ARTIGO ORIGINAL

ESTIGMA, CONHECIMENTO SOBRE SUICÍDIO E PERFIL PSICOLÓGICO DE ADULTOS EM RISCO DE SUICÍDIO EM DUAS CIDADE DO INTERIOR DE MINAS GERAIS, BRASIL

Stigma, knowledge of suicide and psychological profile of adults at risk of suicide in two cities of rural Minas Gerais, Brazil.

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ABSTRACT

Introduction: Suicide is a public health problem, and the identification of risk and protective factors can assist in the creation of public policies aimed at reducing the prevalence of ideation and/or attempts. **Objective:** The present study aimed to trace the psychological and demographic profile of adults at risk of suicide from two cities with suicide rates above the national average. **Method:** The 29 participants were selected by convenience and answered a sociodemographic questionnaire, the Self-Reporting Questionnaire (SRQ-20), the Stigma of Suicide Scale - Short Form (SOSS-SF) and the Literacy of Suicide Scale - Short Form (LOSS-SF). **Results:** The results indicated clinical levels of psychiatric symptoms in 60.8% of the participants. It was also perceived that there is a negative correlation between religiosity, normalization and/or glorification of suicide and that there is a positive relationship between schooling and knowledge about suicide, as well as less stigma against people who commit suicide. **Conclusion:** The study was able to show that younger people tend to present more internalizing symptoms and that people who use substances are less likely to normalize or glorify suicide. It also showed a relationship between higher education, greater knowledge about suicide and less stigma against those who commit it.

Key Words: mental health; suicide; psychology; medicine.

RESUMO

Introdução: Suicídio é um problema da saúde pública e a identificação do risco e fatores protetores pode ajudar a criar politicas públicas que visam reduzir a prevalência de ideação e/ou tentativas. **Objetivo:** O estudo buscou traçar o perfil psicológico e demográfico de adultos com alto risco de suicídio de duas cidades com a taxas de suicídio acima da média nacional. **Método:** Os 29 participantes foram selecionados por conveniência e responderam um questionário sócio demográfico, o Self-Reporting Questionnaire (SRQ-20), o Stigma of Suicide Scale - Short Form (SOSS-SF) e o Literacy of Suicide Scale - Short Form (LOSS-SF). **Resultados:** Os resultados indicam níveis clínicos de sintomas psiquiátricos em 60,8% dos participantes. Também foi percebido que existe uma correlação negativo entre religiosidade, normalização e/ou glorificação do suicídio e que existe uma correlação positiva entre escolaridade e conhecimento sobre suicídio, assim como, menos estigma contra pessoas que realizam o autoextermínio. **Conclusão:** O estudo foi capaz de mostra que pessoas mais jovens tendem a ter mais sintomas internalizantes e pessoas que fazem uso de substâncias são menos propensas a normalizar ou glorificar o suicídio. Ademais, mostrou o relacionamento entre nível de escolaridade, mais conhecimento acerca do suicídio e menos estigma contra aqueles que cometem o ato.

Palavras-chave: saúde mental; suicídio; psicologia; medicina.

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INTRODUCTION

Suicide is the act of taking one's own life. It is a complex phenomenon that represents a major public health problem worldwide.[1] It was estimated in 2015 that suicide accounted for 1.4% of premature deaths around the world, with 78.0% occurring in low-income countries.[2] Brazil is considered the eighth country in number of suicides worldwide, with levels increasing every year.[3] The severity of the situation is evidenced by the 60.0% growth in suicides over the last five decades.[4]

Several studies have sought to understand the factors that increase suicide risks, such as mental health issues (e.g., psychiatric disorders), previous history (sexual abuse, major losses), situational variables (social isolation), or socioeconomic and cultural values (social class, community participation, family support).[2,5,6,7] In addition to these factors, aspects directly related to the act of taking one's own life need to be considered as predictors, such as a history of previous suicide attempts and ease of access to means used for the act.[6,8] The stigma related to suicide also increases the chances that people at risk will seek professional help.[9,10]uicide. The same study showed that people with diagnosed anxiety also had less stigma toward suicide.[11]

This study aims to trace the psychological profile, knowledge, and stigma of individuals who

A less discussed subject associated with suicide behavior is the stigma and knowledge surrounding it. For example, a study showed that people with suicidal behavior and thoughts had more knowledge and less stigma towards are currently at risk of suicide or bereaved by the suicide of a close relative in the populations of two cities in western Minas Gerais. These cities were chosen for their high rates of reported suicide and suicide attempts.[12] It is also worth noting that a previous study indicated that, in the area, most victims of suicides are white men, between the ages of 31 and 50. The method that was most frequently used was hanging, which is interesting considering that, in Brazil, the use of guns in suicide is much more frequent.[4]

These cities have differences that must be highlighted to fully understand their context. City A has an estimated population of approximately 22.000 people, while City B is composed of about 53.000.[13] City A has a Primary Health Care Center, while City B has such a facility as well as a Psychosocial Care Center. The difference between these facilities is that Primary Health Care Centers act as the first point of contact between healthcare professionals and patients, capable of taking care of less complex patients, while Psychosocial Care Centers are more specific mental health units, aiming to help patients clinically while also helping them to be reincluded in society.

It is known that people with suicidal ideation tend to seek help from primary care services before dying. Approximately 75.0% of people who committed suicide sought primary health care services in the year of their death, with 45.0% doing so in the month of their death.[14] Suicide is a matter that demands the attention of professionals from different areas to address the risks and possibilities of prevention.[14,15] Therefore, it is important that healthcare professionals at the various stages of patient contact know how to deal with this issue.

METHOD

This is a quantitative descriptive study, part of a larger project entitled "Correlations between maladaptive schemas and suicide perception in young adults" (CAAE 80070017.3.0000.5134) and approved by the Ethics Committee under the number 4.005.117. This research was incorporated into a university extension project composed of healthcare students from the courses of nursing, physiotherapy, medicine, and psychology and coordinated by psychology professors.

Sample:

Twenty-nine people at risk for suicide, with a history of attempts or a history of attempted or consummated suicides within their families, from two cities in the countryside of Minas Gerais, participated in the study.

Instruments:

Sociodemographic questionnaire: constructed by the research team, it contains items associated with sociodemographic and health aspects, life habits, and risk behaviors for suicide. In this questionnaire, the criteria of economic status made by the Brazilian Association of Research Companies (ABEP) was included.

Self-Reporting Questionnaire (SRQ-20): self-report instrument composed of 20 dichotomous items (yes/no), aiming to screen for non-psychotic mental disorders. Each affirmative response is scored with a value of 1 to compose the final score through the sum of these values. The scores obtained are related to the probability of the presence of a non-psychotic disorder, ranging from 0 (no probability) to 20 (extreme probability).[16]

Stigma of Suicide Scale - Short Form (SOSS-SF): self-report scale, currently being validated for Brazil, which aims to assess levels of knowledge and taboos associated with suicide. The SOSS-SF is the first worldwide scale that aims to identify which characteristics the general population attributes to a person who has completed suicide, focusing on stigma. It is structured into three factors, the first being stigma - the negative view people have of suicide; the second being normalization or glorification - a tendency to understand and/or glorify the person who commits suicide; and the third being isolation or depression - attributes the experience of isolation and loneliness as well as poor mental health as characteristics of victims of suicide.[17]

Literacy of Suicide Scale - Short Form (LOSS-SF): another self-report scale that aims to assess levels of knowledge and taboos. It assesses the four domains of knowledge about suicide, namely: signs and symptoms, causes or nature of suicide, risk factors and treatments, and prevention.[17]

Procedures:

The participants were invited to participate in the study and were informed about the procedures in an individual interview, held in the basic healthcare centers, and those who agreed to participate signed the informed consent form. The questionnaires were applied individually, and the participants completed them within 1.5 to 2 hours.

The compiled data were submitted to a descriptive statistical analysis – frequencies. For continuous variables, we used correlational analysis (Spearman's rho). Correlation values were

classified in magnitude, according to criteria proposed by Cohen (1988) (rho<.3 low; between 0.3 and 0.7 moderate; and rho >0.7 high). Nominal variables were submitted to a nonparametric means comparison (Mann-Witney U Test), which consider significant the results with a p-value of less than 0.05.

RESULTS

Most of the participants were female (93.0%), between 41-50 years old (34.5%), and Catholic (65.5%). Regarding race, most declared themselves as white or brown (79.3%), and in marital status, most were either single or married (37.9% in each). The two cities differed in the prevalence of Catholics, 73.7% in City A, while in City B 50.0% considered themselves Catholic and 40.0% declared they had no religion. In City A, the majority consider themselves not very religious and in City B, the majority do not consider themselves religious, followed by the perception of being very religious. In City A there is a higher percentage of people that have completed higher education. Detailed information about the participants can be found in Table 1.

Table 1. Distribution of the sample based on the city and socio-demographic characteristics.

VARIABLES	FREQUENCY (%)	
	City A (n=19)	City B (n=10)
AGE GROUP		
18-30	3 (15.8)	2 (20.0)
31-40	4 (21.1)	1 (10.0)
41-50	6 (31.5)	4 (40.0)
51-60	4 (21.1)	1 (10.0)
61-70	2 (10.5)	2 (20.0)
RACE		
White	8 (42.1)	5 (50.0)
Brown (mixed race)	8 (42.1)	2 (20.0)
Black	2 (10.5)	1 (10.0)
Preferred not to say	1 (5.3)	2 (20.0)
RELIGION		
Catholic	14 (73.7)	5 (50.0)
Evangelical	2 (10.5)	1 (10.0)
No religion	1 (5.3)	4 (40.0)
Other	2 (10.5)	0 (0.0)
MARITAL STATUS		
Single	7 (36.8)	4 (40.0)
Married	7 (36.8)	4 (40.0)
Divorced	1 (5.3)	1 (20.0)
Widowed	4 (21.1)	1 (20.0)
EDUCATION LEVEL		
Elementary School	9 (47.3)	5 (50.0)
High School	6 (31.5)	4 (40.0)
Higher Education	4 (21.1)	1 (10.0)

The SRQ-20 was answered by 28 of the participants, of which 17 (60.8%) had clinical evidence of internalizing symptoms, with 12 (42.9%) at a severe degree. Depressive disorders make up the most common diagnoses in the group (41.4%) reported during the sociodemographic questionnaire, as can be seen in Figure 1. It is important to note that the participants could report more than one diagnosis. Regarding risk behaviors, 9 (32.1%) have the habit of mutilating themselves, 12 (42.9%) use alcohol or other drugs frequently, and 20 (71.4%) have attempted suicide at least once in their lives. Regarding other risk factors, it was observed that 27 people (96.4%) had at least one acquaintance who had killed themselves, and 18 (64.3%) had already lost at least one family member to suicide. It is worth mentioning that one of the participants chose not to answer part of the questionnaire and the values were adjusted accordingly.

When comparing the two participating cities, we noticed that in City A, where suicide statistics are higher and the culture seems more aware of such occurrences, the prevalence of cases with clinical internalizing symptoms was higher than in City B (63.2% and 55.0%, respectively). As for risk behaviors, in City A more participants presented the habit of self-mutilation (31.5%), substance use within the last 6 months (42.8%), and suicide attempts (72.2%), when compared to City B, with 30.0%, 40.0%, and 50.0%, respectively. When analyzing other factors, it was observed that all participants in City A knew at least one person who had committed suicide, while in City B the percentage was 70.0%. Moreover, 12 (63.1%) participants from City A had already lost at least one family member to suicide, contrasting with the 4 (40.0%) participants from City B.

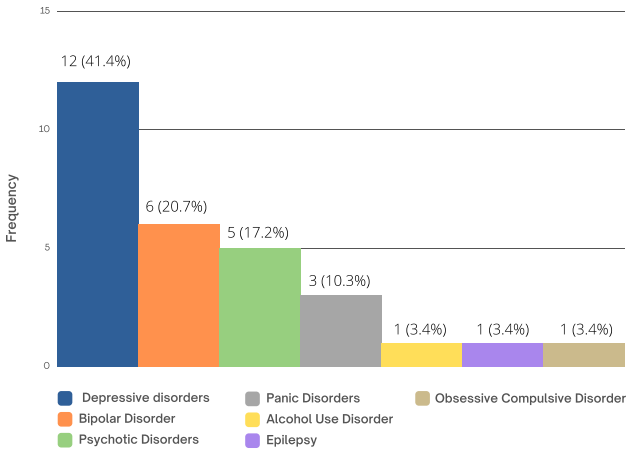

Figure 1. Previous psychiatric diagnoses received by the participants.

To identify possible associations between the characteristics surveyed and the stigmas and knowledge about suicide, for continuous variables we used correlational analysis (Spearman's rho) and for nominal variables we used a nonparametric means comparison (Mann-Witney U Test). The significant correlations found were all of moderate magnitude. Education level correlated significantly with stigma (rho=-0.442; $p<0.05$) and with knowledge about suicide (rho=0.658; $p<0.01$), indicating that individuals with higher education tend to stigmatize less those who have committed suicide, as well as to have more knowledge about the subject. Age showed a negative and significant correlation with psychiatric symptoms (rho=-0.378; $p<0.05$), indicating that younger individuals

tend to have a higher frequency of symptoms. Regarding nominal variables, substance use, self-mutilation, suicide attempt, suicide attempt or consumed in the family, knowing people who committed suicide and psychiatric disorders in the family were submitted to mean comparison, and only substance use groups showed mean differences in Normalization (U=23,500, sig=0,037), indicating that individuals who frequently use alcohol and/or other drugs are less likely to normalize, understand, and/or glorify suicide and its victims.

Table 2. Spearman›s correlations between individual and family factors, stigma, and knowledge about suicide

VARIABLES	SRQ	STIGMA	ISOLATION	NORMAL-IZATION	LOSS
Age	-0,378*	0,396	-0,117	-0,066	-0,209
Religiosity	-0,131	0,101	-0,068	-0,360	0,150
Education	-0,081	-0,442*	0,341	-0,006	0,658**
People at home	0,249	-0,119	0,050	-0,294	0,230

Note: SRQ - frequency of non-psychotic symptoms; Stigma, Isolation, and Normalization- factors of the Suicide Stigma Scale; LOSS - level of knowledge about suicide; People at home: number of people living at the same house.

*p<0.05; **p<0.01

DISCUSSION

The present study aimed to profile the psychological, knowledge, and stigma aspects of individuals at risk of suicide in two cities of Minas Gerais. The results indicate clinical evidence of psychiatric symptoms in most of the sample, mainly depressive and bipolar disorders. Risk behaviors such as self-mutilation and substance use were also common in the group. Regarding sociodemographic factors, most of the participants were female, aged between 41-50 years, and Catholic. Furthermore, correlation analyses indicate that younger people tend to present more psychiatric symptoms, people with higher education have less stigma and more knowledge about suicide, and those who use substances are less likely to normalize or glorify suicide. Such results are partially in line with what would be expected to be found in current literature.[16,17,11] As expected, there is a relationship between suicide cases and several risk factors previously identified in the literature, such as depressive disorder, close contact with relatives and acquaintances who have committed suicide, and previous suicide attempts.[8,19] The negative correlation between religiosity and normalization or glorification of suicide was also expected.[19] It has been identified that there is a relationship between religiosity, life satisfaction, and psychological well-being as they contribute to community support practices, such as religious support groups.[20] In general, studies indicate that people who identified themselves as more spiritual had lower odds for suicide attempt.[20, 21, 22] It is possible that when faced with cases of suicidal ideation or suicide attempts, professionals can assess what is the patient's attachment to religion by identifying its importance in their identity construction, the support practices offered by this religious group, how suicide is considered by the religious group, and whether other past experiences of difficulties of the patient were supported by religion.[20]

The relationship between greater education, greater knowledge about suicide, and less stigma against people who commit suicide was also established as expected.[11] On the other hand, no studies were found to corroborate or refute the data found that states that people who make use of substances have less tendency to normalize or glorify suicide. Analyzing the sample, no data were found to support our hypotheses.

Regarding the differences between the cities evaluated, it is known that City A has a suicide rate of about 25.4 per 100.000 inhabitants per year, about 4.8 times higher than the national average of 5.35. City B has a rate closer to the national average of 6.6. These data were calculated according to the average number of deaths by suicide from 2010 to 2019.[13] Thus, the study was able to present the alarming suicide rates of these cities when compared to the national rates.

In addition, the study made it possible to show the demographic profile as well as its correlations with the SRQ-20, SOSS-SF, and LOSS-SF questionnaires of the population most exposed to the phenomenon of suicide in cities A and B. The study also discussed the possible factors related to the occurrence of suicide as well as the factors that contribute to mitigating the issue, such as education. In this way, the study was able to make unprecedented analyses of this region evidencing an important public health problem that must be addressed.

However, it is important to point out that the study has several limitations. The sample, besides being small, is poorly distributed. These limitations arose because the sample was formed by convenience and the number of participants involved in the data collection process was too small. Another limitation in the study is the low understanding of the questionnaires by the sample participants since some of them had difficulty interpreting the questions due to low education and/or advanced age. The sample also limited the establishment of other correlations between the data more expressively by making the significant data have at most moderate relevance (maximum rho = 0.658). In respect to the sample limitations, it is important to highlight the disproportion between the male and female samples (27 women and 2 men), which makes any meaningful comparison between genders impossible. This disproportion not only limits the analysis but shows the male disengagement from the healthcare system, even though men are the main victims of suicide in Brazil.[12,23,24] Such distancing of the male population from the healthcare system reinforces issues related to the sexist mentality cultivated in Brazilian society that imposes men to deny healthcare by minimizing their complaints as much as possible, since these complaints supposedly make men less virile.[25]

Future studies should expand and better distribute the sample profile to mitigate biases present in this study. In addition, some points perceived in this study but addressed in a superficial manner, such as the impacts of sexism on suicide, can be addressed in other studies to contribute to the formulation of relevant public policies for this population. Finally, other variables can be addressed and correlated in future studies for a more in-depth analysis of this region, such as violence, femicide, family abuse, psychological and psychiatric care, prescription of medications for psychiatric

treatment, among others.

CONCLUSION

The study made it possible to observe some psychological aspects associated with suicide risks in two cities of Minas Gerais (Brazil). The study shows preliminary evidence that confirms national statistics, such as younger people tend to present more internalizing symptoms and that people who use substances are less likely to normalize or glorify suicide. The relationship between higher education, greater knowledge about suicide, and less stigma against people who commit suicide was also evidenced. The limited size and diversity of the sample are among the limitations of the present study. In this way, further studies are still needed to explore these issues in more depth and report the real effect that these factors have on public health.

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