ALNAHRAIN UNIVERSITY
COLLEGE OF MEDICINE
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ASSESMENT THE SOCIODEMOGRAPHIC VARIABLES AND CLINICAL DATA AS A RISK FACTORS FOR SUICIDAL ATTEMPTS

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DEDICATION

My project is dedicated to the first ones who loves me when I entered this land, who greeted me with kiss and hold my tiny hand.

Thank you my parents you help me when I fall down and tought me everything you know.

Thank you for being there I appreciate all you do.

And a special dedication to for my wonderful supervisor, Dr.Zena AL-hussari, for her efforts, help and for supporting me to do my best.

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ABSTRACT

Background: Suicide attempt: Self-injurious behavior with a nonfatal outcome accompanied by explicit or implicit evidence that the person intended to die and There is a range, however, between thinking about suicide and acting it out. Some plan for days, weeks, or even years before acting, while others take their lives seemingly on impulse without premeditation.
Lost in the definition are intentional misclassifications of the cause of death, accidents of undetermined cause, and so-called chronic suicide (e.g., deaths through alcohol and substance abuse and consciously poor adherence to medical regimens for addiction, obesity, and hypertension) ,it is the primary emergency, with homicide and failure to diagnose an underlying potentially fatal illness representing other, less common psychiatric emergencies.
family, psychosocial, and cultural factors contribute to adolescents attempting suicide. Also, suicide can be seen as a psychological phenomenon, social phenomenon, and as a phenomenon associated with psychiatric disorders, genetic and biologic problems.

Aims

To correlate socio demographic variables and to assessment the clinical data as a predictor risk for suicidal attempts among patients who attending AL-Imamein AL-Kadhemein medical study.

Patients and method

This cross sectional study was conducted in AL-Imamein AL-Kadhemein medical study from a period January 2018-to December 2018there was thirty patients , number of female were(23) and number of male were (7) , their age range from 15-83 years. Questionnaire formla prepare to cover socioeconomic data and suicidal risk factor.

Results

This study involve 30 patients attempt of suicide females number were 23(77%) and male number were 7(33%) their age range from 15-83 years minimum age of patients were 15Y and the maximum age was 83Y and were common in adult age group ,the mean was (31.8) and std deviation was (16.2).
females were 23(77%) so the females were common and their no. were 23(77%) . And most of them were married14 (47%).
house wife were most common and their no.were 14 (46,6%).
Most cause of suicide were marital problem 9(30%).
most of them were lived in areas near to hospital.
Most of them were low socioeconomic state17(56.7%) **.**
Most of them were used drug over does 15 (50%) .
The number of patients have previous attempt were 8(26.6%).

Conclusion

the current study revealed that suicide common in adult age group female house wife and have marital problem in patient who are low socioeconomic state .
The most common way of suicide that patients use was drug over does and most of patients have no previous attempt of suicide.

CHAPTER ONE

INTRODUCTION

1-1 INTRODUCTION

Suicide attempt: Self-injurious behavior with a nonfatal outcome accompanied by explicit or implicit evidence that the person intended to die. it is derived from the Latin word for "self-murder." It is a fatal act that represents the person's wish to die. There is a range, however, between thinking about suicide and acting it out. Some plan for days, weeks, or even years before acting, while others take their lives seemingly on impulse without premeditation. Lost in the definition are intentional misclassifications of the cause of death, accidents of undetermined cause, and so-called chronic suicide (e.g., deaths through alcohol and substance abuse and consciously poor adherence to medical regimens for addiction, obesity, and hypertension). In psychiatry, suicide is the primary emergency, with homicide and failure to diagnose an underlying potentially fatal illness representing other, less common psychiatric emergencies. It is to the psychiatrist as cancer is to the internist-the psychiatrist may provide optimal care, yet the patient may die by suicide nonetheless. Thus, it is impossible to predict, but numerous clues can be seen. There are also some generally accepted standards of care that facilitate risk reduction, as well as lessen the likelihood of successful litigation, should a patient death occur and a lawsuit be filed. Suicide also needs to be considered in terms of the devastating legacy that it leaves for those who have survived a loved one's suicide, the impact it has on the treating physician, and the ramification for the clinicians who cared for the decedents. Perhaps the most important concept regarding suicide is that it is almost always the result of mental illness, usually depression, and is amenable to psychological and pharmacological treatment.[1] and it is a multidimensional phenomenon which has different meanings among adolescents in different cultures and places.[2][3] In recent studies, individual, family, psychosocial, and cultural factors contribute to adolescents attempting suicide. Also, suicide can be seen as a psychological phenomenon, social phenomenon, and as a phenomenon associated with psychiatric disorders, genetic and biologic problems[2][4][5][6][7] Thus, suicide is defined by many factors and a deep understanding of this issue is necessary for prevention and rehabilitation of those attempting suicide. Hence, a qualitative method of exploring suicide attempt for nurses can help them understand the depth of suffering experienced by these individuals and provide incentives for nurses to pursue a more deliberate and systematic care for these people. [8][9]

Epidemiology

There are over 35,000 deaths per year (approximately 1 00 per day) in the United States attributed to suicide. This is in contrast to approximately 20,000 deaths annually from homicide. It is estimated that there is a 25 to 1 ratio between suicide attempts and completed suicides. Although significant shifts were seen in the suicide death rates for certain subpopulations during the past century (e.g., increase adolescent and decreased elderly rates), the rate remains fairly constant, averaging about 12 per 1 00,000 through the 20th century and into the first decade of the 21st century. Suicide is currently ranked the tenth overall cause of death in the United States, after heart disease, cancer, chronic lower respiratory diseases, cerebrovascular diseases, accidents, Alzheimer's disease, diabetes, influenza and pneumonia, and kidney disease.[1]

Warning sign of Suicide

isn't always possible to predict outcomes or spot signs of depression and suicidal ideation. Many do, however, exhibit some symptoms. The following are some (but not the only) potential warning signs of suicidal ideation [10]

1-Talking about death, suicide, and/or self-harm.
2-Changes in personality or behavior that is out of character.

3-Talking about feeling worthless, helpless, and/or hopeless .

4-Changes in sleep patterns, including insomnia and hypersomnia .

5-Changes in eating habits, including appetite loss and overeating.

6-Risky or self-destructive behavior.

7-Changes in behavior, including lack of concentration and changes in school performance.

8-Isolating from peers and/or family.

9-Giving away prized possessions.

10-Expressing feelings of overwhelming shame and guilt, and making statements that others don't care or others will be better off without me.

11-Lack of hope for the future – feeling like things can't possibly improve.

Risk Factors

1-Gender Differences: Men commit suicide more than four times as often as women, regardless of age or race, in the United States--despite the fact that women attempt suicide or have suicidal thoughts three times as often as men. Although this disparity remains unclear, it may be related to the methods used. Men are more likely than women to commit suicide using firearms, hanging, or jumping from high places. Women, on the other hand, more commonly take an overdose of psychoactive substances or poison. The use of firearms among women, however, is increasing. In states with gun control laws, the use of firearms has decreased as a method of suicide. Globally, the most common method of suicide is hanging.

2-Age: For all groups, suicide is rare before puberty. Suicide rates increase with age and underscore the significance of the midlife crisis. Among men, suicides peak after age 45; among women, the greatest number of completed suicides occurs after age 55. Rates of 29 per 1 00,000 population occur in men age 65 or older. Older persons attempt suicide less often than younger persons, but are more often successful. Although they represent only 13 percent of the total population, older persons account for 16 percent of suicides. The suicide rate, however, is rising among young persons. Suicide is the third leading cause of death in those aged 15 to 24 years, after accidents and homicides.

3-Religion: Historically, Protestants and Jews in the United States have had higher suicide rates than Catholics. Muslims have much lower rates. The degree of orthodoxy and integration may be a more accurate measure of risk in this category than simple institutional religious affiliation.

4-Marital Status: Marriage lessens the risk of suicide significantly, especially if there are children in the home. Single, never-married persons register an overall rate nearly double that of married persons. Divorce increases suicide risk, with divorced men three times more likely to kill themselves as divorced women. Widows and widowers also have high rates. Suicide occurs more frequently than usual in persons who are socially isolated and have a family history of suicide (attempted or real).

5-Occupation: The higher the person's social status, the greater the risk of suicide, but a drop in social status also increases the risk. Work, in general, protects against suicide .it is higher among the unemployed than among employed persons. The suicide rates increase during economic recessions and depressions and decrease during times of high employment and during wars.

6-Physical Health: The relation of physical health and illness to suicide is significant. Previous medical care appears to be a positively correlated risk indicator of suicide: About one third of all persons who commit suicide have had medical attention within 6 months of death, and a physical illness is estimated to be an important contributing factor in about half of all suicides. Factors associated with illness that contribute to both suicides and suicide attempts are loss of mobility, especially when physical activity is important to occupation or recreation; disfigurement, particularly among women; and chronic, intractable pain. Patients on hemodialysis are at high risk. In addition to the direct effects of illness, the secondary effects-for example, disruption of relationships and loss of occupational status-are prognostic factors. Certain drugs can produce depression, which may lead to suicide in some cases. Anti cancer agents. Alcohol-related illnesses, such as cirrhosis, are associated with higher suicide rates.

7-Mental Illness: Almost 95 percent of all persons who commit or attempt suicide have a diagnosed mental disorder. Depressive disorders account for 80 percent of this figure, schizophrenia accounts for 10 percent, and dementia or delirium for 5 percent. Among all persons with mental disorders, 25 percent are also alcohol dependent and have dual diagnoses. Persons with delusional depression are at highest risk of suicide. A history of impulsive behavior or violent acts increases the risk of suicide as does previous psychiatric hospitalization for any reason. Among adults who commit suicide, significant differences between young and old exist for both psychiatric diagnoses and antecedent stressors. Diagnoses of substance abuse and antisocial personality disorder occurred most often among suicides in persons less than 30 years of age and diagnoses of mood disorders and cognitive disorders most often among suicides in those age 30 and above. Stressors

associated with suicide in those under 30 were separation, rejection, unemployment, and legal troubles; illness stressors most often occurred among suicide victims over age 30.

8-Previous Suicidal Behavior: A past suicide attempt is perhaps the best indicator that a patient is at increased risk of suicide. Studies show that about 40 percent of depressed patients who commit suicide have made a previous attempt. The risk of a second suicide attempt is highest within 3 months of the first attempt.[1]

Etiology

1- Sociological Factors

Durkheim's Theory: The first major contribution to the study of the social and cultural influences on suicide was made at the end of the 19th century by the French sociologist Emile Durkheim. In an attempt to explain statistical patterns, Durkheim divided suicides into three social categories: egoistic, altruistic, and anomic. Egoistic suicide applies to those who are not strongly integrated into any social group. The lack of family integration explains why unmarried persons are more vulnerable to suicide than married ones and why couples with children are the best protected group. Rural communities have more social integration than urban areas and, thus, fewer suicides. Altruistic suicide applies to those susceptible to suicide stemming from their excessive integration into a group, with suicide being the outgrowth of the integration-for example, a Japanese soldier who sacrifices his life in battle. Anomic suicide applies to persons whose integration into society is disturbed so that they cannot follow customary norms of behavior. Anomie explains why a drastic change in economic situation makes persons more vulnerable than they were before their change in fortune. In Durkheim's theory, anomie also refers to social instability and a general breakdown of society's standards and values.

2- Psychological Factors

Freud's Theory: offered the first important psychological insight into suicide. He described only one patient who made a suicide attempt, but he saw many depressed patients. In his paper "Mourning and Melancholia," Freud stated his belief that suicide represents aggression turned inward against an introjected , ambivalently cathected love object. Freud doubted that there would be a suicide without an earlier repressed desire to kill someone else.

Menninger's Theory: Building on Freud's ideas, Karl Menninger, in Man against Himself, conceived of suicide as inverted homicide because of a patient's anger toward another person. This retroflexed murder is either turned inward or used as an excuse for punishment. He also described a self-directed death instinct (Freud's concept of Thanatos) plus three components of hostility in suicide: the wish to kill, the wish to be killed, and important.

3-Biological Factors

Diminished central serotonin plays a role in suicidal behavior. A group at the Karolinska Institute in Sweden first noted that low concentrations of the serotonin metabolite 5-hydroxyindoleacetic acid (5-HIAA) in the lumbar cerebrospinal fluid (CSF) were associated with suicidal behavior.

4-Genetic Factors

Suicidal behavior, as with other psychiatric disorders, tends to run in families. In psychiatric patients, a family history of suicide increases the risk of attempted suicide and that of completed suicide in most diagnostic groups. In medicine, the strongest evidence for involvement of genetic factors comes from twin and adoption studies and from molecular genetics.[1]

Para suicidal Behavior

Para suicide is a term introduced to describe patients who injure themselves by self-mutilation (e.g., cutting the skin), but who usually do not wish to die. Studies show that about 4 percent of all patients in psychiatric hospitals have cut themselves ;the female-to-male ratio than 50times that in the general population. Psychiatrists note that so-called cutters have cut substances and 10percent of all intravenous users admitted to substance-treatment units. These patients are usually in their 20s and may be single or married. Most cut delicately, not coarsely, usually in private with a razor blade, knife, broken glass, or mirror. The wrists, arms, thighs, and legs are most commonly cut; the face, breasts, and abdomen are cut infrequently. Most persons who cut themselves claim to experience no pain and give reasons for this behavior such as anger at themselves or others, relief of tension, and the wish to die. Most are classified as having personality disorders and are significantly more introverted, neurotic, and hostile than controls. Alcohol abuse and other substance abuse are common, and most cutters have attempted suicide. Self-mutilation has been viewed as localized self-destruction, with mishandling of aggressive impulses caused by a person's unconscious wish to punish himself or herself or an introjected object.[1]

Prevention

General measure Include [11]

1- Screening and treating psychiatric disorders.

2-Crisis lines/access to help.

3- Education of parents, the public, and the media.

4- Intervene in cluster situations (e.g. several suicides in a school).

5- Reduce access to means, e.g. limits on paracetemol purchase.

Treatment

Most suicides among psychiatric patients are preventable, because evidence indicates that inadequate assessment or treatment is often associated with suicide. Some patients experience suffering so great and intense, or so chronic and unresponsive to treatment, that their eventual suicides may be perceived as inevitable. Such patients are relatively uncommon, other patients have severe personality disorders, are highly impulsive, and commit suicide spontaneously, often when dysphoric, intoxicated, or both. The evaluation for suicide potential involves a complete psychiatric history; a thorough examination of the patient's mental state; and an inquiry about depressive symptoms, suicidal thoughts, intents, plans, and attempts. A lack of future plans, giving away personal property, making a will, and having recently experienced a loss all imply increased risk of suicide. The decision to hospitalize a patient depends on diagnosis, depression severity and suicidal ideation, the patient's and the family's coping abilities, the patient's living situation, availability of social support, and the absence or presence of risk factors for suicide.[1]

Table 23.1-3

Evaluation of Suicide Risk[1]

Variable	High Risk	Low Risk
Age	Over 45 years	Below 45 years
Sex	Female	Male
Marital status	Divorced or widowed	Married
Employment	Unemployment	Employment
Interpersonal relationship	Conflictual	Stable
Family Background	Chaotic or conflictual	Stable
Physical health	Chronic illness Hypochondriac Excessive substance abuse	Good health Feels healthy Low substance abuse
Mental health	Sever depression Psychosis Sever personality disorder Substance abuse Hopelessness	Mild depression Neurosis Normal personality Social drinker Optimism
Suicide ideation	Frequent,Intense,Prolong	Infrequent,low intensty ,transient

Suicide attempt	**Multiple attempt** **Planned** **Rescue unlikely** **Unambiguous wish to die** **Communication internalized (self blame)** **Method lethal**	**First attempt** **Impulsive** **Rescue inevitable** **Primary wish for change Communication externalized** **Method of low lethality**
Personal resources	**Poor achievements** **Poor insight** **Affected unavailable for poorly controlled**	**Good achievements** **Insightful** **Affected available and appropriately controlled**
Social resource	**Poor rapport** **Social isolated** **Unresponsive family**	**Good rapport** **Socially Integrated** **Concerned family**

1-2 AIMS OF STUDY

1-To estimate sociodemographic variables as a predictor risk for suicidal attempts among patient who attending AL-Imamain ALKadhemin medical city.

2-To correlate clinical data as a predictor risk for suicidal attempts among patient who attending AL-Imamain ALKadhemin medical city.

CHAPTER TWO

PATIENTS AND METHODS

Study Design: This is retrospective study in which continuous data were expressed as mean +_ standard deviation . while categorical data were expressed as frequency and percentage. The software used were Microsoft excel 2010.

Setting: This study was done in AL-Imamian AL-Kadhemain medical city.

Period of study: from 1st of January 2018 to 30th of December 2018.

Sample and data collection : Baseline data were collected from AL-Imamain AL-Kadhemin medical city emergency department among psychiatric patients with suicidal attempts which consist of 30 cases after take permission from hospital.

For the purpose of reaserch questionnaire formula was prepared to cover the following points

Patients age

Sex

Marital status

Occupation

Residency

Socioeconomic state

Cause of suicide

Method of suicide

Pervious attempt of suicide

Inclusion criteria:

All psychiatric patients of both gender with suicidal attempt who attend AL-Imamain AL-Kadhemin medical city emergency department from 1st of January 2018 to 30th of December 2018.

Exclusion criteria:

No exclusion of patients was done during study.

CHAPTER THREE

RESULTS

Table (1)

Show distribution of suicide according to age & it show the The age range between (15-83) ,minimum age of patients were 15Y and the maximum age was 83Y,the mean was (31.8) and std deviation was (16.2).

Table (1): age distribution of cases

	No.	Mean	Std. Deviation	Minimum	Maximum
Age (yr)	30	31.8	16.21	15	83

Figure (1)

Show distribution of suicide according to sex & it shows that females number were 23(77%) and male number were 7(33%) .

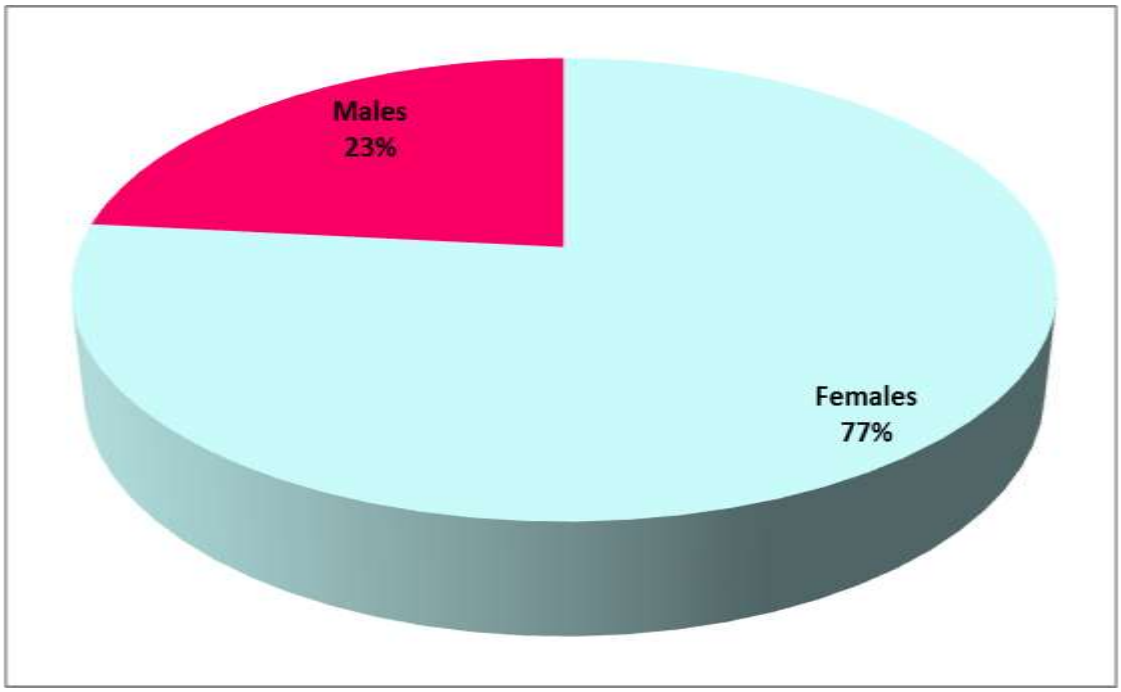

Figure (1): Sex distribution in the study

Figure (2)

Show distribution of suicide according to marital status The singles number were 12 (40%) , the married number were 14 (47%) ,the widow were 3(10%) and the divorced was 1 (3,3%).

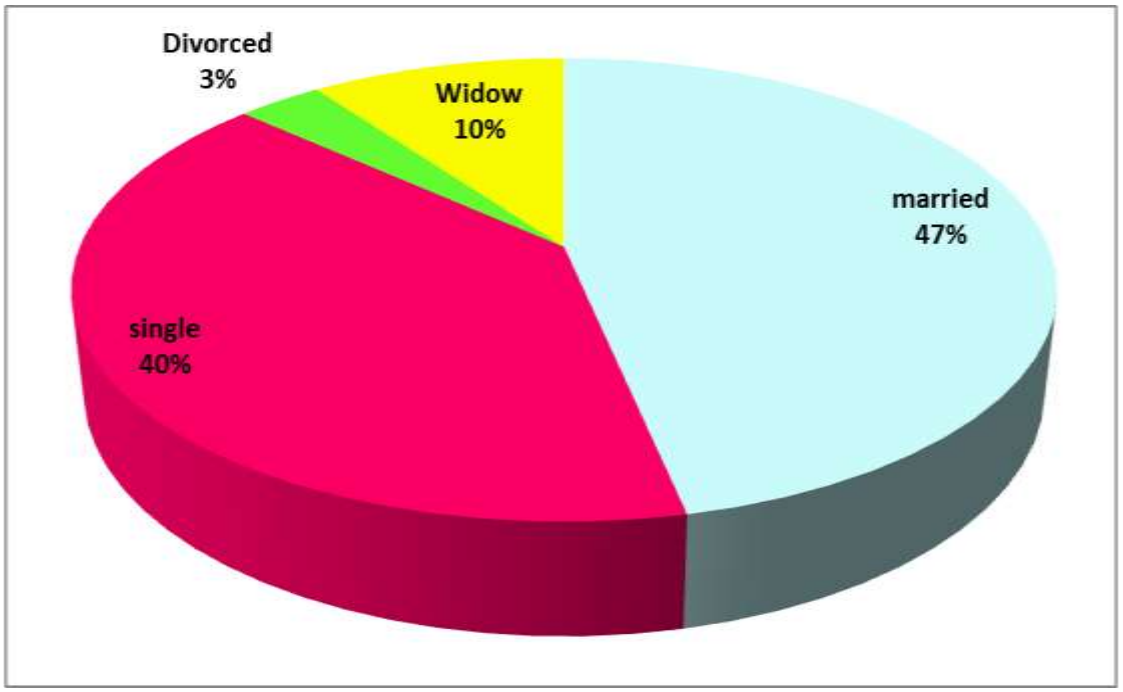

Figure (2): Marital status in the study

Table (2)

Show distribution of suicide according to occupation& show the number of house wife were 14 (46,6%), students were 9 (30.3%) , unemployed were 5(16.6 %) and soldier were 2 (6.7%).

Table(2): Occupation of cases

Parameter		Frequency	Percentage
Occupation	House wife	14	46.7
	Student	9	30.0
	Unemployed	5	16.6
	Soldier	2	6.7

Table (3)

Show distribution of suicide according to residency of cases & show most of them were lived in areas near to hospital.

Table (3): Residency of cases

Parameter		Frequency	Percentage
Residency	AL-Kadhmia	8	26.7
	AL-Hurria	6	20.0
	Sabaa AL-boor	5	16.7
	AL-Shuala	3	10.0
	AL-Taji	3	10.0
	AL-Saydia	2	6.7
	AL-Adhamyia	1	3.3
	AL-Ghazaliya	1	3.3
	AL-Rahmania	1	3.3

Figure (3)

Show distribution of suicide according to socioeconomic state and show the low level were 17(56.7%) , the middle level were 9 (30%) and the high level were 4(13.3%).

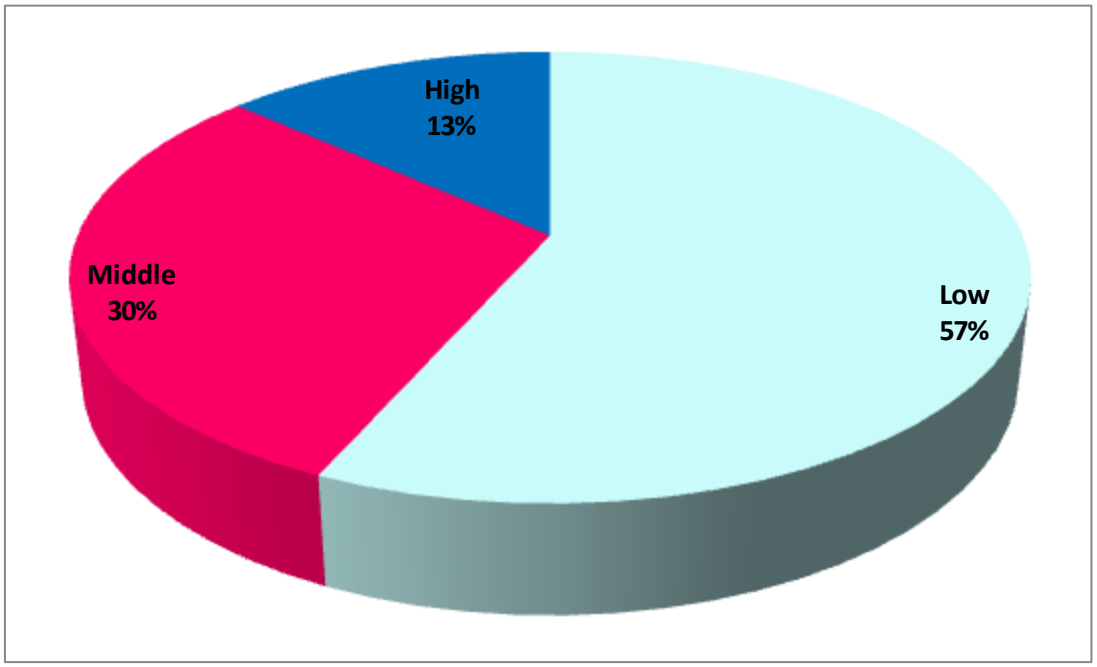

Figure (3): Socioeconomic status in the study

Table (4)

Show distribution of suicide according to motive of suicide the Chronic disease were 3(10%) cases, Depression were 4(13.3%) cases, Marital Problem were 9(30%),family problem were 6(20%), Academic grade were 4(13.3%),Poverty were 4(13.3%).

Table (4): Motive of suicide

Parameter		Frequency	Percentage
Biological	Chronic disease	3	10.0
Psychological	Depression	4	13.3
Social	Marital Problem	9	30.0
	Family problem	6	20.0
	Academic grade	4	13.3
	Poverty	4	13.3

Table (5)

Show distribution of suicide according to method of suicide& show the number of patients used drug over does were 15 (50%), hand wound were 8 (26.7%),shooting head were 2 (6.7%) , the burn were 2 (6.7%) , the executed were 2 (6.7%) , the full from height was 1(3.3) case.

Table (5): Methods of suicide

Parameter		Frequency	Percentage
Method of suicide	Drug poisoning	15	50.0
	Hand wound	8	26.7
	Burn	2	6.7
	Shooting head	2	6.7
	Executed	2	6.7
	Fall from height	1	3.3

Figure (4)

Show distribution of suicide according to previous attempt of suicide and show the number of patients have previous attempt were 8(26.6%)& number of patients have no previous attempt were 22 (73.3%) .

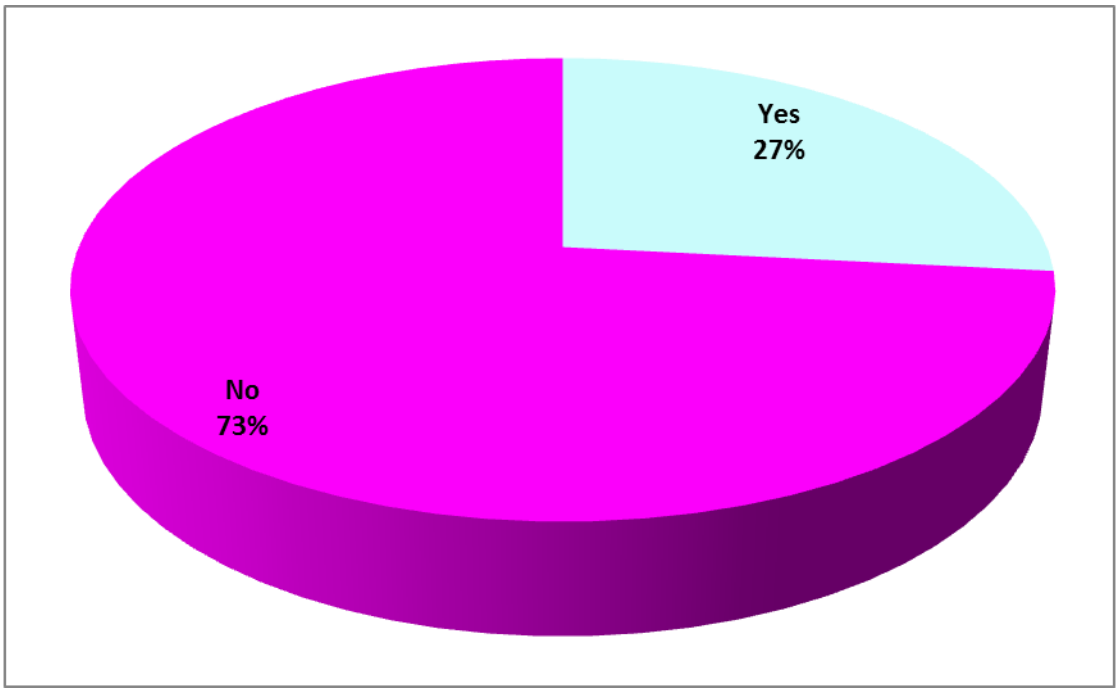

Figure (4): History of previous attempts of suicide

CHAPTER FOUR

DISCUSSION AND CONCLUSION

4-1 DISCUSSION

The present study examine the risk of suicidal attempts from multicultural family. The 12 month prevalence of suicidal behavior among patients who attending AL-Imamain AL-Kadhemin medical city emergency department show 30 patients have suicidal attempt.

In our study the range of patient's age were from 15-83years and the peak of highest suicidal atttemps were in adult age group similar in other study done in Thailand[12] but in Armenia the suicidal attempt were higher in elderly[13].

Female were more common than male and their number were 23(77%) The results of our study are also consistent with the results in korean[14] .

Male number were 7(23%).

Regarding the marital state most of them were married in compare to study done in US were most of them divorce RR (2.08)[15].

Then Single were 12(14%), widow 3(10%)and Divorce 1(3.3%) were the lest common.

house wives were more common and their number were 14(46.7%) lower than study done in India were 51%[16] .

The commonest cause of suicide were the marital problem 9(30%) lower than study done in US were (79%)[17].

This results explain by heavy burden on women , social pressure , poorer mental health status, such as a higher prevalence of depression, as compared to men Stresses may include arranged and early marriage, young motherhood, low social status, economic dependence, marital problem(May cause individuals to have a sense of thwarted belongingness and perceived burdensomeness, Feelings of loneliness, unsupported ,lack of reciprocal care, , lacking in connection to a spouse, withdrawal from a spouse, or domestic violence, Feelings of being a liability and of self-hate, both associated with perceived burdensomeness, can result from feelings of being unwanted, expendability, low self-esteem, self-blame, shame, and agitation)[17] and social stigma of divorce all of which are positively correlated with risk suicide attempt.

The number of student were 9(30%) higher than other study done in Mexico were 2%.[18]

The prevalence for academic grade were 4(13.3%).
This is explain by perceived academic performance, in low academic due to the multiple number of failed courses, and in higher academic , stress and might be under pressure either to maintain their excellent results or to catch up with their peers.

unemployed 5(16.7%),and soldier 2(6.7%) were less common.
In our study most of patients were low socioeconomic status17 (57%) similar to study done in Denmark were 55% . [19]
Poverty were 4(13.3%).
because Poverty, the state of one who lacks usual or socially acceptable amount of money or material possessions ,So those people in that case start to think about suicide because they are not satisseify about their living level the can't even provide their families basic needs, homelessness lose the hope inlife,discrimination and depression.
middle socioeconomic status were 9 (30%), high socioeconomic status were 4 (13%).

The number of patients were lived in AL-kadhimiyah 8(26.7%) ,in al-hyria 6(20%) ,in saba,a alboor 5(16.7%) , in al-taji 3(10%) ,in al-shula 3(10%),in al-saydia 2(6.7%), in al-adhamyia 1(3.3%) , in al-rahmania 1(3.3%) ,so

most of them were lived in areas near the hospital due to geographic because they are emergency cases.

The patients have chronic disease were 3(10%),and who have depression were 4(13.3%).
In recent study patients have family problem 6(20%) this is because The family is very influential in the life of adolescents. Emotional distance between adolescents and their parents, weak communication and conflict between parent and adolescent and significant changes in the family, such as living with step-parents, and parents' divorce.
Regarding method of suicide , the most common method of suicide in were the drug over does 15(50%) which was lower than the study done in US were 21%.[17]
hand wound were 8(26.7%),shooting head were 2(6.7%) ,Executed were 2 (6.7%) and full from height was 1(3.3%).

In our study Most of them has no previous attempt of suicide 22(73%) which was lower than study done in Indian were 25%[20] is compare with patients have previous attempts were 8(27%).
because they are trying to Pay attention to the ways suicide attempter used to solve their problems is an important issue, most of the participants used ineffective stress management strategies when they were faced with problems.

4-2 CONCLUSION

1-The finding of the current study revealed that suicide common in adult age group .

2-It was found that prevalence of suicide in female, house wife and have marital problem .

3-It was found that suicide predominated in patient who are low socioeconomic state .

4- The most common way of suicide that patients use was drug over does.

5- most of patients have no previous attempt of suicide.

CHAPTER FIVE

LIMITATIONS AND RECOMMENDATIONS

5-1 LIMITATIONS

1-Stigma of social toward suicide and mental illness might be a factor behind poor consultations or seeking psychiatric help.

2- The duration suggested for research was too short to conduct such study .

3-Bigger sample size is needed for epidemiological studies.

4-Limited number of school social worker to be support students if needed during academic year who could provide ready reports for planning services.

5-2 RECOMMINDATIONS

1-Performing more studies about the prevalence and risk factor for suicide in population.

2-need more information taken from family.

3-Training of social worker in schools and universities to do initial psychiatric interview discuss with them about their problem and advised to send to psychiatric treatment.

4-advice to do psychiatric assessment in any person has risk factor of suicide that may effect the prognosis and compliance with treatment.

5-if there any concern that a child or adult may be suicide if person has stated an intent to commit suicide ,and has plan and means to carry it out they are at very high risk and need to kept safe and supervised in a hospital.

6-Extra information sheet take from hospital that is beneficial for more research studies.

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