

# *Approach and Treatment of Suicidal Behavior in the Clinical Practice of Different Groups of Health Professionals in Spain*

*Results of the Project Euregenas*

# *Abordaje y Tratamiento de las Conductas Suicidas en la Práctica Clínica de Diferentes Grupos de Profesionales Sanitarios en España*

*Resultados del Proyecto Euregenas*

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**Abstract** — In January 2014, Spain's National Statistics Institute (Instituto Nacional de Estadística – INE) confirmed that the number of suicides had increased in Spain by 11.3% in 2012. This is the highest rate since 2005. The WHO (World Health Organization), the UN (United Nations) and the European Union (EU) consider it a health problem of prime importance. It is a priority in particular for the EU, which considers suicide prevention and the detection of persons at high risk of suicidal behavior as a main concern, together with making public the most effective intervention methods. The Research Project “European Regions Enforcing Actions against Suicide (EUREGENAS), funded by the European Union Health Program 2008-2013, and which is presented in this paper, is aimed at describing specific techniques for an integrated model of Mental Health orientated to the prevention of suicide and the development of an effective and efficient training program for the health professionals involved in this type of behavior.

This goal requires the employment of a qualitative methodological strategy, since it deals with the slippery question of the preferences and the interests of the actors and the apprehension of their discourses. The data collection has been carried out through discussion groups formed by different types of health professionals: psychologists, psychiatrists, primary care staff and staff of the emergency services. During the sessions, each collective describes and explains the meaning of suicidal behavior prevention according to its own work experience. To facilitate the task of analysis, we use a computer application, namely the qualitative data analysis program NVIVO 10. The results highlight the importance of clinical practice, of prevention, and of the differentiation of patients according to the severity of the problem. The experts believe that prophylaxis

should be carried out on the first moment of diagnosis and that the patient should be informed of all the available resources. Lastly, they assert that the major difficulty is the fact that many people who are at risk of suicide do not look for help.

**Keywords** – *suicide; prevention; health professionals; qualitative; EUREGENAS.*

**Resumen** — Los datos ofrecidos a principios de 2014 por el Instituto Nacional de Estadística revelan que el número de suicidios aumentaron en España un 11,3% en 2012, la tasa más alta desde 2005. OMS, ONU y Unión Europea lo califican como un problema de salud pública de primer orden. En concreto, para la Unión Europea es un tema prioritario. Considera necesario la profilaxis y detección de personas en alto riesgo de conductas suicidas y dar a conocer métodos de intervención eficaces. El Proyecto de Investigación European Regions Enforcing Actions against Suicide (EUREGENAS) financiado por Health Program 2008-2013, European Union, que se presenta en esta comunicación, tiene como objetivo describir técnicas específicas para un modelo integrado de Salud Mental orientada a la prevención de suicidio y elaborar un programa formativo en la prevención de suicidio para profesionales sanitarios.

Este objetivo obliga a emplear una estrategia metodológica cualitativa de la investigación ya que se ocupa de la escurridiza cuestión de las preferencias e intereses de los actores y la captación de sus discursos. Como técnica de recogida de información se han realizado grupos de discusión con profesionales sanitarios, en concreto, psicólogos, psiquiatras y personal de atención primaria y urgencias que describen e interpretan las diferencias que permiten discriminar el significado de la prevención de conductas suicidas. Para el

**análisis de los datos hemos utilizado el programa de análisis de datos cualitativos NVIVO10. Los resultados ponen en evidencia la importancia de la práctica clínica, la prevención, y la diferenciación de los pacientes en función de la gravedad del problema. Consideran que la profilaxis debe hacerse desde los primeros momentos del diagnóstico y se debe informar al paciente de todos los recursos disponibles. Finalmente afirman que la mayor dificultad es que hay muchas personas con riesgo de suicidio que no buscan ayuda.**

*Palabras clave – suicidio; prevención; profesionales de la salud; cualitativo; EUREGENAS.*

## I. INTRODUCTION

Suicide is a serious public health problem which is one of the most frequent causes of unnatural death in the world [1] It is estimated that in the last 45 years the prevalence of suicide has increased by 60%, what turns it into the tenth leading cause of death worldwide and into one of the three main causes of death in persons between 15 and 44 years old [2].

Europe has a high suicide rate overall, but the epidemiology of suicide differs considerably from country to country [3]. Some countries such as Finland, Hungary and the Baltic countries, together with Russia and Belarus, have the highest suicide rates in the world reaching 40 suicides per 100,000 inhabitants. Nevertheless, southern European countries such as Italy, Spain and Greece show low suicide rates [4]. Although Spain is positioned among the European countries with lower suicide rates, during the last years this cause of death has increased substantially in our country. According to the data of the National Institute of Statistics [5], the number of suicides increased in Spain by 11,3% in 2012, what is the highest rate since 2005 [6]

Suicidal behavior is a complex phenomenon that is influenced by multiple factors, including biological, clinical, psychological and social factors [1]. Suicidal acts are usually preceded by milder symptoms such as thoughts of death or suicidal ideation [7]. Suicide is closely linked to the model of society in which an individual lives [8] and there exists a direct relationship between the suffering of stressful situations, environment alterations and the risk of suicide [9]. A large number of studies, clinical as well as community ones, have shown with consistent scientific evidence that the presence or a background of mental illness is a major risk factor for suicide in the population in general [10] [11] [12].

In an attempt to reach a breakthrough in the field of suicide prevention in Europe, the project European Regions Enforcing Actions against Suicide (EUREGENAS) brings together 11 regions which have diverse experiences in order to contribute to the prevention of suicide in Europe.

## II. METHOD AND EQUIPMENT

### A. Goals.

The European Regions Enforcing Actions against Suicide Project (EUREGENAS) is funded by Health Program 2008-2013, European Union. Castilla y León is one of the two

Spanish regions that participate in the project and it is represented by the Foundation INTRAS.

The overall aims of the project are the implementation of awareness activities with local and community consultants, in order to create a network of suicide risk detection; to offer training for doctors who work at primary care, and to give support to survivors of suicide (family and near friends of the person who committed suicide).

### B. Methodology.

The methodology used for this study is a qualitative analysis carried out by the research group of the University of Salamanca and the Pontifical University of Salamanca. They used discourses of several health professionals, which comprise psychologists, psychiatrists, primary care staff and staff of the emergency services. The aim was to describe and to explain the differences that allow distinguishing the meaning of the prevention of suicidal behavior among these professional collectives.

To complete the discursive space regarding the development of prevention, the focus group was used. Through discussion groups we obtain information about a specific topic of a social context, where people can express their views in interaction with others. As criteria for the distribution of the groups we used the health staff variable, which consists of four categories: psychologists, psychiatrists, staff of the emergency service, and primary care staff.

### C. Participants.

The recruitment of participants took place in the health area of Zamora and in the different centers of the INTRAS foundation. We structured the groups on a balanced way concerning the stratum, following the selection variable. The length of the sessions ranged from 1 hour to 1,5 hours, and they were recorded on digital video and audio, with written consent from the participants. Six groups were interviewed, with a number of people ranging between five and nine, which in the opinion of the research team, and in light of the results of the data analysis, saturated the discursive space. The meetings took place smoothly and in a participatory environment that encouraged the participants to speak freely, expressing their ideas individually and interactively. In order to ensure, as far as possible, conditions that provided similar discourses in all the groups, the research team decided not to bring up expressions directly related to the topic. This way we could detect how and on which way these notions arose in the spontaneous progression of the sessions. To achieve this goal, the dynamics of the groups took place in an open and non-directive manner. Only when the session was about to end, and the groups had already developed their discourses, if on a spontaneous way all the desired goals were not achieved, the moderators suggested more directly, to the groups to express their views on other issues related to the subject in question.

### D. Transcript and data analysis.

The application of the qualitative analysis program NVIVO 10 was used for the transcript of the discussion groups. The data analysis consists of two phases that arise from different analytical approaches: a first phase is used to detect the discursive positions and the symbolic configurations of the texts [13], and in the second phase, we follow the analytical model of Miles and Huberman [14]. In addition, we use a computer application, namely the qualitative data analysis program NVIVO 10, to facilitate the task of analysis.

### III. RESULTS

The research results are obtained by taking into account the system of categories "Intervention in risk behavior." Category 1 is *Labor Relevance given to suicide prevention*. The importance that the different discussion groups, and therefore, the different health professionals, give to prevention differs. We detect that it is an important issue for professionals of the emergency service and of the primary care service and for psychologists. This might be due to the fact that these professionals are usually the first ones to receive this kind of patients.

*“Yes, because they are the ones who need more attention, they need more care” (doctor of the emergency service).*

Category 2 is *Prevention, what is being done?* The staff of the primary care service is the group of professionals that asks to a greater extent for activities related to the training in suicide prevention. They argue not to be prepared to take care of patients with suicidal behavior, and even less in actions related to intervention in emergency situations for which they consider themselves not to be prepared and they act according to the seriousness they think the case in question might have. The discussion groups of psychologists instead emphasize on actions as the development of policies, protocols, and intervention programs. In this sense, psychiatrists seem to have the same view as psychologists, although psychiatrists prioritize the training in prevention instead of the development of policies, protocols, and intervention programs. The professionals of the emergency service emphasize on the immediacy of their performance as staff of the emergency service, informing the psychiatrist as soon as there is a minor indication of suicidal intentions on behalf of the patient. In addition, all the professionals who participated in the discussion groups highlight, although in a lesser extent, other actions such as "psychological support for people at risk of suicide" and "awareness and sensitivity".

*“I think we are not prepared, I am only speaking in general eh” (a doctor of the primary care service).*

*“We have to be sure about the fact that we do not have structured and specific prevention programs” (a psychologist).*

*“We always, always call the psychiatrist” (a doctor of the emergency service).*

*“I am telling you that we have to be sensitive with this issue and we should try to detect it in other kind of patients who we*

*receive for other reasons” (a doctor of the emergency service).*

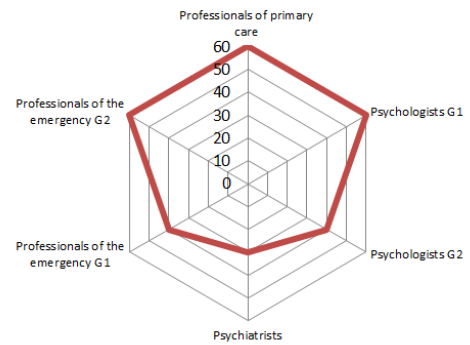


Figure 1. Priority in suicide prevention according to professionals care service

Category 3 is *Prevention, what should be done? human and material resources*. The groups emphasized on the following aspects: accessibility, difficulties, availability, abilities, real possibilities of action which are not done, the time, and they also presented some suggestions for improvement. The different discussion groups, especially the primary care staff, psychiatrists and staff of the emergency service, are above all worried about the difficulties.

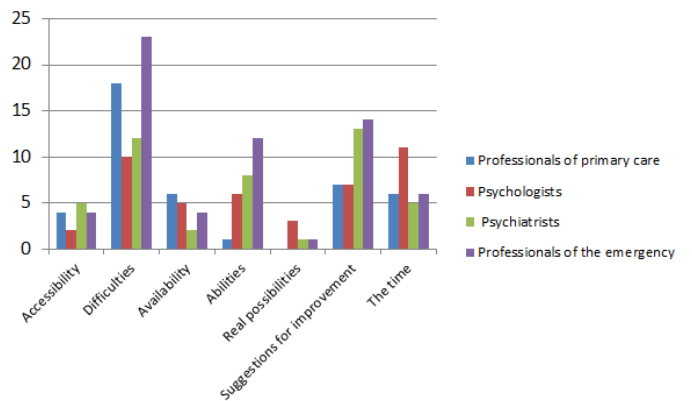
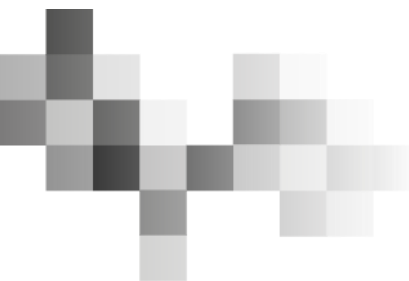


Figure 2. Prevention, what should be done?

### IV. DISCUSSION

All the participating professionals agree that suicide is a priority in the field of health, especially in relation to the necessities of intervention for the prevention of this serious public health problem. All the professionals express in a meaningful way how difficult it is for them to identify people who are at risk of suicide. In this sense, Pagura [15] refers to the existence of a large number of people who, in spite of finding themselves in a high risk suicide situation, do not realize the magnitude of this problem. Thus, they never get to ask for any kind of help, neither from relatives nor from health professionals, what limits considerably the intervention of health professionals. In this same concept, there are many people who, after having had a suicide attempt, do not



maintain a correct continuation of the psychiatric treatment or they stop with the medical supervision [16].

For professionals working at the emergency services, the existence of a psychiatrist who deals with emergencies in these services of a general hospital is a key aspect in the urgent attention of suicidal behavior, and it is very well appreciated by the patients themselves as well as by the staff. These professionals agree in considering this kind of patients as an emergency to which they give high priority, which can be compared for instance with an acute heart attack. In relation to this, it should be pointed out that not all the patients with this kind of behavior have the same degree of emergency of intervention. Each case is based on socio-demographic factors such as age or gender, as well as on the method of self-injury the patient used [17].

The doctors of primary care are the health professionals who most frequently get in contact with the first clinical symptoms related to suicide, nevertheless, they are a collective who think from themselves they have a large gap in abilities of detection and treatment of patients with suicidal behaviors. They also refer to the need of training they require for the care of patients with this kind of behavior or those who are in a situation of suicide risk, and also for the care of psychiatric patients in general. Luoma and Martin [18] point out that most of the people who die through suicide have had contact with the primary care services during the previous months, particularly the adult population, while there exists a percentage of cases that never come in contact with the Mental Health professionals.

This fact highlights the importance of interventions related to suicide prevention in the field of primary care and the impact it would have in the reduction of suicide rates. For this reason, giving the doctors of primary care training in this area becomes a priority.

For psychiatrists, the mayor difficulty lies in identifying patients who present manipulative behavior and their care during crisis situations. Regarding this kind of behaviors of para-suicide, Laget [19] emphasizes on the existence of a psychological profile that is more altered in individuals with a background of repeated suicide attempts compared with other types of attempts. In a recent study, Parra Uribe and Blasco-Fontecilla [20] obtained as results that people who commit suicide had received less accomplished prior monitoring on behalf of the psychiatric and mental health services than people who commit a failed suicide attempt; estimating that for 92 % of the persons who commit suicide, it is their first or second attempt. These data show comorbidity with personality disorders or the presumed existence of secondary benefits in some patients who present repeatedly para-suicidal behaviors.

Psychologists focus on the socio-familiar environment of these people and they highlight the importance of support of the family in these cases. Thus, Sun [21] presents the task that the nursing staff can carry out regarding the education of relatives of patients who are discharged from the hospital after a suicide attempt, in order to achieve appropriate support and care in the family environment. Psychologists also make

reference to the advantage of the existence of intervention teams in the community with respect to the following-up of patients with suicide risk. These teams have proved to be highly effective in suicide prevention [22].

## V. CONCLUSIONS

The group of professionals that participated in this research agrees on emphasizing on the great importance of suicide as a public health problem. The difficulties that exist to detect it and the care show the need to create prevention programs and prevention strategies in this health area. In this sense, the project EREGENAS represents an important breakthrough in the prevention of suicide in Europe.

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