Emergency staff reactions to suicidal and self-harming patients

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Staff in the emergency departments of hospitals are reported as being negative or ambivalent toward suicidal or self-harming individuals. According to the literature, these patients are subjected to stigmatization and lack of empathy. This phenomenon has been linked to a decreased quality of care offered to these individuals and to missing an important opportunity to prevent further suicidal behavior or repetition of deliberate self-harm. Also, protocols, proper guidelines and education for the emergency staff call for a revision and an implementation.

In this paper, evidence suggesting staff attitudes toward suicidal and self-harming patients is reviewed. An overview of related issues such as clinical judgment, the use of scales and nurses' role is also included in this report.
***European Journal of Emergency Medicine* 12:169–178**

European Journal of Emergency Medicine 2005, **12**:169–178

Keywords: emergency, prevention, self-harming, suicide

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Introduction

Suicide is a huge but largely preventable public health problem, causing almost half of all violent deaths and resulting in almost one million fatalities every year and economic costs in billions of dollars, according to the World Health Organization [1]. Estimates suggest fatalities could rise to 1.5 million by 2020. In the year 2000, approximately 1 million people died from suicide, and 10 to 20 times more people attempted suicide worldwide. This represents one death every 40 s and one attempt every 3 s, on average. This also indicates that more people are dying from suicide than in all of the several armed conflicts around the world and, in many places, about the same or more than those dying from traffic accidents. In all countries, suicide is now one of the three leading causes of death among people aged 15–34 years; until recently, suicide was predominating among the elderly, but now suicide predominates in younger people in both absolute and relative terms, in a third of all countries. According to a World Health Organization document [2], suicide is a matter of great and increasing concern in the European region, especially in some of the newly independent states and the countries of eastern and central Europe.

The World Health Organization [3] recognizes suicide as a complex problem for which no single cause or reason exists. It results from a complex interaction of biological, genetic, psychological, social, cultural and environmental factors.

A recent study drew attention to emergency staff's ability to recognize suicidal behavior in people who suffer from deliberate self-harm [4]. These authors investigated factors that may influence emergency department (ED) doctors in the assessment of suicide risk in deliberate self-harm. They found that ED doctors were influenced by key risk factors for suicide in their assessment of deliberate self-harm patients. Not only is it crucial to improve recognition of suicidal behavior but it is also of paramount importance to explore the inner feelings and fears of the people involved in the emergency room toward suicide. Emergency room personnel encounter a large number of suicide attempts and their role is a central one in the management of these patients. Deliberate self-harm may be a life-threatening behavior but is distinguished from suicide by the absence of the overt intention to die. Nevertheless, Farberow [5] drew attention to 'the many faces of suicides', namely, the role of indirect self-destructive behavior in suicidality. Recognizing suicidal behavior, especially when the intention is not clear, is a key element in suicide prevention. Kelly *et al.* [6] pointed to the fact that in several circumstances the emergency room staff have suspected staged suicide attempts to avoid arrest and incarceration and experienced personnel eventually develop clinical acumen about suicidal patients; they also have indications about who remains at considerable risk after an attempt.

Blenkiron *et al.* [7] investigated the timing of acts of deliberate self-harm and reported the results of different hours of the day in relationship to suicide risk, which may be a useful indication for detecting suicidality. Jacobs [8] proposed a sequential protocol for the evaluation and care of suicidal behavior in emergency settings. This protocol

0969-9546

contains the following components: (1) a review of the limitations of clinical and demographic risk factors; (2) an exploration of frequent negative reactions that arise in clinicians during the suicidal encounter; (3) an objective schema for grading suicidal behavior; (4) an understanding of chronic suicidal behavior and (5) a flexible treatment approach. Sletten and Barton [9] drew attention to the evaluation and disposition of suicidal patients focusing on rating scales and the proper approach to these patients.

Emergency physicians can miss psychiatric symptoms in ED patients or attribute these symptoms to an organic, nonpsychiatric etiology. Many emergency physicians do not feel adequately trained in psychobehavioral disorders. The majority of emergency medicine residencies do not include a formal experience in psychiatry [10]. The ED is a busy and sometimes chaotic environment; thus, many emergency physicians may not have time to fully screen patients for mental issues [11].

Staff attitudes toward suicidal and self-harming patients have been considered as a key element influencing whether such patients will ultimately commit suicide.

This paper reviews key studies reporting original contributions or interpretations of the ED staff's reactions toward suicidal patients and their role in influencing a constructive approach with such patients. Elements that may be useful for the development of guidelines are discussed in the paper.

To our knowledge, the issue of staff reactions toward suicidal and self-harming patients has still to be addressed through a systematic review.

Materials and method

Identification of relevant studies

We performed careful MedLine, Excerpta Medica and PsycLit searches to identify papers and book chapters in English during the period 1966–2005 and the Index Medicus and Excerpta Medica prior to 1966. The following search terms were used: 'suicid*', (which includes suicide, suicidal, suicidality and other suicide-related terms), 'self-harm*' and 'Emergenc*'. In addition, each category was cross-referenced with the others using the Medical Subjects Headings (MeSH) method.

Inclusion criteria

We included studies in this review if they added an original contribution to the literature. With this statement, we imply that what we have synthesized for the purpose of this review was the result of an investigation that included staff reactions to suicidal or self-harming patients. Although of great importance, the subject of this article is still in its early development and it is for this reason that evidence-based articles are few, and most often, the topic is discussed as one of those areas that needs further research.

A total of 147 articles were located through our search; the most relevant articles were selected for this overview. By reviewing selected articles, we identified some specific fields of interest in the analysis of ED staff's reaction to suicidal behavior. We therefore report a narrative analysis of the sources located and related articles and book chapters pertinent to the subject of this study.

Results

Toward understanding what lies beneath suicidality

Suicidal individuals place enormous demands on the mental health system in terms of staff resources and financial costs. Interventions that reduce the frequency of attempted suicide could produce collateral benefits in terms of decreased suicide morbidity, increased quality of life and mental health cost savings.

It is argued that presentation at hospital EDs may offer the single best opportunity for intervention with youth, following suicide attempts [12–15].

Attempted suicide and parasuicide have been defined in different ways. The World Health Organization [16] defines both as nonhabitual acts with nonfatal outcomes, deliberately initiated and performed by the person involved. However, unlike attempted suicide, parasuicide is defined as intentionally nonfatal. Evidence supports the assumption that those who commit nonfatal acts of deliberate self-harm are at greatly increased risk of committing suicide.

Approaching a suicidal patient is not easy: the risk of making mistakes may precipitate the situation and facilitate the suicidal act. Nevertheless, much of the fear is connected with stigma toward suicide. This concept has been the subject of many contributions in the psychiatric literature and stigma toward suicide has been recognized as a key issue in suicide prevention. People who stigmatize these individuals do so because of fear. These individuals evoke the concept of death; they look for it, struggle to reach it and are likewise seen as those who do not share common-sense. In normal clinical practice, the doctor interacts with a patient who passionately desires the maintenance of health. On the contrary, the suicidal patient struggles to defeat the doctor and tries the self-annihilation process. Mental health professionals, or doctors as a whole, are often disorientated in relationship to suicidal patients, especially because suicide is the event most alien to the nature of medicine [17]. Platt and Salter [18] reported that psychiatrists were significantly more likely than

physicians to agree that parasuicides are rewarding and challenging to care for, patients that they can 'really help'. These authors found that both physicians and nurses were more likely than psychiatrists to perceive parasuicide as attention-seeking behavior. Ramon *et al.* [19] found that nurses were more accepting of the self-poisoning behavior, more sympathetic, more likely to see it as a manifestation of, or escape from distress. On the other hand, doctors were more accepting of the 'wish to die' motive and tended to see behavior as either suicidal or manipulative, being relatively unsympathetic.

The attitude toward these patients is of paramount importance for a positive outcome. The attitude of the interviewer in obtaining the information should be calm, objective and empathic. If these patients can rely on a person who can talk about suicide without condemnation they feel relieved, and the suicidal plan or the wish to complete suicide can be replaced by the real suffering that caused the pain and led the individual to consider suicide as a solution. Any people, and above all those closely involved in taking care of the suicidal individual, should benefit from a focus on what Edwin Shneidman calls *psychache* [20], meaning an ache in the psyche. Shneidman suggested that the key questions to ask a suicidal person are 'Where do you hurt?' and 'How may I help you?'. If the function of suicide is to put a stop to an unbearable flow of painful consciousness, then it follows that the clinician's main task is to mollify that pain. Shneidman [20] also pointed out that the main sources of psychological pain, such as shame, guilt, rage, loneliness, hopelessness and so forth, stem from frustrated or thwarted psychological needs. These psychological needs include the need for achievement, for affiliation, for autonomy, for counteraction, for exhibition, for nurturance, for order and for understanding. Shneidman [21], who is considered the father of suicidology, has proposed the following definition of suicide: 'Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution'. Elsewhere, Shneidman [20] suggested 'that suicide is best understood not so much as a movement toward death as it is a movement away from something and that something is always the same: intolerable emotion, unendurable pain, or unacceptable anguish. Reduce the level of suffering and the individual will choose to live'. Profound psychic pain is a major part of the clinical picture, so much so that self-harming thoughts and behaviors, including self-mutilation, suicidal ideation, gestures and attempts, may become a way of attempting to cope with this pain. The healing effects of careful listening to the patient's story and the development of empathy, so that the patient feels truly understood, cannot be over-emphasized in this respect. A sound therapeutic relationship, or working alliance (even if it is often hard to schedule follow-ups in the ED), will go a long way toward preventing repeated suicidal behavior, as the individual experiences the feeling of being heard by a doctor who represents relief from pain and an improved quality of life.

Dealing with suicidality in the emergency department

Suokas and Lönnqvist [22] pointed to the fact that emergency personnel in the general hospital are primarily trained to take care of somatic crises, and the patient's psychological distress may result in feelings of helplessness and rejection among the ED staff. The attitudes of the staff toward patients who attempt suicide are often negative or indifferent. This has been in part explained by the evaluation of the particular role of emergency staff in life-saving. In fact, it has been suggested that suicide attempters are first admitted to the emergency room, where the staff are obliged to work under heavy pressure. In this environment, patients are not generally treated with empathy. These authors found the most negative attitudes in the staff of emergency room and emergency ward compared with those of the staff in the intensive care unit. This has been explained by the consideration that most suicide attempters are generally admitted to the emergency room. Also, these individuals only rarely have the opportunity to learn more about the further development of a patient moved to a certain ward. On the contrary, those individuals who are involved in emergency facilities, such as the emergency ward, often cooperate with a psychiatrist and may shift part of the responsibility onto the consulting psychiatrist.

Gairin *et al.* [23] found that 85 of 219 people who later died by suicide had visited an accident and emergency department in the year before death, 15% because of nonfatal self-harm; people whose suicide was a result of ingested poisons were especially represented among those who visited the emergency and accident department.

Negative attitudes of emergency staff toward suicide and attempted suicide were reported in some earlier studies [24–26]. Explanations for such attitudes involved the concept of stigma toward suicide. Stigma refers to a mark that denotes a shameful quality in the individual so marked. Mental illness is widely considered to be such a quality, an assumption supported by a number of beliefs such as the association between mental illness and irrational fear and unpredictable violence as portrayed by the media and the notion that mental illness is not a true illness like organic disease. And yet, people do fear mental illness and do not know how to avoid it by following the types of precautions and guidelines available for so many organic disorders. Not only does the stigmatization of mental illness prevent people from seeking treatment, which in turn exposes them to a greater risk of suicide, but also, suicide can appear to be

the best solution for a stigmatized individual [27]. Staff in the accident departments of hospitals are reported as being negative toward suicidal individuals, manifesting stigmatization toward an individual who has tried to kill himself.

Bailey [28] investigated reactions of nurses and doctors working in EDs and intensive care units toward the parasuicide. The survey showed that the nurses' and doctors' attitudes to parasuicide patients were generally negative and that respondents did not enjoy caring for parasuicide patients. Nurses were significantly more likely than doctors to think that the nurses' attitudes to parasuicide patients were poor. Nurses were also significantly more likely than doctors to self-report that they were afraid of saying the wrong thing to these patients. Eighty three percent of nurses and 61% of doctors stated that they would benefit from suicide-related education.

Black and Creed [29] found that although the poor records may reflect a lack of motivation as much as lack of education, no significant relationship was observed between the doctors' attitudes toward self-poisoning patients in general and the standard of their assessments.

Dealing with youth suicide in the emergency department

Youth suicide, the third leading cause of death among teenagers and young adults, accounts for more deaths in the United States than natural causes combined for 15 to 24-year-olds, according to the National Center for Health Statistics [30]. In Europe, according to the WHO Databank, suicidal behavior among young people has increased over the past 30 years and statistics match those of the United States. Each suicide has a serious impact on at least six other people and the psychological, social and financial impact of suicide on the family and community is immeasurable. Despite its high prevalence, the risk of suicidal behavior in many children and adolescents is often undetected.

Identifying appropriate opportunities for interventions in youth suicidal behaviors is particularly important, because a history of previous suicide attempts has been identified as a strong predictor of the risk of later suicide attempts [31] and an increased risk of eventual death by suicide [32–34]. EDs have previously been identified as suitable sites for potential injury prevention education for suicide prevention among adolescents and children [35,36].

The assessment of the risk for suicide is known to be a difficult task involving many uncertainties [37–39]. Such an assessment is most often carried out by less experienced physicians (young residents on duty in the psychiatric or general emergency wards). It has been shown that work stress has negative effects on the attitude of ED personnel toward suicide attempters. This is especially true with patients who are referred repeatedly because of deliberate self-poisoning; they are often met by a neutral or negative attitude [40]. One possible explanation for the decreased likelihood of follow-up care is that healthcare providers may be more likely to regard self-harming behaviors as impulsive, and therefore less likely to be repeated, if the young person is influenced by alcohol at the time of the attempt, or at the time of presentation to an ED. Alternatively, others have suggested that people who present with attempted suicide, in combination with other self-destructive behaviors such as alcohol abuse/misuse, are more likely to be marginalized by healthcare providers [41], which may have an impact on an individual's likelihood of admission and consequential access to follow-up care.

Clark [42] investigated adolescents in primary care settings and found that 83% of adolescent patients who had attempted suicide were not recognized as suicidal by their primary care physician. Unrecognized suicidality in ED settings is an especially important problem for several reasons, such as increasing numbers of children and adolescents who present to hospital EDs with mental health concern and self-destructive behavior; also, ED staff are increasingly being given the responsibility of triaging children and adolescents with mental health problems to crisis intervention and appropriate follow-up treatments [43].

Deliberate self-harm

The greatest risk of eventual death by suicide is for the people with a previous history of self-harming behavior [32,34,44,45], and this risk is exacerbated when combined with other known risk factors, including the presence of psychiatric disorders or substance abuse [46]. Deliberate self-harm patients are no doubt a distinct group from those who complete suicide; nevertheless, an overlap exists, with a significant proportion (35–50%) of those who self-harm going on to kill themselves in the future [47]. Those who harm themselves are therefore an important group for intervention aimed at suicide prevention.

Crawford *et al.* [48] found that the clients who discharged themselves before completion of initial assessment in emergency had three-fold the rate of repetition of self-harm than clients who completed assessment. Hickey *et al.* [49] analyzed the characteristics of deliberate self-harming patients who were discharged over a 2-year period, comparing those who had a psychiatric assessment with those who did not. They found that substantially more of the nonassessed patients were uncooperative during physical examination. Nonassessed patients were more likely to have left the accident and emergency department before physical assessment and treatment

of their deliberate self-harm had been completed. In follow-up studies of deliberate self-harm patients, this behavior has consistently been found to be associated with suicide risk [50,51]. Nonassessed patients showed difficult behavior at presentation, failing to cooperate with physical examination and physical treatment and asking for premature self-discharge and showing physical aggression. Dealing with these patients requires special training and psychiatric consultation. Negative attitudes toward deliberate self-harm patients are particularly important, as rejection or hostility may prompt further suicidal behavior [52]. Unfortunately, the difficulties in dealing with patients may lead to feelings of rejection and to facilitate their early discharge. Being able to manage these individuals may contribute to their access to psychiatric services, avoid risk of repetition and increased risk of suicide. Barr *et al.* [53] suggested that a more positive and caring attitude by staff who first deal with patients in the ED may discourage some who are prone to leave early. Also, a more rapid assessment service and consequent reduction in waiting time may be beneficial.

Clients have frequently said, however, that they perceive, in the clinician, rejection and hopelessness and absence of empathy [54,55]. Clinicians who are traumatized may have difficulty regulating emotions, become more sensitive to violence, become numb, feel less self-worth or have difficulties in keeping a connection with others. These authors recommend that clinicians working with self-harm clients receive education, supervision and training from trauma-sensitive professionals.

O'Dwyer *et al.* [56] reported that in their sample of adolescent self-harm patients who had been treated in the ED there was inadequate documentation as to whether they were still suicidal when they were discharged against medical advice, and no reference was made to any discussion with the young person's parents, relatives or friends and in many patients, preexisting problems identified by the doctor were not addressed. International evidence indicates that fewer than half of all presentations following deliberate self-poisoning result in nonadmittance to hospital and do not receive any specialist psychosocial assessment or follow-up [57]. Ramon *et al.* [19] pointed out that self-poisoning is a powerful form of communication and that the hospital staff are among the first to react to this communication and their attitudes to this behavior are likely to be important in determining the consequences.

Studies examining the ED nurse's role report the need to address specific needs and the development of a therapeutic relationship with clients; in particular (1) listen attentively, (2) give reassurance and (3) offer support and acknowledge feelings.

Clinical judgment and the use of scales

Crawford *et al.* [48] found that in an intervention study of deliberate self-harm assessment by accident and emergency staff, the impact of specific education on the quality of psychosocial assessment of a self-harm patient correlated with the care provided. Also, communication between emergency staff and the parasuicide team improved. They encouraged staff to use a proforma, which includes the SAD PERSON scale [58]. The assessment was more likely to be rated 'adequate' if the proforma had been used. The SAD PERSON scale is a much less comprehensive proforma than the checklist used elsewhere. Hockberger and Rothstein [59] have modified the SAD PERSON scale and shown that by using this, nonpsychiatric medical staff can confidently identify those patients requiring a specialist's assessment [60]. Others have shown the usefulness of a risk assessment checklist for house physicians on medical wards [61,62].

According to Appleby *et al.* [63], training in the assessment and management of suicide risk can be delivered to approximately half the targeted staff in primary care, accident and emergency departments, and mental health services. These authors pointed to the need to develop a training program that should reach those who would not generally attend.

Clinical judgments are affected by many factors. For example, a preference to admit was found to be inversely related to professional experience [64]. Perceptions by emergency room staff that adolescents attempt suicide to manipulate others also affect judgment [65]. However, fewer adolescent attempters than clinicians identify manipulation as a motivator [66] and only 5% of attempters described this as their primary reason for attempting suicide [67].

Dressler *et al.* [68] reported that in their sample of clinicians, residents were generally more anxious and angry toward suicidal patients, especially if they were on duty in the late evening and early morning. Nevertheless, residents showed empathy toward younger women and were less anxious in the management of women rather than men. Also, they were warmer and less anxious toward patients with no past history of suicide attempts or those who had sought help immediately after the crisis started; more personal involvement was detected when the risk of life for the patient was low. On the contrary, when the risk was considered high, residents were more anxious and angry toward the patient. Some variables studied by these authors, such as depression, conceptual disorganization and suspiciousness, shown by suicidal patients made residents more uncomfortable. Of some interest is the fact that residents showed more empathy toward patients interviewed for less than 30 min, who were admitted, on a voluntary basis, to private or mental

health facilities. It should not be forgotten that residents' workload may be exhausting and this certainly has great importance in the case of complex and difficult patients. Their relative inexperience may also influence residents' attitudes and feelings.

Also noteworthy is the study by Bloom [69], who demonstrated how countertransference reactions such as denied, repressed or suppressed hostility in the therapist prevented the recognition of suicidal risk.

The establishment of protocol aimed at early recognition of negative feelings toward suicidal patients is of paramount importance. Training in the emergency room should include proper recognition of resentful feelings and supervision of those individuals who may react to difficult situations by externalizing negative reactions toward patients. Feelings of anger and frustration should not be denied or acted out but handled with specific resources, such as seminar, supervision and counseling, to name just a few [68].

Residents should be instructed more thoroughly in suicidology before being assigned to the emergency room.

It is of paramount importance that for each case of attempted suicide presenting to the emergency room, especially in the case of those patients who are repeaters, the staff working in the ED assess the risk of completed suicide, but they also have the responsibility to build up as comprehensive a picture as possible of the individual, the family dynamics and the environment surrounding the patient. Emergency hospital treatment of attempted suicides cannot responsibly be considered complete with the treatment of somatic crisis. Staff working in the ED should rely on the professional team concept, and emergency psychiatrists should serve to educate staff on the unsustainable mental pain that afflicts those who attempt suicide or who self-harm.

Clinicians should make it clear that suicididality is a common feature of periods of extreme stress, untreated depression or personal or interpersonal problems for which the patients see no solution. The message should include the statement that with proper help it is possible to eliminate suicidality and take care of the problem that is causing the anguish. Rives [70] pointed out that only through a detailed discussion of patient-specific thoughts, images and urges can clinicians assess the lethality of the current episode. Suicidal ideation should be considered part of the suicide spectrum, which may rapidly evolve from passive low-risk ideation to deliberate high-risk action. Two approaches to the suicidal patient are as follows: (1) take any expression of suicidality very seriously so much so that even patients with only suicidal ideation are monitored very closely and more often hospitalized, giving them the chance to be followed-up and (2) distinguish serious from nonserious suicidal patients, treating them differently and discharging the nonserious after brief evaluation. The two approaches usually represent two different personalities in the doctors who use them. One is concerned with suicide and knows that suicidality should be taken very seriously, and considers the unforeseability of a suicidal gesture. The other personality may sound more comfortable in dealing with a suicidal patient, but the self-confidence may lead them to underestimate the risk or else may in truth hide a poor education concerning suicide. Identifying the patient who will commit suicide may not always be possible, but any patient reporting suicidal intention should be followed-up after discharge. Psychological autopsies [71,72] have shown that most people who commit suicide interact with unsuspicious doctors before their self-inflicted death. A period of gestation seems to exist when intervention may be possible and in some cases thinking, talking or showing suicidal behavior may be a real supplication [71]. For such reason, the ED has the unique opportunity to refer suicidal individuals to a professional psychiatric or psychotherapeutic service.

Horowitz *et al.* [43] identified four items of the Risk of Suicide Questionnaire that, administered in the triage phase, identified 98% of children at risk for suicide, as assessed by a much longer criterion standard instrument administered by a mental health clinician. Nonmental health clinicians can increase their confidence and lower barriers to asking about suicidality. In post-study focus groups, nurses reported a high level of satisfaction with the screening tool. Moreover, nurses who had been working in the ED before the tool was created reported a significant decrease in stress when managing psychiatric patients. Nurses reported that having the screening tool was much preferred to the previous method of judging by intuition when and how to ask about suicidal behavior [43].

The suicide scales are recommended as an adjunct measure only and should not substitute for clinical judgment made on the history of the patient. Although they cannot be the only tool involved, suicide scales provide a structure for systematic enquiry about risk factors for repeated suicide attempts. These scales have been shown to be generally more sensitive than specific in terms of identifying adolescents who may commit suicide [73]. No predictive value has been shown for the use of suicide scales alone [30]. The Child–Adolescent Suicidal Potential Index [73] contains 36 yes/no items and requires 20 min to complete and score. It has been found to be 70% sensitive and 65% specific in its ability to identify children and adolescents with any suicidality among the general population. It is more sensitive, but more specific, in those who have attempted suicide (80% sensitive; 65% specific) [74].

The two major approaches to the evaluation of suicidal behavior are those based on clinical experience and those based on rating scales. The latter have the advantage of concisely presenting items that have a connection with suicide, and they help the clinician to define suicide risk. A scale can never substitute for evaluating risk through an experience-based approach, but it can be of great help when time is limited and the risk is high.

Herron *et al.* [75] pointed out that suicide prevention depends on various health professionals, ED staff included. They suggested that the widespread attitude 'suicide prevention is not my responsibility' may make staff less likely to assess risk or accept training in risk management. These authors administered a short questionnaire (the Attitude to Suicide Prevention Scale) to various health professionals. They found that general practitioners and emergency nurses had the most negative attitudes toward suicide prevention. Such attitudes could result in the underestimation of suicide risk in people with suicidal ideas or recent self-harm. Also, they found more positive attitudes toward suicide prevention in people who have had previous training in suicide risk assessment.

Schnyder *et al.* [76] compared patients' and medical staffs' reasons for attempting suicide. They found that interpersonal reasons such as to get relief from a terrible state of mind or from an unbearable situation were most frequently chosen by patients, nurses and doctors alike. According to this study, the most striking difference was found for 'loss of control': this item was chosen significantly more often by patients than by nurses and doctors. Patients reported significantly more often feelings of anxiety/panic and emptiness, whereas nurses and doctors mentioned feelings of despair and powerlessness/hopelessness most frequently.

Dressler *et al.* [68] investigated psychiatric residents' reactions toward suicide attempters in a general hospital emergency room. Residents expressed warmth toward patients having low suicide risk and limited overall psychopathology. They felt anxious toward patients with high suicidal risk and significant psychopathology. Angry feelings were reported toward patients with high suicidal risk in the absence of recent precipitating events. Residents reported warmth toward patients admitted to private or mental health center versus state hospital facilities and tended to devote more time to their clinical assessment of these patients. Feelings of anxiety and anger characterized the responses to state hospital admissions that were only briefly assessed.

Rund [77] outlined the need for proper guidelines and education for the emergency physician, which should help improve the early management of suicide attempters. Negative attitudes may stem from the emergency medical professional's lack of knowledge about the variety of psychiatric conditions present in the patient who attempts suicide. Information about such conditions and the emotional reactions that certain personalities generate might alter these attitudes.

Nurses' role

Nurses have a key role in working with suicidal patients. Their attitudes toward suicidal patients may also influence the outcome of the suicide crises. Nurses should be able to recognize risk factors for suicide. It has been suggested that community mental health nurses may be more effective than psychiatrists in working with patients who deliberately self-harm. Nevertheless, this topic has been neglected in preventive measures [78]. It would appear that suicidal patients evoke negative attitudes in nurses [79]. Platt and Salter [18] reported that when comparing nurses' and psychiatrists' attitudes toward the suicidal patients, the former were more likely to see overdose patients as displaying 'attention-seeking' behavior. Also, Patel [24] reported that nurses are usually more concerned about and have more positive attitudes toward those patients presenting with a physical illness than those exhibiting suicidal behavior. This author stressed that medical and nursing staff may find it very difficult to understand a patient's problems without adequate knowledge of his social and environmental background. This in turn may lead to a lack of empathic support. The last thing that a suicidal patient needs is to perceive a feeling of rejection, fear and anxiety in the person that is taking care of him or her. Anderson [80] reported that a variable that influences nurses' attitudes toward suicidal patients is the length of experience. More experienced nurses have more favorable attitudes toward suicidal patients.

Nurses should address the development of a therapeutic relationship with clients; they should listen attentively, give reassurance and offer support and empathy. Although nurses acknowledge that counseling is important, they report inadequate preparation and insufficient training opportunities [79]. McAllister *et al.* [36] reported that in their sample, one-third of nurses reported personal experience with deliberate self-harm and nearly all respondents perceived a lack of specialized self-harm education and training. This may lead to inadequate care, such as incomplete documentation of client needs, including mental state, reasons for self-harm, suicidality and therapeutic actions provided.

Palmer [81] noted the ambivalent feelings that nurses can have toward the self-harming patient, and Pyke and Steers [82] indicated that professionals have difficulties in establishing relationships with suicidal clients more often than with other groups. According to Alston and

Robinson [83], these patients may evoke in the nurse negative attitudes such as anxiety, anger and an absence of empathy. Boyes [84] suggests that repetition may represent the development of maladaptive coping patterns and often provokes frustration in staff at their inability to 'cure' the patient. Although these attitudes may be unconscious, patients may sense rejection through the nurse's demeanor and manner. These findings are particularly important as it has been claimed that a response of rejection or hostility may prompt further suicidal behavior [85]. According to McElroy and Sheppard's study [86], attitudes of the staff interviewed were mixed and appeared to be the result of personal history rather than professional background. In most cases, there were expressions of sympathy, but typically staff did not see this group of patients as rewarding or as making an appropriate use of the department. However, a number of staff commented that they very rarely received any follow-up information regarding these patients and that this lack of feedback negatively affected attitudes. As a result, it was recommended that information concerning patient progress and outcomes be incorporated into departmental communication such as team briefing [86].

Conclusions

The early recognition of suicidal behavior has been identified as a major tool for the prevention of self-killing. Very slowly, but constantly, we see the destigmatization of suicide, and more and more often people feel comfortable in discussing it openly. Nevertheless, suicide remains a difficult topic for doctors because of the contradictions that a suicidal patient brings to the therapeutic setting. The attitudes of healthcare staff toward deliberate self-harm patients have also been identified as a factor that can influence quality of care. Doctors need to take care of an individual who wants to die and at the same moment asks to be saved. No doubt people working in the ED are the ones who most often experience this inner struggle. Also, medical training does not often include a proper education on the dynamics of prevention of suicide. The suicidal patient is often seen as totally different from a patient with a somatic complaint. Doctors seem less engaged in the treatment, unless of a serious physical injury, and nurses have been described as less available empathically. Addressing the need of proper training for the management of a suicidal patient must be a high priority for critical care units if these people are to receive more individuals and provide appropriate care and if they are to experience greater work satisfaction and less negative attitudes toward these patients.

ED doctors should bear in mind that the suicidal phenomenon may be described as a spectrum of destructive behaviors. Self-mutilation and indirect self-destructive behavior are two elements of this spectrum. High-risk behavior is strictly linked to indirect self-destructive behavior, which is defined by The Encyclopedia of Suicide [87] as 'A group of behaviors that is distinguishable from overt self-destructive behavior by the criteria of time and awareness. The effect of the behaviors is long-term, and the person is usually unaware of or does not care about the effect of the behavior'. Farberow [5] identified the following features of such behaviors: (1) undermining physical health, (2) need to gratify the present and to overcome feelings of inadequacy, (3) lack of future orientation and little maturity, (4) no immediate action taken toward stress, (5) need of stimulating actions and games, (6) various coping mechanisms (denial, suppression, regression, narcissism), (7) lack of messages and communication with others and (8) superficial and casual relationship. Very often, individuals in crisis give up the chronic process of indirect self-destructive behavior to engage in a more immediate type of action, such as self-harm and attempted suicide. Proper evaluation of these patients may allow the delivery of the support needed. These individuals may precipitate their wish of self-destruction during critical moments to strengthen their 'cry for help', which has not been heard before. Good practice guidelines for assessment and therapeutic actions are therefore paramount. Nowadays, governments are particularly concerned with health costs and a wise strategy should consider that unrecognized suicidality in the ED is associated with substantial morbidity, potential mortality and increased healthcare utilization and increased costs.

The strengths of the present study include its large sample of articles reviewed that highlighted the issue of staff attitudes from different perspectives.

This study has a number of limitations. It does not provide metaanalytic results or comparisons between the studies. As stated by Platt and Salter [18], investigations in this field have employed different conceptual and operational definitions of attitudes, and different techniques of attitudes measurement and it might be unsafe to make a direct comparison of one study with another. Also, major differences might be found between attitudes toward serious suicidal patients and parasuicides and self-harming patients. This is, of course, a major issue for further research in this field. Also, more literature might be available other than that located with our search strategy.

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Appendix

Glossary

Deliberate Self-Harm

Wilful self-inflicting of painful, destructive, or injurious acts without intent to die.

Suicidal Ideation

Thoughts of performing actions to produce one's own death. Suicidal ideation may vary in seriousness depending on the specificity of suicide plans and the degree of suicidal intent.

Suicide Threat

Verbalization of intent to perform a suicidal action or a precursor action which, if fully carried out, could lead to suicide.

Suicide Gesture

Suicidal threat accompanied by a suicidal act (that the patient believes) of low lethality.

Suicide Attempt

Self-injurious behavior with nonfatal outcome that is accompanied by (explicit or implicit) evidence that the person intended to die. A suicide attempt may or may not produce injuries.