Suicidal behaviour: comments, advancements, challenges. A European perspective

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Suicidality is one of the most drastic indicators of mental ill being. Considering the complexity of biological, psychological, existential and social causes behind it, as well as the suicide preventive effect of mental well-being, the utmost way of counteracting suicidality finally seems to be the promotion of mental health and activities belonging to it.

Suicidality in European countries marks out populations at risk, in whole societies but also in their different layers. Thus, it gives a hint about where the burden of stressful changes, at both the societal and the individual level, is most significant. The search for protecting factors seems here as important as the elucidation of the risk factors for suicide: for example, when it can be seen that young males in one country, young females in another society, elderly males in a third country are utmost afflicted, whilst elderly males in a fourth country have no suicidality at all.

Often a polarity has been claimed to exist between those who support the idea of suicide being the consequence of mental disorder and genetic biology and those underlining specific causalities related to psychosocial, economic and existential factors. However, in modern suicide research, this split finally seems having been overcome by the recognition of the mutual interaction between nurture and nature, between biological factors and mental as well as psychosocial, existential and spiritual influences. Thus, to see and to pay regard to the depression behind the majority of all completed suicides is not to medicalize and not to deny the complex multidimensional and multifactorial causality behind depression as such, even if a biological predisposition can be found.

In most individual cases, the existing and complex sociological, psychological and existential burden needs the depressive perceptual distortion to get its decisive suicidogenic effect. As a consequence, effective suicide prevention programs have to be complex. They have to address the depressive disorder, with its symptomatology and cognitive distortion to be recognised in strategies improving clinical practice, but they have also to involve the sectors of society afflicting individual human's life. That needs multidisciplinary teams of psychiatrists, psychologists, nurses, social workers and sociologists, with access to anthropological and existential advice.

Regional, national and local suicidal preventive programs designed according to these principles exist in Europe today and show their efficacy. However, evidence is not always easy to collect. In order to get statistical power, often completed suicides as well as single and multiple suicidal attempts are pooled together as suicidal behaviour. By doing this, however, rather different groups are evaluated together. Many factors are different between multiple suicidal attempts and completed suicides. This is valid regarding gender distribution, age distribution, as well as social variables such as employment and marital status. Actually, some elements of suicide attempting behaviour are preventive with respect to completed suicide: in particular, help seeking through showing helplessness and suicidal desperation.

However, it is true that suicide is a rare event and statistical power should be gained.

To accomplish this, a better idea might be to cluster together completed suicide and death by external or "undetermined" causes, related to risk taking and destructive behaviour in the traffic and on working places. Experience from European countries, especially from Eastern Europe societies, shows that the numbers of deaths by accident or external causes is more closely related to the number of completed suicides than the number of suicidal attempts, especially the multiple ones.

It is amazing how disparate the results of the evaluation of various types of suicide prevention programs can be. This is especially true for programs aiming at only one of the complex spectrum of factors behind completed suicides. More consistent, often positive results, however, can be obtained from more complex programs, that respond to the problem of suicide in a more comprehensive way and that today are the suicide prevention policy recommended by the World Health Organization (WHO) in Europe.

Another challenge is the present demand for control and randomisation in evaluation designs, which often are difficult to obtain in suicide research. In suicidology, as well as in other fields of mental health research, concepts of evidence probably should be widened to integrate qualitative research and quasi-experimental designs, as for example having one population as its own control, comparing the situation before and after the intervention.

Another challenge is represented by gender issues. The possible existence of a male depressive, aggressive, and very suicidal syndrome might be one of the explanations for the overrepresentation of males with substance abuse, personality disorder and psychopathy amongst suicidal persons. Thus, it seems crucial to recognise the psychopathic behaviour or the alcohol addiction often seen in suicidal males as being a depressive syndrome, often different from that of females. Its complex and comprehensive treatment must be an important

intervention in order to fight male excessive suicidality and destructivity. Especially in Eastern European countries, where male excessive suicide, violence and accident mortality has become a public health problem, it seems urgent to develop and implement gender specific suicidal preventive strategies.

To prevent suicide does not only mean to counteract suicide provoking and facilitating factors. It means also strengthening resilience and protective factors that could be identified. For example, female populations, in many countries of dramatic transition, seem to be protected against the consequences of societal stress, e.g. the loss of identity, the helplessness and the loss of social cohesion which have such a strong impact on males. One lesson to be learned from female behaviour, in order to decrease male excessive suicide mortality, would be a strategy of increasing men's help seeking capacity, to facilitate men's possibilities to keep socially connected and to counteract loss of identity, status and helplessness in countries and times of transition.

However, screening male risk populations and identifying male depression and suicidality in time is a tricky task. Diagnostic criteria focusing on the male way of being depressed must be used in specific questionnaires. Here the Gotland Scale for Male Depression has proved to be of value. Even screening instruments, such as the WHO-5-Well-being Scale, not focusing on depressive symptoms but on well-being, have been shown to be a useful tool.

Amongst comprehensive ways to prevent suicides, two approaches have been of special importance. One is the reduction of access to means of suicide. The other are training programmes directed to the first line of contact (in the community, in emergency psychiatry or in primary health care), in order to increase knowledge about suicide and depression, especially its risk assessment and management. Even awareness raising and educational projects directed to schools and working places have been useful.

In Europe, an ardent and partly inflamed discussion is ongoing about the role of antidepressants in the prevention of suicide. Experiences from several European countries show that an increase of antidepressant medication on a population base seems to have a suicide preventive effect, especially when embedded in a comprehensive programme of detecting, treating and monitoring depression. Others claim a potential risk that especially serotoninergic antidepressant medication could trigger aggressive and even auto-aggressive behaviour, increasing suicide risk.

Even if there is evidence for the existence of such cases, which would be in line with known paradoxical or rebound effects of other drug treatments, there seems, however, today no doubt that many more suicides are prevented by antidepressant medication than provoked by it. Even if overtreatment with antidepressants is occurring, it is the undertreatment with regard to depression and the prevention of suicide that is the dominant problem in Europe today.

Finally, suicide is not an isolated phenomenon. It has to be seen as part of a cluster of illness and death, related to stress, helplessness, loss of identity and social insignificance.

A cluster linked to the lack of existential cohesion and manifested by a pattern of conditions, not only including depressive reactions, but also addiction and alcoholism, cardiovascular disorders as well as risk taking lifestyles and self-destructive behaviour.

The fight against suicide must be integrated in public health programmes of health promotion and primary prevention, directed against patterns of mortality and excessive morbidity related to stress and mental ill health in a society.

Modern and redefined social psychiatric approaches, utilising recent knowledge about the interaction between nurture and nature, between body and mind, as well as creating integrated, multisectorial public mental health policies, are the most important activities in order to counteract the ever increasing suicidality in Europe, foreseen by the WHO for the years to come.