



OBJN  
Online Brazilian Journal of Nursing

ENGLISH

Federal Fluminense University

AURORA DE AFONSO COSTA  
NURSING SCHOOL



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Original Articles



## The look of emergency nurse at the patient who attempted suicide: an exploratory study

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### ABSTRACT

**Aim:** to analyze the attitudes of registered nurses in the urgent and emergency sector with regards to care for suicidal patients. **Method:** an exploratory-descriptive, qualitative study, conducted through a semi-structured interview with 13 nurses from a public emergency room in the state of Rio Grande do Norte. The data were systematized into nucleus of significance. **Results:** Nursing care for patients attempting suicide is based on a technical perspective, with an emphasis on a clinical approach. In addition, it was perceived that the professionals feel unprepared to deal with the thematic approach. **Conclusion:** it is essential to rethink the professional training of nurses to deal with suicide, based on the recording of occurrences in health services and the creation of public policies aimed at preventing this phenomenon.

**Descriptors:** Suicide, Attempted; Nursing; Emergency Medical Services.

## INTRODUCTION

The meaning of life has been a restlessness represented throughout the course of the history of the human condition and a questioning in historical and philosophical instruments. In this way, thinking and understanding this sense, referring to the end of life through self-extinction, causes in society a sense of stigma, something of a delicate nature, which generates controversy, especially when life ends of its own accord.

Suicide, which is one of the most enigmatic and disturbing human behaviors, can be characterized as a deliberate act, consciously and intentionally executed by the individual himself, whose desire and ultimate goal is the end of life. Thus, suicidal behavior refers to the thoughts, plans and actual attempt, resulting directly or indirectly from an act that, respectively, can be positive - shot by firearm - or negative - hunger strike, inflicted by the victim himself<sup>(1)</sup>. Already the suicide attempt is defined as an interrupted act before it results in death.

More than a philosophical, religious or social question, it is a serious public health problem as it is estimated that over 800,000 people die from suicide every year<sup>(1,2)</sup>. In addition, the number of suicide cases has increased substantially in the world. In Brazil, studies have shown that in 2012, 11,821 deaths were recorded, which is equivalent to about 30 deaths per day<sup>(3)</sup>.

In order to throw light on the understanding of suicide, a careful look at the singularities of situations and populations where it occurs is necessary, since the complexity of the phenomenon points to internal and external associative factors to the suicidal. Considering that this phenomenon is present in all civilizations, it acquires different meanings according to each culture<sup>(4)</sup>.

Thus, its meanings stored in the society's imaginary, especially among registered nurses in urgent and emergency services, allow the attribution of divergent moral values. These values may be evident in professionals' attitudes to the problem in an urgent care situation, which can influence the health care aimed at the user. Here, urgent services are the gateway for users who need emergency treatment and psychiatric referral, such as with suicide attempt cases; it is a fundamental sector for the evaluation of the cases attended and of powerful visualization of the phenomenon. It is characterized, therefore, as a primary care service to the individual<sup>(5)</sup>.

Faced with this, the current literature shows itself to be weak in terms of studies on the phenomenon of suicide and emergency services. It is also perceived that the studies increasingly point to the lack of clinical management for these users, being restricted to the compendia of psychiatry. In addition, the lack of academic and professional orientation of the nurses has perpetuated an approach with a clinical and physical focus to the individual, whose reestablishment of the biopsychosocial health is compromised.

Thus, one can think about the contributions of the nursing professional in this process and how a humanized assistance, especially within the context of urgent and emergency services, is capable of influencing the prevention of other possible attempts. In this way, is it possible that the humanized care, assistance and greeting that nursing professionals to the patient who experiences the context of suicide influence the process of biopsychosocial recovery of the individual? In this sense, the present study aims to analyze the nurses' look of the urgency and emergency sector regarding the care to the patient who attempted suicide.

## METHOD

It is an exploratory-descriptive research whose approach is qualitative, since it involves a universe of deeper meanings, relations, attitudes and values, in which the level of reality can not be quantified<sup>(6)</sup>.

The study was carried out in an emergency room in the municipality of Natal, located in the state of Rio Grande do Norte, which serves about 12,000 users per month from the host city and the interior of the state, since the service is a reference and has equipment for urgent care and hospitalizations of medium and high complexity. Therefore, many instances of suicide and suicide attempts are directed to this unit.

The population was composed of registered nurses who worked on fixed duty scales in the emergency room in question, comprising a total of 33 professionals. Registered nurses that have been working for at least one year in the sector were used as inclusion criteria, since a longer period of time in the service may provide a greater experience regarding assistance to the patient who attempted suicide. Those who had either witnessed assistance or offered assistance to patients in self-inflicted assaults were also included. Registered nurses who were on vacation or recess during data collection were excluded from the study. Thus, 13 registered nurses constituted the study population, since two were in recess during the period of data collection, seven refused to participate in the study, two did not give feedback to the researchers after contact, and nine were in the service for less than a year.

The data were collected from June 10<sup>th</sup> to July 12<sup>th</sup>, 2015 through a semi-structured interview, since it seeks to obtain information contained in the speech of the social actors, with a free approach of the proposed theme,

with the help of previously elaborated questions<sup>(6)</sup>.

To this end, an interview with open questions relating to the nursing care was elaborated to the patient victim of a suicide attempt, addressing aspects about the humanization of patient and family care, the main difficulties encountered in approaching the patient and the professionals' attitude to the patient. The interviews were conducted individually after signing the Informed Consent Term (TCLE – from the Portuguese Termo de Consentimento Livre e Esclarecido); they were recorded with the consent of the participants and carried out in an environment chosen by the research participant. In order to guarantee anonymity, respondents were identified by the letter "E", preceded by an Arabic numeral.

The process of data analysis took place in the light of the constitution of nucleus of signification. To that end, the interviews were transcribed, aiming to become familiar with the text that expresses the lived experience. Subsequently, several re-readings were made, highlighting the pre-indicators that, once articulated, allowed the elaboration of meanings from the emotional expression of the subject. The analysis process was followed with the agglutination of the pre-indicators, insofar as they appeared similar, complementary or opposite, originating the indicators. From this, significant nucleus was highlighted, evidencing the studied phenomenon and the aspects related to it. Finally, we proceeded with the interpretation of the data, pointing to the articulation of the elements translated in the interview, the researcher's presuppositions and the theoretical frameworks of reference<sup>(4,7,8)</sup>.

Regarding ethical issues, the project respected the norms and procedures set forth in Resolution N<sup>o</sup> 466/13 of the National Health

Council, which regulates research on human beings at the national level, and obtained approval from the Research Ethics Committee (CEP – from the Portuguese Comitê de Ética em Pesquisa) of the Federal University of Rio Grande do Norte, under number 1.086.418 de 29/05/2015, (CAAE 44895315.3.0000.5568).

## RESULTS

The data that emerged from the interviews were analyzed and categorized into four nucleus of significance: the nursing and the attack on life by self-extermination; urgent care of the suicidal; care for the one who contemplates suicide; difficulties found in approaching the patient who attempts suicide.

### *The nursing and the attack on life by self-extermination*

The participants stated that, in reality, care was exclusively clinical and that it did not take into account the biopsychosocial context of the individual who attempts suicide, as presented in the reports below:

E1: Treatment is like any other. He arrives at the emergency room and we do the initial care, first the doctor, then the nursing [...].

E2: At the arrival of the patient, he is seen by the doctor, and we will do the prescribed care. In the case, when there is poison or medication intake, we pass the nasogastric tube, depending on the substance, and will know if you can do gastric lavage or not [...].

E3: The patient is attended to; they are treated so that their lives are no longer at risk and then they go home the same way that they came. There is no continuity [...].

### *Urgent care of the suicidal*

The following statements point out that the nursing care based on the biomedical model is articulated with the absence of an environment conducive to the performance of more humanized practices, a characteristic fact of urgency environments.

E4: Usually, as the emergency room is very busy, we try to give priority. We provide accommodation for patients with exogenous intoxication, which is what they mostly come here for. Sometimes we don't even have a stretcher, only a chair. Then we have to pass the tube while the patient is on the chair anyway. But the care is this: accommodate and do the procedure, which is the passage of a nasogastric tube, do the washing, give medications [...].

E5: We are distressed because we see that what is being offered is not appropriate, it is not what they should have. Today, for example, we cannot give patients adequate attention, unfortunately. The overload is too much. The sector itself does not have a suitable environment for that person [...].

E3: The patient stabilizes and, if they live, they go home. But that part of

us approaching and trying to give a referral does not happen. I've never seen it.

### *Care for the one who experiences the choice for suicide*

The participants understand that there are a large number of external factors associated with the context of suicide that contribute to an individual's decision to end their life. It was also observed that many recognize the importance of being offered humanized care, but they do not carry out this care.

E6: I think that humanized care will make a difference to this person, but I do not know if I can say that I will avoid other attempts, because the factors they generated are not dependent on care, but yes, they are out there. If he comes back with the same stimulus, he's going to try suicide again. I find this part very intrinsic to the patient, and the recurrence of this does not depend on the care.

E7: My contact is very fast. I do not have nearly time to talk, to try to do something. The conversation is short. We have to try and convince him to pass a catheter.

E8: That greeting at the entrance is not done, because there is no time. Usually we ask why he did it.

E9: Uses physical restraint. If he's hurting himself with restraint, he's going to chemistry. The justification is that we do not have enough professionals to do this integral care; And when

you take this patient away from the urgency, it is as if the people's duty has already ended there. After all is just a screaming patient [...].

### *Difficulties found in approaching the patient who attempts suicide*

Respondents say they have difficulties in approaching patients who attempted suicide and did not feel empowered to do so. In addition, the contact with the family member who accompanies the patient is restricted to the collection of information associated with the act.

E10: I have difficulty getting into the subject. Sometimes I feel like talking, but I do not know exactly how. That's why I'm relying on the social worker [...].

E11: There are difficulties, yes, and many people are not prepared for it. It should be a more clearly discussed point in both undergraduate and continuing education. I think that the suicide factor is a subject that still generates discomforts; it is a taboo that we do not experience in training [...].

E12: I feel that it is very difficult. The hospital could offer more courses and lectures, and for us to have a more accessible dialogue. We study psychology, theory and practice, but these disciplines are not greatly experienced in our day-to-day life. This deficiency stems from being an undergraduate. There has to be more practice for suicide assistance [...].

E12: I think they are weak people, both from an emotional and spiritual point of view [...].

E08: Humanization focuses precisely on the family, talking with the family members to try to collect information that can help us to prevent a recurrence.

## DISCUSSION

The health-disease process increasingly passes through a historical evolution, gradually expanding thought and reductionist scientific knowledge, centered on the fragmentation of knowledge, giving space to a look engaged in the subjectivity of the subject and in the complexity of relationships<sup>(9)</sup>.

However, although it's observed a discourse theoretically based on a biopsychosocial dimension in patient care, guided by health promotion, by professionals working in the health services has been perceived in practice, an action in which the approach is centered on the disease, not on the patient<sup>(9)</sup>.

Emergency service professionals, especially the nurses, end up becoming fundamental actors in the care of suicidal patients because of their close and direct contact with them. However, this process is often translated into a clinical perspective, one that is based on technical intervention, without recognizing the individual's subjectivity and life history.

The addressing of suffering, so characteristic in patients that have attempted suicide, is also cast aside, and it becomes evident that the psychological motives that are involved in every attempt of suicide are neglected.

Health professionals need to overcome the biomedical model of health care, aimed at disease, diagnosis and therapeutic procedures, and to invest in the attention model focused on health promotion, taking into account the socio-cultural, biological, psychological dimensions and the life story of the patient attempting suicide<sup>(9)</sup>. In this sense, the first contact with the patient who has attempted suicide should be able to generate a bond that can guarantee trust and collaboration, as individuals are emotionally weak and often uncooperative with the professionals, making it essential to listen to them carefully<sup>(10)</sup>.

In contrast, many nurses recognize and attribute exclusively clinical nursing care to the absence of a welcoming and favorable environment for more humanized practices, a characteristic fact of emergency environments.

However, it can be seen that, in addition to the problematic concerning an unfavorable environment to perform an integral and continuous care, that takes into account the life context of the patient victimized by the suicide attempt, the work overload, present in the daily life of nursing professionals can contribute to a greater aggravation of this reality.

Therefore, nurses must be able to deal with the work environment in which they are inserted and, above all, be prepared to work with the patient who is suffering psychologically to the point of wanting to interrupt his life. In addition, the search for improving in working conditions needs to be considered and put into practice by professionals, in order to culminate in a better professional performance and, consequently, more effective nursing care. The health professional working in the emergency services needs to be prepared to understand the situation and to encounter the characteristics commonly observed in

suicidal patients, i.e., mainly thoughts that portray hopelessness, fear, despair and helplessness. In this sense, impoverished and rushed empathic contact, in addition to the very environment of urgent and emergency care, can prevent a clinical evaluation and an effective therapeutic relationship<sup>(10)</sup>.

The exchange of shifts between the professionals in the establishment also makes it difficult to continue assistance. Thus, there is a drop in continuity of patient care and nurses often do not work with the team to promote ongoing care through referring the patient to other services after discharge. With this, the recurrence of this phenomenon is very great. In this sense, the fragmentation of continuous care in emergency health services can be overcome, insofar as there is a focus on multiprofessional work and, above all, the recording of cases of attempted suicide in the medical record. Thus, interdisciplinarity presents itself as an important therapeutic strategy that allows the integration of the professionals responsible for the care of the suicidal patient, culminating in qualified and effective assistance in the complexity of the suicidal behavior. Thus, there is a fragility regarding the recognition of the person who attempts suicide as a being who needs, besides clinical and urgent care, a differentiated, humanized, continuous and global approach.

On the other hand, humanization refers to the provision of quality care, allowing for the articulation of technological advances with reception, improvement of care environments and working conditions of professionals<sup>(11)</sup>. Thus, humanized care, with its emphasis on qualified listening, dialogue, information and use of attitudes that positively reflect care, such as touching the patient, can significantly influence the professional's decision-making during an emergency, con-

tributing to preventing other possible suicide attempts.

However, it is generally believed that this assistance is not a determining factor for the prevention of recurrence, since a large number of external factors linked to the subjects' life histories and associated with the context of suicide contributes to individuals' decisions to end life. Thus, the adequate referral of the individual to other specialties such as psychiatry and psychology becomes fundamental, since the meanings behind the desire to end life will be reflected upon in depth. Therefore, it is important for the team to be aware that, in addition to care with humanized perspectives and practices, multiprofessional work is necessary. It is also perceived that professionals should recognize the importance of offering humanized assistance, based on the need to listen attentively to the patient, to promote warm care and, above all, to understand the socio-cultural determinants that surround the individual's life. However, due mainly to the high demand for services, they end up not doing this care.

The person who attempts suicide, in turn, finds himself in psychologically suffering, and performs such an act in an attempt to express his suffering. However, this context is often not understood by the nurse, generating an inadequate and dehumanized approach, characterized mainly by an inquisitive dialogue of the reasons for choosing such an act.

On the other hand, the urgent and emergency environment, which is often stressful, or the professionals' unpreparedness to deal with the issue in question, ends up contributing negatively to such a humanized approach. In this sense, when approaching patients in this particular context, the individual's behavior at the time of care must be taken into account. From this, will be thought the

way the professional will dialogue and the conduct that will establish before the patient.

Studies corroborate this idea, reflecting on the use of physical and chemical restraint during this process, which are usually routine in some emergency services, mainly from a mental health perspective<sup>(12)</sup>. Thus, there is no favoring of the warm and humanized practice so much questioned in assisting the individual who attempts suicide. From this, the use of physical restraint should be used in necessary cases, as in the case of a restless, aggressive and uncooperative patient, and not as a routine practice of emergency services.

Some techniques, such as therapeutic communication, in which nurses use communication skills to support, inform and promote the education and training of the individual in the process of transition from illness to health, is a set of therapeutic interventions focused on patient recovery. Thus, methods that promote the dehumanization of care can be avoided and minimized, favoring the biopsychosocial recovery of the individual attempting suicide<sup>(12,13)</sup>.

It was also observed that nurses who daily experience care for the patient who attempted suicide in emergency services are often not qualified to perform this care. Consequently, they end up designating this action to other professionals that make up the health service, such as psychologists and social workers.

The fragility found in the realization of an effective approach to the patient of an integral and multiprofessional character, is often linked to a deficiency in professional training. Thus, it is believed that nursing undergraduate courses need to increasingly incorporate into the curriculum disciplines capable of generating a greater discussion and a better look at the biopsychosocial dimension of

diseases and the patient, such as those who attempt suicide, both in theory and practice.

Thus, in view of the personal and individual search of the professionals for a continuing education, the health services also need to opportunize, stimulate and promote training courses, culminating, therefore, in an effective assistance to the patient who attempts suicide.

On the other hand, the difficulties in carrying out an adequate approach to suicidal patients are also linked to the stigma and beliefs related to this phenomenon, based on religious, social and moral aspects, that cross the formation of the professional as a person and, above all, influence the posture and the reception offered to this type of patient. It could also be observed that the relationship of professionals with the family of the suicidal patient is closely limited to the collection of information inherent to the act. In this way, the biopsychosocial aspects that permeate the lives of these fragile people are left aside.

Study data estimates that 60 people will be directly affected in each suicide death, including family, friends and classmates. Thus, family therapy is quite useful, since it can contribute to the improvement of patient communication, social support and adherence to treatment (3). Therefore, working with the family is fundamental in this process, especially in the sense of offering support in the face of suffering and of providing an awareness of the importance of psychotherapy and psychiatric care, when necessary, to the individual who attempted suicide, alerting them to the possibility of future attempts if they do not have adequate treatment.

On the other hand, the recording of complete data on the suicide attempt does not occur in most cases, which leads to the lack of knowledge of the epidemiological reality

of this phenomenon. Thus, it is believed that nursing professionals' neglect of suicidal patients' life histories contributes to the lack of registration of the cases.

## CONCLUSION

In view of this, the attitudes of professionals that deal daily with the problem of suicide in emergency services, especially nurses, are configured from a technical perspective with a focus on exclusively clinical care. However, the ability to deal with this issue from a biopsychosocial, humanized and welcoming perspective can considerably reduce instances of the phenomenon, especially if both the internal and external factors associated with the attempt and the patient's sociocultural environment are taken into account.

It is thus perceived that this study demonstrates the need for greater support with regard to the establishment of processes of continuous and permanent education, since difficulties in approaching these patients are still commonly reported in care practices. In addition, themes related to the finitude of existence, like suicide, still generate in the professionals a series of conflicts whose moral, religious and historical essence causes a series of thoughts with different meanings. In this way, suicide ends up being seen as taboo, resulting in an exclusively clinical assistance.

It is also noticed the need to notify occurrences and the development of strategies aimed at improving care for the patient who attempts suicide, deconstructing preconceived concepts related to this phenomenon, seeing them from their totality. In addition, it is believed that it is fundamental to elaborate public policies aimed at preventing this phenomenon.

The relationship between the nurse and the patient, in turn, with an emphasis on listening, is an important tool in the effective planning of humanized care, since it must be carried out with safety, promptness and quality and must involve a multiprofessional work to, consequently, help minimize the distress and suffering often present in families, thus contributing to the prevention of other possible attempts.

In this way, the listening and the reception of the professional to the patient will mark, mainly, the way in which the relation between him and the nurse will be constructed. From this, it will be possible to see if such a relationship will be permeated by trust, fear or resistance.

We suggest the continuity of studies that reflect and demonstrate the benefits of humanized care to suicidal patients within the context of urgent and emergency care, mainly for the prevention of a fatal act. It is valid to reinforce the importance of developing strategies for nurses to prevent the phenomenon, since the literature points out that patients who attempted suicide tended to repeat such an act. Therefore, adequate reception and proper referrals, such as psychotherapy and/or psychiatry when necessary, are fundamental for the prevention of other attempts, mainly because they contribute to the process of constructing the meanings brought throughout the life history of the subject.

The recording of maximum information about the attempt in the patient's medical record contributes to continuity of care in the urgent and emergency services. In addition, it allows the provision of data to better understand this reality and to support future research in the area.

The training of nurses and other health professionals needs to be rethought, since

issues such as suicide are still little discussed in the undergraduate curriculum. Thus, in order to act and intervene in a phenomenon that has not yet been well studied, one that is so present in urgent and emergency health services, it is necessary to know the reality in which the individual is inserted. In this way, looking at the patient in their entirety, carrying out integral and humanized care and, above all, together with a multiprofessional team, acting in the resignification of the life of the one who decides to put an end to life still represent a challenge that needs to be overcome in the urgent and emergency services.

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All authors participated in the phases of this publication in one or more of the following steps, in according to the recommendations of the International Committee of Medical Journal Editors (ICMJE, 2013): (a) substantial involvement in the planning or preparation of the manuscript or in the collection, analysis or interpretation of data; (b) preparation of the manuscript or conducting critical revision of intellectual content; (c) approval of the version submitted of this manuscript. All authors declare for the appropriate purposes that the responsibilities related to all aspects of the manuscript submitted to OBJN are yours. They ensure that issues related to the accuracy or integrity of any part of the article were properly investigated and resolved. Therefore, they exempt the OBJN of any participation whatsoever in any imbroglios concerning the content under consideration. All authors declare that they have no conflict of interest of financial or personal nature concerning this manuscript which may influence the writing and/or interpretation of the findings. This statement has been digitally signed by all authors as recommended by the ICMJE, whose model is available in [http://www.objnursing.uff.br/normas/DUDE\\_eng\\_13-06-2013.pdf](http://www.objnursing.uff.br/normas/DUDE_eng_13-06-2013.pdf)

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Received: 12/07/2015  
Revised: 01/31/2017  
Approved: 02/02/2017