Review of Literature

Historical Review

Suicide had been part of the history of the world. People of all walks of life had committed suicide over the years even among the famous people lots had died by suicide [1,4].

History of suicide has been recognized throughout human history. The first recorded case of suicidal attempt was over 4000 years old although Socrates, Nero, Vangogh, Sylvia Ploth, Morgot Hemungway and Kurtcobion all of them had completed suicide. In civil law, the heir's person who completed suicide often was subjected to sever punishment including for feature of all inheritance rights. While people who made an unsuccessful attempt could be put in jail, or if their attempt was discovered, they could be executed. Discrimination of suicide occurred in most societies during the 19th century in United States and other countries, however most cases had been classified suicide as a felony or misdemeanor. Civil and religious sanction for suicidal behavior were unfortunate because suicide and attempt suicide were direct out come of certain psychiatric disorders which are exceeding common in both Westerner and developing nations [23].

In ancient times, suicide sometimes followed defeat in battle, to avoid capture and possible subsequent torture, mutilation or enslavement by the enemy. In modern times, suicide attacks had been used extensively by Islamite militants, especially in the Palestinian Al-Aqsa intifada and Iraqi insurgency. Other wise, in Roman society, suicide was an accepted means by which honor could be preserved to those charged with capital times to

prevent confiscation of their family's estate by taking their own lives before being convicted in court [25].

In most European views as in Ireland, suicide had sometimes be seen as shameful by the victims family often, parent would refuse to acknowledge or publicize that death was from suicide, and instead, had the cause of death listed as something else. Unfortunately, the natural decline of religious influence had allowed for a different attitude towards life. Life is no longer a gift received from god but something obtained without ever having asked for, as result the living have full authority over their own lives if they wish to end they have the right to do so [25,26].

In china, suicide had been closely tied with gender in Chinese culture, both historically and today there were countless examples of females committing suicide in pre-modern Chinese history, usually as a result of oppression or misfortune, such as (family members particularly husbands and mothers – in – low) looking upon them in condemnation, or when women fell into shame. Although, suicide was also glamorized by popular stories among the people, in which lovers were unable to be together in life because of various reasons, were joined together in death they believed they could be together [25,26,27].

In India, suicide had been commonly mentioned throughout Indian history and frequently tolerated ritual. Suicide had historically been relatively common, particularly as a form of political protest, warrior code or as religious undertaking many notable Indian rishis, king and other figures had died through suicide for these reasons. The religions of India had traditionally apposed suicide as Hinduism and Buddhism in Japan, like other all East Asian cultures. The Japanese culture relatively tolerant of suicide however, recent events in Japan some of the highest rates of suicide

in the world among younger people. This had forced the Japanese government to take a more critical view of suicide as a problem.

In ancient Egyptian histories, ***Okash., (1986)***[28], referred to suicide as very rare. They viewed suicide remained popular through the sixteenth century. Through the seventeenth and eighteenth centuries, theologians and philosophers even late of eighteenth century, suicide has been viewed as a mental disorder, psychological response, and as such. Suicide had come under the mandate of the heath care system, until then suicide was considered a "crime", and in all religion as a "sin" [25,28].

Suicide Behavior

Suicide behavior is usually divided into the categories of suicidal threats, suicidal attempt, and completed suicide. In addition certain suicide attempt may be referred to as suicide gestures. The gestures are a suicide attempt directed toward the goal of receiving attention rather than actual destruction of the self and should be taken seriously. Suicidal threat may be valid but usually occurs before overt suicidal activity takes place. The suicidal person may make statement revealing the suicidal threats. While suicidal attempt include any self directed action taken by the individual that would lead to death if not interrupted. Completed suicide usually take place after warning signs have been missed or ignored [29,30].

Suicide is away out of a problem or crisis that is invariably causing intense suffering. Suicide is associated with unwanted or unfulfilled need, emotional reaction of hopelessness and helpless, ambivalent conflict between survival and unbearable stress, a narrowing of perceived option, and a need for escape, the suicidal person out signals of distress. Because life is full of risk, and people Most people go through life accepting some risks as apart of their daily routine while carefully avoiding other(30).

Distinction between suicide and suicide attempt includes an important distinction between those who kill themselves and do not mean to, and those who do not kill themselves but do mean to. Thus a person who commit suicide may either succeed or fail in his or her goal i.e. succeed in killing himself, and an attempt suicide may either fail in his or her goal for example succeed in making cry for help or fail and, in doing so probably die. Suicidal intent is the seriousness or interest of a person to end his life.

The level of intention is associated with the development and specificity of suicide plan, including method, time and place. Suicide is considered intentional when a person takes direct conscious part in self-destructive behavior. Suicide is sub-intentional when a person plays an indirect role in ending their life. The sub-intentional behavior may be a way of fulfilling conscious and unconscious wishes [4,31,32].

All forms are indirect pattern of self destructive behavior including high risk behavior as prostitution, abusive behavior, dangerous sport and a compulsive gambling in which the person concern arises from the long-lasting distress among those left behind that may result from such action

Suicide statistics are at best estimated of suicide. However, sometimes physicians, coroners and police are reluctant to cite a death as a suicide because of variances in criteria that would indicate a completed suicide. It is likely that some deaths that result of accidents “such” as drawing, car wrecks, gunshot wounds, drug abuse, and self poisoning may actually be suicide but are missed in the count. The term of Suicide should be applied to all cases of death that result either directly or indirectly from the positive or negative acts of the victim himself and in which the victim knows the consequences of the act [32,33].

Continuum of Self-Protective Responses

Protection and survival are fundamental need to all individual. A continuum of self- protective responses would have self- enhancement as the most adaptive response, while indirect self destructive behavior, self injury and suicide would be indirect self adaptive responses. Thus self destructive behavior may range from subtle to overt. Direct self destructive behaviors include any form of suicidal activity as suicide threats, attempt, gestures and completed suicide. The intent of these behaviors is death, and the individual is aware of the desired out come. Indirect self- destructive behavior is any activity deter-mental to the person's physical well being that potentially may result in death. However, the person may be unaware of this potential and deny it if confronted, as eating disorders, alcohol abuse, smoking, criminal activity, socially deviant behavior and non-compliance with medical treatment the level of behavior in the continuum may over lab. For instance the nurse must be alert to subtle shift in the mood and behavior of patient when assessing maladaptive self-protective responses [4,14,41,42].

Epidemiology of Suicidal Behavior

Suicidal behavior has a certain set of antecedents that increases lethality for specific group. These factors correlate with serious attempt and completed suicide. They constitute risk factors, which will be reviewed in the following categories increasing risk of suicide in vulnerable person: as gender, age, methods, occupation, religion ,physical and mental health[34].

As for gender and suicide, men commit suicide more than women four times, a rate that is stable over all ages. Women, however attempt suicide four times more than men (4:1)[34,35].

Regarding the method of suicidal attempt, men usually used fire arms, hanging, and jumping from high place. Women used an over dose of psychoactive substance, or a poison, while the use of firearms had decreased as a method of suicide. Among women the most common method of suicide is hanging[35].

Geography of suicide, national statistic rate determine About 30,000 people had completed the act of suicide each year, making it the eight leading cause of death in the United States and the third leading killer of young people. In 2002, according statistics of the center for diseases control and prevention every 100 minute another teenager would commit suicide[36].

Age and suicide; suicidal rate increases with age and underscore the significance of the midlife crisis, among men, suicide peak after age 45; while among women, the greatest number of completed suicide occurs after age 55. Older person attempts suicide less often than adult or younger person but are more often successful. Suicide rate, however, is rising most rapidly among young persons, particularly 15 to 24 years old, and the rate is still rising. The suicide rate in female in the same age group is increasing

more slowly than that for males. Most suicide now occurs among those aged 15 to 44 years old [34,35].

Regarding race and suicide, two of every three suicides are white males. The rate of suicide among whites has been nearly twice than that among all other groups. The suicide rate among blacks is rising. Suicide rates among immigrant are higher. According to religion; historically, suicide rates among Ramon catholic population had been lower than rates among Protestants and Jews. The degree of orthodoxy and integration may be a more accurate measure of risk in this category than simple institutional religious affiliation. In the end Islam, and all religious had forbidden suicide[8,36].

Occupation and suicide; the higher a person's social status, the greater the risk of suicide is, but a fall in social status increases the risk. Work in general protects against suicide. The incidence of suicide also seems to be higher in some occupation. Doctors, dentists, lawyers, police officers, and air traffic controllers had higher suicide rate than other general population [34,36].

As for season and Climate; no seasonal correlation with suicide had been found. Nevertheless, there is slight increase in the spring and fall, but, contrary to popular belief, there is no increase in suicide during December and holiday periods [36,37].

Medical condition and suicide also plays an important role. Pervious medical care appeared to be positively correlated risk mediator of suicide. High percent of all persons who commit suicide had medical disease within six month of death. Most of these diseases were central nervous system as epilepsy, multiple sclerosis, head injury, cardiovascular disease, Huntington's disease, dementia, and acquired immune deficiency syndrome

(AIDS). All these disease are associated with mood disorders. Moreover some patients, as those with epilepsy are given barbiturates and other medication are within their reach, so these persons who could kill themselves easily. Endocrine conditions are also associated with increase suicide risk; as Cushing syndrome, and porphyry. Mood disorders also attended with these disorders. Two gastro intestinal disorders have an increase suicide risk these are peptic ulcer and cirrhosis. There are two urogenetal problems that could also carry increased suicide risk as prostatic hypertrophy and renal disease patients who are treated with hemdialysis. On the other hand certain drugs can produce depression, which may lead to suicide in some cases among these drugs are resrpine l(respridо), corticostroids, anti-hypertensive and some anti-cancer drugs [34].

As for psychiatric illness and suicide; risk for suicide is 3 to 12 times of non-patient. The degree of risk varies depending on age, sex diagnosis and inpatient or out patient status. Female psychiatric patients who had at some times been inpatient had 5 and 10 times higher suicide risk, respectively than their counter parts in the general population. Those in the general population who commit suicide tended to be middle aged or older, but studies increasingly had reported that psychiatric patient who had committed suicide tended to be relatively young. A small, but significant percentage of psychiatric patients who commit suicide did so while they were inpatient. Most of them did not kill themselves in psychiatric ward, but on the hospital grounds, while they were on a pass or weekend leave, or lake of observation from nursing staff [8,10,39].

Psychiatric factors in suicide included substance abuse, depressive disorders, schizophrenia, and other mental disorders. Almost 95 percent of

all people who commit or attempt suicide were diagnosed to have mental disorders. Person with delusional depression are at highest risk of suicide. Previous psychiatric hospitalizations for any reason usually increased the risk of suicide. Among adult who commit suicide, significant differences between young and old exist for both psychiatric diagnosis and antecedent stressors. Stressor associated with suicide in those less than 30 year was as separation, emotional reaction of rejection, unemployment, and legal troubles; while illness as a stressor most often occurred among suicide victim over 30 year[34,35,36].

Depression was associated not only with completed suicide, but also with serious attempts at suicide. Studies showed that about 40 percent of depressed patients who commit suicide had made previous attempts, and thus the risk of a second suicide attempt would be highest within 3 month after the first attempt. The attempters, who were rated as having high suicide intent, were more often male older, single, or separated, and living alone than those with low risk intent. In other words, depressed patient who seriously attempt suicide more closely resembled suicide victim than they did suicide attempters. Not all suicide were committed by insane or severely disturbed individual, suicide can be a “tortuous ethical decision made by moral and san individual, perhaps a third of those who had attempt suicide unsuccessfully were person with out known psychopathology [34,40].

Risk factor for suicide was high-risk characteristics include male gender, divorced, widowed, unemployed, over than 45 years age, alcohol abuse, violent behavior, pervious suicidal attempt, and previous psychiatric hospitalization [8,4,34].

Etiology and Dynamic

Suicide is a complex phenomenon and there is no single explanation for its complicated process. Many theories advanced to explain or to further the understanding for suicide. Current theories fall into one of three categories: biological, psychological, and sociological theories [17,18,23].

1. Psychodynamic theories:

Psychodynamic explanations of suicide had focused on the role of aggression, and the consequences of the internalization of frustrating or disappointing objects on the suicidal individual's inner world.

Freud conceptualized the act of suicide as a result of internal conflicts between sexual or aggressive impulses and the demands of one's conscience and reality. These internal conflicts resulted in a turning of aggressive impulses against the self, with self-destructive behavior. In other words, Freud believed that suicide occurred as a result of an earlier repressed desire to kill someone else that was turned inward against the self[42,14,43].

Building on Freud's concepts, Menninger (1933), stated that suicide was anger turned inward. Also, he linked depression and suicide and described it as an "ever-present spectra". Additionally, he described the wish to kill, the wish to be killed, and the wish to die, which he interpreted as basic causes of suicide. The wish to kill was described as a murderous impulse, which could lead to self-directed aggressiveness. The wish to be killed was aggressiveness, which became an extreme form of masochism or self-punitive gratification. The wish to die was a passive submission to the death instinct" Jung postulated that the suicidal person held an unconscious wish for spiritual re-birth after emotional reaction that life had lost its

meaning. Adler identified the importance of inferiority, narcissism, and low self-esteem in suicidal act. While Homey believed that suicide was a solution for one who experienced extreme alienation of self as a result of great disparity between the idealized self and the perceived psychosocial se1f [42, 43,44].

2. Interpersonal theory:

Sullivan broadened the theoretical knowledge of suicide by emphasizing the importance of interpersonal relationship factors. Sullivan (1940) noted that when a person contemplates suicide his thought does not stop with the completion of self-destruction; it goes further in contemplating what the situation in regard to other people would be after the act. Therefore, he believed that suicidal act should be understood within the context of the perceptions of the suicidal person as well as his or her significant others. In addition, he viewed suicide as evidence of failure to resolve interpersonal conflict. Sullivan studied also failed attempted suicides and noted that many of them were contemplated carefully and the person was aware that he/she would destroy himself/herself but something "stupid" happens and the act fails. This "stupid something" was due to the intervention of a dissociated part of personality which consisted of the experience of human worth and friendliness in contrast to the main pan of the personality which was almost entirely derogatory and hateful [45,14,46].

3. Psychosocial theory:

Leonard (1967) in her developmental theory of suicide and attempted suicide had Marie a strong reference to Erick Eriksson. She suggested that the second and third years of life are crucial for the development of suicidal tendencies. As during these years, conflict could arise when the child was torn between dependence on the mother and

independence from the mother. She suggested that this conflict could be resolved in different ways, each of which should be associated with a kind of suicidal tendency [42,47].

4. Cognitive theory:

Suicidologists had speculated about the cognitive style or the method of thought-processing of those who commit or attempt suicide. Many authors documented the connection between depression and the thought process, or between mood and cognition. The thoughts or cognitive processes were considered to be altered when a person became depressed as in the suicide process. Although there was no single suicidal logic, some cognitive styles predisposed to suicidal behavior. Beck (1979) described the cognitive processes of the suicidal individual as being constricted; and that what had occurred cognitively was "a tunneling or focusing or narrowing of the range of options usually available to that individual's consciousness when the mind was not panicked". This constricted thought generally resulted in the belief that there were only two choices: a magical solution or death. Consequently, it increased the tendency for depressed individuals to negatively distort their incoming perceptions, resulting in negative interpretation of their experience and a negative conception of self and their future. Therefore, in suicidal process, the interaction of cognitive constriction, inability to solve problems and hopelessness might bring about a loss of focus in living and in finding a solution to live, and resulted in a focus on death [45,47,48].

5. Sociological theory:

Sociological theory attempts to show how the social and cultural context in which the individual lives influenced the expression of suicide. Durkheim, (1951) was the pioneer of sociological research in the study of

death by suicide. His conclusions were based on an analysis of patterns of death from official statistics. He chose to focus on the social problem of suicide to demonstrate his sociological explanations of the problem. Durkheim concluded that the suicide rate in a given population varied according to the degree with which the individuals in that group were integrated and regulated by society. Accordingly, if a person was integrated or regulated too little or too much by society, this had to do with suicide. In the light of his previous conclusion, he divided suicides into four social categories. Egoistic suicide; this was the first in which the person no longer could find acceptance or was insufficiently integrated into a social group and lacking close & meaningful relationships. While altruistic suicide; was the second and opposite of egoistic suicide in which the person was excessively integrated into the social group and gave his or her life a martyr to advance the cause or objectives of that group. This form of suicide was viewed as honorable in certain cultures, religions, and sociopolitical contexts. On the other hand anomic suicide; was the third category, here the person was insufficiently regulated. The person experienced the aloneness or estrangement that occurred when there was a precipitous deterioration in one's relationship that disrupted emotional reactions of "relatedness" and instilled emotional reactions of separateness", and fears of being without support from the formerly cohesive group. The last and fourth category was the Fatalistic suicide; in which the person was excessively [45,49,14].

6. Spritual Factors:

In atheistic worldview, persons' sprit was seen to play an important role. There were times in each of our lives, however when we deny the existence of our spirit. On the other hand the spiritual life assessment is important and essential in each patient to maintain life balance. When

people find life is meaningless, without purpose and God seems distant and in coring, there is no reason to live, hopelessness, an expression of depleted spirit, could be fatal [49,50]

Dynamics of suicide

The suicide of a patient, the pre mature end of journey is perhaps the most devastating experience in the practice of psychiatry and psychiatric nursing. Through the act of suicide the individual communicates his or her final message to others. The person may view suicide, as a way to escape life's suffering and to get away from situations that are viewed intolerable, such as the loss a spouse, difficult relation ship, the loss of series jobs, or terminal illness and chronic major psychiatric symptoms of hallucination. Different people meet adversity with their own styles of coping, depending on personal problem solving skills, self esteem, ability to relate with others and defense mechanism a person who has a poorly integrated personality may respond to stress by committing suicide. Suicidal patient chartered their emotional state as emotional reaction of intense anger, divesting depression, profound emotional reaction of hopelessness, and loss of life meaning and purpose. Suicidal attempt patient may express ambivalent about completing the act; while wishing to be dead. This individual sometimes has desired to be saved or rescued. Shnadman, (1990) identified what he called the ten common of suicide as follow; the common purpose of suicide is to seek solution, the common goal of suicide is sedation of consciousness, the common stimulus in unbearable psychological pain, the common stressor of suicide is frustrated psychological need, the common emotion in suicide is hopelessness and helplessness, the common cognitive state in suicide is ambivalence, the common perceptual state in suicide is constriction, the common action in suicide is escape, the common interpersonal act in suicide is communication of intention, and the common pattern in suicide is consistency of life long style.

Suicide in Psychiatric Practice

Suicide is a symptom of some psychiatric illness because suicide is one of the outcomes of untreated depression, delusion, paranoid thought, and social with drawl, schizophrenia, bipolar disorders and substance abuse disorders. Regarding depression as a cause for suicide, a person with depression had 3 to 12 time greater risk of suicide if compared with other population. Not all depressed people commit suicide, a person with depression often feel hopelessness, worthlessness, in adequate and guilty. They feel that they do not deserve happiness. People who feel hopeless are more likely to kill themselves because they believe that suicide is the only viable option to managing (insoluble problems) psychotic depression increases the risk of suicide. Symptoms of these disorders are delusion, hallucination, excessive warning and guilt [4,8,51,52].

On the other hand, psychiatric patients have tendency to withdrawal from seeking adequate psychiatric intervention and often use violent methods to commit suicide. About 10% to 13% of schizophrenic patients are committee suicide. So, schizophrenic patients who have severe symptoms as frequent hospitalization, poor social functioning, patients who have positive and negative symptoms and not respond treatment, young men recently diagnosed schizophrenia, 14 years after diagnosis have highest suicidal rate, all of them are likely to commit suicide. In addition to previous disease, patients with several other psychiatric disorders are associated with suicide behavior such as bipolar disorders, patients with bipolar disorders at risk for suicide when they are depressed. The symptoms of suicide ideation are

particularly important to note when the depressive symptoms in the mania are severe. This suggests that all bipolar patients could be at risk for suicidal potential. Another psychiatric disorder often associated with completed suicide is alcohol and substance abuse. Alcohol is associated with 25% to 50% of all completed suicide. Patients with personality disorders are also at risk for suicide attempts and completed suicide[14,51,53,54].

Suicidal Prevention

Suicide is highly preventable. It is widespread and long standing use by people of all stripes. It is a consequence of under recognition, misunderstanding, inadequate treatment of mental disorder and social stigma. Suicide is not a random or pointless act. On the contrary suicide is a way out problem or crisis that is invariably [38,52].

National institute of health in 2001 had developed the national strategies of suicide prevention in the following goals: promote awareness that suicide is a public health problem that is preventable, develop broad based support for suicide prevention, develop and implement strategies to reduce stigma of mental health suicide prevention services, develop implement suicide prevention program, promote effort to reduce access to lethal means and methods of self harm, implement training for recognition of at risk behavior and delivery of effective treatment, develop and promote effective clinical and professional practices, improve access to and community linkage with mental health and substance abuse services, improve reporting of suicidal behavior in the entertainment and news media. Suicidal attempt and other suicidal behavior are seriously underreported. Numerous studies report under recognition of depression by qualified health professionals. Unreported attempts in both recognized and unrecognized depressed person, and the under use of health care professionals after a suicidal attempt [55,56].

Suicidal prevention occurs through the three levels of prevention, the primary, secondary, tertiary. **The primary** level of prevention aimed to prevent occurrence of suicide attempt and maintain patient safety. This occurs through examining the patient mental state to determine depressive symptom, suicidal thought, intents, plans, and previous suicidal attempt

after assessment and determine the degree of suicidal severity. The primary prevention measures for dealing with a suicidal person includes reducing the psychological pain by modifying the patient's stressful environment, enlisting the aid of the spouse, the employer, or friend building realistic support by recognizing that the patient may have a legitimate complaint and offering alternative solution to suicide behavior as talking to some one trustful person or writing his emotional reaction and complain to express the destructive energy acceptable and safety manner [53, 55, 57].

The secondary prevention; it aimed to treat and provide adequate nursing care to suicidal patient, to prevent complication of this behavior. It occurs through hospitalization. The decision to hospitalize patient depends on diagnosis, severity depression and suicidal ideation, the patient's and family's coping abilities, the patient's living situation, availability of social support, presence of risk factors of suicide, and history of impulsive[39,40]. Many psychiatrist believed that any patient who had attempted suicide despite it's lethality, should be hospitalized. Although most of these patients voluntarily enter to hospital, the danger to self destructive is one of the few clear-cut indication currently acceptable in all states for involuntary hospitalization. Not all such patients require hospitalization as discussed previously. If patient refuses hospitalization the family must take the responsibility to be with the patient 24 hours a day. Thus the family must immediately direct to hospital in emergency cases as well as clinical nurses in hospital should observe the patients 24 hours a day [55,58,59].

In a hospital, patients receive antidepressant or anti psychotic medication as indicate according the underlying causes, individual therapy, group therapy, and family therapy, and patients receive the hospital's social support to provide sense of security. Other therapeutic measures depend on patients underlying diagnoses. During hospital, Electro convulsive therapy

(E.C.T) may be necessary for some severely depressed patient, who may require several treatment courses .Seclusion and restraints can not prevent suicide when patient is resolute. Although some patients are classified as acutely suicidal that means the suicidal for the first time may have favorable prognoses, chronically suicidal that have recurrent times of suicide attempt patients are difficult to treat, and they exhaust the caretakers[59,60].

During hospital period, ideally suicidal inpatients should be treated in a locked ward where the windows are shatter proof, and the patient's room should be located near the nursing station to maximize observation by the nursing staff. The treatment team must assess how much to restrict the patient. Supporting psychotherapy also by psychiatrist shows concern and may alleviate some of patient intense suffering [8,60,61].

Some patient may be able to accept the idea that they are suffering from a recognized illness and that they will probably make a complete recovery. The patient should be dissuaded from making major life decisions while they are have suicidal attempt, because such decision are often morbidly determined and may irrevocable. Patients recovering from depression are at particular risk, the patient become energized and are able to put their suicidal plans into action [paradoxical suicide]. A patient may commit suicide in the hospital. According to some studies about 1%of all suicides were committed by patients who were being treated in general medical surgical words or psychiatric hospitals [8,61, 62].

Nursing roles in caring with suicidal attempt patient is vital and important roles in nurse work. In healthcare setting they are in a unique position to prevent death by suicide. Nurse must be well trained in the assessment of Suicide potential. It is antecedent and factor that enhance risk and know what to do when faced with a client who is actually suicide [62, 63].

Nurses in all areas of work are in contact with people who have a high potential for suicidal behavior such as, Patients on the general medical surgical units often suffer losses in health or losses in function. people at risk for suicidal may be present and treated in medical wards from medical problem, in maternity wards women are often undergoing situational crisis may be related to unwanted new born or loss of a new born on obstetric words, removal of breast or uterus can be resulting in alteration of self-concept. In specialized units, such as burn units and intensive care units, nurses are continually dealing with people in physical and emotional crisis. Appropriate interventions through referral of for psychiatric consultation can prevent a suicide attempt or actual act of suicide [62,63, 64].

Because suicidal patient are found in all health care settings but most frequently primary care settings generalist nurses as well as psychiatric, nurses must be well trained in the identification of persons who are suicidal and in the use of appropriate intervention. Although nurse is the first to identify person who are experiencing extreme stress they have little social support, and have insufficient coping skill to manage the stressors that are affecting the patient [64,65].

Nurses are in extraordinary position to encourage patients to reestablish their purpose in life, to re new their hopes. Some patients may have lost their faith in God or have felt alienation from their own values or from other people. These people experience life as no longer having any meaning or purpose, and they may find it too painful to continue in essence. These people have lost hope. It is possible through a comprehensive nursing assessment and intervention that hope can be restored, patient may fed essence of connectedness to their own values, to themselves, to their God, and to others [63,64,65].

The nurse must use her knowledge about the epidemiology, causes, and dynamics of suicidal behavior when she provides care to the suicidal attempt patient. This knowledge has an impact on the effective ness of the nursing process [66].

To perform a comprehensive assessment, the nurse must focus on the physical, psychological, social, and spiritual dimension that represent the foundation of human functioning. This is assessed by observing the patient's adaptive and maladaptive behavior when the patient confronted with problem. Does the patient use positive physical, spiritual, social and psychological means of examining the problem to determine heath full options, or is the patient using negative physical, psychological, social and spiritual options toward, Problem solving [66,67, 68] .

During hospitalization, most people considering suicide will send out clues, especially to people they think of as supportive. These clues may be verbal, somatic, behavioral or psychodynamic. Verbal clues may involve covert statement as "it's of now, soon every thing will be well" or overt statement as "I wish I were dead". Behavioral clues may be in the form of sudden change of behavior, somatic clues as physiological complaints. This can mask psychological pain and internalized stress e.g. unusual appetite or weightless. Emotional clues can signal possible suicidal ideation e.g. irritability, hopelessness, helplessness. Nurse must be alert to these behavioral, somatic emotional and verbal clues of suicidal patients[10,67, 68].

Nurse must be alert and evaluate the suicidal clues and suicidal plan to determining the degree of suicidal risk. There are three main elements to be considered when evaluating the lethality of a suicide plan (the ability of suicidal plan to successes in inducing death), the first step is specificity of details, the second is lethality of proposed method, and the third availability

of means if a person have definite plans for the times, place and means he is at high risk someone who is thinking of suicide but has not thought about when, where, and how is at a lower risk the lethality of method indicate the level of risk such as how quickly the person would die by that method[8,10,52].

High risk method includes using of gun, jumping, hanging and carbon monoxide poisoning, lower risk methods, also referred to as soft method, include slashing ones wrists, in haling house gas and ingesting of pills. When the means are available, the situation is more serious. When people are psychotic, they are at high risk regardless of the specificity of details, lethality of method, and availability of means because impulse controls, judgment and thinking are all grossly impaired [45,69].

Regarding high risk factor the nurse must assessed the patient at high risk to suicide by using the severity index assist in planning the intensity and type of care the patient requires preventing a suicidal attempt. This high risk group includes people with family history of suicide, people with previous attempt, psychotic patient especially with command hallucination, depressed people, people with personality disorder and people who experience extreme guilt and shame. High risk for suicide may be evidenced by various emotional states. feeling of hopelessness, anger, poor impulse control, frustration and rejection are common among people who are suicidal. Nurse must be alert for that suicide is often related to a loss. The loss of significant person can leave a person feeling of isolated and confused, loss of job, status, money, and sickness can be over whelming. Suicide can be also related to crisis in adolescent and elderly [8,70,71].

Nursing intervention for hospitalized suicidal client mandates stress response and symptoms reduction and enhancement of psychological and social resources. During the early part of hospitalization, the most important way of reducing stress is to help the client to fell more secure and hopeful. Nurses can do by ensuring the clients safety with as little intrusion as possible on the person's exercise of free will[66,72].

Nurses are in an extraordinary position for caring with suicidal attempt patients through four levels (biological, psychological, social, education). The first one is through biological intervention in form of restrain and seclusion. They are two modalities sometimes used in the inpatient setting to maintain client safety. These restrictive interventions, however, are extremely stressful for clients and may interfere with their recovery. More over, seclusion and restrain often are used to compensate for in adequate nursing staff. Unduly restraining client to prevent their suicide interferes with the development of trusting relation ship between the client and nurses [4,63,66,72].

The second role of nurse is psychological intervention is the recent psychiatric nursing care standards requiring that the nurse assists the client in reestablishing self-control, observes the client regularly for suicidal behavior, remove dangerous object for from the client and provide outlet for expression of the clients emotional reactions [72,73].

Nurse need to use the brief hospitalizing period to find out what may have precipitated or contributed of the suicidal behavior. After identifying extreme stressor experienced by the client, the nurse and the client can help determine ways that the client can avoided those stressors in the future or if they cannot be avoided, to manage them when they are present. Hospitalization is also a good time for the nurse to evaluate the clients' ways of thinking about problems and generating solutions. The nurse can point-out that kind of negative thinking and invite the client to begin to note instance in conversation when the client is being pessimistic. The nurse can suggest that the client plays detective and tries to figure out whether the negative view are true. The client and nurse must also advise ways to prevent future suicidal behavior [63,72,73,74] While third level of nursing role, is social intervention through making the client with behavior contact with another person. The most desirable outcome is the return of the client to the community. Because of most hospitalization period for suicidal behavior are brief.

Tertiary prevention, is aimed to prevent recurrence of suicidal attempt and help patient to adapt with under lying stressors this can occur though education to the client's family about treatment of underlying causes of suicidal attempt, reduce stigma that a combined with suicidal attempt, identify the source of social support and prepare the client environment at home must be safe as possible the family member must remove any abject that the client may use it in committing suicide instruct family to maintain medication regimen patient treated from major depressive disorders (MDD) and close observation to this client from family members with increasing client self control [74,75, 77].

Nurses Emotional reaction and Attitude toward Suicidal Attempt Patient

Suicide has occurred since the banging of recorded history with attitudes toward suicide varying from condemnation to tolerance, depending on the time and culture. Probably no group of in patient evokes stronger emotional reaction among staff members as suicidal behavior [23,76, 78].

On the other hand one of the greatest stressors affecting nursing staff caring with suicidal patient and all health care professionals working with suicidal attempt patient is negative reaction. On the other hand, if this negative emotional reaction is not identified, and discussed and resolved the nurse may feel in competent, low self esteem and become anger toward this client [21, 62,79]

There are a four universal reaction may affect nurses during caring with suicidal attempt client (anxiety, irritability, avoidance, denial). **one of this is** anxiety which may be related to numerous explanation. The first explanation is suicidal behavior may be arouse suicidal inclination in all of nurses, the second interpretation is due to suicidal behavior arouse personal rejection from nursing staff this leads to anxiety which working at unconscious level of the nurses [8,21,66,80].

The second emotional reaction may be emotional reaction of irritability and irritation because of people who make repeated suicidal attempt are accused by nurses and all health care team of patient who is just trying to get attention or looking for sympathy. This may be due to sense of responsibility toward patient's state if the nurse gives more attention to patients looking for sympathy. **The third one** is emotional reaction of avoidance, nurses and other team member may get caught up into taking responsibility. Though the nurse may appear sense of helplessness than avoid situation that aggravate emotional reaction of helplessness and in competent. So the nurse is better able to refocus energies back to the client. **The fourth emotional reaction** is denial it also occurs when identification with a suicidal person is strong. The nurse may say "can't understand why any one would want to take his own life [21,78,,81].

Not surprisingly heath professional especially nurses have been found to have difficulties in accepting and understanding suicidal attempters, especially in the absence of psychiatric illness. Nurses emotional reaction and attitude may had a more favorable attitude towards patients whose motives were interpreted as “waiting to die” than those whose behavior was seen as manipulative. Nurses have tendency to interpret suicidal behavior as manipulative, as opposed to the patients themselves, who less often mention interpersonal reasons for attempting suicide [21,65,82]

Clearly, nurses working with suicidal attempt in psychiatric wards or in other settings must go through four stage of emotional experience each stage progress to the next (naiveté, recognition, responsibility, individual choice). The first stage is naiveté, in which emotional reaction of shock and denial is prominent. While the second stage is termed recognition, in this stage involves emotional reaction of anxiety, fear, and helplessness. In addition to the third stage this is the stage of responsibility, brings with it a cycle of emotional reaction responsible and then anger. This is very conflicting time for nurses who are working with suicidal persons. Otherwise, nurses may suffer burnout, may distance themselves from clients, or may leave work situation altogether. At the end the forth stage which is the stage of individual choice, comes through awareness gained through supervision, continuing education and personal therapy. This stage when the nurse comes to a realization she is the only in charge of his or her life. This where the nurse is free to do whatever is humanly possible to help the client, while realizing that one person cannot ultimately control the decisions of others [8,21,83].

So caring with suicidal attempt client is highly stressful and often lead to secondary trauma, in which the nurse has a stronger than usual response to the emotional crisis toward this client or to the repeated stress of coping with suicidal attempt patient. All nurses working with suicidal patient are vulnerable to this syndrome which includes, anxiety, avoidance, increasing work absenteeism, tearful without provocation and, sleep disturbance or nightmares. The symptom's severity increases when the suicidal attempt occurs in front of nurse or at her shift time. These symptoms signal that these nurses are not engaging in sufficient self-care to maintain their own mental health and adaptation capacity. So to successfully care for suicidal client, the nurse must be engaged in the active program of self-care such as program being with proper rest, exercise and nutrition. Therefore the nurse could be better able to mange stress symptom physiologically. The nurse should be alert to symptom of stress and engaged in stress reduction exercise, and regular share their experience and emotional reaction toward this client with other nurses who care with suicidal client. So by demonstration of how to be effective in managing stressor in their own lives, nurses can have a powerful role models for their suicidal client [84, 86, 88]

The nurse attitude must indicate unconditional positive regard not for the act but for the person and his spiritual condition. The nurse must overcome her own negative emotion toward the client as they could become barrier to effective long term intervention[83].

Some studies have described how suicidal behavior can evoke fear and anger among nursing staff members and how such emotional reaction may complicate treatment by causing disagreement among nursing staff if this reaction were negative and not recognized. Nurse may avoid negative emotional reaction toward suicidal attempt patients by being passive and becoming preoccupied with minor individual needs. Focusing on staff members emotional reaction may facilitate nursing intervention and provide nursing team with useful information about the kinds of patients problem and its intervention [85, 87].

So number of clinical studies pointed out the importance of creating milieus that give nursing staff members the opportunity to express and share their emotional reactions to suicidal client. Unrecognized negative emotional reaction of members of team may blind them to the recurrent suicidal potential and ultimately contribute to the patients attempt of suicide[88,89,90].

On the other hand, most common cause of death from psychiatric disorders, suicide has been the topic of many books, articles, and philosophical treatises in the literature on suicide and among the least commonly discussed topics is the reaction of mental health professionals when one of their patient commit suicide[88,89].

Psychological factors within the nurse play vital roles in predicting their responses to suicidal attempt patient. These included an obsessional personality style, tendency to internalize, and vulnerability to anxiety and depression if the nurse is older and has achieved some sense of competence, mature professional identity and some respect within her professional community, the ability to buffer the pain with internal strengths is likely to be greater [87,91].

A substantial proportion of psychiatric nurses would experience the suicide of one or more of their patient. Overall, the field has been relatively silent about this phenomenon; yet, except for protected malpractice suits patient suicide may be the most psychologically difficult experiences encountered in the life of those nurses. It includes post traumatic stress disorder symptoms, shame guilt anger, and isolation and fears having a patient commit suicide early in one's career may be particularly difficult. So, the training programs should prepare trainees for these tragic events (suicidal attempt) [88,92].

In national surveys conducted in the late 1980, indicated that about one-half of psychiatric nursing had experienced the suicidal attempt patient. These surveys found younger, less experienced clinicians to be especially affected by the experience. The study showed that nurses and family members may experience emotional reaction of grief shock, guilt after patient attempt suicide some characteristics on nurse specifically gender, training status, and year in practice appeared to affect vulnerability to sever distress. Most nurses are not prepared for the intense emotional response that accompany a patients' suicide or for reactions of the patients' family. So, they suffer sever distress[88,93,94].

In addition to health care system professional variable as pressure of increased workloads and given the nursing shortage can create additional stress for nurses, professional variables as moral and ethical dilemmas in their work. The symptoms of these stresses could be change in appetite, gastrointestinal disturbances, somatic complaints such as headache, fatigue, exhaustion, clammy hands, increased motor behavior and changes in sleep. Psychological symptoms may include memory loss, anger, low self-esteem, hopelessness, self-doubt, increased isolation and impaired judgment. These nursing reactions may include ambivalence and frustrated [88,95,96,97].

Although stressor that can result in burn out or stress among nurses may not be eliminated immediately, they can be reduced when nurses make caring for themselves by paying attention to their thoughts, emotional reactions and actions. A nurse can also maintain important mind-body-spirit connections. The nurse must promote her physical health by eating well, balanced diet, exercising, (aerobics, yoga, walking, sports) and engaging in restful and relaxing activities as (message therapy, napping taking worm baths) to tolerate this stressful events. In addition to bolstered emotional health by developing a calm mind and focusing on peaceful thoughts. Meditation and listing to quiet music are two good methods. Letting go of negative emotions such as resentment may be difficult but worth while, by recognizing positive emotions each day, interacting with optimistic people and speaking with colleagues, positive emotional reaction may over-take negative ones. All of above are mental and physical training to tolerate negative emotional reaction toward suicide attempt patient [88,95,98,99].