat, Chumphon, Ranong, Phuket, Phangnga, and Krabi. There were six inpatient wards provided for adult patients with schizophrenia, major depressive disorder, and bipolar disorder in the rehabilitative phase. Five wards were one stop service wards and one ward was rehabilitative ward. Time period of hospitalization for severe mentally ill patients were about 2 weeks in acute wards and ≤ 4 weeks in rehabilitative wards.

Population and sampling

Population of the study: The target population for this study composed of

1. Thai adult severe mentally ill patients with suicidal attempt or suicidal ideation, and

2. Caregivers of those severe mentally ill patients

Samples of the study: The sample of this study were

1. Thai adult severe mentally ill patients with suicidal attempt or suicidal ideation who admitted in inpatient units, and

2. Caregivers of those severe mentally ill patients

Sample selection: The researcher used the convenience sampling to achieve participants in this study followed inclusion criteria:

Severe mentally Ill patients

1) Diagnosed of major depressive disorder, or bipolar disorder, or schizophrenia by the diagnostic and statistical manual version V (DSM-V)

2) Age 20-59 years

3) Admitted to the admission wards on the recruitment date

4) Had at least 7 scores of 9-questions of assessment in depression (9Q) which indicate that depression level of the sample was at least mild depression

5) Had at least 1 score of the scale for suicide ideation (SSI-Thai version 2014) which indicated having mild level of suicide ideation or admitted with suicidal attempt

6) Able to use Thai verbal communication

Moreover, exclusion criterion were participants who absence from at least one session of this program.

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Caregivers

1) Lived in the same house with patients or lived in the nearby house

2) Had responsibility to take care the patient

3) Were use Thai verbal communication

Sampling procedures: Convenience sampling was used in this study. Patients who transferred from acute phase (ward) to rehabilitative phase (ward) were screened by 9Q and SSI. When they met the criteria they were samples of this study. The researcher randomly assigned them into either control or experimental group by using

number of screen sequence. For example, ward A had six patients who met the criteria then the first, third, and fifth were in experimental group while the second, fourth, and sixth were in control group.

Sample size: The appropriate sample size was determined based on statistical power analysis. According to Cohen (1988 cited in Chuan, 2006), in order to perform a statistical power analysis, the factors need to be taken into consideration: significance level or criterion, effect size, desired power, and sample size. The relationship among the five factors means that if sample size is determined, the others three factors have to be pre-determined. Alpha is the probability of wrongly rejecting the null hypothesis, thus committing Type I error. The statistical level of significance for most studies is often fixed at alpha = .05. While effect size generally means the degree to which the phenomenon is present in the population or the degree to which the null hypothesis is false (Cohen, 1988 cited in Chuan, 2006). Moreover, the power of a statistical test is defined as the probability that a statistical significance test will lead to the rejection of the null hypothesis for a specified value of an alternative hypothesis. Cohen suggested fixing the power at .80, which is also a convention proposed for general use (Cohen, 1992).

Therefore, the factors pre-determined in order to estimate an adequate sample sizes for this study were, the alpha level was set at 0.05, the effect size was medium at 0.65 and the power was set at 0.80. Then, the sample should be at least 15 patients and 15 caregivers in each group. An attribute rate of 10% was anticipated. There would be 17 pairs of patients and caregivers per group. Total sample would be at least 68 participants.

This study was planed to conduct in one large psychiatric hospital. However, there was a difficulty about transition in that hospital. The researcher had to move to another large psychiatric hospital. Therefore, time for data collecting was suspended until receiving permission from the current hospital. In addition, after research proposal was approved in 2013 there were policy changes in mental health and psychiatric services. Department of mental health had policy to cooperate with local health unit to enhance their role for mental health services (Department of mental health, 2013). Patients could receive mental health services from general hospital or health promotion hospital which had nurses who graduated master degree in mental health and psychiatric nursing or certificated training in mental health and psychiatric nursing. Therefore, the amount of patients in psychiatric hospital was decreased. Likewise, there was limitation of admission in some ward because of infectious disease at data collecting duration. In addition, the patients with psychotic symptom were excluded and there were 33 severe mentally ill patients met the criteria. Therefore after finished data collection, there were 66 participants in this study; 33 severe mentally ill patients, and 33 caregivers.

Research instruments

The instruments used in this study were comprised of data collection instrument, intervention instrument, and validity check instrument. All instruments were examined for content validity by seven experts including two psychiatrists, four advance practice nurses in psychiatric and mental health nursing, and one registered nurse who studied development of a clinical nursing practice guideline in caring for schizophrenia with suicide patients. These instruments were described below:

1. Data collection instrument There were four instruments used to measure the outcome of this study including

1.1 **The personal information sheet for patients**: This instrument was developed by the researcher to collect the personal data; gender, age, marital status, educational level, occupation, income, physical health status, caregiver, relationship between patients and care giver, diagnosis, duration of mental illness, and number of hospitalization.

1.2 **The personal information sheet for caregivers or family members**: This instrument was developed by the researcher to collect the personal data; gender, age, marital status, educational level, occupation, income, physical health status, number of people in charge of caring, duration of caregiving, relation with patient, and relationship between patients and care giver.

1.3 **The scale for suicidal ideation (SSI-Thai version 2014)**: In order to measure suicide ideation, the Scale for Suicide Ideation (Beck et al., 1997) was used to rate the severity of a patient's suicidal and plans. This scale consists of 19 items that are rated on a 3-point scale of suicidal intensity ranges from 0 to 2. The ratings are summed to yield a total score which can range from 0 to 38. This instrument was translated into the Thai version of the scale for suicidal ideation (SSI-Thai version 2014) by Kittiteerasack & Muijeen (2015). The instrument testing showed the psychometric properties that SSI-Thai version 2014 had content validity index (CVI) of 0.89. In addition, the Cronbach's alpha coefficient was .81 and an index of item discrimination was more than 2 ($p < .001$) (Kittiteerasack & Muijeen, 2015). The SSI-Thai version 2014 was used in this study with permission from Asst. Prof. Priyoth Kittiteerasack , Thammasat University, Thailand (Appendix I).

Content validity which examined by experts was shown that S-CVI/Average was 0.93. Internal consistency reliability of ACSS was tested in 30 severe mentally ill patients who had same characteristics with the sample in this study. The testing result was showed high reliability that Cronbach's alpha coefficient was 0.93.

1.4 **The suicidal attempt record**: In order to record suicidal attempt, the suicidal attempt record which developed by the researcher was used. This instrument will have the first item with "had suicidal attempt" or "did not have suicidal attempt" which identified by physician. If the answer was "did not have suicidal attempt", previous suicidal attempt history was recorded. On the other hand if the answer was "had suicidal attempt", detail were recorded including date, time, place, method, negative life events due to suicide attempt and previous suicidal attempt history as well.

2. Intervention instrument The instrument used as the intervention instrument in this study was the interpersonal need program. The researcher developed this program by using the interpersonal theory of suicide as the theoretical framework. This program was a multifaceted intervention aimed to mange risk factors in each construct according to the interpersonal theory of suicide. The constructs of the interpersonal need program are as in table 2. The intervention in this program consisted of four parts.

Part 1 Establishing caring relationship

Since patients moved to rehabilitative ward, nurse contacted them to establish a nurse-patient relationship as a caring relationship. This caring relationship was involved with information giving, cognitive behavioral approach, empowerment, and individual counseling until a nurse-patient relationship was terminated in day

seven of first week after discharge. The continuation of caring relationship in part 1 is shown in table 3.

Table 2 Construct of the interpersonal need program

Construct	Component	Nursing Activities
1. Thwarted Belongingness	1.1 The absence of reciprocally caring relationships	**Part 1 Establishing caring relationship** - Establishment of nurse-patient relationship - Caring relationship involve with cognitive behavioral approach , psycho-education, empowerment, individual counseling, and telephone counseling
	1.2 Loneliness	**Part 2 Promoting sense of belongingness** - Cognitive behavioral approach for reducing loneliness - Psycho-education for caregiver to promote good relationship with patient - Telephone counseling for following up on though modification about loneliness
2. Perceived Burdensomeness	2.1 Self-hate 2.2 Liability	**Part 3 Reducing perceived burdensomeness** - Cognitive behavioral approach for reducing self-hate - Empowerment for reducing perceived burdensomeness - Counseling for conducting safety plan after confront with negative life event - Telephone counseling for following up on though modification about self-hate
3. Acquired capability for suicide	3.1 Increased physical pain tolerance 3.2 Reduced fear of death	**Part 4 Disabling capability for suicide** - Counseling for conducting safety plan to reduce capability for suicide - Psycho-education for caregiver to disable capability for suicide - Telephone counseling for following up with caregiver to disable capability for suicide - Telephone counseling for following up on safety plan

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Table 3 The interpersonal need program part 1

Date	Intervention for patient	Intervention for caregiver
Part 1 Establishing caring relationship		
The rehabilitative phase of hospitalization		
Day 1	Establish nurse-patient relationship	
Day 2	Information given for program reparation	
Day 3	Continued caring relationship involved with cognitive behavioral approach	
Day 4	Continued caring relationship involved with cognitive behavioral approach	
Day 5	Continued caring relationship involved with cognitive behavioral approach	
Day 6	Continued caring relationship	Psycho-education for caregiver
Day 7	Continued caring relationship involved with cognitive behavioral approach	
Day 8	Continued caring relationship involved with cognitive behavioral approach	
Day 9	Continued caring relationship involved with cognitive behavioral approach	
Day 10	Continued caring relationship involved with empowerment activity	
Day 11	Continued caring relationship involved with individual Counseling	
Day 12	Continued caring relationship involved with individual Counseling	
Day 13	Continued caring relationship	Psycho-education for caregiver
After discharge		
Day 1	Confirmed caring relationship involved with telephone counseling	
Day 2		Telephone counseling
Day 4	Confirmed caring relationship involved with telephone counseling	
Day 7	Telephone counseling with terminated caring relationship	

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Table 4 The interpersonal need program part 2, part3 and part 4

Date	Time	Participant	Intervention
		Part 2 Promoting sense of belongingness	
The rehabilitative phase of hospitalization			
Day 3	40 min	Patient	Cognitive behavioral approach for reducing loneliness 1 (Negative though assessment)
Day 4	40 min	Patient	Cognitive behavioral approach for reducing loneliness 2 (Negative though evaluating)
Day 5	40 min	Patient	Cognitive behavioral approach for reducing loneliness 3 (Negative though modifying)
Day 6	40 min	Family	Psycho-education for caregiver to promote good relationship with patient
After discharge			
Day 1	15 min	Patient	Telephone counseling for following up on though modification about loneliness
		Part 3 Reducing perceived burdensomeness	
The rehabilitative phase of hospitalization			
Day 7	40 min	Patient	Cognitive behavioral approach for reducing self-hate 1 (Negative though assessment)
Day 8	40 min	Patient	Cognitive behavioral approach for reducing self-hate 2 (Negative though evaluating)
Day 9	40 min	Patient	Cognitive behavioral approach for reducing self-hate 3 (Negative though modifying)
Day 10	40 min	Patient	Empowerment for reducing perceived burdensomeness
Day 11	40 min	Patient	Counseling for conducting safety plan after confront with negative life event
After discharge			
Day 4	15 min	Patient	Telephone counseling for following up on though modification about self-hate
		Part 4 Disabling capability for suicide	
The rehabilitative phase of hospitalization			
Day 12	40 min	Patient	Counseling for conducting safety plan to reduce capability for suicide
Day 13	40 min	Family	Psycho-education for caregiver to disable capability for suicide
After discharge			
Day 2	15 min	Family	Telephone counseling for following up with caregiver to disable capability for suicide
Day 7	15 min	Patient	Telephone counseling for following up on safety plan

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Part 2 Promoting sense of belongingness

There were five sessions in this part. The first three sessions were cognitive behavioral approach for reducing loneliness. Firstly, in negative though assessment session nurse assessed negative though about family relationship and social support. Secondly, nurse asked patient to prove and evaluate those negative though about loneliness in the second session. The patient discovered that his though in not true or become true in some part. Finally, in the third session nurse encouraged patient to modify his though about family relationship and social support to become valid, realistic, and utilizable though. The fourth session was conducted for family members. At least one family member especially caregiver or significant person participated this session. Psycho-education was provided in order to accompany with family to promote caring relationship for patient. The last session in this part was set up on first day after discharge. Nurse called the patient via phone to give telephone counseling for following up on though modification about loneliness. The intervention in part 2 is shown in table 4.

Part 3 Reducing perceived burdensomeness

Nurse provided six sessions in this part. The first three sessions were cognitive behavioral approach for reducing self-hate. The process of cognitive behavioral approach was similar to part 2. However, nurse focused on negative though about patient's self - hate. The fourth session was empowerment for reducing perceived burdensomeness. Nurse gave patient a sense of control over his life. Nurse asked the patient to find his ability in these aspect; daily life activities, medication adherence, emotional management, psychiatric symptom management, and living with family and community. The patient would believe that his daily life

can be accomplished by himself. The fifth session was counseling for conducting safety plan after confront with negative life event. The patient was asked to discuss how to handle thoughts and feelings related to negative life events which will occur in the future. Safety plan was conducted by himself in order to utilize when he discharge. The sixth session was telephone counseling for following up on though modification about self-hate. This session was set up on day 4 after discharge. The intervention in part 3 is shown in Table 4.

Part 4 Disabling capability for suicide

For the last part of this program, nurse conducted four session of intervention. In the first session nurse asked patient to express his suicide plan including method, time, place, and his physical pain tolerance and fear. Then nurse encouraged patient to conduct safety plan which related to his capability for suicide. The information about suicide plan which nurse received from first session was useful for second session. In this session nurse gave psycho-education for family to disable capability for suicide. Family member especially caregiver would learn about suicide according to the interpersonal theory of suicide, risk factors, methods, and strategies to disable capability for suicide. On day 2 after discharge, nurse called caregiver to follow up with family to disable capability for suicide. Finally, telephone counseling was set up on day 7 after discharged in order to follow up on both safety plans with patient. The intervention in part 4 is shown in Table 4.

It can be concluded as in table 5 that the interpersonal need program was conducted in two phases. Firstly, there were thirteen sessions within two weeks of rehabilitative phase of hospitalization. The interventions in this phase composed of establishing and continuing caring relationship, cognitive behavioral approach,

empowerment, individual counseling, and psycho-education for family. Secondly, there were four sessions in after discharge phase. The interventions in this phase were confirmed caring relationship, and telephone counseling.

Table 5 Structure of the interpersonal need program

Construct	Component	Nursing Activities					
		Rehabilitative phase					After D/C phase
		N-Pt relation-ship	CBT Ap-proach	Psycho-educa-tion	Em-power-ment	Ind. coun-seling	Tel. coun-seling
Thwarted Belongingness	The absence of reciprocally caring relationships	Involved with another interven-tion					Day 1,4,7
	Loneliness		Reduce lone-liness (3 times)	For caregiver			Day 1
Perceived Burdensome-ness	Self-hate		Reduce self hated (3 times)				Day4
	Liability				Find ability	Conduct safety plan 1	
Acquired capability for suicide	Increased physical pain tolerance			For caregiver		Conduct safety plan 2	Day2 (care-giver)
	Reduced fear of death						Day 7

3. **Validity check instrument** There were two instruments used as validity check of this study including

3.1 **The interpersonal need questionnaire (INQ)** This instrument was derived from the interpersonal theory of suicide (Van Oden, Cukrowicz, Witte, & Joiner, 2012). It is a self-report instrument designed to measure beliefs about the extent to which individuals believe their need to belong is met or unmet (thwarted belongingness) and the extent to which they perceive themselves to be a burden on the people in their lives (perceived burdensomeness). The current version of INQ is 15

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items questionnaire consisted of nine indicators of the construct of thwarted belongingness (item7-15) and six indicators of the construct of perceived burdensomeness (item 1-6). To complete the INQ, participants indicate the degree to which each item is true for them recently on a 7-point Likert scale. Scores are coded such that higher numbers reflect higher levels of thwarted belongingness and perceived burdensomeness. The INQ confirmed strong psychometric properties in previous research (Van Oden et al., 2012). Each subscale demonstrated evidence of strong internal consistency as INQ-Thwarted belongingness: $\alpha = .91$; INQ-Perceived burdensomeness: $\alpha = .90$ (Silva, Ribeiro, & Joiner, 2015). The INQ was used in this study with permission from Dr. Kimberly Van Orden, University of Rochester medical center, NY, USA (Appendix I). The original version of INQ was translated into Thai version and back translated by bilingual expert panel. Content validity examined by experts was shown that S-CVI/Average was 0.98. Internal consistency reliability of INQ was tested in 30 severe mentally ill patients who had similar characteristics with the sample of this study. The testing result was showed that Cronbach's alpha coefficient was 0.73.

3.2 **The acquired capability for suicide scale (ACSS)** This instrument was a 20 items self-report instrument designed to assess fearless of death and perceived tolerance for physical pain (Van Orden, Witte, Gordon, Bender, & Joiner, 2008). To complete the ACSS, participants indicate the degree to what extent they feel the statement describes them on a 5-point Likert scale. Scores are coded such that higher numbers reflect higher levels of acquired capability for suicide. The ACSS has demonstrate good internal consistency as $\alpha = .88$ (Smith et al., 2010). The ACSS was used in this study with permission from Dr. Kimberly Van Orden, University of

Rochester medical center, NY, USA (Appendix I). The original version of ACSS was translated into Thai version and back translated by bilingual expert panel. Content validity which examined by experts was shown that S-CVI/Average was 0.98. Internal consistency reliability of ACSS was tested in 30 severe mentally ill patients who had same characteristics with the sample in this study. The testing result was showed that Cronbach's alpha coefficient was 0.76.

Protection of the human right subjects

The study proposal was submitted to the institution review board of Suansaranrom hospital for approval prior to data collection. After obtained the permission to conduct a study from the ethic committee, the participants who meet the inclusion criteria were informed about objective, procedure, benefit, and risk of the study. The inform consent form was declares all the right they have including their right to terminate anytime without any consequence. The participants were assured that their decision to participate or discontinue in this program was not affect their relationship with health care provider. This interpersonal need program was presented to the participants without harm. The atmosphere of intervention was safe, respectful, and comfortable. In addition, personal data were collected confidentially.

Experimental procedure

There were two phases of experimental procedure including preparation phase, and implementation phase.

1. Preparation phase composed of instrument preparation, researcher and research assistant preparation, and participant preparation.

1.1 Instrument preparation There were five manuals for this program which consisted of 1) manual of the interpersonal need program 2) manual for

establishing caring relationship 3) manual for promoting sense of belongingness 4) manual for reducing perceived burdensomeness and 5) manual for disabling capability for suicide. All manuals were given to the research assistants during they participate in training program. In addition there was a booklet for patient which contents were related to cognitive behavioral approach for reducing self-hate, empowerment for reducing perceived burdensomeness, counseling for conducting safety plan after confront with negative life event, and counseling for conducting safety plan to reduce capability for suicide. Moreover, there was a booklet for caregiver which contents were related to psycho-education for family to promote positive relationship with patient, and psycho-education for family to disable capability for suicide. All instruments were conducted by the researcher and were approved for content validity by the experts.

1.2 Researcher and research assistant preparation For program preparation, the researcher reviewed nursing intervention skills and techniques according to the interpersonal need program. Those skills and techniques consisted of**:** therapeutic communication techniques, cognitive behavioral techniques, empowerment skills, psycho-education skill, and counseling techniques.

There was research assistants preparation in order to give the interpersonal need program to experimental group. Because of Suansaranrom hospital has six wards for patients with mood disorder and patients with schizophrenia, the researcher set six groups of research assistant. Each group had two research assistants. All research assistants were the mental health and psychiatric nurses who work in the inpatients wards of Suansaranrom hospital. They had at least two years experience in this field and had certificate training degree in mental health and psychiatric nursing. At least

one research assistant of each group had certificate of basic cognitive behavioral therapy training or higher in order to give CBT approach to patients. Ten research assistants from five wards were set as five teams of research assistants while researcher and one research assistant were in the sixth team. In conclusion, there were two members in each group. The first member who had certificate of CBT was assigned to conduct cognitive behavioral approach while the second member was assigned to implement psycho-education, empowerment, and individual counseling. Both member also established and continued caring relationship. In after discharge phase, first member called for telephone counseling in day 1 and day 4 whereas second member called for telephone counseling in day 2 and day 7. In this study researcher took responsibility as the second member.

All research assistants received training program for research assistants. The aims of this training program were to introduce the interpersonal need program; to refresh knowledge according to the interpersonal need program; to instruct process of the interpersonal need program; and to practice needed nursing skills/ techniques of the interpersonal need program. This three hours training program was conducted by the researcher.

Process of training program started with giving all manuals and booklets to research assistants to study before started training program. On the day of training, the first activity was orientation which spent 15 minutes to inform the purpose of the program, participant characteristics, and period of time in whole program and in each session. As knowledge and skill which mental health and psychiatric nurses had accumulate from their experience and training, the main points of nurse-patient relationship, cognitive behavioral approach, empowerment, psycho-education, and

counseling were lecture briefly. Within 30 minutes, the research assistants also asked questions and discussed about those issues. The most important part of this training program was the lecture about each part of the program. Researcher gave guideline document about the program to research assistants. It was focused on time (when), activities (what), target (who), and content including intensity of those interventions (how). This activity was finish in 90 minutes. After that discussion and conclusion were in 30 and 15 minutes respectively. Concern issues and protection of patient right were emphasized. The activities and contents are in Table 6.

1.3 Participant preparation The participants in both control and experimental groups were informed about the activities in the study by researcher or research assistants. They had opportunity to ask the questions and receive explanation from researcher or research assistants in order to understand their role and cooperate in this study. For experimental group, the researcher or research assistants informed individually about the interpersonal need program including time period, activities, and benefit.

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2. Implementation phase composed of procedure in control group, and procedure in experimental group.

2.1 Procedure in control group The participants in control group received usual care during rehabilitative phase of hospitalization. This usual care was conducted by mental health and psychiatric nurses in each ward included: 1) Individual nursing care due to individual problem: nurse had interaction with the patients due to individual problem. Each interaction spent 20-30 minutes. The frequency of the interaction depended on the situation at that time; 2) Discharge planning: nurse conducted group psycho-education about knowledge of disease and

self care, stress management, and warning signs of relapse; and 3) Psycho-education for family which was focused on depressive disorder, medication, and following up.

Table 6 Training program for research assistants

Activity and Content	Time
1. Orientation	15 minutes
1.1 The purpose of the interpersonal need program	
1.2 Participant characteristics	
1.3 Period of time	
2. Brief lecture/ Refresher	30 minutes
2.1 The interpersonal theory of suicide	
2.2 The nurse-patient relationship	
2.3 Cognitive behavioral approach	
2.4 Empowerment	
2.5 Psycho-education	
2.6 Counseling	
3. Lecture	90 minutes
3.1 Intervention part 1: Establishing caring relationship	
3.2 Intervention part 2: Promoting sense of belonging	
3.3 Intervention part 3: Reducing perceived burdensomeness	
3.4 Intervention part 4: Disabling capability for suicide	
3.5 Intervention after discharge	
3.6 Recording form	
4. Discussion	30 minutes
4.1 Concerned issues	
4.2 Protection of the participant rights	
5. Conclusion	15 minutes
5.1 Question & Answer	
5.2 Summarizing	

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2.2 **Procedure in experimental group** Nursing interventions in this program were conducted by researcher and research assistants in each ward. The interventions in the interpersonal need program were divided into two phases. Rehabilitative phase of hospitalization was comprised of four parts within two weeks: 1) Establishing caring relationship which involved with other parts of the program. Nurse spent 5-15 minutes every day for caring relationship. Issues of interaction were set for each day; 2) promoting sense of belongingness which composed of three

sessions of cognitive behavioral approach for reducing loneliness, and one session for psycho-education for family to promote positive relationship with patient. Each session needed 40-45 minutes; 3) Reducing perceived burdensomeness which were three parts of cognitive behavioral approach for reducing self-hate, one session of empowerment for reducing perceived burdensomeness, and one session of counseling for conducting safety plan after confront with negative life event. Nurse spent 45 minutes for each session; 4) Disabling capability for suicide which consisted of one session of counseling for conducting safety plan to reduce capability for suicide, and one session of psycho-education for family to disabling capability for suicide. Each session was finished in 40 minutes. In addition, every activity in this program was recorded in recording form.

Second phase of this program was after discharge phase. There were four times of telephone counseling within first week after discharge. These calls were made to confirm caring relationship and follow up on intervention in rehabilitative phase. First day after discharge, telephone counseling was conducted to follow up on thought modification about loneliness. Caregiver received telephone counseling on the second day to follow up on disabling capability for suicide. After that telephone counseling was conducted to follow up on thought modification about self hate on fourth day. The last time was seventh day after discharge which telephone counseling was made to follow up on safety plan and terminate nurse-patient relationship.

According to participants of the program, it could be concluded that patients received twelve sessions of intervention in rehabilitative phase of hospitalization (establish caring relationship, continued caring relationship which involved with other interventions, six session of cognitive behavioral approach,

psycho-education, empowerment, and two session of individual counseling) , and four sessions of intervention in after discharge phase (confirmed caring relationship which involved with telephone counseling, and three telephone counseling). In addition, caregivers were given two sessions of intervention in rehabilitative phase of hospitalization (two psycho-education), and one sessions of intervention in after discharge phase (telephone counseling).

Data collection procedure

The procedures of data collection were as follow:

1. After the study proposal was approved by the institution research board, the research contacted with nursing director, head nurses, and practice nurses in the rehabilitative ward of Suansaranrom hospital to inform about the study.

2. The researcher and research assistants recruited the participants who met the inclusion criteria into the study. They read information sheet and signed the inform consent. Furthermore, the researcher and research assistants explained and answered the questions about this study clearly.

3. The personal information sheet of patient was used to collect personal data.

4. The pretest was conducted by researcher and research assistants using the SSI-Thai version 2014 to measure suicidal ideation, and by the suicidal attempt record to record suicidal attempt. In addition, the interpersonal need questionnaire (INQ) was used to measure thwarted belongingness and perceived burdensomeness and the acquired capability for suicide scale (ACSS) was used to measure capability for suicide. In order to find out whether usual care effect interpersonal need and acquired capability for suicide, the INQ and the ACSS were used in control group similarly. Participants were asked to complete the SSI-Thai version, the INQ, and the ACSS by

themselves. This step spent 10-15 minutes. Furthermore, progress note and patients history were checked by researcher and research assistants to complete the suicidal attempt record.

5. The researcher and research assistants explained the participants about the group they was assigned and then randomly assigned them into either experimental group or control group.

6. While the participants in control group obtained usual care from the psychiatric nurses in the inpatient ward routinely, the participants in experimental group received the interpersonal need program from researcher and research assistants. The program was established within two weeks of rehabilitation phase and in first week after discharge.

7. Researcher and research assistants contacted caregivers who met the criteria and were specified in the personal information sheet of patient as caregiver. They were asked to complete the personal information sheet of caregiver.

8. Caregivers in control group obtained usual care from the psychiatric nurses in the inpatient ward whereas caregivers in experimental group received the interpersonal need program from researcher and research assistants. They were given two sessions of psycho-education. Appointment for telephone counseling was made in order to give intervention in after discharge phase.

9. In order to improve the program, open-ended questions were asked to research assistants, patients, and caregivers. Those questions were “How do you think about this program”, “What did you receive from this program”, and “What would you like to suggest to improve this program”. The results were presented in Appendix H.

10. Two weeks after discharge, the validity check was conducted by using the INQ to measure thwarted belongingness and perceived burdensomeness, and by the ACSS to measure acquired capability of suicide. Participants were asked to answer these questionnaires via phone. It took 10-15 minutes.

11. Two weeks after discharge, the posttest was conducted by researcher using the SSI to measure suicidal ideation. This step spent 5-10 minutes via telephone. Suicidal attempt record was used to record suicidal attempt if patients readmitted with suicidal attempt within two weeks after discharge.

12. The researcher checked the correct data regarding SSI score, and suicidal attempt record. The data were cleaned before data analysis.

In this procedure, there were thirty-three patients and thirty-three caregivers participate in the study. These patients were admitted to five inpatient ward, except one ward for Muslim patients which was no patient with suicidal attempt or suicidal ideation. This situation was consistent with the usual situation in this ward that there was a very few patient with suicide. In addition, in one – two weeks of data collection, there was chicken pox disease occurred in one ward, they had to limit new admission.

Data analysis procedure

The obtained data were analyzed by the statistical package for the social science for windows. Satisfy significant at the $p < .05$ level was used as a statistical significant for all analysis. Descriptive statistic was used to describe the socio-demographic characteristics of the samples. Fisher's exact test was used in order to test the differences in socio-demographic data between the experimental group and the control group.

The independent samples t-test was employed to compare suicidal ideation between experimental and control group at pre-test and at post-test. The -pair samples t-test was performed to compare suicidal ideation in experimental group between pre-test and post-test. In addition, the Kolmogorov-Smirnov Z test was used to compare suicidal attempt between experimental group and control group at pre-test and at post-test. The McNemar test was performed to compare suicidal attempt in experimental group between pre-test and post-test.

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CHAPTER 4
RESEARCH RESULT

The purpose of this study was to examine effects of the interpersonal need program on suicidal ideation and suicidal attempt in severe mentally ill patients. The criteria were made for sample selection then the sample consisted of 33 pairs of patients who hospitalized at Suansaranrom hospital, Suratthani province, and their caregivers. They were randomly assigned to either experimental group or control group. Participants in experimental group were perceived the interpersonal need program whereas participants in control group were received usual care. The interpersonal need program was conducted within two weeks of rehabilitative phase of hospitalization and was continued to first week after discharge. Data were collected on the recruited date and 14 days after discharge. The participants were asked to complete personal information sheet, Thai version of the scale for suicidal ideation (SSI-Thai version 2014), interpersonal need questionnaire (INQ), and acquired capability for suicide scale (ACSS). In addition, the suicide attempt record was completed by researcher and research assistants according to physician diagnosis and suicidal attempt history.

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The obtained data were analyzed by the statistical package for the social science for windows. Satisfy significant at $p < 0.05$ level was used as a statistical significant for all analysis. The research findings were presented in two parts: socio-demographic and clinical characteristics of the participants and results of the study related to hypotheses testing.

Part 1: Socio-demographic and clinical characteristics of the participants

There were sixty-six participants met the criteria in this study. Seventeen patients and seventeen caregivers were in experimental group whereas sixteen patients and sixteen caregivers were in control group. Characteristics of the participants were divided to

1. Socio-demographic characteristics of the patients comprised of gender, age, marital status, educational level, occupation, income, physical health status, caregiver, and relationship between patients and care giver.

2. Clinical characteristics of the patients comprised of diagnosis, duration of severe mental illness, and number of hospitalization

3. Socio-demographic characteristics of the caregivers composed of gender, age, marital status, educational level, occupation, income, physical health status, number of people in charge of caring, duration of caregiving, relation with patient, and relationship between patients and caregiver.

From Table 7, the majority of both experimental and control group were female (64.7% and 62.5% respectively), in adult aged (76.5% and 68.8%), do not have partner; single, separated, and divorced (76.5% and 62.5%), and graduated high school or higher (82.4% and 93.8%). More than 60% of them were employed (64.7% and 87.5%), however, their income was not enough to cost (52.9% and 75.0%). They had healthy physical status (58.8% and 81.2%). Blood relation; father/mother, son/daughter, brother/ sister were the majority caregiver of both group (82.4% and 62.5%) In addition there were intimate relationship between patient and caregiver in both group (70.6% and 75.0%).

Table 7 Socio-demographic characteristics of the severe mentally ill patients in experimental group and control group

Socio-demographic Characteristics	Experimental (n = 17)	Control (n = 16)	Total (n = 33)	*p*-value
	n (%)	n (%)	n (%)	
Gender				1.00
Male	6 (35.3)	6 (37.5)	12 (36.4)	
Female	11(64.7)	10 (62.5)	21(63.6)	
Age (years)				0.73
20-39	13 (76.5)	11(68.8)	24 (72.7)	
40-59	4 (23.5)	5 (31.2)	9 (27.3)	
Marital status				0.33
Single/ Separated/ Divorced	13 (76.5)	10 (62.5)	23 (69.7)	
Married	4 (23.5)	6 (37.5)	10 (30.3)	
Educational Level				1.00
Primary education or lower	3 (17.6)	1 (6.2)	4 (12.1)	
High school or higher	14 (82.4)	15 (93.8)	29 (87.9)	
Occupation				0.18
Unemployed	6 (35.3)	2 (12.5)	8 (24.2)	
Employed	11 (64.7)	14 (87.5)	25 (75.8)	
Income				0.22
No income/ Not enough to cost	9 (52.9)	12 (75.0)	21 (63.6)	
Enough to cost	8 (47.1)	4 (25.0)	12 (36.4)	
Physical health status				0.20
Healthy	10 (58.8)	13 (81.2)	23 (69.7)	
Have slightly ill/ chronic health conditions	7 (41.2))	3 (18.8)	10 (30.3)	
Caregiver				0.16
Blood relation	14 (82.4)	10 (62.5)	24 (72.7)	
Non blood relation	3 (17.6)	6 (37.5)	9 (27.3)	
Relationship between patient and caregiver				1.00
Intimate	12 (70.6)	12 (75.0)	24 (72.7)	
Separate/ Opposed	5 (29.4)	4 (25.0)	9 (27.3)	

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Table 8 Clinical characteristics of the severe mentally ill patients in experimental group and control group

Clinical Characteristics	Experimental (n = 17)	Control (n = 16)	Total (n = 33)	*p*-value
	n (%)	n (%)	n (%)	
Diagnosis				1.00
Major depressive disorder	4 (23.5)	4 (25.0)	8 (24.2)	
Schizophrenia	13 (76.5)	12 (75.0)	25 (75.8)	
Duration of mental illness (years)				0.09
Mean ± SD	5.76 ± 5.08	3.50 ± 2.34	4.67 ± 4.10	
Number of hospitalization (time)				0.89
Mean ± SD	2.94 ± 3.40	2.81 ± 1.64	2.88 ± 2.66	

According to clinical characteristics in Table 8, schizophrenia was the majority diagnosis in both groups (76.5% and 75.0%). In the experimental group mean duration of mental illness was 5.76 years whereas in the control group was 3.50 years. In addition number of hospitalization in both groups was about three times (2.94 times and 2.81 times). Fisher's exact test revealed no statistically significant difference between characteristics of patients in experimental and control group ($p > 0.05$). Particularly, participants were random into groups, it could be affirmed that both groups had similar socio-demographic and clinical characteristic. As a consequence patients characteristics in this study were not affect the study result.

Table 9 Socio-demographic characteristics of the caregivers in experimental group and control group

Socio-demographic Characteristics	Experimental (n = 17)	Control (n = 16)	Total (n = 33)	*p*-value
	n (%)	n (%)	n (%)	
Gender				1.00
Male	6 (35.3)	6 (37.5)	12 (36.4)	
Female	11 (64.7)	10 (62.5)	21 (63.6)	
Age (years)				0.16
39 or under	5 (29.4)	5 (31.2)	10 (30.3)	
40 or over	12 (70.6)	11 (68.8)	23 (69.7)	
Occupation				0.58
Unemployed	1 (5.9)	2 (12.5)	3 (9.1)	
Employed	16 (94.1)	14 (87.5)	30 (90.9)	
Income				0.61
No income/ Not enough to cost	3 (17.6)	3 (18.8)	6 (18.2)	
Enough to cost	14 (82.4)	13 (81.2)	27 (81.8)	
Physical health status				0.33
Healthy	13 (76.5)	10 (62.5)	23 (69.7)	
Have slightly ill/ chronic health conditions	4 (23.5)	6 (37.5)	10 (30.3)	
Number of people in charge of caring				0.59
Mean ± SD	2.41 ± 1.42	2.19 ± 1.33		
Duration of caregiving				0.09
Mean ± SD	5.76 ± 5.08	3.50 ± 2.34		
Relation with patient				0.16
Blood relation	14 (82.4)	10 (62.5)	24 (72.7)	
Non blood relation	3 (17.6)	6 (37.5)	9 (27.3)	
Relationship between patient and caregiver				1.00
Intimate	12 (70.6)	12 (75.0)	24 (72.7)	
Separate/ Opposed	5 (29.4)	4 (25.0)	9 (27.3)	

Table 9 revealed that the majority of both experimental and control group were female (64.7% and 62.5% respectively), in middle aged (70.6% and 68.8%), and had healthy physical status (76.58% and 6252%). Most of them were employed (94.1% and 87.5%), and their income were enough to cost (82.4% and 81.2%). The majority of their relations with patients were blood relation (82.4% and 81.2%).

In addition there were intimate relationship between patients and caregivers in both groups (70.6% and 75.0%). The mean number of people in charge of caring in both groups was about two persons (2.41 and 2.19). The mean duration of caregiving in experimental group was 5.76 years whereas in control group was 3.50 years. Fisher's exact test revealed no statistically significant difference between characteristics of caregivers in experimental and control group (p > 0.05). It could be assumed that both groups had quite similar socio-demographic. Therefore caregiver characteristics in this study were not affect the study result**.**

Part 2: Result of the study related to hypotheses testing

1. **Suicidal ideation**

Table 10 Comparison of suicidal ideation between experimental group and control group at pre-test and post-test

Suicidal ideation	Experimental group (n = 17)		Control group (n = 16)	
	Mean	SD	Mean	SD
Pre-test	11.00	6.38	9.44	5.43
Post-test	5.06	3.11	8.56	4.70

Table 10 revealed mean score of suicidal ideation at pre-test and post-test in experimental group, and control group. The result showed that at pre-test suicidal ideation mean score of experimental group and control group were 11.00 (SD = 6.38), and 9.44 (SD = 5.43) respectively. While at post-test, suicidal ideation mean score of experimental group and control group were 5.06 (SD = 3.11), and 8.56 (SD = 4.70) respectively.

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Table 11 Comparison of suicidal ideation between experimental group and control group at pre-test

Variable	Experimental group (n = 17)		Control group (n = 16)		t	*p*-value
	Mean	SD	Mean	SD		
Suicidal ideation	11.00	6.39	9.44	5.43	0.76	0.46

At pre-test, the independent samples t-test was employed to compare suicidal ideation between experimental and control group. The results in Table 11 showed that at pre-test, mean score of suicidal ideation in experimental group was 11.0 (SD = 6.39) while in control group was 9.44 (SD = 5.43). There was no statistically significant difference of suicidal ideation between both groups at pre-test ($p > 0.05$). These result showed similarity of suicidal ideation in experimental group and control group before hypotheses testing.

Hypothesis 1: Suicidal ideation in experimental group after received interpersonal need program have significantly lower than before.

Table 12 Comparison of suicidal ideation in experimental group between pre-test and post-test

Variable	Pre-test		Post-test		t	*p*-value
	Mean	SD	Mean	SD		
Suicidal ideation	11.00	6.39	5.06	3.11	6.14	0.00

To test this hypothesis, the paired samples t-test was performed to compare suicidal ideation in experimental group between pre-test and post-test. Table 12 revealed that mean score of suicidal ideation in experimental group at post-test (5.06, SD = 3.11) was lower than at pre-test (11.00, SD = 6.39) and there was

statistically significant difference of suicidal ideation in experimental group between pre-test and post-test ($p < 0.05$). Therefore hypothesis 1 was supported.

Hypothesis 2: Suicidal ideation in experimental group who received the interpersonal need program have significantly lower than in control group who received usual care.

Table 13 Comparison of suicidal ideation between experimental group and control group at post-test

Variable	Experimental group (n = 17)		Control group (n = 16)		t	*p*-value
	Mean	SD	Mean	SD		
Suicidal ideation	5.06	3.11	8.56	4.70	2.54	0.02

To test this hypothesis, the independent samples t-test was performed to compare suicidal ideation between experimental group and control group at post-test. Table 13 revealed that mean score of suicidal ideation in experimental group at post-test (5.06, SD = 3.11) was lower than in control group (8.56, SD = 4.70) and there was statistically significant difference of suicidal ideation between experimental group and control group at post-test ($p < 0.05$). Hence hypothesis 2 was supported.

2. Suicidal attempt

Table 14 Comparison of suicidal attempt between experimental group and control group at pre-test and post-test

Suicidal attempt	Experimental group (n = 17)		Control group (n = 16)	
	Pre-test n (%)	Post-test n (%)	Pre-test n (%)	Post-test n (%)
Suicidal attempt	10 (58.8)	0 (0.0)	7 (43.8)	0 (0.0)
Non-suicidal attempt	7 (41.2)	17 (100)	9 (56.2)	16 (100)

Table 14 revealed numbers of suicidal attempt at pre-test and post-test in experimental group, and control group. The result were shown that at pre-test number of suicidal attempt in experimental group, and control group were 10 (58.8%), and 7 (43.8%) respectively. While at post-test, number of suicidal attempt in experimental group, and control group was 0 (0%) similarly. In addition, at pre-test number of non-suicidal attempt in experimental group, and control group were 7 (41.2%), and 9 (56.2%) respectively. At post-test number of non-suicidal attempt in experimental group, and control group were 17 (100%), and 16 (100%).

Table 15 Comparison of suicidal attempt between the experimental group and control group at pre-test

Suicidal attempt	Experimental group (n= 17)		Control group (n=16)		Z test value	*p*-value
	n	(%)	n	(%)		
Suicidal attempt	10	58.8	7	43.8	0.43	0.99
Non suicidal attempt	7	41.2	9	56.2		

At pre-test, the Kolmogorov-Smirnov Z test was used to compare suicidal attempt between experimental group and control group. The results in Table 15 were

showed that at pre-test, number of suicidal attempt in experimental group was 10 (58.8%) while in control group was 7 (43.8%). There was no statistically significant difference of suicidal attempt between both groups at pre-test ($p > 0.05$). These result showed similarity of suicidal attempt in experimental group and control group before hypotheses testing.

Hypothesis 3: Suicidal attempt in experimental group after received interpersonal need program have significantly lower than before.

Table 16 Comparison of suicidal attempt in experimental group between pre-test and post-test

Suicidal attempt	**Pre-test**		**Post-test**		***p*-value**
	n	**%**	**n**	**%**	
Suicidal attempt	10	58.8	0	0	0.00
Non suicidal attempt	7	41.2	17	100	

To test this hypothesis, the McNemar test was performed to compare suicidal attempt in experimental group between pre-test and post-test. The results in table 16 were shown that in experimental group, there were 11 (58.8%) suicidal attempters at pre-test whereas there was 0 (0%) suicidal attempters at post-test. Moreover, there was statistically significant difference of suicidal attempt in experimental group between pre-test and post-test ($p < 0.05$). Therefore hypothesis 3 was supported.

Hypothesis 4: Suicidal attempt in experimental group who received the interpersonal need program have significantly lower than in control group who received usual care.

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Table 17 Comparison of suicidal attempt between experimental group and control group at post-test

Suicidal attempt	Experimental group (n = 17)		Control group (n = 16)		Z test value	*p*-value
	n	%	n	%		
Suicidal attempt	0	0	0	0	0.00	1.00
Non suicidal attempt	17	100	16	100		

To test these hypotheses, the Kolmogorov-Smirnov test was performed to compare suicidal attempt between experimental group and control group at post-test. Table 17 revealed that at post-test suicidal attempt in experimental group was 0 (0%) and non-suicidal attempt were 17 (100%) similar to suicidal attempt in control group which was 0 (0%) and non-suicidal attempt were 16 (100%). There was no statistically significant difference of suicidal attempt between experimental group and control group at post-test ($p > 0.05$). As a result, hypothesis 4 was rejected.

Table 18 Proportion of suicidal attempt before and after receiving program in experimental group and control group

Variable	Experimental group (n = 17)		Control group (n = 16)	
	Pre-test	Post-test	Pre-test	Post-test
Suicidal attempt	0.59	0	0.43	0

Although the result in Table 17 showed rejected hypothesis, Table 18 revealed that after receiving the interpersonal need program, proportion of suicidal attempt in experimental group was decreased from 0.59 to 0, whereas proportion of suicidal attempt in control group was decreased from 0.43 to 0.

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CHAPTER 5
DISCUSSION

This study was an experimental study using a pretest-posttest control group design. It aimed to examine effects of the interpersonal need program on suicidal ideation and suicidal attempt in severe mentally ill patients. The participants in this study were severe mentally ill patients who hospitalized at Suansaranrom hospital in Suratthani province, Thailand and their caregivers. Thirty-three patients and thirty caregivers were met the criteria. They were randomized into either experimental group or control group. Participants in experimental group received the interpersonal need program whereas participants in control group obtained usual care. The interpersonal need program which was developed by the researcher is the nursing intervention for severe mentally ill patients based on the interpersonal theory of suicide. This program was conducted within two weeks of rehabilitative phase of hospitalization and continued to first week after discharge.

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Ethical approval for this study was granted by the institution research board of Suansaranrom hospital. Patients and their caregiver were read information sheet and signed inform consent before participated in the study. The researcher explained the study to the participants till they were satisfied. The program was provided in a private area of inpatient ward to make participants felt comfortable. The participants were assessed using Thai version of the scale for suicidal ideation (SSI-Thai version 2014), the suicidal attempt record, the interpersonal need questionnaire (INQ), and the acquired capability for suicide scale (ACSS) on the recruitment date and 14 days after discharge.

Nursing interventions in the interpersonal need program were divided into four parts. Firstly, establishing caring relationship which conducted for patients including establishment of nurse-patient relationship, and caring relationship involve with another parts of the program. Second part was promoting sense of belongingness which provided for both patients and caregivers. This part consisted of cognitive behavioral approach for reducing loneliness, psycho-education for family to promote good relationship with patient, and telephone counseling for following up on though modification about loneliness. Reducing perceived burdensomeness was the third part of this program. It comprised of cognitive behavioral approach for reducing self-hate, empowerment for reducing perceived burdensomeness, counseling for conducting safety plan after confront with negative life event, and telephone counseling for following up on though modification about self-hate. Lastly, the fourth part was disabling capability for suicide which was provided for patients and also their caregivers. This part composed of counseling for conducting safety plan to reduce capability for suicide, psycho-education for family to disable capability for suicide, telephone counseling for following up with family to disable capability for suicide, and telephone counseling for following up on safety plan.

Descriptive statistics, Fisher's exact test, independent samples t-test, pair samples t-test, Kolmogorov-Smirnov test, and McNemar test were used for data analysis. The results of this study were:

1. Suicidal ideation in experimental group after received interpersonal need program was significantly lower than before.

2. Suicidal ideation in experimental group who received the interpersonal need program was significantly lower than in control group who received usual care.

3. Suicidal attempt in experimental group who received the interpersonal need program was not significantly lower than in control group who received usual care. However, the proportion of suicidal attempt in experimental group after received the interpersonal need program was lower than in control group.

Discussion of research finding

According to hypothesis one and two, suicidal ideation in experimental group after received interpersonal need program was significantly lower than before. Suicidal ideation in experimental group who received the interpersonal need program was significantly lower than in control group who received usual care. In addition, there was statistically significant difference of interpersonal need between pre-test and post-test in experimental group (Appendix G).

According to the interpersonal theory of suicide, suicidal ideation is related to the absence of reciprocally caring relationship and loneliness. These two factors cause the patients felt like they were not belong to a valued relationship (thwarted belongingness). Since the researcher established nurse-patient relationship, the patients may realize the consistency and continued relationship as a caring relationship and the social connection. , Even the relationship between patients and caregivers were intimate, the patients had offended feeling because of speech and behavior of their caregiver. Hence the process for modifying negative thoughts about their relationship, and psycho-education for caregivers to promote positive communication and attention were efficient to produce more social connection and social support for patients.

Furthermore suicidal ideation is also related to self hate and liability especially negative life event which induced the patients perceived that they were a burden on

other (perceived burdensomeness). In the part of reducing perceived burdensomeness the patients not only had a chance to modify their negative thoughts about themselves, but also empowered to find out their self-esteem and abilities. Moreover, the patients had their safety plan written on handbook which they may realize as a guideline to confront with negative life event that might occur in the future. The participants could express their profitable application via telephone counseling. The finding of the present study was congruent with the interpersonal theory of suicide and consistent with the previous study which found that both thwarted belongingness and perceived burdensomeness correlated with suicidal ideation (Christensen, Batterham, Soubelet, & Mackinnon, 2013). The fulfillment of the interpersonal need is effect to suicidal ideation reduction.

In the same way, there was statistically significant difference of interpersonal need between pre-test and post-test in control group (Appendix G) similarly. This finding suggested that usual care may reduce thwarted belongingness and perceived burdensomeness in control group. Because of However, there was a need to examine in further study.

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According to hypothesis three and four, there was no statistically significant difference of suicidal attempt between two groups after intervention acquiring. Similarly, there was no statistically significant difference of acquired capability for suicide (Appendix G). However, the proportion of suicidal attempt in experimental group after received the interpersonal need program was lower than in control group.

This result reveals that suicidal attempt is a suicide-related behavior which depends on a crisis situation. The severity of crisis may difference due to individual’s perception. Moreover, durations of situation occurrence in each person are various.

A pervious study found that patients who recently hospitalized with a suicide attempt or suicidal ideation were at extremely high risk for suicide in the first week after discharge (Qin & Nordentoft, 2005). In addition, after hospitalized in psychiatric hospital, there was 9% of suicidal death within one day of discharge (Litts et al., 2008). In Thailand, 14.3% of mood disorder patients did suicide complete five days after discharge (Ruengorn, 2011). These findings were mentioned the important of suicide prevention within the first week after discharge. This was the reason that the present study focused on this duration. However, there were other durations of high risk as within 90 days, 57.1% of mood disorder patients did complete suicide, and 38.9% did nonfatal suicide reattempt (Ruengorn, 2011). Approximately 16% of patients who served in hospital settings exhibit a repeat suicide attempt within one year of the index attempt (Owens, Horrock, & House, 2002). According to various high risk durations, suicidal attempt in these participants may difference significantly at another durations. As a result, there was no evidence about suicidal attempt and repeat suicide attempt within two weeks from this study.

In addition to Acquired capability for suicide scale, it was conducted to measure a sense of fearlessness about pain and death, and an elevated tolerance for physical pain in order to be capable of suicide. This scale was expected to reflect the nature of acquired capability for suicide, however, there are others factors predict this capability more than in the scale. From the study of Van Orden and colleagues, individuals with greater number of past suicidal attempts as well as greater experiences of other types of pain and provocation may be more able than others to overcome the fear and pain involved in the lethal self-injury and was more capable of suicide behavior (Van Orden et al., 2008). These factors are not measured by the

ACSS, whereas the interpersonal need program consider them. Conversely, the part of disabling capability for suicide in this program focus on safety plan and strategies to prevent suicidal attempt but less focus on alteration of a sense of fearlessness about pain and death, and an elevated tolerance for physical pain. In addition some items in the ACSS are sensitive to change, for example: "things that scare most people do not scare me", and "I like watching the aggressive contact in sports games". As a result, there was no statistically significant difference of acquired capability for suicide between two groups after post-test. Hence this program needs to reconsider about disabling capability for suicide in further study.

Research implication and recommendation

Implication for nursing practice

The findings of the study suggest that the systematic nursing intervention is essential to reduce suicide rate in severe mentally ill patients. The interpersonal need program in this study could be applied by psychiatric and mental health nurses to manage suicide prevention for severe mentally ill patients in order to reduce suicidal ideation. Decreasing of suicidal ideation may reduce suicide rate in this group of patients.

Furthermore, the activities in this program enhanced psychiatric and mental health nurses to work at their true potential. According to additional outcomes in Appendix H, psychiatric and mental health nurses realized that they had knowledge and skills of psychosocial intervention and they would like to utilize those knowledge and skills more efficiently. The intervention in the interpersonal need program could be done by a nurses team which assign nurses to have responsibilities on each phase or each part of the program to make congruent with nurse shift. Most particularly, the

interpersonal need in severe mentally ill patients could be promoted in order to prevent suicide in this group.

Implication for nursing education

According to effectiveness of this program, knowledge and skills of nurse are very essential. Nurses have to understand concepts of cognitive behavioral approach, psycho-education, empowerment, and counseling. Certificated training curriculum for mental health and psychiatric nurse could be considered for advance of practice. Nurses could have ability to not only apply this program but also develop another program for other group

Implication for policy

Nowadays, some psychiatric hospitals have had policy to manage inpatient ward according to phases of psychiatric symptom. Suicidal patients in acute phase have suicide precaution as a standard of caring for suicide prevention. Similarly, there could be a standard for suicide prevention in rehabilitative phase. The interpersonal need program could be one part of that standard which evidence to reduce suicidal ideation. Furthermore, following up at various times are needed.

Recommendation for further research

From findings of this study, there could be further research as following:

1. This study could be examined effects of the interpersonal need program on longer duration. The long term outcome of this program could be assessed in order to test the differences of suicidal ideation and also suicidal attempt.

2. The interpersonal theory of suicide could be guided nursing intervention in other groups of patient experienced mental health and psychiatric problem which related to the interpersonal need.

3. Telephone counseling in this program was conducted for convenience of the patients and caregivers. It could be a part of home visit which is an extended service for them. Consequently, intervention for severe mentally ill patients in the community could be designed for further study.

4. A study focus on satisfaction could be established in order to assess outcome of the interpersonal need program in patients, caregivers, and nurses perspective.

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APPENDICES

จุฬาลงกรณ์มหาวิทยาลัย
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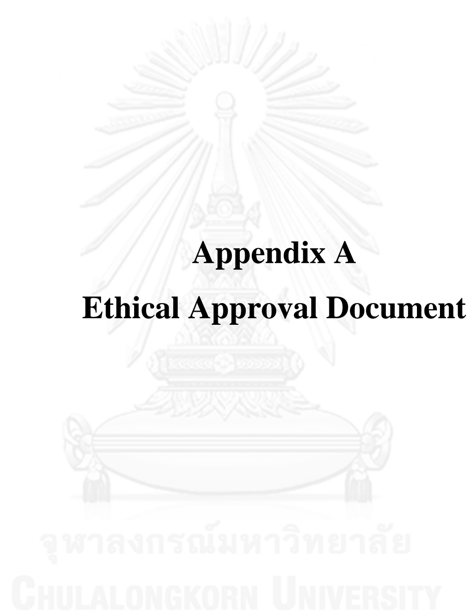

Appendix A

Ethical Approval Document

เอกสารรับรองด้านจริยธรรมการทำวิจัยในมนุษย์

เลขที่ ๐๘๘/๒๕๕๙

คณะกรรมการวิจัย และคณะกรรมการจริยธรรมการวิจัย โรงพยาบาลสวนสราญรมย์
ขอให้การรับรองว่า

ชื่องานวิจัย : ผลของโปรแกรมความสัมพันธ์ระหว่างบุคคลที่มีต่อความคิดฆ่าตัวตายและการพยายามฆ่าตัวตายในผู้ป่วยโรคจิต

ผู้วิจัยหลัก : นางสาวทานตะวัน แย้มบุญเรือง

หน่วยงาน : คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย

เอกสารที่เกี่ยวข้อง :

๑. โครงร่างวิทยานิพนธ์
๒. ใบยินยอมให้ทำการวิจัยในมนุษย์
๓. เครื่องมือที่ใช้ในการวิจัย
๔. เอกสารชี้แจงข้อมูลสำหรับผู้เข้าร่วมวิจัย

เป็นการวิจัยที่มีลักษณะตรงตามเกณฑ์ของ International Guidelines for Human Research Protection ได้แก่ Declaration of Helsinki, the Belmont Report, CIOMS Guidelines and the International Conference on Harmonization's Good Clinical Practice (ICH-GCP) ทุกประการ

วันที่ยื่นพิจารณา : ๑๓ พฤษภาคม ๒๕๕๙
เลขที่งานวิจัยที่ยื่นพิจารณา : ๙๕/๒๕๕๙
วันที่ได้รับการรับรอง : ๑๐ มิถุนายน ๒๕๕๙

ลงนาม .... ประธานคณะกรรมการวิจัย
(นายแพทย์วิศิษฏ์ ธานีรัตน์)

ลงนาม .... ประธานคณะกรรมการจริยธรรมการวิจัย
(นายอัตถพงศ์ ถนิมพาสน์)

ลงนาม .... ผู้อำนวยการโรงพยาบาลสวนสราญรมย์
(นายแพทย์จุมภฏ พรมสีดา)

จุฬาลงกรณ์มหาวิทยาลัย
Chulalongkorn University

Appendix B
List of Expert

List of expert

1. Mrs. Jarunee Ratsamisuwiwat

   Advanced Practice Nurse in Psychiatric and Mental Health Nursing,

   Suanprung Hospital

2. Dr. Nopparat Chaichumni

   Advanced Practice Nurse in Psychiatric and Mental Health Nursing,

   Suansaranrom Hospital

3. Dr. Norrawee Phoomchan

   Psychiatrist, Somdej Chaopraya Institute of Psychiatry

4. Mrs. Skaorat Puangladda

   Advanced Practice Nurse in Psychiatric and Mental Health Nursing,

   Srithanya Hospital

5. Mrs. Somsook Sommaluan

   Professional Nurse, Suansaranrom Hospital

6. Dr. Thitiphan Thaneerat

   Director, Mental Health Center Region 11

   Deputy directy, Suansaranrom Hospital

7. Dr. Wipawee Phaokuntarakorn

   Advanced Practice Nurse in Psychiatric and Mental Health Nursing,

   Somdej Chaopraya Institute of Psychiatry

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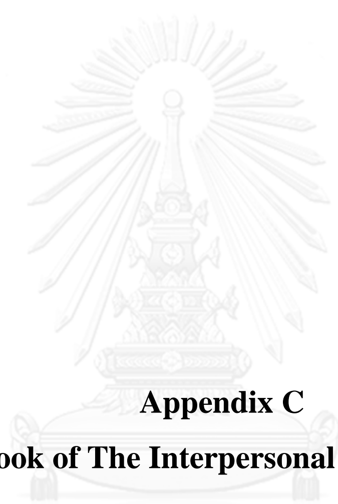

Appendix C
Handbook of The Interpersonal Need Program

จุฬาลงกรณ์มหาวิทยาลัย
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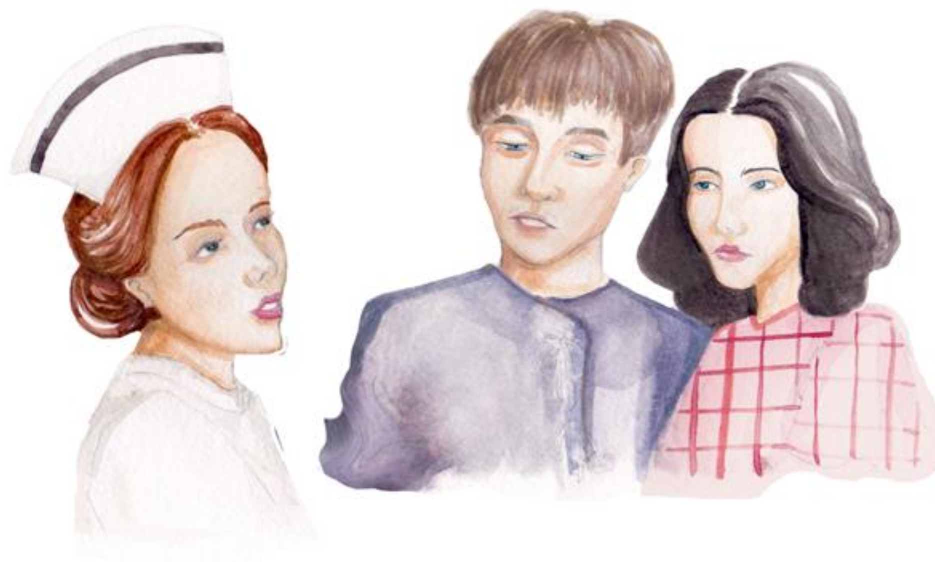
โปรแกรมความต้องการระหว่างบุคคล

The Interpersonal Need Program



ทานตะวัน แย้มบุญเรือง
รศ.ดร. จินตนา ยูนิพันธุ์

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สำหรับโปรแกรมความต้องการระหว่างบุคคล

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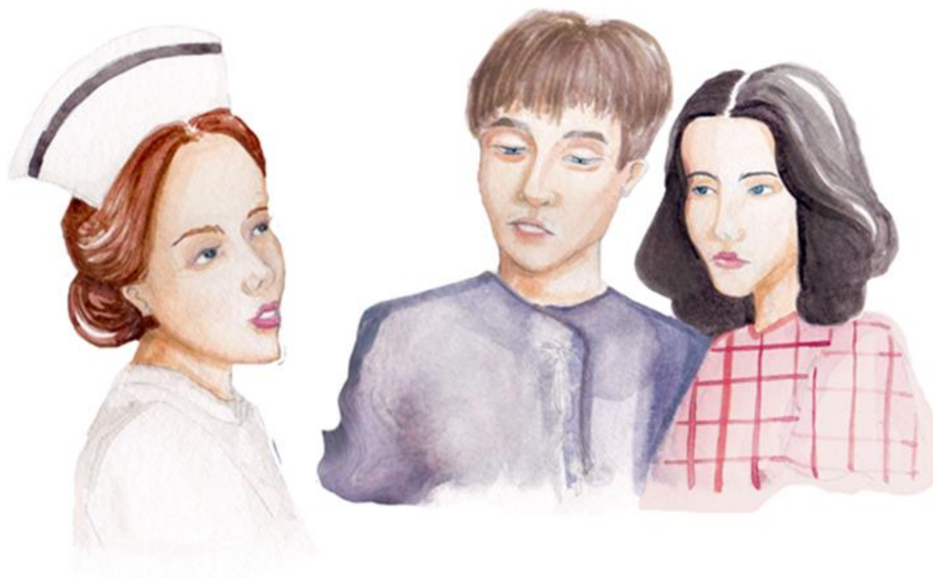

ทานตะวัน แย้มบุญเรือง
รศ.ดร. จินตนา ยูนิพันธุ์

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The Interpersonal Need Program

ทานตะวัน แย้มบุญเรือง
รศ.ดร. จินตนา ยูนิพันธุ์

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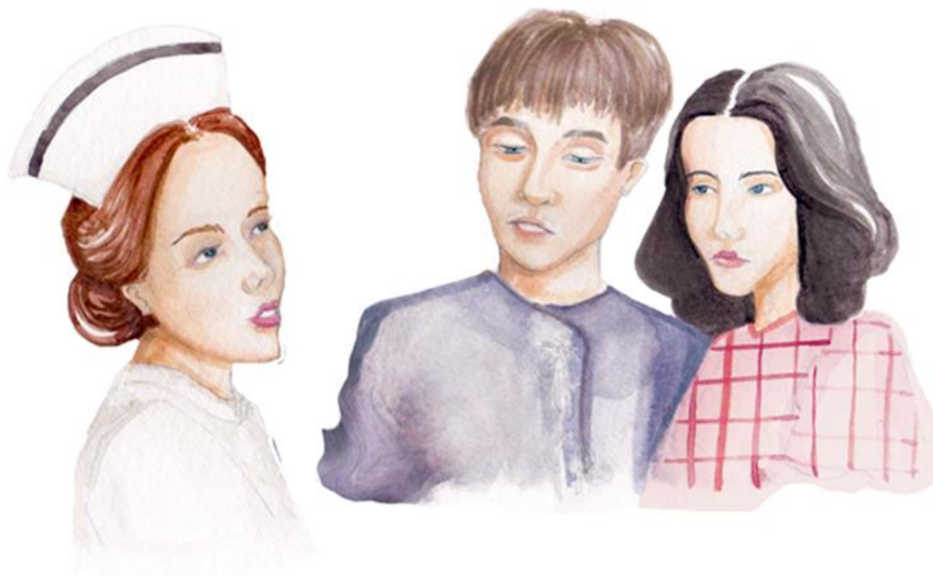

ทานตะวัน แย้มบุญเรือง
รศ.ดร. จินตนา ยูนิพันธุ์

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ทานตะวัน แย้มบุญเรือง
รศ.ดร. จินตนา ยูนิพันธุ์

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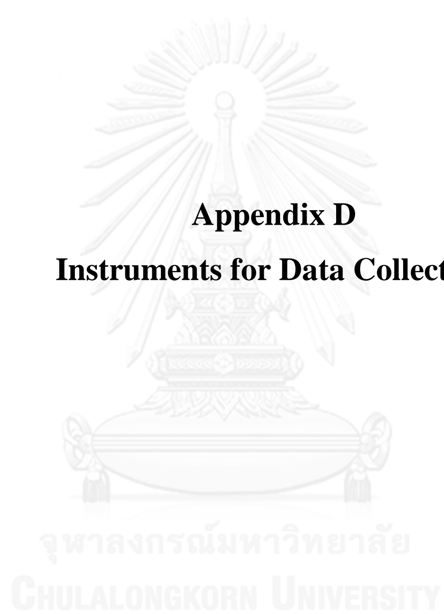

Appendix D

Instruments for Data Collection

แบบประเมินความคิดฆ่าตัวตาย

คำชี้แจง แบบสอบถามชุดนี้ต้องการทราบความรู้สึกของท่านที่ตรงกับความเป็นจริงในปัจจุบัน โปรดอ่านข้อความแต่ละข้อให้เข้าใจและเติมเครื่องหมาย ✓ ในช่องที่ตรงกับความรู้สึกหรือความคิดเห็นของท่านมากที่สุด

1. ท่านอยากมีชีวิตอยู่

☐ ปานกลางถึงมาก ☐ เล็กน้อย ☐ ไม่เลย

2. ท่านคิดอยากตาย

☐ ไม่เลย ☐ เล็กน้อย ☐ ปานกลางถึงมาก

3. หากเปรียบเทียบเหตุผลของการอยากมีชีวิตหรืออยากตาย

☐ อยากมีชีวิตอยู่มากกว่าอยากตาย

☐ เหตุผลทั้งสองอย่างเท่ากัน

☐ อยากตายมากกว่าอยากมีชีวิตอยู่

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แบบบันทึกการพยายามฆ่าตัวตาย

คำชี้แจง แบบบันทึกนี้**<u>บันทึกโดยพยาบาล</u>**ซึ่งอ้างอิงจากการวินิจฉัยของแพทย์และประวัติ การเจ็บป่วย

1. การพยายามฆ่าตัวตายก่อนมาโรงพยาบาล<u>ในครั้งนี้</u>

    ☐ ไม่มีการพยายามฆ่าตัวตาย (หากเคยมีการพยายามฆ่าตัวตายในอดีตให้บันทึกข้อ 3, 4 ด้วย)

    ☐ มีการพยายามฆ่าตัวตาย (ให้บันทึกข้อ 2 เพิ่มเติม)

2. ประวัติการพยายามฆ่าตัวตายก่อนมาโรงพยาบาล<u>ในครั้งนี้</u>

    2.1 วันที่มีการพยายามฆ่าตัวตาย ....

    2.2 ....

    2.3 ....

    2.4 ....

    2.5 ....

3. ....

4. ....

แบบสอบถามเกี่ยวกับความจำเป็นด้านความสัมพันธ์กับผู้อื่น

คำชี้แจง คำถามต่อไปนี้ใช้เพื่อถามให้ท่านคิดเกี่ยวกับตัวท่านเองและผู้อื่น กรุณาตอบแต่ละคำถามตามความเชื่อ ณ ปัจจุบันและประสบการณ์ของท่านเอง โดยไม่ตอบตามที่ท่านคิดว่าคำตอบที่ถูกควรจะเป็นเช่นนั้นหรือตอบตามที่คนโดยทั่วไปเชื่อว่าเป็นเช่นนั้น กรุณาตอบตามที่ท่านรู้สึก**<u>ในขณะที่ตอบแบบสอบถามนี้</u>** โดย**<u>เลือกวงกลมรอบตัวเลข</u>**ซึ่งตรงกับความรู้สึกของท่านมากที่สุด ทั้งนี้ไม่มีคำตอบถูกหรือผิด ผู้ทำวิจัยประสงค์เพียงจะทราบว่าท่านคิดและรู้สึกอย่างไร

ลำดับ	ข้อคำถาม	1 ไม่เป็นจริงเลยสำหรับตัวฉัน	2	3	4 ค่อนข้างเป็นจริงสำหรับตัวฉัน	5	6	7 เป็นจริงอย่างยิ่งสำหรับตัวฉัน
1.	ทุกวันนี้คนรอบตัวของฉันน่าจะมีชีวิตที่ดี กว่านี้ถ้าฉันจากไป	1	2	3	4	5	6	7
2.	ทุกวันนี้คนรอบตัวของฉันน่าจะมีความสุขมากกว่านี้ถ้าปราศจากฉัน	1	2	3	4	5	6	7
3.	ทุกวันนี้ฉันคิดว่าฉันเป็นภาระของคนรอบตัว	1	2	3	4	5	6	7
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จุฬาลงกรณ์มหาวิทยาลัย
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มาตรวัดความสามารถที่อาจจะพัฒนาไปสู่การฆ่าตัวตาย

คำชี้แจง กรุณาอ่านคำบรรยายด้านล่างและประเมินตนเองว่าคำบรรยายแต่ละข้อตรงกับความรู้สึกของท่านมากน้อยเพียงใด โดย**<u>เลือกวงกลมรอบตัวเลข</u>**ซึ่งตรงกับความรู้สึกของท่านมากที่สุด ทั้งนี้ไม่มีคำตอบถูกหรือผิด ผู้ทำวิจัยประสงค์เพียงจะทราบว่าท่านคิดและรู้สึกอย่างไร

ลำดับ	ข้อคำถาม	0 ไม่ตรงกับตัวฉันเลย	1	2	3	4 ตรงกับตัวฉันอย่างมาก
1.	สิ่งที่ทำให้ผู้คนส่วนใหญ่กลัวไม่ทำให้ฉันรู้สึกกลัว	0	1	2	3	4
2.	เมื่อฉันเห็นเลือดของตัวเองฉันไม่รู้สึกตกใจ	0	1	2	3	4
3.	ฉันหลีกเลี่ยงสถานการณ์บางอย่าง (เช่น กีฬาบางประเภท) เพราะมีโอกาสทำให้เกิดการบาดเจ็บได้	0	1	2	3	4
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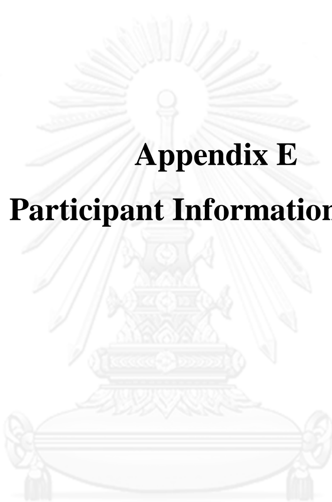

Appendix E
Participant Information Sheet

เอกสารชี้แจงผู้เข้าร่วมการวิจัยสำหรับผู้ป่วย

ชื่อโครงการวิจัย	ผลของโปรแกรมความต้องการระหว่างบุคคลต่อความคิดฆ่าตัวตายและการพยายามฆ่าตัวตายในผู้ป่วยโรคจิต
ชื่อผู้วิจัย	นางสาวทานตะวัน แย้มบุญเรือง นิสิตปริญญาเอก คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย
การปฏิบัติงาน	อาจารย์ประจำภาควิชาสุขภาพจิตและการพยาบาลจิตเวช วิทยาลัยพยาบาลบรมราชชนนี จังหวัดนนทบุรี
สถานที่ติดต่อผู้วิจัย	คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย หรือ 47/99 หมู่ 4 ถนนติวานนท์ ตำบลตลาดขวัญ อำเภอเมือง จังหวัดนนทบุรี 11000
โทรศัพท์มือถือ	08-7708-1993
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เอกสารฉบับนี้ผู้วิจัยจัดทำขึ้นเพื่อขอเรียนเชิญท่านเข้าร่วมในการวิจัย ซึ่งก่อนที่ท่านจะตัดสินใจเข้าร่วมในการวิจัยนี้ ท่านมีความจำเป็นที่จะต้องทราบรายละเอียดของการวิจัยก่อน ดังนั้นเอกสารฉบับนี้จึงเป็นการบอกเล่าข้อมูลเกี่ยวกับการดำเนินการวิจัย ซึ่งท่านสามารถนำข้อมูลในเอกสารฉบับนี้ไปใช้ประกอบ การตัดสินใจว่าจะเข้าร่วมการวิจัยครั้งนี้หรือไม่ กรุณาอ่านข้อมูลต่อไปนี้อย่างละเอียด และท่านสามารถสอบถามข้อมูลเพิ่มเติมหรือข้อมูลที่ไม่ชัดเจนจากผู้วิจัยได้ตลอดเวลา

1. การที่ผู้ป่วยจิตเวชมีความคิดฆ่าตัวตายหรือพยายามฆ่าตัวตายเป็นผลมาจากภาวะซึมเศร้าซึ่งเป็นส่วนหนึ่งของการเจ็บป่วยทางจิต นอกจากนี้ยังเป็นผลมาจากความรู้สึกไม่เป็นที่ยอมรับ การรับรู้ว่าตนเองเป็นภาระ และความสามารถที่อาจพัฒนาไปสู่การฆ่าตัวตาย ซึ่งทั้ง 3 ประการนี้สามารถปรับเปลี่ยนได้ ด้วยเหตุนี้ผู้วิจัยจึงสร้าง "โปรแกรมความต้องการระหว่างบุคคล" ขึ้นเพื่อเป็นการพยาบาลที่จะดูแลช่วยเหลือผู้ป่วยให้ลดความคิดฆ่าตัวตายและยับยั้งการพยายามฆ่าตัวตาย ซึ่ง "ความคิดฆ่าตัวตาย" ในที่นี้หมายถึง ความคิดหรือแผนการเกี่ยวกับการทำให้ตนเองเสียชีวิต และ "การพยายามฆ่าตัวตาย" ในที่นี้หมายถึง การทำร้ายตนเองโดยมีจุดมุ่งหมายให้ตนเองเสียชีวิต ทั้งนี้มีวัตถุประสงค์ของการวิจัยคือ เพื่อทดสอบประสิทธิผลของโปรแกรมความต้องการระหว่างบุคคลที่มีต่อความคิดฆ่าตัวตายและการพยายามฆ่าตัวตายในผู้ป่วยจิตเวช

2. ท่านและผู้ดูแล/สมาชิกในครอบครัวได้รับเชิญให้เข้าร่วมการวิจัยนี้เพราะท่านคือ ผู้ป่วยจิตเวชที่มีความคิดฆ่าตัวตายหรือพยายามฆ่าตัวตาย และได้รับการช่วยเหลือโดยการเข้ารับการรักษาในโรงพยาบาล ซึ่งเป็นกลุ่มที่ผู้วิจัยต้องการศึกษาในครั้งนี้ โดยระยะเวลาในการดำเนินการวิจัยคือ ในช่วงเวลาประมาณ 2 สัปดาห์ที่ผู้ป่วยรับการรักษาในระยะฟื้นฟูสมรรถภาพทางจิต และในสัปดาห์แรกหลังผู้ป่วยจำหน่ายออกจากโรงพยาบาล

3. ผู้เข้าร่วมการวิจัยในครั้งนี้แบ่งเป็น 2 กลุ่ม ซึ่งท่านและผู้ดูแล/สมาชิกในครอบครัวจะอยู่ในกลุ่มใดกลุ่มหนึ่ง ดังต่อไปนี้

3.1 กลุ่มควบคุม ประกอบด้วยผู้ป่วยจิตเวชที่ได้รับการพยาบาลตามปกติ จำนวน 17 คน และผู้ดูแล/สมาชิกในครอบครัวผู้ป่วยที่ได้รับการพยาบาลตามปกติ จำนวน 17 คน

3.2 กลุ่มทดลอง ประกอบด้วยผู้ป่วยจิตเวชที่ได้รับการพยาบาลตามโปรแกรมความต้องการระหว่างบุคคล จำนวน 17 คน และผู้ดูแล/สมาชิกในครอบครัวผู้ป่วยที่ได้รับการพยาบาลตามปกติร่วมกับโปรแกรมความต้องการระหว่างบุคคล จำนวน 17 คน

4. หลังจากได้รับการพิจารณาจากคณะกรรมการจริยธรรมโครงการวิจัย และได้รับอนุมัติจากผู้อำนวยการโรงพยาบาลสวนสราญรมย์ให้เก็บรวบรวมข้อมูลแล้ว ผู้วิจัยได้เข้าพบหัวหน้าพยาบาล หัวหน้าหอผู้ป่วย และพยาบาลประจำหอผู้ป่วยตามลำดับเพื่อแนะนำตัว อธิบายวัตถุประสงค์ และกระบวนการวิจัย จากนั้นผู้วิจัยจะขอให้ท่านตอบแบบสอบถามจำนวน 4 ฉบับ ใช้เวลาประมาณ 15 นาที (ซึ่งท่านจะได้ตอบแบบสอบถาม 3 ฉบับในชุดเดียวกันนี้อีกครั้งหลังจากที่ท่านออกจากโรงพยาบาลไปแล้วเป็นเวลา 2 สัปดาห์) จากนั้นผู้วิจัยจะสุ่มท่านและผู้ดูแล/สมาชิกในครอบครัว เข้าเป็นกลุ่มควบคุมหรือกลุ่มทดลอง โดยท่านจะได้รับการดูแลจากพยาบาลวิชาชีพประจำหอผู้ป่วยและผู้วิจัย ดังต่อไปนี้

การพยาบาลตามปกติ สำหรับผู้ป่วยในกลุ่มควบคุม ได้แก่

1. การบำบัดทางจิตสังคมตามปัญหาของผู้ป่วย
2. การวางแผนการจำหน่าย โดยการทำกลุ่มสุขภาพจิตศึกษาเกี่ยวกับโรค การดูแลตนเอง การจัดการความเครียด และสัญญาณเตือนของอาการทางจิตกำเริบ

การพยาบาลตามโปรแกรมความต้องการระหว่างบุคคล สำหรับผู้ป่วยในกลุ่มทดลอง โดยการพยาบาลในข้อ 1-8 จะดำเนินการเป็นรายบุคคลในสถานที่ซึ่งมีความเป็นส่วนตัวและมีความปลอดภัยภายใน หอผู้ป่วย และการพยาบาลในข้อ 9 – 11 จะดำเนินการทางโทรศัพท์โดยท่านสามารถเลือกช่วงเวลาที่รับโทรศัพท์ได้ตามที่ท่านสะดวก การพยาบาลดังกล่าวได้แก่

1. การทำความรู้จักระหว่างพยาบาลและผู้ป่วย ในวันที่ 1 ใช้เวลา 15 นาที
2. การทำความเข้าใจเพิ่มเติมเกี่ยวกับโปรแกรม ในวันที่ 2 ใช้เวลา 30 นาที
3. การดำเนินสัมพันธภาพเพื่อการดูแล ในวันที่ 3-13 ใช้เวลาครั้งละ 15 นาที
4. การใช้เทคนิคความคิดและพฤติกรรมเพื่อลดความรู้สึกโดดเดี่ยว จำนวน 3 ครั้ง ในวันที่ 3, 4, 5 ใช้เวลาครั้งละ 45 นาที
5. การใช้เทคนิคความคิดและพฤติกรรมเพื่อลดความรู้สึกเกลียดตัวเอง จำนวน 3 ครั้ง ในวันที่ 7, 8, 9 ใช้เวลาครั้งละ 45 นาที
6. การเสริมสร้างพลังอำนาจเพื่อลดการรับรู้ว่าตนเองเป็นภาระ ในวันที่ 10 ใช้เวลา 45 นาที
7. การให้การปรึกษาเพื่อวางแผนความปลอดภัยจากการเผชิญเหตุการณ์ด้านลบ ในวันที่ 11 ใช้เวลา 45 นาที
8. การให้การปรึกษาเพื่อวางแผนความปลอดภัยจากความสามารถในการฆ่าตัวตาย ในวันที่ 12 ใช้เวลา 40 นาที
9. การให้การปรึกษาทางโทรศัพท์เพื่อติดตามการปรับเปลี่ยนความรู้สึกโดดเดี่ยว โดยพยาบาลจะโทรศัพท์ถึงผู้ป่วยในวันที่ 1 หลังจำหน่ายออกจากโรงพยาบาล ใช้เวลา 15 นาที

10. การให้การปรึกษาทางโทรศัพท์เพื่อติดตามการปรับเปลี่ยนความรู้สึกเกลียดตัวเอง โดยพยาบาลจะโทรศัพท์ถึงผู้ป่วยวันที่ 4 หลังจำหน่ายออกจากโรงพยาบาล ใช้เวลา 15 นาที

11. การให้การปรึกษาทางโทรศัพท์เพื่อติดตามแผนความปลอดภัย โดยพยาบาลจะโทรศัพท์ถึงผู้ป่วยในวันที่ 7 หลังจำหน่ายออกจากโรงพยาบาล ใช้เวลา 15 นาที

5. ในการวิจัยครั้งนี้อาจมีความเสี่ยงเพียงเล็กน้อย เช่น ท่านอาจเหนื่อยล้าจากการสนทนากับพยาบาลอย่างต่อเนื่องในแต่ละครั้ง ซึ่งท่านสามารถขอหยุดพักช่วงสั้นๆได้ หรืออาจมีหัวข้อสนทนาที่ทำให้ท่านรู้สึกอึกอัดไม่สบายใจหรือไม่สะดวกที่จะตอบ ซึ่งท่านมีสิทธิ์จะไม่ตอบหรือหยุดการสนทนาในหัวข้อนั้นได้ทุกเวลา

6. ในการวิจัยครั้งนี้มีประโยชน์ที่ท่านจะได้รับจากการเข้าร่วมการวิจัยคือ ได้รับการดูแลช่วยเหลือเพื่อป้องกันการฆ่าตัวตาย โดยการจัดการกับความรู้สึกไม่เป็นที่ยอมรับ การรับรู้ว่าตนเองเป็นภาระ และความสามารถที่อาจพัฒนาไปสู่การฆ่าตัวตาย ทั้งนี้ประโยชน์ของงานวิจัยที่จะเกิดขึ้นคือ สามารถนำผลการวิจัยที่ได้ไปพัฒนาทั้งทางด้านนโยบายและด้านการปฏิบัติ เป็นแนวทางสำหรับพยาบาลในการดูแลเพื่อป้องกันการฆ่าตัวตายสำหรับผู้ป่วยจิตเวชที่มีความคิดฆ่าตัวตาย และ/หรือพยายามฆ่าตัวตาย ช่วยให้ผู้ป่วยใช้ชีวิตด้วยการปรับเปลี่ยนความคิดทางลบ รับรู้ว่าตนเองมีพลังอำนาจที่จะดูแลตนเอง และสามารถป้องกันตนเองจากความคิดหรือเหตุการณ์ที่จะนำไปสู่การฆ่าตัวตายได้ อันจะส่งผลให้อัตราการเสียชีวิตจากการฆ่าตัวตายในผู้ป่วยจิตเวชลดลง

7. การตอบแบบสอบถามแต่ละข้อ ไม่มีข้อใดถูกหรือผิด คำตอบของท่านเป็นเพียงข้อมูลส่วนบุคคลและความคิด ความรู้สึกของผู้เข้าร่วมการวิจัยเท่านั้น ข้อมูลที่ได้จากการตอบแบบสอบถามของท่านจะถูกนำไปรวมกับข้อมูลของคนอื่นๆ โดยผู้วิจัยจะใช้รหัสแทนชื่อ-นามสกุลในแบบบันทึกข้อมูล นอกจากนี้ข้อมูลที่ท่านสนทนากับพยาบาลจะได้รับการรักษาความลับ มีเพียงแพทย์และพยาบาลในทีมรวมทั้งผู้วิจัยเท่านั้นที่จะทราบเพื่อเป็นข้อมูลประกอบการวางแผนการดูแล หากผู้วิจัยตีพิมพ์ผลการศึกษา ผู้วิจัยจะไม่มีการระบุชื่อ – นามสกุลหรือที่อยู่ของท่านไม่ว่ากรณีใดๆ

8. หากท่านมีข้อสงสัย ผู้วิจัยยินดีให้คำตอบโดยไม่ปิดบัง ซึ่งท่านสามารถสอบถามโดยติดต่อผู้วิจัยได้ตลอดเวลาที่หมายเลขโทรศัพท์ 08-7708-1993 และหากผู้วิจัยมีข้อมูลเพิ่มเติมที่เกี่ยวข้องกับการวิจัย ผู้วิจัยจะแจ้งให้ท่านทราบอย่างรวดเร็ว เพื่อให้ท่านได้ทบทวนว่ายังสมัครใจจะเข้าร่วมการวิจัยต่อไปหรือไม่

9. การเข้าร่วมการวิจัยในครั้งนี้เป็นไปโดยสมัครใจ และไม่มีค่าใช้จ่ายใดๆ ท่านสามารถปฏิเสธที่จะเข้าร่วมหรือถอนตัวจากการวิจัยได้ทุกขณะ โดยจะไม่มีผลกระทบต่อการรับรักษา

10. การวิจัยครั้งนี้มีการมอบกระเป๋าผ้า จำนวน 1 ใบเป็นของที่ระลึกแก่ท่านเมื่อท่านออกจากโรงพยาบาล

11. หากท่านไม่ได้รับการปฏิบัติตามข้อมูลดังกล่าว สามารถร้องเรียนได้ที่ คณะกรรมการพิจารณาจริยธรรมการวิจัยในคน โรงพยาบาลสวนสราญรมย์ เลขที่ 298 ถนนธราธิบดี ตำบลท่าข้าม อำเภอพุนพิน จังหวัดสุราษฎร์ธานี รหัสไปรษณีย์ 84130 หมายเลขโทรศัพท์ 077-916500, 077-311308, 077-311444, 077-240566, 077-240567 โทรสาร 077-240565 หรือร้องเรียนที่ผู้วิจัยโดยตรง คือ นางสาวทานตะวัน แย้มบุญเรือง หมายเลขโทรศัพท์ 08-7708-1993

เอกสารชี้แจงผู้เข้าร่วมการวิจัยสำหรับผู้ดูแลผู้ป่วย

ชื่อโครงการวิจัย	ผลของโปรแกรมความต้องการระหว่างบุคคลต่อความคิดฆ่าตัวตายและ การพยายามฆ่าตัวตายในผู้ป่วยโรคจิต
ชื่อผู้วิจัย	นางสาวทานตะวัน แย้มบุญเรือง นิสิตปริญญาเอก คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย
การปฏิบัติงาน	อาจารย์ประจำภาควิชาสุขภาพจิตและการพยาบาลจิตเวช วิทยาลัยพยาบาลบรมราชชนนี จังหวัดนนทบุรี
สถานที่ติดต่อผู้วิจัย	คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย หรือ 47/99 หมู่ 4 ถนนติวานนท์ ตำบลตลาดขวัญ อำเภอเมือง จังหวัดนนทบุรี 11000
โทรศัพท์มือถือ	08-7708-1993
E-mail	tantawany@gmail.com

เอกสารฉบับนี้ผู้วิจัยจัดทำขึ้นเพื่อขอเรียนเชิญท่านเข้าร่วมในการวิจัย ซึ่งก่อนที่ท่านจะตัดสินใจเข้าร่วมในการวิจัยนี้ ท่านมีความจำเป็นที่จะต้องทราบรายละเอียดของการวิจัยก่อน ดังนั้นเอกสารฉบับนี้จึงเป็นการบอกเล่าข้อมูลเกี่ยวกับการดำเนินการวิจัย ซึ่งท่านสามารถนำข้อมูลในเอกสารฉบับนี้ไปใช้ประกอบการตัดสินใจว่าจะเข้าร่วมการวิจัยครั้งนี้หรือไม่ กรุณาอ่านข้อมูลต่อไปนี้อย่างละเอียด และท่านสามารถสอบถามข้อมูลเพิ่มเติมหรือข้อมูลที่ไม่ชัดเจนจากผู้วิจัยได้ตลอดเวลา

1. การที่ผู้ป่วยจิตเวชมีความคิดฆ่าตัวตายหรือพยายามฆ่าตัวตายเป็นผลมาจากภาวะซึมเศร้าซึ่งเป็นส่วนหนึ่งของการเจ็บป่วยทางจิต นอกจากนี้ยังเป็นผลมาจากความรู้สึกไม่เป็นที่ยอมรับ การรับรู้ว่าตนเองเป็นภาระ และความสามารถที่อาจพัฒนาไปสู่การฆ่าตัวตาย ซึ่งทั้ง 3 ประการนี้สามารถปรับเปลี่ยนได้ ด้วยเหตุนี้ผู้วิจัยจึงสร้าง “โปรแกรมความต้องการระหว่างบุคคล” ขึ้นเพื่อเป็นการพยาบาลที่จะดูแลช่วยเหลือผู้ป่วยให้ลดความคิดฆ่าตัวตาย และยับยั้งการพยายามฆ่าตัวตาย ซึ่ง “ความคิดฆ่าตัวตาย” ในที่นี้หมายถึง ความคิดหรือแผนการเกี่ยวกับการทำให้ตนเองเสียชีวิต และ “การพยายามฆ่าตัวตาย” ในที่นี้หมายถึงการทำร้ายตนเองโดยมีจุดมุ่งหมายให้ตนเองเสียชีวิต ทั้งนี้ มีวัตถุประสงค์ของการวิจัยคือ เพื่อทดสอบประสิทธิผลของโปรแกรมความต้องการระหว่างบุคคลที่มีต่อความคิดฆ่าตัวตายและการพยายามฆ่าตัวตายในผู้ป่วยจิตเวช

2. ท่านได้รับเชิญให้เข้าร่วมการวิจัยนี้เพราะท่านคือ ผู้ดูแลผู้ป่วยจิตเวชที่มีความคิดฆ่าตัวตายหรือพยายามฆ่าตัวตาย และได้รับการช่วยเหลือโดยการเข้ารับการรักษาในโรงพยาบาล ซึ่งเป็นกลุ่มที่ผู้วิจัยต้องการศึกษาในครั้งนี้ โดยระยะเวลาในการดำเนินการวิจัยคือ ในช่วงเวลาประมาณ 2 สัปดาห์ที่ผู้ป่วยรับการรักษาในระยะฟื้นฟูสมรรถภาพทางจิต และในสัปดาห์แรกหลังผู้ป่วยจำหน่ายออกจากโรงพยาบาล

3. ผู้เข้าร่วมการวิจัยในครั้งนี้แบ่งเป็น 2 กลุ่ม ซึ่งท่านและผู้ป่วยจะอยู่ในกลุ่มใดกลุ่มหนึ่ง ดังต่อไปนี้

3.1 กลุ่มควบคุม ประกอบด้วยผู้ป่วยจิตเวชที่ได้รับการพยาบาลตามปกติ จำนวน 17 คน และผู้ดูแลผู้ป่วยที่ได้รับการพยาบาลตามปกติ จำนวน 17 คน

3.2 กลุ่มทดลอง ประกอบด้วยผู้ป่วยจิตเวชที่ได้รับการพยาบาลตามโปรแกรมความต้องการระหว่างบุคคล จำนวน 17 คน และผู้ดูแลผู้ป่วยที่ได้รับการพยาบาลตามโปรแกรมความต้องการระหว่างบุคคล จำนวน 17 คน

4. หลังจากได้รับการพิจารณาจากคณะกรรมการจริยธรรมโครงการวิจัย และได้รับอนุมัติจากผู้อำนวยการโรงพยาบาลสวนสราญรมย์ให้เก็บรวบรวมข้อมูลแล้ว ผู้วิจัยได้เข้าพบหัวหน้าพยาบาล หัวหน้าหอผู้ป่วยและพยาบาลประจำหอผู้ป่วยตามลำดับเพื่อแนะนำตัว อธิบายวัตถุประสงค์ และกระบวนการวิจัย จากนั้นผู้วิจัยจะขอให้ท่านตอบแบบสอบถามจำนวน 1 ฉบับ ใช้เวลาประมาณ 5 นาที จากนั้นผู้วิจัยจะสุ่มท่านและผู้ป่วยเข้าเป็นกลุ่มควบคุมหรือกลุ่มทดลอง โดยท่านจะได้รับการดูแลจากพยาบาลวิชาชีพประจำหอผู้ป่วยและผู้วิจัย ดังต่อไปนี้

การพยาบาลตามปกติ สำหรับผู้ดูแลผู้ป่วยในกลุ่มควบคุม ได้แก่ การให้สุขภาพจิตศึกษาเกี่ยวกับโรคทางจิตและการดูแลผู้ป่วย

การพยาบาลตามโปรแกรมความต้องการระหว่างบุคคล สำหรับผู้ดูแลผู้ป่วยในกลุ่มทดลอง โดยการพยาบาลในข้อ 1-2 จะดำเนินการในสถานที่ซึ่งมีความเป็นส่วนตัวและมีความปลอดภัยภายในโรงพยาบาล และการพยาบาลในข้อ 3 จะดำเนินการทางโทรศัพท์โดยท่านสามารถเลือกช่วงเวลาที่รับโทรศัพท์ได้ตามที่ท่านสะดวก การพยาบาลดังกล่าวได้แก่

1) การให้สุขภาพจิตศึกษาสำหรับครอบครัวเพื่อการสร้างความสัมพันธ์ในครอบครัว โดยพยาบาลจะให้ความรู้และแลกเปลี่ยนความคิดเห็นกับท่าน ใช้เวลา 40 นาที

2) การให้สุขภาพจิตศึกษาสำหรับครอบครัวเพื่อขจัดความสามารถในการฆ่าตัวตาย โดยพยาบาลจะให้ความรู้และแลกเปลี่ยนความคิดเห็นกับท่าน ใช้เวลา 40 นาที

3) การให้การปรึกษาทางโทรศัพท์สำหรับครอบครัวเพื่อติดตามการขจัดความสามารถในการฆ่าตัวตาย โดยพยาบาลจะโทรศัพท์ถึงท่านในวันที่ 2 หลังจำหน่ายผู้ป่วยออกจากโรงพยาบาล ใช้เวลา 15 นาที

5. ในการวิจัยครั้งนี้อาจมีความเสี่ยงเพียงเล็กน้อย เช่น ท่านต้องเดินทางมาที่โรงพยาบาลตามวันที่กำหนดนัด ซึ่งหากท่านไม่สะดวกในวันดังกล่าวท่านสามารถขอเลื่อนวันได้ โดยให้เป็นช่วงเวลาก่อนที่ผู้ป่วยจะจำหน่ายออกจากโรงพยาบาล รวมทั้งท่านอาจเหนื่อยล้าจากการรับฟังความรู้และแลกเปลี่ยนความคิดเห็นกับพยาบาล ซึ่งท่านสามารถขอหยุดพักช่วงสั้นๆได้ หรืออาจมีหัวข้อสนทนาที่ทำให้ท่านรู้สึกอึกอัด ไม่สบายใจหรือไม่สะดวกที่จะตอบ ซึ่งท่านมีสิทธิ์จะไม่ตอบ หรือหยุดการสนทนาในหัวข้อนั้นได้ทุกเวลา

6. ในการวิจัยครั้งนี้มีประโยชน์ที่ท่านจะได้รับจากการเข้าร่วมการวิจัยคือ ได้รับความรู้ความเข้าใจเกี่ยวกับองค์ประกอบที่มีผลต่อความคิดฆ่าตัวตายและการพยายามฆ่าตัวตายของผู้ป่วย ได้เข้าใจถึงความสำคัญของท่านในการดูแลช่วยเหลือผู้ป่วย รวมทั้งมีแนวทางในการดูแลเพื่อป้องกันไม่ให้ผู้ป่วยฆ่าตัวตาย ทั้งนี้ประโยชน์ของงานวิจัยที่จะเกิดขึ้นคือ สามารถนำผลการวิจัยที่ได้ไปพัฒนาทั้งทางด้านนโยบายและด้านการปฏิบัติ เป็นแนวทางสำหรับพยาบาลในการดูแลเพื่อป้องกันการ ฆ่าตัวตายสำหรับผู้ป่วยจิตเวชที่มีความคิดฆ่าตัวตาย และ/หรือพยายามฆ่าตัวตาย อันจะส่งผลให้อัตราการเสียชีวิตจากการฆ่าตัวตายในผู้ป่วยจิตเวชลดลง

7. การตอบแบบสอบถามแต่ละข้อ ไม่มีข้อใดถูกหรือผิด คำตอบของท่านเป็นเพียงข้อมูล ส่วนบุคคลของผู้เข้าร่วมการวิจัยเท่านั้น ข้อมูลที่ได้จากการตอบแบบสอบถามของท่านจะถูกนำไป รวมกับข้อมูลของคนอื่นๆ โดยผู้วิจัยจะใช้รหัสแทนชื่อ-นามสกุลในแบบบันทึกข้อมูล นอกจากนี้ข้อมูลที่ท่านสนทนากับพยาบาลจะได้รับการรักษา

ความลับ มีเพียงแพทย์และพยาบาลในทีมรวมทั้งผู้วิจัยเท่านั้นที่จะทราบเพื่อเป็นข้อมูลประกอบการวางแผนการดูแลผู้ป่วย หากผู้วิจัยตีพิมพ์ผลการศึกษา ผู้วิจัยจะไม่มีการระบุชื่อ – นามสกุลหรือที่อยู่ของท่านไม่ว่ากรณีใดๆ

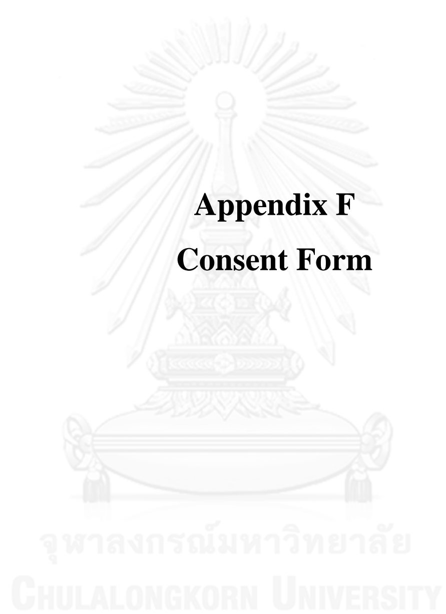
8. หากท่านมีข้อสงสัย ผู้วิจัยยินดีให้คำตอบโดยไม่ปิดบัง ซึ่งท่านสามารถสอบถามโดยติดต่อผู้วิจัยได้ตลอดเวลาที่หมายเลขโทรศัพท์ 08-7708-1993 และหากผู้วิจัยมีข้อมูลเพิ่มเติมที่เกี่ยวข้องกับการวิจัย ผู้วิจัยจะแจ้งให้ท่านทราบอย่างรวดเร็ว เพื่อให้ท่านได้ทบทวนว่ายังสมัครใจจะเข้าร่วมการวิจัยต่อไปหรือไม่

9. การเข้าร่วมการวิจัยในครั้งนี้เป็นไปโดยสมัครใจ และไม่มีค่าใช้จ่ายใดๆ ท่านสามารถปฏิเสธที่จะเข้าร่วมหรือถอนตัวจากการวิจัยได้ทุกขณะ โดยจะไม่มีผลกระทบต่อการรักษาผู้ป่วย

10. การวิจัยครั้งนี้มีการมอบถุงผ้า จำนวน 1 ใบ เป็นของที่ระลึกแก่ท่านเมื่อสิ้นสุดการให้สุขภาพจิตศึกษาในวันที่ 13 ที่ผู้ป่วยเข้ารับการรักษาในหอผู้ป่วยฟื้นฟู

11. หากท่านไม่ได้รับการปฏิบัติตามข้อมูลดังกล่าว สามารถร้องเรียนได้ที่ คณะกรรมการพิจารณาจริยธรรมการวิจัยในคน โรงพยาบาลสวนสราญรมย์ เลขที่ 298 ถนนธราธิบดี ตำบลท่าข้าม อำเภอพุนพิน จังหวัดสุราษฎร์ธานี รหัสไปรษณีย์ 84130 หมายเลขโทรศัพท์ 077-916500, 077-311308, 077-311444, 077-240566, 077-240567 โทรสาร 077-240565 หรือร้องเรียนที่ผู้วิจัยโดยตรง คือ นางสาวทานตะวัน แย้มบุญเรือง หมายเลขโทรศัพท์ 08-7708-1993

จุฬาลงกรณ์มหาวิทยาลัย
Chulalongkorn University



Appendix F
Consent Form

จุฬาลงกรณ์มหาวิทยาลัย
Chulalongkorn University

หนังสือแสดงความยินยอมเข้าร่วมการวิจัยสำหรับผู้ป่วย

ทำที่โรงพยาบาลสวนสราญรมย์

วันที่............เดือน...............................พ.ศ. 2559

ผู้เข้าร่วมการวิจัยเลขที่ ....

ข้าพเจ้าซึ่งได้ลงนามท้ายหนังสือนี้ ขอแสดงความยินยอมเข้าร่วมโครงการวิจัย เรื่องผลของโปรแกรมความต้องการระหว่างบุคคลต่อความคิดฆ่าตัวตายและการพยายามฆ่าตัวตายในผู้ป่วยโรคจิต ซึ่งผู้วิจัยคือ นางสาวทานตะวัน แย้มบุญเรือง นิสิตปริญญาเอก คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย ที่อยู่ที่สามารถติดต่อได้คือ บ้านเลขที่ 47/99 หมู่ 4 ถนนติวานนท์ ตำบลตลาดขวัญ อำเภอเมือง จังหวัดนนทบุรี 11000 โทรศัพท์ 08-7708-1993 ได้อธิบายให้ข้าพเจ้าได้ทราบแล้วเกี่ยวกับโครงการวิจัย

ข้าพเจ้า **ได้รับทราบ**รายละเอียดเกี่ยวกับที่มาและวัตถุประสงค์ในการทำวิจัย โดยข้าพเจ้า ได้ทราบว่า การศึกษาในครั้งนี้ มีวัตถุประสงค์เพื่อเพื่อทดสอบประสิทธิผลของโปรแกรมความต้องการระหว่างบุคคลที่มีต่อความคิดฆ่าตัวตายและการพยายามฆ่าตัวตายในผู้ป่วยจิตเวช ซึ่งประโยชน์ของงานวิจัยนี้ทำให้พยาบาลและผู้ที่เกี่ยวข้องสามารถนำผลการวิจัยที่ได้ไปพัฒนาทั้งทางด้านนโยบายและด้านการปฏิบัติ เป็นแนวทางสำหรับพยาบาลในการดูแลเพื่อป้องกันการฆ่าตัวตายสำหรับผู้ป่วยจิตเวชที่มีความคิดฆ่าตัวตายและ/หรือพยายามฆ่าตัวตาย ช่วยให้ผู้ป่วยใช้ชีวิตด้วยการปรับเปลี่ยนความคิดทางลบ รับรู้ว่าตนเองมีพลังอำนาจที่จะดูแลตนเอง และสามารถป้องกันตนเองจากความคิดหรือเหตุการณ์ที่จะนำไปสู่การฆ่าตัวตายได้ อันจะส่งผลให้อัตราการเสียชีวิตจากการฆ่าตัวตายในผู้ป่วย จิตเวชลดลง ข้าพเจ้า**ได้อ่านคำอธิบาย**ในเอกสารชี้แจงผู้เข้าร่วมการวิจัยโดยตลอด และ**ได้รับคำอธิบาย**จากผู้วิจัย**จนเข้าใจเป็นอย่างดี**แล้ว

ข้าพเจ้าได้ทราบว่าในการเข้าร่วมการวิจัยครั้งนี้จะมีความเสี่ยงเพียงเล็กน้อย โดยผู้เข้าร่วมการวิจัยอาจเหนื่อยล้าจากการสนทนากับพยาบาลอย่างต่อเนื่องในแต่ละครั้ง ซึ่งผู้เข้าร่วมการวิจัยสามารถขอหยุดพักช่วงสั้นๆได้ หรืออาจมีหัวข้อสนทนาที่ทำให้ผู้เข้าร่วมการวิจัยรู้สึกอึกอัด ไม่สบายใจหรือไม่สะดวกที่จะตอบ ซึ่งผู้เข้าร่วมการวิจัยมีสิทธิ์จะไม่ตอบ หรือหยุดการสนทนาในหัวข้อนั้นได้ ทุกเวลาตามที่ระบุไว้ในเอกสารชี้แจงผู้เข้าร่วมการวิจัย ข้าพเจ้าจึง**สมัครใจ**เข้าร่วมในการวิจัยนี้ โดยข้าพเจ้า**ยินยอม**ตอบแบบสอบถามจำนวน 4 ฉบับ โดยตอบแบบสอบถามฉบับที่ 1 จำนวน 1 ครั้ง และตอบแบบสอบถามฉบับที่ 2-4 จำนวน 2 ครั้ง ซึ่งได้แก่

1. แบบสอบถามข้อมูลส่วนบุคคลของผู้ป่วย จำนวน 12 ข้อ
2. แบบประเมินความคิดฆ่าตัวตาย จำนวน 19 ข้อ
3. แบบสอบถามเกี่ยวกับความจำเป็นด้านความสัมพันธ์กับผู้อื่น จำนวน 15 ข้อ
4. มาตรวัดความสามารถที่อาจพัฒนาไปสู่การฆ่าตัวตาย จำนวน 20 ข้อ

ข้าพเจ้ายินยอมรับการพยาบาลตามปกติ ซึ่งได้แก่

1. การบำบัดทางจิตสังคมตามปัญหาของผู้ป่วย
2. การวางแผนการจำหน่าย โดยการทำกลุ่มสุขภาพจิตศึกษาเกี่ยวกับโรค การดูแลตนเอง การจัดการความเครียด และสัญญาณเตือนของอาการทางจิตกำเริบ

หรือ รับการพยาบาลตามโปรแกรมความต้องการระหว่างบุคคล ซึ่งได้แก่

1. การทำความรู้จักระหว่างพยาบาลและผู้ป่วย ในวันที่ 1 ใช้เวลา 15 นาที

2. การทำความเข้าใจเพิ่มเติมเกี่ยวกับโปรแกรม ในวันที่ 2 ใช้เวลา 30 นาที

3. การดำเนินสัมพันธภาพเพื่อการดูแล ในวันที่ 3-13 ใช้เวลาครั้งละ 15 นาที

4. การใช้เทคนิคความคิดและพฤติกรรมเพื่อลดความรู้สึกโดดเดี่ยว จำนวน 3 ครั้ง ในวันที่ 3, 4, 5 ใช้เวลาครั้งละ 45 นาที

5. การใช้เทคนิคความคิดและพฤติกรรมเพื่อลดความรู้สึกเกลียดตัวเอง จำนวน 3 ครั้ง ในวันที่ 7, 8, 9 ใช้เวลาครั้งละ 45 นาที

6. การเสริมสร้างพลังอำนาจเพื่อลดการรับรู้ว่าตนเองเป็นภาระ ในวันที่ 10 ใช้เวลา 45 นาที

7. การให้การปรึกษาเพื่อวางแผนความปลอดภัยจากการเผชิญเหตุการณ์ด้านลบ ในวันที่ 11 ใช้เวลา 45 นาที

8. การให้การปรึกษาเพื่อวางแผนความปลอดภัยจากความสามารถในการฆ่าตัวตาย ในวันที่ 12 ใช้เวลา 40 นาที

9. การให้การปรึกษาทางโทรศัพท์เพื่อติดตามการปรับเปลี่ยนความรู้สึกโดดเดี่ยวโดยพยาบาลจะโทรศัพท์ถึงผู้ป่วยในวันที่ 1 หลังจำหน่ายออกจากโรงพยาบาล ใช้เวลา 15 นาที

10. การให้การปรึกษาทางโทรศัพท์เพื่อติดตามการปรับเปลี่ยนความรู้สึกเกลียดตัวเอง โดยพยาบาลจะโทรศัพท์ถึงผู้ป่วยวันที่ 4 หลังจำหน่ายออกจากโรงพยาบาล ใช้เวลา 15 นาที

11. การให้การปรึกษาทางโทรศัพท์เพื่อติดตามแผนความปลอดภัย โดยพยาบาลจะโทรศัพท์ถึงผู้ป่วยในวันที่ 7 หลังจำหน่ายออกจากโรงพยาบาล ใช้เวลา 15 นาที

ทั้งนี้การพยาบาลในข้อ 1-8 จะดำเนินการเป็นรายบุคคลในสถานที่ซึ่งมีความเป็นส่วนตัวและมีความปลอดภัยภายในหอผู้ป่วย และการพยาบาลในข้อ 9 – 11 จะดำเนินการทางโทรศัพท์ โดยผู้เข้าร่วมการวิจัยสามารถเลือกช่วงเวลาที่รับโทรศัพท์ได้ตามความสะดวก

ข้าพเจ้าได้รับคำรับรองว่า ผู้วิจัยจะปฏิบัติต่อข้าพเจ้าตามข้อมูลที่ระบุไว้ในเอกสารชี้แจงผู้เข้าร่วมการวิจัย และข้อมูลใดๆ ที่เกี่ยวข้องกับข้าพเจ้า ผู้วิจัยจะ**เก็บรักษาเป็นความลับ** โดยจะนำเสนอข้อมูลการวิจัยเป็นภาพรวมเท่านั้น ไม่มีข้อมูลใดในการรายงานที่จะนำไปสู่การระบุตัวข้าพเจ้า

ข้าพเจ้ามีสิทธิ**ถอนตัว**ออกจากการวิจัยเมื่อใดก็ได้ตามความประสงค์**โดยไม่ต้องแจ้งเหตุผล** ซึ่งการถอนตัวออกจากการวิจัยนั้น จะไม่มีผลต่อการดูแลรักษาหรือผลกระทบในทางใดๆต่อข้าพเจ้าทั้งสิ้น

หากข้าพเจ้าไม่ได้รับการปฏิบัติตรงตามที่ได้ระบุไว้ในเอกสารชี้แจงผู้เข้าร่วมการวิจัย ข้าพเจ้าสามารถร้องเรียนได้ที่คณะกรรมการพิจารณาจริยธรรมการวิจัยในคน โรงพยาบาลสวนสราญรมย์ เลขที่ 298 ถนนธราธิบดี ตำบลท่าข้าม อำเภอพุนพิน จังหวัดสุราษฎร์ธานี รหัสไปรษณีย์ 84130 หมายเลขโทรศัพท์ 077-916500, 077-311308, 077-311444, 077-240566, 077-240567 โทรสาร 077-240565 หรือร้องเรียนที่ผู้วิจัยโดยตรง คือ นางสาวทานตะวัน แย้มบุญเรือง หมายเลขโทรศัพท์ 08-7708-1993

ข้าพเจ้าได้ลงลายมือชื่อไว้เป็นสำคัญต่อหน้าพยาน ทั้งนี้ข้าพเจ้าได้รับสำเนาเอกสารชี้แจงผู้เข้าร่วม การวิจัยและสำเนาหนังสือแสดงความยินยอมไว้แล้ว

ลงชื่อ..	ลงชื่อ..
(นางสาวทานตะวัน แย้มบุญเรือง)	(..)
ผู้วิจัยหลัก	ผู้เข้าร่วมการวิจัย
	ลงชื่อ..
	(..)
	พยาน

หนังสือแสดงความยินยอมเข้าร่วมการวิจัยสำหรับผู้ดูแลผู้ป่วย

ทำที่โรงพยาบาลสวนสราญรมย์

วันที่............เดือน...............................พ.ศ. 2559

ผู้เข้าร่วมการวิจัยเลขที่ ....

ข้าพเจ้าซึ่งได้ลงนามท้ายหนังสือนี้ ขอแสดงความยินยอมเข้าร่วมโครงการวิจัยเรื่อง ผลของโปรแกรมความต้องการระหว่างบุคคลต่อความคิดฆ่าตัวตายและการพยายามฆ่าตัวตายในผู้ป่วยโรคจิต ซึ่งผู้วิจัยคือ นางสาวทานตะวัน แย้มบุญเรือง นิสิตปริญญาเอก คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย ที่อยู่ที่สามารถติดต่อได้คือ บ้านเลขที่ 47/99 หมู่ 4 ถนนติวานนท์ ตำบลตลาดขวัญ อำเภอเมือง จังหวัดนนทบุรี 11000 โทรศัพท์ 08-7708-1993 ได้อธิบายให้ข้าพเจ้าได้ทราบแล้วเกี่ยวกับโครงการวิจัย

ข้าพเจ้า **ได้รับทราบ**รายละเอียดเกี่ยวกับที่มาและวัตถุประสงค์ในการทำวิจัย โดยข้าพเจ้าได้ทราบว่า การศึกษาในครั้งนี้ มีวัตถุประสงค์เพื่อเพื่อทดสอบประสิทธิผลของโปรแกรมความต้องการระหว่างบุคคลที่มีต่อความคิดฆ่าตัวตายและการพยายามฆ่าตัวตายในผู้ป่วยจิตเวช ซึ่งประโยชน์ของงานวิจัยนี้ทำให้พยาบาลและผู้ที่เกี่ยวข้องสามารถนำผลการวิจัยที่ได้ไปพัฒนาทั้งทางด้านนโยบายและด้านการปฏิบัติ เป็นแนวทางสำหรับพยาบาลในการดูแลเพื่อป้องกันการฆ่าตัวตายสำหรับผู้ป่วยจิตเวชที่มีความคิดฆ่าตัวตาย และ/หรือพยายามฆ่าตัวตาย ช่วยให้ผู้ป่วยใช้ชีวิตด้วยการปรับเปลี่ยนความคิดทางลบ รับรู้ว่าตนเองมีพลังอำนาจที่จะดูแลตนเอง และสามารถป้องกันตนเองจากความคิดหรือเหตุการณ์ที่จะนำไปสู่การฆ่าตัวตายได้ อันจะส่งผลให้อัตราการเสียชีวิตจากการฆ่าตัวตายในผู้ป่วยจิตเวชลดลง ข้าพเจ้า**ได้อ่านคำอธิบาย**ในเอกสารชี้แจงผู้เข้าร่วมการวิจัย โดยตลอด และ**ได้รับคำอธิบาย**จากผู้วิจัย**จนเข้าใจเป็นอย่างดี**แล้ว

ข้าพเจ้าได้ทราบว่าในการเข้าร่วมการวิจัยครั้งนี้จะมีความเสี่ยงเพียงเล็กน้อย โดยผู้เข้าร่วมการวิจัยต้องเดินทางมาที่โรงพยาบาลตามวันที่กำหนดนัด ซึ่งหากข้าพเจ้าไม่สะดวกในวันดังกล่าวข้าพเจ้าสามารถขอเลื่อนวันได้ โดยให้เป็นช่วงเวลาก่อนที่ผู้ป่วยจะจำหน่ายออกจากโรงพยาบาล รวมทั้งผู้เข้าร่วมการวิจัยอาจเหนื่อยล้าจากการรับฟังความรู้และแลกเปลี่ยนความคิดเห็นกับพยาบาล ซึ่งข้าพเจ้าสามารถขอหยุดพักช่วงสั้นๆได้ หรืออาจมีหัวข้อสนทนาที่ทำให้ผู้เข้าร่วมการวิจัยรู้สึกอึดอัด ไม่สบายใจหรือไม่สะดวกที่จะตอบ ซึ่งข้าพเจ้ามีสิทธิ์จะไม่ตอบ หรือหยุดการสนทนาในหัวข้อนั้นได้ ทุกเวลาตามที่ระบุไว้ในเอกสารชี้แจงผู้เข้าร่วมการวิจัย ข้าพเจ้าจึง**สมัครใจ**เข้าร่วมในการวิจัยนี้ โดยข้าพเจ้า**ยินยอม**ตอบแบบสอบถามจำนวน 1 ฉบับ ซึ่งได้แก่ แบบสอบถามข้อมูลส่วนบุคคลของผู้ดูแล จำนวน 11 ข้อ

ข้าพเจ้า**ยินยอม**รับการพยาบาลตามปกติ ซึ่งได้แก่ การให้สุขภาพจิตศึกษาเกี่ยวกับโรคทางจิตและการดูแลผู้ป่วย

หรือ รับการพยาบาลตามโปรแกรมความต้องการระหว่างบุคคล ซึ่งได้แก่

1. การให้สุขภาพจิตศึกษาสำหรับครอบครัวเพื่อการสร้างความสัมพันธ์ในครอบครัว โดยพยาบาลจะให้ความรู้และแลกเปลี่ยนความคิดเห็นกับผู้ดูแลผู้ป่วย ใช้เวลา 40 นาที

2. การให้สุขภาพจิตศึกษาสำหรับครอบครัวเพื่อขจัดความสามารถในการฆ่าตัวตาย โดยพยาบาลจะให้ความรู้และแลกเปลี่ยนความคิดเห็นกับผู้ดูแลผู้ป่วย ใช้เวลา 40 นาที

3. การให้การปรึกษาทางโทรศัพท์สำหรับครอบครัวเพื่อติดตามการขจัดความสามารถในการฆ่าตัวตาย โดยพยาบาลจะโทรศัพท์ถึงผู้ดูแลผู้ป่วย ในวันที่ 2 หลังจำหน่ายผู้ป่วยออกจากโรงพยาบาล ใช้เวลา 15 นาที

ทั้งนี้การพยาบาลในข้อ 1-2 จะดำเนินการในสถานที่ซึ่งมีความเป็นส่วนตัวและ มีความปลอดภัยภายในโรงพยาบาล และการพยาบาลในข้อ 3 จะดำเนินการทางโทรศัพท์โดยผู้เข้าร่วมการวิจัยสามารถเลือกช่วงเวลาที่รับโทรศัพท์ได้ตามความสะดวก

ข้าพเจ้าได้รับคำรับรองว่า ผู้วิจัยจะปฏิบัติต่อข้าพเจ้าตามข้อมูลที่ระบุไว้ในเอกสารชี้แจงผู้เข้าร่วมการวิจัย และข้อมูลใดๆ ที่เกี่ยวข้องกับข้าพเจ้า ผู้วิจัยจะ**เก็บรักษาเป็นความลับ** โดยจะนำเสนอข้อมูลการวิจัยเป็นภาพรวมเท่านั้น ไม่มีข้อมูลใดในการรายงานที่จะนำไปสู่การระบุตัวข้าพเจ้า

ข้าพเจ้ามีสิทธิ**ถอนตัว**ออกจากการวิจัยเมื่อใดก็ได้ตามความประสงค์**โดยไม่ต้องแจ้งเหตุผล** ซึ่งการถอนตัวออกจากการวิจัยนั้น จะไม่มีผลต่อการดูแลรักษาหรือผลกระทบในทางใดๆต่อข้าพเจ้าทั้งสิ้น

หากข้าพเจ้าไม่ได้รับการปฏิบัติตรงตามที่ได้ระบุไว้ในเอกสารชี้แจงผู้เข้าร่วมการวิจัย ข้าพเจ้าสามารถร้องเรียนได้ที่คณะกรรมการพิจารณาจริยธรรมการวิจัยในคน โรงพยาบาล สวนสราญรมย์ เลขที่ 298 ถนนธราธิบดี ตำบลท่าข้าม อำเภอพุนพิน จังหวัดสุราษฎร์ธานี รหัสไปรษณีย์ 84130 หมายเลขโทรศัพท์ 077-916500, 077-311308, 077-311444, 077-240566, 077-240567 โทรสาร 077-240565 หรือร้องเรียนที่ผู้วิจัยโดยตรง คือ นางสาวทานตะวัน แย้มบุญเรือง หมายเลขโทรศัพท์ 08-7708-1993

ข้าพเจ้าได้ลงลายมือชื่อไว้เป็นสำคัญต่อหน้าพยาน ทั้งนี้ข้าพเจ้าได้รับสำเนาเอกสารชี้แจงผู้เข้าร่วมการวิจัยและสำเนาหนังสือแสดงความยินยอมไว้แล้ว

ลงชื่อ..	ลงชื่อ..
(นางสาวทานตะวัน แย้มบุญเรือง)	(..)
ผู้วิจัยหลัก	ผู้เข้าร่วมการวิจัย
	ลงชื่อ..
	(..)
	พยาน

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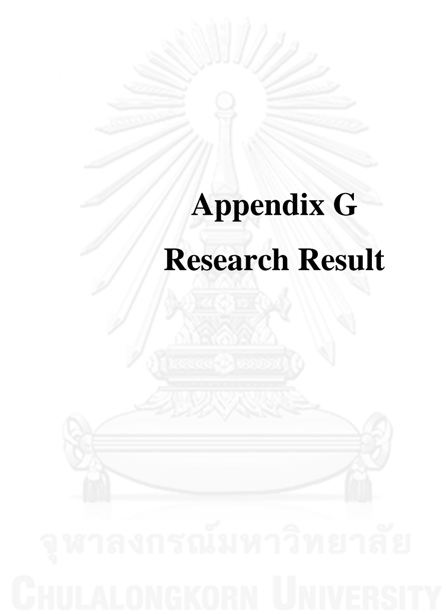

Appendix G
Research Result

1. Comparison of suicidal ideation between experimental group and control group at pre-test

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Differ-ence	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
SSI_Pre	Equal variances assumed	.298	.589	-.755	31	.456	-1.563	2.069	-5.783	2.658
	Equal variances not assumed			-.759	30.700	.454	-1.563	2.059	-5.763	2.638

2. Comparison of suicidal ideation in experimental group between pre-test and post-test

Paired Samples Test

	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pair 1 SSI_E_Pre - SSI_E_Pos	5.941	3.992	.968	3.889	7.994	6.137	16	.000

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3. Comparison of suicidal ideation between experimental group and control group at post-test

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Differ-ence	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
SSI_Post	Equal variances assumed	2.524	.122	2.538	31	.016	3.504	1.380	.688	6.319
	Equal variances not assumed			2.507	25.798	.019	3.504	1.397	.630	6.377

4. Comparison of suicidal attempt between experimental group and control group at pre-test

Test Statistics[a]

		SAR_Pre
Most Extreme Differences	Absolute	.151
	Positive	.151
	Negative	.000
Kolmogorov-Smirnov Z		.433
Asymp. Sig. (2-tailed)		.992

a. Grouping Variable: Group

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5. Comparison of suicidal attempt in experimental group between pre-test and post-test

Test Statistics[a]

	SAR_E_Pre & SAR_E_Pos
N	17
Exact Sig. (2-tailed)	.004[b]

a. McNemar Test

b. Binomial distribution used.

6. Comparison of suicidal attempt between experimental group and control group at post-test

Two-Sample Kolmogorov-Smirnov Test

Test Statistics[a]

		SAR_Post
Most Extreme Differences	Absolute	.000
	Positive	.000
	Negative	.000
Kolmogorov-Smirnov Z		.000
Asymp. Sig. (2-tailed)		1.000

a. Grouping Variable: Group

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7. Comparison of interpersonal need and acquired capability for suicide in experimental group and control group between pre-test and post-test

Variables	Pre-test		Post-test		t	*p*-value
	Mean	SD	Mean	SD		
Experimental group						
Interpersonal need	46.76	15.98	32.00	14.65	4.72	0.00
Acquired capability for suicide	42.53	15.15	35.88	12.02	4.86	0.00
Control group						
Interpersonal need	41.94	13.84	41.06	12.94	2.21	0.04
Acquired capability for suicide	42.50	16.47	41.69	15.44	2.28	0.04

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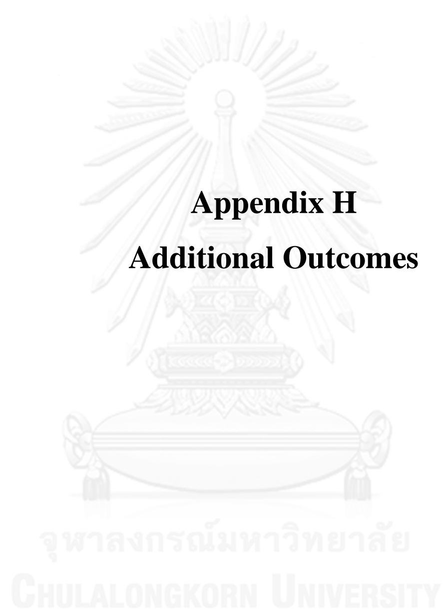

Appendix H

Additional Outcomes

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Additional outcomes

During the program researcher asked open-ended questions with research assistants, patients, and caregivers in order to improve the program. Additional outcomes were as followed.

Opinion about the interpersonal need program

1. Nurse's perspective (research assistants)

"This program was appropriate for suicidal patients. Constructs of the program were consistent with the situations in their life especially perceived burdensomeness. Most of suicidal patients had self-hated and felt themselves as a burden on other"

"The manuals were useful and easy to follow"

"Patients and caregiver participated in this program willingly. They expressed satisfaction to nurses"

2. Caregiver's perspective

"It seemed like nurse pay attention to patients and also caregiver"

"When nurse offered this program, I dared to discuss with less hesitation. I felt relaxed and comfortable"

"I was excited when researcher called via phone. I did not expect before that nurse offer us a caring after discharge"

Benefits from the interpersonal need program

1. Nurse's perspective (research assistants)

"It was an opportunity for mental health and psychiatric nurses to implement special skill which we learn from certificated training. We have learned a lot to apply those skills to help our patients"

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2. Patient's perspective

"I realized what I ever talk with nurse. It reminded me early when I thought about negative things"

"I appreciated safety plan which I did when I admitted. Once thought about substance abuse, finally I decided to do follow safety plan"

3. Caregiver's perspective

"I got techniques to communicate with patient. I did not realize before how hated speech hurt patients"

"I learned and understood what suicidal patients think. It helped me to protect my patient"

Suggestion for improvement of the interpersonal need program

Nurse's perspective (research assistants)

"Cognitive behavioral approach had three sessions, it may be combined into two sessions because some patient can assess and evaluate negative thought in one session"

"Perceived burdensomeness seemed more important than thwarted belongingness"

"According to nurse duty, telephone counseling may set once or twice a week"

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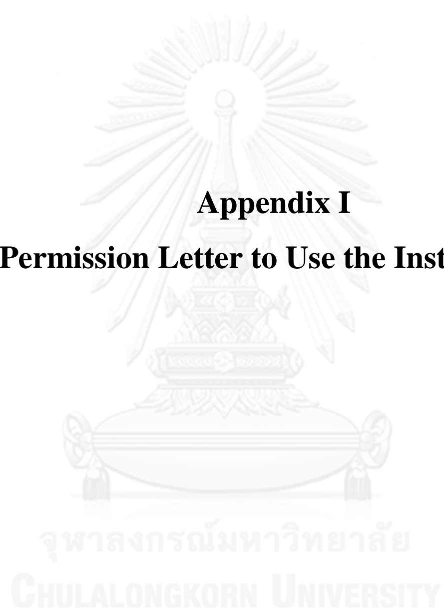
Appendix I
Permission Letter to Use the Instrument



The Thai version of the scale for suicidal ideation (SSI-Thai version 2014)

Date: Thu, 10 Dec 2015 15:27:18 +0700
Subject: Ask the permission to use The SSI-Thai Version
From: tantawany@gmail.com
To: priyoth_k@hotmail.com

Dear Professor Priyoth

My name is Tantawan Yamboonruang. I am a Ph.D. student of Faculty of Nursing, Chulalongkorn University, Bangkok, Thailand. I am developing the dissertation entitled "Effects of the interpersonal need program on suicidal ideation and suicidal attempt in mentally ill patients". The SSI-Thai Version which developed by you and your colleges is very useful for my study. Therefore, I would like to ask the permission to use "The SSI-Thai Version" in my dissertation. I also send a letter from CUFON as you can see in the attached file.

Thank you very much in advance. I'm looking forward to hearing from you.

Sincerely yours.

Tantawan Yamboonruang

Priyoth K <priyoth_k@hotmail.com>
to me

Jan 5

Thai > English Translate message Turn off for: Thai

สวัสดีครับ

ผมส่งแบบประเมิน SSI-Thai version 2014 มาให้ครับ สำหรับการแปลผลของแบบประเมิน SSI ต้นฉบับนั้น Beck ไม่ได้แบ่งการแปลผลออกเป็นช่วงครับ การแปลผลจะดูจากคะแนนรวมของแบบประเมิน โดยค่าคะแนนที่สูงขึ้นหมายถึงความรุนแรงของความคิดที่เพิ่มมากขึ้น ดังนั้นการนำไปใช้แปลผลอาจจะใช้ตามวิธีต้นฉบับได้ครับ แต่สำหรับงานที่ผมตีพิมพ์ไป ผมนำค่าคะแนนเฉลี่ยของแบบสอบถามจากกลุ่มตัวอย่างทั้งหมดมา plot Graph เพื่อดู curve ซึ่งสามารถแบ่งออกเป็นสามช่วงคะแนน (0-9 = low, 10-19= moderate, more than 19 = high) ตามคุณลักษณะที่พบครับ

ผศ.ปริยศ

Priyoth Kittiteerasack
College of Nursing, University of Illinois at Chicago,
854 S. Damen Ave. Chicago, Illinois 60612

The interpersonal need questionnaire (INQ)

The acquired capability for suicide scale (ACSS)

From: Tantawan Yamboonruang <tantawany@gmail.com>
Date: Tuesday, October 20, 2015 at 3:56 AM
To: Kim Van Orden <Kimberly_VanOrden@urmc.rochester.edu>
Subject: Ask the permission to use The Interpersonal theory of suicide, The INQ, and The ACSS

...

Dear Professor Dr. Kimberly A. Van Orden

My name is Tantawan Yamboonruang. I am a Ph.D. student of Faculty of Nursing, Chulalongkorn University, Bangkok, Thailand. I am developing the dissertation entitled “Effects of the interpersonal need program on suicidal ideation and suicidal attempt in mentally ill patients”. The objectives of this study are: 1) to compare the differences of suicidal ideation and suicidal attempt between mentally ill patients who receive the interpersonal need program combined with the conventional nursing care and those who receive the conventional nursing care 2) to compare the differences of suicidal ideation and suicidal attempt among pre and post intervention in mentally ill patients who receive the interpersonal need program combined with the conventional nursing care.

I have decided to use “The Interpersonal Theory of Suicide” which developed by you and your colleges as the theoretical framework of my dissertation. In addition “The Interpersonal Need Questionnaire (INQ)” which developed by you and your colleges in 2012 and “The Acquired Capability for Suicide Scale (ACSS)” which developed by you and your colleges in 2008 are very useful for my study as well. Therefore, I would like to ask the permission to use The Interpersonal Theory of Suicide, The INQ, and The ACSS in my dissertation.

Thank you very much in advance. I'm looking forward to hearing from you.

Sincerely yours.

Tantawan Yamboonruang

tantawany@gmail.com, tantawanybr@gmail.com
(+66)877081993

Van Orden, Kimberly <Kimberly_Vanorden@urmc.rochester.edu> 10/20/15

to me

Sure, good luck.

Kim
--
Kim Van Orden, Ph.D.
University of Rochester Medical Center
300 Crittenden Blvd, Box Psych
Rochester, NY 14642
P: 585-275-5176; F: 585-276-2065
Office # 4.9246
Kimberly_vanorden@urmc.rochester.edu

VITA

Tantawan Yamboonruang was born in 1973. She got Diploma in Nursing Science Equivalent to Bachelor of Science in Nursing from Suratthani Nursing College in 1994. She got a Master of Nursing Science (Nursing Education) from Faculty of Nursing, Chulalongkorn University in 1998. Tantawan had eight years of working as a nursing instructor at Boromarajonani College of Nursing Suratthani and started working as a nursing instructor at mental health and psychiatric nursing department, Boromarajonani College of Nursing Changwat Nonthaburi since 2002-present. She received a scholarship from Praboromarajchanok Institute of Health Workforce Development, Ministry of Public Health to study Philosophy Program in Nursing Science, Faculty of Nursing, Chulalongkorn University Since 2010-2016.

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