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Psychosocial care for people with suicidal behavior from the perspective of users and health professionals*

Atenção psicossocial às pessoas com comportamento suicida na perspectiva de usuários e profissionais de saúde

Atención psicosocial para personas con conducta suicida desde la perspectiva de usuarios y profesionales de la salud

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ABSTRACT

Objective: To understand the implications of the assistance provided to people with suicidal behavior within the scope of the Psychosocial Care Network, from the perspective of users and health professionals. **Method:** A qualitative research, under the theoretical framework of complex and methodological thinking in Grounded Theory. Interviews were conducted from May to December 2017, with users assisted due to suicidal behavior and with health professionals in psychosocial care settings. The comparative data analysis technique was used **Results:** 18 users and health professionals participated. Non-acceptance intensifies users' introspection, demotivation and hopelessness, increasing the difficulty of exposing their desires. In situations of embracement, availability and bonding with professionals, patients feel more open, to the point of giving new meanings to life and reducing thoughts of death. **Conclusion:** Weaknesses and potentialities were noticed in the care provided by health professionals to users with suicidal behavior, within the scope of the Psychosocial Care Network. The need for management committed to the quality of care in the face of the risk of suicide stands out.

DESCRIPTORS

Suicide; Suicide, Attempted; Self-Injurious Behavior; Psychiatric Nursing; Psychosocial Support Systems; Mental Health Assistance.

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INTRODUCTION

Suicidal behavior expresses an act full of ambivalence, since death is announced not as wanting to die, but as the desire for a life free from the unbearable pain that makes them so sick. The complexity that permeates the suicidal act requires services prepared and organized in a network for caring for people's mental health, this being *sine qua non* for the reduction of the disease's morbidity and mortality rates.

The numbers related to suicide are growing and alarming worldwide, with more than 800 thousand self-inflicted deaths per year. In the United States of America, suicide rates increased by about 16% between 2006 and 2014[1]. In Brazil, the number of suicide deaths does not differ so much, having increased by 12% between the years 2011 and 2015, placing the country in the 8th position in the ranking worldwide of the highest suicide rates[2].

It is estimated that, in 2020, the burden of suicide attempts and the morbidity they bring will reach approximately 2.4% worldwide[3]. In the national setting, from 2011 to 2016, about 1,173,418 cases of interpersonal or self-harm were reported in the injury information system, of which 42% were related to self-harm and attempts of suicide[4].

In view of the health demands related to suicide attempts, two studies show that services, regardless of specificity for mental health, constitute an entrance door for actions related to psychosocial care, which makes them become *locus* privileged for care in relation to suicidal behavior. A Mexican study shows the need for psychological and psychiatric assessment in all cases attended due to suicide attempts in a general hospital of high complexity, in order to determine possible risk factors[5]. A similar research conducted in the city of Fortaleza, state of Ceará, Brazil, with 360 victims of attempted suicide attended at various services that make up the Psychosocial Care Network (RAPS – *Rede de Atenção Psicossocial*), promotes the importance of professionals attentive to suicidal behavior at all levels of assistance such as suicide prevention strategy[6].

The RAPS aggregates the Brazilian Unified Health System (SUS – *Sistema Único de Saúde*) and establishes points of attention for the care of people with mental health problems. It aims to articulate health actions and services at different levels of complexity, from the access and promotion of people's rights, based on coexistence within society[7]. The Network is made up of various services and equipment, such as Psychosocial Care Centers (CAPS – *Centros de Atenção Psicossocial*); Residential Treatment Services (RTS); Community and Culture Centers, Embracement Units (EU) and Beds for Comprehensive Care (in General Hospitals, in CAPS III)[7].

However, despite the entire structure of care at RAPS, a Brazilian study carried out in a psychiatric hospital in the state of Rio Grande do Norte signals the difficulties of access and inadequate functioning of RAPS services, especially in CAPS. These services experience frequent problems regarding the high demand of users and the lack of psychiatrists, which compromises care regarding the continuity of treatment, increasing the chances of successive hospitalizations of users[8], as well as suicidal acts.

In addition to the structural difficulties faced in RAPS services, it is still possible to encounter stigmatizing attitudes, expressed by the professionals' non-acceptance and discredit around the suffering that culminates in suicidal behavior. Likewise is shown in a study carried out in Emergency Care Units (ECU – in Portuguese *Unidades de Pronto Atendimento* (UPA)) and hospital emergencies in southern Brazil[9].

When considering the relevance of the quality of care provided in the face of suicidal behavior, with a view to the well-being and prevention of suicide, it is necessary to understand the implications of the assistance provided to people with suicidal behavior within the scope of RAPS, from the perspective of users and health professionals. What contributes to give visibility to the impacts of these implications for the mental health of users, and, consequently, for the reduction of thoughts and acts of suicide. Therefore, this study aims to understand the implications of the assistance provided to people with suicidal behavior within the scope of the RAPS, from the perspective of users and health professionals.

METHOD

Type of the study

This is a qualitative study anchored in the theoretical framework of complex and methodological thinking from Grounded Theory (GT). The GT seeks to understand social phenomena from the perceptions or meanings of the relationships and interactions among people[10]. Complex thought[11] is relevant because it allows, through an experienced reality, identifying the parts that involve people at risk for suicide, as well as understanding the whole that is associated and affects health care.

Population

Thirty-three people participated in this research. Among these, there are 18 users, 15 women and three men, undergoing therapeutic monitoring for suicidal behavior in an outpatient service specializing in assisting people at risk of suicide and 15 health professionals working to provide assistance to these users in different RAPS services. These participants were chosen intentionally.

Professionals worked in the fields of nursing, social work, psychology, psychiatry, occupational therapy, in one of the RAPS component settings: a general hospital emergency, in the ECU, in Emergency Medical Services (SAMU – *Sistema de Atendimento Móvel de Urgência*), Psychiatric Emergency Services (PES), and the CAPS. They were interviewed in their workplaces, in a private environment. Meanwhile, users were interviewed at the Center for the Study and Prevention of Suicide (NEPS – *Núcleo de Estudo e Prevenção do Suicídio*).

The NEPS is an outpatient service specialized in assisting people at risk of suicide, linked to a Toxicological Information Center (TIC) that is part of the own network of the Health Office of the State of Bahia (SESAB – *Secretaria de Saúde do Estado da Bahia*), in the city of Salvador, state of Bahia, Brazil. The NEPS has a multidisciplinary team composed of nursing, psychology, psychiatry, and occupational therapy professionals. It acts in technical support to the RAPS, offering assistance to people with suicidal behavior and training with a multidisciplinary approach for Network health professionals. It is worth noting that the NEPS, opened in August 2007, presents itself as the only public service specialized exclusively in assisting people with suicidal behavior in Brazil[12].

Selection criteria

Inclusion criteria for users were considered: age equal to and/or older than 18 years; in any follow-up period at NEPS; with emotional and psychological stability after assessment and indication of NEPS professionals. Exclusion criteria for these participants were: suicide attempt and/or psychiatric hospitalization in the last 90 days (due to the possibility of emotional instability); difficulties to express ideas and/or feelings and propensity to emotional lability regardless of the association with psychological disorders.

For health professionals, inclusion criteria were defined as having technical or higher education in the health field; acting at levels of assistance and/or management in at least one of the services that make up the RAPS; and having provided assistance to people with suicidal behavior within the scope of the RAPS, without delimiting the period. Professionals who were away from work for any reason during the collection period were excluded.

Data collection

Initially, contact was made with participants by phone or e-mail, to carry out the invitation and schedule a meeting to present the research objective and conduct the interview. The data were collected by the main researcher through an open-ended and individual interview, in a private place, from May to December 2017. Interviews were recorded in audio-digital recording in order to preserve, in full, the lines for later transcription. The following question was used as a guiding question for users: how did you feel after being attended by health professionals in services due to thoughts of suicide or attempted suicide? For health professionals: how do you believe that people assisted due to suicidal behavior feel after situations of (non) embracement evidenced in the care provided by RAPS professionals?

Interviews were interrupted when the information offered by users and professionals became repeated, confirming the absence of new elements to add to the analysis.

Analysis and treatment of data

According to the GT theoretical principles, the stages of data collection, analysis and categorization occur simultaneously, through constant comparison of data[10]. Thus, each interview after collected, transcribed and analyzed generated conceptual cores that guided the following interviews.

Users' interviews analysis revealed the following assumption: people with suicidal behavior perceive themselves to be more vulnerable to the risk of suicide or more strengthened for the continuity of life, depending on the situations of (non) embracement resulting from the assistance provided by professionals working at RAPS. Coding respected the three steps presented by open coding, axial coding and integration, following the paradigmatic model. It consisted of the following components: condition, which answers about why, when and how the phenomenon occurs; action-interaction, which consists of the response expressed by people to events that have occurred; and consequence, which expresses the expected or actual outcomes and results[13].

Code grouping gave rise to the categories and subcategories defined and developed in their properties and dimensions, allowing to unveil the phenomenon. It was revealed that care based on comprehensiveness and embracement of people with suicidal behavior goes through qualified professionals and structured services within the scope of the RAPS. In this context, it was decided to broaden and deepen the discussion of Consequence entitled: recognizing the role of the RAPS in weakening or strengthening people with suicidal behavior, based on the assistance provided by health professionals.

Ethical aspects

The study was approved under Opinion 1.813.544/2016. The ethical precepts of Resolution n. 466/2012 of the Brazilian National Health Council were met. Participants were informed about the purpose of the research, and signed the Free and Informed Consent Term, after acceptance for participation.

In order to guarantee participant anonymity, the letters U (users) and P (health professionals) were used followed by a number in order of the interview, taking as examples: U1, U2, P1, P2.

RESULTS

Consequence emerged from two categories and six subcategories related to the weakening and strengthening of people with suicidal behavior, based on experiences in the assistance provided by health professionals within the scope of the RAPS.

The first category, feeling more vulnerable to suicidal behavior, is supported by two subcategories that express consequences in the face of non-acceptance by RAPS professionals. This event has a negative impact, leaving users even more fragile in their suffering conditions. The subcategory, perceiving themselves introspective, unmotivated and hopeless, shows that, when seeking health services and not perceiving care, they become shyer, without motivation and/or hope for life, which makes them vulnerable to isolation

and the silence of their thoughts, as well as the intensification of their pains:

I no longer talked about what I felt or thought so as not to disturb people (...) *I was no longer able to expose my pains and I no longer knew how to do it* (U1).

Not having been cared for left very deep marks (...) *they did not believe in my suffering and my pain became much greater* (...) *I fell down and locked myself more and more* (...) *nothing was worth more and I no longer had the courage to follow* (U4).

Non-embracement causes more suffering, intensifying weaknesses, disbelief in themselves, signs of isolation and feeling of loneliness (...) *little things are no longer carried out, such as not taking a shower or combing the hair* (P7).

Failure to embrace suicidal behavior can cause people to lose even more sense of existence, starting to believe that they are not worthy to have something better in life (P4).

In second subcategory, noting themselves more susceptible to the recurrence of suicide attempts, non-existence emerges to users as a possibility to get rid of intense suffering, when not taken care of and accepted in their pain. Thus, thoughts of death become more frequent, and may contribute to the recurrence of suicide attempts and the effective outcome of self-destruction. Hence, participants expressed that after seeking the health service as a protection and care tactic, and not receiving the expected support, users start to present suicide as the only way out:

Not caring intensifies pain and slows down the process of change (...) *it weakens, increases thoughts of death and the desire to not exist, to commit suicide* (U13).

When there is a place where care is not adequately provided and professionals are not trained to attend, what was a protective factor becomes a risk. Carelessness can precipitate new and more effective suicide attempts (P8).

When the person does not receive care and does not feel embraced, he/she becomes even more fragile (...) *the feeling is to fall apart, making it much easier to try suicide again* (P9).

The second category, feeling more empowered with care in the RAPS, reflects the results of respectful and sensitive care received by users with suicidal behavior in the health services they visited, based on four subcategories. The first subcategory, motivating themselves with embracement and bonding, reveals that users perceive themselves as valued in their complaints, which contributes to the sharing of bonds and favors adherence and attendance in services, as well as the continuity of treatment:

When the person who attempts suicide is not humiliated, he/she always comes back to talk. When professionals treat in a humanized way, the person continues the treatment because they know they can talk about what they feel, without any kind of problem (U2).

I am a regular user of NEPS, because I feel cared for and respected: professionals listen to me, believe in me and make me feel valued (U9).

When we are able to take care, even establishing links with other services, we observe that the patient adheres more quickly to therapy and participates more assiduously in consultations and meetings, facilitating success in treatment (P2).

When people receive more humanized care, being heard and embraced, they feel more encouraged, favoring bond strengthening (P5).

In the second subcategory, giving new meanings to life, the data signaled, from the perception of participants, that users feel more empowered and encouraged to think about the future and to undertake changes in the way of seeing and living life, thus seeing other perspectives in the face of suffering:

When I felt I was being cared for by people who care about me, I started to feel able to make changes in my life (...) *I know that there is a way out of suffering and be happy* (...) *I hope that everything can be different* (U4).

Today I feel super strengthened (...) *my way of seeing and living life has changed a lot* (...) *my priority is with myself, in being happy* (U8).

Care expands the network of relationships and makes people feel that they can do things they didn't even realize before (...) *they start to believe in changing perspectives and other possibilities appear, as well as the ability to have dreams again and to learn things that before they thought it was impossible to do* (P7).

With care, people begin to project other perspectives for life: they awaken to the desire to work, study and, above all, to remain in life (P1).

The third subcategory, awakening to take care of yourself and others, reveals that users feel more motivated to take care of themselves and still wake up to care for other people. They believe that, by sharing their experiences, they can reduce the suffering of their pain and help those who experience similar situations:

Care taught me to take care of myself and help other people, talking about my experiences (...) *taking care of others does us great good* (...) *talking about what we went through can help to reduce suffering of those who still feel a lot of pain* (U7).

Care made me want to have more information about what happens to me and directs me to talk about what I feel (...) *I know I can help other people deal with pain* (U6).

Many who already feel better, more able to continue with treatment, seek to help others. By doing this, they will also be helping each other (P10).

Over time, care becomes more effective and people begin to realize that taking care of the body is important, that they need to get dressed, shower, have a good diet, be attentive to periodic exams (P6).

The fourth subcategory, realizing the decrease in thoughts and/or suicide attempts, shows that user embracement on RAPS devices positively interferes in their lives, strengthening them and producing greater emotional stability, so that the thoughts and/or suicide attempts decrease or even cease:

Today I don't think about dying anymore, as before (...) *I feel very happy because I know that I receive support and care from everyone* (U16).

The care I receive makes me feel good and embraced (...) *despite having relapses and still thinking about suicide, I can say that I feel stronger and with less thoughts of death* (U15).

Care does not make thoughts of suicide disappear, but it certainly decreases ideation and makes them stable for a longer time. (...) *it helps to strengthen, to think about strategies and to have more resources in the face of thoughts of suicide so that the person gets up, sustain themselves and moves on* (P3).

DISCUSSION

The findings suggest that in the various consultations provided by health professionals in RAPS services, people with suicidal behavior may become strengthened or even more vulnerable to suicide attempts. The first category points out that in the face of barriers to accessing the RAPS and/or inadequate care by professionals, users find themselves more introspective, unmotivated and hopeless. These feelings contribute to make them feel lonely and reflective in relation to the situations that caused suffering, increasing the difficulties in exposing their pain, such as introspection.

In the process of introspection, it is common for people to become shyer. This prevents them from expressing what they feel, abstaining from the external environment and depleting more fruitful relationships that occur in *complexus*[11], based on their own experiences. Introspection, with regard to locking yourself in as a way of dealing with the disease, was also evidenced in a research carried out with 20 patients due to complications of sickle cell anemia, coming from North America, Central America, and Africa[14].

In the present research, the introspection presented by people with suicidal behavior appears in the face of suffering, intensifying the weaknesses, reinforcing the isolation for not feeling embraced, in addition to the demotivation and disbelief in themselves, making them even more silent and dejected in the face of life. Similar situations were narrated by 80 patients hospitalized for attempted suicide in a South African hospital, who reported introspection for the psychological suffering related to the death wish, and the intensification of this isolation in the absence of adequate health care[15].

From the perspective of complex thinking[11], in the process of introspection, there is a closed system as in any inanimate object, in which the absence of energy flow would cause deregulation and rapid weakening. Thus, in analogy to such a system, suffering, accentuated by not caring, cooperates so that users increase the devaluation in the face of their own existence and potentiate thoughts of death. They can become more and more recurrent and are manifested, through the speeches, by the desire to no longer exist and as a possibility to get rid of anguish and intense pain. The suicidal intention due to the feeling of devaluation was also signaled by a Mexican study, carried out with 13,198 adolescents, whose findings pointed to the lack of meaning for the continuation of life and the suicidal ideation related to low self-esteem by 25.6% of the sample[16].

Imbalance instigated by not caring can act as a risk factor for suicide. From the moment that care does not occur properly, there is a tendency to precipitate new and more effective suicide attempts, which can culminate in suicide itself. This situation reinforces that, due to incomprehension and rejection around death, there is a need for specialized training in health services. The data of this research corroborate a French study carried out with young people who attempted suicide, which reveals the professional unpreparedness, as well as the feelings of anguish and impotence in the face of the suicidal act[17].

In relation to the second category, the reports that express the vulnerabilities of people with suicidal behavior revealed that, when these vulnerabilities are embraced by health professionals, users perceive themselves to be more respected and valued in their pain and, thus, more strengthened. This embracement occurs due to the professional's availability to listen and believe in the suffering of others. Such evidence was also apprehended in a Brazilian research carried out at the Clinics Hospital in the *Triângulo Mineiro* (an area in the west of the state of Minas Gerais, Brazil), which relates embracement, respect and interest in care by professionals, reflecting on the trust placed by patients in the health team and, consequently, adherence to treatment[18].

From the interaction between professionals and users, there is a greater approximation and reciprocal recognition that, unlike closed systems, makes the phenomenon of self-organization increasingly rich and vast, making users return to chat and participate more assiduously to consultations, meetings and/or any activities related to their treatment. Corroborating, an international survey on health linkage, carried out with 119 respondents, showed that 67% of the participants considered that the positive interactions between professionals and users facilitated good communication, empathy and especially the value of patient-centered care, thus favoring the feeling of confidence related to treatment and adherence to therapy[19].

Embracement and bonding are revealed as practices of a self-eco-organizing system that assembles, from complexity to complexity[11], the health care. According to the data, in this way, users feel happier, encouraged and able to envision new perspectives. In fact, international studies on embracement and interaction, involving psychiatric patients, health professionals and students, revealed that from positive interactions in health, patients showed more happiness and enthusiasm, including the encouragement to better deal with the limitations related to illness, thus contributing to the direction of new expectations regarding life[20-21].

Therefore, demotivation and hopelessness, mentioned as consequences of not caring for people with suicidal behavior, give rise to the encouragement and desire that, finally, adjusted to individuals reflective about their own existence, and able to undertake changes in their lives, they

can open up to different realities. As a consequence, activities that previously seemed impossible to be performed become achievable, awakening, in users of this research, the aspiration for work, for studies and for the continuity of life.

Positive implications, related to the improvement in self-esteem, with stimuli to better understand the illness and promote changes in the way of thinking and acting, mainly related to discrimination regarding the disease, were also observed in 40 patients diagnosed with schizophrenia, in the Psychiatric Hospital Vrapče, Zagreb, Croatia. After the care received in group psychotherapy, these patients felt more empowered and hopeful about life[22-23].

The data reveal that when users receive humanized care, they feel more integrated and motivated to care for themselves, which is expressed in the concern with the continuity of treatment. Self-care consists of conducting exams, taking care of appearance again and opening yourself up to eventual progress in the complex conception of the vibrant notion of subject, based on actions, interactions and feedback with the environment. The development of self-care after the adaptation period to the treatment, as well as the motivation for improving self-image were also highlighted in a study carried out with 33 ostomized women attended at a reference center in Rio Grande do Norte state, Brazil[24].

In the perception of the participants of this study, over time and the stimuli they receive, users start to want more information about what they feel and, based on what they learn about care, they also want to share their experiences with other people in similar situations of suffering, as in a dynamic and continuous process, in order to help lessen their pain. The desire to understand about illness, with repercussions for self-care, and the sharing of experiences in order to prevent or avoid suffering in others, was also evidenced in Brazilian research on the prevention of diabetic foot[25].

As they felt more strengthened by the care and the notion of organization that goes beyond merely biological needs, users participating in this research report that thoughts and/or suicide attempts decrease or cease. Suicidal behavior may not disappear, but with care it is possible to reduce suicidal ideation, with more resources for the person to rise, sustain themselves and move on, thus promoting important changes for the maintenance of life. Research carried out with 473 women and 207 men at a day hospital in Krakow, Poland, showed a reduction or cessation of suicidal ideation after 12 months of group and individual psychotherapeutic care, with success for 84.3% of women and 77.5 % of men[26].

From the look at the interactional processes between users and health professionals regarding the assistance provided to people with suicidal behavior within the RAPS, it was possible to explain, from the perspective of this study, phenomena that interconnect and complement each other. Non-embracement, in the eminence of suicide, intensifies introspection, demotivation and hopelessness, increasing the difficulty to expose yearnings. On the other hand, in the plurality of the embracement, availability and the bond are established, allowing the opening for the continuity of life and the reduction of the risk of suicide.

In view of the implications of the quality of care in the scope of the RAPS for the well-being of people with suicidal behavior, it is worth highlighting the fundamental role of professionals who work in healthcare spaces. Thus, there is an urgent need for management that focuses on the implementation of practices based on integrality, on the protagonism of users and on the promotion of care in the RAPS[27], with a view to the challenge of complex thinking, which refuses to simplify the phenomena in the human ways of doing.

Although this research presents as a limitation, not establishing a cause-effect relationship with regard to the implications of quality of care in the RAPS, given the nature of the research and the multi-causality of suicidal behavior, it provides subsidies for raising the awareness of managers and professionals, contributing to the reflection on suicide prevention strategies within the scope of psychosocial care. Besides, it warns of the need for health management committed to embracement and caring for people at risk of suicide.

CONCLUSION

The implications of the assistance provided to people with suicidal behavior within the RAPS, from the perspective of users and health professionals, present negative and positive aspects inherent to the complexity of the relationships and interactions between individuals. Thus, when users do not feel embraced in the RAPS, they feel introspective, demotivated and hopeless, which makes them more closed in on themselves, making them, consequently, expose less or nothing about their desires and expectations, as a result of a reductionist view of the world that is often presented by attitudes of health professionals.

Moreover, one witnesses the negligence and disrespectful behaviors practiced by professionals who should be available for care, thus reinforcing the feeling of discouragement, the lack of reasons to continue life and, with this, more vulnerabilities to suicide, especially considering that such users already present psychological suffering evidenced by suicidal behavior.

This research also showed that in situations of embracement, availability, interested listening and consequent connection between professionals and users, there is a feeling of appreciation and improvement of self-esteem. From this, people with suicidal behavior open up to the infinite possibilities of complex systems, feel more empowered, protected and happy, believe that they are able to think about new ways and meanings for life, awaken to care for themselves and others, to the point of reducing thoughts of death and/or suicide attempts.

From this perspective, it is possible to understand the importance of well-prepared and qualified professionals to embrace and care for people at risk of suicide. For this, it is essential to direct actions that instigate, within the services that integrate the RAPS, ethical care practices, respectful and sensitive to the pain of others.

RESUMO

Objetivo: Compreender as implicações da assistência prestada às pessoas com comportamento suicida no âmbito da Rede de Atenção Psicossocial, na perspectiva de usuários e profissionais de saúde. **Método:** Pesquisa qualitativa, sob o referencial teórico do pensamento complexo e metodológico na Grounded Theory. Foram realizadas entrevistas, no período de maio a dezembro de 2017, com usuários assistidos por comportamento suicida e com profissionais de saúde em cenários da atenção psicossocial. Utilizou-se a técnica de análise comparativa dos dados. **Resultados:** Participaram 18 usuários e 15 profissionais de saúde. O não acolhimento intensifica a introspecção, desmotivação e desesperança nos usuários, aumentando a dificuldade de exporem seus anseios. Em situações de acolhimento, disponibilidade e vinculação com os profissionais, os mesmos sentem-se mais abertos, a ponto de darem novos sentidos à vida e reduzirem os pensamentos de morte. **Conclusão:** Foram identificadas fragilidades e potencialidades no atendimento prestado por profissionais de saúde aos usuários com comportamento suicida, no âmbito da Rede de Atenção Psicossocial. Ressalta-se a necessidade de uma gestão comprometida com a qualidade da assistência em face do risco de suicídio.

DESCRITORES

Suicídio; Tentativa de Suicídio; Comportamento Autodestrutivo; Enfermagem Psiquiátrica; Sistemas de Apoio Psicossocial; Assistência à Saúde Mental.

RESUMEN

Objetivo: Comprender las implicaciones de la asistencia brindada a las personas con conducta suicida dentro del alcance de la Red de Atención Psicosocial, desde la perspectiva de los usuarios y profesionales de la salud. **Método:** Investigación cualitativa, bajo el marco teórico del pensamiento complejo y metodológico en la Grounded Theory. Se realizaron entrevistas, de mayo a diciembre de 2017, com usuarios asistidos por conducta suicida y con profesionales de la salud en entornos de atención psicosocial. Se utilizó la técnica de análisis de datos comparativos. **Resultados:** Participaron 18 usuarios y 15 profesionales de La salud. La no recepción intensifica la introspección, la desmotivación y la desesperanza de los usuarios, lo que aumenta la dificultad de exponer sus deseos. En situaciones de recepción, la disponibilidad y la vinculación con profesionales, se sienten más abiertos, hasta el punto de dar nuevos significados a la vida y reducir los pensamientos de muerte. **Conclusión:** Se notaron debilidades y potencialidades en la atención brindada por profesionales de la salud a usuarios con conducta suicida, dentro del alcance de la Red de Atención Psicosocial. Destaca la necesidad de una gestión comprometida con la calidad de la atención ante el riesgo de suicidio.

DESCRIPTORES

Suicidio; Intento de Sucidio; Conducta Autodestructiva; Enfermería Psiquiátrica; Sistemas de Apoyo Psicosocial; Atención a la Salud Mental.

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