How to cite this article: Santos, M. J. S., Medeiros, E. M. (2019). Prevention of suicide: psychology's contributions to public health. *Journal of Psychology, Diversity and Health, 8*(3), 388-401. doi: 10.17267/2317-3394rpds.v8i3.2357

Theoretical essays

Prevention of suicide: psychology's contributions to public health

Prevenção do suicídio: contribuições da psicologia no âmbito da saúde pública

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RESUMO | Este artigo revisou as contribuições da atuação do psicólogo na prevenção do comportamento suicida no âmbito da saúde pública. Trata-se de uma pesquisa qualitativa de revisão de literatura que utilizou a combinação dos descritores: "Prevenção do Suicídio, comportamento suicida, epidemiologia do suicídio, fatores de risco para o suicídio, fatores de proteção, atuação do psicólogo e saúde pública", nas bases de dados: Scientific Eletronic Library Online (SciELO) e na Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS). Foram selecionadas 26 publicações que atendem ao critério de inclusão. Discutiu-se as contribuições da atuação do psicólogo na saúde pública e suas funções no contexto do SUS. Perceberam-se os desafios da atuação da equipe de saúde diante da demanda do suicídio. Não foi encontrado no levantamento das publicações nenhuma pesquisa que tratasse da atuação exclusiva do psicólogo na prevenção do suicídio. Concluiu-se que existe a necessidade de se realizarem estudos empíricos documentando os benefícios da atuação do psicólogo na prevenção do suicídio no âmbito da saúde pública para incrementar o progresso das políticas públicas de saúde.

PALAVRAS-CHAVE: Psicologia da saúde. Suicídio. Prevenção.

ABSTRACT | This article reviews the contributions of the psychologist's role in preventing suicidal behavior in the public health context. It is a qualitative research of systematic literature review, which using the combination of the descriptors: "Suicide prevention, suicide behavior, suicide epidemiology, suicide risk factors, protection factors, psychologist performance. The following databases were consulted: Scientific Online Library in Electronic Health (SciELO) and Health Sciences Literature of Latin America and the Caribbean (LILACS). We selected 26 publications that met the inclusion criteria. The contributions of the psychologist's role in public health and their functions in the context of the SUS were discussed. The challenges of the health team's performance in the face of suicide demand were perceived. No research was found in the survey of the publications that dealt with the psychologist's exclusive role in suicide prevention. It was concluded that there is a need to conduct empirical studies documenting the benefits of the psychologist's role in preventing public health suicide to increase the progress of public health policies.

KEYWORDS: Psychology of health. Suicide. Prevention.

Submitted 05/07/2019, Accepted 11/01/2019, Published 11/07/2019
J. Psycho. Divers. Health, Salvador, 2019 November;8(3):388-401
Doi: 10.17267/2317-3394rpds.v8i3.2357 | ISSN: 2317-3394

Introduction

This article aimed to review the contributions of the psychologist's role in preventing suicidal behavior in public health. The motivation for the development of this theme came from the observation made in 2013 by the Federal Council of Psychology (CFP) that there is a lack of publications that address the importance of the work of psychology professionals in the prevention of suicide (Federal Council of Psychology, 2013). This is a matter of concern as we live in a context of increasing suicide cases both nationally and worldwide (Bachmann, 2018; Bertolote & Fleischmann, 2015; Freitas et al., 2013; Júnior, 2015; Machado & Santos , 2015; Marín-León, Oliveira, & Botega, 2012; Silva, Prates, Cardoso, & Rosas, 2018; Teti et al., 2014) .

According to the World Health Organization (WHO), suicide is responsible annually for about one million deaths and is considered a serious public health problem, as it has contributed more than 2% to the global burden of disease by the year 2020. However, this figure does not consider the impact that suicide has on the lives of individuals, families and society (Bachmann, 2018; World Health Organization, 2012; Pan–American Health Organization, 2016).

Thus, the accomplishment of this work is relevant because it brings up a serious public health problem that articulates in multiple dimensions of the subject that demands from the Public Health Policies the planning and the development of actions that assure the support to the life of the users. Public health network is plausible, as it allows a critical reflection on the actual situation of suicide cases among the Brazilian population. It contributes by presenting the main interventions that psychologists develops in public health regarding suicidal behavior. Thus, in order to fulfill the proposed objective a search of articles and academic works that address pertinent issues was carried out through literature review (Appolinário, 2009; Galvão & Pereira, 2014; Koller, Couto & Hohendorff, 2014).

Epidemiological characteristics of suicide

Suicide has become a hotly debated topic, prompting the Federal Council of Psychology to launch in 2013 a book entitled "Suicide and the Challenges for Psychology", which was born through various dialogues on the subject where in one of these discussions the historicity of the term was explained by demonstrating that the term suicide arose around the 12th century. Previously which there were ways to report the act. But it was through St. Augustine that suicide came to have a reprehensible meaning. And in the Middle Ages suicide was understood as a crime since it damaged the business of the Crown. Already at the end of the Middle Ages the division between the Crown and the Church occurred, thus opening a space for the mastery of medical knowledge which had an important influence on society. Thus, the doctors began to untie the voluntary death of sin and calling it madness (Federal Council of Psychology, 2013).

However, in the literature there are some authors who sought to study suicide and among them is the French sociologist Émile Durkheim, who published his work entitled "Le Suicide", stating that suicide is every act of death committed by the subject himself. The suicide attempt was defined as a deliberate action, but stopped before it causes death. Durkheim presents in his book suicide as a purely social phenomenon, not an individual one, emphasizing that it is a disease of the time where he emphasizes the great influence that society has on the subjects, even when it comes to personal order, that is, the decision. To stay alive or choose one's own death (Durkheim, 2014).

In addition, the same author in his writings classifies that there are three types of suicide according to the level of social integration of the subject. Namely, the selfish, the altruistic, and the anomic. The first type being selfish suicide in which the individual is not deeply connected to a social group, having as factors depression, melancholy and the feeling of moral helplessness that is attributed by separation

from the group. The second type is altruistic suicide, where the subject sacrifices himself for the benefit of the group, being understood as an obligation and if not obeyed the subject is penalized for dishonor and religious punishment. And finally, the third type is called anomic and occurs in individuals living in a society in crisis where rules do not exist or are no longer important (Durkheim, 2014).

The term suicidal behavior encompasses both suicide attempt, suicidal ideation without attempts, the risk of suicide, the planning, and consummation of the act. That is, the suicidal behavior are characterized as a difficult process, as it may differ from the idea of removing one's life which may be notified by verbal and non-verbal means to design the action, the trial and the act of execution (Federal Council of Psychology, 2013; Kohlrausch, 2012; Pan–American Health Organization, 2016).

Regarding epidemiological characteristics, the age groups with the lowest suicide rates are in individuals under 15 years old. And the highest rates are found among subjects over 70, in both sexes, in virtually every region of the world. Thus, a study by Wasserman, Cheng and Jiang (2008) on youth suicide rates, with data from 90 countries, evaluated the rate among 7.4/100,000 young people aged between 15-19. Where presented the highest rates in countries such as: Sri Lanka (46.5/100 thousand), Lithuania (23.9/100 thousand) and Russia (23.6/100 thousand). In Brazil, the ratio was 4.2/100 thousand, being considered the Low Cost worldwide, occupying the 71th position. Higher percentages were also found among young males (10.5/100 thousand) than females (4.1/100 thousand) (Júnior, 2015; Waiselfisz, 2014; Wasserman, Cheng & Jiang, 2008).

In 2012, the World Health Organization (WHO) analyzed the global suicide numbers were 11.4 deaths per 100,000 inhabitants. In which the largest percentage are located in Eastern Europe and the lowest in Latin America and in Western Europe. While United States and Oceania have intermediate rates. Since the data of African countries are not trusted it prevents the exact figures of the charges. Thus, in total numbers, the countries with the highest suicide deaths are India, China, United States, Russia, Japan, South Korea, Pakistan and Brazil. However, the countries that stand out of suicide rates are Guyana, South Korea, North Korea, Sirilanka, Lithuania, Suriname, Mozambique and Nepal. Soon, the number of countries such as China, India and Brazil, although they have high occurrence rates, expose low percentage of suicides. But Guyana, with less than one million residents, shows the world's highest rate with 44.0/100,000 inhabitants (Júnior, 2015; Waiselfisz, 2014).

Thus, in a search to ascertain the suicide numbers in Brazil from 1980 to 2012 it revealed that the sum per year increased from 3,896 cases to 10,321, an increase of 62.5%. It was also observed in the study that between the years 2002 to 2012 there was an addition of 33.6%, higher than the increase in number of homicides (2.1%), of deaths from vehicle accidents (24.5%), and the increase in Brazil's population in the same period (Waiselfis, 2014).

According to the same author, the distribution of suicide rates in relation to sex in Brazil follows the world trend, where the men practice more suicide than women. Therefore, it is more common among the men, and the attempting to take the own life is more frequent among women. Thus, the suicide rate among the men have a tendency to rise, while among women decreases. Also between 1980 and 2012 there was a growth in suicide deaths in all age groups, except among young women. However, the largest increase was among young men, going from 5.7 in 1980 to 8.9 in 2012, an increase of 54.1%.

Although the indices have grown in Brazil, there are variations between regions. The highest index is in the South, with 9.8/100 thousand inhabitants and in the Midwest, with 7.6/100 thousand, followed by the Southeast with 5.6, the North with 5.3 and the

Northeast with 5,2. Although the South and Midwest regions had the highest rates between 2000 and 2012, suicide deaths have been decreasing in these two regions, but there has been an increase in the rates of the others. And between 2002 to 2012, in the North, deaths from suicide rose 37.2%, going from 3.8 to 5.3/100,000 inhabitants. The Northeast had the largest increase in the index in the last 13 years, growth of 72.4%, going from 3.0 in 2000 to 5.2/100,000 inhabitants in 2012. In the Southeast, the suicide deaths grew 34.8%, going from 4.2 in 2000 to 5.6 in 2011. And in the Midwest was the largest national fall of 2000 to 2011, more than 13% and 2011 to 2012 decreased by 1.8% (Machado & Santos, 2015).

Similarly, the research by Waiselfisz (2014) shows which Brazilian states have the highest suicide death rates and lowest in 2012. Thus, Rio Grande do Sul points to the index of 10.9; Santa Catarina with 8.6; Mato Grosso do Sul with 8.4 and Roraima with 8.1. These States led the highest rates in the country. However, the units of the federation with the lowest rates are Rio de Janeiro with 2.9, Amapá with 3.0 and Pará 3,1. The research also shows the suicide numbers in the Northeast states in 2012, where Piauí presented the rate of 7.4 and Ceará 5.9 per 100 thousand inhabitants. These are the highest rates of suicide deaths, above the national average. And Rio Grande do Norte had the rate of 5.3 deaths per 100 thousand inhabitants, followed by the state of Sergipe with 5.1 per 100 thousand inhabitants. Paraíba is in fifth place, with a rate of 4.9 suicides per 100 thousand inhabitants and the state of Pernambuco with an index of 3.8 per 100 thousand inhabitants. Thus, Maranhão is the lowest rate with 3.1 per 100 thousand inhabitants, followed by Bahia and Alagoas, both with 3.4 per 100 thousand inhabitants (Waiselfisz, 2014).

Regarding the methods used for suicide, some research indicates that in high-income countries the main means for the act are hanging, employed in 50% of cases, and the use of firearms with 18%. In rural areas and in low and middle-income countries, pesticides use stands out, as it accounts for 30% of suicide occurrences in the world. And the most used methods in Brazil are hanging, firearm injury and pesticide self-poisoning, accounting for around 80% of occurrences (Machado & Santos, 2015).

However, even with the repercussion about the high rate of cases, it is worth noting that these numbers do not accurately expose reality, since suicide rates are even higher than those revealed. That's because they're underreported (Trigueiro, 2015).

Major risk and protective factors for suicide

According to the literature by Carvalho et al. (2013), risk factors are contexts, life facts, pathologies or personality traits that are able to intensify the chances of someone attempting suicide or committing suicide. Also according to the same authors, knowledge of risk and protective factors is indispensable in a suicide prevention strategy, considering that, helps to identify the nature and type of an appropriate intervention, being suggestive of the context in which the subject is vulnerable to the act.

Thus, when a succession of negative factors is located there is a greater possibility of suicidal behaviors. It also facilitates assessing the overall level of suicide risk for a person and contributes to the progress of treatment programs that address the various factors involved, which can be identified and altered.

Carvalho et al. (2013) point out that there is no single factor risk or protection to cause or prevent suicidal behavior, considering that not all the factors are equally important in terms of prevention. Against that, it needs to be assessed together and placed in the context of the subject and it's historicity. So many are the factors that influence suicidal behavior, and one factor is not satisfactory to clarify it. Generally, several factors add to it and thus increase the vulnerability of the subject to present suicidal behavior. So it is able to be associated with multiple factors such as psychologicals, economics, socials and culturals.

Regarding the possible risks, studies reveal some sociodemographic factors, such as men, age groups between 15 and 35 years, or over 75 years old, extreme economic situations, very rich or very poor people, urban dwellers, unemployed, especially those who recently lost employment, retirees, atheists, single or divorced, and migrants. And the socio-cultural factors such as social withdrawal, lack of social support, the prejudice related to the behavior of seeking help. As well as barriers to access to health

services - particularly mental health and treatment of substance use, cultural and religious beliefs in relation to suicide, and the act as a dignified exit of an individual conflict. Such as the influence of other suicidal behaviors, including those linked by the media. Finally, the situational factors such as the methods available to practice, troubled family background - such as physical abuse or sexual, and family neglect. As well as a history of this family attitude or mental disorder (World Health Organization, 2012; Carvalho et al., 2013).

However, in another research conducted at the University Hospital of Santa Catarina, they sought to identify the influence of diseases on suicidal behavior, which evaluated the ideation of patients hospitalized in different specialties such as gastroenterology, medical clinic, cardiology, pneumology, hematology, neurology and endocrinology. The results showed a prevalence of 7.2% suicidal ideation, which is higher in the general population (Stefanello & Furlanetto, 2012). Thus, physical disease can intensify the risk, especially if it is related to functional deficits, body image deformation, chronic pain, being dependent on other people. The most risky diseases are chronic obstructive pulmonary, oncologic and neurological diseases (World Health Organization, 2012; Carvalho et al., 2013).

In addition, among the causes of risk is the previous attempt of suicide which is the most relevant risk factor. Whereas patients who have previously attempted suicide are five to six times more likely to try again. Thus, it appears that 50% of those who committed suicide already had tried before (Federal Council of Medicine, 2014; Ferreira, 2014; Trigueiro, 2015).

Psychological aspects are also risk factors for suicidal behavior, which includes the psychic state in which the subject shows intolerable emotional pain and agony for not being able to relieve the suffering for which he is experiencing. Impulsiveness and aggressiveness are risk factors, especially among adolescents and young people (World Health Organization, 2012; Federal Council of Medicine, 2014).

Still, the vulnerabilities of personality such as the ability to conduct psychological pain, the personality traits and skills to solve problems using the internal and external resources are important factors that could appease or increase the risk of suicide. Personality traits regularly related to risk are helplessness, hostility, rigidity, perfectionism and dependence. Thus, the high levels of hopelessness with or without depression are connected to a high risk factor (Carvalho et al., 2013).

Also the presence of mental disorder is a risk cause that is more closely linked to suicide, regardless of age group, having as the main ones: mood disorders (depression and bipolar disorder), alcohol and other substance dependence, schizophrenia and disorders of personality as borderline (Miranda, 2014).

Just as there are risk factors for suicide there is also the protection. Where the protectives are equivalent to the individual and collective characteristics and socio-cultural contexts, and when present or strengthened, are linked to the prevention of suicidal behavior. Thus, the individual protective factors are: the ability to solve problems and conflicts, willingness to ask for help, design of personal value, be opened to new knowledge, developed communicative resources, dedication to life projects. And family issues, such as good family life, help from family, bonds of trust. Finally, the social issues: being employed, opportunity to make use of health services, the cultural values, and belong to a religion (World Health Organization, 2012; Federal Council of Medicine, 2014; Junior, 2015).

In addition, some issues such as security in general, proper nutrition, adequate rest periods, emotional relationships, be included in the community, have a fixed partner and still dependent children may contribute to the stabilization of physical and mental health as well as decrease the effects of risk factors or mental disorders (Ferreira, 2014).

Most occurrences of self-harm are handled in some type of health service, which provides assistance to patients who attempt suicide. However, the appropriate health facility for the initial care is the general hospital of emergency, as offers technical support and staff prepared to assist people at risk of death (Gondim, 2015). Knowing that pesticide and drug intake are regularly used in suicide attempts, the demand for these units is high. Thus, these patients arrive referred by various places, such as Emergency Care Units (UPA), Health Centers, the Mobile Emergency Care Service (SAMU), firefighters or spontaneous search of the population (MacChiaverni, Borges & Oliveira, 2013).

In addition, the emergency is a healthcare facility that has some features such as high turnover of patients and the short stay in the service of users, requiring from the psychology's professional to play a psychotherapeutic care brief and focal. Thus, the hospital emergency unit plays a key role in suicide prevention, as it is usually the first health service that the subject or family seeks after the suicide attempt. In this space, the interventions starts in order to reduce the suffering of the patient, but later, these interventions should be continued in another health services (Ferreira & Gabarra, 2014; Gonçalves, Silva, & Ferreira, 2015; Gondim, Pan–American Health Organization, 2016).

Thus, when the patient receives assistance in the health services after the attempt, the risk assessment should take place from the first moment and during his or her hospital stay. This first contact with the service user is a great opportunity for professionals to check the risk level and to intervene to reduce it. Thus, the therapeutic relationship is a relevant instrument to increase adherence and achieve significant results in welcoming. For developing a good relationship with the patient can generate a great impression on the quality of care offered and helps prevent further attempts (Vidal & Gontijo, 2013).

However, according to Gonçalves, Silva and Ferreira (2015), Gondim (2015), Vidal & Gontijo (2013) and Zana and Kovács (2013) , the team does not always know how to take advantage of this opportunity, either due to the particularities of the service or the lack of adequate training to treat suicidal patients. This unpreparedness of professionals can lead to inappropriate positions and conduct, compromising the therapeutic process. This can manifest difficulties when dealing with the topic within the health team and in contact with the patient himself or his family. This conduct undermines the professional practice, where it can be related to incompetence to assist the patient in his suffering.

However, the psychologists being part of each sector of the hospital offers assistance to the patient, providing guidance and monitoring to family members and staff. It's main function is to evaluate and conduct psychological complications of users who are being monitored at the hospital. Thus, in emergencies, it is usual to experience difficulties in assisting users of the service. In general, staff do not provide adequate attention to patients, as they often do not consider attempting suicide as an expression of a mental disorder that can lead to death. Where it is customary for health professionals , in the face of suicidal behavior, to constitute their judgment based on their own convictions, and may be intolerant, indifferent and give lessons of courage or religiosity. And rarely does the healthcare professional seek to hear the patient or make an effort to know without judgment what led to the suicide attempt (Gondim, 2015).

According to the same author, psychologists to be part of the mental health team appears as the main agent of transformation in these events, since he has worked in the welcome, listening, care, guidance and referral to units of the mental health network. Thus, the function of psychologists also includes interventions by the health team, helping in the relationship between the team and the family. Also in this environment, this professional acts from the first moment the patient arrives at the unit, or after the necessary initial procedures. However, when in the emergency arrives a patient who is unable to have an initial reception, though he is in serious condition, the professional first begins the activities welcoming the family until the patient is able to be treated. And after discharge, the psychologist is in charge of referral or transfer to the referral service for suicide attempts. Thus, becoming the reference professional for both comprehensive care and for the patient during the hospitalization.

In this sense, according to the same author, the psychology professional facing suicidal behavior should analyze the patient's level of suffering checking if he has a desire to live. Just as when listening to the subject, it can help him see other ways in he's own life. And, in the context of welcoming and accompaniment, it should provide a space for the patient to talk about his anguish, sadness and pain, and offering him a judgmentless listening. As well as creating a non-suicide contract, this happens when the subject needs a support point and the professional-patient

bond has already being formed. And, lastly, expand family care and support networks that the patient is inserted into. From this perspective, we will cover another study focused on the development of a psychological registering patients service instrument for attempted suicide at the Hospital of the Federal University of Santa Catarina. The authors point out that it is important to understand the registering instrument, as well as the technical information, because the patient's suffering should be welcomed, offering a listening to what is verbalized. And should also be point out with the patient what gives the desire to live. Offering him hope to keep he's desire to stay alive (MacChiaverni, Borges & Oliveira, 2013).

Moreover, within the public health beyond the hospital setting, the psychologists also acts in the prevention of suicide in Psychosocial Care Centers (CAPS), which according to the Brazilian Association of Psychiatry, are secondary services of the Unified Health System and shall ensure that all subject after a suicide attempt are assisted in the 1st seventy-two hours after the attempt to, at least for one psychiatrist (PBL, 2014). Thus, the CAPS are characterized as the main mental health devices and constitute various types as the CAPS I, II and III which are for severe and persistent mental disorders. Yet the CAPS AD II and III are intended for the treatment of subjects with disorders arising from the use of alcohol and other drugs and the CAPS I for children and adolescents with severe mental disorders (Wood, 2014).

In a study with the purpose of presenting the performance of the professionals of a CAPS in front of users with suicide attempt and risk, the welcoming was characterized as an instrument that favors humanized care and also the interdisciplinary work performed by professionals. Where the importance of work among the doctor, nurse, psychologists and social worker was highlighted, having teamwork as a framework to respond to occurrences of suicide risk in the community. Thus, in the research, the professionals cited an element of fundamental relevance, which is the formation or rescue of the bond, with the patient and his family, in these crisis circumstances (Heck et al., 2012).

Thus, according to the ideas of the same authors, care needs to be efficient, dialogical and conscious, in order to intervene and offer assistance in a humane and empathic manner towards the subject who presents suicidal behavior. In this respect, the family is characterized as an ally to help professionals understand what induced the subject to attempt suicide and to overcome the occasions of psychological distress. Thus, family approximation of the suffering subject also collaborates to demystify some beliefs formed by the patient, as if death would extinguish all existing difficulties and conflicts. So when these motivations are heard is more likely to prevent suicidal behavior, considering that, often the family seeks assistance in community health devices.

Also after hospitalization, the family can cooperate to prevent suicidal behaviors. Where health professionals can perform interventions, such as guiding the family to organize the patient's routine to prevent access to utensils that may be used to commit suicide. Also, seek to hear this familiar about its concerns, including how to deal with the person who committed self-harm. Other interventions such as individual or psychotherapeutic care group are strategies used by professionals to help these individuals who are affected by the suicidal act, since family conflicts can turn the context into a sicker situation (Figueiredo, 2012; Oliveira et al. , 2016) .

In short, according to the authors cited above, the intervention of health professionals need not be performed exclusively at the hospital. Because networking needs to be continually stimulated for communication to occur between the various health devices, such as the hospital, basic health units, CAPS, among others. Thus, being able to eliminate with the fragmented work, operating at the same time on the prevention and promotion factors in mental health (Gonçalves, Silva, & Ferreira, 2015; Gondim, 2015; Pan–American Health Organization, 2016 ; Zana & Kovács, 2013).

Method

This work is a qualitative research that justifies itself, for the qualitative analysis makes possible the researcher's performance in professional practice and search, decomposing the subjectivity of the phenomena in the investigation process, raising data that support the evidence of the research for the objectives proposed by the research (Campos, 2008).

Thus, a literature review was perform, which is a method that maximizes the potential of a search, finding the largest possible number of results in an organized manner making a critical analysis of publications, aiming to systematize, compose and judge important research about a delimited theme (Galvão & Pereira, 2014; Koller, Couto & Hohendorff, 2014).

Also conducting a documentary research, which is justified because the concept of documents covers a wider range of publications that contain recorded information that form a unit, providing support that can serve for consultation, study or proof (Appolinário, 2009).

Methodological procedures

For this research, it was determined the search question that guided the study: What are the contributions of the performance of the psychologists in the prevention of suicidal behavior in the context of public health?

The DeCS / MeSH system and the Virtual Health Library in Psychology (BVS–Psi Brazil) defined the descriptors: "Suicide Prevention, Suicidal Behavior, Suicide Epidemiology, Suicide Risk Factors, Suicide Protection Factors, Psychologists and public health".

Inclusion criteria were: books; essay; documents were limited to suicide prevention booklets; Masters dissertation; Doctoral thesis; original and review articles published in the period from 2012 to 2018, written in Portuguese, which deals with the objective of this study, which is to review the contributions of the psychologist's role in preventing suicidal behavior in public health.

Studies were excluded, that do not take into account the contributions of the psychologist's role in preventing suicidal behavior in the public health context; studies that contain little conceptual analysis of the objects of this research; studies that deviate from the issue addressed; repeating published articles and studies with publication date prior to the year 2012.

Later, in search of scientific publications in English, we have consulted the electronic databases: Scientific Electronic Library Online (SciELO) and the Latin American and Caribbean Health Sciences (LILACS) using a combination of descriptors already mentioned. Data collection was performed from February 2017 to March 2018.

Thirty results were found, however, after going through a preliminary reading of their abstracts in order to verify the efficiency and viability of the material collected for further analysis and discussion of the materials found. And also being submitted to the inclusion and exclusion criteria were selected 26 documents that meet the established methodological criteria. Then the texts were read, so that an updated reflection on the proposed theme could be made.

The present study was limited to conducting a bibliographic-documental review research on the contributions of the psychologist's action in the prevention of suicidal behavior in public health, because of our structural, temporal and financial limitations, the specific limitations have already been stated in the inclusion and exclusion criteria item.

Discussion of results

It is evident that there is a variation in suicide rates in relation to age, gender and geographic regions. Where Brazil follows the world trend, suicide is more commonly practiced by men and suicide attempts are more frequent among women. Thus, we learn that this index can be assigned because the men employ more lethal methods to commit suicide, are more impulsive and look less help for psychological

problems. As well as having a higher rate of alcohol and drug abuse linked to depression and the obligation attributed by society to be the maintainer of the house (Carvalho et al., 2013, Ferreira, 2014).

As for geographical variations, Brazil presented from 2000 to 2012 the highest suicide numbers at the South and the largest percentage increased was in the Northeast. Where, in 2012, the states of Piauí and Ceará had the highest rates, above the national average (Waiselfisz, 2014; Machado & Santos, 2015).

However, research showed that the group with the lowest suicide rates were individuals under 15 years old. The age groups most at risk of suicide are people in their late teens and early adulthood, and after their 70s. Thus, it is clear that the high rate of suicide among the elderly may be due to social isolation, ease ways of obtaining medicine and grief. The higher rate in late adolescence may be due to mental disorders, such as depression that begins in this period (Waiselfisz, 2014; Ferreira, 2014). As well as impulsivity and aggressiveness are characterized as risk factors, especially among adolescents and young people (World Health Organization, 2012; Federal Council of Medicine, 2014).

It is emphasized in the literature that suicide occurs due to a series of factors and pathologies, and mental disorder is a risk cause that is more closely linked, regardless of age group, having as main: mood disorders (depression and bipolar disorder), alcohol and other substance dependence, schizophrenia and personality disorders, such as borderline (Miranda, 2014; Júnior, 2015). However, among the main risk factors there is the previous attempt of suicide, which is the most relevant risk factor. Since, in the continuous attempt, more lethal and more severe methods are generally employed (Ferreira, 2014; Federal Council of Medicine, 2014; Trigueiro, 2015).

Thus, it was realized that there is not a single risk or protective factor that causes or prevents suicidal behavior, since not all factors are equally relevant in preventive conditions. Therefore they need to be evaluated together and inserted in the context of the subject and his historicity. Thus, one can not define a factor for suicide but triggers, which under some circumstances can stimulate suicidal behavior (Carvalho et al., 2013). Studies show that, during adolescence, suicide is a complex and multifactorial phenomenon, encompassing biological, psychological, sociodemographic and cultural factors (Braga & Dell'Aglio, 2013). Regarding protective factors, the studies present the individual, collective and sociocultural characteristics and circumstances that, when present and reinforced, are linked to the prevention of suicidal behaviors (World Health Organization, 2012; Pan–American Health Organization, 2016; Federal Council of Medicine, 2014).

Actuation of psychologists on public health and its functions in the context of SUS

In addition, the research revealed that the public institutions responsible for treating people with suicide attempts are: the General Hospitals of Emergencies and the Centers for Psychosocial Care (CAPS). Where the professionals of the General Hospitals and the CAPS have a fundamental role in the prevention of suicide, since it can usually be the first health device that the subject or family seeks after the attempt of the act (Ferreira; Gabarra, 2014; Gondim, 2015; Oliveira et al., 2016).

However, it was identified that many professionals of the public health network are unprepared to receive patients who present suicidal behavior. And this unpreparedness can lead to inappropriate positions and conduct, compromising the therapeutic process. However, it can be verified that such difficulties may be due to the emergency of the hospital being a space of tension and stress. Also for the high demand of the service, lack of professional training and shortcomings of the system or even by not knowing how to manage time in the emergency, leading the professionals to act impersonally. (Gonçalves, Silva & Ferreira, 2015; Vidal & Gontijo, 2013).

However, it is important to note that these difficulties of professionals in not knowing how to work with people who attempted suicide may be due to the gap in the training of these professionals on the subject. For the lack of knowledge was exposed by most research, where professionals reported not having

received academic or hospital training to deal with suicidal behavior. In addition, poor training can be related to incompetence to assist the patient in his suffering (Vidal & Gontijo, 2013; Oliveira et al., 2016).

Thus, it is important to point out that suicide can be pointed out as a taboo where many have no interest in discussing about the topic. Even with the countless consequences caused by the high rate of occurrences, the theme needs to be debated, because without knowledge the population does not perceive it as a problem. However, suicide rates have not been sufficient to change this scenario. It is necessary to break this paradigm, since it will not be possible to decrease the statistical data without information (Trigueiro, 2015). Thus, there is the importance of this issue be discussed within the universities, since it is complex and brings devastating consequences on the lives of those who exposes the suicidal behavior (Pan–American Health Organization, 2016; Vidal & Gontijo, 2013).

From this, some authors ask some questions about the real situation of suicidal behavior, as well as the work processes and the relations with the Higher Education Institutions. Which claim that the fact of suicide be a public health problem, the universities would need to discuss more about this topic. But also should not miss training for these professionals act appropriately on these cases because the suicidal acts are characterized as a reality in hospitals (Oliveira et al., 2016).

The scientific productions present that the psychologist is the main agent of transformation in the occurrences of suicide. For the professional's performance involves welcoming, listening, care, guidance and referral to the devices of the mental health network (Federal Council of Psychology, 2013; Gonçalves, Silva, & Ferreira, 2015; Gondim, 2015; Zana & Kovács, 2013). Thus, the psychology's professional actuation before the suicidal behavior also includes interventions by the health team, in order to facilitate the relationship between the team and the family, and promote health education with the health team (Gondim, 2015; MacChiaverni, Borges & Oliveira, 2013; Pan–American Health Organization, 2016).

Thus, the work of psychologists consists mainly on analyzing the level of the patient suffering, making sure that he has the desire to live. Just as when listening to the subject, it can help him see other ways in his own life. And provide a space for the patient to talk about their anxieties, offering him a listening without judgment. As well as creating a non-suicide contract, this is when the subject needs a support point and the bond between professional and patient is already formed. And it should also expand care for the family and support networks that the patient is inserted (MacChiaverni, Borges & Oliveira, 2013).

Challenges of acting in the health team facing the suicide demand

Another relevant aspect presented in the research is the psychologist's work with the patient's family. Where health professionals can perform interventions, such as guiding the family to organize the patient's routine to prevent access to utensils that may be used to commit suicide. Also, seek to hear this family member about their concerns. They may even be able to perform psychotherapeutic care to help these subjects who are affected by the suicidal act (Figueiredo, 2012; Oliveira et al., 2016).

Concerning the performance of CAPS in the prevention of suicide, welcoming was evidenced as an instrument that favors humanized care and also the interdisciplinary work performed by professionals. Where teamwork was identified as a framework for responding to occurrences of suicide risk in the community. Another aspect mentioned in the research was the relevance of formation or rescue of the bond, with the patient and its family, in these crisis circumstances (Heck et al., 2012). As well as the family approach of the suffering subject collaborates to demystify some beliefs formed by the patient (Oliveira et al., 2016).

An important point to be debated is that the growing challenge facing the suicide problem that health professionals face is also a consequence of factors such as the deficiency in professional training, since most academic centers do not have disciplines in their curriculum regarding the professional's role in the prevention of suicide. Also, there is an absence

of public health educational policies that would favor the continuing education of professionals. Thus, this problem is reflected in the daily work of health professionals and has as one of its consequences the psychiatric hospitalization as the only way of referral perceived by professionals, due to the lack of knowledge about the patient's demand for suicidal behavior, difficulty in clinical management and insecurity on the part of the professionals who make up the health team in the care practice of this type of demand (Gonçalves, Silva, & Ferreira, 2015).

Therefore, research is unanimous in stating that the patient with suicidal behavior needs assistance that meets more than their physical demands. It is important that in these occasions of crisis the patient is heard and welcomed. Thus, it is essential that, before going home, the patient is evaluated and referred to other devices that will be able to follow up the mental health treatment. For networking needs to be continuously stimulated to occur integration between the various services of health, as the hospital, basic units of health, CAPS, among others (MacChiaverni, Borges & Oliveira, 2013; Ferreira & Gabarra, 2014; Oliveira et al. , 2016).

Final considerations

Whereas the study aimed to review the possible psychological interventions for prevention of suicidal behavior in public health, it was found that this research could achieve these goals. In the first moment it was possible to know the epidemiological profile of suicide in Brazil and in the world, which presented a variation of suicide rates in relation to age, sex and geographic regions. Where Brazil follows the global trend, where the men practice more suicide than women. As well as the group that poses the highest risk of suicide are the people who are in their late teens and early adulthood, and the oldest.

As for the main risk factors for suicide, it has been shown to occur due to various factors and pathologies, with mental disorder being the most closely linked factor, regardless of age group. It was also highlighted the previous attempt of suicide as one of the main risk factors. Thus, it was evidenced that one can not define a factor for suicide but triggers, which in some circumstances can stimulate suicidal behavior.

To the research of scientific production, it was observed that the dominant themes were the psychologists acting on public health and its functions in the context of SUS, as in CAPS and General Hospitals. And, above all, the criticism of the authors about the performance of the health team when dealing with suicidal patients. In which it was evidenced that this occurs because of the gap in the formation of these professionals regarding the theme of suicide. The lack of knowledge on the subject was described by much of the research, which the professionals have described as not having received an institutional training to deal with the behavior of self-harm.

Thus, the researched literature confirms that the attempts to take one's own life have grown considerably in Brazil and worldwide. It is essential to conduct discussions about strategies to overcome this problem. For the unpreparedness of the health team in not knowing how to work in the face of suicidal behavior is verified by the lack of discussions on the subject in academic circles. Thus, this is reflecting on the performance of these professionals. Thus, the psychologists should be considered as professional reference both in comprehensive care to the patient and hospital. The performance of psychologists is of fundamental importance in the care of individuals who attempt suicide, but what worries is the fact that psychologists did not received training because their education is deficient in relation to the theme, as in other courses from the health area.

As a result of this study, highlights the importance of conducting more research in relation to the performance of psychologists at the Centers for Psychosocial Care (CAPS), which shows the characteristics of the working procedure, care about the prevention of suicide, as well as the role played by the professional within this service. Where this deficiency was found in this research. For it was not found at publications no research that dealt with the exclusive action of the psychologists in suicide

prevention. Therefore, it is recommended that this practice might be accompanied by an empirical study to document the beneficial impact on the quality of life of patients with suicidal behavior, resulting from the work of public health psychologists. Thus, future works will contribute to the dissemination and understanding of the various care strategies in the face of self-harm and suicide behavior, and increase the progress of public health policies.

Finally, it is hoped that this review will stimulate future researches using other scientific research techniques and methods that further explore the seriousness of this public health problem. That requires public health policies, the planning and development of actions that ensure the support to the lives of users of the public health network (Benevides, 2005). And document the empirical evidence of the contributions of the psychologist's role in preventing suicidal behavior in the public health context.

Author contributions

Santos, M. J. S. participated in the conception, design, search and analysis of researched data, interpretation of results, and writing of the scientific article. Medeiros, E. M. participated in the research data collection, data interpretation and writing of the scientific article.

Competing interests

No financial, legal or political conflict involving third parties (government, companies and private foundations, etc.) has been declared by any aspect of the work submitted (including but not limited to grants and funding, advisory board membership, study design, manuscript preparation, statistical analysis, etc.).

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