

Suicide prevention: a long-lasting Italian tradition. Toward understanding the suicidal mind

*La prevenzione del suicidio: una tradizione italiana di lunga data.
Verso la comprensione della mente suicida*

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Summary

Objective

Suicide is a serious public health problem. The World Health Organization (WHO), recognizing the growing problem of suicide worldwide, and urged member nations to address the phenomenon.

Methods

Since Enrico Morselli's report, suicide rates have changed dramatically in some Italian areas, whereas the rates have remained approximately the same in other regions (Figs. 1, 2). Italy has a long-lasting tradition in the study of suicide and nowadays it is crucial to learn more about assessment and management of suicide risk. Suicidal individuals often talk about suicide, death, and/or having no reason to live.

Results

Most suicidal individuals give definite warnings of their suicidal intentions, but significant others are either unaware of the significance of these warnings or do not

know how to respond to them. The assumption that these individuals want to die because they suffer from a psychiatric disorder must be substituted by a phenomenological approach of suicide. An approach centred on intersubjectivity recognizes the unbearable psychological pain for which the suicide is perceived as the best solution. Suicide is best understood not so much as a movement toward death as it is a movement away from something and that something is always the same: intolerable emotion, unendurable, or unacceptable anguish. If the level of suffering is reduced the individual will choose to live.

Conclusions

The author discusses the drama occurring in the mind a comparison of suicide rates at the time of Morselli with the present ones and overviews the drama occurring in the mind of suicidal individuals and how to help them.

Key words

Suicide • Rate • Assessment • Risk • Management

Riassunto

Obiettivo

Il suicidio è un problema serio nell'ambito della salute pubblica e l'Organizzazione Mondiale della Sanità riconosce il suicidio come un fenomeno in espansione per il quale è stato sollecitato un intervento in tutte le nazioni.

Metodi

Dai tempi di Enrico Morselli ad oggi il tasso di suicidio in Italia è notevolmente cambiato in alcune aree mentre si è mantenuto sostanzialmente simile in altre regioni come quelle del nord est (Figg. 1, 2). L'Italia ha una lunga tradizione nello studio del suicidio e oggi più che mai è cruciale saper valutare e gestire i soggetti a rischio.

Risultati

Spesso questi individui comunicano di voler morire in

modo esplicito e vari segnali di allarme possono essere riconosciuti. L'assunto che questi individui si vogliono suicidare perché sono affetti da un disturbo psichiatrico deve essere rivisto alla luce di una comprensione fenomenologica del suicidio. Un approccio centrato sull'intersoggettività permette di rilevare che spesso c'è un dolore psicologico insopportabile nella mente di questi individui per il quale il suicidio è visto come la migliore soluzione. Sono i loro pensieri nel flusso di coscienza che provocano disperazione e dunque alleviare anche lievemente tale stato spesso esita nel desiderio di vivere.

Conclusioni

L'autore propone il confronto dei tassi di suicidio rilevati da Morselli con quelli attuali e passa in rassegna il processo che porta al suicidio e come aiutare gli individui in crisi.

Parole chiave

Suicidio • Tasso • Valutazione • Rischio • Gestione

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Although suicide is generally considered to be a rare event, in the last 45 years suicide rates have increased by 60% worldwide, with global suicide figures potentially reaching 1,5 million deaths by the year 2020¹. Traditionally, suicide rates have been highest among elderly males, but rates among young people have been increasing to such an extent that they are now the group at highest risk in a third of countries, in both developed and developing countries. Mental disorders (particularly depression and substance abuse) are often associated with cases of suicide; however, suicide results from many complex socio-cultural factors, and is likely to occur particularly during periods of socioeconomic, family and individual crisis situations (e.g., loss of a loved one, employment, dignity, etc.). At the moment, the strategies proven to be effective in preventing suicide are: treatment of psychiatric patients; restricting gun possession; detoxification of domestic gas; detoxification of car

emissions; control of toxic substance availability; and toning down reports in the press. Suicide has been a topic of great interest for Italians in various contexts. Back in 1880, Enrico Morselli², a physician and professor at the University of Turin, wrote a comprehensive and brilliant book on suicide and reported detailed statistics of suicide in Italy and across Europe. Analyzing data from Italy, he concluded that suicide was primarily a result of the struggle for life and nature's evolutionary process, by which weak-brained individuals were sorted out by insanity and voluntary death. Other unhappy results included misery, disease, prostitution, and insanity. That men committed suicide more often than women and adults more often than children merely illustrated the struggle of life that led to suicide. To reduce suicide one needed to reduce the number of people, which could be accomplished only by birth control. In Morselli's opinion the progress of civilization and Protestantism, which refused centralized

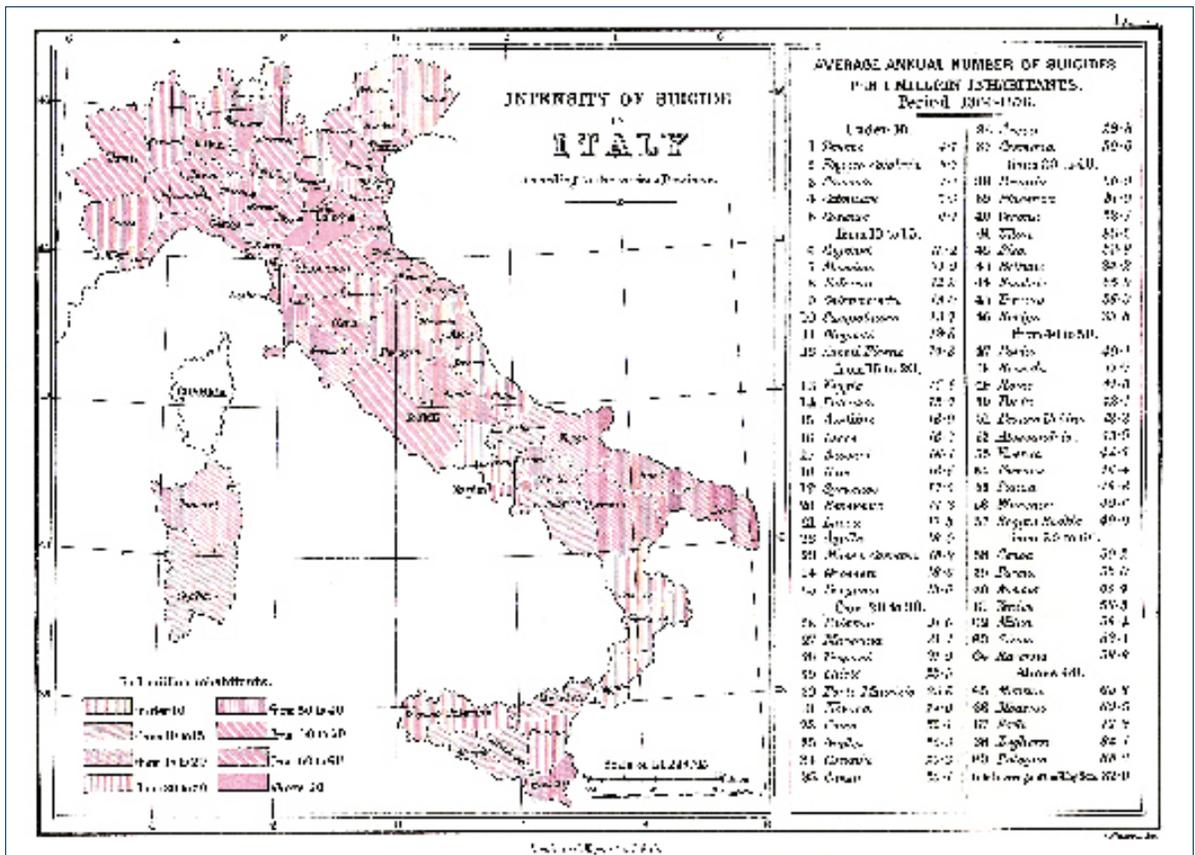


FIGURE 1. Suicide rates as reported by Enrico Morselli in Italy for the period 1864-1876 for various Italian provinces. *I tassi di suicidio proposti da Enrico Morselli nel periodo 1864-1876 per le diverse province italiane (da Morselli, 1881)².*

religious control in favor of free discussion and individual thought, were the most powerful factors in increasing the number of suicides.

Despite the fact that his book is about statistics (Fig. 1), the author was eager to stress that a more phenomenological approach is needed when

studying suicide and stated "... Thus, again, when it is only said 'suicides caused by *'taedium vitae'*, very different cases are probably united under this heading. Neither 'monomania' nor 'mental alienation' is one single cause in itself; it is possible to pass from political and religious exalta-

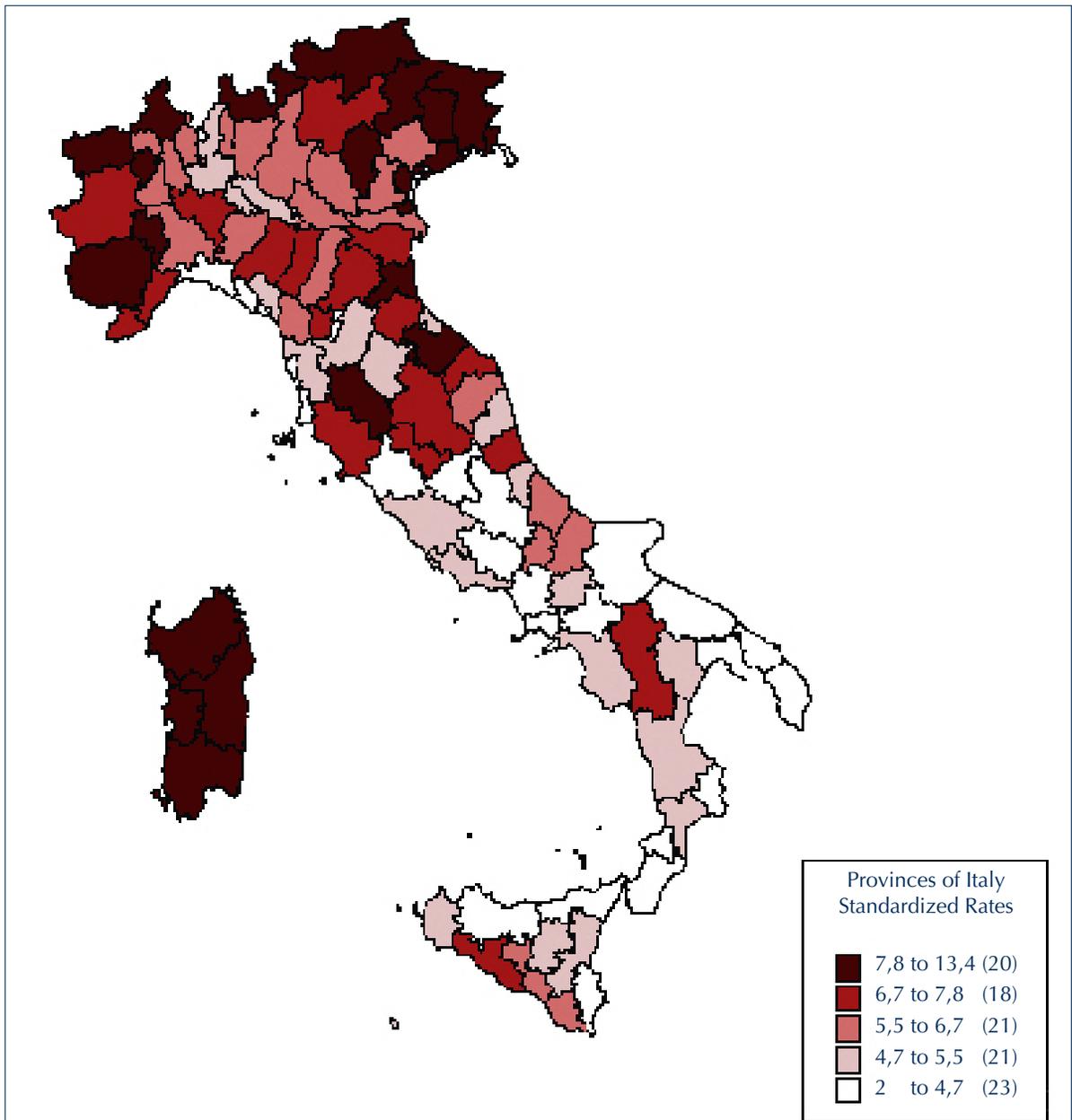


FIGURE 2.

Suicide rates across Italy as recently reported in official data (from Vichi et al., 2010) ⁶. Note the shift in suicide rates for some provinces as compared to the statistics reported by Morselli in 1881. *I tassi di suicidio attuali riportati da statistiche ufficiali (da Vichi et al., 2010) ⁶. Si noti il cambiamento dei tassi di suicidio in alcune province nel confronto con le statistiche di Morselli nel 1881.*

tion to the most profound melancholia, through a thousand psychical phases which statistics neither do nor can estimate. And the origin, often quite ordinary, of certain mental phases, registered as mere presumptive causes of suicide, shows the weakest side of this part of statistics". He reported that there were physical and moral causes of suicide, such as: psychopathic conditions; physical diseases; weariness of life (*taedium vitae*); violent passions; vices and drunkenness; anguish of the affections; financial derangements; misery; remorse and shame; and despair.

In Italy, the overall suicide rate increased from 1955 to 1987 and then remained stable from 1986 to 1996; a decrease among 45 year-olds and over was observed from 1986 to 1996 in both men and women, while the rate for young males increased³⁻⁵.

During the period 1980–2002, about 4,000 suicide deaths among Italian residents were certified on average each year. The mortality rate for suicide in men declined from 11.4 in 1980 to 10.2 in 2002 (from 13.7 to 12.2, based on the population 15 years old and over), while in women the rates for the same years declined from 5.0 to 2.8 (from 5.9 to 3.3 for those 15 years old and over), a decrease of about 11% in men and 44% in women, respectively. The male/female suicide ratio increased from 2.3 in 1980 to 3.6 in 2002⁶ (Fig. 2).

Being married appeared to be a protective factor for suicide, but the impact of being never-married, divorced/separated or widowed varied with age and gender^{7,8}.

Getting to know the suicidal individual

Most suicidal people find other solutions to their problems and do not attempt or commit suicide. Because of the large number of suicidal persons and small number of suicides, individual suicides are impossible to predict in a reliable manner. However, there are a number of warning signs that can help determine if a person is at risk. Many more people will always be identified as at risk than actually attempt or commit suicide. Since the outcome is irreversible and tragic, it is best to take all indications of suicide risk seriously.

It is rare that a person who attempts or completes a suicide does not give prior indications of his or her suicidal intentions. This is because relatively few persons who commit suicide do so impulsively without having thought about ending their own

lives beforehand for days, weeks, or months. Suicides rarely occur because of a sudden traumatic event. However, people at risk of suicide who experience a sudden traumatic event are at much greater risk of ending their lives at that time.

People who are suicidal are often seen as having changed their personality or mood recently. Changes include depression or apathy, pessimism, irritability, or "not seeming to be themselves". There may be changes in eating patterns (eating much more or much less) and sleeping habits (sleeping much more or being unable to sleep, particularly waking up early and not being able to get back to sleep).

Suicidal people often feel lonely, misunderstood, helpless, hopeless, worthless or ashamed, guilty, and/or full of hate for themselves. These feelings are not normal, even for a person who has a mental disorder or psychiatric illness. They are indications that something is desperately wrong.

Any behavior that may be interpreted as "preparing" for death may be an indication of suicidal intent. For example, suicidal persons may put their personal affairs in order and update or write a will. Even more direct preparations include giving away important objects (particularly if the person makes statements like, "I won't need them anymore" or "I don't care about them anymore"). Sometimes people say good-bye or express feelings in a way they never did before (e.g., "I never really told you how much I care about you; I just wanted you to know").

Another danger sign for suicide is a preoccupation or interest in obtaining means for killing oneself. The purchase of a gun or getting hold of potentially lethal medications may be an indication of suicidal intent.

Most suicidal persons express their suicidal intentions to others beforehand. These expressions may be in the form of direct suicide threats ("I can't stand it and I'm going to kill myself") or they may be much less direct ("Sometimes I think it's not worth going on"). Suicidal persons may be indirect in the communication of their intent because they are afraid of how a friend or family member will react. Depending upon the reaction, they may continue to confide their thoughts and plans or they may change the subject.

On average, 45% of suicide victims had contact with primary care providers within 1 month of suicide⁹. In fact, people who are considering suicide

often contact their doctors for a general consultation prior to the suicidal action, and those who are at risk for suicide could be recognized promptly by their physicians. The physician may encounter many suicidal patients and has an opportunity to establish anti-suicide measures for these patients¹⁰. Suicidal ideation in primary care patients may constitute an important warning sign that should lead to a thorough suicide investigation¹¹. For this reason, both in primary care and in other medical settings, suicide risk should be assessed through direct enquiry. Suicide is not something someone can suggest by asking questions about what a person is thinking and feeling and whether or not a person is thinking about suicide. Conversations about suicide serve the purpose of communicating to a person who is considering whether or not he or she should end their life that someone else is interested in helping—despite the fact that the suicidal person is thinking of doing something that most people find difficult to speak about. Most people feel quite relieved that they are able to talk openly about suicide and the problems they are having. The crisis situation in which a person attempts or commits suicide is often precipitated by a stressful life event. Suicides are more likely to occur after an argument with family members or lovers following rejection or separation, financial loss and bereavement, job loss, retirement, or failure at school. Usually these events are “the last straw” for a suicidal person. They are generally not what caused the suicide but what resulted in an increased likelihood that the suicide would occur then.

Among the factors associated with early adversity, childhood abuse and neglect are one of the strongest predictors of major depression and suicidality. Childhood sexual abuse, in particular, is associated with an earlier age of onset of depression, a chronic course and a more severe depressive outcome. Moreover, a history of childhood sexual abuse increases the odds of suicidal behavior up to 12 times. Detrimental long-term consequences of childhood adversity extend beyond major depression and suicidality as, in addition to being associated with these outcomes, childhood abuse has been found to influence the risk of other psychiatric conditions and to predict increased comorbidity. A pivotal question, however, is how does childhood adversity influence the risk – many years later – of major depressive episodes and suicidal behavior? A related and important question

is what are the molecular mechanisms that are involved in this process?

People who consider suicide generally feel ambivalent about ending their own life. It is this ambivalence that leads desperately suicidal people to talk about their plans as they “cry for help”. Telephone help lines, therapists, and friends can strengthen the will to live of ambivalent people by helping them explore other options for changing their situation.

Traditional suicidology supports the notion that suicidal individuals are experiencing unbearable psychological pain (psychache) or suffering and that suicide may be, at least in part, an attempt to escape from this suffering. Shneidman¹² focused on the mentalistic aspects of suicide and suggested that the study of suicidal acts should concentrate on the phenomenology of suicide. Psychache can be clearly distinguished from depression or other psychiatric disorders because of the uniqueness of the suffering perceived by the person and because of the fact that the person cannot stand it. The individual cannot see a way out and believes that ending life is a solution. Shneidman¹³ considered psychache to be the main ingredient of suicide. Shneidman¹⁴ reported that psychological pain may be related to the fact that, if tormented individuals could somehow stop consciousness and still live, they would opt for that solution. Suicide occurs when the psychache is deemed by that individual to be unbearable. It is an escape from intolerable suffering; and this approach views suicide not as a movement toward death but rather as an escape from intolerable emotion unendurable or unacceptable anguish. Suicide risk is associated with constriction or narrowing the range of options usually available to an individual. Suicidal individuals experience dichotomous thinking, that is, wishing either some specific (almost magical) total solution for their psychache or cessation, in other words suicide. Suicide is the result of an interior dialogue during which the mind scans its options¹⁵. During the early phases of this process, suicide is considered as an option, but it is rejected a number of times. However, after persistent failure to find a solution for the suffering, suicide is accepted as a solution. The individual, therefore, starts planning it and considers it as the only answer; “The spark that ignites this potentially explosive mixture is the idea that one can put stop to the pain. The idea of cessation provides the solution for the desperate person”¹⁶.

Shneidman believes that in suicide, “death” is not the key word. The key word is “psychological pain” and, if the pain were relieved, then the individual would be willing to continue to live.

Two main concepts are relevant to this discussion: perturbation and lethality. Perturbation refers to how upset (disturbed, agitated, discomposed) the individual is; while lethality refers to the likelihood of an individual committing suicide in the future (Lethality is a synonym for suicidality). Perturbation supplies the motivation for suicide, while lethality is the fatal trigger. One way to reduce lethality is to enquire what causes distress to the suicidal individual. Only rarely, when dealing with a suicidal individual, do medical personnel enquire about psychological pain. Many resources are devoted to decrease suicide risk but not what energizes it. Asking “Where do you hurt?”, “How may I help you”, “What is going on?” and so forth proves to be a key factor in opening a dialogue with the suicidal person and establishing a connection. Suicidal people are ambivalent about death; they want both to live and to die, and so our task is identify and arouse those vital components that counterbalance death wishes. In doing so, we may resolve the ambivalence and give the tormented individual a little hope and some peace of mind.

Dealing with suicide risk

Whenever a person gives some of the above indications that he or she may be suicidal, others may be of great help if they talk to the person about how he or she is feeling. Unfortunately, most people hesitate to ask questions or talk about suicide because they are afraid that they will say or do the wrong thing. Often they feel that they may make things worse or even cause someone who is vulnerable to get the idea of committing suicide.

When confronted with a suicidal person, health practitioners recommend that it is important to stay calm and listen empathically to what the person is saying. Despite the possibility that the attempt may not be serious or the person may be manipulative, it is important to take the situation seriously and to ask questions to find out how serious the intentions really are. Friends and helpers should ask specific questions about risk factors such as previous attempts and mental health problems. Generally, people who know when and how they are going to commit suicide are at much greater risk

than people whose plans are vague and uncertain. For this reason it is useful to ask if the person has considered how and when he or she plans to commit suicide. Asking such a direct question can do no harm and can provide important information. If the person knows how they plan to commit suicide and has the means at hand, the risk is great and immediate help is needed. If a person has a means of suicide available, such as a firearm or lethal medication, it is important to remove the means from the home. Concerned parties should consult a suicide prevention service or agency or skilled health or mental health care provider who is knowledgeable about suicide. If a person is at high risk, that is, if the person appears to be ready to take his or her own life soon, it is best to stay with the person or have someone else stay with the person during this crisis period.

Some facts about suicide

In the year 2000, approximately one million people died from suicide: a “global” mortality rate of 16 per 100,000, or one death every 40 seconds. In the last 45 years suicide rates have increased by 60% worldwide. Suicide is now among the three leading causes of death among those aged 15-44 years (both sexes); these figures do not include suicide attempts which are up to 20 times more frequent than completed suicide. Suicide worldwide was estimated to represent 1.8% of the total global burden of disease in 1998, and 2.4% in countries with market and former socialist economies in 2020. Although traditionally suicide rates have been highest among the male elderly, rates among young people have been increasing to such an extent that they are now the group at highest risk in a third of countries, in both developed and developing countries. Mental disorders (particularly depression and substance abuse) are often associated with cases of suicide; however, suicide results from many complex sociocultural factors and is more likely to occur particularly during periods of socioeconomic, family and individual crisis situations (e.g., loss of a loved one, employment, honour). It is acknowledged that since killing oneself is against nature, no normal person would commit such an act, therefore, those who commit suicide are considered mentally ill; however the vast majority of mentally disordered people even if faced by the same dramatic situations encountered by

suicides do not actually kill themselves. Suicide should not be considered merely a symptom of the various psychiatric disorders; this view impairs proper suicide assessment.

The economic costs associated with completed and attempted suicide are estimated to be in the billions of dollars. One million lives lost each year are more than those lost from wars and murder annually in the world. It is three times the catastrophic loss of life in the tsunami disaster in Asia in 2005. Every day of the year, the number of suicides is equivalent to the number of lives lost in the attack on the World Trade Center Twin Towers on 9/11 in 2001¹⁷.

Everyone should be aware of the warning signs for suicide: someone threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself; and someone looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; someone talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person. Also, a high risk of suicide is generally associated with hopelessness; rage, uncontrolled anger, seeking revenge; acting reckless or engaging in risky activities, seemingly without thinking; feeling trapped – like there's no way out; increased alcohol or drug use; withdrawing from friends, family and society; anxiety, agitation, and being unable to sleep or sleeping all the time; dramatic mood changes; no reason for living; and no sense of purpose in life¹⁸.

Suicide is preventable. Most suicidal individuals desperately want to live; they are just unable to see alternatives to their problems. Most suicidal individuals give definite warning of their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them. Talking about suicide does not cause someone to be suicidal; on the contrary the individual feel relief and has the opportunity to experience an empathic contact¹⁷⁻²¹.

Ways to be helpful to someone who is threatening suicide:

1. be aware. Learn the warning signs;
2. get involved. Become available. Show interest and support;
3. ask if he/she is thinking about suicide;
4. be direct. Talk openly and freely about suicide;
5. be willing to listen. Allow for the expression of feelings. Accept the feelings;
6. be non-judgmental. Don't debate whether suicide is right or wrong, or whether the feelings are good or bad. Don't lecture on the value of life;
7. don't dare him/her to do it;
8. don't give advice by making decisions for the person or tell them to behave differently;
9. don't ask "why". This encourages defensiveness;
10. offer empathy, not sympathy;
11. don't act shocked. This creates distance;
12. don't be sworn to secrecy. Seek support;
13. offer hope that alternatives are available, do not offer glib reassurance; it only proves you don't understand;
14. take action! Remove means! Get help from individuals or agencies specializing in crisis intervention and suicide prevention.

Suicide profoundly affects individuals, families, workplaces, neighborhoods and societies. The economic costs associated with suicide and self-inflicted injuries are estimated to be in the billions of dollars. Surviving family members not only suffer the trauma of losing a loved one to suicide, but may themselves be at higher risk for suicide and emotional problems.

Toward comprehensive prevention

Strategies involving the restriction of access to common methods of suicide have proved to be effective in reducing suicide rates; however, there is a need to adopt multi-sectoral approaches involving other levels of intervention and activities, such as crisis centres. There is compelling evidence indicating that adequate prevention and treatment of depression, alcohol and substance abuse can reduce suicide rates. School-based interventions involving crisis management, self-esteem enhancement and the development of coping skills and healthy decision-making have been demonstrated to reduce the risk of suicide among youths. Worldwide, the prevention of suicide has not been adequately addressed due to a lack of awareness of suicide as a major problem and the taboo in many societies to discussing suicide openly. In fact, only a few countries have included prevention of suicide among their priorities.

The reliability of suicide certification and reporting is an issue in great need of improvement. It is clear that suicide prevention requires intervention also

from outside the health sector and calls for an innovative, comprehensive multi-sectoral approach, including both health and non-health sectors, including education, labour, police, justice, religion, law, politics, and the media.

With a highly suicidal person, our task is to serve as an anodyne, that is analogous to a substance or process that relieves pain. In suicidology we must redefine the kind of pain we are dealing with, a concept not always completely understood.

Suicide has stolen lives around the world and across centuries. The meanings attributed to suicide and the notions of what to do about it have varied with time and place, but suicide has continued to exact a relentless toll. Only recently have the knowledge and tools become available to approach suicide as a preventable problem with realistic opportunities to save many lives.

World Suicide Prevention Day (September 10th, www.prevenireilsuicidio.it) is a call for action and involvement by all governments and organizations worldwide to contribute to the cause of suicide awareness and prevention through activities, events, conferences and campaign in their county. By collaborating together in this endeavor, we can save lives.

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