

TECHNOLOGICAL INNOVATION

Support for families and psychoeducation on childhood suicide: validation of a simulation script

HIGHLIGHTS

1. Presents a validated simulation script on child suicide prevention.
2. Offers an experiential resource for interprofessional health education.
3. Emphasizes skills for family support and psychoeducation in mental health.
4. Original tool for training health professionals and students.

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ABSTRACT

Objective: To construct and validate a simulation-based teaching script for interprofessional health training, focused on supporting families and providing psychoeducation about suicidal behavior in children. **Method:** Methodological study on the development and validation of an educational technology. Validation was carried out in 2022 with eight experts, using a self-administered form. Data were analyzed using descriptive statistics and the Content Validity Index. **Results:** The script includes objectives, target audience, resources, and pre-briefing, briefing, and debriefing stages. Most of the experts were women, nurses, and PhDs, with expertise in child suicide. Of the items evaluated, 85% presented a Content Validity Index ≥ 0.70 . The items related to the objective, time, and expected actions were revised, resulting in the validated version of the script. **Conclusion:** The validated script is original and relevant for interprofessional health training, contributing to the strengthening of family support and the prevention of suicidal behavior in children.

DESCRIPTORS: Suicide Prevention; Child; High Fidelity Simulation Training; Simulation Exercise; Family.

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INTRODUCTION

Childhood Suicidal Behavior (CSB) is a multifactorial and complex phenomenon, with specificities and risk factors associated with children's development process. The experience of conflictual family relationships, social vulnerability, adverse childhood experiences, losses, a family history of mental disorders and suicide, as well as the diagnosis of mental disorders and/or the experience of self-inflicted violence, are among the factors associated with Childhood Suicide (CS)¹⁻³.

Some studies indicate that excessive use of social media, challenging school experiences (bullying), difficulties in conflict resolution, behavioral changes, easy access to lethal means, and food and financial insecurity are also associated with mental health problems in childhood⁴⁻⁶. Furthermore, the results of a meta-analysis that analyzed children aged six to 12 years indicated that 7.5% presented suicidal ideation before they turned 13, 2.2% went so far as to develop a plan, and 1.4% manifested self-harming behaviors⁷. In the Brazilian context, mortality rates in recent years have pointed to an increase in deaths by suicide among children and adolescents under 14 years of age, reinforcing the importance of preventing suicidal behavior also in childhood⁸.

The adults responsible for children, especially family members and health professionals, play a central role in care, in promoting mental health, and in preventing harm in this population. These adults commonly strengthen healthy emotional bonds, offer support and protection, and contribute to the development of socio-emotional skills in younger people⁵. In parallel, health professionals provide care to children at various levels of health care, with emphasis on the context of Primary Health Care (PHC)⁹.

Despite the important work carried out by health professionals with children, gaps are evident in training processes, low affinity with care, and fragility in working with this population. These factors contribute to the distancing of different professional categories from understanding the phenomenon of CSB and from carrying out the necessary actions in the face of these needs¹⁰⁻¹¹. Furthermore, the difficulty in recognizing processes of emotional suffering and harmful behaviors in children persists.

Among the strategies for addressing this reality, investment in the training and development of current and future health professionals appears as a promising path for promoting more effective and humanized care in the field of mental health¹⁰⁻¹¹. The scientific literature points to the need to improve literacy on the prevention of CS, both among health professionals and among family members^{1,10}.

In this sense, the importance of advancing knowledge and practices that enhance care in the face of this phenomenon is evident, encompassing early identification, welcoming, follow-up, and prevention actions. Furthermore, the need to promote psychoeducation and support for families is highlighted, recognizing them as agents of care and protection in the daily lives of children¹²⁻¹³.

The use of active teaching-learning strategies that promote the development of knowledge, skills and attitudes aimed at suicide prevention has been widely recommended and applied in different contexts. Among these strategies, Simulation-Based Teaching (SBT) stands out, which strengthens professional training in a realistic, responsible, safe and ethical manner¹⁴.

SBT articulates theory and practice, favoring the development of technical, socio-emotional, communicational, clinical reasoning, and decision-making skills, with positive effects observed in participants' satisfaction and self-confidence, their engagement in

the activities, and reduced anxiety¹⁵. Along with this, the validation of health education resources by specialists, such as the scripts developed for SBT, constitutes a fundamental step in the evaluation of materials, with the objective of certifying their reliability, relevance, and suitability to the target audience for which they were developed¹⁶.

In this context, the study aimed to construct and validate a simulation-based teaching script for interprofessional health training, focused on supporting family members and psychoeducation about suicidal behavior in children.

METHOD

This is a methodological study on the development and validation of a script for SBT, described using the Methodological Study Reporting Checklist (MISTIC). The script was developed in 2022, based on a template validated in previous studies and international recommendations on clinical simulation^{14,17-19}.

The approach to CSB was based on scientific articles, guidelines, and manuals available in the literature, and enriched by the authors' expertise in the subject¹⁻⁴. The scenario proposed in the simulation allows participants to develop skills, attitudes, and behaviors related to supporting family members and psychoeducation about suicidal childhood behavior.

The script was submitted to content validation by experts between June and September 2022. The selection of experts was carried out using the curriculum search tool of the Lattes Platform, a Brazilian database of academic curricula, focusing on the search for professionals with expertise in the themes of CSB and/or SBT.

Thirty-six experts were invited by means of an invitation letter sent via institutional email, of which eight accepted to participate and comprised the study's final sample. This is a non-probabilistic, intentional sample, composed of experts selected based on criteria of academic background (masters and doctoral degrees) and professional experience in the area of interest (CSB and/or SBT). This type of sampling is used in national validation studies, in which the participation of experts with proven experience contributes to the evaluation of the pertinence, clarity, and relevance of the materials developed¹⁸⁻¹⁹.

The form sent to the experts contained the Free and Informed Consent Term (FICT) for reading. If they agreed to the FICT, the experts were directed to answer a characterization questionnaire (gender, age, geographic location, profession, postgraduate level, area of expertise, and length of experience) and to evaluate the script, based on answers indicated as: adequate, regular, or inadequate, in addition to a space for suggestions.

The collected data were processed using Microsoft Excel software and analyzed using the R program, version 4.1.2. Descriptive analyses and the calculation of the Content Validity Index (CVI)¹⁶ were performed. The calculation was conducted based on the sum of the adequate and regular items. The acceptance criterion for the items was $CVI = 0.70$ (70.0%). The study followed the recommendations of Resolution No. 466 of December 2012, of the Brazilian National Health Council (CNS), in accordance with Law No. 14,874, of May 28, 2024, and was approved by the Research Ethics Committee (REC) of the institution of origin, under opinion No. 4,692,421.

RESULTS

The script was validated by eight experts, six (75.0%) of whom were female, with a mean age of 40.7 years (SD = 6.7; minimum = 33 years; maximum = 51 years) and residents of the Southeast Region (75.0%) of Brazil. Regarding their education, four (50.0%) were nurses, three (37.5%) psychologists, and one (12.5%) biomedical scientist, of whom six (75.0%) held a doctoral degree. Five (62.5%) professionals stated that they had expertise in the area of CSB and three (37.5%) in the area of SBT, with a mean of 13.3 years of experience (SD = 7.5; minimum = 5 years; maximum = 28 years).

In the CVI analysis, the objective (0.63), duration (0.63), and the second item of expected actions obtained results below the cutoff value. Furthermore, the items "instructions for the director" (SBT = 0.33; CSB = 1.00) and "expected action" 2 (SBT = 1.00; CSB = 0.40) showed discrepancies in the evaluations in relation to the expertise of the specialists (Table 1).

Table 1. Content Validity Index of the simulation-based teaching script on family support and psychoeducation on childhood suicide by experts (n=8). Ribeirão Preto, SP, Brazil, 2022

Items	CVI [†]		
	SBT [‡]	CSB [§]	Geral
Title	1.00	0.80	0.88
Objective	0.67	0.60	0.63
Target Audience	1.00	1.00	1.00
People Involved	1.00	1.00	1.00
Physical Resources	1.00	0.80	0.88
Material for Prior Study	1.00	0.80	0.88
Duration	0.67	0.60	0.63
Prebriefing	1.00	1.00	1.00
Briefing	1.00	0.60	0.75
Instructions for the Facilitator	0.33	1.00	0.75
Expected Action 1 - To welcome and encourage the expression of feelings and needs	1.00	1.00	1.00
Expected Action 2 - To clarify doubts and demystify beliefs that may hinder prevention	1.00	0.40	0.63
Expected Action 3 - To promote communication skills	1.00	1.00	1.00
Expected Action 4 - To promote the recognition of protective behaviors or emotional distress	1.00	1.00	1.00
Expected Action 5 - To encourage the identification and reduction of risk factors and strengthen protective and well-being factors	1.00	1.00	1.00
Expected Action 6 - To promote the recognition of warning signs, support resources, and access	1.00	1.00	1.00
Debriefing - Descriptive Phase	1.00	1.00	1.00
Debriefing - Analytical Phase	1.00	1.00	1.00
Debriefing - Application Phase	1.00	1.00	1.00
References	0.67	0.80	0.75

Notes: [†]CVI: Content Validity Index; [‡]SBT: Content Validity Index value obtained from experts in the field of Simulation-Based Teaching; [§]CSB: Content Validity Index value obtained from experts in the field of Child Suicidal Behavior.

Source: The authors (2022).

Based on the suggestions, modifications were made to promote greater clarity and facilitate understanding of the following items: wording of the general objective, adjustment of item two of the expected actions, and updating the duration of each stage, changing the simulation from 20 to 25 minutes and the debriefing from 40 to 50 minutes. After the corrections, the validated version of the script was obtained: "Initial assistance for welcoming the family and psychoeducation on the prevention of childhood suicide", which can be accessed through the QR Code provided below (Figure 1).



Figure 1. QR Code for access to the validated script for simulation-based teaching regarding family support and psychoeducation on the prevention of childhood suicide. Ribeirão Preto, SP, Brazil, 2022

Source: The authors (2022).

DISCUSSION

CSB is a phenomenon with implications that are still little explored in the training of health professionals, especially in the Brazilian context. The prevention of suicidal behavior in childhood has been discussed in light of community and social approaches to care. Thus, family involvement, the community, and health services becomes fundamental, since health professionals are sought by family members in search of understanding and assistance in the face of the challenging experiences of CSB^{12,20}.

In the developed script, Bernardo's grandmother was defined as the reference in the child's care, this choice being based on the simulated case, which addresses child's mother's history of suicide. A Brazilian study on care for children with suicidal ideation shows that, in reports of care for children, mentions of the presence of the female figure predominate¹¹. In this context, the role of the grandmother was played by a simulated participant, who is a participant in the SBT who must undergo rigorous prior preparation, based on the script instructions²¹.

In this sense, the expected actions are established as objectives that must be carried out by the participants during the assistance, which are only available for monitoring by the facilitators, who should evaluate their achievement and possible points of attention related to participants' interaction with the simulated participant^{14,21}. From the performance of these actions, the participants develop procedural and attitudinal skills regarding care in the face of CSB. Therefore, for this to materialize, it is essential that the participants have prior training, subsidies and sufficient resources for the approach and care to be carried out¹¹.

During the simulation, participants taking on the role of healthcare professionals should adopt a welcoming and empathetic stance, interacting with Bernardo's grandmother to understand the context and individualities of the case, identify emotional distress, risk and protective factors, behaviors, history, vulnerabilities, and aspects related to grief over childhood suicide²²⁻²³. Furthermore, they can promote

psychoeducation, reinforcing the child's specific interests, activities, and needs, while the facilitator provides additional clues that enrich the care^{14,21-23}.

In addition, studies highlight that family and school connection, perceived emotional support, self-esteem, the development of healthy coping strategies, the practice of physical activities, peer relationships, the feeling of belonging, and the quality of communication act as protective factors against CS²³⁻²⁴. For these factors to take effect, it is essential that family members have their concerns validated, participate in careful dialogues on the subject without moralistic attitudes, and receive emotional support, literacy, and access to healthcare.

Among the expected actions, attention to clarifying doubts and demystifying beliefs about child suicide stands out, supported by the recognition of the triple taboo related to death, suicide, and child suicide. Socially, the myth persists that children do not exhibit suicidal behavior; however, records indicate that, although the expression of the desire to die is distinct, it does in fact occur in this group¹⁰.

The complaints and needs identified reflect findings from the literature on child suicide, which can manifest itself through signs such as expression of the desire to die, irritability, drop in school performance, social isolation, and difficulty understanding feelings, observed in Bernardo. The script also highlights relevant risk factors, including the death of a loved one by suicide, grief over suicide, feelings of guilt, beliefs that children do not attempt suicide, weaknesses in the sense of belonging and hope, difficulties in emotional expression, family conflicts, and situations that show the child in danger, such as falls from a height^{10,23}.

Concerns may intensify in cases involving families bereaved by suicide. Thus, the welcoming process should begin with the grandmother, through empathetic listening, without judgment or stigma related to death by suicide, in order to favor the construction of new perspectives on care by the health professional. The experience of suicidal behavior and suicide of family members, especially parents or guardians, can constitute a significant risk factor for bereaved children and adolescents²⁵⁻²⁶.

Findings from a North American study pointed to associations between experiencing parental suicide attempts and the identification of mental disorders in children and adolescents between the ages of eight and 16, highlighting the potential existence of suffering processes in this group²⁶. Moreover, the absence of an approach and explicit communication between family members regarding suicide of a loved one can potentiate suffering, hinder the grieving process, and intensify feelings commonly experienced by the bereaved, such as guilt, shame, isolation, and stigma²⁵.

In these contexts, the role of suicide postvention stands out, which encompasses the care and assistance to bereaved individuals or groups²⁵⁻²⁶. In children, individual and group psychoeducation is recommended, with safe, welcoming approaches adapted to the age group, the participation of trusted adults in guiding and supporting grief, strategies for promoting mental health within the family environment, and the use of playful resources, such as books and games, to encourage interaction and care²⁶⁻²⁷.

Another important aspect in approaches to CSB concerns the constant and sometimes abusive use of virtual environments by children, especially social networks, games, and other applications. This is relevant even in contexts that require supervision by guardians and the application of minimum age rules for access²⁸. Furthermore, there is an increase in the number of children and adolescents who seek content related to self-harm and suicide on social networks²⁹.

With regard to SBT, the strategy favors reflection on the importance of the adult's emotional preparedness, the construction of a protective environment with the potential to contribute to the child's care. For simulated teaching to be more effective, it is essential to value the criteria for operationalizing the simulation, including the provision of recommendations, guidance, and preparation of both participants and activity's facilitators¹⁴. However, it is important to emphasize that this teaching-learning process, using this script, becomes effective when the simulated participant and facilitators have undergone sufficient prior training²¹.

The study materials and teaching proposals that precede the simulation contribute to the participants' preparation, promoting a more effective and safe learning environment¹⁴. Methodological studies that describe the construction and validation of simulated scripts on suicide prevention indicate that experts positively evaluate the availability of these materials to participants¹⁷⁻¹⁸.

The care context proposed in the SBT considered the potential of PHC to establish bonds, identify needs, welcome and intervene early in situations related to suicidal behavior. Although the script does not involve direct interaction with the child, the last objective of the expected actions reinforces participant's role in assisting the family in the search for support networks, valuing the continuity of care. Understanding the devices that make up the Psychosocial Care Network (*Rede de Atenção Psicossocial - RAPS*) of the Unified Health System (*Sistema Único de Saúde- SUS*), as well as strengthening the interprofessional approach, can favor appropriate referrals and continuity of care for the child^{11,30}.

Furthermore, the composition of the SBT allows the teaching-learning process to be strengthened after the simulation through debriefing, which should involve participants, facilitators, observers, and the facilitator^{14,17}. Debriefing is a moment intended for deepening discussions and reflections on the CSB, being fundamental for participants to build their clinical-assistance practice without reinforcing myths, beliefs, or potentially harmful behaviors related to the topic. To this end, it is essential that this process be conducted by facilitators with mastery of the topics covered, including the development of the SBT^{14,17}.

It is worth highlighting that the proposed script does not necessarily work with the presence of a concrete case of suicidal ideation or risk in children. To identify risk situations, it is essential to conduct a health assessment directly with the child, conducted by qualified professionals, avoiding reductionist approaches based only on reports from family members or caregivers, which, although relevant, do not replace listening directly to the child.

The perspective of expanded care in child and adolescent mental health requires centering the child in the care process, recognizing them as a subject of rights and an active participant in their care. This implies intersectoral articulation with other actors and contexts - such as schools, social assistance services, the community, and the health system - that can act as agents of protection, health promotion, and strengthening of support networks. Understanding and acting on suicidal behavior remains a challenge for health professionals, families, and support networks, making it essential that care be systematized and based on scientific evidence^{2,9,11,23,29-30}.

In this sense, the script includes initial actions to be developed within the scope of PHC, promoting advances in care in a safe and structured way, which contributes to a more prepared clinical-assistance practice in addressing suicidal behavior in children. In addition, it is a replicable material, whose dissemination can favor training processes in health and education, from an interprofessional perspective that values initial reception,

psychoeducation and collective suicide prevention, recognizing that this prevention must occur in an integrated way and not just individually.

The study is not without limitations. The approach is restricted to the experience of a child's family member, without considering the experiences of children, the social markers of inequality and the intersectionality present in mental health demands in Brazil. In the validation stage, the selection of experts occurred exclusively through digital means, which may have favored the participation of professionals linked to academia and the lower coverage of other regions of the country. Furthermore, the script was not evaluated with the target audience, pointing to the need for future investigations that address this stage. The importance of future studies that can broaden the discussion on childhood suicide is also evident, especially from the perspective of Brazilian contextual characteristics and listening to children to understand the phenomenon.

CONCLUSION

The study achieved its objective by constructing and validating a simulation-based teaching script aimed at interprofessional health training, focusing on supporting families and providing psychoeducation on suicidal behavior in children. Validation by experts generally showed adequate content validity, with high levels of agreement on most of the evaluated items. Specific items, such as the objective, duration, and one of the expected actions, presented values below the cutoff point, as well as discrepancies between evaluators with different expertise, which supported adjustments to the material.

The revisions made included improvements in the clarity of the writing, the expected actions, and the temporal organization of the steps, resulting in the final validated version of the script, with greater consistency and comprehensibility. The material proves to be original and potentially relevant for health education, focusing on the development of knowledge, skills, and attitudes in family support and the prevention of suicidal behavior in children.

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The authors have no conflicts of interest to declare.

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The authors declare that the data are available in an online repository (<https://sites.usp.br/inspiracao/wp-content/uploads/sites/1533/2026/04/Roteiro-Avaliacao-Cogitare.pdf>).

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