Original Article

Nursing students' attitude towards suicide attempters: A study from rural part of Northern India

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ABSTRACT

Context: Majority of health professionals have unfavorable attitudes towards patients presenting with self-harm, which further compromises their willingness and outcome of care. **Aims:** To assess the nursing students' attitudes toward suicide attempters. **Settings and Design:** Cross-sectional study was conducted in two nursing colleges of north India. **Material and Methods:** Three hundred and eight nursing students were recruited through total enumeration method from May to June 2012. 'Suicide opinion questionnaire' was administered to assess their attitudes towards suicide attempters. **Statistical Analysis Used:** Descriptive statistics was employed with Statistical Package for Social Sciences version 14.0 for Windows. **Results:** Majority were single females, from urban locality, with the mean age of 20 years. Only minority had previous exposure to suicide prevention programs and management of such cases. Majority of students agreed for mental illness, disturbed family life, and depression as major push to attempt suicide. They held favorable attitude for half of the attitudinal statement, but they were uncertain for rest half of the statements. **Conclusions:** They generally had favorable attitude towards suicide attempters. Their uncertain response highlights the need for enhancing educational exposure of nursing students and new staff at the earliest opportunity, to carve their favorable attitude towards patients presenting with self-harm.

Key words: Attitudes, nurses, nursing students, self-harm, suicide

Introduction

Current suicide rate in India is 11.2 per 100,000 population[1] and nearly three-fourth of suicide is reported in persons <44 years, which further contribute to significant social and economic burden.[2] Suicide is the most preventable cause of death among the top 20 leading causes of mortality for all ages.[3]

Suicide attempters not only present with multiple medical and administrative problems, but also pose considerable strain on busy medical and nursing staff.[4] Research evidence has indicated that unfavorable attitudes among doctors and nurses exist towards suicide attempters, which further influence their suicide risk assessment, management skills, including the quality and impact of care.[5,6]

Suicide is a multifaceted problem and hence management of patients with self-harm should also be multidimensional.[7] In this regard, nurses have the highest level of contact with patients and their attitudes, and knowledge about self-harm, may further influence their willingness and ability to deliver effective care.[8] Thus, studying the nurses' attitude towards suicide attempters has paramount importance in understanding and addressing the existing gaps in healthcare delivery system. The data is limited in this area[5,9] and we could not find any such study in nursing population from India. Hence, this study was aimed to assess the nursing students' attitude toward suicide attempters.

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Materials and Methods

Study design: Cross-sectional

Nursing students pursuing either General Nursing and Midwifery or Bachelor of Science (BSc) course

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were recruited from two nursing colleges of north India in May 2012. Total enumeration method was employed, in which all the students were recruited to maintain high level of accuracy and to provide a complete statistical coverage. Study was approved by the college authorities. Study proforma, containing sociodemographic profile sheet and suicide opinion questionnaire (SOQ), were distributed in classroom setting. Students were explained about the study aim and subsequently written informed consent was taken from all the subjects. They were also asked to read the questionnaire first and ask in case of problem in understanding any question. After answering their queries, they were asked to fill the questionnaire, for which they took nearly 30 min.

Following instruments were administered

Sociodemographic profile sheet

It included students' demographic profile along with their additional information about attending any suicide awareness/prevention workshop as well as experience of managing/observing patients with self-harm.

SOQ

It is a 52-item, self-rated, and 5-point Likert scale which measures suicide attitude on the basis of five factors: Acceptability, perceived factual knowledge, social disintegration, personal defects, and emotional perturbation.[10,11] It has been used in several studies.[12-16] Factor analysis revealed that the 15 factors accounted for 77% of the total variance.[17] Its psychometric reliability and validity have been established.[10,11,17-19]

Statistical analysis

Statistical Package for Social Sciences (SPSS) version 14.0 for Windows (Chicago, Illinois, USA) was used. For sociodemographic profile, frequencies with percentages were calculated for categorical variables and mean and standard deviation were calculated for continuous variables.

Attitudinal statements were scored on a 5-point Likert scale: 1. 'Strongly agree', 2. 'agree', 3. 'don't know', 4. 'disagree', and 5. 'strongly disagree'. Means and standard deviations (SDs) were also calculated to categorize attitudes into 'favorable', 'unfavorable', and 'uncertain' and *t*-test was administered for comparing mean attitude scores among two groups. Scores between 1 and 2.4 were considered 'positive dispositions' or 'favorable attitude', between 2.5 and 3.4 'unsure' or 'uncertain attitude', and 3.5 and above 'negative dispositions' or 'unfavorable attitude'.[14] The descriptors were reversed for negatively-worded items.[14]

Results

Sociodemographic profile

As shown in Table 1, total sample consist of 308 nursing students from two institutes. Majority were single females, from nuclear family, who were pursuing BSc Nursing with the mean age of 20.38 years (range 18-29 years). Students from both the institutes were comparable for sociodemographic profile. Only minority of students had previous exposure to attend any workshops or education forum on management of patients with self-harm and suicide prevention. Again minority of students had actually managed or observed patients with self-harm.

Attitude towards suicide attempters

As detailed in Table 2; majority of the students considered mental illness, disturbed interpersonal relationships, unreturned love, and depression as major push for suicide. Nearly half of the students believed that suicidal attempters were impulsive, self-punitive, and nonbelievers in after life. One-third of students considered those people as rigid, weak in personality, mentally ill, and interested to get public attention.

Table 1: Sociodemographic profile

Variable	Mean (SD)
Age	20.83 (1.90)
Income (INR)	28147 (25256)
	Frequency (%)
Sex	
Male	15 (4.9)
Female	293 (95.1)
Education	
GNM	36 (11.7)
BSc	272 (88.3)
Marital status	
Single	302 (98.1)
Married	6 (1.9)
Religion	
Hindu	157 (51.0)
Sikh	143 (46.4)
Other	8 (2.5)
Family type	
Nuclear	226 (73.4)
Joint/extended	82 (26.6)
Locality	
Urban	171 (55.8)
Rural	136 (44.2)
Attended workshop on suicide prevention	10 (3.2)
Professional experience to manage suicidal patient	18 (5.8)
Had seen a patient who attempted suicide	68 (22.1)
Had seen a patient who committed suicide	35 (11.4)

INR: Indian rupees, GNM: General nursing and midwifery, BSc: Bachelor of science, SD: Standard deviation

Table 2: Attitude towards suicide attempters

Statements	Frequency (%)					Score mean±SD
	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Most persons who attempt suicide are lonely and depressed	78 (25.3)	187 (60.7)	19 (6.2)	19 (6.2)	5 (1.6)	1.98 (0.84)
Most suicides are triggered by arguments with a spouse	17 (5.5)	96 (31.2)	89 (28.9)	90 (29.2)	16 (5.2)	2.97 (1.01)
The higher incidence of suicide is due to the lesser influence of religion	8 (2.6)	25 (8.1)	63 (20.5)	158 (51.3)	54 (17.5)	3.75 (0.93)
I would feel ashamed if a member of my family committed suicide	73 (23.7)	104 (33.8)	55 (17.9)	55 (17.9)	21 (6.8)	2.50 (1.22)
Most suicide attempts are impulsive in nature	36 (11.7)	136 (44.2)	74 (24)	49 (15.9)	13 (4.2)	2.57 (1.02)
People with incurable diseases should be allowed to commit suicide in dignified manner#	12 (3.9)	70 (22.7)	37 (12)	105 (34.1)	84 (27.3)	3.58 (1.21)
Suicide is an acceptable means to end an incurable illness#	9 (2.9)	34 (11)	35 (11.4)	118 (38.3)	112 (36.4)	3.94 (1.08)
People who commit suicide are usually mentally ill	24 (7.8)	70 (22.7)	50 (16.2)	101 (32.8)	63 (20.5)	3.35 (1.25)
Some people commit suicide as an act of self-punishment	24 (7.8)	180 (58.4)	58 (18.8)	35 (11.4)	11 (3.6)	2.44 (0.92)
Suicide is acceptable for aged and infirm persons#	4 (1.3)	14 (4.5)	38 (12.3)	133 (43.2)	119 (38.6)	4.13 (0.89)
Suicide is clear evidence that man has a basically aggressive and destructive nature	23 (7.5)	116 (37.7)	67 (21.8)	81 (26.3)	21 (6.8)	2.87 (1.09)
Suicide happens without warning#	50 (16.2)	109 (35.4)	51 (16.6)	70 (22.7)	28 (9.1)	2.73 (1.23)
Most suicide victims are older persons with little to live for#	3 (1)	16 (5.2)	55 (17.9)	169 (54.9)	65 (21.1)	3.90 (0.82)
About 75% of those who successfully commit suicide have attempted suicide at least once before	22 (7.1)	124 (40.3)	102 (33.1)	46 (14.9)	14 (4.5)	2.69 (0.96)
It's rare for someone who is thinking about suicide to be dissuaded by a "friendly ear"#	22 (7.1)	110 (35.7)	87 (28.2)	74 (24)	15 (4.9)	2.84 (1.02)
People who commit suicide must have a weak personality structure	23 (7.5)	105 (34.1)	50 (16.2)	104 (33.8)	26 (8.4)	3.02 (1.14)
Social variables such as overcrowding and increased noise can lead a person to be more suicide-prone#	2 (0.6)	25 (8.1)	45 (14.6)	146 (47.4)	90 (29.2)	3.96 (0.90)
A large percentage of suicide victims come from broken homes	27 (8.8)	151 (49)	67 (21.8)	55 (17.9)	8 (2.6)	2.56 (0.96)
A rather frequent message in suicide notes is one of unreturned love	36 (11.7)	163 (52.9)	55 (17.9)	50 (16.2)	4 (1.3)	2.43 (0.94)
People who set themselves on fire to call attention to some political or religious issue are mentally unbalanced	13 (4.2)	103 (33.4)	86 (27.9)	96 (31.2)	10 (3.2)	2.96 (0.97)
The possibility of committing suicide is greater for older people (≥60 years) than for younger people (20-30 years)#	5 (1.6)	17 (5.5)	41 (13.3)	176 (57.1)	69 (22.4)	3.93 (0.85)
Most people who commit suicide do not believe in an after life	35 (11.4)	145 (47.1)	67 (21.8)	49 (15.9)	12 (3.9)	2.54 (1.01)
In times of war, for a captured soldier to commit suicide is an act of heroism#	24 (7.8)	56 (18.2)	51 (16.6)	123 (39.9)	54 (17.5)	3.41 (1.19)
Once a person is suicidal, he is suicidal forever#	13 (4.2)	69 (22.4)	58 (18.8)	135 (43.8)	33 (10.7)	3.34 (1.07)
There may be situations where the only reasonable resolution is suicide#	22 (7.1)	85 (27.6)	53 (17.2)	97 (31.5)	51 (16.6)	3.23 (1.22)
Improvement following a suicidal crisis indicates that the risk is over#	3 (1)	64 (20.8)	87 (28.2)	137 (44.5)	17 (5.5)	3.33 (0.89)
Suicides among young people (e.g., students) are particularly puzzling as they have everything to live for	33 (10.7)	164 (53.2)	48 (15.6)	52 (16.9)	11 (3.6)	2.49 (1.01)
Once a person survives a suicide attempt, the probability of his trying again is minimal#	8 (2.6)	71 (23.1)	66 (21.4)	133 (43.2)	30 (9.7)	3.34 (1.02)
Suicide is a normal behavior#	3 (1)	8 (2.6)	14 (4.5)	107 (34.7)	176 (57.1)	4.44 (0.78)
Many victims of fatal automobile accidents are actually unconsciously motivated to commit suicide#	4 (1.3)	41 (13.3)	74 (24)	141 (45.8)	48 (15.6)	3.61 (0.94)
If a culture were to allow the open expression of feelings like anger and shame, the suicide rate would decrease substantially	63 (20.5)	149 (48.4)	47 (15.3)	35 (11.4)	14 (4.5)	2.31 (1.06)
From an evolutionary point of view, suicide is a natural means by which the less mentally fit are eliminated#	7 (2.3)	53 (17.2)	64 (20.8)	123 (39.9)	61 (19.8)	3.58 (1.06)
Suicide attempters who use public places (such as a bridge or tall building) are more interested in getting attention#	30 (9.7)	101 (32.8)	63 (20.5)	91 (29.5)	23 (7.5)	2.92 (1.14)
Suicide rates are a good indicator of the stability of a nation; that is, the more suicides the more problems a nation is facing	44 (14.3)	136 (44.2)	38 (12.3)	53 (17.2)	37 (12)	2.69 (1.25)
Sometimes suicide is the only escape from life's problems#	43 (14)	130 (42.2)	23 (7.5)	73 (23.7)	39 (12.7)	2.79 (1.29)
If someone wants to commit suicide, it is their business and we should not interfere#	10 (3.2)	12 (3.9)	26 (8.4)	114 (37)	146 (47.4)	4.21 (0.98)
Obese individuals are more likely to commit suicide than persons of normal weight#	3 (1)	11 (3.6)	24 (7.8)	102 (33.1)	168 (54.5)	4.37 (0.84)
Usually, relatives of a suicide victim had no ideas of what was about to happen	28 (9.1)	133 (43.2)	86 (27.9)	48 (15.6)	13 (4.2)	2.63 (0.99)

Contd...

Table 2: Contd…

Statements	Frequency (%)					Score mean±SD
	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Long-term self-destructive behaviors, such as alcoholism, may represent unconscious suicide attempts	30 (9.7)	176 (57.1)	59 (19.2)	40 (13)	3 (1)	2.38 (0.86)
We should have "suicide clinics" where people who want to die could do so in a painless and private manner#	14 (4.5)	26 (8.4)	39 (12.7)	80 (26)	149 (48.4)	4.05 (1.16)
Those people who attempt suicide are usually trying to get sympathy from others#	11 (3.6)	69 (22.4)	80 (26)	102 (33.1)	46 (14.9)	3.33 (1.09)
People who commit suicide lack solid religious convictions	8 (2.6)	55 (17.9)	104 (33.8)	119 (38.6)	22 (7.1)	3.30 (0.93)
Passive suicide, such as an overdose of sleeping pills, is more acceptable than violent suicide such as by gunshot#	32 (10.4)	144 (46.8)	44 (14.3)	56 (18.2)	32 (10.4)	2.71 (1.18)
Suicide occurs only in civilized societies#	5 (1.6)	38 (12.3)	44 (14.3)	150 (48.7)	71 (23.1)	3.79 (0.98)
Most people who commit suicide don't believe in God#	16 (5.2)	49 (15.9)	47 (15.3)	123 (39.9)	73 (23.7)	3.61 (1.16)
Children from larger families (i.e., three or more children) are less likely to commit suicide as adults than single or only children	15 (4.9)	65 (21.1)	61 (19.8)	139 (45.1)	28 (9.1)	3.32 (1.05)
Suicide attempters are, as individuals, more rigid and less flexible than non-attempters	13 (4.2)	95 (30.8)	108 (35.1)	85 (27.6)	7 (2.3)	2.93 (0.91)
The large majority of suicide attempts result in death#	14 (4.5)	146 (47.4)	72 (23.4)	68 (22.1)	8 (2.6)	2.71 (0.94)
Some people are better off dead#	9 (2.9)	53 (17.2)	74 (24)	128 (41.6)	44 (14.3)	3.47 (1.02)
People who attempt suicide are, as a group, less religious	6 (1.9)	31 (10.1)	83 (26.9)	163 (52.9)	25 (8.1)	3.55 (0.85)
Those who commit suicide are cowards who cannot face life's challenges	74 (24)	164 (53.2)	19 (6.2)	34 (11)	17 (5.5)	2.21 (1.09)
Individuals who are depressed are more likely to commit suicide	80 (26)	185 (60.1)	20 (6.5)	21 (6.8)	2 (0.6)	1.96 (0.81)

#Negatively-worded item, SD: Standard deviation

Attitude scores were derived for individual items and based on those scores attitudes were categorized into three categories: 'Positive disposition' or 'favorable attitude', 'unsure' or 'uncertain attitude', and 'negative disposition' or 'unfavorable attitude'. The descriptors were reversed for negatively-worded items. For half of the items, the students showed favorable attitudes towards suicide attempters. They showed positive disposition by agreeing with nine items: Majority of suicide attempters were lonely and depressed; I would have been ashamed if a member of my family committed suicide; some of the suicide attempts were act of self-punishment; unreturned love was a main content in suicide notes; suicide among students was puzzling as they had everything to live for; suicide rates were going to reduce substantially on allowing them for emotional expression; alcoholism and other self-destructive behaviors were different forms of unconscious suicide attempts; suicide attempters were cowards; and depressed individuals were more commonly attempting suicide [Table 2].

Positive disposition towards suicide attempters were also shown by disagreement with 16 negatively-worded items: People with incurable diseases should be allowed for suicide in dignified manner; suicide was an acceptable measure to end an incurable illness as well as for aged and infirm persons; most of suicide victims were older with little to live for; overcrowding and increased noise could enhance suicide risk; possibility of suicide attempts was greater in older than younger population; suicide by captured soldier was considered as an heroic act; suicide was a normal behavior; many fatal automobile accidents were unconscious suicide attempts; suicide was a natural measure to eliminate mentally unfit; if anyone wanted to attempt suicide, one should not be interfered; obese individual were more likely to attempt suicide; suicide clinics should be established where interested individuals could die in a painless and private manner; suicide was occurring only in civilized societies; most of suicide attempters were atheist; and some people were better off dead. Students showed negative disposition or unfavorable attitudes for following two somewhat similar items: Higher suicide rates were because of lesser religious influence and suicide attempters were less religious people [Table 2].

Students had uncertain responses for the remaining 25 attitudinal statements as presented with mean attitude score from 2.5 to 3.4 [Table 2]. Thus, overall their attitude towards suicide attempters remained favorable for half of the attitudinal statements and uncertain for rest half of the items.

Relationship between respondents' characteristics and attitude

Institute

As shown in Table 3, attitudes scores among students from both the institutes were significantly different for 17 attitudinal statements [Table 3]. By and large, students from institute – I were having more positive

Table 3: Attitudes towards suicide attempters: Comparison of two institutes

Statements	Score (mean (SD))		*t* value
	Institute-I	Institute-II	
Most persons who attempt suicide are lonely and depressed	1.85 (0.74)	2.11 (0.91)	−2.73**
Most suicides are triggered by arguments with a spouse	3.10 (0.97)	2.85 (1.04)	2.13*
I would feel ashamed if a member of my family committed suicide	2.33 (1.20)	2.68 (1.21)	−2.53*
Most suicide attempts are impulsive in nature	2.37 (0.95)	2.77 (1.06)	−3.49**
Most suicide victims are older persons with little to live for#	3.99 (0.83)	3.81 (0.79)	2.00*
People who commit suicide must have a weak personality structure	2.74 (1.12)	3.29 (1.11)	−4.33***
Social variables such as overcrowding and increased noise can lead a person to be more suicide-prone#	4.08 (0.81)	3.85 (0.98)	2.33*
People who set themselves on fire to call attention to some political or religious issue are mentally unbalanced	2.98 (1.01)	2.94 (0.94)	0.40*
Most people who commit suicide do not believe in after life	2.38 (0.98)	2.70 (1.02)	−2.77**
There may be situations where the only reasonable resolution is suicide#	3.41 (1.21)	3.05 (1.20)	2.56*
Once a person survives a suicide attempt, the probability of his trying again is minimal#	3.51 (1.01)	3.18 (1.01)	2.86**
If a culture were to allow the open expression of feelings like anger and shame, the suicide rate would decrease substantially	2.18 (1.04)	2.44 (1.07)	−2.12*
From an evolutionary point of view, suicide is a natural means by which the less mentally fit are eliminated#	3.44 (1.12)	3.71 (0.98)	−2.20*
People who commit suicide lack solid religious convictions	3.18 (0.92)	3.42 (0.92)	−2.30*
Passive suicide, such as an overdose of sleeping pills, is more acceptable than violent suicide such as by gunshot#	2.93 (1.22)	2.50 (1.10)	3.29**
Suicide attempters are, as individuals, more rigid and less flexible than non-attempters	2.76 (0.87)	3.10 (0.93)	−3.29**
Individuals who are depressed are more likely to commit suicide	1.83 (0.73)	2.09 (0.86)	−2.85**

#Negatively-worded item, SD: Standard deviation

and less uncertain attitude compared to their peers in another institute. The same group was apparently more knowledgeable about suicide and suicide attempters.

Gender

Compared to females, males had more favorable attitude for following four items: I would have been ashamed if a member of my family committed suicide (1.47 ± 0.74 vs. 2.56 ± 1.22, t = −3.42**); most suicide attempts were impulsive in nature (1.93 ± 0.59 vs. 2.60 ± 1.03, t = −2.47*); suicide rates were going to reduce substantially on allowing them for emotional expression (1.67 ± 0.81 vs. 2.34 ± 1.06, t = −2.43*); and sometimes suicide was the only escape from life's problems (4.27 ± 0.88 vs. 2.71 ± 1.27, t = 4.67***).

Religion

Compared to students of Hindu religion, Sikh students had more favorable attitude for following eight attitudinal items: Most suicide attempters were lonely and depressed (1.83 ± 0.72 vs. 2.13 ± 0.91, t = −3.16**); I would have been ashamed if a member of my family committed suicide (2.35 ± 1.25 vs. 2.65 ± 1.81, t = −2.15*); most suicide attempts were impulsive in nature (2.42 ± 0.98 vs. 2.71 ± 1.04, t = −2.55*); overcrowding and increased noise could enhance suicide risk (4.11 ± 0.81 vs. 3.83 ± 0.96, t = 2.71**); suicide survivors were having minimal probability for subsequent suicide attempts (3.48 ± 1.01 vs. 3.22 ± 1.02, t = 2.25*); most of suicide attempters were nonbelievers in after life (2.39 ± 1.0 vs. 2.68 ± 1.0, t = −2.53*); suicide clinics should be established where interested individuals could die in a painless and private manner (4.21 ± 1.08 vs. 3.90 ± 1.22, t = 2.38*); and depressed individuals were more likely to attempt suicide (1.82 ± 0.69 vs. 2.10 ± 0.89, t = −3.0**).

Family

Compared to students from nuclear families, students from joint/extended families were more strongly disagreed in considering suicide as an acceptable measure to end incurable illness (4.15 ± 0.97 vs. 3.87 ± 1.12, t = 2.0*).

Locality

Compared to students from urban locality, students from rural locality had more favorable attitude for two attitudinal items: People with incurable diseases should have been allowed to commit suicide in dignified manner (3.80 ± 1.13 vs. 3.44 ± 1.24, t = 2.32*); and suicide was acceptable for aged and infirm persons (4.25 ± 0.86 vs. 3.99 ± 0.93, t = 2.19*).

Discussion

Suicide is a complex human behavior as well as multifaceted health problem.[7] Patients with self-harm pose a significant challenge to healthcare delivery system. They also face negative attitude of hospital staff in most medical and surgical settings. The more negative

attitude expressed towards repeated attempters of self-harm, which is really alarming as this population has significantly higher risk of subsequent self-harm.[20,21] This highlights the importance of increasing the knowledge and understanding of health professionals' about patients with self-harm.

Nursing students reflect a group of future gatekeepers, insofar as they might have first contact with subjects with self-harm in their professional life. Nursing professionals' attitude toward this population is immensely important because their willingness to help such patients affect the content and outcome of care.[22,23]

Similar to earlier reports;[9,15] weak interpersonal skills and relations, mental illness, and disturbed family life were commonly thought triggers for suicide in our study. Majority of students considered association of lack of emotional expression, difficulty in facing life's challenges and depression with suicide. Nearly half of students believed that persons with suicidal attempts were impulsive, self-punitive, and nonbelievers in after life.

Generally, our respondents held favorable attitude towards patients presenting with self-harm, which is consistent with the findings of McLaughlin[24] and Anderson[25], but contrasts with those of McAllister, *et al*.,[26] who found negative attitudes predominantly. But they were uncertain for nearly half of the attitudinal statements. This may be due to several factors, such as lack of education and experience of managing patients with self-harm, younger age, and ambivalence towards this clinical population.[26]

More than half of the students did not consider permanency of suicidal ideation, which revealed a sense of hope for suicide attempters. Similar to earlier studies,[14,27] majority of our students were disagreed with primary motive of self-harm act was gaining sympathy.

In our study, male students had more favorable attitude than female students for some attitudinal items, while other studies[12,28,29] reported more positive attitudes in female staff. Similar to a study,[30] majority of our students considered suicide as an impulsive behavior.

It is unclear whether age of staff and experience to manage individuals with self-harm influence attitudes. As greater experience was found to be associated with improvements in attitude in psychiatric setting,[29,31,32] but not in general hospital setting.[28,33] Greater education was more consistently associated with positive attitudes.[34,35] Our mean attitude scores were similar to other study.[9] but we could not find any of such association as our subject was nearly of same age, with limited clinical experience and minority has attended any workshop/ lecture on suicide prevention.

Majority of our respondents were disagreeing with the statements that people who attempt suicide were atheist or lacking solid religious convictions. Our findings are similar to earlier reports,[12,13] but one study[30] found strong agreement for these statements. Similar to earlier findings,[13] most of our students were disagreed about acceptability of suicide as normal behavior, even not for aged and infirm persons.

There was a paucity of studies of cultural variations of health professionals' attitude towards suicide and suicide attempters. One study[36] found much similarity between the attitudes held by doctors from the UK and Israel. Another study[37] reported very restrictive attitude of medical students in Madras (India), rejecting the right to commit suicide; while on the other hand, in Vienna (Austria) a more permissive attitude was found.

In an Indian study, majority of the suicide survivors perceived that their suicidal attempt could have been prevented.[3] A recent review of patient experiences of self-harm services[38] emphasized their negative experiences with inappropriate staff behavior, lack of staff knowledge, and perceived lack of involvement in management decision. Another Indian study found significant positive attitude among mental health professionals compared to nonmental health professionals and concluded that the simple training and education of nonmental health professional could change their attitudes.[39]

The results of our study must be seen within its limitations. Our findings cannot be generalized as the samples were recruited from only two educational institutes. Attitude towards suicide prevention scale is not adapted for Indian population. Solely using quantitative method had inherent limitation of restricting responses to the given options. As only minority of students have attended specific lectures on suicide and had experience of managing suicide attempters, thus we could not establish any association between these variables and their attitudes. Similarly, we could not collect information about respondents' personal or family history of any suicidal idea or acts.

However, with these limitations the study leads to the following conclusions. Weak interpersonal skills/ relations, mental illness, and disturbed family life were commonly thought triggers for suicide. Only minority had previous exposure to workshops regarding

management of suicidal patients and suicide prevention programs. They held favorable attitude for half of the attitudinal statement, but they were uncertain for rest half of the statements.

Future studies should assess various health professionals' attitude towards patients with self-harm with large sample size in different clinical and community settings. Researchers should also incorporate qualitative methods, such as detailed interviews and examine relationships between professionals' attitude towards suicide and their demographic, clinical, and other parameters such as social support, coping skills, spiritual values, religious beliefs, psychosocial stressors, personal or family history of suicidal behaviors, etc.

These findings have implications for changing nurses' attitudes towards patients with self-harm. It may be considered by enhancing educational exposure of nursing students or new staff at the earliest opportunity through regular training programs/workshops, improving their awareness, knowledge, and communications and clinical skills for managing suicidal patients with the help of easily understandable and implementable suicide risk assessment methods. Such formal training should be made available to all medical and paramedical students, and clinical staff at their first entry. Regular clinical supervision and ongoing support of budding health professional will definitely ameliorate their worries and difficulties in working with suicide attempters.

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