ABSTRACT

Objective: to describe the elements of social representations of members of the health team in the care of individuals who attempted suicide. Method: field research, qualitative and descriptive, which uses the Social Representation Theory as a theoretical and methodological reference. The implementation of socioeconomic questionnaire and semi-structured interview for data collection were used, the analysis was done by the software ALCESTE 4.5. The study protocol was approved by the ethics committee of the Hospital das Clínicas, Federal University of Goiás (approval protocol no. 099/08) and Emergency Hospital of Goiás (approval protocol no. 029/08). Results: four main themes were found: Attitudes observed and experienced, position regarding suicide, Rethinking the care and Theoretical and conceptual aspects. Conclusions: there was no testimony in regards to the ethical aspects of care, which reinforces the negative representations of the group, since the disapproval of the suicidal conduct can allow / accept unethical professional behavior and contrary to the principles of the Unified Health System. It is identified the need for the insertion of trained, qualified professionals to deal with the topic, as well as including throughout the training of these workers spaces for discussion of topics like Death and Dying. Descriptors: suicide attempt; social psychology; health personnel.

RESUMEN

Objetivo: describir los elementos acerca de las representaciones sociales de los miembros del equipo de salud en la atención de personas que han intentado suicidarse. Método: investigación de campo, cualitativa y descriptiva, que utiliza la Teoría de las Representaciones Sociales como referencial teórico y metodológico. Se utilizó la aplicación de cuestionario socio-económico y la entrevista semi-estructurada para la recolección de datos; el análisis fue hecho por el software Alceste 4.5. El protocolo fue aprobado por los comités de ética de la Hospital de Clínicas, Universidad Federal de Goiás (aprobación del protocolo no. 099/08) y el Hospital de Urgencias de Goiás (aprobación del protocolo no. 029/08). Resultados: se encontraron cuatro temas principales: Actitudes observado y experimentalizado, La postura en contra del suicidio, Repensar la atención e Aspectos conceptuales y teóricos. Conclusiones: no hubo testimonio en cuanto a los aspectos éticos de los cuidados, lo que refuerza las representaciones negativas del grupo, ya que no aprueban el suicidio conducta puede permitir o aceptar una conducta profesional ética y contraria a los principios del Sistema Único de Salud es identificado la necesidad de la inserción de profesionales capacitados, calificados para tratar el tema e incluir toda la formación de estos trabajadores espacios para la discusión de temas como la muerte y los moribundos. Descriptores: intento de suicidio; psicología social; personal de salud.
INTRODUCTION

There are people that cannot overcome disillusions and everyday obstacles and thus cannot achieve their objectives and individual achievements. In many cases in which the sense of existence is lost, these people develop the suicidal behavior, trying to find a radical way of solving everyday problems. Thus, the suicidal or self-destructive behavior may be one of these negative effects.

[...] It is called suicide, every case of death that is resulted direct or indirectly from a positive or negative act made by the own victim, which the victim knew this would be the result. The suicide attempt is the act, defined this way, stopped before death happens.¹ ²

In general, the suicide and its attempts cause impact, especially, in the family environment. The self-destructive actions are seen by the society as a prejudice, like a prohibited and shameful subject. Nowadays, it is associated to craziness and it is less discussed inside the houses and/or health and teaching institutions.³

There is an environmental and genetic predisposition of some families and/or groups to develop self-destructive conducts. So, risk factors (low socioeconomic and educational level, unemployment, gender inadequacy, family breakdown) and also the predisposal conditions (abuse of alcohol, drugs, social isolation and psychic disorders) are of great relevance in the studies of this behavior.⁴

Despite the suicide is present throughout history as a real and increasing practice, only in 2000 the World Health Organization (WHO) begins to consider it as a public health problem.⁵,⁶ In this sense, the developed countries see the suicide as a priority to be faced. This is justified because this situatin is among the ten main causes of death in general population, and the third among individuals in the 15-35 group age, which increases its incidence in the young population.⁷

In Brazil, this process was even slower, since the Health Ministry took preventive measures five years later. These measures were to advise the health professionals that the care of these people is more effective in a preventive environment.⁸ In general, it is among the countries with low rates of suicide cases, with a variation between 3.9 and 4.5 for every 100 thousand inhabitants per year between 1994 and 2004. However, as Brazil has continental proportions, both in territory and population, it is among the ten countries with the highest number of suicides.⁹

The WHO associates suicide and/or the suicidal act to mental disorders, physical diseases and social and demographic factors. Thus, the interventions in cases of suicide attempts can take many forms. These go from simple conversation with the person that intends to commit suicide, until the coercive intervention for the impediment of the suicidal act. However, the different forms of intervention are not so clear in the first visit.⁹

In the study about the assistance to suicidal patients in a psychiatric clinic in Ribeirão Preto-SP, most of the patients arrived too aggressive. Because of this, they were sedated and then restrained in the beds. Regarding the professionals that assisted these patients, because of personal difficulties, they treated the patients with prejudice and contempt.⁹⁰

During the professional formation, the courses prepare people to save lives at risk, by voluntary reasons. Traditionally, when subjects like death and suicide are mentioned, they are only correlated to the clinical perspective. Thus, there may be a gap among the professional positions in the face of determined cases, for besides technical knowledge, other concepts are required regarding the phenomenon.

In the hospital environment there are situations of intentional death in a way more or less painful, so these professionals provide or not the proper care to those patients and their families. Also, this place is the location of production, reproduction and dissemination of the representations of professionals, including the suicide attempts.⁹ Therefore, the existent fragilities in the formation courses lead these professionals to not provide care, in most cases, considering the cultural, religious, personal aspects, etc. The emotions and feelings experienced by this professional in the moment of the assistance to the patients may be varied, nevertheless, this must not influence in the assistance. This must be based on the Code of Ethics that rules their profession when they see any patient.

Thus, questions have been made during the assistance/care of suicidal patients, which favors the restlessness of the theme: what are the social representations of the health professionals regarding the care of people who attempted suicide? For different reasons it is important to reflect deeply about the subjects that somehow may raise expressions of a blatant disrespect. It stands out, in particular, the possibility of its minimization, perhaps elimination, by means of healthy,
academic and scientific discussion, consequently expanding range and the perspective of these professionals, encouraging new concepts, values and behavior involved in this assistance. The knowledge of the representations built in the group is configured as fundamental for the access and discussion of reality beyond the numbers, since most of the existent works mention the epidemiological view of the subject, both in the regional and national ambit.

Therefore, this study aims to describe elements of the social representations of members of the health staff about the assistance to an individual who attempted suicide.

**METHOD**

This is a descriptive and exploratory study, with a qualitative approach and theoretical reference of the Social Representations (SR). The SR as a product reveal a content that circulate and portray the truth of reality, as a process, and refer to psychological and social mechanisms that subsidize the formation, organization and transformation of the content. In other words, they are systems that interpret and rule the relations of the subjects with the world and the others, orientate and organize the behavior and the social communications.

Workers from the health care voluntarily participated in this study. Specifically doctors, nurses or nursing technicians, all public servants with one year or more in the profession, some located in a unit of emergency or a clinic of the Hospital School of Federal institution, while others in a state hospital in emergencies and urgency, in units identified as resuscitation I intermediate clinic I. To everyone it was guaranteed the precepts of the Resolution 196/96.

After the approval of the Ethics Committee in Research of the aforementioned fields (Hospital School Protocol of approval No. 099/08 and Hospital of Urgency Protocol of approval No. 029/08) happened the selection of the subjects. The data collection was made by means of semistructured interview, which was recorded in MP3 with later full transcription and being available for the subjects to read it.

The criterion used for the termination of the data collection was the saturation. The interviews were gathered into a single corpus called Initial Context Units (ICU) and submitted to the software ALCESTE (Contextual Lexical Analysis of a Set of Segments of Texts), this was used to investigate the distribution of the vocabulary in a written text. The program divides the ICU into Elementary Context Units (ECU), which are segments of texts analyzed hierarchically descending, in classes of words, from different discourses about a relevant topic.

### RESULTS

#### Socioeconomic characterization

This study was carried out with a group of twenty one health professionals, from which: eight nursing technicians, eight nurses and five doctors.

The group is formed by more than a half of the women, most of them married, and almost all of them are Christians. The average age and time in the profession is lower for the doctors (28 years old and three years in the profession), followed by nurses (35 years old and five in the profession) and then the nursing technicians (37 years old and eight years in the profession). Most of them work in units of urgency and emergency.

#### Treatment of the corpus by the ALCESTE

The analysis of the corpus by the ALCESTE showed four themes, namely: “Suicide: attitudes observed and experiences”; “The position of the Professionals in the face of suicide”; “The care of people who attempted suicide” and “The act of attempting suicide from the perspective of the professionals”. The Figure 1 shows all the themes, classes and its respective most frequent key-words.

In the THEME I, the first class named “Restlessness and attitudes about the attempt of suicide” it appears words that express moments experienced by the professionals when they observe “co-workers” in the care of people who attempted suicide.

Some excerpts identified in this class show that when these professionals encounter patients who attempted suicide they express restlessness and questions about the origin of the act, highlighting that there is another “way-out” for this type of event.

[...] I keep thinking why? They could have searched another way-out. He ended up doing this because he did not seek the family, friends, church, religion or professional assistance [...] E1; [...] He keeps thinking that he could have avoided that, why is that? We see that when there is a suicidal person, usually the family is also sick. E3
There are situations in which the suicide attempt is seen as something that represents risks for the patient’s life. In these cases, these professionals refer to this act as something without a real intention of committing suicide, thus, they do not give much value to this event. “[…] So many professionals think that the individual is kidding, acting badly, or even misbehaving. But if we really see, right from the bottom, we see that it is not like this […]”. (E9)

There is also the reference to professionals that see the arrival of this patient as something that bothers the service routine, that is, they could see sick people that directly did not want to be there: “[…] Most of the professionals face this situation as something that disturbs […] because the patient sought assistance by his own. He is here because he wants. The one that does not want is sick as well, but did not seek assistance […]”. (E11)

The interference of personal values and concepts in the care of the person that attempted suicide are explicit in the following statements:

[…] But I already witnessed various professionals who rebel. Mistreat patients saying: ah you are here occupying the spot of a person that is sick […]E33; […] The doctor asked me to pass the nasogastric tube number twenty or one thicker so I could make you vomit then I told him that the cocaine was inhaled and not ingested, therefore, the tube in the stomach was not needed, the thing was in the lung, it has already been absorbed […]. (E2)

The class II named “Suicide: how professionals deal with the situation?” focus on some of the professionals’ feelings in the face of suicide, as well as their expectations and difficulties about this problem, which are perceived in the following excerpt: “[…] Take care of these patients at risk of committing suicide is too delicate. The suicidal person has also different personalities. You do not believe that he is going to commit suicide. He threatens, blackmails […]”. (E12)

The professionals who provide care to people that attempted suicide do not comprehend the reasons or factors that led him to this initiative. However, the emotional condition of these professionals can be determinant in providing the assistance: “[…] At the first time I was a little bit scared […] Take care of these patients at risk of committing suicide is depressing. Little depressive; it affects our emotions […]”. (E5)

Still, in this class, it is notorious that the professionals recognize the existent gaps in the assistance to the people that attempted suicide. The following excerpts show the fragilities that can possibly happen in the moment of assistance, by the lack of technical and psychological preparation:

[…] It is too complicated to take care of patients at risk of committing suicide. It is very complicated! I guess we have to have a better psychological preparation. Also a better technical preparation […]E2; […] Because we do not know how to deal with this pain, which is so great. A feeling, an emotion so profound that the patient feels, very complicated, because you do not know what you will say to help […]. (E17)

In the THEME II, the Class III, named “Position of the professionals in the face of the suicide attempt”, focus on the professionals’ attitudes when they receive these patients, as well as their opinions about the suicide attempt. Such fact is fundamental for the position adopted by this professional in the moment in which they assist these patients: “[…] Normally, I have a
characteristic of warn the person. When it is the case of drawing attention of the spouse, I have already seen some men doing, women doing. Because they keep asking: ah! Is my husband outside? Is my boyfriend outside?\[E3\]

Regarding the Class VI, named “the technical care provided and the depreciation about the suicide attempt”, it focuses on the use of procedures and expressions in the daily care of people that attempted suicide, such as: inadequate and moralistic comments that are observed in some statements:

\[\ldots\] When the patient flees, sometimes, you listen a colleague, unfortunately, saying: because he does not do his duties properly.\[\ldots\] Caustic soda does not kill, if he wanted to kill himself he would have jumped in front of a truck, something like that.\[\ldots\] Why did he kill himself properly? If he wanted to kill himself he had just drunk rat poison.\[\ldots\] \[E15\]

Other professionals think that the patient should suffer in the moment of the assistance. Thus, the care/therapeutic techniques routinely employed in the assistance may not be necessary: “\[\ldots\] they taught me, it was the doctor who taught me! When he is conscious, he is supposed to be taken to the bathroom, I would adjust the bathroom and turn it on \[\ldots\]”.\[E2\]

In the THEME III, the Class IV named “The idealized care”, is observed in the statements of the interviewed subjects the ideal care of the patients with suicidal ideation, taking into account the suicide as any pathology and that they must be treated with impartiality: “\[\ldots\] I face and take care of this patient as he had another pathology, of any other diagnosis.”\[EB\]; “\[\ldots\] I think there is a difference in the treatment \[\ldots\] I see as other pathologies of the patients \[\ldots\]”.\[E13\]

In the THEME IV, the Class V named “Suicide in the view of professionals”, combines words that allude conceptual aspects about this subject, as well as explain that the admission/care of this patient is common in institutions of emergency care:

\[\ldots\] suicide is this mental discomfort that the person experiences. When he only finds the solution in death \[\ldots\] Here in our unit is common the admission... of self-destruction attempt.\[\ldots\] Suicide is the attempt of taking your own life. I already took care of many.\[\ldots\] I believe that it is something to fill the empty space inside. So suicide is the condition to fill certain spaces that are empty.\[\ldots\] Suicide is really the interruption of life. Here I already took care of many people who attempted suicide [...].\[E6\]

DISCUSSION

All participants come from units that often assist patients who attempted suicide and, therefore, they have proximity to the object of study.

In general, the THEME I evokes words that refer to the observations and experiences of the professionals, as well as some difficulties faced in daily life in the care of people who attempted suicide. Such contexts are found in the first and third person. The THEME II is composed of signs issued to refer to the position of the professionals (their own or their colleagues position) in the face of suicide. The THEME III mentions aspects of the ideal or idealized care to be dispensed by health professionals to those people that attempted suicide; all of the contexts in this theme are in the first person. Finally, the THEME IV highlights the theoretical and conceptual aspects of suicide in the professionals’ perspective.

According to the elements that form the THEME I (classes I and II), it can be inferred that when the health professionals and workers face people that attempted suicide they present questions about the contingencies that triggered the fact. Actually, these questions reveal restlessness in the search of understanding such act, which is constituted as an opposite attitude to the laws of nature, according the religious, moral and philosophical aspects.\[E14\] In a first look, it can be said that these situations provoke discomfort to the staff. However, the immersion in the context of the excerpts that are the base of the class, in most cases, considers that the self-destruction attempt is just the search for the other people’s attention, and that there is no real purpose of taking his own life, that is the reason why they have difficulties in the moment of assistance. From this perception, the care being offered does not need to be right as a whole. This is confirmed when a question of incredulity appears about the suicidal act as a concrete fact. It is as if there weren’t proper importance to this event and also disdain.

The existence of taboos and stigma toward the suicide person over the centuries continues to guide the behaviors and practices today. There is prejudice about the person who attempts suicide, shown by the contempt, aggressiveness and many times mistreating the patients in the moment of assistance. Thus, instead of establishing an adequate relationship, it is observed a
relation of conflicts.15

Critical and moralistic attitudes must be avoided, once they may influence in the care provided and that conflicts experienced in the professional exercise may cause wrong conducts and this may bring catastrophic consequences.6 Thus, it is observed that these professionals do not see these patients as people who need help. It seems that they see these patients as people who blatantly confront life with no reason or for an irrelevant issue.

The reports of the subjects in this THEME are in agreement with other authors, who say it is difficult for the professionals to deal with this circumstance, because even realizing these difficulties; they have some concerns in performing a broader monitoring.16

It can be shown from the analysis of this set of statements that the professionals find themselves without basic psychoemotional tools in order to work with such individuals. In this context, the perpetuation of unprepared attitudes refers to discrimination.

It is extremely important that these workers have dominion over the specific technical dimension, as well as ethical-political dominion, associated with the capacity of communication and social interrelations in order to improve the assistance of these people, contributing to the implementation of the plan of care and participate as subjects transforming reality.17

The THEME II (classes III and VI) refers to the position or professional conduct adopted in the face of the circumstance of care. In this aspect, the approaches continue to point out in the previous direction, making it possible to identify the presence of negative representations that embody and trigger “harsh attitudes”. According to the statements, the professionals understand that “the person who wants to commit suicide does it at once”, that is, the attempt would be “just” something premeditated to “draw attention”. There is evidence that the professionals believe that there is blackmail, intent to harm or generate blame to others. The suicide attempt thus relates in an act to impress, scare or coerce who the patient is in contact in order to give him attention.

There was no testimony regarding the ethical aspect of care. In some way, such finding reinforces the negative representations of the group, once not approving the suicidal behavior may allow/accept unethical professional behavior and contrary to the principles that govern the profession and the Unified Health System, what occurs in public institutions of reference in the state. In this sense, it is noteworthy that the Federal Constitution in force says that the actions of the public service are part of a organized network and have as one of their priorities the integrate care, with a priority for the preventive activities, without damage to health care, since: “[...] Health is everyone’s right and duty of the State, guaranteed by social and economic policies aiming the reduction of the risk of diseases and other hazards and the universal egalitarian access to actions and services for its promotion, protection and recovery”.18

When some professionals do not comprehend the problem that involves the suicide attempt, they end up distorting the therapeutic actions. Most of the subjects reported the event of techniques and behavior of care out of the ideal mold, in order to minimize the suicidal ideation of these people through their suffering. These attitudes are coercive interventions that when used after the suicide attempt serve to undo the suicidal ideation, which does not find echo in theoretical and practical aspects.6

Thus, it is imperative that these health professionals rethink the care that has been provided to the individual with this behavior. There is a gap between the received attention and the one needed, it can be in general hospitals or in services of urgency, what reveals, once more, the necessity of specific training in order to enable the proper care to the patients.16

The distorted view, especially related to the mechanisms of the origin and evolution of the suicide act shows the need of specific training for the health professionals in order to enable the adequate care of the patients.

Thinking about the origin of the term “caregivers” may There is no doubt about the necessity of a greater discussion among the professionals about the specific care to be adopted in the assistance of suicide patients. Improving the professional capacity of detecting and how to deal with these patients is a way of prevention of the suicide act.8,204

help in the process of reflection that is applied for the change of behaviors reported and performed inside the units that receive victims of self-destruction attempt. The word “care” comes from Latin “cure”, used in the context of love and friendship in order to express concern and/or unrest for the beloved person or object. In this sense, the care appears when someone’s existence is important. In other words, the individual that takes care of someone else feels involved and
connected with affection to the other person. In the health environment, the challenge for the professionals is to combine work and care, since they are mutually limited and complementary. The mistake is to oppose one dimension to the other, which seems confusing for this studied group.  

Opposing the aforementioned, the Theme III refers to the impartiality in the care of the patient who attempted suicide. According to these reports it is perceived in this context that the professionals see the patient as someone who needs help, like all the others inside the hospital, and should receive the best assistance that the staff can offer, not only regarding the general technical care, but also the specialized assistance, among them the psychological and psychiatric support.

Some professionals express the importance of staying alert to the patients’ reactions and that:

[...] The fact that the professional face the suicide act cannot impede him to investigate conflicts and desires of death, and, mainly, it should warn him not to overlook the emotional needs of his patients. The professionals need to be alert in the face of the possibility of suicide acts. 

This professional must be alert to the situations that can still bring the risk of suicide. Thus, he should also investigate the persistence of the suicidal ideation during care. It is the professional role to understand the acute state of the patient and the personal circumstances that can have guided the patient to the suicidal ideation. So, they can assist the patients friendly or impartially, what it is shown in the statements of this theme.

The WHO refers to the proper care that is based on the offer of emotional support. To this end, it recommends that the ideal action is to have someone trained in the staff to guide individuals with the suicidal ideation, and: “Focus on the feelings of ambivalence. The health professional should focus on the ambivalence felt by the individual at risk of suicide between living and dying, until gradually the desire to live is strengthened”. 

In the excerpts that characterize this THEME, it is perceived the proper behavior in the treatment of people that attempted suicide: referral to a specialized professional who can properly monitor these patients, as ratified in the scientific literature. It is part of a correct care to send these patients, when necessary, to see a specialist, mainly in cases where there is proof of a psychiatric disease, history of previous attempts, poor support, presence of physical disease, among others. 

The THEME IV focus on the professionals’ opinion and conceptual aspects about suicide. It is observed in the correspondent statements that when the professionals conceptualize this act, they move between the common sense and the scientific elements in the construction of their social representations. They see suicide or the attempt of it under different facets, like filling the empty space, request of help, lack of self-love, emotional problems, mental discomfort, as well as related to the poor socioeconomic situation. These elements are supported in the literature as risk factors. Because of this, nowadays, suicide is understood as a multidimensional disorder resulting from the interaction of environmental, social, physiological, genetic and biological factors.

Overall, the analysis of the four themes allows us to infer that the professionals present restlessness when they face the suicide attempt, and many times, they also feel a range of feelings that emerge in the moment of the assistance. Such feelings may influence in the behavior they adopt and their position ends up being in most cases, “inhumane”, “discriminatory” and “prejudiced”. Thus, they distort the therapeutic techniques in order to reduce the repeated attempts through the suffering imposed to these people.

It is shown in the reports that the professionals, in everyday practice, deal with the problem mentioned here with disgust, what is similar to the representations of the rest of social segments. Such situation imposes difficulties to the assistance of these people. In theory, they recognize these people as patients and that they must be cared with impartiality. Besides, they need specialized assistance, but they do not feel prepared to provide the proper care.

It was observed that there is a lack of preparation in this group of professionals in relation to the commitment of saving lives. In this case, it includes people that attempted suicide, since values, unethical and moral conceptions apparently outweigh the ethical care based on the scientific base.

Thus, it is necessary that during the academic formation of these professionals, there is one moment for the discussion of subjects as death/die, as well as situations of intentional death, even if the limits, conflicts and ambiguities in the professional
exercise never cease to exist. 7

FINAL CONSIDERATIONS

In general, suicide is configured as a difficult subject to be mentioned. Nowadays, this difficulty is maintained because of the religious and cultural precepts, consequently, of the solid anchorage of the representations that surround the subject.

Over the centuries, the ideas of some thinkers brought new conceptions about this problem. However, this issue is still complex and polemic and requires new approaches and ongoing discussions, mainly in the area of the professional formation.

The health professionals are prepared to save lives in the imminence of involuntary death during their academic formation. When confronted with situations of attempt/suicide they make it clear that the fragilities of the teaching system are turned into reality in the formation courses.

The SR rule the relationships of the subjects with the world and the knowledge of these representations allow the individuals to comprehend their “conceptions” through the assistential practice. So, it allows the comprehension of some elaborated elements by the group and that participate in the command of everyday actions dispensed to the people with suicide intentions, considering that the statements mentioned in the testimonials express their beliefs, ideologics and values about this problem.

The results of this study allow us to say that regardless the education level (high school or college) there is a clear lack of preparation of these professionals, considering that the moral and discriminatory attitudes seem to replace behaviors based on ethics and technical aspects.

In general, some concerns are shown by professionals in the face of the mentioned act. Many of them adopt rigid positions and dissatisfaction in the assistance of people who attempted suicide. Thus, they ended up, in some way, abstaining from the therapeutic techniques, as if this situation were the solution to minimize the suicide ideation.

Therefore, the professional behavior of the studied population is not shown itself as ideal, both in the citizen aspect and professional. The origin of such behaviors is probably inherent to the social-cultural context that was inherited.

Although some professionals know that these patients are people that need specialized help, they do not have consistent and robust ethical-scientific conceptions on the suicidal ideation, and it seems that also in the assistential practice for the adequate care. Thus, it is extremely important that actions of permanent education exist, these ones directed to the group of health workers, with the purpose of providing better conditions to face situations of intentional death attempt and consequently give ethical assistance and with a better quality.

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