# Facing a Patient Who Seeks Help After a Suicide Attempt

## The Difficulties of Health Professionals

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**Abstract.** *Background:* Although intervention with suicidal patients is one of the hardest tasks in clinical practice, little is known about health professionals' perceptions about the difficulties of working with suicidal patients. *Aims:* The aims of this study were to: (1) describe the difficulties of professionals facing a suicidal patient; (2) analyze the differences in difficulties according to the sociodemographic and professional characteristics of the health professionals; and (3) identify the health professionals' perceived skills and thoughts on the need for training in suicide. *Method:* A self-report questionnaire developed for this purpose was filled out by 196 health professionals. Exploratory principal components analyses were used. *Results:* Four factors were found: technical difficulties; emotional difficulties; relational and communicational difficulties; and family-approaching and logistic difficulties. Differences were found between professionals who had or did not have training in suicide, between professional groups, and between the number of patient suicide attempts. Sixty percent of the participants reported a personal need for training and 85% thought it was fundamental to implement training plans targeted at health professionals. *Conclusion:* Specific training is fundamental. Experiential and active methodologies should be used and technical, relational, and emotional questions must be included in the training syllabus.

**Keywords:** suicidal behaviors, health professionals, difficulties, needs, perceived skills

Psychiatrists, general practitioners, and psychologists are at great risk of encountering suicidal behaviors among their patients. Clinical practice with suicidal people was identified as one of the most stressful and anxiety-provoking areas of practice for many health professionals, regardless of their level of experience (Kleespies & Ponce, 2009; Menninger, 1990). In addition, suicidal behavior poses a major challenge to health professionals owing to its limited predictability (Hawton & Van Heeringen, 2009).

However, few data are available on the specific difficulties health professionals experience when they follow up a suicidal patient (Ramberg & Wasserman, 2003). Despite the lack of a dataset focused on the difficulties, studies from subdomains of suicidology, as referred to below, have provided support for the hypothesis of the specificity and multidimensionality of these difficulties. Research on the impact of patient suicide has shown that in addition to emotional reactions (e.g., shock, anger, guilt, anxiety, feelings of failure, fear that it happens again), professionals had technical concerns, namely, related with risk assessment skills (e.g., Brown, 1987a, 1987b; Gulfi, Dransart, Heeb, & Gutjahr, 2010; Rothes, Scheerder, Van Audenhove, & Henriques, 2013; Ruskin, Sakinofsky, Bagby, Dickens, & Sousa, 2004; Wurst et al., 2011).

Other data come from the set of studies carried out by Neimeyer and colleagues on the ability of health professionals and other caregivers to respond appropriately to suicidal persons using the Suicide Intervention Response Inventory (SIRI; Neimeyer & MacInnes, 1981; Neimeyer & Bonnelle, 1997). These and subsequent studies that also used the SIRI instrument (e.g., Palmieri et al., 2008) highlighted another potential difficulty when dealing with suicidal people – the relational difficulties in the therapeutic context. In a study about suicide intervention skills with a wide sample of professionals, Scheerder, Reynders, Andriessen, and Van Audenhove (2010) found: (1) skill scores below acceptable levels in some professionals; (2) a tendency of the low-skilled professional groups to overestimate their skills; and (3) differences between professional groups in responding appropriately to suicidal people. Moreover, higher levels of skills have been associated with higher levels of training in suicidology and more experience with suicidal patients, while no significant associations have been found with gender, age, or years of experience (Neimeyer & Bonnelle, 1997; Neimeyer, Fortner & Melby, 2001; Neimeyer & MacInnes, 1981; Scheerder et al., 2010). These results support the idea of the specificity of suicide intervention and associated difficulties.

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In a previous qualitative study on the perceived difficulties and needs of professionals toward suicidal patients, we found that a lack of specific training, the absence of a multidisciplinary team, and a perceived lack of time by the professionals were the most commonly reported difficulties by doctors and psychologists (Rothes, 2006). These results were derived from an in-depth qualitative study using a small sample, and therefore more research is recommended to understand the specificity of the difficulties and the professionals' training needs. The perceptions of health professionals about the training needed to deal with suicidal patients affect their work with these patients (Ramberg & Wasserman, 2004). To set up training guidelines in suicide prevention, it is important to identify how different sociodemographic and professional characteristics are related to difficulties. Training directed at increasing knowledge about suicidal behaviors, including risk factors, and at improving skills in suicide risk detection and in the management of suicidal individuals is not usual in psychology and medical graduate or postgraduate programs, even though suicide training is on the rise (e.g., Hawgood, Krysinska, Ide, & De Leo, 2008; Palmieri et al., 2008; Schmitz et al., 2012). Despite the lack of suicide prevention training and the recent culture of assessment of training impact, research has clearly established the positive effects of suicide prevention training aimed at health professionals. Various studies, using different assessment methodologies and types of training, have achieved similar outcomes, demonstrating effectiveness in improving knowledge, attitudes, confidence, and skills (e.g., Cais, Silveira, Stefanello, & Botega, 2011; Cross, Matthieu, Lezine, & Knox, 2010; Jacobson, Osteen, Jones, & Berman, 2012; Smith, Silva, Covington, & Joiner, 2013) and promising results in suicidal behavior reduction (Isaac et al., 2009). However, doubts remain about the changes in skills (e.g., Cross et al., 2010) and mainly in the endurance of the effects (e.g., Gask, Dixon, Morriss, Appleby, & Green, 2006; Levav et al., 2005; Moore, Cigularov, Chen, Martinez, & Hindman, 2011), reflecting the need for further research in order to inform a more tailored training.

The general goal of this study was to assess the difficulties of professionals and their training needs, in order to improve training programs in suicidology. More specifically, the study had four main goals: (1) to develop an instrument that enables the assessment of the health professionals' difficulties; (2) to describe the main difficulties of health professionals; (3) to analyze differential difficulties according to the sociodemographic and professional characteristics of the health professionals; and (4) to identify the health professionals' perceived skills and thoughts on the need for training in suicide.

With regard to differential analyses, we formulated the following hypotheses: (1) General practitioners have more difficulties than psychiatrists and psychologists; (2) health professionals with specific training in suicide have fewer difficulties than health professionals without specific training; and (3) health professionals with more experience in suicidal behaviors have fewer difficulties than those with less experience.

# Method

## Development of Survey Instrument: Difficulties in Suicidal Behaviors Intervention Questionnaire – Version for Psychologists and Doctors (DSBQ)

To assess the difficulties of health professionals when facing a patient who seeks help after a suicide attempt, a questionnaire was developed based on the results of a previous qualitative study conducted with 30 professionals (psychologists, psychiatrists, and general practitioners). In the previous study, the free association technique was used as a method for data collection, in order to gather the spontaneous responses of participants, using as stimuli the *needs* and *difficulties* of intervention with suicidal patients. To select the most important difficulties reported by professionals, we used frequency analysis and correspondence factor analysis (Rothes, 2006). For the construction of the Difficulties in Suicidal Behaviors Intervention Questionnaire (DSBQ), the most important statements were transformed into items and additional items were added based on the literature. The DSBQ resulted in 32 difficulties, each scored on a 5-point Likert scale from 1 (*not frequent at all*) to 5 (*very frequent*) allowing a global score to be calculated. An additional set of questions focused on specific training and on professionals' perception about the need for training in suicide. Specific training in suicide is considered training aimed at increasing knowledge about suicidal behavior and risk factors and at improving skills related to the detection of suicide risk and the management of suicidal individuals. The questionnaire also collects information about experience with suicidal behavior in clinical practice and sociodemographic and professional data. The DSBQ is presented in the Appendix.

## Participants and Procedures

Prospective participants – psychologists, psychiatrists, and general practitioners – were approached in order to gather participants from the entire country and from different workplaces. A mixed methodology was used in the sampling process: targeted sampling (Watters & Biernacki, 1989) and snowball sampling (Browne, 2005; Faugier & Sargeant, 1997). In the first technique, target work settings were identified (such as hospitals, health centers, community intervention centers) according to a previous geographical mapping: In each district of the country (18 plus two islands) three or four work settings were designated for data collection. In each of these settings, a presentation of the research was carried out (11 in person and the rest by email or letter) in order to invite the professionals to participate. Associations of psychotherapy and the Portuguese Society of Suicidology were also contacted and their members were invited to participate in the survey. The second sampling method, snowball, is characterized by participants recruiting other potential participants through

 

their professional or personal networks. In order to select a more representative sample than the traditional snowball technique enables, an additional set of methodological procedures recommended in the literature was used: (1) Professionals helped in the recruiting in two ways – they directly invited other colleagues to participate and they designated prospective participants, sending their contacts to the researchers; (2) the number of professionals that some participants could recruit was limited to three to five colleagues; and (3) a set of inducements to promote participation were used (e.g., customized letter; Heckathorn, 1997, 2002; Negreiros & Magalhães, 2009). The additional set of procedures used has an advantage over traditional snowball techniques, promoting the composition of samples that converge and reach equilibrium after a relatively limited number of recruitment chains, independently of the initial sample (the seeds). This way, despite the nonrandom selection, the bias introduced is progressively eliminated. Moreover, the additional procedures reduce the biases resulting from differences in the size of personal networks and from the designated voluntarism.

Data were collected in 2010 and 2011 through both a Web survey and a mail survey. The cover letter, participation invitation, and questionnaire were sent by email or by mail, including the link to the online version or the paper version, respectively. Professionals who had contact with suicidal behaviors in clinical practice were invited to rate the difficulties scale. In this research, we considered contact with suicidal behaviors as contact with a patient suicide attempt, a patient suicide, and a patient at serious risk of suicidal behavior. Anonymity and confidentiality of the data collected were guaranteed.

The study protocol was approved by the Portuguese Society of Suicidology and by the Ethics Committee of the hospital Centro Hospitalar do Nordeste, E.P.E., Bragança, Portugal.

## Data Analysis

Statistical analyses were carried out using SPSS version 19 (IBM Statistics). Descriptive statistics were calculated. Principal components analysis (PCA; a first- and a second-order exploratory factor analysis) was performed in order to identify the underlying dimensions and to reduce items to a more manageable set of data.

Component loadings of at least 0.35 were considered meaningful. To determine the number of components, a *parallel analysis* was conducted and different possible solutions were explored. Promax was used to rotate the components to a simple structure and obtain oblique solutions, allowing factor correlations. The reliability (internal consistency) was calculated by Cronbach's $\alpha$. Additionally, a global score of difficulties was calculated.

Factor scores were obtained by the mean of items with a meaningful loading on the respective components. Each factor was taken as a type of difficulty, and to investigate the mean differences among the type of difficulties, a one-way repeated measures ANOVA was conducted followed by a post-hoc multiple means comparison with Bonferroni adjustment.

Differences in difficulties between professional groups and differences according to sociodemographic and professional characteristics (e.g., gender, age, years of practice, having specific training in suicide, experience with suicidal patients) were determined by the independent samples *t* test and by one-way between groups ANOVA followed by Tukey's HSD post-hoc comparisons. Bonferroni adjustment was applied to these comparisons. For these analyses, age, years of practice, and number of patient suicide attempts were re-coded into interval categories. To explore the impact of age and professional group on difficulties, two-way between groups ANOVA tests were carried out. The relationships between professional group and specific training, number of patient suicide attempts, patient suicide experience, and perceived skills were investigated by $\chi^2$ analyses. Finally, the relationship between professional group and perception of training needs was analyzed by one-way between groups ANOVA followed by Tukey's HSD post-hoc comparisons.

*Table 1.* Participants' characteristics

| | *N* | % |
|---|---|---|
| Participants (*N* = 196) | | |
| Psychologists | 94 | 48.0 |
| Psychiatrists (general and child) | 50 | 25.5 |
| General practitioners | 52 | 26.5 |
| Gender (*N* = 196) | | |
| Female | 132 | 67.3 |
| Male | 64 | 32.7 |
| Age (*N* = 196) range 24–77 years, *M* = 39.6, *SD* = 12.0 | | |
| Younger ≤ 33 | 70 | 35.7 |
| Middle aged 34–42 | 62 | 31.6 |
| Older ≥ 43 | 64 | 32.7 |
| Years of practice (*N* = 196) range 1–48 years, *M* = 14.0, *SD* = 10.9 | | |
| Low experience ≤ 6 | 67 | 34.2 |
| Middle experience 7–15 | 64 | 32.7 |
| High experience ≥ 16 | 65 | 33.2 |
| Specific training in suicide (*N* = 193) | | |
| Yes | 37 | 19.2 |
| No | 156 | 80.8 |
| Experience with suicidal behaviors in clinical practice (*N* = 196) | | |
| Patient suicide attempt or serious risk of suicidal behavior | 194 | 99.0 |
| Patient suicide | 64 | 32.7 |
| Number of patient suicide attempts (*N* = 185) | | |
| Few ≤ 3 | 83 | 44.9 |
| Moderate 4–8 | 43 | 23.2 |
| Many ≥ 9 | 59 | 31.9 |

 

# Results

## Participants' Characteristics

A total of 242 health professionals filled out the questionnaire, but 46 provided no information on or had no contact with suicidal behaviors in clinical practice, resulting in 196 participants. The characteristics of the participants are reported in Table 1. With regard to specific training in suicide intervention, significant differences were found between professional groups ($\chi^2$ = 12.02, $df$ = 2, $p$ = .002). General practitioners were the professional group with less specific training (6%) and psychiatrists were the professionals who reported having more suicide training (33%). There were also significant differences between professionals groups regarding experience with suicidal behaviors in clinical practice. The difference in proportions of psychologists, psychiatrists, and general practitioners with few, moderate, and many patient suicide attempts was statistically significant ($\chi^2$ = 39.12, $df$ = 4, $p$ = .000). The proportion of psychologists with few patient suicide attempts was 56%, and those with moderate and many suicide attempts were 23% and 21%, respectively. Of the psychiatrists, 16% had few, 18% had moderate, and 66% had many patient suicide attempts. The proportion of general practitioners with few patient suicide attempts was 55%; that of general practitioners

*Table 2.* Principal components of health professionals' difficulties toward suicide attempters

| Component label | Items – Difficulties | F1 | F2 | F3 | F4 |
|---|---|---|---|---|---|
| Technical difficulties | Lack of specific training | .942 | | | |
| | Lack of technical and theoretical knowledge | .881 | | | |
| | Afraid of not being able to assess suicidal risk | .755 | | | |
| | Lack of specific risk assessment instruments | .724 | | | |
| | Lack of specific intervention protocols | .638 | | | |
| | Lack of specific intervention techniques for children | .574 | | | |
| | To feel helpless | .441 | | | |
| | Lack of clinical supervision | .381 | | | .366 |
| Emotional difficulties | To think about the case when one does not want to | | .911 | | |
| | Distressed | | .878 | | |
| | Preserving one's own well-being | | .838 | | |
| | Burnout | | .681 | | |
| | To get disturbed | | .644 | | |
| | I question my professional ability to help the patient | | .620 | | |
| | Afraid that patient completes suicide | .388 | .541 | | |
| | Maintaining technical distance | | .514 | .358 | |
| Relational and communicational difficulties | Being empathic with the patient | | | .880 | |
| | Approaching the theme of death | | | .838 | |
| | To accept the patient unconditionally | | | .739 | |
| | Dealing with the theme of death | | | .696 | |
| | How to have a dialogue with the patient about the theme | | | .638 | |
| | To feel angry at the patient | | | .632 | |
| | To feel rejection toward the patient | | | .604 | |
| | Lack of confidence in the professional by the patient | | | .418 | |
| Family-approaching and logistic difficulties | Lack of time | | | | .711 |
| | Having the family's collaboration | | | | .695 |
| | Unsuitable setting | | | | .682 |
| | Lack of social support structures | | | | .660 |
| | Working with the family | | | | .568 |
| | Absence of a multidisciplinary team | | | | .521 |
| | Providing support to the family | | | | .487 |
| | Cronbach's α | .89 | .88 | .86 | .79 |



 

with moderate attempts was 29% and with many attempts was 16%. The proportion of psychologists, psychiatrists, and general practitioners who had at least one patient suicide was also significantly different ($\chi^2 = 30.71$, $df = 2$, $p = .000$): 14%, 56%, and 44%, respectively.

## Health Professionals' Difficulties

The difficulties most commonly felt as frequent or very frequent by health professionals when facing a suicidal patient were: lack of intervention techniques for children (63%), absence of a multidisciplinary team (51%), lack of social support structures (48%), lack of risk assessment instruments (47%), lack of specific protocols (42%), lack of training (40%), being afraid that patient commits suicide (38%), lack of time (31%), working with patient's family (30%), lack of clinical supervision (30%), and the assessment of suicidal risk (29%). The mean global score of difficulties was 2.47 ($SD = 0.55$) with minimum 1 and maximum 4.

Parallel analysis suggested the extraction of four or five factors. To determine the final number of factors, the retention of three, four, or five factors was explored. The most theoretically interpretable and consistent solution consisted of 31 items grouped into four factors. In Table 2, the Promax-rotated results are shown. One item that did not have a meaningful loading on any component was eliminated. The three items with meaningful loadings on two components were assigned to the component on which they loaded the highest.

The first component was named *technical difficulties* and includes eight items related to the lack of specific training and lack of technical and theoretical knowledge on suicidal behaviors, namely, on suicide risk assessment and protocols of assessment and intervention in the absence of which professionals tend to feel helpless.

The second component called *emotional difficulties* contains eight items concerning the emotional impact of working with suicidal patients, such as feeling distressed, experiencing fear that the patient dies by suicide, or becoming disturbed by the case.

The third component labeled *relational and communicational difficulties* comprises eight items focused on the therapeutic relational and communicational attitude including the death theme approach.

Finally, the fourth component was named *family-approaching and logistic difficulties* and contains seven items related to work with the family, logistic conditions of intervention, and the absence of teamwork.

Cronbach's $\alpha$ ranged between .89 and .79, revealing a good internal consistency. The DSBQ also has a high sensitivity: Answers to 24 items ranged from the lowest to the highest value (1 to 5), and answers to six items scored from 1 to 4.

A second-order factor analysis yielded one dimension revealing that the four specific types of difficulties have an underlying common and broader difficulty factor. The loadings of the four factors were: F1 = .83, F2 = .77, F3 = .76, and F4 = .74. Cronbach's $\alpha$ was .78, indicating a good internal consistency.

There were statistically significant differences between all four difficulties components (Wilks' $\lambda = .254$ $F(3, 193) = 189.07$, $p = .000$). The difference in the mean scores between the four types of difficulties was very large (multivariate partial eta squared, $\eta_p^2 = .746$). Technical difficulties were the ones most frequently reported by health professionals ($M = 2.99$, $SD = 0.90$), followed by family-approaching and logistic difficulties ($M = 2.84$, $SD = 0.71$) and then by emotional difficulties ($M = 2.32$, $SD = 0.66$). Relational difficulties were perceived as the ones less frequently felt ($M = 1.77$, $SD = 0.56$).

## Factors Related to Difficulties

As predicted, DSBQ scores (global score and components difficulties scores) were statistically significantly related to the professional group, to specific training in suicide, and to the number of patient suicide attempts. These results are presented in Tables 3, 4, and 5. The magnitude of differences was moderate to large. The three professional groups (psychologists, psychiatrists, and general practitioners) showed significant differences in the global difficulty score, as well as in technical, relational, and family-approaching and logistic difficulties. General practitioners reported more difficulties than psychologists and psychiatrists did. Professionals without specific training

*Table 3.* Differences in difficulties according to professional group

| Variables | Psychologists *M* (*SD*) | Psychiatrists *M* (*SD*) | GPs *M* (*SD*) | *F*(2, 193) | *p* | $\eta^2$ | Post-hoc (*p* values) Psychologists vs. psychiatrists | Psychologists vs. GPs | Psychiatrists vs. GPs |
|---|---|---|---|---|---|---|---|---|---|
| Technical | 2.99 (0.96) | 2.42 (0.65) | 3.53 (0.60) | 24.01*** | .000 | .20 | .000 | .000 | .000 |
| Emotional | 2.36 (0.69) | 2.10 (0.50) | 2.45 (0.68) | 4.21(*n.s.*) | .016 | .04 | – | – | – |
| Relational | 1.67 (0.53) | 1.65 (0.51) | 2.07 (0.57) | 10.94*** | .000 | .10 | *n.s.* | .000 | .000 |
| Family-approaching and logistic | 2.63 (0.69) | 2.70 (0.55) | 3.34 (0.63) | 21.84*** | .000 | .18 | *n.s.* | .000 | .000 |
| Global score | 2.41 (0.57) | 2.21 (0.42) | 2.84 (0.44) | 21.12*** | .000 | .18 | *n.s.* | .000 | .000 |

*Notes:* GPs = general practitioners. *** Significant level at .001 (Bonferroni adjustment). *n.s.* = not significant



 

*Table 4.* Differences in difficulties according to specific training in suicide

| Variables | Yes *M* (*SD*) | No *M* (*SD*) | *t* (191) | *p* | $\eta^2$ |
|---|---|---|---|---|---|
| Technical | 2.32 (0.80) | 3.15 (0.85) | –5.38*** | .000 | .13 |
| Emotional | 2.14 (0.64) | 2.35 (0.66) | –1.76 (*n.s.*) | .081 | .02 |
| Relational | 1.52 (0.42) | 1.83 (0.58) | –3.70*** | .000 | .07 |
| Family-approaching and logistic | 2.54 (0.73) | 2.91 (0.69) | –2.93 (*n.s.*) | .004 | .04 |
| Global score | 2.12 (0.53) | 2.56 (0.53) | –4.49*** | .000 | .10 |

*Notes:* *** Significant level at .001 (Bonferroni adjustment). *n.s.* = not significant.

*Table 5.* Differences in difficulties according to number of patient suicide attempts

| Variables | Few (≤3) *M* (*SD*) | Moderate (4–8) *M* (*SD*) | Many (≥9) *M* (*SD*) | *F*(2, 193) | *p* | $\eta^2$ | Post-hoc Few vs. moderate | Few vs. many | Moderate vs. many |
|---|---|---|---|---|---|---|---|---|---|
| Technical | 3.23 (0.87) | 3.07 (0.92) | 2.57 (0.74) | 10.83*** | .000 | .11 | *n.s.* | .000 | .011 |
| Emotional | 2.50 (0.68) | 2.21 (0.71) | 2.09 (0.51) | 7.64*** | .001 | .08 | .044 | .001 | *n.s.* |
| Relational | 1.83 (0.58) | 1.81 (0.59) | 1.62 (0.47) | 2.69 (*n.s.*) | .070 | .03 | – | – | – |
| Family-approaching and logistic | 2.84 (0.70) | 2.87 (0.64) | 2.82 (0.75) | 0.05 (*n.s.*) | .942 | .00 | – | – | – |
| Global score | 2.60 (0.56) | 2.48 (0.56) | 2.26 (0.48) | 6.70 (*n.s.*) | .002 | .07 | | | |

*Notes:* *** Significant level at .001 (Bonferroni adjustment). *n.s.* = not significant.

*Table 6.* Health professionals' needs for specialized training

| Items | | | | Fully disagree or disagree | | Somewhat agree | | Agree or fully agree | |
|---|---|---|---|---|---|---|---|---|---|
| *N* = 195 | Mode | *M* | *SD* | *N* | % | *N* | % | *N* | % |
| I feel the need for specialized training in suicide | 4 | 3.75 | 0.96 | 19 | 9.7 | 59 | 30.3 | 117 | 60.0 |
| I believe that my experience/training makes me a suitable trainer in this area. | 2 | 2.30 | 1.02 | 115 | 58.9 | 55 | 28.2 | 25 | 12.8 |
| Implementing training plans on suicide aimed at health professionals is fundamental | 5 | 4.37 | 0.78 | 3 | 1.5 | 27 | 13.8 | 165 | 84.7 |

reported more technical and relational difficulties and scored higher in the global difficulty score. Thus, hypotheses 1 and 2 were confirmed. Finally, results showed significant differences in technical and emotional difficulties according to the number of patient suicide attempts, but there were no differences according to having experienced a patient suicide or not. Therefore, the third hypothesis was only partially confirmed. Difficulties scores were not related to gender, age, or years of experience and age differences did not moderate the relationship between professional group and difficulties.

## Health Professionals' Perceived Skills and Training Needs in Suicide

With regard to the perceived risk assessment skills, 89% of health professionals self-rated their ability as positive and results revealed significant differences according to the professional group. Psychiatrists were the group that felt more capable of assessing suicide risk (98%), followed by psychologists (90%) and general practitioners (79%; $\chi^2$ = 9.63, *df* = 2, *p* = .008). Concerning the ability to deal with suicidal patients, half of the health professionals perceived their training as sufficient, and significant differences were also found between the groups. Seventeen percent of the general practitioners rated their training as sufficient, while this proportion was 88% for psychiatrists and 48% for psychologists ($\chi^2$ = 50.34, *df* = 2, *p* = .000).

The perceptions of health professionals about the need for training are presented in Table 6. There were statistically significant differences between professional groups in the need for training plans (*F*(2, 192) = 5.48, *p* = .005) but the actual difference in mean scores between the groups was small ($\eta^2$ = .05). Statistically significant differences were found between the general practitioner group (*M* = 4.08, *SD* = 0.86) and the other two professional groups; psychiatrists (*M* = 4.45, *SD* = 0.71) did not differ from psychologists (*M* = 4.50, *SD* = 0.73).



 

## Discussion

To our knowledge, this is the first survey to investigate health professionals' difficulties, specifically when facing a patient who seeks help after attempting suicide. The implications of our results for the content and format of training are discussed.

The main findings of the study were:

1. The questionnaire constructed for this study (DSBQ) presented good, albeit preliminary, psychometric properties.
2. Difficulties with suicidal people in a clinical setting are a multidimensional construct comprising four factors: (1) technical, (2) emotional, (3) relational and communicational, and (4) family-approaching and logistic difficulties.
3. As expected, specific suicide-related variables, namely, having training in suicide and a higher number of patient suicide attempts, were associated with lower levels of difficulties. General practitioners reported more difficulties than psychologists and psychiatrists did.
4. Health professionals revealed low levels of specific training, had a high perception of their risk assessment skill, held a view of their ability to deal with suicidal patients that ranged from low to high, and had a consensual perception of the need for training.

The results show that the DSBQ has good psychometric properties, presenting a high sensitivity, favorable exhaustiveness, good factorial validity, good internal consistency, and favorable construct validity, discriminating difficulties between professional groups, between professionals who had/did not have specific training, and between professionals dealing with different rates of suicide attempters.

Despite the low global score, the proportion of health professionals reporting difficulties is not negligible (63–29%) and provides important data about the particular content to be emphasized in training programs (viz., assessment of suicide risk, intervention with children, instruments and protocols, work with the suicidal patient family).

The results allow us to conclude that health professionals perceived the four types of difficulties in a different way: They reported fewer emotional and relational difficulties toward suicidal patients than technical and family-approaching and logistic difficulties. This may derive from the fact that for health professionals it could be easier to be aware of external technical difficulties than relational and communicational ones. Empirical and clinical works showed that relationship and communication skills with a patient following an attempted suicide are critical in the prevention of life-threatening behaviors and suicide (Michel, 2011; Michel & Jobes, 2011; Wolk-Wasserman, 1985). Gibbs (1990), on the basis of the literature on communicational aspects, concluded that the treatment of patients who have attempted suicide is hampered by a lack of self-awareness of the health professional. But there may be other explanations for the results of lower emotional and relational difficulties when compared with technical and family-approaching difficulties, which should be explored in future works. These aspects could be studied by adding case vignettes (e.g., Jacobson et al., 2012) to the study protocol, for example, combined with items about communication (e.g., SIRI-2, Neimeyer & Bonnelle, 1997) and items referring to the ability to "connect" with the patient or the ability to maintain a "trusting" relationship with open communication. A very important and informative finding from our study is that although only 19% of health professionals reported specific training in suicide, 89% felt competent to assess suicide risk and 50% thought they had adequate suicide training. Thus, an important clue for training can be formulated: Not only should it comprise a technical syllabus, but it should also include communicational and relational content, using case-based learning methodology and self-evaluations in order to increase self-awareness.

With regard to actual suicide intervention training, our results revealed similarity to those from other countries, underscoring that training in suicide intervention is not usual in psychology and medical graduate or postgraduate programs (e.g., Hawgood et al., 2008; Palmieri et al., 2008). For example, 12% of Italian health professionals reported having received specific training in suicide intervention (Palmieri et al., 2008).

The results of the differential analyses provide further evidence of the critical function of specific training for health professionals who deal with suicidal patients. Specific suicide-related variables, namely, having training in suicide and a higher number of patient suicide attempts, were associated with lower levels of difficulties, adding further support to the proposal of experience-based training as adequate methodology. These results are in line with reports from the literature that found significant associations between higher suicide skills and the two aforementioned variables (e.g., Neimeyer et al., 2001; Scheerder et al., 2010). However, some questions about specific suicide-related variables that may be relevant for setting up training in suicide prevention remain unanswered: What mediates the relationship between higher *number of attempts* and the lower levels of difficulties? Could it be related to apparently better skilled/more well-skilled professionals admitting higher-risk patients more often than professionals who indicate higher levels of difficulties? Or does the specific experience with suicidal patients promote the acquisition of important knowledge, thereby reducing difficulties? The confidence of health professionals has been identified as an important variable in clinical suicide prevention and has been the target of studies on training effects (e.g., Jacobson et al., 2012; Oordt, Jobes, Fonseca, & Schmidt, 2009). Which interaction effect could exist between confidence and training on perceived difficulties? These issues warrant further investigation.

Moreover, general practitioners reported more difficulties than psychologists and psychiatrists did, showing that this professional group may have special needs for training and support in this area. Indeed, general practitioners were the professional group found to have less specific training: 6% in our study and 4% in the Italian sample (Palmieri et al., 2008). This is in contrast to psychiatrists, who have higher levels of training: 33% in our Portuguese sample and 30% in a Belgian sample (Rothes et al., 2013) and in



 

an Italian sample (Palmieri, et al., 2008). Recent systematic reviews on evidence-based suicide prevention strategies agree that improvements at the general practitioner competence level is a crucial component of suicide prevention (Mann et al., 2005; Van der Feltz-Cornelis et al., 2011) or at least a promising strategy to reduce suicide rates (Isaac et al., 2009).

In line with other research, in our study the proportion of respondents who rated the adequacy of their training as sufficient varied according to the professional group (ranging between 88% for psychiatrists and 17% for general practitioners). Swedish studies also found differences in perceived skill between groups: 74% of the psychiatrists considered themselves sufficiently trained for their work, while in nurses and assistant nurses this number ranged between 43% and 25% (Ramberg & Wasserman, 2003; Samuelsson, Asberg & Gustavsson, 1997). In a wide Belgian sample, the authors concluded that highly skilled groups have a realistic view of their competence in intervention with suicidal people, while low-skilled groups tend to overestimate their skills level (Scheerder et al., 2010).

In our study, the difference between the ability to assess suicide risk and adequacy of training to deal with suicidal patients, particularly pronounced in general practitioners (79% and 17%), but also evident in psychologists (90% and 48%), suggests that the clinical competency perception of health professionals in suicide prevention includes two apparently different components: the recognition of suicide risk and the perception of the ability to manage suicidal patients effectively.

This finding is supported by the research of Inman, Bascue, Kahn, and Shaw (1984), who studied the relationship between suicide knowledge and intervention skills; nevertheless more recent studies on perceived suicide prevention skills did not seem to take into account this distinction perceived by health professionals (Palmieri et al., 2008; Ramberg & Wasserman, 2003; Scheerder et al., 2010). It is important to promote awareness that the risk assessment process cannot be made by a simple identification and compilation of risk factors. In order to be reliable, this assessment has to be made in the therapeutic and relational context of confidence. In other words, clinical management of suicide risk by mental health gatekeepers, such as general practitioners, is needed.

Emotional difficulties were found to be independent of professional group and specific training. With regard to professional group, our results are in line with studies on patient suicide impact that did not find differences in emotional reactions or distress levels between professional groups (e.g., Grad, Zavasnik, & Groleger, 1997; Wurst et al., 2011). However, our results are not consensual: A study with Swiss and German therapists found that psychiatrists were significantly more distressed than psychologists (Wurst et al., 2010). Beyond informational units, specific training must include a practical component monitored by health professionals with know-how in suicidal behaviors that enables confrontation with specificities of how to effectively manage suicidal patients. We suggest case-based learning combined with role-play strategy, as a methodology for overcoming the limitation of not having enough actual practice opportunities. This proposal is in line with the importance of experiential learning in the field of suicide prevention underlined by other authors (e.g., Neimeyer & Bonnellle, 1997; Pasco, Wallack, Sartin, & Dayton, 2012; Scheerder et al., 2010).

The results also show that health professionals perceive a need for training in suicide both for themselves and for health professionals in general, anticipating the willingness and interest of professionals to be involved in training.

There are some methodological limitations to this study that should be taken into consideration when drawing implications from these results. First, representativeness cannot be guaranteed with the sampling process used. However, a systematic bias is unlikely since additional methodological procedures were used. Second, owing to the originality of the DSBQ and the lack of studies on the specific area, we could not directly compare its components with previous research. Third, although the psychometric properties are promising, a deeper analysis of the questionnaire is required. Future analyses of the DSBQ should introduce items in order to clarify the interpretation of *to feel helpless*, which may be taken either as a consequence of technical limitations (component 1) or as representing an inability to "connect" with the patient (component 3). More specific items approaching communicational/relational issues should also be included, as discussed above. Future research should investigate the eventual existence of different clusters of professionals in relation to the difficulties, using cluster analysis, and study the relationship between the current practices and difficulties of health professionals and the influence of patient profiles on difficulties.

The results of the study reinforce that:

1. Specific training in suicide prevention aimed at health professionals, especially at general practitioners, is fundamental.
2. Planning of training programs should take into account the specific difficulties of the professional group at whom training is addressed. The DSBQ can constitute a basic element for performing the needed adjustment in training.
3. Experiential and active strategies and clinical case discussions should be used as learning methodologies.
4. The training content should focus on risk assessment and management and also on family issues, addressing technical, relational, and emotional questions.

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# Appendix: Difficulties in Suicidal Behaviors Intervention Questionnaire – Version for psychologists and doctors (DSBQ)

**1st Part – Professional and sociodemographic characterization**

| | | | |
|---|---|---|---|
| 1. Gender | Female 1 ◯ | Male 2 ◯ | |
| 2. Age | _____ | years | |
| 3. Years of practice | _____ | years | |
| 4. Professional group | Psychologist 1 ◯ | Psychiatrist 2 ◯ | General practitioner 3 ◯ |
| 5. Work place | _____ | | |
| 6. District of work | _____ | | |

**Training**

| | | |
|---|---|---|
| 7. My training to deal with suicidal patients is: | Sufficient 1 ◯ | Insufficient 2 ◯ |
| 8. I feel capable of identifying a patient at risk of suicide | Yes 1 ◯ | No 2 ◯ |
| 9. I have specific training in the area of suicidology | Yes 1 ◯ | No 2 ◯ |

| If your answer to Question 9 was *YES*, choose your type of training | Yes | No |
|---|---|---|
| Epidemiology | ◯ | ◯ |
| Forensic sciences | ◯ | ◯ |
| Detecting and management of suicide risk | ◯ | ◯ |
| Crisis intervention | ◯ | ◯ |
| SOS hotlines | ◯ | ◯ |

10. For each statement, choose the option that suits your opinion best on a scale from 1 to 5

| | Fully disagree | | | | Fully agree |
|---|---|---|---|---|---|
| I feel the need for specialized training in suicide | ◯ | ◯ | ◯ | ◯ | ◯ |
| I believe that my experience/training makes me a suitable trainer in this area. | ◯ | ◯ | ◯ | ◯ | ◯ |
| Implementing training plans on suicide aimed at health professionals is fundamental. | ◯ | ◯ | ◯ | ◯ | ◯ |

**2nd Part – Contact with suicidal behaviors in clinical practice**

1. Did (or do) you have any patient/client who has made one or several suicide attempts?

| | | | | |
|---|---|---|---|---|
| Yes | 1 ◯ | How many patients/clients? | How long ago was the last case? | Years |
| No | 2 ◯ | | | |

2. Have you had a patient/client suicide?

| | | | | |
|---|---|---|---|---|
| Yes | 1 ◯ | How many patients/clients? | How long ago was the last case? | Years |
| No | 2 ◯ | | | |

3. Have you ever had a patient representing a serious risk of suicide or suicide attempt even though he/she hasn't carried it out?

| | | | | |
|---|---|---|---|---|
| Yes | 1 ◯ | How many patients/clients? | How long ago was the last case? | Years |
| No | 2 ◯ | | | |



 

If your answer to questions 1, 2, and 3 was *NO*, i.e., if in your professional practice you NEVER had any contact with suicide or suicide attempts, nor with patients at serious suicide or suicide attempt risk, your QUESTIONNAIRE IS FINISHED. We thank you for your collaboration

If your answer to questions 1, 2, or 3 was *YES*, i.e., if in your professional practice you already had contact with suicide or suicide attempts or with patients at serious suicide or suicide attempt risk, please answer the last part of the questionnaire.

**3rd Part – Difficulties**

To what extent is it frequent or not to feel the following difficulties when facing a patient who seeks your help after a suicide attempt. Even though answers may vary depending on each case, try to answer according to the most general and frequent situations. Don't give too much thought to your statements. Spontaneous answers are the more valid ones.

| Difficulties | Not frequent at all 1 | Not frequent 2 | Somewhat frequent 3 | Frequent 4 | Very frequent 5 |
|---|---|---|---|---|---|
| 1. I feel difficulties in working with the family | ○ | ○ | ○ | ○ | ○ |
| 2. I get disturbed/upset with the case | ○ | ○ | ○ | ○ | ○ |
| 3. I easily feel burnt out | ○ | ○ | ○ | ○ | ○ |
| 4. I haven't got the right setting to see the patient | ○ | ○ | ○ | ○ | ○ |
| 5. I lack the time that a case like this requires | ○ | ○ | ○ | ○ | ○ |
| 6. There is a lack of social structures to offer support | ○ | ○ | ○ | ○ | ○ |
| 7. I'm afraid that I might not be able to assess suicidal risk correctly | ○ | ○ | ○ | ○ | ○ |
| 8. I lack specific training for cases like this one | ○ | ○ | ○ | ○ | ○ |
| 9. I'm afraid that the client might die by suicide | ○ | ○ | ○ | ○ | ○ |
| 10. I experience difficulties in having the family's collaboration | ○ | ○ | ○ | ○ | ○ |
| 11. I lack technical and theoretical knowledge on suicidal behaviors | ○ | ○ | ○ | ○ | ○ |
| 12. I feel it difficult to accept the patient unconditionally | ○ | ○ | ○ | ○ | ○ |
| 13. I have difficulties in dealing with the theme of death | ○ | ○ | ○ | ○ | ○ |
| 14. I feel the absence of a multidisciplinary team | ○ | ○ | ○ | ○ | ○ |
| 15. I feel rejected by the patient who attempted suicide | ○ | ○ | ○ | ○ | ○ |
| 16. I experience difficulties in providing support to the family | ○ | ○ | ○ | ○ | ○ |
| 17. I experience difficulties in being empathic with the client | ○ | ○ | ○ | ○ | ○ |
| 18. I have difficulties in approaching the theme of death | ○ | ○ | ○ | ○ | ○ |
| 19. I get disturbed by the patient | ○ | ○ | ○ | ○ | ○ |



 

| | | | | | |
|---|---|---|---|---|---|
| 20. There is a lack of specific intervention protocols | ○ | ○ | ○ | ○ | ○ |
| 21. I don't know how to talk to the patient about death | ○ | ○ | ○ | ○ | ○ |
| 22. I feel difficulties in maintaining technical distance | ○ | ○ | ○ | ○ | ○ |
| 23. Managing adherence to therapeutic counseling is difficult | ○ | ○ | ○ | ○ | ○ |
| 24. I feel helpless about this case | ○ | ○ | ○ | ○ | ○ |
| 25. I have a hard time preserving my well-being | ○ | ○ | ○ | ○ | ○ |
| 26. I feel a lack of clinical supervision | ○ | ○ | ○ | ○ | ○ |
| 27. I feel a lack of confidence and this is felt by the client | ○ | ○ | ○ | ○ | ○ |
| 28. I think about the case when I don't want to | ○ | ○ | ○ | ○ | ○ |
| 29. I question my ability/skill to help the patient | ○ | ○ | ○ | ○ | ○ |
| 30. I feel distressed by the case | ○ | ○ | ○ | ○ | ○ |
| 31. There is a lack of specific risk assessment instruments | ○ | ○ | ○ | ○ | ○ |
| 32. There is a lack of specific intervention techniques for children | ○ | ○ | ○ | ○ | ○ |

**Thank you very much for your collaboration and contribution!**



 