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Original Article

Training and attitudes related to suicide attempts among Family Health Strategy professionals*

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Objective: to investigate, among Family Health Strategy (FHS) professionals, the association between training and attitudes related to suicidal behavior. Method: a quantitative study developed with 65 FHS team professionals from a city of Minas Gerais. Data were collected by self-application of the sociodemographic questionnaire and the Questionnaire of Attitudes to Suicidal Behavior (*Questionário de Atitudes Frente ao Comportamento Suicida*, QUACS). Descriptive statistics, association and correlation tests were used. Results: most of the participants reported no suicide training (89%) and denied reading specific material (54%). Suicide training was associated with greater self-perceived professional ability (p=0.017). More negative attitudes were associated with a lower perception of professional ability and more condemnatory attitudes. Professionals who read specific material about suicide had both higher self-perceived professional skills and less negative attitudes (p=0.023). Less condemnatory attitudes were found in people without a religion (p=0.000), who read about suicide (p=0.042), and who had contact with profession colleagues who attempted suicide (p=0.013). Conclusion: in order for the potential of the FHS in risk detection, suicide prevention, and the treatment to be translated into effective actions, it is important to invest in training resources for the health professionals that make up these services.

Descriptors: Suicide Attempt; Attitude; Health Care; Primary Health Care.

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Formação e atitudes relacionadas às tentativas de suicídio entre profissionais de Estratégias de Saúde da Família

Objetivo: investigar, entre profissionais da Estratégia Saúde da Família, associação entre a formação e as atitudes relacionadas ao comportamento suicida. Método: estudo quantitativo desenvolvido com 65 profissionais de equipes de ESF de um município de Minas Gerais. Os dados foram coletados por autoaplicação de questionário sociodemográfico e do Questionário de Atitudes Frente ao Comportamento Suicida (QUACS). Utilizada estatística descritiva, testes de associação e correlação. Resultados: a maioria dos participantes declarou-se sem treinamento sobre suicídio (89%) e negou ter lido material específico (54%). Treinamento sobre suicídio esteve associado à maior capacidade profissional autopercebida (p=0,017). Atitudes mais negativas estiveram associadas à menor percepção de capacidade profissional e a atitudes mais condenatórias. Profissionais que leram material específico sobre suicídio tiveram tanto maior capacidade profissional autopercebida (p=0,023) quanto atitudes menos negativas (p=0,042). Atitudes menos condenatórias foram encontradas em pessoas sem religião (p=0,000), que leram sobre o suicídio (p=0,042), e tiveram contato com colegas de profissão que tentaram suicídio (p=0,013). Conclusão: para que o potencial da ESF na detecção de riscos, prevenção e tratamento do suicídio se traduza em ações eficazes, é importante investir em recursos de formação aos profissionais de saúde que compõem tais serviços.

Descritores: Tentativa de Suicídio; Atitude; Assistência à Saúde; Atenção Primária à Saúde.

Capacitación y actitudes relacionadas con intentos de suicidio entre los profesionales del programa Estrategia de Salud Familiar

Objetivo: investigar, entre los profesionales de la Estrategia de Salud Familiar, la asociación entre la capacitación y las actitudes relacionadas con el comportamiento suicida. Método: estudio cuantitativo desarrollado con 65 profesionales del equipo de ESF de una ciudad de Minas Gerais. Los datos fueron recolectados por autoaplicación del cuestionario sociodemográfico y el Cuestionario de Actitudes ante el Comportamiento Suicida (QUACS). Se utilizaron estadísticas descriptivas, pruebas de asociación y correlación. Resultados: la mayoría de los participantes informaron no haber recibido capacitación sobre suicidio (89%)y negaron haber leído material específico (53%). El entrenamiento suicida se asoció con una mayor capacidad profesional autopercibida (p=0,017). Más actitudes negativas se asociaron con una menor percepción de la capacidad profesional y más actitudes condenatorias. Los profesionales que leyeron material específico sobre el suicidio presentaron más habilidades profesionales autopercibidas y actitudes menos negativas (p=0,023). Se encontraron actitudes menos condenatorias en personas sin religión (p=0,000), que leyeron sobre el suicidio (p=0,042) y tuvieron contacto con colegas profesionales que intentaron suicidarse (p=0,013). Conclusión: para que el potencial de la ESF en la detección de riesgos, la prevención y tratamiento del suicidio se traduzca en acciones efectivas, es importante invertir en recursos de capacitación para los profesionales de la salud que integran estos servicios.

Descriptores: Intento de Suicidio; Actitude; Cuidado de La Salud; Atención Primaria de Salud.

Introduction

Suicidal behavior represents an important health problem and can manifest through thoughts of self-destruction, self-aggression, suicide attempts and, eventually, committing suicide[1].

For the World Health Organization (WHO), in the world it is estimated that one death due to suicide occurs every forty seconds, and an attempt every three seconds, approximately[1]. Suicide causes the loss of potential years of life and also important emotional and economic impairments to the subjects and health services[2]. The WHO recommends that suicide prevention be a priority in programs, agendas, and public policies[1].

Primary health care is not in a privileged position for tracking the prevention of suicide risk. A study in Australia showed that approximately 90% of the individuals who died due to suicide had contact with a health professional in the three months prior to their death[3].

The assistance to the individual with suicidal behavior is essential to save lives and can be influenced by multiple factors among which are attitudes related to suicidal behavior, beliefs, cultural factors, religion, professional background, and ability to evaluate the risk, planning, and implementation of care measures[3-5].

Knowledge about the training and attitudes of the health professionals in relation to suicidal behavior is essential, as it indicates the true team willingness to care for people at risk[6-7]. In Brazil, there are few studies that assess the attitudes and the suicide attempt or suicidal behavior of health professionals, mainly identifying studies involving students and nursing professionals[7-11]. Some studies have been showing that negative attitudes related to suicidal behavior are associated with the unpreparedness of professionals and can reinforce stigma and discrimination, as well as impair the care provided to individuals at risk of suicide[12-17].

The literature points out the need for research studies about the attitudes, meanings, experiences, and beliefs related to suicidal behavior in different contexts[4,18]. There is a lack of studies on primary health care teams, which could provide a better comprehension of the preparedness and willingness of these professionals to act in the prevention of suicide, potentialities, limitations, and demands in training. This knowledge can offer subsidies for planning academic training strategies and also of psychosocial support for the students, contributing to the improvement of the qualification for providing care. Thus, this study investigated, among the Family Health Strategy professionals, the association between training and the attitudes related to suicidal behavior, differing from other studies on the theme, as it was carried out with professionals that make up Primary Health Care.

Method

This is a quantitative study conducted with 65 professionals and 6 teams of the Family Health Strategy from the municipal health network in a city of the state of Minas Gerais. All the professionals (physicians, nurses, nursing technicians, oral health assistant, dentist, and community health agents) who were included in the staff registry of the Family Health Strategy teams in the municipality were eligible to participate in the study, considering a minimum period of 3 months working in this service. Two professionals were excluded from the study because they worked in the services under study for less than 3 months.

The researcher went to the units on days and times previously booked with the nurse responsible for the services. At this moment, the team would already be assembled so that the objectives of the study and the guidelines on completing the instruments to be applied could be explained. It was made clear to the professionals that their participation would be voluntary, anonymous and that, in case they wanted to withdraw from the study at any time, this would be possible without any kind of detriment to them. All the professionals who were invited accepted to participate and signed the Free and Informed Consent Form to validate their participation.

Data collection occurred between 2016 and 2018 and took place by the application of a sociodemographic questionnaire, as well as of the Questionnaire of Attitudes to Suicidal Behavior (*Questionário de Atitudes frente ao Comportamento Suicida*, QUACS)[10]. The questionnaires were self-applied in the health units of each team, with dates and times previously booked. The researcher was present during the time for filling in the questionnaires.

The QUACS is a Brazilian instrument with 21 statements on attitudes. Each statement is followed by a 10 centimeter (cm) (10 points) analogic visual scale that ranges from "I totally disagree" at one end, to "I totally agree" at the other. The participants are invited to indicate a point on each line that best represents their attitudes. The score was computed in centimeters and the values were transferred to the database with one decimal place. The instrument allows for the analysis of items alone and also in three factors. Factor 1, "negative feeling when facing the patient", includes questionnaire items 5, 13, and 15 (higher scores indicate more negative feelings). In Factor 2, "perception of professional ability", the values obtained in items 1, 10, and item 12 with a negative value (higher scores indicate greater self-perceived professional ability) are added up. Factor 3, "right to suicide", is obtained by adding up items 3, 6, and 16, with the two last items being considered with inverse values (and higher scores indicate a less condemnatory attitude)[10].

Two Sociodemographic Questionnaires were developed; one of them aimed at the professionals with higher or technical education, and the other for the community health agents (CHAs). The questionnaires had information on age, gender (female/male), professional practice (physician, nurse, dentist, nursing technician/assistant, oral health assistant), background (Technical/Professional, Incomplete Higher Education, Complete Higher Education, Specialization/Internship, Master's degree, PhD), training or professional experience directly related to mental health (yes or no), working time in the profession (complete years), working time in the institution (complete years), contact with an individual who attempted suicide (yes or no), and if the respondent has already read specific material on suicide (yes or no).

Descriptive statistics were used to present the socio-demographic and educational variables, as well as those related to the attitudes towards suicidal behavior. Then, the *Kolmogorov-Smirnova* and *Shapiro-Wilk* normality tests were applied to direct the option for parametric or non-parametric tests. Comparison of means tests were used (T-test and Mann-Whitney's test) to assess associations between the categorical variables and the values obtained in the QUACS factors. Pearson's correlation test was used to assess the correlations between the quantitative variables and the scores from the QUACS factors. Spearman's correlation was used to assess the non-parametric variables (age and Q 21). The minimum alpha value considered was $p<0.05$ in all the tests.

The study followed the recommendations on research with human beings and was submitted to and approved by the Ethics and Research Committee of the Ribeirão Preto School of Nursing, with approval and regulation number CAAE: 56529816.0.0000.5393.

Results

In this study, data obtained by means of two questionnaires applied to the participants were analyzed for surveying sociodemographic data, one for the health professionals and the other for the community health agents.

The study was conducted with 65 FHS professionals, 29 (45%) were health professionals: nurses (8%), physicians (20%), nursing technicians and assistants (11%), and other categories (6%). Considering the time of professional experience, 23% of them have 8 months or less of professional experience; 30% have 1-5 years of experience; 27% have 6-15 years of experience and 20% have 16-30 years of experience. There were 36 (55%) Community Health Agents participating in the study, with a varied time of experience. The majority (61%) had 2-10 years; 11%, 11-13 years; and 28%, less than 01 year of experience. There was predominance of females (86%), aged 20-59 (95%), with a religion (92%), and having had contact with someone who attempted suicide (78%). Most of the professionals stated having no previous training on suicide prevention (89%) or reading about the topic (54%), denied suicide cases in their families (81%) or contact with profession colleagues who attempted suicide (81%).

Table 1 presents the associations between sociodemographic characteristics, experience, and professionals training of the participants, as well as the attitudes related to suicidal behavior, assessed by the Questionnaire of Attitudes to Suicidal Behavior (QUACS). In Factor 1, which indicates more negative attitudes in relation to suicide, women had higher scores ($p=0.044$), and also the professionals who did not read specific material on suicide ($p=0.001$), who have a religion ($p=0.010$), and who had no contact with profession colleagues who attempted suicide ($p=0.001$) (Table 1).

Factor 2 indicates greater perception of professional ability, and higher scores were obtained by professionals who received training on suicide ($p=0.017$), had contact with a person who attempted suicide ($p=0.013$), read specific material on suicide ($p=0.023$), and had contact with profession colleagues who attempted suicide ($p=0.013$) (Table 1).

Factor 3 refers to less condemnatory attitudes in relation to suicide, with higher scores obtained by the professionals who have read specific material on suicide ($p=0.042$), did not have a religion ($p=0.000$), and had contact with profession colleagues who attempted suicide ($p=0.001$) (Table 1).

In relation to Question 21 of the questionnaire (QUACS), which assesses suicidal thoughts, the test results did not show a statistically significant association between Question 21 and the study's categorical variables.

According to the data presented in Table 2, a weak negative correlation ($r=-0.159$) is observed between Factor 1 and Factor 2 of the QUACS, which means that the greater the perception of professional ability, the lesser the negative feelings regarding patients with suicidal behavior. The same is observed between Factor 1 and Factor 3 of the QUACS ($r=-0.447$) and ($p=0.00$); the more negative feelings, the lower the perception of the right to suicide. Between Factor 1 and Question 21 of the QUACS, there was also a weak negative correlation ($r=-0.045$), indicating that the professionals who have already thought of killing themselves had fewer negative feelings towards people with suicidal behavior. A weak negative correlation ($r=-0.197$) was also observed between age and Factor 3, representing that the older the person, the lower the perception of the right to suicide.

Table 1 - Sociodemographic characteristics, experience, and professional training of the study participants according to the factors of the Questionnaire of Attitudes to Suicidal Behavior (QUACS) (n=65). Borda da Mata, MG, Brazil, 2016-2018

Variables	Factor 1 – Negative feelings			Factor 2 – Professional ability			Factor 3 – Right to suicide		
	M*	SD†	p‡	M*	SD†	p‡	M*	SD†	p‡
Gender									
Female	12.9	6.3	**0.04**§	13.6	5.4	0.763‖	7.8	6.3	0.47‖
Male	8.3	3.9		14.2	8.3		14.4	9.4	
Training on suicide									
Yes	12.1	8.9	0.958§	18.5	5.7	**0.017**‖	12.3	8.9	0.189‖
No	12.2	5.9		13.0	5.5		8.2	6.8	
Contact with a person who attempted suicide									
Yes	12.0	6.6	0.631§	14.5	5.4	**0.013**‖	9.4	7.3	0.110‖
No	12.9	4.5		10.3	5.7		6.1	5.9	
Reading of specific material									
Yes	9.6	5.0	**0.001**§	15.4	6.0	**0.023**‖	10.8	7.8	**0.042**‖
No	14.5	6.2		12.1	5.1		6.8	5.9	
Religion									
Yes	12.8	6.0	**0.01**§	13.3	5.6	0.126‖	7.6	6.2	**0.000**‖
No	5.4	3.9		17.4	6.8		20.8	5.3	
Suicide case in the family									
Yes	12.8	4.5	0.714§	12.4	9.0	0.419‖	8.8	8.5	0.780‖
No	12.1	6.5		13.9	4.8		8.6	6.8	
Profession colleague who attempted suicide									
Yes	6.9	3.9	**0.001**§	17.3	5.8	**0.013**‖	15.3	7.3	**0.001**‖
No	13.4	6.0		12.8	5.4		7.1	6.1	

*M = Mean; †SD = Standard Deviation; ‡p = p-value; §T-test; ‖Mann-Whitney's U test

Table 2 - Correlation test of the QUACS factors and the scores obtained in Question 21 of the QUACS with the participants' age (n=63). 2016-2018. Borda da Mata, MG, Brazil, 2016-2018

Variables	Factor 1 – Negative feelings	Factor 2 – Professional ability	Factor 3 – Right to suicide
	p*(r)†	p*(r)†	p*(r)†
Factor 1 – Negative feelings	(1)		
Factor 2 – Professional ability	0.204* (-0.159)§	1	
Factor 3 – Right to suicide	0.000* (-0.447)§	0.15* (0.299)§	1
Q21 – Suicidal thoughts	0.721* (-0.045)§	0.073* (0.224)§	0.005* (0.346)‖
Age	0.012* (0.316)§	0.373* (0.114)§	0.121* (-0.197)‖

*p = p-value; †r = Correlation Value; §Pearson's Correlation Coefficient; ‖Spearman's Correlation Coefficient

Discussion

In this study, associations between attitudes were investigated, which were related to suicidal behavior and to sociodemographic characteristics. Most of the interviewees were women, and this characteristic was associated with more negative attitudes. In the literature, a variety of results related to attitudes towards suicidal behavior and sociodemographic factors is found, considering studies with students and professionals in their practice. Studies that identified women with less moralist attitudes[19], other studies did not identify any difference in gender-related attitudes[14,20], and also studies that found more moralist attitudes in women[8-9]. This question is heterogeneous in the literature and needs to be further studied.

Older individuals had more condemnatory attitudes in relation to suicidal behavior. The literature presents heterogeneous results on the relationship between age and the attitude towards suicidal behavior[12,14,17]. In this

study, most of professionals claimed to have a religion, and having religion was a characteristic associated with more negative and condemnatory attitudes. The literature presents heterogeneous results regarding religion and attitudes towards suicidal behavior[7,10].

In this study, most of the participants reported not receiving any training on suicide prevention and never having read specific material on the subject matter, although having had contact with someone who attempted suicide. Educational exposure related to the theme does not seem to be a specificity of primary care, as corroborated by a Brazilian study conducted with nursing students[9] and was also identified among professionals of the Brazilian emergency services[8]. On the other hand, a Spanish study identified that most of the nurses had training on the prevention of suicidal behavior[19]. The literature points out the need for investigating the factors linked to the low educational exposure on suicidal behavior in Brazil[8], considering the relevance of the subject matter in the world scene and the difference in the professionals' training on the theme in different contexts.

Various studies have demonstrated that the lack of preparedness and training of the professionals is linked to negative attitudes[5,12,19-20] while professional training is associated with positive attitudes in relation to suicidal behavior[8-9] and provides clarity and confidence in relation to the role of the professional in the care provided[20].

In the present study, training on suicide was associated with a greater perception of one's own ability for care. This result corroborates with a Brazilian study that found that different types of training (subject, lecture, or laboratory) were associated with the perception of the professional competence[9].

Reading specific material about suicide was associated both with a greater perception of professional ability and with less negative attitudes. It was identified that the more negative attitudes towards suicidal behavior were associated with a lower perception of professional ability and more condemnatory attitudes, demonstrating that the attitudes measured by the QUACS instrument were integrated to each other.

The promotion of positive, empathetic, and safe attitudes among the professionals is important because, although there is evidence on positive attitudes of the health professionals in relation to the individual with suicidal behavior[21], most of the studies evidence a predominance of negative attitudes that affect the care provided to individuals at risk of suicide[12,21].

In this study, most of the professionals reported having had contact with someone who attempted suicide, but denied suicide cases in their families or suicidal behavior among profession colleagues. Having contact with individuals with suicidal behavior was associated with a greater perception of the professional ability, as already identified in a Brazilian research study[8].

It is also highlighted that, in this study, contact with profession colleagues who attempted suicide was associated with less condemnatory attitudes as well as with a greater perception of the professional ability. It is possible that having contact with a person with suicidal behavior can provide opportunities for learning, reflection, and redefinition of one's own ability for care. A comprehensive and empathetic attitude is an important factor in the prevention of suicide[19,22-23] that needs to be approached to in the training of health professionals[24].

Conclusion

This study investigated, among FHS professionals, the association between training and the attitudes related to suicidal behavior and identified that, despite low educational exposure to suicide, most of the participants had contact with someone who attempted suicide. The training on suicide was associated with greater self-perceived professional ability.

The most negative attitudes towards suicidal behavior were associated with a lower perception of professional ability and with more condemnatory attitudes. The professionals who read specific material about suicide had both greater self-perceived professional ability and less negative attitudes.

As for the associations of attitudes and experiences with sociodemographic characteristics, the least condemnatory attitudes were found in people without a religion who had contact with profession colleagues who attempted suicide. Older individuals had more condemnatory attitudes in relation to suicidal behavior. Women and individuals with fewer suicidal thoughts throughout their lives had more negative attitudes.

This study allowed deepening on the knowledge about attitudes of the primary care professionals on suicidal behavior and found that the attitudes are associated with personal characteristics and professional training. In this way, it is important to develop and assess continuing education actions that can promote better attitudes.

The main limitations of this study were the use of a reduced convenience sample belonging to a single city and its cross-sectional design. It is recommended that future analyses investigate the questions addressed in this study in different contexts. However, this research significantly contributes to a better understanding of the attitudes and meanings related to suicidal behavior among professionals who work in Primary Health Care.

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Author's Contribution

Study concept and design: Aline Siqueira de Almeida and Kelly Graziani Giacchero Vedana. Obtaining data: Aline Siqueira de Almeida. Data analysis and interpretation: Aline Siqueira de Almeida and Kelly Graziani Giacchero Vedana. Statistical analysis: Aline Siqueira de Almeida and Kelly Graziani Giacchero Vedana. Drafting the manuscript: Aline Siqueira de Almeida and Kelly Graziani Giacchero Vedana. Critical review of the manuscript as to its relevant intellectual content: Aline Siqueira de Almeida.

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