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RESEARCH

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# Brazilian population perception about suicide

## Percepção da população brasileira sobre o suicídio

## La percepción de la población brasileña en el suicidio

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## ABSTRACT

**Objective:** The study's goal has been to understand the perception of the Brazilian population about the suicide issue. **Methods:** It is a descriptive-exploratory research with a quantitative approach that was carried out through a survey on the Internet, which had a non-probabilistic sample by convenience composed of 246 participants, who answered the Attitudes Questionnaire Regarding the Suicidal Behavior (AQRSB). Data were evaluated using descriptive and bivariate statistics, using SPSS statistical software. **Results:** The existence of negative feelings towards the suicidal patient was identified in a reduced number of participants ($f$ = 25; 8.90%); also, it was identified a general perception of inability to deal with suicide and the recognition of the other's right to commit suicide. **Conclusion:** Given the results, it was observed the existence of myths and prejudices about the matter, which disfavor the assistance to the suicide.
**Descriptors:** Suicide, suicidal thinking, public opinion.

## RESUMO

**Objetivo:** Compreender a percepção da população brasileira sobre o suicídio. **Método:** Pesquisa exploratória e descritiva, de cunho quantitativo, realizada por meio de levantamento na internet, que contou com amostra não probabilística por conveniência composta por 246 participantes, que responderam ao Questionário de Atitudes em Relação ao Comportamento Suicida (QUACS), cujos dados foram avaliados por meio de estatística descritiva e bivariada, com auxílio do *software* estatístico SPSS. **Resultados**: Identificou-se a existência de sentimentos negativos perante o paciente suicida em uma quantidade reduzida de participantes ($f$ = 25; 8,90%), uma percepção geral de incapacidade para lidar com suicida e o reconhecimento do direito do outro de cometer suicídio. **Conclusão**: Existência de mitos e preconceitos sobre o tema, que desfavorecem a assistência ao suicida.
**Descritores:** Suicídio, Ideação suicida, Opinião pública.

## RESUMEN

**Objetivo:** Comprender la percepción de la población sobre el suicidio. **Método:** investigación exploratoria y descriptiva, naturaleza cuantitativa, realizada por el levantamiento de la Internet, que incluye muestra de conveniencia no probabilística compuesta por 246 participantes que respondieron el cuestionario de actitudes en relación con el comportamiento suicida (QUACS), cuyos datos ellos

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fueron evaluados por estadística descriptiva y bivariante, con la ayuda de software estadístico SPSS. **Resultados:** Se identificaron la existencia de sentimientos negativos hacia el paciente suicida en una cantidad reducida de participantes ($f$ = 25; 8,90%), una incapacidad percepción general que lidiar con el suicidio y el reconocimiento del derecho de otro a suicidarse. **Conclusión:** La existencia de mitos y prejuicios sobre el tema, a la asistencia perjuicio de suicidio.

**Descriptores:** Suicidio, Ideación suicida, La opinión pública.

## INTRODUCTION

Each year the number of deaths from suicide has risen alarmingly. Increasing rates have generated great concern worldwide, and the World Health Organization (WHO) has therefore drawn attention to this seriousness as a public health problem on a global level and pointed to the importance of building concrete prevention strategies and control. The WHO emphasizes the need to include suicide prevention as a priority on the global health agenda, and also highlights that only 28 countries have some kind of preventive strategy or attach some attention to the issue.[1-3]

In order to better understand the problem scale, it is emphasized that high suicide rates have surpassed the number of homicide and human immunodeficiency virus (HIV) deaths combined, being the second leading cause of death in the world, trailing only transit accidents. Translating in numbers, every 40 seconds, a person takes his own life and takes 20 failed attempts, totaling 800,000 deaths a year. Although reliable, those records are still underreported, since they do not consider cases identified as accidents and camouflage acts of self-infringing violence.[1]

According to the United Nations, the most vulnerable people are those from low-income countries, where 75% of cases are registered; where the socioeconomic conditions are a factor of great influence. Among these countries, Brazil is the 8$^{th}$ largest number of suicides in the world ranking. There is a predominance of cases among the male population, with a rate of 10.70%; with the index among women being lower (2.60%), since men generally use more effective methods. The most commonly used methods by the general population are poisoning from pesticide ingestion, hanging, and the use of firearms.

According to the Brazilian Health Ministry, the most common risk factors that should be evaluated to detect a suicide potential early are due to clinical, sociodemographic and genetic factors. The existence of some kind of mental disorder (depression, anxiety, personality disorder, schizophrenia...), the use of psychoactive substances (alcohol, drugs...) or the existence of some kind of comorbidity risk (e.g. alcohol + depression). It is also relevant to consider psychological factors (recent losses, impulsivity, aggressiveness, disturbed family dynamics), incapacitating clinical conditions (acquired immunodeficiency syndrome [AIDS], malignant neoplasms, organic and chronic diseases, spinal cord trauma), and sociodemographic factors (social isolation, Unemployment, room, economic statement...). It also contemplates the differentiation between predisposing factors, those that cause suicide (sociodemographic characteristics, mental disorder, illness...) and precipitating factors, which are triggered by stressors (separation, loss or mourning...). Further, according to the WHO, a previous suicide attempt is the most significant risk assessment factor since it will serve as a starting point for an assessment of the existence of plans and methods, ensuring appropriate treatment.[4-5]

In addition to the identification of risk factors, it is necessary to prepare health professionals and other areas on the identification of potentially suicidal patients, since this is the most effective form of prevention. It is a complex task, because it is not exactly the suicidal behavior that needs to be evaluated, but its risk, the *ante facto*. Thus, the health professional and the relatives and friends of the subject with suicidal thinking need to observe whether there is a real risk of suicide, and if so, to seek out their severity. It is necessary to perceive the beginning of the process, which begins with dark thoughts, related to death, followed by investigation of ways of performing the act, until the act of suicide attempt.[4,6]

It is recognized that another very effective means of suicide prevention is talking about the issue, since, according to the WHO, the stigma of this type of death still has devastating effects on the population and is still considered a great taboo in the social environment. A fact that hinders the search for help by those who have suicidal thinking, and makes it impossible to understand the people who could help. For this reason, it becomes *sine qua non* to withdraw from the silence on the subject and bring it to discussion with society, making and disseminating research on the subject, and recognizing the population's perception of suicide, in order to carry out education and health promotion.[5-7]

Many people who attempt suicide are not understood by health professionals as well as by their own family. Many suicide bombers feel neglected about their feelings. Moreover, for those who have already made attempts, they are still identified as people who are trying to get attention, which are nothing more than banal actors, and who do not deserve the attention of health professionals, and in some cases even family.[8] It is important, therefore, to think about people's perception of suicidal conditions, so as to be able to bring an intervention vision of education and prevention. For this task, researchers are constantly called upon to address this issue, approaching different aspects of diagnosis of risk and protection factors, but also about understanding the population on the subject, in order to generate subsidies that guide campaigns of demystification of prejudices, for education and health promotion of the population in general, so that they can identify, care for and prevent suicide.[6,9]

In this perspective, after selection in national journals, it was possible to detect that there are some studies that bring generous contribution to the literature on the subject. Morais and Sousa[10] aimed to construct a mapping and awaken the population to the problem of suicide in the municipality of *Dormentes-PE*. He detected as personal and financial problems such as lack

of employment, depression, anxiety, deep sadness and will to end suffering, consanguinity, unhealthy jealousy, excessive activities, lack of vitamins and adequate food, excessive medication and problems Psychological. In a similar way, Hildebrandt, Zart and Leite[11], with the purpose of knowing the reasons that led adolescents to try suicide, carried out a research in a hospital institution in *Rio Grande do Sul* State, detecting that the main cause of the suicide attempts are the family conflicts. Similarly, the study by Ribeiro, Coutinho and Nascimento[12] with 276 high school adolescents from *João Pessoa-PB* indicated that depression that triggers suicide is associated with four aspects: psycho-affective, depression as a synonym of sadness and amorous disappointment, psychosocial difficulty of social relationship and dark ideas, idea of death or suicidal thinking.

Vieira and Coutinho[13] with the aim of investigating the occurrence of suicide in the academic environment carried out a research with 233 students of the Psychology course of a public university. The results indicated a significant index of depression and suicidal thinking. Correia *et al.*[14] conducted a study to understand the structure of social representations about suicide with 30 women who suffered domestic violence and attempted suicide by poisoning. It was found that the social representation of women against suicide is linked to stories of life permeated by rejection and lack of love, which leads to depression. The feeling of powerlessness in the face of the need for change can cause emotional problems, which may lead to the decision to interrupt one's life. The relevance of studies that address not only the suicide, but also the population, including the perception of everyone on the subject, is reinforced in order to have subsidies that guide decision-making on prevention, promotion and education programs.

Given the aforementioned, the present study meant to understand the perception of the Brazilian population about the suicide issue.

# METHODS

## Study Type

The present study is a descriptive-exploratory research. It was performed by means of a survey carried out via Internet in Brazil.

## Sample

After the data collection, which was executed during four months (from August to December/2016), there was a non-probabilistic sample for convenience composed of 246 participants, of which 183 (76.44%) women and 58 (23.60%) men; with a average age of 28.09 years old (± 9.18), ranging from 17 to 70 years. There were 14 (5.70%) with basic or medium schooling, 144 (58.50%) with incomplete college level and 88 (35.80%) with complete college level of different courses in all areas of knowledge. Regarding all the participants, 109 (44.70%) are not considered religious and 135 (55.30%) consider themselves religious. They are of different religions: Catholic (f = 88, 35,80%); Evangelical (f = 33, 13.40%); Spiritist (f = 21, 8.50%); Others (f = 14, 5.70%); None (f = 90, 36.60%).

## Instrument

The Attitudes Questionnaire Regarding the Suicidal Behavior (AQRSB) was used.[15] It comprises a 21-item scale that gathers beliefs, feelings, and reactions toward suicides. The items are arranged on an analogue visual scale with a distance of 10 cm between "total disagreement" and "total agreement", in which the respondent should mark a point from 1 to 10, according to the level of approach with each end.

The questions contained in the AQRSB are grouped into three factors:

1) "Negative feelings towards the suicidal patient" - where the higher the score, the greater the presence of such feelings, which may make it difficult to assist the individual who has committed suicidal behavior (Q2 + Q5 + Q9 + Q13 + Q15 + Q17 + Q19 = 70 points);
2) "Perception of professional ability" - the higher the score, the more confident the person feels to deal with individuals with suicidal behavior (Q1 + Q7 + Q10 + Q12 = 40 points)
3) "Right to suicide" - a higher score may mean a more "moralistic" attitude (Q3 + Q4 + Q6 + Q16 + Q18 = 50 points).

It is considered that items 3 and 12 should be reversed; and the questions Q8, Q11, Q14, Q20 and Q21 are not added to the scale factors, since they do not have similarity to the constructed factors. Therefore, these questions can be analyzed either separately or excluded from the scale analysis.

## Approach

Considering the ethical aspects related to research involving human beings, the present study was submitted to the Research Ethics Committee from *Unifor*, approved under Legal Opinion No. 1.228.013 of 09/15/2015. The instrument was made available on the Internet along with the Free and Informed Consent Term, through a specific page and private domain. The disclosure occurred during four months (from August to December/2016) through online social networks (Facebook) in divulgation of interest groups in general interest. It should also be noted that the ethical aspects required by the Resolution No. 466/12 from the National Health Council were respected.

## Data Analysis

Data analysis was performed using the statistical package SPSS (Statistical Package for Social Science) for Windows version 20, divided into four stages. First the sample profile was drawn, through descriptive statistics (frequency, percentage and measures of central tendency and dispersion). Subsequently, a descriptive analysis of the

factors of the questionnaire was carried out, performing summation of points of each factor. Ultimately, comparisons of factor and sub-factor evaluations were performed according to sociodemographic data: sex, age, schooling, course and religion.

## RESULTS AND DISCUSSION

In this section we present the results found in the total score of Attitudes in Relation to Suicidal Behavior and in the previously described factors: Factor 1 - Negative feelings towards the suicidal patient; Factor 2 - Perception of professional capacity; and Factor 3 - Right to suicide. The results of the comparisons by sociodemographic data will be presented below.

The scores of Factor 1 - "Negative feelings towards the suicidal patient" had an average of 20.46 (SD = 9.40), with scores varying between 7 and 49. In this sense, it is observed that these feelings are relatively low. It shows that, generally, people understand suicides; feeling that facilitates assistance to the individual who has engaged in suicidal behavior. Nonetheless, 25 subjects (8.90%) presented scores above half (35 points), demonstrating that there is still a significant number of people with negative feelings regarding suicide (see Table 1). From the analysis of the items of this factor, it is verified that all had low scores, evidencing that there is no anger, but rather respect to those who attempt suicide (see Table 2).

Factor 2 - "Perception of professional capacity" presented an average score of 17.31 (SD = 6.94), with scores varying between 4 and 33. It is therefore recognized that people do not feel able to deal with individuals with suicidal behavior (see **Table 1**). Likewise, all items were found to have low scores (see **Table 2**).

Factor 3 obtained a mean score of 24.88 (SD = 9, 20), with scores ranging from 10 to 50. It should be noted that the average near 50% of the maximum score, representing a more "moralistic" attitude. Yet, the majority ($f$ = 171; 62.20%) of the individuals presented up to 25 points, recognizing the other's right to commit suicide (see **Table 1**). In the analysis of the items, attention is drawn to the high scores in items 4 and 18, evidencing that the participants think that dialogue can avoid suicide and that if they have the opportunity, they would try to change the plans of a suicidal person.

**Table 1 -** Factor scores from the Attitudes Questionnaire Regarding the Suicidal Behavior

| Factors | Maximum Score | Average (SD) |
|---|---|---|
| Factor 1 - Negative feelings towards the suicidal patient | 70 | 20.46 (SD = 9.40) |
| Factor 2 - Perception of professional capacity | 40 | 17.31 (SD = 6.94) |
| Factor 3 - Right to suicide | 50 | 24.88 (SD = 9.20) |

**Table 2 -** Item scores from the Attitudes Questionnaire Regarding the Suicidal Behavior

| Factor and Items | Average | SD |
|---|---|---|
| **Negative feelings towards the suicidal patient** | | |
| Q2- Whoever keeps threatening usually does not kill himself/herself. | 2.53 | 2.20 |
| Q5- At the end of the day, I prefer not to get too involved with patients who have attempted suicide. | 2.56 | 1.97 |
| Q9- I am afraid to ask about ideas of suicide and end up inducing the patient to do it. | 3.24 | 2.46 |
| Q13- Sometimes it gives me anger because so many people is willing to live.... and that patient wanting to die. | 2.01 | 1.86 |
| Q15- I feel powerless in front of a person who wants to kill himself/herself. | 4.54 | 2.82 |
| Q17- In the case of patients who are suffering a lot from a physical illness, I think the idea of suicide is more acceptable. | 3.54 | 2.78 |
| Q19- Whoever wants to die does not only "try" to kill himself/herself. | 2.04 | 1.87 |
| **Perception of professional capacity** | | |
| Q1- I feel capable of helping. | 4.94 | 2.55 |
| Q7- I can feel when a patient is at risk of killing himself/herself. | 4.31 | 2.46 |
| Q10- I think I have a professional background in dealing with patients at risk of suicide. | 3.73 | 2.59 |
| Q12- I fell insecure when try to take care of patients at risk of suicide. | 4.33 | 2.60 |
| **Right to suicide** | | |
| Q3- In spite of everything I think a person has the right to kill himself/herself. | 3.98 | 3.06 |
| Q4- When faced with the suicide issue, I think: if someone had talked it through, the person would have found another way. | 6.12 | 2.70 |
| Q6- The life is a gift from God and only Him can take it back. | 4.08 | 3.19 |
| Q16- Whoever believes in God is not going to kill himself/herself. | 2.38 | 2.44 |
| Q18- When the person talks about taking his/her own life, I try to take it off from his/her mind. | 5.28 | 2.98 |

It was possible to verify that in the attributions of the resilience scores there were differences perceived by the comparisons made from the sociodemographic variables. Comparisons by age did not show differences. The following are only the evaluations that were highlighted by the existence of statistically significant differences. In order to do so, it should be noted that all these variables were non-normal from the Shapiro-Wilk test: factor 1 ($W = 0.93$; $p < 0.01$), factor 2 ($W = 0.96$; $p < 0.01$), factor 3 ($W = 0.91$; $p < 0.01$). Therefore, the non-parametric Mann-Whitney and Kruskal-Wallis tests were used.

There were statistically significant differences in the comparisons of the scores by sex, with no differences in factor 3, in which men had higher scores than women: (U = 3269.50; p < 0.05) [male (M = 25.12; DP = 9.62); (M = 19.03; SD = 8.88)] and factor 2 (U = 4068.00; p < 0.05) [male (M = 19.33; SD = 6.23); Female (M = 16.69; SD = 7.05)]. Therefore, it is observed that men have more negative feelings about suicidal behavior and feel more capable of dealing with suicides.

There were statistically significant differences in scores comparisons by area of knowledge only in factors 1 (13.70; p < 0.05) and 2 (15.36; p < 0.05). The professionals and student of psychology stood out because they presented the lowest scores in factor 1 (M = 18.63; SD = 8.10) and the highest scores in factor 2 (M = 19.23; SD = 7.39); in other words, they are the ones who have the least negative feeling in front of the suicide and those who feel better able to deal with them. It is noteworthy that the participants in the area of natural sciences and engineering were the ones that most have negative feelings about suicide; and those in the sciences of nature, engineering, and life sciences are those who feel less qualified.

There were statistically significant differences in scores comparisons among people with or without religion only in factor 3 (U = 110.96, p < 0.05) [religious (M = 27.35; SD = 9.66); (M = 21.94, SD = 7.68). It was observed that religious have a more moralistic attitude, while non-religious recognize the other's right to commit suicide.

From the study's data, it was possible to verify that most people do not present negative feelings towards suicidal subjects, although there are still some people who point out negative feelings towards individuals with suicidal thinking. Therefore, it is possible to affirm that there is still a lot of prejudice with people who try to kill themselves, since many health professionals who deal with this situation present a behavior characterized by hostility and rejection towards subjects with suicidal thinking. Furthermore, these professional behaviors may lead to decreased care for their patients, in which many professionals believe they are wasting their time because they are not caring for more serious patients. Thus, many patients are not regularly followed and stop seeking help.[16]

The results about the perception of the professional capacity confirm the literature that have demonstrated the need to strengthen the discussions on the subject, since there is a great difficulty in dealing with the situations that involve the suicidal behavior and, still to be considered among the professionals as a challenge. There is also the difficulty in identifying what the patient is really feeling and to satisfactorily detect the risk factors, including the patient as a whole, emphasizing the need for further discussion as a possibility of further improvement in favor of appropriate intervention for reducing damage.[17]

Data about the perception of the other's right to commit suicide confirm the literature that shows that the first reaction when seeing someone with the desire to die is the fear of dealing with this situation. The first feeling is of defense for the gift of life, to the detriment of our right to decide about it. Especially among health professionals, particularly physicians, there is an incessant search for the prolongation of the life of a subject, even if this brings suffering, consequently, the loss of the patient, either by illness or suicide, is often interpreted as professional failure.

It is possible to perceive that the population's perception of suicide and suicide is permeated by their personal experiences and characteristics, highlighting the differences in perceptions between participants with different religions and different courses or professional categories. Psychology students and practitioners are aware of disorders and mental illnesses, such as depression, that lead people to suicidal thinking and attempts, leading them to understand such behaviors, have more positive attitudes, and feel better able to do so.[18] Moreover, among Catholic, Evangelical and Spiritist people, evangelicals were those who presented the greatest rigidity of moralistic discourse and non-acceptance of the other's right to commit suicide. Therefore, it is understood that religious people, especially those who follow more rigid guidelines, understand that life as a divine right and its withdrawal as something unacceptable.[19-20]

## CONCLUSION

Despite the alarming number of suicides in Brazil and the world, and national campaigns such as the Yellow September, there is still misinformation and prejudice against suicide people, which hampers the search for help. In part, this reality is due to a certain taboo in relation to the subject, since it is little discussed, which causes lack of information of the population, even of the health professionals, who often do not know how to deal with patients who already had thinking suicidal. So, it is important to ensure that both professionals and the population itself have a minimum knowledge on the subject in order to reduce the difficulties of dealing with suicidal behavior, then cooperating in order to reduce the harm to the patient with this type of conduct.

From the present study it was found that although most people do not feel negative about suicidal patients, there are still prejudices and stigmata related to people attempting to kill themselves, as well as hostility and rejection by some people, mainly due to the difficulty of dealing with the situation, cooperating with the reduction of the demand for help from the patients, which constitutes a serious problem and requires immediate and careful intervention.

As a limitation of the present study it can be cited the focus on the general population, without characterizing specific groups as patients with suicidal thinking or who attempted to commit suicide, professionals of certain categories. It is recognized that these approaches would bring great contribution to the debate and understanding on the subject, although it was not the study's aim. It is also suggested that qualitative and longitudinal researches be carried out, for a deeper understanding of the beliefs of different subjects about suicide.

Conclusively, it is recognized that there is still a great lack of preparation on the part of the professionals in dealing with individuals who have tried to take their own lives, which causes that many people are not understood and they stop

to look for help. Therefore, it is claimed that there is a need for greater promotion of mental health, by having more debates on the matter, as well as support groups for people experiencing difficult times.

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