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ORIGINAL ARTICLE

SUICIDAL BEHAVIOR IN A GENERAL HOSPITAL AND THE KNOWLEDGE OF NURSING PROFESSIONALS: CROSS-SECTIONAL STUDY

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ABSTRACT

Objective: to evaluate the knowledge of nursing professionals about suicidal behavior of patients in a general hospital. Method: cross-sectional study conducted in a general hospital in Paraná, Brazil, with 228 nursing professionals. Data were collected in the period between May 2019 and September 2020 by means of a structured instrument containing 20 sentences about suicidal behavior and its characteristics. Data were analyzed by descriptive statistical methods. Results: participants reported having experiences with patients whose behavior was suicidal (RMi=3.83); as for the statements that evaluated knowledge (RMi=2.73), they agreed on care and disagreed with the stigmatizing statements, demonstrating adequate conceptions about the phenomenon, however, it was identified that they need more knowledge to improve suicide preventive strategies (RMi=3.99). Conclusion: the study contributes to the construction of a comprehensive view regarding the care of patients in general hospital, encompassing the psycho-emotional needs, demystifying, and further promoting mental health.

DESCRIPTORS: Nursing; Suicide; Knowledge; Mental Health; Hospitals, General.

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INTRODUCTION

Suicidal behavior encompasses ideation, planning, attempt, and suicide. Suicide is defined as the deliberate act, consciously and intentionally performed by the individual himself with the purpose of dying. It is a complex, multifaceted, and multifactorial phenomenon, interrelated to biological, psychological, social, environmental, and/or cultural factors[1].

Worldwide epidemiological data show that every 40 seconds a person dies due to suicide. Each year, there are about 800,000 deaths by suicide, making the phenomenon the second leading cause of death for people between 15 and 29 years old in 2016, and the 15th in the general population[1].

Given the dimension of this public health problem, the World Health Organization (WHO) has, in recent years, encouraged its member countries to develop public policies for suicide prevention. The WHO highlights, among its publications on the subject, the role of health professionals in effectively identifying, assessing, and addressing people at imminent and significant risk of suicide[1-2].

Patient assessment and early identification of risk and protective factors are key parts of suicide prevention and the development of appropriate intervention plans. The skills to assess and approach patients are based on observation and communication by which it is possible to identify signs, establish a bond, and demonstrate interest and understanding, which help the health professional to have a comprehensive view of the hospitalized person. Thus, understanding the suicide phenomenon is essential for health professionals at all levels of care, so that the assessment and classification of the risk of harm can promote effective actions in the prevention, approach, and care of people with suicidal intentions[2-3].

It is worth noting that the presence of mental or behavioral disorders, chemical dependence, and characteristics such as impulsiveness and aggressiveness, disabling physical illnesses, and lack of social and emotional support increases a person's risk of suicide[4]. This also requires health professionals to look at the multidimensionality of patients[3].

In Brazil, data from the Ministry of Health (MH) indicate that the incidence of suicides in hospitals is high (26%), being the second place with the highest occurrence of suicide. In the 15-29 age group, the phenomenon reaches a percentage of 17.6% of the cases, being exceeded only by suicides at home (57.3%)[5].

The tendency to prioritize physical needs to the detriment of addressing psychic-emotional issues and the little ability to care for mental health are barriers encountered by health professionals in general hospitals which can hinder suicide prevention actions in these settings[3]. However, nursing professionals, since they spend most of their time caring for patients, are more likely to identify early risk factors and warning signs related to the need for immediate intervention. This possibility makes the nursing team an essential element to identify suicidal potential in patients and act efficiently to prevent this grievance[6].

Based on the above description, the research question arose what the knowledge of nursing professionals in a general hospital about suicidal behavior is. Therefore, the objective of the study was to evaluate the knowledge of nursing professionals about suicidal behavior of patients in a general hospital.

METHOD

This is a cross-sectional survey, conducted in the units: Surgical, Cardiovascular (Clinical Cardiology service and Coronary Unit), Clinical Medicine (Clinical Medicine services, back-up beds and Infectology), Maternity (Obstetrics Services, Gynecology, Joint Accommodation), Neurology, Oncology and Hematology (chemotherapy service, Bone Marrow Transplant), Adult Urgent Care and Emergency (Intensive Care Unit, Semi-intensive Care and Emergency Care) of a large university hospital in Paraná - BR.

The sample size calculation for a finite population considered the universe of 550 nursing professionals, a confidence level of 95%, and a sampling error of 5%. Thus, 228 professionals participated in the study: 25 nurses, 183 nursing technicians, and 20 nursing assistants.

The inclusion criteria were being a nursing professional working in direct patient care; and not being on vacation or on leave. As for the exclusion criteria: not answering the instrument's questions or answering them unsatisfactorily.

Data were collected between May 2019 and September 2020 through the application of a structured instrument composed of items for characterization of the participants and 20 statements with Likert scale responses with degrees of response to measure opinions, perceptions, and behaviors based on a scale ranging from one extreme attitude to another: (1) totally disagree; (2) disagree; (3) no opinion; (4) agree; and (5) totally agree. The statements highlighted aspects related to the professional experience in caring for people with suicidal behavior, the participants' level of knowledge about conceptions and peculiar aspects of this behavior. The questions and the guidelines for assessing knowledge were based on the WHO guidelines for suicide prevention and risk reduction[7]. It is noteworthy that 89% of the participants answered the instruments in a period before the restrictions caused by the Covid-19 pandemic in Paraná, being recruited in person and answering the physical instrument. The remaining participants were recruited via message and/or e-mail and responded to the structured instrument transcribed electronically on Google forms®. For this, an access link was sent via virtual social networks or e-mail.

Data were stored and analyzed by the Statistical Package for the Social Sciences (SPSS®) 21.0 software through statistical-descriptive methods. Numerical variables are presented as measures of central tendency (mean± standard deviation), and categorical variables as absolute and relative frequencies, presented in tables.

The Average Ranking of the item (RMi) was also calculated using the formula RMi=$\sum$(fr.ve)/NTi where $\sum$= summation; fr=frequency of answers; ve=value of the Likert scale; NTi=total number of answers of the same item, to verify the agreement or disagreement of the questions based on the score assigned to the answers. Thus, values greater than three were considered as agreeing, less than three as disagreeing, and three as a neutral point[8].

The research was approved by the Research Ethics Committee of the Hospital de Clínicas of the Federal University of Paraná (UFPR), under opinion number 2,297,442.

RESULTS

There were 228 nursing professionals, 25(11%) nurses, 183 (80.3%) nursing technicians, and 20 (8.8%) nursing assistants. The time in the profession of the participants was 10±7.15 years, ranging from one to 37 years. Regarding the work shift, 97 (42.5%) worked in the morning, 101 (44.3%) in the afternoon, 12 (5.3%) worked 12 hours in the day, and 18 (77.9%) at night. Table 1 shows the distribution of participants by professional category

and unit of work.

Table 1 - Distribution of participants according to professional category and unit of practice. Curitiba, PR, Brazil, 2021

Unit	Professional Category						Total	
	Nurse practitioner		Nursing Technician		Nursing Auxiliary			
	n	%	n	%	n	%	n	%
Surgical	2	0.9	40	17.5	3	1.3	45	19.7
Cardiovascular	2	0.9	13	5.7	---	---	15	6.6
Clinical Medicine	4	1.8	36	15.8	6	2.6	46	20.2
Maternity	3	1.3	13	5.7	2	0.9	18	7.9
Neurology	2	0.9	12	5.3	2	0.9	16	7
Oncology/hematology	3	1.3	6	2.6	4	1.8	13	5.7
Urgency/ emergency	9	3.9	63	27.6	3	1.3	75	32.9
Total	25	11.0	183	80.3	20	8.8	228	100

Source: authors (2021).

Table 2 presents the results referring to the statements about the participants' experience in caring for patients with suicidal behavior. The RMi for these statements ranged from 3.65 to 3.90, which inferred agreement among the participants.

Table 2 - Distribution of participants according to the experience in the care of patients with suicidal behavior in their service (n=228). Curitiba, PR, Brazil, 2021

Affirmatives	Totally Disagree n (%)	Disagree n (%)	No opinion (%)	Agree n (%)	Totally Agree n (%)	RMi†
I notice the existence of patients with suicidal behavior in my service.	3(1.3)	18(7.9)	29(12.7)	126(55.3)	52(22.8)	3.90
I have cared for patients with suicidal thoughts in my service.	7(3.1)	33(14.5)	14(6.1)	83(36.4)	91(39.9)	3.95
I took care of patients who attempted suicide in my service.	16(7)	47(20.6)	23(10.1)	55(24.1)	87(38.2)	3.65

†RMi-average item ranking

Source: authors (2021).

Table 3 presents the results regarding the participants' knowledge about suicidal behavior. The RMi for these statements infers agreement of most of the participants in the self-assessment of knowledge.

Table 3 - Distribution of participants regarding the self-assessment of knowledge about suicidal behavior of patients in a general hospital. Curitiba, PR, Brazil, 2021

Affirmatives	Totally Disagree n (%)	Disagree n (%)	No opinion (%)	Agree n (%)	Totally Agree n (%)	RMi†
I have the knowledge to identify signs of suicidal behavior.	3(1.3)	34(14.9)	33(14.4)	136(59.6)	22(9.6)	3.61
I have the conditions and knowledge to take care of patients who have attempted suicide.	3(1.3)	42(18.4)	25(10.9)	130(57)	25(10.9)	3.53
I need more knowledge and skill to develop care for patients with suicidal behavior.	9(3.9)	10(4.3)	17(7.4)	130(57)	62(27.1)	3.99

†RMi-average item ranking

Source: authors (2021).

Table 4 presents statements about conceptions present in guidelines for suicide prevention and risk reduction described in the WHO guidelines.

Table 4 - Distribution of participants regarding the assessment of knowledge about suicidal behavior. Curitiba, PR, Brazil, 2021

Affirmatives	Totally Disagree n (%)	Disagree n (%)	No opinion (%)	Agree n (%)	Totally Agree n (%)	RMi†
Patients who attempt suicide have mental disorders.	13(5.7)	80(35.1)	42(18.4)	65(28.5)	28(12.3)	3.06
People who attempt or think about suicide need emotional support.	4(1.8)	2(0.9)	2(0.9)	84(36.8)	136(59.6)	4.51
People who attempt or think about suicide need spiritual support.	8(3.9)	16(7.9)	36(17.7)	84(41.4)	59(29.1)	3.83
Suicidal behavior patients are people without faith in God.	105(46.1)	81(35.5)	34(14.9)	5(2.2)	3(1.3)	1.77

Affirmatives	Totally Disagree n (%)	Disagree n (%)	No opinion (%)	Agree n (%)	Totally Agree n (%)	RMi†
People who are admitted to general hospitals are not at risk of suicide, because it is not a psychiatric hospital.	115(50.4)	93(40.8)	9(3.9)	4(1.8)	7(3.1)	1.66
People who say they are going to commit suicide want to get attention.	73(32)	109(47.8)	25(11.0)	12(5.3)	9(3.9)	2.01
Those who want to kill themselves, don't talk, just go and do it.	67(29.4)	105(46.1)	29(12.7)	20(8.8)	7(3.1)	2.10
To all people who have thoughts or plans to attempt against life, health professionals must intervene, even without the patient's will.	7(3.1)	16(7.0)	18(7.9)	107(46.9)	80(35.1)	4.03
When a patient refers suicidal thoughts or plans to me, I have an ethical duty to keep this information confidential.	84(36.8)	107(46.9)	13(5.7)	15(6.5)	9(3.9)	1.93
Asking the patient about suicidal ideas can induce him to carry out his attempt.	21(9.2)	118(51.8)	58(25.4)	25(11.0)	6(2.6)	2.46
Patients with suicidal behavior need to have constant vigilance.	2(0.9)	5(2.2)	16(7.0)	94(41.2)	111(48.7)	4.34
Suicide is a cowardly act	96(42.1)	99(43.4)	24(10.5)	5(2.2)	4(1.8)	1.78
Suicide is a heroic act.	128(56.1)	73(32.0)	24(10.5)	3(1.3)	---	1.57
Not all suicides can be prevented.	17(7.5)	59(25.9)	29(12.7)	86(37.7)	37(16.2)	3.29

†RMi-average item ranking

Source: authors (2021).

Table 5 shows the comparison between the RMi by professional category, where there was a difference in the answers between nurses and mid-level professionals regarding two statements in which mid-level professionals (nursing assistants and technicians) answered more correctly.

Table 5 - Distribution of participants, according to the Average Item Ranking and professional category. Curitiba, PR, Brazil, 2021

Affirmatives	Nurse practitioner	Nursing Technician	Nursing Auxiliary
I notice patients with suicidal behavior in my workplace.	3.92	3.88	4.05

Affirmatives	Nurse practitioner	Nursing Technician	Nursing Auxiliary
I have cared for patients with thoughts of suicide (here at my workplace).	4.60	3.84	4.15
I have cared for patients who have attempted suicide (here at my workplace).	3.88	3.58	4.05
Patients who attempt suicide have mental disorders.	4.00	2.93	2.95
People who attempt or think about suicide need emotional support.	4.88	4.47	4.45
People who are admitted to general hospitals have no risk of suicide, because they are not in a psychiatric hospital.	1.12	1.75	1.45
Suicidal behavior patients are people without faith in God.	1.24	1.84	1.75
People who say they are going to commit suicide want to get attention.	1.48	2.10	1.85
Those who want to kill themselves, don't talk, just go and do it.	1.48	2.16	2.30
I have the conditions and knowledge to identify signs of suicidal behavior.	3.20	3.65	3.80
I am able and knowledgeable to care for patients who have attempted suicide.	3.36	3.64	3.40
I need more knowledge and skill to develop care for patients with suicidal behavior.	4.36	3.96	3.80
In situations where people have thoughts or plans to attempt suicide, health professionals must intervene, even without the patient's will.	3.84	4.03	4.30
When a patient refers suicidal thoughts or plans to me, I have an ethical duty to keep this information confidential.	1.92	1.97	1.65
Asking the patient if he has suicidal ideas can induce him to carry out his attempt.	2.36	2.46	2.55
Patients with suicidal behavior need to be constantly vigilant.	4.68	4.31	4.25
Suicide is a cowardly act.	1.56	1.77	1.90
Suicide is a heroic act.	1.52	1.54	1.95
Not all suicides can be prevented.	2.68	3.35	3.50

Source: Authors (2021)

DISCUSSION

The confirmation given by the participants regarding noticing and caring for patients with suicidal behavior in their practice is consistent with the literature on the high prevalence of attempted and actual suicide in health services[1,5,7]. Thus, the probability of general hospital professionals encountering cases of attempted suicides is high[3-4,6]. It is estimated that 26% of deaths by suicide in Brazil occurred in hospitals, which is three to five times higher than in the general population, and the incidence of suicide in these services is high[5]. Recognizing the existence of patients at imminent and significant risk of suicide in

general hospitals is the starting point for establishing contingency plans and prevention strategies[3-4,6].

The identification of signs of suicidal behavior is fundamental to clinically determine the risk and establish effective interventions. Initially, the degree of risk is identified through periodic evaluations, since it is difficult to predict exactly which patient will attempt suicide, but the risk can be estimated by anamnesis and data collection from third parties (family members, friends, companions)[9].

Along with other professions, nursing makes up the health teams that intervene in mental health emergencies in general or specialized psychiatric hospitals. Nursing professionals are in a privileged position, from the assistance point of view, due to the time spent caring for patients. This condition can be considered a facilitator to identify factors that can lead to a higher suicide risk or to self-injurious actions without suicidal intentions[3].

Thus, systematized care becomes important, with comprehensive assessment, considering the multidimensional needs of the person, and not only the physical-biological, which becomes a challenge, especially for professionals working in general hospitals; this is because Brazilian studies describe that these professionals show difficulties in caring for people with suicidal behavior due to judgment, discomfort, and lack of preparation to deal with this demand[3-4,6,10-11]. The professionals' knowledge deficit is due, in great part, to gaps in their education, especially regarding mental health issues, which end up perpetuating some stigmas and prejudices regarding people with suicidal behavior, directly interfering in the care[3,6,12].

Studies have concluded that continuing education actions on the theme "suicidal behavior" can promote professional reflection on specific care practices by understanding the psychosocial and subjective demands presented by this clientele: care in the emotional and spiritual dimensions[3].

Most of the participants agreed on the existence of a relationship between suicidal behavior and mental disorders. The presence of a mental disorder is one of the risk factors most strongly associated with suicide. Like what is observed in the general population, a diagnosis of mental disorder can be found in approximately 90% of the cases of people who commit suicide. Studies that consider the implications of risk factors for suicide show the predominance of mood disorders, especially depression, followed by schizophrenia and substance use disorders such as alcohol. The fact that the individual has a history of attempted suicide is another factor that considerably increases the risk of suicide[7].

Mental disorders can express themselves in different ways in relation to suicidal behavior. In general, in mood disorders the person no longer sees an alternative and a reason to live; in the most severe cases of anxiety disorders, there is a strong feeling of hopelessness and helplessness. In schizophrenia, it is associated with psychotic episodes, auditory hallucinations, in which voices or images order or incite the act. Chemical dependency and personality disorders are associated with traits of aggressiveness, impulsiveness, and anger, generating hasty and sudden attitudes in moments of anger and sadness[7].

The participants did not agree with the statement that people who attempt suicide want to get attention. The literature[13] describes that this situation is a false belief present among some professionals and family members that the act was a way for the patient to provoke, manipulate, and manifest hostility against those around him. Generally, the reaction presented by these family members and professionals when faced with a potential suicide is one of repression or passive indifference, because they believe that this will discourage new attempts. Some authors[3,13] affirm that such actions are an expression of disregard for psychological suffering related to lack of knowledge of the psychological and emotional aspects of suicide. Even if the professional can recognize this condition of psychological suffering, the use of the term "calling attention" becomes pejorative due to the lack of knowledge of the situations experienced by the patient, disqualifying the signs that precede the practice of suicide, which does not contribute to the prevention of

suicidal actions[13].

According to the WHO[7], it is a myth that some professionals believe that patients who talk about wanting to commit suicide rarely do so, or that those who want to kill themselves do not talk. The evidence is that most people who commit suicide give some hint or warning in advance. Therefore, threats should be considered and investigated.

Warning signs may or may not occur, being verbal such as phrases that directly or indirectly mean that the person will not be present in the future: "It's my last time here", among others. The behavioral signs are variable and appear as changes in personality, pessimism, frequent mention of death, and planned situations such as organizing documents, making a will, and concluding unfinished personal matters. It should be emphasized that some individuals with suicidal behavior experience the ambivalence of the desire for death (for the psychic pain to cease) and the will to be helped and to live[14].

Suicide is a dilemma for health professionals because it is a conflict between the principles of respect for the patient's autonomy, always praised by bioethics, and those of beneficence and non-maleficence, in which the professional should care for life and not cause any harm. Knowing these principles becomes imperative when it comes to professional intervention to suicidal behavior that, when facing the possible risk of death, the principle of beneficence overrides the patient's will[15]. The potential suicide is usually in intense suffering, and the fundamental question is how to reduce it. Some authors consider it inappropriate to be guided only by legal issues but defend the position of understanding and not condemning the person who attempts suicide[15-16].

Another myth related to the approach to suicidal behavior is the belief that by asking about suicidal ideas, one can induce the individual to carry out his plan; however, the WHO[7] guides that one should approach the patient and ask, because that way, there is a great chance of helping him. Thus, the nursing professional should not be afraid to investigate the possibility of suicide, since the topic should be approached gradually and cautiously, and it is extremely important to approach and discuss it, because dialogue and active listening can relieve the anguish and tension caused by suicidal thoughts, thus generating better conditions for coping and adherence to the proposed treatment[17].

Among the main care to be developed with patients with suicidal behavior, constant surveillance by the multi-professional team must be implemented in a systematized manner. In accordance with different studies that emphasize that it is not possible to predict exactly when the patient will commit suicide, we only have the existing risk, which makes it necessary to frequently monitor the individual. Measures such as avoiding leaving the patient alone, providing support, electing therapeutic companions who are usually family members in the home and in specific circumstances, in addition to full hospitalization in psychiatric services can be solutions to maintain the necessary vigilance. The care must be planned, based on supportive and non-judgmental attitudes, which strengthen the collective and interdisciplinary actions of the professionals involved in the care[17-18.]

Social and cultural factors can influence suicidal behavior, intensifying it as well as the professionals' conception of the phenomenon, resulting in different ways of caring. Thus, healthcare professionals should contextualize sociology and suicide[19].

It is possible to make an approximation between the cowardly act cited in the research with Durkheim's selfish suicide and the heroic with the altruistic, the first being that in which the patient does not have strong connections with the group in which he is inserted, which, together with depression and social disintegration, lead him to consummate the act; and the altruistic, conceptualizing itself as the opposite extreme, since the patient is connected to the group, but no longer feels useful in it, for example, due to age or disease, showing as a solution the choice of ending one's life[19]

Suggested by the sociologist, suicide is translated as a response to the collective disease existing in society, demonstrating its influence on individuals; however, despite this

comparison, both categories were disowned by the participants of this study, based on the understanding that suicide is still an individual psychological issue, which goes beyond the social conception established for it[19].

Despite the RMi=3.29 for the statement that not all suicides can be prevented, this question had an almost homogeneous distribution among the answers, which suggests some doubt about the statement. It is worth remembering that suicide is a multifaceted and complex phenomenon; there is no way to define the definitive causes of suicidal behavior, because biological, psychological, social, environmental, and cultural factors are included. Therefore, not all suicides can be prevented; however, many lives can be saved if patients with suicidal behavior are identified, approached, listened to, and treated appropriately[10,20].

The limitation of this study was the restriction of the sample to a single institution. Thus, it was possible to portray only the local reality, not being possible to cover a sample or statistical analysis with greater representativeness of the universe to make comparisons and generalizations.

CONCLUSION

The participants, for the most part, understand the main conceptions and nuances of suicidal behavior. However, they feel the need for more knowledge and skills to improve care and suicide prevention strategies. Homogeneity of knowledge among nurses, technicians and nursing assistants was verified, as well as little stigmatization of the phenomenon by the participants.

Thus, the study can contribute to building the comprehensive view in the care of patients with suicidal behavior in general hospital, encompassing the psychic and emotional needs as well as spiritual and mental health support by the nursing team.

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - Pypcak EM, Schultz JV, Mildemberg R, Machado EM; Drafting the work or revising it critically for important intellectual content - Pypcak EM, Schultz JV, Paes MR, Nimtz MA; Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - Pypcak EM. All authors approved the final version of the text.

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