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Literacy of Suicide among Doctors and Nurses at a Tertiary Care Hospital in Nepal

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ABSTRACT

Introduction

Increased knowledge and improved attitudes about suicide are important factors for suicide-prevention strategies. Not only mental health professionals and public, but doctors and nurses working in other departments and general hospitals, especially in resource limited low-middle income country like Nepal, need to be knowledgeable identifying and making appropriate referrals for mental health issues and suicidal patients. This study was conducted to assess doctors and nurses' literacy of suicide at a tertiary care government center in Nepal.

Methods

A descriptive cross-sectional questionnaire-based study was conducted among doctors and nurses working at the hospital. Literacy of suicide scale was utilized to assess the status of literacy regarding suicide among 188 study participants. Descriptive statistics were applied.

Results

The total mean literacy of suicide scale (LOSS) score was calculated to be 13.07 (SD=3.65). Higher number of participants, 117 (62.2%) scored above mean on total LOSS score. Performance was the poorest on recognizing the signs of suicide while it was best on identifying the cause of suicide. People with relationship problems or financial problems have a higher risk of suicide was correctly identified by 89.9% of the participants. While only 60 (31.9%) participants correctly answered item "men are more likely to suicide than women" from the domain risk.

Conclusions

Majority of nurses and doctors performed better on the literacy of suicide scale. Health professionals were found knowledgeable about suicide. Those with higher level of education, specialization and training in mental health scored higher. Future studies among various categories of population and association of level of literacy and attitude, practices is needed.

Keywords: doctors and nurses; literacy; suicide.

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INTRODUCTION

Suicide accounts for huge number of lives lost untimely globally. It is an important matter of public health concern in Nepal. Suicide can be understood as a complex phenomenon resulting from biopsychosocial, environmental and cultural factors.[1-3]

Improving literacy on mental health, decreasing stigma, utilizing the knowledge base to change attitude and behavior, early recognition, appropriate referral in time to bridge the mental health gap is a high priority need of current times to deal efficiently the huge burden of mental health problems affecting lives from all spheres.[4-7] Widespread misinformation, myths, stigma, lack of knowledge, resource constraints all are causing treatment barriers. Literacy of suicide can be one important dimension to be improved bringing out changes in attitudes, behavior, stigma reduction ultimately empowering the suicide reduction campaigns.[8-13]

As mental health literacy has been associated with destigmatization and bridging the gap by improving help seeking part, medical personnels from all spheres of health sectors need to be knowledgeable about suicide as people with mental illness could be in access of them irrespective of the unit of work. The timely identification, proper dealing and appropriate referral could have significant impact.[8] Much study has not been conducted with the concept of suicide literacy in our context. The aim of the study is to assess the literacy of suicide among the doctors and nurses at a tertiary level government hospital.

METHODS

This is a descriptive cross sectional study conducted at a tertiary level hospital in Bagmati province, Nepal after IRC approval (Ref: 078/79-007), among doctors and nurses working at the hospital, with informed consent, in December 2021. Convenient sampling method was adopted. The minimum sample size calculated was 163, taking prevalence of 63% with 5% margin of error and 95% CI, whereas this study was conducted by taking 10% non-responses and study was conducted among 188 respondents.[10] A semi-structured questionnaire for basic characteristics of participants and the 26 item Literacy of Suicide Scale, was circulated among the participants. Only doctors and nurses currently working at the hospital and available on duty were enrolled. Those on leave, not available for any reason were excluded.

The literacy of suicide scale (LOSS) is useful for following four important purposes: cross sectional and longitudinal assessment of suicide literacy, to look for link between suicide literacy, socio demographic factors and other mental health problems, to assess knowledge gap and design corrective measures and to evaluate the effectiveness of steps taken to improve suicide literacy. Literacy of Suicide scale has 26 items with true, false and don't know option for each of the statements. Suicide literacy is evaluated on the following 4 domains: (a) signs and symptoms, (b) causes or the nature of suicidality, (c) risk factors, and (d) treatment and prevention. Each of the correct response is given a score of 1 and incorrect or "I don't know" responses accounts to a score of 0. Total scale scores are calculated by adding the individual item scores. The scale has been validated by using Item Response theory. The 26 statements of LOSS scale are categorized into four domains as follows- (a) sign - 7, 8, 12, 19, 23, (b) cause/nature-2, 9, 11, 14, 20, 21, 22, 24, 25, 26, (c) risk factor- 4, 6, 10, 15, 16, 17, 18 and (d) treatment prevention- 1, 3, 5, 13.[10] Scores above the total LOSS score were categorized as having higher literacy while scores below the mean as lower literacy. In order to maintain the confidentiality of information and identity of respondents, data was coded with serial number and raw information was used only for

this research purpose. Collected data was checked for completeness and coded. Data was entered in to Microsoft Excel and data analysis was done using SPSS-16 software. Categorical variables were presented in the form of tables with frequency and percentage. For continuous variables, mean and SD was calculated after checking the normality of data.

RESULTS

A total of 188 participants responded, of which 82 (43.6%) were from the age group 25 to 35 years, followed by 15 to 25 years category. Mean age of the sample was 30.11±7.68, the age range being 18 to 55 years and 138 (73.4%) of them were females. Majority of them were nurses (64.4%). Eighty-three (44.1%) of them were having PCL level of education. Only 22 (11.7%) of them reported having specialization or formal training in mental health (Table 1).

Table 1. Sociodemographic information of the respondents. (n = 188)

Sociodemographic variables	Frequency	Percent
Age (years)		
15-25	65	34.6
25-35	82	43.6
35-45	29	15.4
45-55	12	6.4
Mean (SD)	30.11+7.68	
Min (Max)	18(55)	
Gender		
Female	138	73.4
Male	50	26.6
Occupation		
Doctors	67	35.6
Nurses	121	64.4
Education level		
Bachelor	50	26.6
Masters	53	28.2
PCL	83	44.1
PhD and equivalent	2	1.1
Formal Training		
No	166	88.3
Yes	22	11.7

Performance on LOSS as per socio-demographic variables was observed as follows. Participants in the age group 25 to 35 and males had better literacy. Doctors were observed having better literacy of suicide than nurses. Those with education PhD and equivalent and those with specialization or formal training on mental health had better literacy of suicide (Table 2).

Table 2. Levels of literacy as per sociodemographic variables.

Sociodemographic variables	Performance on LOSS scale	
Age (years)	Higher Literacy Frequency (%)	Lower Literacy Frequency (%)
15-25	38(58.5)	27(41.5)
25-35	55(67.1)	27(32.9)
35-45	15(51.7)	14(48.3)
45-55	9(75)	3(25)
Gender		
Female	83(60.1)	55(39.9)
Male	34(68)	16(32)
Occupation		
Doctors	50(74.6)	17(25.4)
Nurses	67(55.4)	54(44.6)
Education level		
Bachelor	28(56)	22(44)
Masters	37(69.8)	16(30.2)
PCL	50(60.2)	33(39.8)
PhD and equivalent	2(100)	
Formal Training		
No	99(59.6)	67(40.4)
Yes	18(81.8)	4(18.2)

Item-wise, number of participants and their percentage, who could correctly reply to the statements of the LOSS was calculated. Item no 18 (risk factor domain), "People with relationship problems or financial problems have a higher risk of suicide"; item no 3 (treatment prevention domain), "seeing a psychiatrist or psychologist can help prevent someone from suicide"; and item no 10 (risk factor domain), "a person who has made a past suicide attempt is more likely

Table 3. Correct responses on each item of LOSS.

	LOSS Items	Frequency	%
1	Nothing can be done to stop people from making the attempt once they have made up their minds to kill themselves	145	77.1
2	If assessed by a psychiatrist, everyone who suicides would be diagnosed as depressed	108	57.4
3	Seeing a psychiatrist or psychologist can help prevent someone from suicide	167	88.8
4	Most people who suicide are psychotic	118	62.8
5	Only experts can help people who want to suicide	141	75.0
6	There is a strong relationship between alcoholism and suicide	79	42.0
7	People who talk about suicide rarely kill themselves	100	53.2
8	People who want to attempt suicide can change their mind quickly	111	59.0
9	Talking about suicide always increases the risk of suicide	80	42.6
10	A person who has made a past suicide attempt is more likely to attempt suicide again than someone who has never attempted	154	81.9
11	Media coverage of suicide will inevitably encourage other people to attempt suicide	78	41.5
12	Not all people who attempt suicide plan their attempt in advance **S**	93	49.5
13	People who have thoughts about suicide should not tell others about it	112	59.6
14	Very few people have thoughts about suicide	63	33.5
15	People who are anxious or agitated have a higher risk of suicide	114	60.6
16	Most people who suicide are younger than 30	63	33.5
17	Men are more likely to suicide than women	60	31.9
18	People with relationship problems or financial problems have a higher risk of suicide	169	89.9
19	Most people who suicide don't make future plans	95	50.5
20	If you asked someone directly "Do you feel like killing yourself?" it will likely lead that person to make a suicide attempt	113	60.1
21	A suicidal person will always be suicidal and entertain thoughts of suicide	75	39.9
22	A person who suicides is mentally ill	72	38.3
23	A time of high suicide risk in depression is at the time when the person begins to improve	75	39.9
24	Motives and causes of suicide are readily established	60	31.9
25	Most people who attempt suicide fail to kill themselves	93	49.5
26	Those who attempt suicide do so only to manipulate others and attract attention to themselves	89	47.3

to attempt suicide again than someone who has never attempted" were the three statements that had highest no of participants responding correctly, 89.9, 88.88 and 81.9 % consecutively. Item no 17, 16 (risk factor domain), and 14 (cause domain), were the 3 statements that were responded correctly by the least % of participants, 31.9%, 33.5% and 33.5% respectively. Item no 17 answered correctly by the least % of the participants was, "men are more likely to suicide than women."

Only 42.6% of the participants were aware that the statement "talking about suicide always increases the risk of suicide" was false. Similarly, only 41.5% correctly identified that the statement "media coverage of suicide will inevitably encourage other people to attempt suicide" is false. Furthermore, only 42% correctly responded that the item no 6 statement "there is a strong relationship between alcoholism and suicide" is true (Table 3).

Mean scores and standard deviation (SD) on the 4 domains/themes of suicide literacy namely sign, cause, risk and treatment were as follows. The mean score was lowest 2.52 (SD=1.20) on the domain sign, while highest 4.42 (SD=2.07) for the domain cause. The total mean score was calculated to be 13.07 (SD=3.65). Thus, the performance was the poorest on recognizing the signs of suicide while it was best on identifying the cause of suicide (Table 4).

The proportion of respondents scoring above and below the mean of the total LOSS score were categorized as having good literacy and poor literacy consecutively. A total of 117 (62.2%) respondents scored above mean, falling in the category having good literacy on suicide (Table 5).

Table 5. Categorization of Literacy of Suicide Scale scorers above and below mean. (n=188)

Level of literacy	Frequency	Percent
Higher (above mean)	117	62.2
Lower (below mean)	71	37.8

DISCUSSION

The aim of this questionnaire study was to assess literacy of suicide of doctors and nurses at a tertiary care government hospital in Bagmati province.

Nine (75%) health professionals in the age group 45 to 55 years, had higher literacy of suicide. Both males and females scored well on LOSS, but males performed relatively better. Doctors (74.6%) had higher literacy about suicide than nurses (55.4%). Those with highest level of education, specialization and formal training in mental health showed higher literacy in this study. Higher number of participants, 117 (62.2%) scored above mean on total LOSS score. That is, the majority of hospital doctors and nurses had better literacy of suicide. These findings have been supported by other studies. Doctors were

Table 4. Descriptive statistics on the 4 domains of LOSS. (n=188)

Variables	Mean	SD	Minimum	Maximum
SIGN	2.52	1.20	0	5
CAUSE	4.42	2.07	0	10
RISK	4.03	1.25	1	7
TREATMENT	3.01	0.98	0	4
Total	13.97	3.65	6	24

found more knowledgeable and skilled about suicide than social workers, case managers, nurses, paramedics and administrators.[14] In our study the mean (SD) LOSS score observed was 13.97 (3.65) ranging from 6 to 24. In a study by Arafat, low level of literacy in suicide was seen; the mean score of LOSS was 4.27 ± 1.99 ranging from 0 to 10, and only 43.3% of the students scored more than 4.[15] Similarly in an Arabic study, mean score of the LOSS was 5.63 ± 1.85 out of 12 with a passing rate of 55%.[16] This difference observed could be due to the professional experience, their basic knowledge and formal trainings of the study participants of our study while the respondents in the Bangladesh and Arabic study were students.

In our study item no 18 (risk factor domain), "people with relationship problems or financial problems have a higher risk of suicide" was the statement that had highest no of participants responding correctly, 89.9%; while in a study done in Arabic population, majority of the students (80%) responded correctly on the item about seeking help from a psychiatrist or psychologist.[16] Differences in the socio-cultural and economic status of these two populations may explain these findings.

Considering findings in this study, domain-wise, first of all, in the domain "signs" of LOSS, mean score (SD) was 2.52 (1.20). Next, mean (SD) score on the domain "causes" was 4.42 (2.07). Then, mean (SD) score of domain "risks" was 4.03 (1.25). Lastly, mean (SD) score on the domain "treatment and prevention" was 3.01 (0.98). Performance of the participants was relatively better in recognizing the causes of suicide, followed by identifying risk factors of suicide. They were less aware about treatment and prevention of suicide and had least knowledge about signs and symptoms. In a validation study in 2021, mean % correct were 44.0%, 54.6%, 66.1% and 88.8% and SD 25.0%, 23.2%, 22.3% and 19.1% as per themes/domains, signs, risk factors, causes/triggers, treatment/prevention, respectively.[9] In a study done in Arabic population, on items related to signs/symptoms and risk factors of suicide, students had difficulty.[16]

Out of the items related with theme signs, item no 23- "time of high suicide risk in depression is at the time when the person begins to improve," was the least correctly responded (39.9%), while item no 7- "people who talk about suicide rarely kill themselves", had the highest correct responses (53.2%). In "cause and nature" theme, item no 24- "motives and causes of suicide are readily established" was the least correctly responded (31.9%), while item no 20- "if you asked someone directly ''Do you feel like killing yourself?'' it will likely lead that person to make a suicide attempt" was the most correctly responded (60.1%). In the domain risks, item no 17- "men are more likely to suicide than women" was the least correctly responded (31.9%), while item no 18- "people with relationship problems or financial problems have a higher risk of suicide" was the most correctly responded (89.9%). Regarding treatment and prevention, Item no 3- "seeing a psychiatrist or psychologist can help prevent someone from suicide" was most frequently responded correctly (88.8%), while item no 13- "people who have thoughts about suicide should not tell others about it" was the least frequently responded correctly (59.6%). In this study, the item correctly answered by maximum of participants was no 18- "people with relationship problems or financial problems have a higher risk of suicide" from the theme risk. Participants who responded rightly were 169 (89.9%). While the item correctly answered by the least of the participants here was, item 17, belonging to theme risk and item 24 of cause/nature domain, by 60 (31.9%) each. While in another study done among university students in

2021 in Bangladesh, "if assessed by a psychiatrist, everyone who suicides would be diagnosed as depressed" from the dimension cause/nature was answered correctly by only 10 (1.89%), and "seeing a psychiatrist or psychologist can help prevent someone from suicide" from treatment/ prevention theme was correctly responded by the maximum, 408 (77.13%).[15] This difference observed in these studies could be explained by the educational background of the participants. Socio cultural factor differences could be contributing too.

Half of the total 26 items, 6,9,11,12,14,16,17,21,22,23,24,25 and 26 were answered correctly by less than 50% while the rest 13 items were answered correctly by more than 50% of the participants. In another study by Ferlatte, less than half of the participants correctly answered the following statements on LOSS: "people who want to attempt suicide can change their mind quickly" (49.8%) and "there is a strong relationship between alcoholism and suicide" (43.8%). In contrast, more than 90% of respondents correctly answered the following three items: "People who have thoughts about suicide should not tell others about it" (96.9%), "Most people who suicide are psychotic" (92.7%), and "Men are more likely to die by suicide than women" (90.1%).[17] Study population being doctors and nurses in this study, while sexual and gender minorities in the Canadian study, could account for the difference in the beliefs and knowledge.

Professional experience and knowledge base is associated with better literacy of suicide and could lead to less stigmatizing mindset towards mental illness.[2] Like this study, university sample had a mean score of 16.5 on LOSS as compared to 15.1 of community sample's mean LOSS score. The university sample correctly answered 63.4% (SD 4.05) of the items as compared to 58.2% (SD 5.13) items by community sample. Mental health literacy and literacy of suicide both has been seen better with education.[3] This was echoed in the findings of a 2017 study in South India.[4] Training on mental health have improved attitudes of health professionals' attitudes towards mental illnesses and suicide prevention.[5-7] These effects could be attributable to the impact of training, knowledge, academics, culture, societal background.

A 2020 study in Canada states that LOSS score has not been found necessarily improving factors like seeking help, or ensuring positive changes in attitude and behavior all the times. Positive association has been implied only by 50% of literature.[1] Managing suicidal patients is an art which has been found lacking even in professionals. But at the same time experience and education has been found enhancing skills and confidence in managing suicidal cases efficiently.[8] Another study of 2014 by Calear and team, states that better scores, correct answers on LOSS were associated with positive changes in attitude and help seeking behavior while poor performance was seen associated with lesser help seeking.[9] It is noteworthy that health care providers need to improve their own attitudes and behavior towards mental illness and take care that they are not responsible for adding up to stigmatization.[10] Improving literacy, decreasing stigmatizing attitudes, early identification and appropriate referral and help seeking are important to combat the burden of mental illness.[11] The treatment gap would be better bridged with improvement of literacy and destigmatization.[12]

Limitations and recommendation: This study has some limitations. It was a single hospital-based cross-sectional study. Cause and effect relation could not be specified. As this was based on a questionnaire at a single center reporting bias is likely. Results may not be generalizable.

CONCLUSIONS

Majority of the health professionals at the hospital had better literacy on suicide. Doctors had scored better than nurses. Those with specialization and formal training on mental health had better literacy. With better health professionals' literacy of suicide, campaigns to reduce stigma, bridging the treatment gap, stigma reduction and suicide prevention strategies may be strengthened and accomplished better.

Conflict of Interest: None

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