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Opinion article

Suicidal Behavior Prevention: The Time to Act is Now

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Every life lost to suicide is one life to many. Evidence-based suicide prevention strategies save lives. Thus, suicidal behavior prevention is everyone's business.

An important fact to remember about suicidal behaviors is how widespread they are. Globally, suicide is an enormous social and public health issue accounting for almost a million deaths annually, with another twenty attempts for each death by suicide (World Health Organization [WHO, 2014]). The human cost associated with suicidal behavior for individuals, families, communities, health care, and society is beyond doubt. Despite these data and decades of research into suicidal behavior, there are still significant gaps among policy, research, prevention, and clinical practice. For example, in Spain, in the 21st century there is still no national strategy for suicidal behavior prevention (although there are interesting local and provincial multidisciplinary initiatives). Nor is there a national Spanish center for the prevention of youth suicide—or anything similar—to address this issue in adolescents and the general population. Nonetheless, increases in the rates of death by suicide are not inevitable. In fact, currently we are facing a situation which, by its very nature, can only be tackled by prevention. This is a moment in history when suicidal behavior prevention must be prioritized as a global health concern. If specific and evidence-based strategies can be implemented with COVID-19-specific threats to the population's mental health and suicide risk in mind, this pandemic may provide not only a sense of “now is the time”, but also a path forward for addressing suicide risk at national and community levels.

Completed suicide is one of the leading causes of years of life lost due to premature death, the leading external cause of death in many countries, and one of the world's leading causes of death among adolescents and young people (WHO, 2014). In Spain, the latest report from the National Institute of Statistics states that 3,671 people lost their lives by suicide (Instituto Nacional de Estadística [INE, 2019]). On average that is ten deaths a day, one death every two and a half hours (one every forty seconds if we consider the global level), and almost 73,000 attempts (some with serious consequences). The surprise that people usually feel when someone reveals these numbers is only comparable to the importance of the issue. Despite these overwhelming numbers, it is still a phenomenon surrounded by stigma and taboo as well as myths and false beliefs,

even among mental health professionals (Al-Halabí, García Haro, Rodríguez Muñoz, et al., 2021), which is another barrier to tackling and preventing it (Fonseca-Pedrero & Pérez de Albéniz, 2020). In many situations, the stigma associated with completed suicide leads to a death being declared an accident rather than a suicide if there is ambiguity around the circumstances in which it occurred. Faced with this, we must stop thinking that the taboo of suicide comes from any “natural” principal preventing attempts on one's own life, and instead face the challenges (including the existential challenges) it raises.

However, there is more. This is not only about completed suicide, we must also be aware of the broad range of suicidal behaviors that can be present. Suicidal behavior refers to a variety of manifestations, ranging from ideation and planning, through suicidal communication to suicidal attempts and completed suicide. Attempted suicide is much more common than completed suicide, and suicidal ideation, or thinking about suicide, is by far the most common form of suicidality (Chiles et al., 2019). In any case, this is not one single phenomenon, as each of its manifestations can vary in intensity, control, duration, lethality, impulsivity, or functionality, among other aspects. The numbers can also vary depending on different factors such as age, gender, education, or country. Cultural differences can be important. For example, during the last twelve months, 4.5% of adolescents have tried to end their lives, 7.5% had a plan to attempt suicide, and 14.2% had suicidal ideation (Lim et al., 2019). Women attempt suicide three times more than men, but men die by suicide three times more than women, with some exceptions, such as in China (Chiles et al., 2019). Moreover, these expressions which do not result in completed suicide, such as previous attempts, are among the main risk factors for completed suicide, although not without some debate (Berman & Silverman, 2017; Chiles et al., 2019). Regardless of that, each attempted or completed suicide means not only suffering for persons themselves, but for their families and those close to them, who often feel helpless, left unable to respond by the potency of a suicidal act, and without institutional resources to fall back on. It is not the aim of this text to talk about postvention, but if prevention fails, support must be offered to those close to the person who has died by suicide. Most receive help within their own wider social environment. In some countries and areas, therapeutic support is available and offered in a

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variety of settings with varying content, whereas in other places, help is still non-existent and support networks ought to be developed as a matter of urgency (Grad & Andriessen, 2016).

So, what we are facing is a complex, multidimensional, multifactorial, fundamentally psychological phenomenon, characterized by the presence of suffering and by intolerable psychological pain in which a person, in a certain circumstance (insufferable, insoluble, interminable, inescapable, without a future or hope) decides to end their life. A broad mix of biological, psychological, and socio-cultural factors that are in continuous, dynamic interaction seem to explain why a person decides to attempt suicide. Thus, linear causal or single-cause interpretations do not fit. Instead, suicidal behaviors must be understood in people's biological and cultural contexts and in the "sense" of their suffering, as well as in their own experience of their difficulties and their life's ups and downs (Al-Halabi & García Haro, 2021). Suicide is rarely due to a single cause and requires a range of prevention initiatives and methods of evaluation (Al-Halabi et al., 2016). It is essential to avoid automatically conflating directly linking deterioration in mental health with the presence of suicidal behavior, as if they were both due to a single causal explanation, and to avoid using alarmist language or increasing the stigma or sensation of helplessness in the population. Fundamentally, suicidal behavior is not a mental disorder or a symptom of a psychopathological problem, nor is it a problem of the brain. Any reductionist view means losing the essence of the phenomenon. We encourage looking beyond the diagnostic label a "patient" carries and instead being curious about how that "person" deals with emotional suffering.

The study by Pirkis et al. (2021), the first to publish collaborative data from twenty-one countries about rates of suicide during the first few months of the pandemic, gave a clear result: there has been no record of an increase in the numbers of completed suicides during the beginning of lockdown. The numbers of deaths by suicide is not significantly higher than expected in any of the countries or areas examined by the study (including Spain). In contrast, the study did find statistical evidence of a fall in the numbers of completed suicides compared to the expected numbers in twelve of the countries examined.

What can we infer from these results? Firstly, that the self-reported increase in levels of anxiety, depression, and suicidal thoughts does not seem to have directly translated to a corresponding increase in completed suicides, at least in the countries examined in that study (Pirkis et al., 2021). The findings allow us to reflect on the contextual nature of suicidal behavior, which does not emerge automatically as a "symptom" of increased mental health problems (such as anxiety or depression), but instead presents as a complex, multifaceted, multicausal, dynamic phenomenon in which realities of different types and orders participate simultaneously (Al-Halabi & García Haro, 2021; Fonseca-Pedrero et al., 2020).

Secondly, various protective factors seem to have been operating, such as a collective feeling of community, support for vulnerable people through information technologies, and spending long periods of time accompanied at home—reducing perceived stress and feelings of isolation or loneliness (Pirkis et al., 2021). In addition, sharing concerns, mutual support in times of despair, proper information about available services to help, making the population aware of and sensitive to the need for social support, breaking down the stigma associated with suicidal behavior, and sharing responsibility for caring for vulnerable people all seem to be valuable strategies for containing and even reducing rates of completed suicide (Pirkis et al., 2021). Indeed, those who belong to a community in which they feel loved and valued are much less likely to die from suicide (Knapp, 2020). Unfortunately, many people lack that sense of connection.

Finally, government and other official institutions' rapid implementation of new ways to access mental health services seems to have been a critical aspect in the prevention of suicidal behavior. Most of the countries in the study took measures to mitigate the

predicted economic crisis, giving financial help to many families who, without that assistance, would have been facing significant risk factors (Pirkis et al., 2021). This is not, therefore, about fixing supposed symptoms or "faults" in the psyche, but rather about giving people resources that allow them to improve their access to health services in crises, reducing risk factors, and strengthening protective factors. These factors may be influenced positively or negatively, depending on the economic, cultural, and social actions taken by politicians and decision-makers. But action without understanding is not enough, as without understanding what would be active is the explanation of the biomedical model (Pérez-Álvarez, 2019). It is essential to help people deal with distress more effectively, to take their challenges on board, and to recover the authorship and continuity of their lives. Psychological help should be given without falling into the trap of thinking that there is a disease called mental "illness". We must remain alert to the iatrogenic consequences of internal, stable, and global attributions that are often used to recount problematic experiences (Al-Halabi, García Haro, Rodríguez Muñoz, et al., 2021).

It seems that the lack of increase in suicides since the pandemic began represents new opportunities for suicidal behavior prevention. Moreover, publications in 2020 about suicidal behavior during this extraordinary time present it as an occasion for social cohesion and the activation of protective factors such as social support, feelings of belonging, and the provision of reliable information about what help is available for crisis situations. Nevertheless, it is still too early to say what the ultimate effect of the pandemic will be on the rates of completed suicides. Data so far provide some reassurance, but the overall picture is complex. One guiding principle, however, is that suicide is preventable, and action should be taken now to protect people's mental health (Knipe et al., 2021). It must be prioritised while we wait for a clearer picture.

The suicide prevention strategies proposed by the WHO (2014) based on the socio-ecological model include levels of intervention in social, community, interpersonal, and individual contexts. Combining multiple strategies may not only have additive effects in preventing suicide, but also synergistic and catalytic effects. In the same way as the idea noted above that nobody attempts suicide for a single reason, the prevention of suicide does not come down to a single event. Primary prevention strategies are divided into universal, selective, and indicated (Wasserman et al., 2020). A universal prevention strategy addresses the entire population and is aimed at raising awareness of suicide and mental health, educating people and reducing stigma, removing obstacles from access to healthcare systems, promoting help-seeking, mitigating the impact of economic recessions, and promoting protective factors such as social support and coping skills. Examples of universal interventions include awareness campaigns, educational programs, reducing access to potentially lethal means, guidelines for communication media to allow them to provide responsible information, and policies to address economic crises.

Selective prevention is aimed at specific groups who are more vulnerable or at greater risk, such as those with mental health problems, consumers of alcohol and drugs, the prison population, victims of physical and sexual violence, and migrants, among others. This category of protection may include screening programs in health care or other facilities, gatekeeper training for frontline helpers, or psychological support and treatment of mental health problems and substance abuse in people who do not display signs of suicidality yet.

Indicated suicide prevention strategies are aimed at people labelled "high risk", who exhibit signs of suicidal behavior and who are particularly vulnerable, such as people who have recently been diagnosed with mental health problems (Labouliere et al., 2018) or women during the perinatal period (Al-Halabi et al., 2019; Al-Halabi, García Haro, Rodríguez Muñoz, et al., 2021). These strategies are aimed at timely and appropriate assessment and treatment of the suicide risk using case management, skill building interventions, support groups, and referral to psychological treatment and care. In

this regard, previous studies support the efficacy of psychotherapies such as Cognitive Behavioral Therapy (CBT) and Dialectic Behavior Therapy (DBT) (Al-Halabí & García Haro, 2021; Al-Halabí, García Haro, & Gutiérrez López, 2021; Fonseca et al., 2021). In adults, both types of psychological treatment have demonstrated better effects than the usual treatment in the reduction of ideation and suicide attempts. These types of evidence-based therapies offer people the opportunity to discuss existential problems in a safe environment, where the psychologist can validate the suffering of people who want to die, or rather, who want to stop living in the circumstances in which they are suffering, at the same time as reorienting them towards living, with new coping strategies (Al-Halabí & García Haro, 2021). A body of brief interventions has also been developed to respond to people's clinical emergencies in suicide crisis situations. Caring Contacts and the Safety Planning Intervention are among the most effective and can be combined with other types of more comprehensive therapies (Zortea et al., 2020). In young people, without a doubt the therapy with the most scientific backing is DBT for adolescents (DBT-A). Previous studies also strongly support the fundamental importance of the family situation both in the explanation and understanding of the suicidal process, and in its manifestations and resolution. Improvements in family functioning and in attachment relations between parents and children have been associated with reduced suicide risk in adolescents (Al-Halabí, García Haro, & Gutiérrez López, 2021).

Apart from the evidence-based therapies noted above, preventive interventions in schools with the adolescent population are of particular interest for several reasons (Fonseca-Pedrero et al., 2019):

- Completed suicide is one of the main causes of adolescent death worldwide. In addition, the prevalence of suicidal behavior in this population seems to have increased in recent years.
- Most of the risk and protective factors for suicidal behavior play their role before the age of 25 (Fusar-Poli, 2019). In addition, in many cases, completed suicide can be preceded by a period of progression (of days, months, or years), and by different warning signs or prior suicidal behavior (e.g., ideation, attempts).
- Adolescence is ideally responsive to actions promoting health, emotional wellbeing, and prevention of problems. The optimal window of opportunity to improve the outcomes of suicidal behaviors is during the developmental stage.
- Early identification through screening and early effective intervention are among the best forms of prevention (Diez-Gómez et al., 2020). The sooner the better.
- Special care should be taken when describing suicidal behavior in young people as this group is particularly susceptible to suicide contagion (Hawton et al., 2020).
- The school is an excellent intervention context for psychologists, where in addition to more in-person and clinical interventions, students may benefit from screening protocols or multicomponent evidence-based prevention programs. The objective is to reduce risk factors and reinforce protective factors for suicidal behavior (e.g., learning to manage crisis situations, promoting good mental health, encouraging social support networks, identifying high-risk situations, and improving emotional regulation strategies). Reiterating this, according to the World Health Organization (WHO, 2017), given the importance of natural settings for health prevention and intervention in infancy and adolescence, schools are one of the most important settings for health promotion and for carrying out the best preventive practices available.
- School personnel can benefit from training in skills for identifying and referring students to available social and health resources.

In this regard, following a literature review, Fonseca-Pedrero et al. (2019) categorized five types of suicidal behavior prevention programs in schools that seem to have demonstrated a certain level of empirical support: a) awareness and education via transversal content in students' education, b) peer leadership training, c) training

in socio-emotional skills, d) gatekeeper training for school personnel, and e) screening for at-risk students. Nonetheless, the focus would be to promote adolescents' mental health and emotional wellbeing rather than on prevention of risk factors. In this regard, many authors have advocated for a change of paradigm, or an additional complementary focus that is not limited to dealing with psychological problems, mental disorders, and risk factors, but rather one which addresses strengths, capacities, and protective factors.

The review by Zalsman et al. (2016) noted that suicide prevention interventions that had proven to be most effective included restriction of access to lethal means, school-based awareness programs, policies to reduce harmful use of alcohol, treatment of depression, chain of care and follow-up of at-risk individuals, responsible media reporting, and policy responses to mitigate the impact of economic downturns. There is insufficient or conflicting evidence concerning the effectiveness of other approaches. Platt and Niederkrotenthaler (2020) suggest that major improvement in the extent and quality of collaboration between researchers, policymakers, and practitioners and a considerable increase in funding for evaluation studies in suicide prevention are required. Many authors have called for not only effective strategies, but strategies that are also efficient in preventing suicidal behavior. McDaid (2016) established four key economic components for selecting and investing in actions aimed at suicide prevention:

- The cost of inaction: what are the consequences of not carrying out any action against suicide?
- The cost of action: how much will it cost to invest in measures for reducing the likelihood of suicide?
- The relationship between the cost and the efficacy of the action: what is the balance between the cost of an intervention and the impact on suicides?
- Incentivize the implementation: what kind of incentives may be used to increase the use of efficient suicide prevention strategies rather than other, less efficient ones?

The pandemic has posed a singular challenge for public health, with significant implications for these suicidal behavior prevention strategies. We must remain alert to emerging risk factors for suicidal acts, but also recognise how known risk factors may be exacerbated by the pandemic (John et al., 2020). In this regard, there is a consensus that mitigating risk will to a large part depend on a proactive, collaborative, effective response by states, NGOs, universities, and local governments, along with a coordinated response by the various government ministries including health, education, security, social services, wellbeing, and the treasury (Niederkrotenthaler et al., 2020). Appropriate services must be made available for people in crisis and those with new or existing mental health problems, along with active labour market policies to help people who are unemployed obtain work. Responsible media reporting also has a role: promoting the importance of mental health support, signposting sources of help, reporting stories of hope and recovery, and avoiding alarmist or speculative headlines that may heighten risk of suicide. Researchers and those involved in academic and scientific publications also have a role to play. The International Covid-19 Suicide Prevention Research Collaboration indicated the following considerations:

- Where possible, remove references to methods of suicide.
- Avoid simplistic explanations of suicide and sensational language (associating the negative effects of the pandemic with suicidal behavior carries substantial risk of normalizing it as a way of coping at times of crisis).
- And, above all, do remind people that suicide is preventable.

Although completed suicide is a statistically rare event, its health, social, economic, educational, family, and psychological impacts are so clear that suicide prevention remains a priority. Combining the prevention strategies outlined in this article will provide new opportunities and interventions for closing the implementation gap between evidence, policy, and practice, and ultimately reduce the

number of suicide deaths. We must not lose sight of the fact that young people are one of society's most valuable assets which is why it is necessary to act and take measures to stop, alleviate, or reduce this silent problem.

Implementing psychological interventions that are based on empirical evidence will allow informed decision making about the prevention of this problem, as well as appropriate management of school, economic, and socio-health resources. This paradigm must be fundamentally approached from a psychology perspective, and planned and executed with the assistance of the psychological experts in this field. Psychologists must be trained and prepared to lead multidisciplinary initiatives aimed at preventing and dealing with a phenomenon that, as we understand, is genuinely psychological. Furthermore, the involvement of each and every agent in society and all health professionals is essential. We cannot look the other way. Psychologists must take on the lead role in this joint responsibility. It is time to act. And remember: anyone can learn to save a life.

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