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PERCEPTIONS OF PATIENTS IN PSYCHIATRIC HOSPITAL ABOUT SUICIDAL BEHAVIOR AND ASSISTANCE

Percepções de pacientes em hospital psiquiátrico sobre o comportamento suicida e a assistência

Percepciones de los pacientes en un hospital psiquiátrico sobre la conducta suicida y la asistencia

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RESUMO

Objetivo: analisar as percepções de pacientes internados em hospital psiquiátrico devido a comportamento suicida, com enfoque em suas experiências emocionais, na assistência e tratamento recebidos. **Método:** estudo qualitativo e exploratório-descritivo com entrevistas semiestruturadas realizadas com 13 participantes, a maioria mulheres (12), brancas, entre 19 e 29 anos, solteiras, sem filhos, com baixa renda e escolaridade média. Os dados foram analisados por abordagem temática de conteúdo. **Resultados:** os pacientes relataram sofrimento emocional intenso, com sentimentos de vazio e desesperança. A assistência foi criticada pela ausência de abordagens específicas e fragmentação dos serviços, embora alguns tenham mencionado acolhimento pontual. A maioria reconheceu a necessidade da internação durante crises, mas apontou falhas estruturais e na continuidade do cuidado. **Conclusão:** os achados reforçam a importância de um suporte especializado e contínuo no pós-alta, com intervenções mais integradas e sensíveis às necessidades emocionais dos pacientes com comportamento suicida.

DESCRITORES: Comportamento suicida; Internação psiquiátrica; Percepção do paciente; Saúde mental; Tratamento; Assistência integral.

ABSTRACT

Objective: to analyze the perceptions of patients hospitalized in a psychiatric facility due to suicidal behavior, focusing on their emotional experiences, care, and treatment received. **Method:** a qualitative, exploratory-descriptive study with semi-

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structured interviews conducted with 13 participants, mostly women (12), white, aged 19–29, single, childless, with low income and average education. Data were analyzed using thematic content analysis. **Results:** patients reported intense emotional suffering, marked by feelings of emptiness and hopelessness. Care during hospitalization was criticized for the lack of specific approaches and fragmented services, although some mentioned isolated experiences of support. Most recognized the need for hospitalization during crises but pointed out structural failures and discontinuity in care. **Conclusion:** the findings highlight the importance of specialized and continuous support after discharge, with more integrated interventions sensitive to the emotional needs of patients with suicidal behavior.

DESCRIPTORS: Suicidal behavior; Psychiatric hospitalization; Patient perception; Mental health; Treatment; Comprehensive care.

RESUMEN

Objetivo: analizar las percepciones de pacientes hospitalizados en un hospital psiquiátrico debido a comportamiento suicida, con énfasis en sus experiencias emocionales, atención y tratamiento recibidos. **Método:** estudio cualitativo, exploratorio-descriptivo, con entrevistas semiestructuradas realizadas a 13 participantes, en su mayoría mujeres (12), blancas, entre 19 y 29 años, solteras, sin hijos, con bajos ingresos y nivel educativo medio. Los datos fueron analizados mediante análisis temático de contenido. **Resultados:** los pacientes relataron un sufrimiento emocional intenso, caracterizado por sentimientos de vacío y desesperanza. La atención durante la hospitalización fue criticada por la falta de enfoques específicos y la fragmentación de los servicios, aunque algunos destacaron momentos puntuales de acogida. La mayoría reconoció la necesidad de la hospitalización durante las crisis, pero señalaron fallas estructurales y en la continuidad del cuidado. **Conclusión:** los hallazgos refuerzan la importancia del apoyo especializado y continuo tras el alta, con intervenciones más integradas y sensibles a las necesidades emocionales de los pacientes con comportamiento suicida.

DESCRIPTORES: Conducta suicida; Hospitalización psiquiátrica; Percepción del paciente; Salud mental; Tratamiento; Atención integral.

INTRODUCTION

Suicidal behavior is a complex phenomenon that affects people of different backgrounds and ages, influenced by social, economic, cultural, psychological, and biological factors.[1]

Although initial care for patients with suicidal behavior in Emergency Care Units (ECUs) is, in many cases, rapid and efficient in terms of clinical stabilization, continuity of care presents significant gaps. [2]

Post-suicide attempt care, as pointed out by Silva and Soratto,[3] is still a critical issue in Brazil's healthcare networks. The lack of adequate referral to specialized mental health services, such as psychiatric hospitals or Psychosocial Care Centers (CAPS), has been a determining factor in patients' loss of hope, increasing the risk of new attempts.

Hospitalization is also influenced by the lack of nighttime support at CAPS III and the limited availability of psychiatric beds in general hospitals in the municipal network.

Psychiatric hospitalizations do not occur only because of a lack of resources or failures in the service network, but also because there is a control circuit that captures and custodians lives considered deviant. What appears to be a failure of the network is, in fact, the control mechanism itself operating effectively.[5]

The literature on individuals admitted to psychiatric hospitals for suicidal behavior is limited, highlighting a gap that this study seeks to fill with data, especially given its pioneering nature in the institution and municipality studied. The objective was to analyze perceptions of suicidal behavior and the care received by patients admitted to psychiatric hospitals due to suicidal behavior.

METHOD

This qualitative, exploratory, descriptive study used interviews based on a semi-structured questionnaire and data analysis using thematic content analysis.[6]

It was conducted between August 2021 and June 2022 in the inpatient units of a psychiatric hospital located in São José dos Campos, São Paulo. The research involved adult patients hospitalized due to suicidal behavior who had adequate cognitive conditions to participate in the investigation, as assessed by the health team and the researcher. Patients from other sectors and those who chose to withdraw their data after the interview were excluded, which did not occur.

The research was approved by the Research Ethics Committee of the Federal University of São Paulo (opinion number 4,868,551), with registration CAAE

47094021.1.0000.5505, issued on July 10, 2021. All collection procedures followed established ethical guidelines, with participants being informed about the study's objectives, confidentiality, and anonymity. The Free and Informed Consent Form (FICF) was signed in accordance with Resolution 466/12 of the National Health Council.

The interviews took place weekly, in a private setting, lasting from 1 to 1 hour and 40 minutes. They were audio recorded and later transcribed in full. For data collection, a semi-structured questionnaire developed by the researchers was used, which included sociodemographic information and 25 open-ended questions addressing the participants' perceptions of suicidal behavior, as well as the care and treatment received.

Data analysis was performed using thematic content analysis.6 The analytical process followed the three proposed stages: 1) pre-exploration, which involved initial readings and hypothesis formulation; 2) content exploration, with data coding and category definition; and 3) categorization and subcategorization, a phase in which the data were refined and interpreted. The focus was on the depth of information, without quantifying the data.

Participants were identified by alphanumeric codes (E1, E2, etc.) to ensure anonymity.

RESULTS

The study included 13 participants, mostly women (12), aged 19 to 29, single, without children, Catholic, white, with a high school education, from a variety of professions, with five without a source of income.

The reports indicate that hospitalizations occurred due to referrals from SAMU (2 cases), UPA (7 cases), and general hospitals (4 cases), with hospitalization periods ranging from 10 to 28 days.

During data analysis, two thematic categories and five thematic units were identified. This article will present the second category, Perception of suicidal behavior and treatments, which refers to the participants' perceptions of suicidal behavior, the care received, and hospitalization.

The first thematic unit concerns the perception of suicidal behavior, reporting their experiences with suicide, highlighting the need to share their feelings with others, and discussing fantasies, feelings of guilt, and negative interpretations associated with the topic. They emphasized the absence of adequate guidance, lack of information, and deficit of specialized care.

The second thematic unit deals with perceptions of the assistance received; they expressed dissatisfaction with hospitalization, did not want to be hospitalized; emphasized the importance of specialized treatment focused on suicidal behavior during hospitalization, as well as the scarcity of preventive measures and limited access to information. Among the treatments mentioned were psychotherapy, the use of psychiatric medications, support groups, and alternatives. Some participants highlighted the effectiveness of these approaches, while others criticized both the lack of access to adequate treatment and the adverse effects of medications.

Participants reported their emotions when describing their perception of suicidal behavior, highlighting the need to share feelings, as well as expressing fantasies, guilt, and negative associations about the topic.

> *"...Having someone to talk to...attention...is very important." E1*

> *"For me, it's normal. I've tried four times, it's become a habit. Although I feel useless. I'm laughing, but it's nervous laughter. I don't remember, I can't think of how I did it. ...when a person feels alone even though they have someone, but inside they feel alone. Inside, they are suffering. It's the suffering of loss, as if the world had ended and you were on autopilot. As if you were living just to live... In other words, you're just surviving, because you're not really living! You're on autopilot, which is like turning off your brain. It's as if you were here just for the sake of being here." E4*

> *"My powerlessness to try and fail, because if I still had the chance to do it, I would. Suicide can do nothing for me, but it ends everything, it ends my pain, everyone else has their life, I lived a crazy life in which I failed to build my own life, today I have nothing..." E6*

> *"It was very taboo, especially because of religion. I didn't like to talk about it, there was a lot of prejudice, it was something that scared me. Today it doesn't scare me anymore, because I've tried so many times, it's a normal thing, even though I know it's not normal. And those who do it go to hell. I just wonder if there is time to repent or not? No one ever said, if you commit suicide, you lose the right to be saved. But even that didn't become a protective factor, something trivialized by me. I was very afraid, but today I am no longer afraid." E8*

> *"It hurts because, as I said, it's like a drug, it comes and goes. I don't want that thought to come back to me, because I'm afraid that someday I'll try and succeed. I don't want to die, I'm very afraid of dying. I didn't think about death at the time. I never thought I would die losing so much blood. I didn't think anything, I didn't even think about my children when I did it. I was in despair because I thought I would never see them again. That I wouldn't be able to live." E12*

Participants reported dissatisfaction with hospitalization and expressed the need for specific treatment focused on suicidal behavior.

"I have never seen an activity specifically geared toward this; they treat it in a generic way, because each person has their own difficulties, so there is no way to do something more specific..." E8

"...they keep an eye on us, they are attentive, they count how many people are in the room so no one runs away, the only thing that bothers me..." E5

"Because here I feel kind of disconnected. I think I'm fine. I really want to go home because I'm not any trouble. I take my medicine, I don't scream, I don't kick and scream, I stay quiet. I want to leave, I want the doctor to discharge me, I've been here for a long time." E10

"I've been hospitalized three times, I really didn't want to anymore. Because I keep thinking, who would accept someone who has already been hospitalized for a job? And even more so, someone who has been hospitalized four times? (...) Then I was seen by CAPS. I told them what I had done and that I would never talk to my mother or tell her about it... they sent me here... It was the first time I was admitted here. In the private hospital, I stayed for 30 days. The private hospital was more peaceful, because after my experience with the SUS, I was a little traumatized. The first time I was admitted, there were about eight women sharing the room with me. Most of these women had depression, anxiety, panic attacks; there was one who was chemically dependent and one who had schizophrenia, but... she didn't attack anyone, she was very calm. When I came to the SUS the second time I was admitted, it was a shock... Here, people are more debilitated." E8

The transition to the hospital, which should be a comprehensive care measure, often occurs in a fragmented manner, highlighting the gap in psychosocial care. As described in the following statements regarding the process of seeking help and the care received:

"I went straight to the village hospital, where I was treated, got a few stitches, and after that everything was fine. I wasn't referred anywhere, after that I was sent home, and since I had taken all my pills, I didn't have any more to take the next day, so I went to the mental health clinic to get medication, (...) the doctor saw that I was at risk... I was referred to Francisca Julia, (...) I stopped because I thought I was fine, I was better, and... I had a doctor's appointment... he was very concerned about my complaints... I told him I wasn't going to come back on the 13th... because I was going to kill myself... I was referred to the UPA again. Then I was evaluated and returned to Francisca Júlia. I've been here for 23 days now... you feel humiliated, it's bad to be here, in this environment." E1

"First I was treated by SAMU, then I went to mental health and then they referred me here... Last month I also attempted suicide. I saw the doctor this past month, November, and she considered last month's suicide attempt. ... I've been here for 21 days. It's the first time I've been hospitalized for so long." E7

"I went to the emergency care unit and mental health services." E9

Most participants responded similarly regarding diagnosis and treatment, revealing misinformation, doubts, and a certain indifference to the topic, as shown in the following statements.

"... I believe I have depression and I accept that, and I am looking for a way to improve... I don't know how the medication works, because the number of medications I take has increased... I was at home, only taking fluoxetine, just one, I stopped because I said I didn't need it anymore, I'm fine, and then you know when you stop... I'm taking seven medications, two in the morning and five at night, but I can't tell you what they're for. E1

"They said I'm bipolar and depressed, I wanted to understand these problems better. ...I practically don't know the correct diagnosis for my treatment, I don't understand. They put the ICD number, which is 60.3. I don't know if that's right." E2

"...for me, the treatment doesn't help at all. It's not that I don't want to be treated, but in my case... It's tiring because she knows that my problem won't be solved. Not even the medications solve my problem."E7

When asked about their admission to a psychiatric hospital due to attempted suicide, twelve participants agreed with the measure, while one disagreed.

"I think it's the best thing, because I've been hospitalized twice, and it saved me, helped me, from thousands of times, because if I hadn't been there, I wouldn't be here anymore." E1

"I think hospitalization is important, but I think that in addition to hospitalization, medication and the work team are very important. In my case, the first time I was hospitalized, I left there afraid. I left afraid of trying to commit suicide again. I didn't leave saying I wanted to leave, I left afraid, but here, for example, I want to leave, I don't want to be here. That's it, feeling alone, I feel alone, I don't want to talk about my problems to anyone. First, because it's very personal, and second, because they speak another language." E6

"I went first to Santa Casa, which referred me to mental health, and from there I came straight here... I think it's good, I'd like to be at home and not here." E3

Participants reported varying experiences regarding the care they received during hospitalization. Some expressed feeling cared for and respected, but there was a general perception that there were no specific actions aimed at treating suicidal behavior, and the absence of activities focused on well-being and emotional health seemed to be an important gap in care, leading participants to feel that their specific needs were not being fully met.

"I'm more apathetic, it seems like I don't care, it seems like nothing makes sense. I'm here, but my mind is far away... There are some cool things to do, but they're not related to suicide..." E8

Nothing that could hurt you is there, not even colored pencils, just so you know. They're afraid someone will take them and try to pull out the stitches, so everything is very carefully looked after... I receive a lot of affection here. One of the other patients told me that if I cut my wrist again, she'll punch me in the face. I see that as a form of affection. Some nurses are also caring, they're really nice, they talk to you with dignity. However, there are others who talk to you as if you were an animal, as if you were there because you wanted to be." E4

"It's very difficult to talk, since there are a lot of people here. I've never seen an activity specifically geared toward that, they treat it in a generic way, because since each one has a different difficulty, there's no way to do something more specific..." E8

"It's more these conversations. I think those who already have it. Someone comes, talks to us to try to understand what we did and tells us what's wrong and what's right. For me, all these words are great, I've already learned a lot." E10

"They use threats and punishment a lot. You won't be discharged, and honestly, I'm here, but my mind isn't here anymore, don't judge me. I've only been here for two weeks and so far they haven't readjusted my medication..." E6

DISCUSSION

Suicidal behavior is often related to moments of intense adversity, social pressures, and internal and interpersonal conflicts. Participants described how their decisions to attempt suicide were influenced by these moments of great adversity. They highlighted specific contexts in which they felt an intense desire to die and circumstances that influence suicide attempts, such as serious personal problems, oppressive social expectations, and deep internal struggles, as well as conflicts with others.

Suicidal behavior must be understood beyond the biomedical perspective, considering social, economic, cultural, and personal factors that influence both suicide and other dysfunctional behaviors, reflecting the collective and relational conditions of human existence.[8]

Suicide was represented as a result of loneliness caused by the lack of recognition of psychological suffering by people in the social environment. When this suffering is not validated by others, people seek suicide as a way out of this unmet emotional demand. It was also mentioned that loneliness and isolation were factors linked to suicide, due to unrecognized psychological suffering and unmet social expectations.[9]

Most participants considered suicide to be a desperate search for a solution to end suffering.[10]

It is necessary to recognize that suicide attempts are related to a variety of factors, both external and internal, which can contribute to an increase in their rates. Therefore, health care networks should promote continuing education among professionals, in addition to providing improved care in these cases.[3]

Professionals face significant difficulties when dealing with the issue of suicide and often reproduce stigmatizing, moralistic, religious, paternalistic, and hypervigilant behaviors. Violations of patients' human rights were found, which negatively affected the care provided, the continuity of treatment, patient autonomy, privacy, and decision-making capacity, increasing patients' vulnerability and the risk of further suicide attempts.[11]

In the context of hospital emergencies, the emergency psychiatric care model for the municipality of São Paulo is an interesting alternative, as it integrates psychiatric care with the emergency room of a general hospital. This model was considered effective for the treatment of acute crises, avoiding immediate hospitalization, and promoting continuity of care through the UBS or Day Hospital, currently at the CAPS. However, psychiatric reform still faces challenges regarding the adequacy of treatment for hospitalizations, especially medium-term ones.[12]

This indicates gaps in the Psychosocial Care Network, which aims to avoid prolonged hospitalizations.

However, although emergency care is fast and effective, multidisciplinary support and appropriate referral to specialists remain insufficient, especially in municipal emergency rooms.[2]

This demonstrates that, despite advances in immediate care, mental health care in the hospital setting lacks a more solid and integrated support network to prevent and treat suicidal behavior in an effective and comprehensive manner. The integration of psychosocial, family, and community

approaches, combined with adequate training of health professionals, is essential to improve care for these patients and thus reduce suicide rates.

Inadequate care is a persistent issue, as individuals who attempt suicide are often severely impacted by different forms of violence. This can include external violence, self-inflicted violence, and psychological/emotional violence experienced in emergency health services. This psychological/emotional violence may involve neglect or insensitive treatment by healthcare professionals, such as minimizing the situation or making cruel comments. In addition, in some situations, physical violence may occur, such as the use of handcuffs to restrain the patient, which can further aggravate the situation.[13]

With regard to the care provided in hospital emergencies, demands for care related to self-harm, such as suicide attempts, are often seen as obstacles. Professionals express indifference, indignation, and nonconformity in these situations. There is a tendency to interpret suicide attempts as mere cries for attention, which can result in a less effective approach to care for these patients.[11]

The contempt expressed by some health professionals when referring to patients with mental health problems or after suicide attempts. Phrases such as "the patient was admitted to the emergency room putting on a show," "she just wants attention," "go talk to the disturbed person in bed x," "if he wants to die, I don't know why he doesn't do it right," "so many people fighting for their lives and this one trying to die," among others, reveal stigmatizing and prejudiced bias. Such attitudes reveal the urgent need to change the inappropriate mindset and approach of healthcare professionals.[14]

Individuals who attempt suicide challenge the usual care protocols, as they do not fit into categories such as accident, acute or chronic illness, and are not necessarily experiencing an episode. This situation involves an apparently healthy person who arrives at the hospital after causing injuries with the intention of dying, which promotes distinct feelings in the professionals who will attend to them. Management requires approaches that include the implementation of new work methodologies, immediate safety measures, and reception. The stigmatization of patients who have attempted suicide poses a threat in urgent and emergency services, especially when there are limitations on ventilatory support equipment or beds in the intensive care unit, where the team must make choices about which patients to prioritize and which have the greatest chance of survival. It is important to work on this in training spaces, as recognizing and accommodating the feelings and emotions of healthcare professionals can promote their comfort and contribute to more appropriate care.[15]

In relation to hospital practices, actions aimed at promoting good mental health care practices in general hospitals are still in their infancy and need more support and encouragement. Specifically in the field of nursing, cultural and technical transformation is needed to implement psychosocial care actions in all care settings. Deficiencies in theoretical and practical understanding, combined with professionals' personal conflicts regarding suicide, result in a lack of personal involvement with these patients during the course of care.[16]

When it comes to caring for these individuals, it is necessary to provide emotional support, quality, and safety in the service so that they approve of the care and feel comfortable sharing their anxieties. Attentive listening, emotional support, and comprehensive care are important.[17]

The invisibility of suicidal behavior, even though it is one of the leading causes of death among young people. Among the challenges faced by professionals are the lack of training and the stigma that hinders understanding of the issue. User satisfaction was associated with aspects related to care, such as patience and welcoming attitudes on the part of professionals, while criticism focused on communication failures, the use of technical language, and attitudes perceived as cold and harsh during care.[18]

Psychiatric hospitalization in general hospitals in Brazil is recommended in severe cases, when available extra-hospital resources are exhausted and there is a risk of self-harm and harm to others. The results pointed to ambivalent views about hospitalization in mental health beds. Some see it as a place of protection, where they are safe and cannot hurt themselves, while others perceive it as a suffocating and stigmatizing experience, in which their complaints are not always taken seriously by professionals.[18]

Mental health care remains predominantly concentrated in Psychosocial Care Centers (CAPS), and hospitalization is often used to deal with psychiatric emergencies. Due to the increase in the number of patients with mental health needs treated in psychiatric emergencies, it is necessary to improve the flow of care and invest in staff training.[19]

During hospitalization, patients experience emotional distress or feelings of emptiness and suffocation, where routine becomes mechanical and restricted to sleeping and taking medication for control in the hospital environment.[20]

When care is lacking, imbalance occurs, which can act as a risk factor for suicide. Inadequate care can lead to new and more effective suicide attempts, increasing the risk of a fatal outcome. This fact highlights the importance of specialized training in health services, due to misunderstanding and rejection of issues related to death.[21]

In addition, there is no standard pattern of suicidal behavior, and each person has a unique experience when it comes to suicidal thoughts and intentions, which can make it challenging for professionals to identify these signs. It is essential to listen to the patient, show empathy, and demonstrate a genuine desire to help. This person-centered approach often leads to more effective results, as it recognizes and values the particularities of each individual. Direct and attentive contact allows us to identify which signs are present and how best to support the person in their moment of vulnerability.[22]

Everyone has the right to health and to be treated with dignity and respect when accessing health services. However, the stigma associated with patients who have attempted suicide can impair the quality of care received, potentially resulting in the exclusion of procedures or treatments.[11]

The duality of feelings regarding psychiatric hospitalization. Although there are reports of discomfort due to the feeling of imprisonment, pleasure was also expressed in activities outside the ward, even without access to the outside environment. These reports contradict the principles of psychosocial care, which emphasize the urgency of overcoming approaches of isolation, promoting care that recognizes the freedom, dignity, and uniqueness of the individual.[23]

There are many potential risks in psychiatric hospitalization for people at risk of suicide, as it can exacerbate suffering, feelings of vulnerability, coercion, and loss of autonomy, as well as generate traumatic experiences. Without adequate support from transition services after hospitalization and outpatient or partial hospitalization services, the potential for mental harm after discharge can be high.[24]

Suicidal behavior is an expression of ambivalence, as it does not necessarily indicate a desire to die, but rather a desire to escape the unbearable pain that afflicts life. To deal with this complexity, it is essential that health services are prepared and organized in a network to provide adequate mental health care to people. This approach is essential to reduce suicide-related morbidity and mortality rates. Thus, when people with suicidal behavior receive adequate support and qualified care from well-trained professionals, they tend to open up to new perspectives and possibilities in life. They feel empowered, protected, and happier, and begin to believe in their ability to find new paths and meaning in their lives. This leads them to take care of themselves and others, which can result in a reduction in suicidal thoughts and suicide attempts.[21]

In the assessments of individuals at high risk of suicide in the public health context of a municipality in Santa Catarina, complex challenges were faced, involving both limitations in the organization of services and issues related to the care model itself. Concrete obstacles were encountered in the coordination between primary care, the SAMU (Mobile Emergency Care Service), and the referral hospital for psychiatric hospitalization. This gap shows a disproportion between the demands and capacity of health facilities, compromising access, continuity of care, and coordination of care and services. There was also a division of care due to the physician-centered model.[25]

When it comes to psychiatric hospitals, there are tons of bad stories throughout history.

Two patients reported on their experiences in psychiatric hospitals, with negative perceptions of the environment and treatment. One described the hospital as inhumane and hostile, where professionals were rude and indifferent, showing no care or attention to patients, unconcerned with their well-being, contributing to a feeling of abandonment and neglect. Another shared an equally traumatic experience that patients, upon entering the hospital, often left "in a coffin," a reference to high mortality and the suffering witnessed, as they were mistreated and, if they disobeyed or caused trouble, marked.[26]

Patients reported discomfort related to feeling imprisoned and lacking freedom while hospitalized in a psychiatric hospital, with hospitalization being seen by some as a form of punishment. Reports indicated negligence and violence by those responsible for their care. The need for meaningful activities and improvements in infrastructure was highlighted, such as the lack of entertainment, idleness, lack of space, the presence of bars, and strict bedtimes, factors that were considered negative. They indicated that hospitalization was primarily adopted without considering alternative interventions.[23]

These reports expose a reality of disrespect and violence in the psychiatric hospital environment that has been very common throughout history, highlighting the violation of human rights and the lack of adequate and humane care.

Most of the professionals surveyed did not receive adequate training or capacity building to deal with suicide attempts. This lack of preparation is more evident among groups with less training. Most professionals did not have the knowledge or skills to stratify patient risks. The majority of the health team did not know how to or were unable to properly refer patients who had attempted suicide to the city's mental health network.[27]

These challenges were reflected in the complaints raised by the participants in this study, who reported that the care they received during hospitalization did not fully meet their specific needs. The perception of gaps in care, such as the absence of actions aimed at treating suicidal behavior and the lack of activities focused on well-being and emotional health,

highlights the need for a more comprehensive and personalized approach, aligned with the real demands of patients.

The creation of a broad support network, including mental health services outside the hospital context, can be an effective way to prevent suicide and promote sustainable recovery.

FINAL CONSIDERATIONS

When analyzing participants' perceptions related to suicidal behavior, a complexity of meanings was observed. They emphasized the importance of sharing feelings, while expressions of fantasies, guilt, and negative associations emerged, highlighting the intense impact of this experience.

Treatment focused excessively on biomedical aspects, without offering continuous and specialized psychological follow-up, limiting the effectiveness of the intervention.

Although hospitalization in a psychiatric hospital is necessary at critical moments, it does not provide adequate care for multifactorial needs. The lack of a holistic approach that considers the subjective and emotional aspects of patients contributes to feelings of helplessness and insecurity during hospitalization.

The limitations of being in a single institution and verifying the moment of hospitalization indicate the need for future research investigating the interaction of socioeconomic, cultural, and individual factors in mental health. Longitudinal studies may identify effective early interventions.

The contribution of this study reveals important gaps in the care of suicidal behavior and highlights the need for a comprehensive humanized care model. The data provide an opportunity for public policies aimed at reformulating the care model to consider the emotional, social, and cultural needs of patients.

REFERENCES

1. Brasil. Ministério da Saúde. Mortalidade por suicídio e notificações de lesões autoprovocadas no Brasil. Boletim Epidemiológico: Secretaria de Vigilância em Saúde, Ministério da Saúde. [Internet]. 2021 [acesso em 5 de dezembro 2022];52(33). Disponível em: https://www.gov.br/saude/pt-br/centrais-de-conteudo/publicacoes/boletins/epidemiologicos/edicoes/2021/boletim_epidemiologico_svs_33_final.pdf/view.

2. Guedes AO, Januário G da C, Ribeiro MILC, Silva AT da, Gonçalves JS, Alves AC. Tentativa de suicídio e acolhimento: a visão da equipe de enfermagem quanto à assistência prestada em um serviço de urgência e emergência. Cad. Bras. Saúde Ment. [Internet]. 2023 [acesso em 20 de abril 2024];15(42). Disponível em: https://periodicos.ufsc.br/index.php/cbsm/article/view/71512.

3. Silva AMC da, Soratto MT. Acolhimento ao paciente após a tentativa de suicídio. Inova Saúde. [Internet] 2024 [acesso em 30 de março de 2024];14(1). Disponível em: https://doi.org/10.18616/inova.v14i1.4376.

4. Teixeira VDS, Monteiro CB, Ferreira EC, Pacheco MAB, Santiago MP, Loyola CMD. Primeira internação psiquiátrica na visão dos familiares. Rev Latinoam Psicopatol Fundam. [Internet]. 2021 [acesso em 2025 mar. 22];24. Disponível em: http://dx.doi.org/10.1590/1415-4714.2021v24n3p704.12.

5. Braga CP, d Oliveira AFPL. Motivos e mecanismos de internação de crianças e adolescentes em hospital psiquiátrico: o circuito do controle. Cad Saúde Pública. [Internet]. 2022 [acesso em 2025 mar. 21];38:e00170821. Disponível em: https://doi.org/10.1590/0102-311XPT170821

6. Bardin L. Análise de Conteúdo. Lisboa: Edições 70; 2016

7. Ming-Wau C, Boris GDJB, Melo AK, Silva RM da. A decisão de tentar o suicídio sob a lente fenomenológico-existencial sartriana. Revispsi. [Internet]. 2020 [acesso em 22 de março 2025];20(4). Disponível em: https://doi.org/10.12957/epp.2020.56663.

8. Prado AS, Pinto LR. Prevenção do suicídio na escola na perspectiva da teoria interpessoal-psicológica do suicídio:: uma revisão de literatura. Ed. Foco. [Internet]. 2022 [acesso em 21 de março 2025];25(47). Disponível em: https://doi.org/10.36704/eef.v25i47.5770.

9. Calile OHBO, Chatelard DS. Representações sociais sobre suicídio. Rev Fam Ciclos Vida Saude Contexto Soc. [Internet]. 2021 [acesso em 11 de junho 2024];9(2). Disponível em: https://doi.org/10.18554/refacs.v9i2.5408.

10. Plazzi MAPC, Fernandes Lemos M, Silva GC, Souza R, Lucchese R. Educação permanente para unidade de terapia intensiva na atenção ao suicida. CLIUM. [Internet]. 2022 [acesso em 20 de março 2024];22(5). Disponível em: https://doi.org/10.53660/clm-408-518.

11. Lima L, Boeira LD dos, Albuquerque, Marques TA. Violação dos direitos humanos dos pacientes com tentativa de suicídio no Brasil. Saúde soc. São Paulo. [Internet]. 2022 [acesso 4 de março 2024];31(3). Disponível em: https://doi.org/10.1590/S0104-12902022200331pt.

12. Migliari FFF, Marcolan JF. Modelo de atenção à saúde mental no governo Erundina (1989-1992) na cidade de São Paulo, Estado de São Paulo, Brasil. Research, Society and Development. [Internet]. 2020 [acesso em 22 de

março 2025];9(9):e28996176. Disponível em: https://doi.org/10.33448/rsd-v9i9.6176.

13. Silva SL, Machado CLB, Albuquerque PP de, Nery GEC. Violência suicidária: um empurrão para o suicídio. Sustinere. [Internet]. 2023 [acesso em 10 de setembro 2023];11(1). Disponível em https://doi.org/10.12957/sustinere.2023.66328.

14. Azevedo DCR, Schrock CGGC. Os sabores e dissabores do psicólogo no atendimento ao comportamento suicida: vivências na residência multiprofissional em saúde mental. Revista IGT na Rede. [Internet]. 2021 [acesso em 10 de setembro 2023];35(18). Disponível em https://doi.org/10.5281/zenodo.15149260.

15. Pereira WSB. Desafios e perplexidades no atendimento de emergência a quem tenta suicídio. REASE. [Internet]. 2022 [acesso 23 de março 2023];8(6). Disponível em: https://doi.org/10.51891/rease.v8i6.5895.

16. Fontão MC, Rodrigues J, Lino MM, Lino MM. Cuidado de enfermagem em urgência/emergência às pessoas que tentam suicídio. SMAD. [Internet]. 2020 [acesso em 7 de abril 2023];16(4). Disponível em: https://doi.org/10.11606/issn.1806-6976.smad.2020.152045.

17. Coelho AKR, Cunha AG, Silva ABC da, Cid AS, Castro LCC, Lopes BCM et al. Nursing practices associated with suicide prevention dynamics: an experience report. RSD. [Internet]. 2021 [cited 2023 mar 28];10(4):e50310413819. Available from: https://doi.org/10.33448/rsd-v10i4.13819.

18. Freitas SOR. O suicídio na sociologia de Durkheim e os reflexos da agenda global. Rev. Eletrônica Ciênc. Soc. Apl. [Internet]. 2022 [acesso em 22 de maio de 2023];9(2):. Disponível em: https://revista.fisul.edu.br/index.php/revista/article/view/125/128.

19. Dias LF, Perez K, Reuter É. O encontro entre psicologia e internações psiquiátricas: cuidado em saúde mental em unidade de urgência e emergência de hospital de ensino do interior do Rio Grande do Sul. Mental. [Internet]. 2022 [acesso em 29 de março 2024];14(25). Disponível em: https://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1679-44272022000100005&lng=pt&tlng=pt.

20. Pegoraro RF, Vicentin MCG. O que nos ensinam os itinerários terapêuticos de adolescentes/jovens que tentaram suicídio. Rev Cocar. [Internet]. 2023 [acesso 13 de julho 2024];(16). Disponível em: https://periodicos.uepa.br/index.php/cocar/article/view/6757/2889.

21. Correia CM, Andrade ICS, Gomes NP, Rodrigues GRS, Cunha KS, Diniz NMF. Psychosocial care for people with suicidal behavior from the perspective of users and health professionals. Rev Esc Enferm USP. [Internet]. 2020 [cited 2023 mar 27];54:e03643. Available from: https://doi.org/10.1590/S1980-220X2019028803643.

22. O'Rourke MC, Jamil RT, Siddiqui W. Suicide screening and prevention. [Internet]. Treasure Island (FL): StatPearls Publishing. [Internet]. 2023 [cited 2024 jan 16]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK531453/.

23. Pereira NA, Silva MLD, Matsukura TS. Adolescentes usuários de substâncias psicoativas: experiências e desafios durante a internação psiquiátrica. Cadernos Brasileiros de Terapia Ocupacional. [Internet]. 2023 [acesso em 3 de julho 2024];31. Disponível em: https://doi.org/10.1590/2526-8910.ctoAO261434121.

24. Ward-Ciesielski EF, Rizvi SL. The potential iatrogenic effects of psychiatric hospitalization for suicidal behavior: a critical review and recommendations for research. Clin Psychol Sci Pract. [Internet]. 2021 [acesso em 3 de fevereiro 2025];28. Disponível em: https://doi.org/10.1111/cpsp.12332

25. Rodrigues J, Ferreira LM, Vargas AOM, Zilli F, Trentin D, Antunes L. Perspectivas da rede de atenção primária à saúde ao comportamento suicida. Rev Paul Enferm [Internet]. 2023 [acesso em 24 de abril 2025];34(1). Disponível em: https://doi.org/10.33159/25959484.repen.2023v34a01.

26. Rocha LA, Prates TBS, Souza VS, Gusmão ROM. Percepção dos usuários de um centro de atenção psicossocial sobre o cuidado em saúde mental. Mental. [Internet]. 2021 [aceso em 23 de Janeiro 2025];13(23). Disponível em: https://pepsic.bvsalud.org/pdf/mental/v13n23/v13n23a08.pdf.

27. Langaro PM, Carvalho D de, Bonamigo EL. Atendimento aos pacientes com comportamento suicida: percepção de profissionais da saúde. Mundo Saude. [Internet]. 2021 [acesso em 24 de março 2023];45. Disponível em: https://doi.org/10.15343/0104-7809.202145533540.