Nurses attitudes and beliefs to attempted suicide in Southern India.

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Abstract

Background There is growing global interest into the attitudes and clinical management of persons who have attempted suicide. **Aims** 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. **Methods** A qualitative methodology was employed with audio-taped interviews utilising four level data coding. This paper reports on a group of 15 nursing staff from a large general hospital in Mysore, Southern India .**Results** Findings suggested that patient care and treatment is directly influenced by the nurse's religious beliefs within a general hospital setting with physical duties prioritised over psychological support, which was underdeveloped throughout the participant group. **Conclusion** 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. In addition interventions must focus on current resources and context to move the evidence base suicide prevention forward.

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 for the study 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). Suicide rates in India now average 21 deaths per 100,000 people against a global average

of 11 (WHO, 2014). However, Suicide rates vary considerably around the world and are influenced by the cultural, social, religious and economic environments in which people live (WHO, 2014). Some of the worst affected countries have more than 40 times more suicides than the least affected areas. India is second only to China in the absolute number of annual deaths by suicide (Patel et al, 2005). 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). 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.

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 attempts 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). Suicides are preventable for some and for national responses to be effective they must have a comprehensive multi-sectorial suicide prevention strategy, and crucially implemented locally (WHO, 2014).

There is an urgent need for qualitative studies to complement the findings from quantitative studies allowing the interpretation of the findings too generate more culture specific hypotheses. We could not find any such qualitative publications of Indian nursing staff attitudes towards those who self-harm. However, 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 for cross cultural comparison that may also drive up care standards and educational avenues for exploration and subsequent interventions. This study aimed to assess qualified general nursing staff attitudes toward suicide attempters by using a qualitative method to inform future study directions (Freshwater, 2007; O'Carhain et al, 2007). A qualitative research design was used to capture the lived experiences of senior clinical and educational nursing staff in a large general hospital. The study investigated how participants present realistic accounts of their uniquely individualised experiences for service users in times of heightened physical, psychological and social distress through an Individual Phenomenological Analysis (IPA) approach (Smith et al, 2009). Moreover, qualitative investigation better addresses shifts in attitudes, perceptions, and changes between the data interviews perhaps at positional extremes within treatment environments (Coolican, 2014; O'Leary, 2014).

Aims

The primary aim of the research project was to explore the experiences and attitudes of nurses treating patients who have attempted suicide and admitted to a large general hospital, in South India, through the use of Interpretive Phenomenological Analysis (IPA). 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.

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2. An exploration of the participants' subjective meaning and appraisal of their experiences of working with patients who have attempted suicide.

Methods

Setting:

The hospital is an ex-missionary general hospital which is a leading provider for ventilator support for those attempting suicide through pesticide poisoning. Agricultural pesticides are widely available and are a common method of attempting suicide in this region and throughout India. The hospital operates a Christian ethos to care and treatment that underpins the day to day management and is located in what Westernised cultures would identify as an inner city deprivation area. Hospitals in India do charge for treatment and not all health care is free, only the large state hospitals do not charge. Intensive care beds are at a premium and this can lead to resource challenges in emergencies when time is a crucial factor. The hospital has one full time psychiatrist and one part time psychiatrist for sessional work. Mental health nurses within the city predominantly work at the larger mental health units within the state hospitals. There are no other allied mental health professionals or liaison mental health nurses at the hospital as there would be in most Westernised general hospital settings. Ethical approval was granted by the hospital ethics committee.

Participants

We approached 21 nurses with at least 10 years of clinical experience of working with suicide survivors and who spoke fluent English. The participants were issued with a study participant's information sheet and a consent form to agree to participate in the project. The nurses were informed of their right to discontinue their participation at any time without prejudice. 15 agreed to participate and were all women aged between 35-58 years of age. The general nurse participants were drawn from different areas of clinical service- outpatient, casualty, intensive care, general

wards and nurse tutors. No male participants were recruited from the sample which was unintentional, but is representative of the predominantly female nursing workforce in India.

Development of the semi-structured interview

A semi-structured interview schedule was specifically developed to investigate nursing staff attitudes, beliefs and knowledge base to patients who attempt suicide in India in the absence of an existing validated qualitative measure (Wexler and Fletcher, 2007). Two investigators (SJ and PK), academics with a background in nursing from Edge Hill University, and two consultant psychiatrists from India (MK and RR) met and developed the interview schedule with open ended questions allowing the interviewer to seek further clarification in a non judgmental and non leading manner. 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 revision to the questions. The refining of the interview questions was essential to ensure contextualisation of the questions whilst the standard of English language from participants was good, both the UK and India members of the project team wanted to ensure the questions targeted beliefs and attitudes specifically to reduce opportunities for misinterpretation of the questions.

Interviews:

All participants from one hospital site were interviewed individually by two UK members of the research team (SJ and PK) and participants allocated randomly to both researchers. The interviews were conducted in English, and audio recorded. Each nurse was briefed about the interview, techniques and assured of the confidentiality and informed consent secured. The interviews lasted on average up to 30 minutes. The interviews allowed for the flexibility to capture nurses 'narratives'. It is noteworthy that all of the research team have worked in Mysore in general hospital settings.

The two medical members are full time psychiatrists in Mysore (MK and RR), and the two UK members have worked in Mysore on two prior occasions over several hospitals.

Transcription:

On completion of the interview the recordings were anonymously coded and stored for transcription. Transcription of the data was undertaken verbatim by an independent medical transcription agency in India. This was to mitigate against any bias and also to aid with the understanding of the participant dialects by the accented use of English. Once completed, the transcripts were checked by the two Indian project members (MK and RR) for accuracy. However, attempts to reduce bias from both UK and India team members are acknowledged and the cultural influence presents a challenge.

Analysis

a. 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 (Biggerstaff and Thomson 2008). 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).

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 a concept group of themes 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 were often used which the researchers believe 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 again in England in order to begin the analysis.

b. 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 who participated throughout the analytical stages to reduce cultural misinterpretations with the two UK project team members. This was paramount to increase reliability and validity in the analysis and offered cultural competence and sensitivity. 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. The researchers considered the possibility for narrative data being misinterpreted during the analytical stage and this had to be controlled for throughout the process. The UK researchers provided balance throughout the analytical process by questioning contexts and true meaning behind the words, one member of the Indian team attended the UK in person for this process, and the other member via Skype call.

Results

Introduction

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 crucial as negatively held attitudes hold 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 these beliefs are woven with attitudinal insights emergent from the data. In many ways it is the cultural and attitudinal differences between the UK and India that becomes a central focus of this research to generate areas for future exploration.

Data themes synopsis

Background influences for attempting suicide from the data

Participants considered suicide to be an impulsive momentary act following arguments with family or relationship tensions, with the exit strategy being suicide. Similar theories posited identified the upbringing of some 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 was being 'mentally strong' to cope with pressure or 'mental weakness' when not coping. 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 resilience or mental strength in UK and Indian cultures lean towards stigmatisation and negatively held beliefs, that does little for mental health care progression within marginalised groups.

Methods of suicide

A range of methods were forwarded but the wide availability and access of poisons (Pesticides or Organophosphates) are a preferred method of suicide throughout India. Persons attempting suicide can use combinations within attempts and also are subject to variations if unsuccessful following first attempt. Methods can vary, but include burning, drowning, self-immolation, hanging, and ingestion of harmful substances (NCRB, 2010). The availability and effectiveness of pesticide ingestion if not received into hospital care and treatment within a few hours post ingestion often leads to death. Poverty and debt are major causative factors in the lead up to harm attempts and are often identified as triggers for suicide (Jones et al, 2014).

Pressure and cultural expectations

Family expectations and relationship success place pressures on individuals and can influence attitudes adopted by nursing participants. An example concisely forwarded '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 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. The use of 'us' and 'them' could also be construed as harmful attitudinally. However, for some participants the individual circumstances aid staff acceptance or not after the attempt. Furthermore that nursing approaches do not fully consider the individual's psychological care needs, acceptance, and compassion levels are significantly culturally influential on treatment approaches.

Dowry death and love failure

The event of 'dowry death' raises further cultural attitudes held with participants disassociated with the events to the point of' us and them suicide people' (Participant 4).This introduced a hierarchy of participant compassion by 'it is the ones left behind that suffer' (Participant 7) that provided insights

of the wider consequences of suicide. This might also be explained in the aftermath of a suicide attempt as nurses cope by a process of depersonalisation from the attempt and the patient. A consequence of this process is that patients can become objects and encounter social loss of role, but that the process is transferred on participants by prioritising physical duties and avoiding the culturally taboo issue of suicide.

Childhood cultural influences.

School reports are identified as triggers to harm attempts when children do not meet parental exam grade expectations and the fear of failure becomes considerable. Educational attainment, the 10th grade (around age 14) can decide if that child progresses to 11th grade that increases the pressure on children. Failure in exams does impact on suicide attempts at results time 'I pity them, they don't know what they are doing' (Participant 12) referring to children who attempt suicide after exam failure. A tangible level of empathy was associated with younger harm attempts.

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 of language within the nursing culture was fascinating to the researchers by 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 harms and are admitted, a sweeping generalisation, if not a true account of experiences and adjustments required to cope or not (Participant 2). However, the data did not acknowledge the wide range of mental health issues and the multifaceted influences that drive a person to attempt suicide. The suggestion is that a common person 'type' is presented for suicide, those who have failure and cannot cope, reasons that are understood better by some staff and rejected as less valid by others.

Attitudes and beliefs from nurses over attempted suicide

Nurses attitudes to attempted suicide.

Poverty

Poverty was 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.

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. Family members are asked to remain with all patients admitted to undertake basic care and dietary needs for example.

Poverty in training was foremost and acknowledges the pre-registration nurse training does not sufficiently 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 individual issues and triggers, stresses, and explore 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 acknowledged after intensive care concludes.

Financial poverty is a significant risk factor in many suicide attempts relayed by participants. This can be compounded after hospital treatment as care is costly in some hospitals and this places additional worries upon the family and can raise levels of risk as patients leave hospital physically well, but can be financially compounded by admission and treatment. There is potential for a paradoxical effect in hospital, if not delivered in subsidised state hospitals, 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). This only serves to compound the isolation and self-esteem and is 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. However, a more pragmatic advising role in the philosophy of care from participants was in the main 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'. Summarily this suggests that the skills of active listening, being non-judgemental, and telling patients may inhibit communication and is not patient centred (Cutcliffe and Santos, 2012).Whilst lessons from practice in the UK have advanced in the past 30 years in part learning from professionals and patients, this process in India requires development.

Figure one outlining a conceptual model for poverty here.

Competing priorities

The process of psychological support competing with physical tasks was tangible '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. Participant 4 suggesting that 'wards are generally not the best place to provide holistic 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 perhaps to convenient an answer and does not move towards problem based learning. Participant 12 encapsulated the dilemma and forwards 'suicide is a way of coping, maybe even culturally conditioned response to stressful situation within a family unit, the media perpetuate this, 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 sadly, suicide for some is considered the only way out and that degree of human despair is a tragedy. Furthermore,

the lack of work undertaken in society to promote resilience in the population from a young age, coping strategies, mental health awareness, practical problem solving and psychological support should be widely available.

Religion, Faith and beliefs

It is crucial not just to ask the question in the right way in practice but also within qualitative interviewing which is a challenge within 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 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, but it is a term used that attempts to capture vulnerability of learnt helplessness from a professional and cultural competence level in this study. Participant 6, 'suicide is a bad thing' suggesting attempting it is wrong and value laden that does not accept the many reasons and for some they may be understandable.

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 further 'God has given you a life' (Participant 14) and the patient is told off for attempting suicide, which adds more guilt and lowers esteem. Religious beliefs overspill into professional and personal exchanges at a ward level. Religion is a cornerstone in Indian culture and at the forefront of participant data. 'Jesus solves our problems' is offered to patients 'God only has the solution' (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 assist in distancing nurses from patients, intentionally or otherwise. Situational helplessness is an issue and 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 must acknowledge the patients perspective, which would move towards holistic patient care.

Skills and qualities/ Psychological

Participants did recognise the cornerstones for psychological support (Time, empathy, trust, non-verbal's etc) but acknowledged that they are inconsistently applied. These skills involve being reflective and being aware of their 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). Crucially there is a need to deliver problem solving skills and also other clinical support mechanisms. India is a nation that is developing and religion is a crucial part of Indian culture, but other consideration such as mental health stigma and attitudes need to be addressed. Reflective practice for nurses is essential, as is clinical supervision and these would be instrumental developments in driving care and attitudinal change combined with educational initiatives.

Limitations

We interviewed a total of 15 nurses from one large hospital site and this may limit generalising the findings beyond the study setting. All participants were female and senior nurses and representative of the nursing profession from one hospital. Subsequently the findings unintentionally in the recruitment of participants do not consider male nurses attitudes. Future study designs should perhaps consider allied health professions and other religious faith influences from participants.

The researcher's presence during data gathering, which is unavoidable in qualitative research may have affected participant responses. This is of particular relevance here as the investigators (authors) were senior mental health practitioners, well established academics from the 'developed world' and would generally be viewed as 'superior' in 'knowledge and expertise' and 'modern' in

culture by the participants. This may have generated socially acceptable responses by the participants. Likewise the different cultural upbringing of the investigators may have influenced interpretations and analysis though this was minimised by having an investigator with local origins and culture for analysis. Issues of anonymity and confidentiality (though this was assured to all the participants) is likely to have influenced some responses particularly when reporting about hospital systems and practices.

Despite these limitations, this exploratory study has provided attitudinal and cultural insights to generate hypotheses that need to be investigated in larger multisite studies. The study recognises that the findings cannot be generalised with confidence to other hospitals or staff groups in Mysore, or indeed India. But what it does contribute is the attitudes and beliefs from a representative sample of senior nurses of religion and faith that directly influences patient care and this is indeed relevant for all nurses to reflect upon in their clinical practice.

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; WHO, 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. Often suicide attempts are triggered by more than one stressor and the evidence from the qualitative data supports this multifaceted phenomenon. Suicides 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). Restricting access to the means for suicide does work but in combination with other actions, in this case restricting means to pesticides may be one way ahead (Appleby, 2012; WHO, 2014). Developing a strategy and targeting resources must be given serious

consideration and goals should be measureable, achievable, and facilitate development of care pathways that allows reports to be operationalised into practice.

Conclusions

Stigma, stereotypes, and negative attitudes toward medical conditions are a major impediment in the provision of healthcare; 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, not just in India but in other continents. Culturally sensitive interventions that respect staff beliefs and attitudes must also balance against the needs of the patient and their immediate family. Health-care services in general hospitals need to incorporate suicide prevention as a core component, ensuring that people receive the care they need (WHO, 2014). Implementing clinical supervision systems in support of educational initiatives may assist in this endeavour.

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 must be on a par with physical care needs after intensive care concludes.

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). Communities, of which hospital are very much part of in India, can play a critical role in suicide prevention. They can provide social support to vulnerable individuals, engage in follow-up care, fight stigma and support those bereaved by suicide (WHO, 2014).

This study has directly influenced an ongoing knowledge and attitudinal study of one thousand male and female health care participants, including doctors, nurses and Psychologists at all levels, over two general hospital sites in Mysore commencing June 2014. 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 systemically 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 further preventative work, as well as attempting remediation and community follow up care.

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Figure 1.

Nurses attitudes to attempted suicide.