

Nurses attitudes to attempted suicide in Southern India.

Nurses attitudes and beliefs to attempted suicide in Southern India.

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Jones, S., Krishna, M., Rajgopal, and Keenan, P. (2014) Nurses attitudes and beliefs to attempted suicide in Southern India.

WORD COUNT including reference list;

Research undertaken at Holdsworth Memorial Hospital, Mysore, Karnataka, Southern India

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Abstract There is growing interest into the attitudes and clinical management of persons who have attempted suicide. This paper reports on a group of 15 nursing staff from a large general hospital in Mysore, Southern India. The principal purpose was to determine senior nursing staff attitudes towards patients who had attempted suicide from a professional and cultural perspective, which might influence care following hospital admission. The focus concerned nursing staff interactions at a psychological level that compete with physical tasks on general hospital wards. A qualitative methodology was employed with audio-taped interviews utilising four level data coding. Findings suggested that patient care and treatment is directly influenced by the nurse's religious beliefs within a general hospital setting. The results allow a series of recommendations for educational and skills initiatives before progressing to patient assessment and treatment projects and cross cultural comparison studies.

Introduction

The research examined nursing staff attitudes towards patients who have attempted suicide and were admitted onto general hospital wards. All the nursing staff participants interviewed work at one large 330 bed inner city general hospital in Mysore, Southern India.

Background

The World Health Organisation (WHO) recognises suicide as one of the three leading causes of death in young adults globally (WHO, 2011). The greatest burden of suicide is now in low and middle income countries like India where annual suicide rates are 10-11 per 100,000 (NCRB, 2010; Patel et al, 2012). India is second only to China in the absolute number of annual deaths by suicide (Patel et al, 2005). The number of individuals who die by suicide each year in India alone is more than the total number of suicides in the four top ranked European countries combined (Gunnell et al, 2007).

Suicide and deliberate self-harm have been recognised as major public health problems in India for some time, but there are significant obstructions to effective intervention, including difficulties in following western models to understand these behaviours and some unfavourable attitudes of health care professionals towards those who self-harm (Aaron et al, 2004; Bose et al, 2006; Gunnell et al, 2007). Research evidence has indicated that such unfavourable attitudes among doctors and nurses further influence their suicide risk assessment, management skills, including the quality and impact of care(Ouzouni and Nakakis, 2009; Saunders et al, 2012).

Nurses have the highest level of daily contact with survivors of self-harm and their families. Therefore, their attitudes and knowledge about self-harm can influence their willingness and ability to deliver interventions effectively (Anderson et al, 2003). Such data from low and middle income countries is hard to capture and only a few studies from the developing world have examined health professionals' attitude towards suicide attempters. In the main these studies are limited to collecting quantitative data by means of administering questionnaires with little evidence of validation to local population (Sethi and Uppal, 2006; Nebhinani et al , 2013).

There is an urgent need for qualitative studies to complement the findings from quantitative studies allowing the interpretation of the findings and to generate more culture specific hypotheses that can be explored by studies adopting mixed methods. We could not find any such qualitative publications of Indian nursing staff attitudes towards those who self-harm.

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The explicit aim is not to place one countries mental health care above another, but to identify areas of practice that can be taken forward in a transparent and systematic way. This does open possibilities however for cross cultural comparison that may also drive up care standards and educational avenues for exploration and subsequent interventions. This pilot study aimed to assess qualified nursing staff attitudes toward suicide attempters by using a qualitative method of data collection and analysis to inform future study directions.

Aims

The aim of the research project was as follows:

Through the use of IPA explore nurses' experiences and attitudes within a large general hospital in Mysore, India, treating patients who have attempted suicide and admitted to general hospital wards.

The project adhered to two research objectives:

1. Undertake a narrative appraisal of participants' experiences and attitudes when working with patients' who have mental health concerns and have attempted suicide.
2. An exploration of the participants' subjective meaning and appraisal of their experiences of working with patients who have attempted suicide.

The researchers (two academics with a background in nursing from Edge Hill University, Lancashire and two psychiatrists from India) met and developed a list of open ended prompting questions used to encourage qualitative content from the interview. The questions where considered for any cultural and language difficulties that could be predicted. The questions where piloted amongst senior nurses (not part of the project) and any comments and anomalies encountered where used to inform changes to the questions. Transcription of the data was undertaken by an Indian medical transcription service verbatim and cross checked by the Indian member of the research team for accuracy.

Methodology

A questionnaire was specifically developed in the absence of a suitable measure to investigate nursing staff attitudes, beliefs and education to patients who attempt suicide in India.

Analytical approach

Interpretive phenomenological analysis (IPA) aims to explore in detail how participants make sense of their personal and social world and has social cognition as its central analytic focus (Smith & Osborn, 2007). It provides a framework for the research process and a structured system for data analysis. The approach is phenomenological in that it attempts to explore an individual's personal perception of an object or event rather than produce an objective statement of the object or the event itself.

IPA assumes a 'chain of connection' between peoples use of language and their thinking and emotional state. However, it also recognises that it is impossible to gain an 'insider's perspective' completely or directly. Access depends upon and is complicated by the interpretations of the

researcher. The onus in this method is to make those interpretations explicit and open to challenge and modification. Therefore within IPA the research exercise is a dynamic process, with the researcher taking an active role is a vital part of the process. IPA involves a two stage process of interpretation known as a double hermeneutic: the participant trying to make sense of their world whilst the researcher is also trying to make sense of the participant making sense of their own world. Inherent within the process is a combination of an empathic hermeneutic and a questioning hermeneutic (Farrell et al, 2014).

In this study data was gathered by 15 face to face semi structured interviews, having developed a semi structured interview schedule with themes to stimulate discussion with the participants (Biggerstaff and Thompson 2008). The interviews were recorded, transcribed and then analysed in conjunction with the original recordings. IPA analysis involves the close reading and re-reading of the text, the researcher's notes of any thoughts, observations, reflections that occur while reading the text (Smith et al, 1999). These notes include recurring phrases, their own emotions and descriptions of or comments on the language used (Smith et al, 1995).

The researcher is charged with the task of providing an overall structure to the analysis by grouping identified themes into clusters or concept group of themes and to identify super-ordinate categories that suggest a hierarchical relationship between them (Biggerstaff and Thomson 2008). A master list of themes was produced in a table with evidence aligned from the interview. Quotations are often used which the researcher believes best captures the essence of the participant's thoughts and emotions about their experience of the phenomenon being explored. Following the transcription of the interviews the research team met in England in order to begin the analysis, following IPA principles.

All researchers were present at every stage of coding and theme identification that progressed manually. The sensitivity and involvement of the Indian member of staff (MK) on return to the UK participated throughout analysis meetings to reduce cultural errors and misinterpretations. This was paramount to increase reliability and validity in the analysis stages and offered cultural competence and sensitivity. This process attempts to limit opportunities for skewing the data and increase analytical accuracy of the participant narrative. The real meaning of words within the data and contexts had to be closely monitored with interpretation and contexts following a process of member checking.

In summary the method adopted by IPA is a cyclical process where the researcher proceeds through several stages:

1. First encounter with the text.
2. Preliminary themes identified.
3. Grouping themes together as clusters.
4. Tabulating themes in a summary table

(Biggerstaff and Thompson, 2008).

Inclusion

The participants' selection criteria were based on being senior clinicians at the hospital, and their fluency with the English language. The participants were then issued with a study participants information sheet and a consent form to agree to participate in the project. The nurses were informed throughout of their right to discontinue their participation at any time without prejudice.

Ethical approval was granted by the hospital ethics committee and the Head of the Nursing College (Mysore, India). The participants were interviewed individually by two UK members of the research team (SJ and PK) and participants allocated randomly to both researchers. The interviews were recorded (with the participant's permission) and on average lasted up to thirty minutes. On completion of the interview the recordings were anonymously coded and stored for transcription. The transcription was completed in India by an external agency that addressed local dialect influences. This was to mitigate against any bias and also to aid with the understanding of the participants accented use of English and transcribed verbatim, and checked by the two Indian project members (MK and RR).

Results

Introduction

The paper follows the analytical structure of the research by dividing into sub headings and supporting with evidence from the participant interviews. The reasons for attempting suicide and method of suicide are examined to bring cultural influences to the reader before the qualitative data is examined. The exploration of nurse's attitudes is a focus of this study, as negative attitudes have the potential to lead people towards bias in their interactions with the person for which the attitudes are held (Brehm et al, 2002). In this study nursing participants forward a range of influences and beliefs on patients who attempt suicide, and these beliefs are woven with attitudinal insights emergent from the data.

Data themes synopsis

Background influences for attempting suicide from the data

Evidence gathered suggests that senior nursing staff considered suicide to be an impulsive momentary act following arguments with family or relationship tensions, with the exit strategy of suicide. Similar theories posited identified the upbringing of young Indian children that don't talk about failure and coping with stress, and are ill prepared or ill equipped for failure and this makes them less resilient in life (Participant 10). The phrasing within the interviews as not being 'Mentally strong', which can lead to 'mental weaknesses'. This highlights the use of language and context in translation in India and the need to be culturally sensitive, 'they can't do anything or tolerate anything' (participant 2) which could suggest poor problem solving skills, and care is needed for context and for translation analysis. The construct within the UK resonates with emotional resilience and in India this equates to being 'mentally strong'. The opposites of this exist in both UK and Indian cultures and move towards stigmatisation and negatively held beliefs that does little for mental health care and less for those marginalised by mental health concerns.

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Methods of suicide

A range of methods to attempt and succeed at suicide in India are forwarded. Participants from the study identified the wide availability of poisons (Pesticides or Organophosphates) that are a preferred method of suicide. Persons attempting suicide can use combinations within attempts and also are subject to variations if unsuccessful following first attempt. Methods vary, but include burning, drowning, immolation (setting fire to self), hanging, and ingestion of harmful substances (NCRB, 2010). The availability and effectiveness of pesticide ingestion to end life if not received into hospital care and treatment within a few hours post ingestion leads to a successful attempt. Poverty and debt are major causative factors in the lead up to harm attempts and are clearly identified as triggers for suicide (Jones et al, 2014). Often suicide attempts are triggered by more than one stressor and the evidence from the qualitative data supports this multifaceted phenomenon.

Pressure and cultural expectations

Family expectations and relationship success place pressures on individuals and the cultural significance of these cannot overstated. A raft of issues permeated the data in this key area that suggests a strong influence on care approaches and attitudes adopted by nursing participants. One participant phrasing the issue succinctly, 'Marriage problems make *them* think drastically, and they become disconnected like that' (Participant 6). Identifying the stressor trigger, but also the emotional detachment and lack of options are considerable and acknowledges the drastic actions taken. Some readers of this article may take umbrage with the term '*them*' used in data above, this might be considered labelling, even stigmatised to 'us and them' and requires future investigation.

Some participants could not appreciate the desperation and that suicide is a strategy to remove themselves from the situation when no other options present. However, for some participants the individual circumstances aided staff acceptance or not after the attempt. Nonetheless this does highlight that approaches and understandings vary considerably and are situational and circumstance dependant. Furthermore that nursing approaches do not fully consider the individual's psychological care needs, acceptance, and empathy levels are significantly culturally influenced and treatment approached vary dependant on the circumstances.

Domestic violence

Husbands beating their partners (domestic abuse) and historical societal attitudes in the main acknowledge this drastic method of harm, but also some participant staff admire this courage as bravery in adversity which ante cedes suicide attempts for some patients. Highlighting the attitude of society that is for some heavily stigmatised, judgemental and suggests a lack of understanding irrespective of the circumstances that triggered event. In some way this attitudinal portrayal from nursing participants again reflects societal influences on nursing practices, but also that nursing staff are influenced by culture and society, that might be considered judgemental.

Dowry death and love failure

The event of 'dowry death' raises further cultural attitudes held, but crucially there was a divide between nurses being immune or disassociated with the events to the point of 'us and them suicide people' (Participant 4). This was further justified from the data that raised levels of compassion by 'it is the ones left behind that suffer' (Participant 7) that provided insights of the wider consequences

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of suicide, although understanding for the family does not always equate to understanding of why the person ended their life. This suggests in the aftermath of suicide attempts that nurses cope by a process of depersonalisation from the attempt and also subsequently the patient. A consequence of this process is that patients become objects and encounter social loss of role, but that the process is transferred onto nursing staff who focus on physical duties as way of dealing with the cultural issues of suicide. The language used from participants was different to that of more Westernised groups, and 'Love failure' articulated as cause of limited finances and a societal expectation to achieve through education and better the family standing in society (Participant 4).

Childhood cultural influences.

The pressure to succeed in children is constant and places a lot of pressure to succeed in their education qualifications. Education and teenage years present their own unique challenges to family units. School reports are reported as triggers to harm attempts when they do not meet their own or more importantly their parent expectation, the fear of failure and not making the grade or considerable. The difficulty is sifting through those who can cope and against those who cannot. Educational attainment, the 10th grade (around age 14) can decide if that child progresses to 11th grade, with reducing places available, this increases the pressure on children. Failure in exams does impact on suicide attempts at the time of results 'I pity them, they don't know what they are doing' (Participant 12) referring to children who attempt suicide after exam failure. Higher and tangible levels of empathy was associated with younger harm attempts, combined with not meeting their educational expectation. However, others who attempt suicide for a range of other reasons and not of a very young age are not very well accommodated from a nursing attitudinal perspective.

What is apparent is the use of language from participants that reflect a section of society, the word 'failure' used synonymously with love failure, marriage failure and exam failure. The use a language within the nursing culture was fascinating as researchers and bringing meaning to the narrative. An example with relationships was the element of 'Love disappointment' and family background which could influence economic and social factors to the triggers' (Participant 3). 'Patients always will be depressed' referring to those who attempt harm and are admitted, a sweeping generalisation, if not a true account of experiences and adjustments required to cope or not (Participant 2). However, what this data did not acknowledge is the wide range of mental health issues that can present as well as depression and the multifaceted influences that drive a person to attempt suicide. The suggestion is that a common type is presented for suicide attempts, those who have failure and cannot cope, reasons that are understood better by some staff and rejected as less valid by others. What the above highlights is the misinformation surrounding suicide attempts and the uniquely individual act but also that care and treatment must also be individually constructed less we lose the patient in that process.

Attitudes and beliefs from nurses over attempted suicide

Poverty

Poverty is a key theme in the narrative data, but poverty in the widest sense and considerably broader than financial poverty. The themes raised may resonate with general hospital staff as well as those from mental health irrespective of ward or country they are likely shared but to differing degrees.

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Poverty of human resources within general hospital for specialist assessments and treatment was foremost. The environments are nightingale ward type in design and up to 35 beds per ward. A myriad of conditions accommodated in any one ward. Healthcare generally is not free in India except for some state hospitals and the demands on them are considerable. Staffing levels average four nursing staff per shift, and reduced levels at night. Family members are encouraged to remain with all patients admitted to undertaken basic care and dietary needs for example.

Poverty in training was foremost and acknowledges the pre-registration nurse training does not take into account the skills of supporting a patient psychologically and who may have attempted to end their life. The approach from participants was more aligned towards telling the patient what to do, rather than working with them to identify the issues and triggers, stresses, and explore basic problem solving strategies.

Physical resources poverty evidenced by limited availability of ventilators in Mysore that are crucial in the acute management of pesticide ingestion. The lack of hospital beds and lack of interview or quiet spaces to undertake mental health support, lack of staff and time also have to be considered in acknowledging the problem following on from the acute care.

Financial poverty is a significant risk factor that is present in many suicide attempts relayed by participants. This can be compounded after days of hospital treatment as care is costly in some hospitals that places additional worries upon the family and can raise levels of risk as patients leave hospital physically well, but if motivations for suicide are not addressed then they can be financially compounded by admission and treatment. A *genuine* suicide attempt and the underlying circumstances in some cases meant that they were treated with more empathy and given additional care. The attention in the form of psychological support resonating with a sense of hopelessness from the data. However, the pragmatic advising role was foremost in the philosophy of care and was in the main very well intended. Participant 7 articulating 'why are you wasting your life' that may have encouraged thought and reflection when managed correctly and phrased another way, but may also be counterproductive, 'We will tell the patients'. What this then does is press the point that the skills of listening, being non-judgemental, and telling patients what do in some way inhibits communication in those already compromised. Lessons from practice in the UK have advanced in the past 30 years, hearing the messages being communicated and the deeper meanings involves active listening.

This process of psychological support competing with physical tasks was explicitly relayed 'psychological support is out last priority as physical care takes priority'(Participant 13) and recognises on some level the need for psychological support, but staffing levels impact on the ability to deliver this support. What this suggests is that staff are comfortable and able to manage physical care to high standards within current staffing levels, but at a cost of not meeting the psychological care needs. Participants 4 suggesting that 'wards are generally not the best place to care, you meet the physical needs but not the psychological and better for them if they were cared for on another ward for this', again this could add to stigma whilst it acknowledges the need to care it is to convenient an answer and not a solution. The element of the use of 'us' and 'them' could be construed as harmful attitudinally. Those reading this may well think on stigma and labelling theories but this is not the main focus of this piece, and will not be covered.

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Additional narrative data proposed 'our nurses need to have empathy' the physical tasks are time pressured, that reduce opportunity for psychological support time' they compete' 'we feel sorry for them the patients, feel pity' (Participant 1). Whilst pity might not be high on the list of what assist patients to recover it moves in the right direction away from telling patients what they should be doing to relaying understanding. Participant 12 encapsulated the dilemma and considers that 'suicide is a way of coping, maybe even culturally conditioned response to stressful situation within a family unit, the media perpetuate this and it has an effect, children are not prepared for life in India which is hard' (Participant 12). The data raised the cultural sensitivities and the wider socio political influences of suicide, but more than that, suicide for some is considered the only way out of the situation at the time and that degree of human despair is a tragedy.

Significantly, follow up care was mentioned once in all interviews and suggests the care ends when discharged from hospital, but in real terms hospital care provides physical respite from the issues surrounding admission that the patient may still have to address beyond discharge. This lack of support post discharge combined with limited psychological support in hospital is under researched and concerning. Furthermore, the lack of work undertaken in society to promote resilience in the population from a young age, coping strategies and an awareness of mental ill health, problem solving, support agencies raised, hospital care and treatment that can refer into community agencies, and of course practical problem solving work and psychological support in the community made available. This is a care pathway that requires joined up working, individualised care planning, and recognise the need for cultural of professional change. Religion is a sensitive issue and runs deeply and one that has to be taken account of not just within this research but also within nursing practice and is raised for that issue alone below.

Religion and suicide.

It is crucial not just to ask the question in the right way in practice but also within qualitative interviewing which is a challenge with cross cultural studies, and necessitates local interpretation and checking during the analytical process, no more so than in qualitative research investigation. The 'weakness of mind' is one example, meaning a lack in problem solving skills and hopelessness in their situation, but that God was used a measure to address these imbalances, and if they did not then they had not 'found the lord yet' (Participant 5). Weakness of mind could also be interpreted as labelling, even derogatory in some cultures, but it is a term used that attempts to capture vulnerability of learnt helplessness from a professional and cultural competence level in this study.

There could also be a paradoxical effect in hospital, as care is not free in India other than in the large state hospital, and for the poor, then patients or their families have to pay. By imposing financial treatment costs for those who have attempted suicide, 'only then will they know it is wrong' (Participant 8). Whilst that is one approach it may only compound the problems of the patient and family, especially is financial motives instigated the harm attempt. This can only serve to compound the isolation and self-esteem and may be considered counterproductive no matter what the intention. Participant 10, 'what they did is wrong' (*suicide attempt*) and therefore financial payments may also be levied as a deterrent, but may also compound psycho social pressures further.

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Patient's problems presenting

A hierarchy of illness existed, society neglects HIV, it separates them through ignorance and misinformation; they are marginalised and treated similarly in that respect those who attempt suicide. Participant 6, 'suicide is a bad thing' suggesting attempting it is wrong and value laden opinion that does not accept the many reasons and for some they may be understandable. Negativity and shame a consequence on admission and limiting communication attempts from patients, 'we feel pity and it is so sad for the people, Suicide is a sin, but for some I can understand why they want to die' (Participant 15). Increased guilt from the person, lowered self-esteem or self-worth, also expressed that diseases are set aside from suicide attempts as somehow less deserving. They are also fearful, perhaps even scared of the family and they are expected to care for their family member, this recognises the trauma but again places nurses and the family are somehow at a loss regarding how address this sensitive subject, to start the process of repair.

Skills and qualities/ Psychological

Psychological support skills, but couldn't elaborate beyond build a relationship, establish trust and observe for behaviour and no verbal cues, 'spend time with them'. Mentions psychological care if they are fully conscious and gave an example of positive reinforcement, so there are theories and some level of knowledge but they are disjointed, patchy, inconsistently applied. In one way a negative case was from a participant who relayed the attributes or cornerstones of good mental health/ psych support. These skills involve being reflective, empathic, aware of own feelings and beliefs and how these can influence patient care and support. Talking and listening **with** the person rather than **to** them, and be interested in their welfare (Participant 3). Displaying insight and understanding of the gravity that a suicide can have not just on the person but on the family unit. 'Sometimes I feel they are very courageous people' those who attempt suicide. Crucially there is a need to deliver problem solving skills and also other support mechanisms. India is a nation that is developing and religion is a crucial part of Indian culture, but other consideration such as MH and stigma, attitudes need to be addressed. Reflective practice for nurses is essential, as is clinical supervision and these would be instrumental in driving care and attitudinal change combined with educational and attitudinal initiatives.

Religion, Faith and beliefs

Religion and faith featured strongly in interviews, and we have to write about religion in India by way of introduction before we explore this element in the article.

'God has given you a life' (Participant 14) and the patient is told off for attempting suicide, which adds more guilt and lowers esteem, no matter how well intended it is perhaps counterproductive, religion and religious beliefs overspill into professional and personal exchanges on the ward. Religious is a cornerstones in Indian culture and at the forefront of participant data. 'Jesus solves our problems' is offered to patients 'God only has the solution' so a lot of religion focus within care settings' (Participant 6).

Strong themes emanated from the data and centre on the influence of CULTURE, RELIGION, BELIEFS, and also BLAME as a consequence being experienced. Value judgements assists in distancing nurses from patients, intentionally or not it is likely to occur. Situational helplessness is an issue and

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forwarded by repeated attempters presenting to emergency rooms brought in by family members, but also is echoed within participants who presently lack the resources to intervene in mental health issues such as attempted suicide unless it involves physical nursing duties. This suggests a psycho social model that incorporates religion but crucially acknowledged from the patient perspective, should provide a move towards holistic patient focussed care.

Limitations

Limitations are that the study was completed on one hospital site with a total of 15 participants limiting generalizability. However, the small scale study does provide some direction for larger multisite studies that might engage a mixed method approach.

A larger attitudinal study commenced in June 2014 over two general hospital sites in Mysore, with 900 participants interviewed. This larger scale study has been informed by this small scale qualitative study. Further limitations are that all participants were female and senior nurses within one hospital, and representative of the nursing profession of that hospital and no other professional groups. The larger scale study extends the health care professional groups to include doctors, nurses and Psychologists at all levels.

Summary

Suicide attempts in India often involve the deliberate ingestion of Organophosphates Compounds (OPC), widely available as pesticides driven by poor mental health, financial poverty, and other life pressures which all impact on suicide motivations (Jones et al, 2014). The scale of the problem is unknown and is probably much greater than estimated (WHO, 2012). Advances in survival rates and hospital care have raised a gap in nursing staff ability to psychologically support patients and commence support for the underlying issues that first led to the attempt. In comparison UK suicide statistics indicate 4,500 suicides per year (hanging 44% and ingestion of poisons 24%)(Appleby,2012).The highest rate of suicide is in the North of England at 9.9 per 100,000 against the population of India that is approximately 1.22 billion that identifies the considerable scale of the human cost in India from mental health problems and suicide.

Suicides and harm attempts are multifactorial, approaches to prevention must be multi-pronged, by macro and micro level initiatives aimed at individual, family and societal levels (Gururaj, 2004). Developing a strategy and targeting resources must be given serious consideration and goals should be measurable, achievable, and realistic.

Conclusions

Stigma, detracting stereotypes, and negative attitudes toward mental conditions are a major impediment in the provision of healthcare; with research showing that such attitudes can have a direct impact on patients' well-being and the type of health care they receive (Link et al, 1997). Trained nursing staff (and therefore student nurses on placement) may hold pre-conceived beliefs and values that are cultivated in the working environment. It is important for mental health practice to examine these attitudes, beliefs, and perceptions about suicide and the need to treat patients individually. Culturally sensitive interventions that respect staff beliefs and attitudes but also balanced against the needs of the patient and their immediate family.

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Cultural interpretation of the data and perspectives is paramount to progress patient staff relationship, however the interventions must have the patient at the centre of them. Little sense of what to do psychologically or individual care planning combined with a significant dependence on religion to promote healing rather than a part of that process.

Mental health assessment and principles of treatment must consider the scope of cultural sensitivity in India, and time for staff on the wards is a premium. The first aim of this study was to identify the issues for future initiatives, nurses forwarding that patients need counselling, psychological support and identify those needs, but acknowledge that they do not have the practical skills, or confidence to be able to deliver them consistently. Negative attitudes formed on suicide make it more likely that they will be treated differently, rejected and devalued within society (Christison and Haviland, 2003). Furthermore, negative attitudes for people who have psychological disabilities and attempt suicide will impact on their lifestyle options, educational and vocational opportunities, quality of life and a decline in community participation(Gething,1992).

Multisite studies being undertaken aim to better understand staff attitudes to mental illness and establish if different hospital and staff groups have attitudinal differences. Finally, understanding the attitudes and beliefs towards suicidal patients and those who are psychologically compromised is a fundamental step in addressing the issue of the unintentional negative attitudes reported within this study (Boyle et al, 2010). Student nurse education in India also has to balance the psychological care needs with the physical in general hospital settings if psychological care standards are to be raised for this marginalised patient group. Whilst this study has been undertaken on nursing professionals the attitudes and beliefs of the wider community is a direction for preventative work, as well as attempting remediation. However, societal acceptance and political drivers may take a little longer to change.

Declaration of interests. The first visit in 2012 to Mysore was funded by a start-up grant from the Tropical Health Education Trust (THET) that facilitated this follow up research visit. No other conflicts from all parties.

Acknowledgement and thanks to the 15 nurses who volunteered their time and honesty to this study with the aim of raising care standards.

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Figure 1. model proposed from data

