1 SUICIDE: CAN WE PREVENT THE MOST MYSTERIOUS ACT OF THE HUMAN BEING?

| José Carlos Santos[1] |

Suicide was, is, and may continue to be the most mysterious act of the human being!

Some attempts of explanation and clarification have helped understand the phenomenon, but we are still far from making it easily understood in the logics of human behavior. Recent advances in the field of neurobiology have given us some clues. Social psychiatry has identified some aspects. Other areas of anthropological, sociological, philosophical knowledge... have given their contributions. However, suicide persists as a complex and multidimensional phenomenon, regardless of the perspective or filter of analysis.

Suicide prevention has become a public health priority (WHO, 2013, 2014). There is still no effective response to reduce suicide rates, despite all efforts made in this direction and the greater attention received in recent years. Every year, more than 800,000 people voluntarily put an end to their lives; more men than women; more older people than adolescents; more in developing countries than in developed countries. Today, we have a detailed knowledge of the profile of the suicidal person in the various contexts. However, with a few exceptions, the number of suicides continues to increase or at least not to decrease.

Even taking into account the complexity of the phenomenon, we can identify some reasons for its existence.

The first reason relates to the lack of prevention plans in some countries and specific contexts. Given the heterogeneity of this behavior, we must think globally, plan nationally, and act locally. Together with universal measures, selective and indicated prevention measures are also needed. Together with health measures, social, professional and educational measures are also needed.

The second reason relates to identifying the need for help. Understanding when it is necessary to seek external help, either within family and friends, or with the nearest health care providers or mental health care services, is essential for prevention at the individual level. It is essential to fight against the standardization or vulgarization of the symptomatology experienced. Fighting against the internal and social stigma is another cornerstone of prevention.

The third reason relates to the accessibility of services. Prevention does not benefit from economic barriers, such as user fees or decreased support; the lack of human resources, by concentrating them in major urban centers and reducing them in inland areas; and the decreased support for proper intervention and follow-up after the suicidal crisis, thus hindering a systemic and ecological intervention.

The fourth reason relates to the unpredictability of the act. Several studies have demonstrated the low capacity of health care professionals to foresee an imminent suicide, despite their knowledge of risk factors and careful assessment. However, the early diagnosis of mental suffering, hopelessness or mental illness contributes to its prevention.

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Despite its complexity, psychological pain, as defined by Edwin Shneidman, seems to be present throughout the suicidal process.

Psychological pain is individual and personalized. It is often, but not always, verbally expressed using quite primary or more complex language where meta-communication is common. For this reason, it is not always clear or understandable.

Closeness, empathy and availability seem to be important conditions to help someone in psychological pain and, possibly, with suicidal ideation. For this reason, the training of health care professionals during their undergraduate or post-graduate degrees and in-service training is essential for dealing with someone wanting to legitimize his/her psychological pain.

In Portugal, around 1,000 suicides are committed every year. The National Plan for Suicide Prevention includes the principles of multiculturalism and multidisciplinarity, among others. We are all called to take suicide prevention as a priority. More vulnerable groups require specific attention. Adolescents and elderly people are traditionally groups with higher incidence of self-harm behaviors and completed suicides, respectively. Police forces, prisoners, lesbians, gays, bisexuals, transsexuals/transgenders, prostitutes and the homeless have higher suicide rates than the rest of the population.

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However, the presence of ambivalence in the suicidal person gives us a window of opportunity to legitimize psychological suffering and help find alternatives, even though these may be invisible to the individual undergoing a crisis or difficult to identify by health care professionals.

1 PhD in Mental Health; Coordinator Professor at Nursing School of Coimbra, Rua 5 de Outubro / Avenida Bissaya Barreto, Apartado 7001, Coimbra, jcsantos@esenfc.pt

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Successful cases of reducing suicide rates help us believe that it is possible to reduce the overall rates of this phenomenon. However, to this end, greater political and social awareness, better access to health care services, and best practices are needed. In this context, nurses, particularly nurse specialists in mental health and psychiatric nursing, have increased responsibilities. Hence, an adequate training and knowledge, a less defensive practice and more training in psychosocial skills may help suicidal people move from a death-orientated place to a life-orientated place (Cutcliffe & Santos, 2012), i.e. make a difference between life and death.

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