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PROFESSIONAL ATTITUDES TOWARDS SUICIDAL BEHAVIOR IN PRIMARY HEALTH CARE: A QUASI-EXPERIMENTAL STUDY

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ABSTRACT

Objective: to analyze the attitudes of health professionals working in Primary Health Care before and after participating in workshops about how to approach people with suicidal behavior.
Method: a before-and-after quantitative and quasi-experimental study, conducted in a municipality in the inland of the state of São Paulo from August to September 2019. The sample consisted of 34 workers who answered a Sociodemographic Questionnaire and the Questionnaire on Attitudes towards Suicidal Behavior, applied before and after three workshops on how to approach people with suicidal behavior in the Primary Health Care context. The data were analyzed by means of the Wilcoxon and McNemar tests, considering $p<0.05$.
Results: a statistically significant difference was identified before and after the workshops regarding professional ability ($p=0.011$), negative feelings towards the patient ($p=0.025$) and without a category ($p=0.006$), evidencing the effectiveness of the workshops on how to approach people with suicidal behavior for management and care professionals working in Primary Health Care.
Conclusion: the short-term results observed after the workshops point to a change in the professionals' conception and management in relation to people with suicidal behavior. Permanent and continuous training strategies as spaces for learning, reflection and action are fundamental to qualify the approach to people with suicidal behavior.

DESCRIPTORS: Suicide. Attempted suicide. Training of human resources in health. Primary health care. Knowledge, attitudes and practice in health.

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ATITUDES PROFISSIONAIS EM RELAÇÃO AO COMPORTAMENTO SUICIDA NA ATENÇÃO PRIMÁRIA À SAÚDE: UM ESTUDO QUASE-EXPERIMENTAL

RESUMO

Objetivo: analisar as atitudes dos profissionais de saúde da Atenção Primária à Saúde antes e após a participação de oficinas acerca da abordagem em relação à pessoa com comportamento suicida.
Método: estudo de natureza quantitativa e quase-experimental do tipo antes e depois, realizado em município do interior do estado de São Paulo de agosto a setembro de 2019. A amostra foi composta por 34 trabalhadores que responderam a um Questionário Sociodemográfico e ao Questionário sobre Atitudes em Relação ao Comportamento Suicida, aplicados antes e após a realização de três oficinas sobre abordagem à pessoa com comportamento suicida no contexto da Atenção Primária à Saúde. Os dados foram analisados por meio dos testes de Wilcoxon e McNemar, considerando $p<0,05$.
Resultados: identificou-se diferença estatisticamente significativa antes e após as oficinas no que se refere à capacidade profissional ($p=0,011$), sentimentos negativos em relação ao paciente ($p=0,025$) e sem categoria ($p=0,006$), evidenciando a efetividade das oficinas sobre a abordagem da pessoa com comportamento suicida para os profissionais da gestão e do cuidado na Atenção Primária à Saúde.
Conclusão: os resultados a curto prazo, observados após oficinas, apontam para uma mudança na concepção e no manejo dos profissionais frente à pessoa com comportamento suicida. Estratégias permanentes e continuadas de formação como espaços de aprendizagem, reflexão e ação são fundamentais para qualificar a abordagem à pessoa com comportamento suicida.

DESCRITORES: Suicídio. Tentativa de suicídio. Capacitação de recursos humanos em saúde. Atenção primária à saúde. Conhecimentos, atitudes e prática em saúde.

ACTITUDES PROFESIONALES EN RELACIÓN A LAS CONDUCTAS SUICIDAS EN LA ATENCIÓN PRIMARIA DE LA SALU: UN ESTUDIO CUASI-EXPERIMENTAL

RESUMEN

Objetivo: analizar las actitudes de los profesionales de la salud que trabajan en Atención Primaria antes y después de participar en talleres sobre el enfoque en relación a personas que presentan conductas suicidas.
Método: estudio de carácter cuantitativo y cuasi-experimental del tipo antes y después, realizado en un municipio del interior del estado de San Pablo de agosto a septiembre de 2019. La muestra estuvo compuesta por 34 trabajadores que respondieron un Cuestionario Sociodemográfico y el Cuestionario sobre Actitudes en Relación a las Conductas Suicidas, aplicados tanto antes como después de asistir a tres talleres sobre cómo tratar a personas con conductas suicidas en el contexto de la Atención Primaria de la Salud. Los dados se analizaron por medio de las pruebas de Wilcoxon y McNemar, considerando $p<0,05$.
Resultados: se identificó una diferencia estadísticamente significativa antes y después de los talleres en lo que se refiere a la capacidad profesional ($p=0,011$), a sentimientos negativos en relación al paciente ($p=0,025$) y a ninguna categoría específica ($p=0,006$), evidenciando así la efectividad de los talleres sobre cómo tratar a personas con conductas suicidas destinados a profesionales de gestión y atención en el contexto de la Atención Primaria de la Salud.
Conclusión: los resultados a corto plazo que se observaron después de los talleres señalan un cambio en la concepción y el manejo de los profesionales frente a personas que presentan conductas suicidas. Estrategias permanentes y sostenidas en el tiempo como espacios de aprendizaje, reflexión y acción son fundamentales para cualificar debidamente la forma de atender a personas con conductas suicidas.

DESCRIPTORES: Suicidio. Intento de suicidio. Capacitación de recursos humanos en salud. Atención primaria de la salud. Conocimientos, actitudes y práctica en salud.

INTRODUCTION

Suicide is among the three leading causes of death in people aged from 15 to 44 years old. Annually, around one million people commit suicide in the world; in proportion, this result corresponds to one death every 40 seconds[1–2]. It accounts for 12.4% of the deaths due to external causes in the Americas, representing 65,000 suicides a year, according to the Pan American Health Organization/ World Health Organization (PAHO/WHO)[3].

The numbers are even more serious when considering suicidal behavior, defined as any act by which a person causes injuries to themselves, regardless of the lethality degree and the reason for this act. It is evidenced in this conception that suicidal behavior is interpreted as a process: threats, self-injury, frustrations, despair, social escape, depressive symptoms, thoughts of self-destruction, suicide attempts and suicide itself[4–5].

This context categorizes suicidal behavior as a severe public health problem, albeit with a preventive nature. This conformation has led health systems to organize coping strategies and plans that involve mental health promotion, prevention and early detection actions, as well as an effective approach to cases of suicide attempts and suicidal behavior[3].

Organized according to the logic of Health Care Networks, the services that comprise the mental health thematic network, the Psychosocial Care Network (*Rede de Atenção Psicossocial*, RAPS), work from the perspective of comprehensive care for the management of people in mild, moderate and severe psychological distress. Its guideline is committed to defending the rights of people with mental disorders, in order to provide autonomy, equality and quality in the services, with an emphasis on comprehensive and multiprofessional care in the transdisciplinary logic of community care, as well as with care strategies and intersectoral actions[6–8].

In this direction, Primary Health Care (PHC) is one of the components that integrate the RAPS, developing functions such as resoluteness, accessibility and communication center of the system. As its structuring axis, the Family Health Strategy (FHS) is guided by the attributes of access, longitudinality, integrality, coordination, community guidance, cultural competence and family- and user-centered care[7]. Articulated to the RAPS, this component plays a central role in achieving the principles advocated by the Brazilian Psychiatric Reform expressed in the production of care[9].

This importance is pointed out by the scientific literature, as a considerable percentage of people with suicidal behavior were seen by physicians months before such occurrence. Data from France and the United States indicate that 80% of the people with depressive symptoms are treated in PHC, which represents 20% of the total consultations[10]. Early identification of signs related to suicidal behavior and an accurate assessment of the risk of suicide are related to effective prevention, a situation that points to the increasing need for technical preparation of the PHC professionals[11].

In this way, PHC professionals can act in the monitoring of people with suicidal behavior through surveillance and risk reduction actions, reducing the negative consequences associated with suicide attempts and ideation. However, weaknesses for the management of this problem are observed, found in the scarcity of training on the topic and in the influence of personal conceptions, generating stigma and moralistic beliefs around the professionals' performance in the care provided to people with suicidal behavior[12].

In this scenario, there is a mismatch between the field of public health policies and that of health care and training of professionals. The weakness in training has direct repercussions on the attitudes evidenced in the training of uncritical professionals who are not politically engaged in the context of the Psychiatric Reform[13–15].

The objective of training is to develop diverse knowledge, skills and attitudes; however, the Mental Health and Psychiatry academic disciplines are marked by the normal *versus* pathological approach, centered on Psychopathology and on psychiatric institutions. Unpreparedness of newly trained professionals for the service is related to the biomedical nature of training, which is insufficient for working in the context of the territorial, community-based model[13–15].

From the theoretical perspective, attitudes can be understood as the stance adopted in the face of social objects. When analyzed, attitudes aggregate three interrelated components: cognition, affection and behavior, which maintain a coherent relationship with each other. By means of Social Psychology studies, it is asserted that attitudes are built throughout the socialization of a subject mediated by life experiences. Once attitudes become part of the personality, it is known that the acquisition of new attitudes is a process that is more easily accepted for the subject when compared to their modification[16–17].

In this sense, the social object adopted in this research, suicidal behavior, has been investigated under the aspect of how professional attitudes are configured. There is diverse quantitative and qualitative evidence that corroborates positive attitudinal changes on the part of health professionals in the face of suicidal behavior after having participated in training experiences, which, in turn, add diverse knowledge and technical skills for the management of these situations[12].

However, it is noted that the attitude construct can be analyzed from the qualitative and quantitative perspectives, which are complementary to each other. In Nursing and in the Mental Health area, instruments have been used to investigate professional attitudes towards complex problems, such as suicidal behavior[18–20] and alcohol consumption[21], with relevant contributions for us to understand the most potential training processes for incorporating new attitudes and modifying stabilized attitudes that are sustained based on common sense, moral precepts and religious beliefs that can negatively influence the health professionals' attitude when dealing with suicidal behavior, as in the case of this research.

The study locus is one of the municipalities with a high rate of suicide attempts in the state of São Paulo, in which 288 suicide attempts and four deaths were recorded between January 2016 and December 2019. Most of the cases were identified from admission to the municipal Emergency Care service and the others, from admission to the Psychosocial Care Center (*Centro de Atenção Psicossocial*, CAPS). This symptom indicates the obvious: when faced with people with suicidal behavior, health professionals from the other services immediately refer them through the referral guides to the corresponding specialty or to urgency services.

Part of overcoming this challenge stems from the development of continuous training strategies so that PHC professionals understand the difficulties in the identification, approach and humanized, comprehensive and integrated management of people with suicidal behavior in the territory, a concrete way to apply the public policy on mental health and suicide prevention[22].

Given the above, the objective of this paper was to analyze the attitudes of health professionals working in Primary Health Care before and after participating in workshops on how to approach people with suicidal behavior.

METHOD

This is a quantitative study with features of a quasi-experimental nature with pre- and post-test in a single group[23].

The research was conducted in a medium-sized municipality from the inland of the state of São Paulo, located in the Nova Alta Paulista region, with ten municipalities and nearly 34,000 inhabitants. It is part of the IX Health Region Directorate, acting as a reference in mental health for Inúbia Paulista and Mariapólis. With regard to the RAS, the municipality under analysis has a *Santa Casa*, ten FHS

units, three Health Care Centers (*Postos de Atendimento à Saúde*, PAS), an Expanded Center for Family Health and Primary Care (*Núcleo Ampliado de Saúde da Família e Atenção Básica*, NASF-AB) and a CAPS - Modality I. It is worth noting that the municipality in question has 100% of its population covered by PHC.

With the intention of encompassing the largest number of PHC professionals, all 116 health professionals who comprise the PHC services in the municipality were invited to participate in the research; with physicians, nurses, nursing technicians and Community Health Agents (CHAs) from all 10 FHS units and from the three PAS services among them. In addition to that, epidemiological surveillance and PHC coordination managers were also considered for participation, due to the governability degree they enjoy in the RAS of the municipality. Therefore, the inclusion criterion was working in PHC for at least 3 months; and the exclusion criterion consisted in being on vacation or sick leave during the data collection period.

The participation of 53 workers, including the PHC coordinator, the directors of the FHS units, the director of the nurses working in the FHS and the nurse responsible for regulating vacancies, was planned in a collaborative way with the health management of the municipality. However, data from 19 participants were considered as excluded due to incomplete filling out of the data collection instruments. Thus, the final data analysis was performed considering a sample comprised by 34 participants.

Between August and September 2019, three fortnightly workshops were held on how to approach people with suicidal behavior targeted at Primary Health Care workers and managers, in which the theme was addressed using the theoretical framework of problematization based on Charles Maguerez Arch. In the first workshop, a problem situation was processed, and there was a plenary session followed by debriefing and presentation of the municipal data on suicidal behavior. The second workshop developed the identification of the professional and team skills for the management of suicidal behavior and operationalized a role-play activity. The last workshop addressed the network care dimensions, from psychosocial care to an intersectoral conformation[24].

A sociodemographic and occupational questionnaire was used to characterize the participants. In this instrument, applied at the beginning of the workshop, aspects of the participants' previous contacts regarding suicidal behavior were also addressed. Data were collected on gender, year of birth, position, religion and attendance to religious services, experience in providing care to people with suicidal ideation and family history of suicide.

To verify the outcome, the Questionnaire on Attitudes towards Suicidal Behavior was used, applied before starting the training session offered by the workshops and immediately after the third workshop. It is an instrument consisting of 21 statements, followed by a visual analogue scale anchored, at its extremes, by the "I strongly disagree" and "I strongly agree" options. Of these statements, 16 items are distributed into three factors: Negative feelings towards the patient; Perception about professional ability; and the right to commit suicide. The remaining five items did not reach sufficient magnitude in the factor analysis to be attributed to any of the three factors, being kept as remaining items of the questionnaire[18–19].

Below each item there is a visual analogue scale consisting of a 10-centimeter line (10 points) that varies from "I strongly disagree" at one end to "I strongly agree" at the other. The participants were instructed to indicate a point on each line that best reflected their opinions, feelings or reactions. These points were measured in centimeters and the agreement criterion assumed in this research corresponded to scores greater than or equal to 6[18–19].

The reasons for developing the instrument to assess attitudes were theoretical and practical weaknesses. Analysis by experts and a pilot test were used during its elaboration, which involved a bibliographic research and focus groups to write the statements. Finally, its internal consistency was evaluated by means of factor analysis and the aforementioned factors were extracted among the

21 statements, with a total variance of 43%. It is therefore considered as sensitive to the changes in attitudes that take place after the training on suicide prevention[18–19].

The printed questionnaires were handed in to the participants and collected once they were filled out. The answers were typed and compiled into a database organized in a spreadsheet (*Excel*®). Descriptive statistics was used to present the results, employing absolute and relative values and central tendency measures. The *McNemar* and *Wilcoxon* tests for time-sensitive samples were employed for the statistical analysis. Statistically significant differences were considered if $p<0.05$. The analysis was performed in the *Statistical Package for Social Sciences* software, version 21.

The ethical procedures were complied with based on Resolution Nº. 466 of December 12th, 2012; thus, the participants were invited and informed about the study objectives and, upon agreeing to participate, they signed a Free and Informed Consent Form.

RESULTS

Of the 34 study participants, the majority were female (85.3%), married (50%), had children (58.8%) and belonged to the age group from 23 to 57 years old, with a mean of 34. In relation to schooling, 73.6% have complete Higher Education and 38.2% attended graduate studies. The participants' time since graduation varied between 6 months and 34 years, with a mean of 5.5 years.

In the current study, the participation of community agents (35.3%) was predominant, followed by nurses (32.3%) and physiotherapists (8.8%), although there were other professional categories, as shown in Table 1. The participants reported having worked from 3 months to 18 years in PHC, with a mean of 36 months. In turn, they indicated that their working time in the same coverage territory varied from 3 months to 18 years, with a mean of 24 months.

When asked about training in mental health, less than half of them reported having attended lectures and training sessions, among other events. 43.4% had some training that addressed the theme of suicide and 45.3% had already been in contact with people who had attempted suicide. A minority (7.7%) of the participants had already had contact with the mandatory notification form.

Table 1 – Distribution of the participants' sociodemographic data and training. Adamantina, SP, Brazil, 2019. (n=34).

Variables		n	%
Gender	Female	29	85.3
	Male	5	14.7
Marital status	Married	17	50.0
	Single	16	47.1
	Divorced	1	2.9
Has children	Yes	20	58.8
	No	14	41.2
Religion	Yes	29	85.3
	No	5	14.7
Schooling	High School/Technical Education	6	17.6
	Incomplete Higher Education	3	8.8
	Complete Higher Education	25	73.6

Table 1 – Cont.

Variables		n	%
Profession	Community Agent	12	35.5
	Nurse	11	32.3
	Physiotherapist	3	8.8
	Physician	2	5.9
	Nutritionist	2	5.9
	Nursing Technician	2	5.9
	Psychologist	1	2.9
	Social Worker	1	2.9
Attended graduate studies	Yes	13	38.2
	No	21	61.8
Training in mental health	Yes	15	44.1
	No	19	55.9
Training on how to approach suicide	Yes	15	44.1
	No	19	55.9
Contact with attempted suicide	Yes	16	47.1
	No	18	52.9
Contact with mandatory notification	Yes	3	8.8
	No	31	91.2

The data presented in Table 2 illustrate the participants' agreement with the statements, expressed by means of absolute and relative frequencies. Thus, it is possible to verify in detail aspects that have changed in the participants' attitudes towards suicidal behavior before and after the workshops offered. The answers were allocated according to the three theoretical categories proposed by the framework used: professional ability, feelings towards the patient and the right to suicide, as well as the five remaining items[18–19].

Table 2 – Distribution of the participants' agreement with the INSTRUMENT items before and after the workshop. Adamantina, SP, Brazil, 2019. (n=34).

Categories	Items	Before*		After*		p
		n	%	n	%	
Professional ability	I feel capable of helping a person who tried to commit suicide.	18	52.9	24	70.6	0.210
	I feel capable of telling when a patient is at risk of committing suicide.	11	32.4	21	61.8	0.002
	I think that I'm professionally prepared to deal with patients at risk of suicide.	8	23.5	18	52.9	0.013
	I feel insecure to care for patients at risk of suicide.	25	73.5	16	47.1	0.035

Table 2 – Cont.

Categories	Items	Before*		After*		p
		n	%	n	%	
Negative feelings towards the patient	Those who threaten to do it generally don't kill themselves.	2	5.9	0	0.0	1.000
	Deep down, I'd rather not get too involved with patients who tried to commit suicide.	6	17.6	4	11.8	0.500
	I'm afraid to ask about ideas of suicide and end up inducing the patient to do it.	18	52.9	8	23.5	0.021
	Sometimes it even makes me angry, because so many people want to live... and that patient wants to die.	6	17.6	5	14.7	1.000
	You feel powerless in front of a person who wants to commit suicide.	22	64.7	16	47.1	0.238
The right to suicide	In the case of patients who are suffering a lot due to a physical illness, I find the idea of suicide more acceptable.	4	11.8	4	11.8	1.000
	Whoever really wants to commit suicide doesn't go around "trying."	2	5.9	2	5.9	1.000
	Despite everything, I think that any person has the right to commit suicide.	2	5.9	4	11.8	0.500
	In the face of a suicide case, I think: if someone had talked to them, the person would've found another way out.	30	88.2	32	94.1	0.625
	Life is a gift from God, and only He can take it away.	24	70.6	26	76.5	0.687
	He who has God in his heart will not try to commit suicide.	5	14.7	5	14.7	1.000
Remaining items	When a person speaks of putting an end to their life, I try to withdraw that from their mind.	31	91.2	32	94.1	1.000
	Generally, those who commit suicide have some mental illness.	8	23.5	6	17.6	0.687
	I think that a person needs courage to commit suicide.	13	38.2	9	26.5	0.289
	If I suggest referral to a psychiatrist for a patient who has talked about committing suicide, I think that the psychiatrist will see it with good eyes.	29	85.3	22	64.7	0.039
	Hospitalized patients rarely commit suicide unless they have a strong reason to do it	9	26.5	7	20.6	0.754
	I've already gone through situations that made me think about suicide.	11	32.4	10	29.4	1.000

*McNemar test

As evidenced in Table 3, there was a statistically significant difference in the score between the pre- and post-test moments in the professional ability (p=0.011) and feelings towards the patient (p=0.025) categories, as well as in the grouping of remaining items (p=0.006). The mean values corresponding to the agreement manifested by the participants before and after all three workshops were used for this analysis.

Table 3 – Analysis of the categories and of the remaining items, based on the mean corresponding to the participants' agreement, both before and after the workshop. Adamantina, SP, Brazil, 2019. (n=34).

Categories	Pre-test*			Post-test*			p-value
	Mean	Min.	Max.	Mean	Min.	Max.	
Professional ability	2.0	1.0	4.0	2.5	0.0	4.0	**0.011**
Negative feelings towards the patient	2.0	0.0	4.0	1.0	0.0	5.0	**0.025**
The right to suicide	3.0	0.0	4.0	3.0	0.0	4.0	0.106
Remaining items	4.0	1.0	8.0	3.0	0.0	6.0	**0.006**
Score	10.0	5.0	16.0	8.5	5.0	15.0	0.084

*Wilcoxon test

DISCUSSION

This study showed that the professionals' attitudes towards suicide were positively modified after the workshops were held, especially with regard to the professional ability to care for a user with suicidal behavior and to the feelings related to this situation.

It is known that the health professionals' attitudes towards people with suicidal behavior are associated with the interrelationship and to the dynamic nature existing between knowledge, attitude towards the theme and confidence in caring for these people. These points, in turn, can be influenced by factors such as beliefs, previous training and previous personal and professional experience with individuals who have attempted or are at risk of suicide, among others[12,25].

In the categories proposed by the instrument, no statistical difference was identified in the right to suicide. For society, suicide represents a taboo, an attitude that transgresses its norms, understanding death as a phenomenon associated with old age, biological illness and fatality. Judgment from a moral perspective corroborates stigmatization of the act and of the person who performs it, contributing to the increase in the suicide rates through loss of engagement and therapeutic management[12,25–26].

Given this directionality, interpretations like these should be substituted by health conceptions. Therefore, the participation of health professionals in training on mental health is fundamental, linked to sensitization about the real dimension and complexity of this problem as a multifactorial and public health issue that cannot be attributed or reduced to simplistic, unidirectional and a-historical understandings[15,26].

In the professional ability category, which corresponds to the competences and skills necessary to care for people with suicidal behavior, the indispensability of training on the theme of suicide is once again noticed, addressing issues such as prevention, management and notification. The low levels of knowledge, confidence and perception of competence impair effectiveness and quality of the care provided[25,27].

Adequate training is evidenced as the main influencing factor of the response behaviors and attitudes shown by the professionals. It corroborates the increase in skills for the recognition of appropriate clinical responses, self-perception of the general ability to interact with these users and mastery of essential competences, knowledge about risk assessment and management, and the ability to evaluate and manage these cases. The perception of sufficient training to work with suicidal behavior increases significantly after training sessions with a preventive approach[26–28].

In the current study, statistical differences were observed before and after the workshops in the "I feel capable of telling when a patient is at risk of committing suicide" (p=0.002); "I think that I'm professionally prepared to deal with patients at risk of suicide" (p=0.013) and "I feel insecure to care for

patients at risk of suicide" (p=0.035) items. Such results validate the effectiveness of training sessions and other educational strategies discussing how to approach, manage and prevent suicidal behavior.

A reduction in the score corresponding to the "I'm afraid to ask about ideas of suicide and end up inducing the patient to do it" item was noticed (p=0.021). The frequency with which health professionals are exposed to suicidal behavior exerts an influence on care quality. It was identified that an exposure frequency lower than 10 is associated with positive attitudes; a higher frequency, however, leads to feelings of professional incompetence, impotence for not being able to assist in or avoid suicidal acts and doubts about the prevention of suicidal behavior; resulting in the development of negative attitudes[25].

The manifestation of these feelings can be related to the questioning of suicidal behavior, as well as to the occurrence of a defense mechanism of the health professional. The result obtained in the aforementioned item and its scientific support point to the deconstruction of a hypothesis about the frequency in which a person is exposed to suicidal behavior, as it does not lead to a more effective way of approaching and managing it. Establishing a judgment-free communication channel favors development of the bond between the professional and the user, which in turn can favor both of them in reducing the anxiety associated with this situation and allowing the user to feel understood and welcomed[25,27].

In addition to that, the use of clinical tools that assist health professionals in clinical reasoning and in establishing the risk of suicidal behavior represents an alternative for the screening and management of people with suicidal behavior. Psychometric, adaptation and validation studies for Brazil have been a research object for Nursing teams[28].

Nearly half of the participants stated having attended training sessions in which the theme of suicidal behavior was addressed. It is noted that the quality of the care provided to these users is evidenced by the attitudes of the team, which, in turn, are associated with preparedness of the professional for the proper handling and management of these cases[26–29].

Nonetheless, permanent training spaces and in the undergraduate courses from the health area are scarce. There is no in-depth approach to suicidal behavior in the curricula, which provide superficial knowledge about the theme, with its gap filled by personal, previous and empirical experience. This unpreparedness arises for the professionals as a feeling of inadequacy, which can lead to negative attitudes towards people in distress[30–31]. Improvements are identified in the attitudes associated with specialized training sessions to educate professionals in more effective approaches[15,29].

85.3% of the study participants considered themselves religious people and most of them stated being Catholics (72.4%, n=21). For most occidental religions, suicide is approached as a break with one of their main dogmas. Attempted suicide and interruption of life are considered sins, representing a moral violation, which can lead to condemnatory attitudes and actions on the part of the professionals, in addition to inhibiting empathic expressions to people with suicidal behavior. However, religion can be correlated to positive attitudes. Therefore, in isolation, it cannot be considered as a predisposing factor for negative or positive attitudes[25,27,32].

As contributions to Nursing in PHC, the study promoted an improvement in the attitudes of the professionals who participated in a workshop on suicidal behavior; discussing the importance of managers paying attention to this demand as a way of qualifying access and resoluteness to users with suicidal behavior. In view of the above, lack of dialogical training strategies is observed, and it is proposed to encourage reflection movements through exchange of diverse knowledge, between know-how and theoretical knowledge.

The following are considered as study limitations: the impossibility of evaluating attitudes towards suicidal behavior in the long term, the sample size, and the fact that the research was carried out in a municipality. The study points to the need to establish a way to verify acquisition and fixation of the knowledge obtained during the workshops addressing the theme in the medium- and long-term.

CONCLUSION

The short-term results observed after workshops on how to approach people with suicidal behavior allow confirming a positive change in the participants' attitudes towards suicidal behavior. Although this study was carried out with health professionals from a medium-sized municipality, the scarcity of training spaces for professionals in relation to psychological distress and suicidal behavior in most of the Brazilian municipalities stands out. It is considered that the results and strategies presented in this research have the potential to contribute if replicated and discussed with other contexts, emphasizing that 70% of the municipalities in the country have the same size as the scenario herein researched. Suicidal behavior remains a challenge and responsible for the leading causes of death in Brazil and in the world, which evidences the importance of training spaces for all health professionals.

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CONFLICT OF INTEREST

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