PSP
PSYCHOLOGICAL
FIRST AID

PSYCHOLOGICAL FIRST AID :
A GUIDE TO APPROACH USERS WITH SUICIDE ATTEMPT IN GENERAL HOSPITALS

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A GUIDE TO APPROACH USERS WITH SUICIDE ATTEMPT IN GENERAL HOSPITALS

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Index

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PRESENTATION

This manual was developed as a teaching product in the Professional Master's Program in Teaching in Health and Environmental Sciences of the Centro Universitário de Volta Redonda – UniFOA. Composed of textual material and videos in QR Code format to address the theme of suicide, it was designed as a tool for Continuing Education in Health, with a view to contributing to the qualification of care for users with a suicide attempt in general hospitals.

The proposal is to disseminate concepts and information about suicidal behavior, present possible care strategies and, in this way, enable reflection on the work process, favoring the construction of individual and collective knowledge and practices in health.

PSP

PSYCHOLOGICAL FIRST AID

List of Acronyms

CAPS	Psychosocial Care Center
CVV	Life Valuation Center
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
OMS	World Health Organization
PSP	Psychological First Aid
SAMU	Mobile Emergency Care Service

PSP

PSYCHOLOGICAL FIRST AID

Introduction

The General Hospital is one of the main devices for health care and, among the demands for care, there are those related to suicidal behavior. As a serious public health problem, suicide affects populations around the world, reaching more than 800,000 deaths per year. However, a portion of these deaths can be avoided through an integrated effort between different sectors of society and the correct use of prevention strategies.

The hospital entrance doors, the so-called Emergency Care, are extremely important for the prevention of suicide, as it is there that these people are taken to obtain primary care, in addition to being places to seek help for the suicidal behaviors. A suicide attempt must always be taken seriously and acting appropriately at this time is one of the main prevention strategies, as a previous attempt is the biggest risk factor for suicide.

Often, the handling of emotional demands related to suicidal behavior is referred to psychologists and psychiatrists. However, suicide prevention is everyone's responsibility. Although these professionals have specific knowledge for this type of care, there are strategies that can be used by other health professionals. Knowing them can contribute to a humanized care that is more adequate to the needs of these users, which go beyond the physical demands, enabling the reduction of self-inflicted deaths.

With thas in mind, this manual was designed for professionals who work in general hospitals, especially at urgent and emergency entrances, with the aim of broadening the understanding of the phenomenon of suicide and contributing to the construction of more effective approaches.

1

Suicide as a serious public health problem: **RELEVANT FACTS**

The World Health Organization (2018) published in its news-sheet alarming data on suicidal behavior:

- More than 800 thousand people take their own lives every year in the world, which is equivalent to more than 3000 deaths a day and one suicide each 40 seconds.

- The number of attempts exceeds between 10 to 20 times the number of suicides.

- In general, men commit more suicide than women, but among them, the number of suicide attempts is higher.

- It is estimated that about 90% of individuals who commit suicide have some mental disorder.

- The most used methods of suicide refer to ingesting pesticides, hanging and firearms.

- Suicide is the second leading cause of death in the world among young people aged between 15 and 29 years, however, the incidence among people over 70 years is even higher.

- Suicide is a phenomenon that occurs in all regions of the world, however 79% of suicides occurred in low- and middle-income countries.

This information demonstrates the seriousness and severity that involves the phenomenon of suicide, pointing to the need to act on it.

Reflection

As a starting point, initial reflections on the phenomenon of suicide are proposed:

1

Do you know anyone who has tried or thought about suicide?

2

Have you ever met someone with this demand in your work?

3

Is this reality part of your daily work?

Note that, in some way, the phenomenon of suicide can approach your reality, being essential to understand it so that you can support people under this condition.

2 SUICIDAL BEHAVIOR

Suicide can be considered the worst of human tragedies, because it represents the peak of unbearable suffering for those who commit it, but it also means shocking and excruciating and endless questioning for those who remain (BERTOLOTE, 2012).

Since the most remote antiquity, there are reports of events in which human beings opted for their own death. The way of treating and understanding this phenomenon has changed, acquiring different meanings and values, according to the peculiarities of each historical moment. However, this “choice” was never perceived in an ordinary way, being accepted and acclaimed, in few circumstances, and reprehensible, in most cases (MINOIS, 2018).

Etymologically, the term suicide derives from Latin and means “death of oneself” (sui-self / caedare – action of killing). But it is considered suicide only the death in which the individual performs an act, consciously and intentionally, using a way that he believes will determine his death (WHO, 1998). Thus, there are other attitudes that refer to the desire or act by which a person purposely seeks to harm himself, which are suicidal behaviors, and include everything from suicidal ideation, threats, gestures, suicide attempts, to the completed suicide (BERTOLOTE et al., 2015).

Despite different definitions and theories on the subject, running through biological, psychological, social and philosophical currents, suicide still figures as an enigma and there is no universal explanation to understand it (MINAYO, 1998).

Regardless of the point of view from which it is analyzed, the central dimension is related to the suffering that this act causes, whether in the individual who externalizes the extreme of their pain, in family coping and in the social consequences that such act causes.

3 DEFINITIONS

It is normal, at some point in life, when faced with a difficulty, to think about solving a certain situation by dying. But when this becomes frequent and the person starts to consider it seriously, ideas of death, of being dead or of committing suicide arise, which are characterized as SUICIDAL IDEATION (BARRERO, 1999).

In addition to thoughts of death, speeches may appear that demonstrate the intention to commit the suicidal act, configuring the **SUICIDAL THREATS**. However, if the person starts to make a plan, considering when, how and where he would consummate the act and takes steps to implement it, we are referring to the elaboration of a SUICIDAL PLAN (SIMONETTI, 2018).

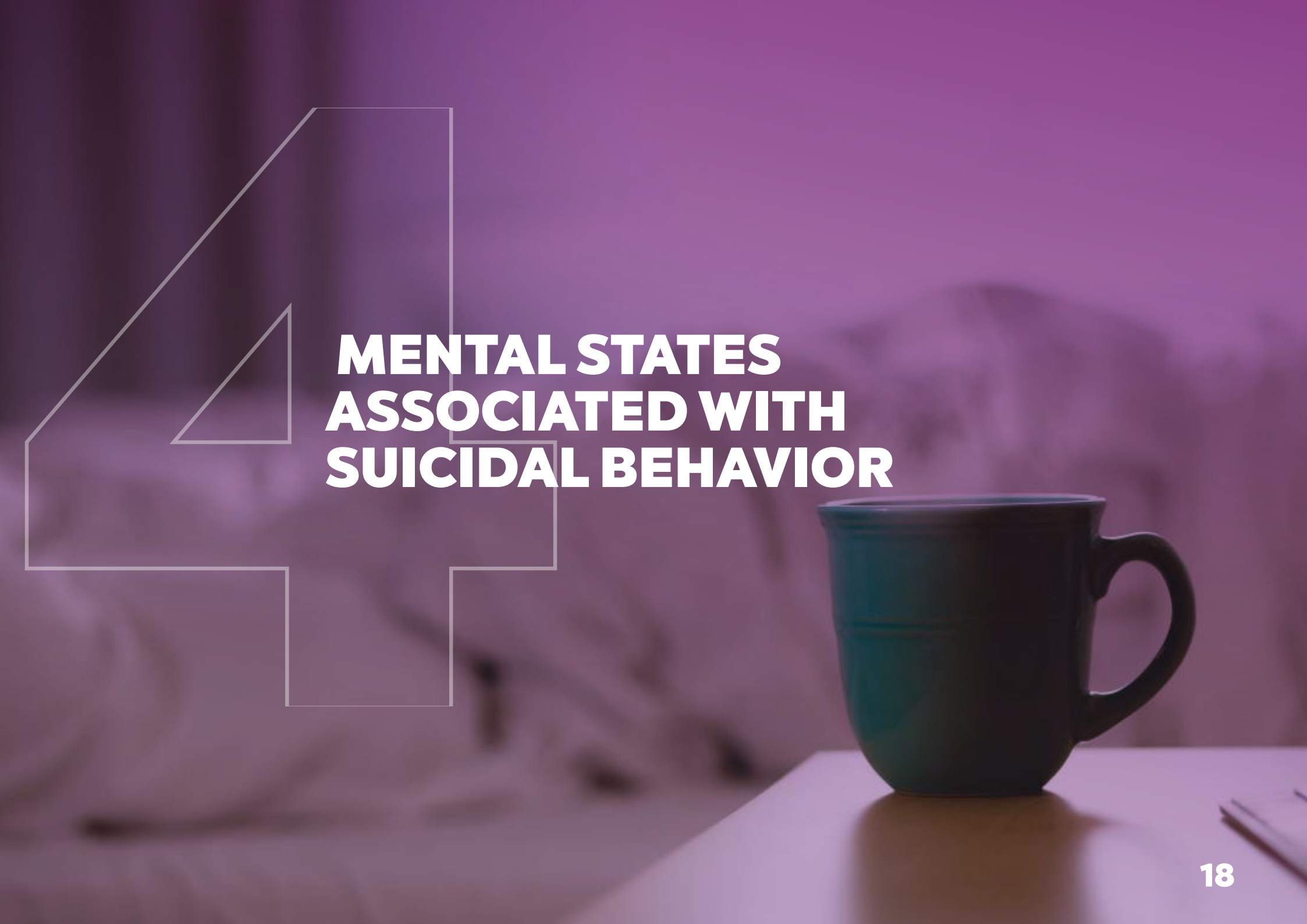
SUICIDAL ATTEMPTS are related to passing on to the act, that is, when the person presents a selfinjurious behavior with a non-fatal outcome, in which there is some evidence of the intention to kill himself (O'CARROLL et al., 1996). They can occur in quite different ways, some being carefully planned while others are done impulsively.

SUICIDE, on the other hand, refers to the act performed by the person with the purpose of taking their own life. Shneidman (1993), considered the father of modern suicide, refers to suicide as the response to an urgent psychic need in the face of intense, unbearable and intolerable existential suffering, also being understood as an attempt to communicate something and a request for help.

There are also **SELF-LESSIVE BEHAVIORS WITHOUT SUICIDAL INTENT**, defined as the act of deliberately injuring oneself, resulting in immediate damage to the body part, without suicidal intent and not socially approved within the culture itself (QUESADA et al., 2020). In practice, it is an alternative found to momentarily relieve suffering, psychic pain. Although it distances itself in many aspects of suicidal behavior, there is evidence that individuals who self-harm are at increased risk of later attempting suicide (FRANKLIN et al., 2017).

4

MENTAL STATES ASSOCIATED WITH SUICIDAL BEHAVIOR



There are some characteristics that are often present in suicidal behavior. Understanding and acting on them can contribute to a more adequate and efficient approach.

Ambivalence

Affective state that refers to the conflict between the desire to die and to live at the same time. Therefore, it is very common for people with a suicide attempt to send signals or inform their attitude (BERTOLOTE; MELLO-SANTOS; BOTEGA, 2010).

In many cases, this can be mistakenly understood as a way of attracting attention or disqualifying the real intention, since there was a search for help. It is important that professional performance seeks to strengthen the part that wants to live. É importante que a atuação profissional busque fortalecer a parte que deseja viver.

Impulsivity

These are quick and unplanned reactions to put an end to suffering, without adequate assessment of the consequences, usually triggered by experiences considered negative (BRASIL, 2005; BOTEGA, 2015).

These responses are fleeting, and may last for minutes or hours. By calming down the crisis and buying time, the health professional can help reduce the risk of suicide.

Mental Constriction

Cognitive state in which there is a lack of flexibility and perspective, as thoughts, feelings and actions are rigid, overestimating the difficulties without seeing other solutions to the problems, finding suicide as the only solution (Brasil, 2006). This aspect must be taken into account when seeking to make an agreement so that the person does not attempt suicide, since due to this mental state the person may not be able to comply with the agreement. The professional will be able to stimulate reflection for other ways of solving and overcoming, other than suicide.

Reflection

Have you ever stopped to wonder why a person thinks, tries, or commits suicide?

Often, we face situations in which people verbalize a suffering that led them to that moment. Is this alone able to explain why suicidal behavior occurs?

5 MULTICAUSALITY OF SUICIDAL BEHAVIOR

MULTICAUSALITY OF SUICIDAL BEHAVIOR

Suicide is recognized as a complex and multi-determined phenomenon, which means that it encompasses the role of biological, psychological, social, environmental and cultural factors, affecting individuals of different origins, social classes, ages and sexual orientations (BOTEGA; WERLANG, 2004). There are several variables that interpenetrate each other, interfering with each other in different ways and according to each person.

The apparent reasons are just the last straw, the trigger, the final link in a long chain of events that interacted with each other, related to life situations and with each person's own sensitivity to deal with lived experiences (CASSORLA, 2017). Often, the person himself knows little about his real reasons or cannot even find external explanations and motivations to explain the suffering he feels. Reducing suicide only to a specific fact (such as, for example, because it ended with a girlfriend, lost a job, or because of a mental disorder) is to disregard the complexity of the phenomenon and the individual and social life history of the person who suffers.

Therefore, today people talk about suicide, in the plural, because each one responds to suffering in their own way, revealing their unique way of coping with problems and adversities (FUKUMITSU, 2019).

6 MYTHS AND TRUTHS ABOUT SUICIDE

MYTHS AND TRUTHS ABOUT SUICIDE

When faced with suicidal behavior, it is very common to hear opinions about how to understand this phenomenon. There are some ideas that are widespread and can lead to a misunderstanding about this fact. Therefore, the more you know, the more you can act and help people who experience this situation.

MYTHS	TRUTHS
Whoever wants to kill himself doesn't warn.	**FALSE**. Most people give signs of their intentions.
People who talk about suicide just want to get attention.	**FALSE**. The expression of the desire for suicide must always be taken seriously, as it calls attention to a life that is not well lived.
Suicide cannot be prevented.	**FALSE**. Not all suicides are preventable, but recognizing warning signs and offering support helps most to prevent.
The person who overcomes a crisis or survives a suicide attempt is out of danger.	**FALSE**. Many suicides can occur even during the period of improvement.
Once suicidal, always suicidal.	**FALSO**. Thoughts may come back, but they are not permanent.
Thinking about suicide is common.	**TRUTH**. But only 7 to 10% of people who think about suicide kill themselves.
Suicide is an act of courage. Suicide is an act of cowardice. Anyone who commits suicide is crazy.	**FALSE**. Anyone who attempts or commits suicide is in intense existential suffering.
Talking about suicide can stimulate the act.	**FALSE**. Talking about your intentions relieves the anguish and tension these thoughts bring. The way it is approached is what will be the difference.

Source: Adapted from WHO, 2006.

Reflection

Is it possible to prevent a suicide?
Is it possible to act to prevent a person from taking their own life?

RISK FACTORS AND PROTECTIVE FACTORS

Knowing the risk factors for suicide can help health professionals to identify situations of danger and crisis, as well as the protective factors that contribute to coping with the risk, enhancing the

RISK FACTORS

The risk factors associated with suicidal behavior are not determinant, but are more frequently present in people who have committed the act. Although this relationship is well established, many suicides occur impulsively and in crisis situations, given the difficulty in dealing with situations of stress and suffering. The main risk factors for suicide are: previous suicide attempt and mental disorder (BRASIL, 2006).

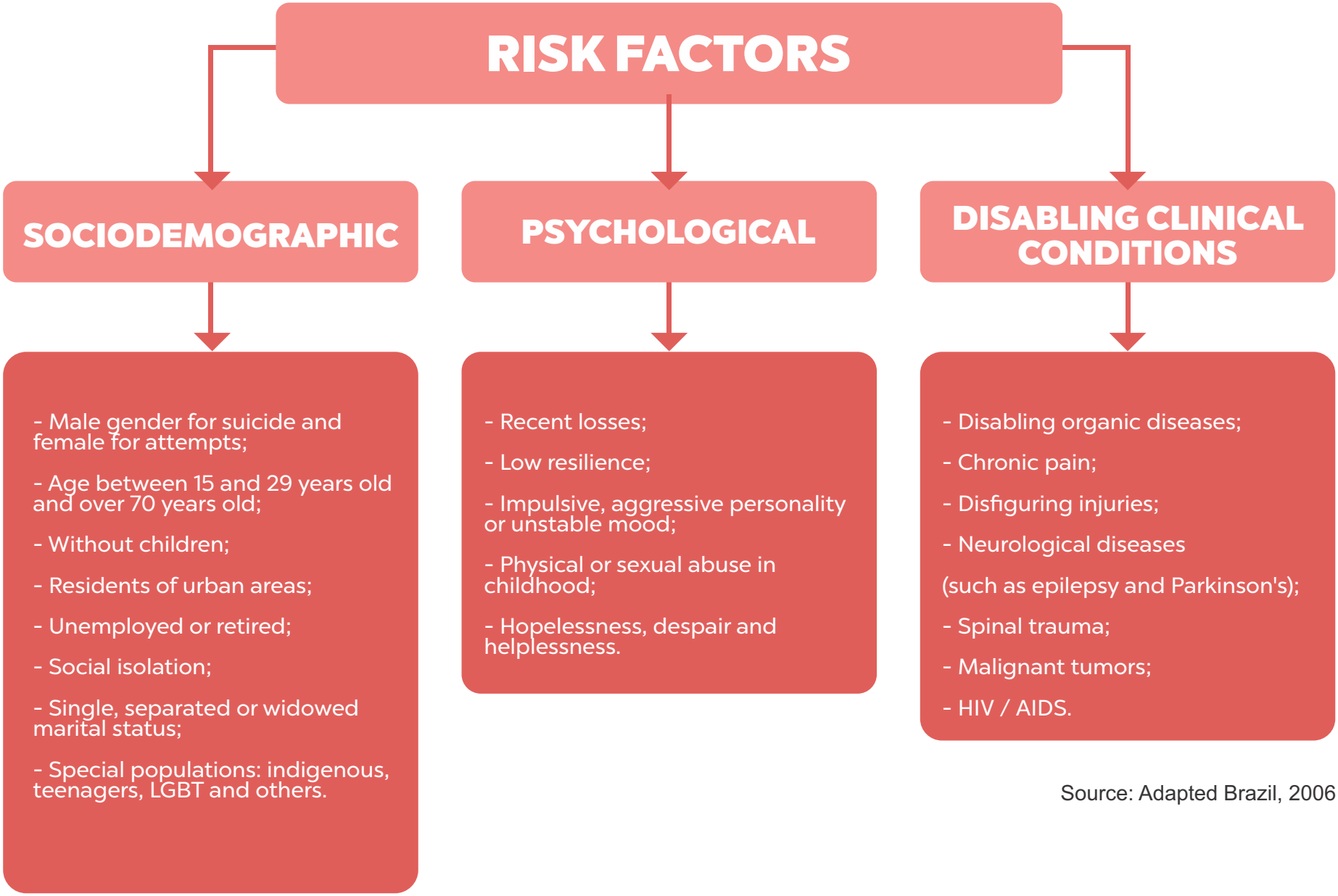
PRIOR SUICIDE ATTEMPT

People with a history of suicide attempts are five to six times more likely to repeat this behavior (BOTEGA et. al, 2006; BOTEGA, 2015), the danger being greater during the first months and years, tending to decrease over time. Therefore, intervening at this time is one of the main prevention strategies.

MENTAL DISORDERS

Estudos têm demonstrado que grande parcela dos suicídios estava associado a transtornos mentais, sendo os mais comuns depressão, transtorno bipolar do humor, alcoolismo/dependência de outras drogas, transtornos de personalidade e esquizofrenia (BERTOLOTE; FLEISCHMANN, 2002; SANTOS et. al, 2009). Os casos de comorbidades aumentam ainda mais o risco, como por exemplo, depressão e alcoolismo.

Figure 2 - Flowchart regarding risk factors for suicide



Source: Adapted Brazil, 2006

Risk Assessment for Suicide

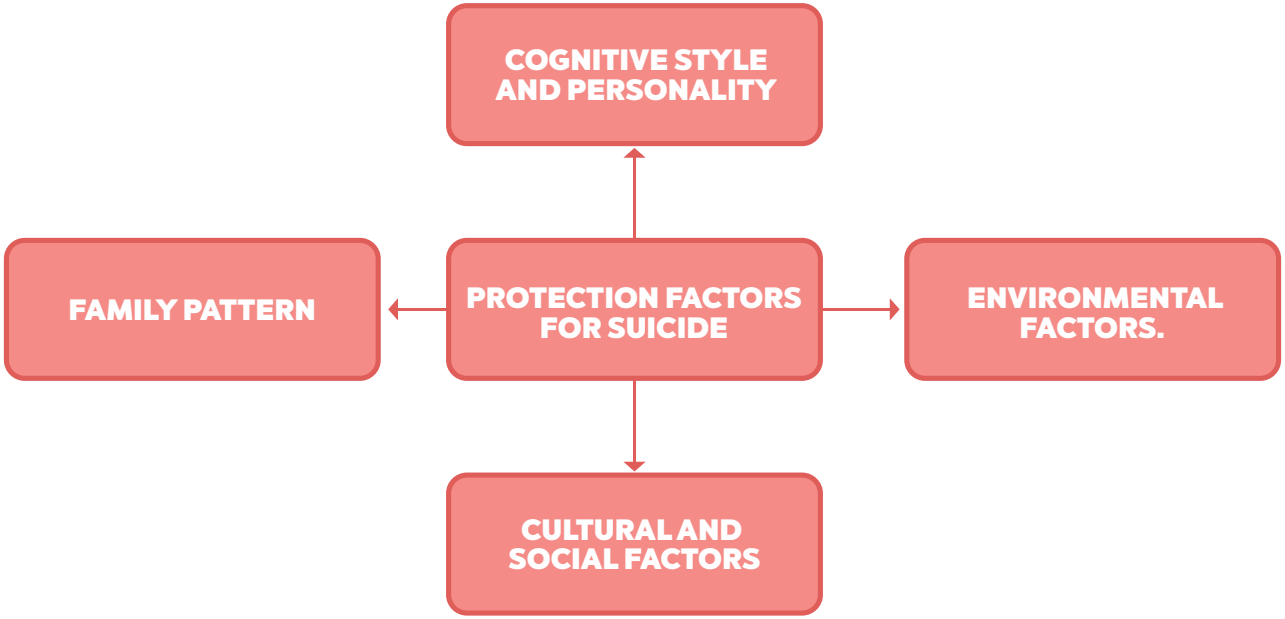
This is an important tool used in the approach to suicidal behavior, as it can lead to a better direction of the case. In this process, the persistence of suicidal ideation or planning is analyzed, if there is access to the way you planned, if there were previous attempts, presence of comorbidities (mental disorder or use of alcohol/other drugs), if you consider you have reason to live and pending matters were organized in the event of his death. Attention should also be paid to other risk factors for suicide (BOTEGA, 2015).

	LOW RISK	MEDIUM RISK	HIGH RISK
FEATURES:	No history of previous attempts; Ideas and thoughts of death and suicide are fleeting but disturbing; There is no planning.	There is a history of attempted suicide; Frequent and persistent ideation; There is no planning.	There is previous trying and persistent thoughts; There is planning for suicide and access to the way you planned.
APPROACH	In this case, it is important to address the feelings related to suicide, talking to the patient to reduce emotional confusion. Focusing on positive aspects of your personality and problems you've already faced and resolved can restore confidence.	The action should build alternatives to suicide in solving the problems faced.	Demands emergency intervention as it is considered a serious situation. Attention should be paid to dangerous objects that can be used against you and remain in bed (place) for easy observation, in addition to informing the team involved in care and protection about the risk.
REFERRALS	: The user must be assisted by a mental health professional, either at the hospital by the psychologist, or referred to the municipal mental health service, with priority. It is considered important to verify the possibility of access to family members and reinforce this support and/or other social support (such as friends).	In these cases, it is necessary to approach a mental health professional at the hospital. First, the psychologist will carry out the approach and will be able to activate the mental health network for joint referrals. The family must be informed about the risks and prevention and protection measures (staying close, avoiding access to means such as weapons and medicines), preferably with the patient's authorization. Psychiatric hospitalization is not ruled out.	Hospital psychology should approach and activate the mental health network, as well as a psychiatrist. The family will be informed and approached about the seriousness of the condition. The patient may be referred to: psychiatric hospitalization, which, in case the patient refuses, may be involuntary (that is, against his will), due to the risk of death in which he may be placed; home care and/or intensive monitoring in a mental health referral service. These referrals should be discussed with family members and, if possible, with the user, being conducted by the health team.

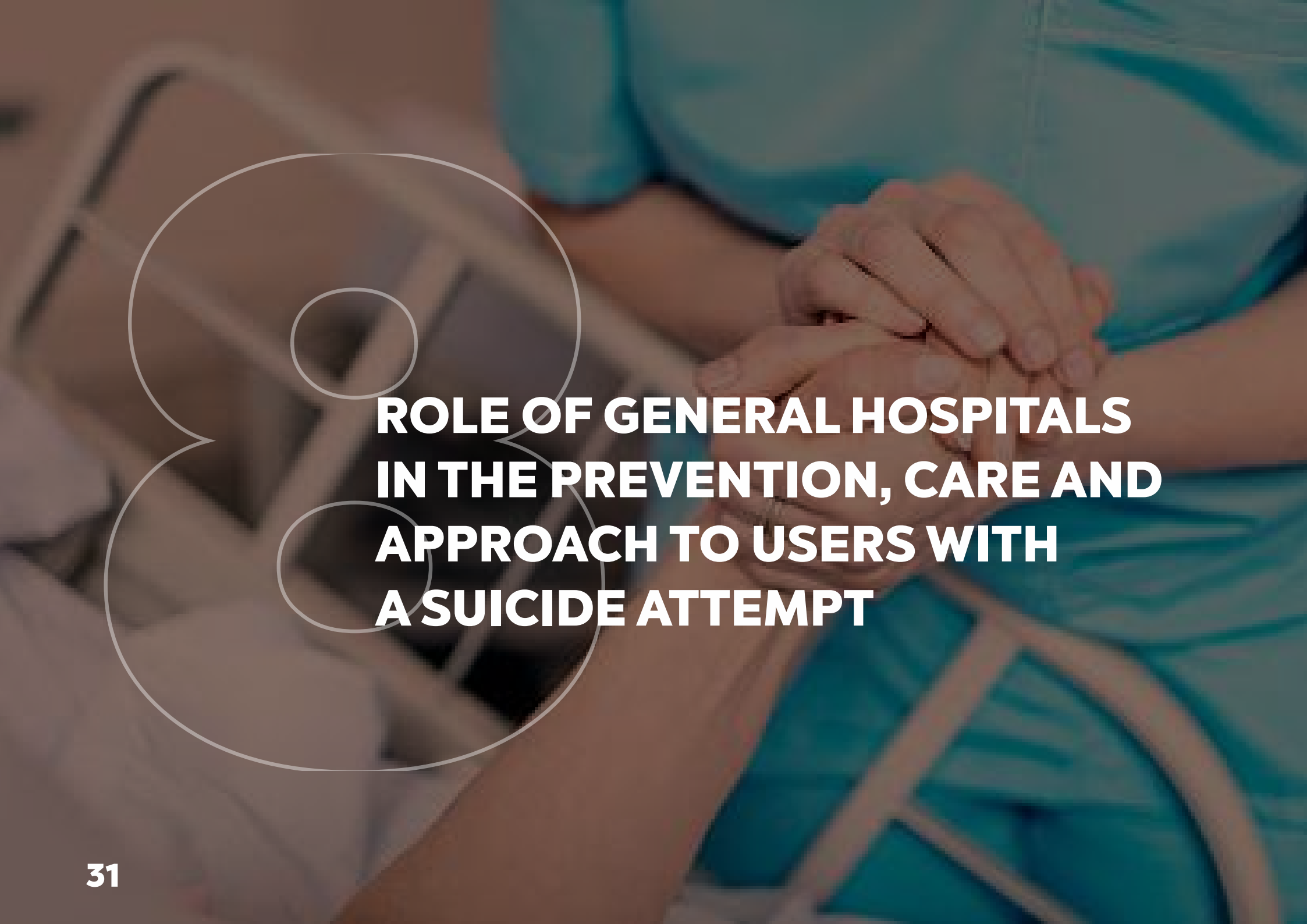
Source: Prepared by the authors based on Brazil, 2006.

Protection Factors

Associated with this, the protective factors show that, when certain actions are reinforced,lower rates of suicidal behavior are observed. These refer to the aspects that lead to a healthy and productive life, leading to a sense of well-being, as they are related to cognitive skills, emotional flexibility and social integration, providing more resources and subsidies to deal with the feeling of stress, which , consequently, leads to a reduction in the risk of suicide (BERTOLOTE, 2012; BOTEGA, 2015; QUESADA, et. al, 2020).



Source: Prepared by the authors



8 ROLE OF GENERAL HOSPITALS IN THE PREVENTION, CARE AND APPROACH TO USERS WITH A SUICIDE ATTEMPT

Suicide is unpredictable death. There is no specific profile of people who will kill themselves, except for a human being, who in a situation of despair has suicidal potential (FUKUMITSU, 2019).

But suicide can be prevented. In Public Health, prevention is considered any measure that aims to prevent a disease before it affects any individual, thus preventing its occurrence (BERTOLOTE, 2012). Suicide prevention will aim to reduce suicidal behavior, reducing the chance of a lethal outcome, which means offering other possibilities for coping with the difficulties that lead individuals to seek a solution to their suffering in this act (BOTEGA et al.,2006). One of the main suicide prevention strategies is related to health care provided by professionals in the face of suicidal behavior, which is associated with their perception and understanding of these acts.

As suicide attempts are part of health emergencies, the initial objective in this approach should be the provision of first aid as a way to alleviate the risk of death or worsening of the clinical condition. However, despite the biological aspect being paramount, after clinical stabilization, the approach to suicide attempts should include attention to other factors in the patient's life, seeking to understand the subject as a whole, articulated to their family context, the environment and to the society in which it is inserted.

The emergency space, such as hospital entrance doors, is considered a privileged place for the care and prevention of suicide, as adequate care can contribute to the identification of risk, prevention of relapses and continuity of treatment after hospital discharge (VIDAL; CONTIJO , 2013; GUTIERREZ, 2014; GONÇALVES, SILVA; FERREIRA, 2015).

Any health professional can carry out the initial approach to suicidal behavior, as long as they have adequate knowledge for it. Most of the time, it is these professionals, not specialists, who carry out the first visits and spend most of the time with the users, being in a privileged position to approach them to act in a meaningful way. Thus, training professionals to take an appropriate approach at this time can save lives.

Reflection

What aspects should be addressed in a suicide attempt?

Can I act at this time? Can I save a life?

THE IMPORTANCE OF CARE QUALIFICATION

Studies point to the direct reflection of the increase in suicide cases in the daily work of health professionals, especially those who work in urgent and emergency services, such as general hospitals, as it is there that these people are taken to obtain first aid , in addition to functioning as spaces to search for help (FREITAS; BORGES, 2014).

Promoting special attention to those who attempted suicide is one of the main prevention strategies, because it is difficult for the person to try it once, with a previous attempt being the biggest risk factor for suicide (BOTEGA et al., 2006). Hence the relevance of an adequate and efficient action at this time.

Considering that a portion of these users remain hospitalized in general hospitals, it is the responsibility of all professionals to carry out an approach in accordance with their health needs, which, in suicidal behavior, go beyond just physical and biological demands, and must achieve the psychosocial aspects.

In addition, research shows that the incidence of suicide in general hospitals is high, being 3 to 5 times higher than in the general population, with the preparation of the team among the protective factors for this conduction (MARTELI; AWAD; HARDY, 2010) . This is due to the fact that these patients are subject to various situational causes of increased anxiety and depression related to hospitalization and illness, such as: reactions to diagnosis, worsening of preexisting clinical conditions, discussions about prognosis, waiting for results, fear of pain and death, fear of recurrence after completion of a given treatment and possible conflicts with family and staff, and others (BOTEGA; RAPELI; CAIS, 2012).

Although many hospitals have specialist professionals to perform these services, suicide goes beyond the limits of psychology and psychiatry in such a way that all health professionals are essential for its prevention (BOTEGA, 2005).

Reflection

At this point, we propose a different reflection.
Imagine or remember a time when you or afamily member /
someone close to you was seen at a hospital or other health service.

Try to remember what you experienced, how you felt...
What you expected from the service and
how it was carried out...
Remember the people who took care of you, who they were.

Did you feel taken care of?

10 APPROACH TO USERS WITH ATTEMPTED SUICIDE IN GENERAL HOSPITALS

The first contact with the user is considered extremely important, as the way in which this approach is carried out can contribute to an effective handling of the case.

In this sense, two concepts linked to the Unified Health System (SUS) may contribute to reflection on the care of patients with suicidal behavior in the general hospital, in addition to enabling the strengthening of attitudes aimed at the humanization of this care by favoring the organization of the process of health work, they are: comprehensive care and welcoming.

Considered one of the most important principles of the SUS, comprehensive care is related to the full understanding of the human being, which means understanding the user in their social context and, from there, meeting the specific demands and needs of this person. Comprehensive health action is associated with qualified listening, care, welcoming, dignified and respectful treatment, through looking at the human being as a whole, replacing the focus on the disease with attention to the person, with their life story and their own way. of living and falling ill (PINHEIRO, 2009).

On the other hand, reception, a guideline of the National Humanization Policy, is understood as a relational technological tool (relationship established between professional and user), for which there is no place and time to happen and no specific professional to perform, and implies listening to the user in their complaints, in the construction of bonds, guarantee and access with accountability and resolution of services (BRASIL, 2003). It can be considered the most important technology of an emergency service, as it enables active and qualified listening by the professional, favoring empathy, building bonds and offering comprehensive care with adequate and resolute responses (GUTIEREZ, 2014).

Understanding the user as an integral being and performing the embracement can be a big difference, because, contrary to what is imagined, talking to the patient about suicide does not encourage him to kill himself, and may even have a protective effect, as it can favor the feeling of security and comfort by being able to talk about issues that cause discomfort (DAUTD et al., 2014). Therefore, it is important to take time, be present and be available to listen carefully to the patient, showing empathy and respect for their values and actions, without making judgments.

PSYCHOLOGICAL FIRST AID IN APPROACHING USERS WITH SUICIDE ATTEMPTS IN GENERAL HOSPITALS

Just as there is first aid aimed at providing immediate care to people with a destabilizing physical condition, there is psychological first aid. Both can be performed by anyone, as long as they obtain the necessary knowledge to do so.

Which is?

It is an early and immediate psychological care, with the purpose of alleviating a situation of acute suffering of a person in crisis, with emotional instability or in acute stress. It is an empathetic and non-invasive care, that is, it allows the expression of pain in the way the person wants and can, in a situation of suffering (WHO, 2015).

Who can apply?

Anyone can offer this welcome, as long as they have the necessary knowledge, in addition to physical and psychological conditions.

What is not?

It is not only done by professionals .
It is not psychological care .
It is not imposition of help.

When to offer it?

In emergency and/or crisis situations, which can be community or individual, such as disasters, attacks, pandemics, accidents, significant losses, violence and individual crises, such as suicide attempts.

STEPS FOR PERFORMING PSYCHOLOGICAL FIRST AID (WHO, 2015; COUTO; SANTOS, 2011).

The first step in dealing with suicidal behavior must be physical care, with the objective of ending the risk of death or worsening of the physical condition. After that, it is possible to address the other aspects involved, verifying whether the user is able to receive the PSP. If so, the approach starts after accessing the services and care offered so far, as well as data on what led to that moment.

When faced with a person in psychological distress, one can find different attitudes, from the expression of emotions such as sadness, crying, anxiety, fear, as people with refusal to approach and aggressive/hostile behavior, people with inconsistent behavior, or even people who cannot express their emotions and thoughts. Therefore, it is essential to observe the situation that occurs. In this process, communication is an important tool, because the way it is developed can contribute to the person feeling understood, safe, protected and respected, favoring the care process.

The steps presented below refer, in a didactic way, to the general idea of the PSP strategy. Therefore, they do not need to be followed sequentially, as well as performed in their entirety. The intention is to enable reflection on ways to address the subjective and social aspects present in every destabilization process, whether physical or psychic.

OBSERVE

1. Observe and assess the situation (make sure the person is able to approach).

The first step in dealing with suicidal behavior must be physical care, with the objective of ending the risk of death or worsening of the physical condition. After that, it is possible to address the other aspects involved. Check if the user is able to receive the PSP.

2. Be aware of the person's uniqueness and their most immediate needs.

The initial preparation refers to respect for the human being, in their pain, in their actions and in the way they express themselves. One must respect his meaninglessness, his emotional condition and the life situation that led him there, without judgment and without minimizing the suffering. At this point, it is important to bring up for reflection the feelings that caring for a person with a suicide attempt awakens in you, so that they do not interfere with your approach. Faced with the feeling of anger, for example, I may not be able to understand that there is existential suffering, while if I feel pity, I may disqualify the other's ability to overcome.

LISTEN

3. Introduce yourself by explaining who you are and what you do. Communicate properly, calmly and at ease, without using technical terms.

State your name and role at the hospital.
Ex: Good afternoon. I'm Cristina, a psychologist at the hospital.

4. Offer your listening. Ask respectful and simple questions (not out of curiosity), and don't pressure to speak:

Ex, "Would you like to talk?"
"How do you feel?"
" Would you like to talk about what happened?"

Common acts of courtesy can make it easier to approach, such as offering a glass of water or a tissue when you are crying.

5. Listen to feelings and thoughts without giving personal opinions and judgments.

Making yourself available to listen to the other requires presence, acceptance and lack of judgment. That itself is therapeutic.

It is necessary to put aside prejudices, beliefs and personal values and be open to what the person wants to say and convey at that moment in life.

LISTEN

Speaking does not cause suicide, because suffering is existential and is in the person who feels it, but speaking reduces anxiety and anguish, promoting relief and a sense of comfort.

Perform risk assessment.

6 - Listen to feelings and thoughts without giving personal opinions and judgments.

Making yourself available to listen to the other requires presence, acceptance and lack of judgment. That in itself is therapeutic. It is necessary to put aside prejudices, beliefs and personal values and be open to what the person wants to say and convey at that moment in life.

It is essential to give importance and demonstrate interest, concern and desire to help. This is already a protective factor against suicide and facilitates the construction of bonds and adherence to treatment during hospitalization and after discharge.

Speaking does not cause suicide, because suffering is existential and is in the person who feels it, but speaking reduces anxiety and anguish, promoting relief and a sense of comfort.

Perform risk assessment during this step.

LISTEN

7. Don't talk about yourself, don't offer a solution. Ask how you can help. Sometimes the only thing a person needs is to vent or share their feelings and frustrations.

Caring involves paying attention to the other's needs. It doesn't help taking into account our way, but the way t h e person feels at ease and needs. If you want to help, ask how the person wants to be helped. If you want to care, ask how the person needs to be cared for.

Ex.: "How can I help you?"

"Is there anything you need right now that I can help?"

LISTEN

8 - Try to reassure realistically. Don't try to remedy or give false hope.

AVOID

“this will pass soon”
“I would instead...”
“things aren't so bad”
“you have to make an effort”

PREFER

R “I'm here with you”
“I imagine it shouldn't be easy to face this”
“Can I do something for you?”
"What do you need?"

APPROXIMATE

9. Check for other needs (offer practical assistance such as food, water, information, contacts).

APPROXIMATE

10. Encourage connection with the support network: family, friends and community.

Family and social relationships are considered protective factors for suicide and it is important to encourage them. In many moments, the user may not be able to initially recognize people in whom he/she feels trust, being ecessary to help him/her to identify.

11. Help to find strategies to face the situation experienced, trying to refer to mechanisms used in the past by the person and not what you think will be good or what is good for you.

Due to rigidity of thinking, it is common for people with suicidal behavior not to be able to see other ossibilities in their life. Encouraging this reflection can contribute to coping with pain. Remind her of difficult situations she's been through that she has overcome and how she did it. Reinforce the protective factors. At this stage, you can use the Security Plan (Annex 1) .

12. Connect with available services needed now or in the future as experts. Some people will need specialist support in addition to the PSP.

Considering that a previous suicide attempt is the biggest risk factor for suicide, one should be referred for specialist care, either at the health service where you are being treated (psychology or psychiatry) or for outpatient services , such as CAPS and Family Health Units. Providing contact centers and emergency services can also be useful for future situations (CVV, SAMU, Fire Department).

APPROXIMATE

13. Make yourself available.

In many moments what a person needs is to feel welcomed and understood. The simple presence and availability help in the internal reorganization, provide comfort and reference. The more understanding is shown, the more it is organizational and therapeutic

TO THINK ABOUT

Case 1 - Pedro is 25 years old, he met Ana and they are in love. They started dating, but even for no apparent reason, he is insecure and is jealous of his friends and activities. Faced with these attitudes, after some attempts and conversations, Ana decides to break off the relationship. Pedro gets desperate and doesn't conform, reaching out to use all his resources to try to win her back. Without success, time passes and the persistence of feelings remains, disrupting his study routines and his relationships with friends and family, since he isolated himself from everything. Peter begins to think that death could ease his suffering. As the days go by, he starts thinking about how he could commit suicide, until he makes a plan and tries to commit suicide by ingesting natural tranquilizers. By taking this attitude, Pedro sends a message to a friend, saying goodbye to her and thanking her for supporting him in this difficult period. Suspicious, the friend decides to go to Pedro's house, but finds him sleepy and decides to take him to the city hospital. After being treated at the hospital, Pedro was referred to continue treatment at the city's CAPS. During this follow-up, it was discovered that Pedro was a rejected child in infancy. Son of separated parents, at the age of 2 he was abandoned by his mother, who never appeared again. The father, faced with abandonment, distanced himself from Pedro, who ended up being raised by his grandmother. Despite the care and affection received by this family member, Pedro did not feel wanted by his parents, feeling rejected and insecure with the fear of abandonment. Thus, unconsciously, he reproduced in his relationships the feelings experienced and internalized in childhood, which ended up interfering negatively in the established relationships. Recalling the concepts of suicidal behavior and the multi-causality present in suicide, it is proposed to reflect on this situation.

TO THINK ABOUT

Case 2 - Henrique arrived at the hospital taken by SAMU after a family call. He was drunk and had cuts on his arms. Still agitated, he referred to the desire to die and, expressing himself aggressively, told no one to come near him because he didn't want any kind of help. He was accompanied by his sister, but asked for his mother who was nervous outside. It was after 8 p.m.. How could we conduct this case, referring to learning related to Psychological First Aid?

Case 3 – Fernanda is 21 years old and has been followed by CAPS for many years. Her diagnosis is still imprecise, hypothesized by bipolar mood disorder and personality disorder. Fernanda is frequently seen at the hospital, with suicide attempts. Usually brought in by SAMU, she threatens to throw herself off the city bridge. She never got around to doing it. Her affection is incongruous with the situation, as she spoke of her intention to kill herself smiling. When asked about what happened, she said that she wanted to die because she had had a fight with her mother. She said that whenever she is faced with difficult situations, she goes into crisis and ends up acting without thinking too much, seeing suicide as a way to reduce her suffering. She doesn't plan, but it's the fifth time she's tried and says that at the time of crisis she can't think of other alternatives. Reflecting on the characteristics of suicidal behavior, psychological first aid and considering the risk assessment and the safety plan in approaching suicidal behavior, how could these strategies contribute to the initial management of the case?

12

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ANNEX 1
Safety Plan - A possible strategy to save lives.

The safety plan refers to a strategy of ognitive-behavioral psychological theory, based on the idea that the crisis is temporary, seeking, through structured activities, to create time so the person in suffering can deal with the critical moment (SCHREIBER; CULPEPPER, 2019).

Constructed together by the professional and the user, they should be helped to discover and record on paper, preferably by hand, positive ways to react in a crisis situation (HENRIQUES; BECK; BROWN, 2003; WENZEL; BROWN; BECK, 2010) . The document must remain with the user and be in an easily accessible place for moments of anguish and risk, such as a photo on a cell phone or kept in a wallet, with its application encouraged in the face of suicidal thoughts and behavior.

The effective use of the safety plan can contribute to a reduction of up to 76% in the performance of a new suicide attempt in the next six months (BRYAN; RUDD, 2018).

To start building the safety plan, it is important that the professional first seeks to establish a trusting relationship with the patient, remaining close and available, seeking to understand their feelings and not express personal judgments and opinions (BOTEGA, 2015).

ITEMS THAT MAKE UP THE SAFETY PLAN (HENRIQUES et al., 2003; WENZEL et al., 2010; BOTEGA, 2015)

1- Warning signs (list situations and/or triggers that usually trigger suicidal ideation).

Possible questions:
Can you identify what happens when the crisis approaches?
What is a trigger to start a crisis?

2- Identification of ways of coping (how to deal with thoughts and moments of anguish)
Possible questions:
When the crisis arrives, what do you do to deal with it?

Observation 1- Encourage people to think of ways to relax and distract, but not something negative.
Note 2- Reminder to avoid means that could be used for self-harm.

3- Reasons to live (record one or more reasons to stay alive)
Possible questions:
What makes you stay alive?
What motivates you to still be here?

4- Personal support network (record the name and telephone number of two or more people who usually provide support)
Possible questions:
Who do you trust you can call or look for in bad times? (If the person does not identify it at first, help them find it. Do not leave this item blank).

5- Professional support network (information on how to contact the doctor, psychologist or reference professional)

6- Registration of telephone numbers for crisis centers, such as CVV, and emergency services, such as SAMU and the Fire Department. The professional must encourage the patient to follow the steps of the safety plan, so that each step can bring relief that allows them to overcome the crisis, often being able to control it without even using all the resources described.

USEFUL PHONES TO CALL

CVV - 188

FIRE DEPARTMENT - 193

EMERGENCY MOBILE CARE SERVICE - 192