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SUICIDE - THE UNDERSTANDING OF THE ACT WITHIN MENTAL DISORDERS

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Abstract: In Brazil, statistics confirm that, the rate of suicides in the 15 to 29 age group is close to 6.9 cases for every 100 thousand inhabitants, 3% to 20% of people in this age period can attempt suicide. The leading countries in this ranking, such as: India, Zimbabwe and Kazakhstan, for example, which have more than 30 cases for every 100,000 inhabitants, this puts Brazil in a position below these countries, as Brazil is in 12th place on the list of the Latin American countries with the most deaths from suicides, logically still an uncomfortable position. Observing through the study of psychology, suicidal behavior is a phenomenon that has stimulated and promoted several researches and studies aiming at its cultural and universal understanding. Studies show that, in biological terms, suicide is an analytical disorder, to carry out the suicidal act, a specific brain circuit decompensation corroborates for the execution of suicide. There are two types of suicide, passive and active, the passive being characteristic in which the individual wishes to die, however, he did not draw any plan. The active suicide, on the other hand, wishes to cease to exist, and has a definite plan to commit suicide. Another factor that must be considered in relation to suicide is the brain symptoms due to various oppressions the individual ends up committing suicide through impulsive behavior.
Keywords: Suicide, Disorder, Behavior, Suicide, Self-extermination, Pain.

INTRODUCTION

It was in 1778 that the word suicide, meaning to kill oneself, was included in the French language dictionary. Although the word has a clear meaning, the aspects and points surrounding social and motivational variables do not make the term simple to debate. It is necessary to check the various possibilities regarding terminology and seek

the best understanding of what they are, their causes, management and prevention of suicide. Suicide can mean conscious, voluntary and intentional self-extermination. In the broadest sense, suicide includes unconscious, slow and chronic self-destructive processes.

From a psychological point of view, suicidal behavior is a phenomenon that has stimulated and promoted several researches and studies aiming at its cultural and universal understanding. In Brazil, statistics confirm that, the rate of suicides in the 15 to 29 age group is close to 6.9 cases for every 100 thousand inhabitants, 3% to 20% of people in this age period may attempt suicide considering that the juvenile phase is a marked period with physiological changes such as; hormonal, bodily and psychological changes in a constant dynamic, which refers to a relatively low rate when compared to the leading countries in this ranking, such as: India, Zimbabwe and Kazakhstan, for example, which have more than 30 cases for every 100 thousand inhabitants. Brazil is in 12th place on the list of Latin American countries with the most deaths from suicides.

It is not so common that people trying to commit suicide are saved by others, and finally, they end up facing the contradiction of their feelings. Since the fact of wanting to end the overwhelmingly devastating anguish is what drives the attempt. Perceiving oneself in a control situation, when medicated and cared for by a multidisciplinary care team, in addition to other factors, can reduce the pressure for the desire to die.

As some studies point out, the implications that religiosity/spirituality has on an individual, becoming an influencing resource, as it directs a large majority of people to have an aggregating behavior and, consequently, social protection and that this can be considered a strategy that reduces and prevents suicide attempts. It is not the main objective of this chapter to discuss the religiosity/spirituality aspects in the theme of suicide, however, this introduction must highlight this practice as a resource to minimize and even nullify the individual's desire to end their chronological cycle.

FEATURES COMMONLY POINTED OUT IN SUICIDE STUDIES

According to data from the World Health Organization (WHO), the second cause of death among young people between 15 and 29 years old is suicide and, according to Oliveira et al. (2020), it is estimated that around 3% to 20% of people in this age period, they may attempt suicide, bearing in mind that the juvenile phase is a marked period with constant hormonal, bodily and psychological changes. Thus, having psychological and family support is important for the young person to have fundamental conditions for discovering their skills and detecting eminent opportunities, and thus, feel belonging and competent in self-fulfillment, in view of this, usually the suicide attempt it is also a mechanism used to ask for help, as it is common to be experiencing some type of conflict or mental disorder (Oliveira *et al*, 2020; OPAS, 2020; OMS, 2019;).

According to Santos et al (2017), in Brazil, the most used methodology is hanging, followed by poisoning and the use of firearms. Unlike the author above, the study with 144 cases in the city of Arapiraca - AL showed that of all victims treated with suspected suicide ideation in the analyzed period, intoxication was the predominant means of cases, and of these cases, there was a majority and preference for female intoxication followed by the use of bladed weapons (Santos *et al*, 2017).

A survey of data in relation to the time of care for victims of suicide attempts, carried out by a group of the fire department, pointed out that from the activation of help to the arrival of the victim in the emergency room,

in cases of greater complexity than required more than an hour of care, 90% of all cases that required that time were male victims, and that this is related to the complexity and violence used by the rescuer in the attempts to implement the autocide plan, with that, more attention and rescue assistance was required. This corroborates the literature and research on this theme, that men use more lethal and aggressive ways of self-destruction, thus, the need for pre-hospital care tends to be greater, requiring more time and care at the time of rescue. (Magalhães *et al*, 2014).

RELATIONSHIP OF DISORDERS TO SUICIDE

Levy (1978 *apud* KOVÁCS, 1992, p. 172) scame up with the etymology of the word suicide, which comes from the prefix sui (of oneself) and caedes (action of killing). In 1778 it was then that the word suicide, meaning to kill oneself, was included in the French language dictionary. Although the word has a clear meaning, the aspects surrounding social and motivational variables do not make the term simple to discuss. We will then look at several possibilities about the terminology and try to get the best understanding of what they are, their causes, the management and prevention of suicide. Suicide can mean conscious, voluntary and intentional self-elimination. In the broadest sense, suicide includes unconscious, slow, and chronic self-destructive processes (Fremouw et al, 1990).

There is a tendency to confuse suicide with attempted suicide, both terms differ, as suicide attempts are deliberate acts of self-harm that manifest a self-destructive intention with vague awareness or uncertainty of survival. The sociological perspective of suicide, in 1897, was brought up by Émile Durkheim, who in his publication "Suicide: a sociological study", sought to explore the issue of suicide as the case of death that results directly or indirectly from a positive or negative act, and that it is practiced this way by the victim himself. In the attempt, which would be the act thus defined, but interrupted before resulting in death. However, this last characteristic of the suicide attempt would be called suicidal behavior nowadays (BOTEGA *et al*, 2004 e 2006).

Suicidal behavior would then be behaviors that range from gestures, attempts and the suicide itself completed and/or completed the attempts. Suicidal plans and actions that have little chance of culminating in death are called suicidal gestures by experts. Suicidal actions whose intention to kill is present, but for some factor does not reach consummation, is called suicide attempts. Self-destructive or suicidal behavior is divided into: direct and indirect, as described below:

» Direct suicidal behaviors: are related to directly consummated suicidal gestures, attempts and actions. Examples: jumping off bridges/buildings, using weapons, ie, shooting at you vital parts (head, chest and/or mouth) hanging (WERLANG e BOTEGA, 2004).

» Indirect suicidal behaviors: are related to routine and repeated actions that put the individual's life at risk. These are dangerous activities in which the subject participates, but which does not have a conscious intention to die. Scoring as examples: dangerous driving (practicing cracks), drug and other substance consumption, abusive use of tobacco and uncontrolled eating habits, criminal behavior (such as involvement in robberies) (WERLANG and BOTEGA, 2004).

The risk of suicide stands out from the existence of a mental disorder, and approximately 90% of individuals who commit suicide have some type of mental disorder according to research survey. Consequently, within the field of prevention, the treatment of mental disorders becomes an important element. A list of mental disorders

holds suicidal thinking as characteristics of associated symptoms, namely depression, anxiety, delusions, use of psychoactive substances (alcohol), schizophrenia, also highlighting other factors such as the components of the physical and social environment, a survey conducted by WHO, other diseases such as AIDS/HIV, Parkinson's disease (PD) and (MS) multiple sclerosis (Machado, 2011).

Freud, in his psychoanalyst view, identified aspects related to suicide, observing in his clinical patients, such factors as suicidal fantasies, delusional manifestations, attempts to demand the forbidden impulse and also, in the pathological form of mourning, a narcissistic irresolution. Freud's formulations linked to the concept of death drive, aggressiveness and self-destruction, were received with much questioning by the scientific community at the time, due to the difficulties of a precise confirmation of its existence. However, Freud ended up asserting the inherent human propensity towards aggressiveness, towards destruction and towards non-erotic cruelty, described in the article "The malaise in civilization". The suicidal person, identified as a lost object, disappearing from life becomes a desire, just as his exciting object has disappeared. Suicide is an aggression to the outside and, secondarily, to a complete and finalized revolt. It is a procedure to satisfy the aggression that the environment causes, as well as a means of recovering the lost libidinous object, killing itself manages to psychologically cancel the loss of the object and avenge itself on the environment that gave rise to its despair. (Werlang *et al,* 2004).

We observes then that suicide is not an act that occurs without some kind of planning, with intention, quite the contrary, it is a phenomenon experienced as the response found by the individual who suffers in order to escape the destructive psychological pain. A state that is within the subject and is loaded with negative emotional states and followed by ideas of death, serve as a stimulus to put an end to intolerable emotions. However, internally, there is a dubious feeling which makes the individual, while wanting death, think about a rescue intervention, even if unconsciously, this being the last means used to try to get rid of the pain (Machado, 2011).

The study by Oliveira (2020) conducted a survey of victims' relatives about the presence of mental disorders in the victims, which indicated the presence of mental disorders in some of the victims and that predominantly, the majority were male victims, corresponding to a number greater than 75%. It is believed that this survey is linked to the fact that men seek less preventive medical care than women and, therefore, the probability of men having mental disorders and not undergoing psychological follow-up is greater than the female population, making them more likely to be on the verge of autocide (Santana *et al*, 2011).

Mental disorders, such as mood disorder, substance use disorder, schizophrenia and personality disorder, are some disorders that induce suicidal behavior, however, such operating modes are not an exclusive feature of these. Humans, in their condition of biopsychosocial beings and who are inserted in cultural, moral and ethical contexts that differ in some aspects, over the course of the existence of this individual, formulate a particular subjectivity and this formulation when introduced in the life of someone within some situations, added to some contingencies, such as the family history of that being, the absence of a monetary source such as unemployment and/or retirement, loneliness, the absence of a life companion, traumas such as childhood abuse, among others, are circumstances that contribute to the induction

of self-extermination (Bertolote *et al*, 2010).

In a study on suicide prevention, people who were diagnosed with depressive disorder, had psychological follow-up in primary care or referred to psychiatric support clinics, and this led to a significant drop in the regularity of autocide and hospitalizations for care of people with the depression (Oliveira *et al*, 2020).

Estimates reveal that 50% of people with Bipolar Disorder attempt suicide, and that about 11% to 19% reach their goal, people with this disorder have a propensity to feel a lot of pain, and may even be chronic pain, a priori this pain ends being interpreted as emotional conflicts rather than a psychological correlation with organic events and this difficulty of rapid identification and diagnosis to start psychological and psychiatric care increases the probability of suicide since a late intervention causes these pains to have a significant increase (Scippa, 2020).

When an exacerbated increase in pain, consequently, psychiatric symptoms tend to aggravate, usually musculoskeletal pain with daily frequency, significantly interfering with the routine of these people, ie, the greater the pain, the greater the suicidal ideation. Suicidal behavior in bipolar people tends to be high in the first years of the disease, due to diagnostic delays, and the stabilization of mood, part of the population with bipolar disorder suffers neglect because they are in street situations or because of a misdiagnosis (Stubbs et al, 2015).

Bipolar Disorder, when diagnosed late, causes significant damage both to the patient with the disorder and to their families and society. The drug treatment of Bipolar Disorder is done with mood stabilizers, anticonvulsants and atypical antipsychotics, the risk of death in people with the disorder is high, and to achieve a better treatment result it is necessary to combine medication with psychotherapy, as this junction has been obtained good results in several cases. (Rosa e Leão, 2021)

THE RELATIONSHIP OF SUBSTANCE USE TO DISORDERS AND THE EMINENCE OF SELF-DESTRUCTION

A cross-sectional epidemiological study (Oliveira et al, 2020) carried out through the analysis of data records of emergency care, prepared by the 7th Group of Military Firefighters of the State of Alagoas in first aid assistance to victims suspected of suicide attempts, aims to carry out a mapping of the profile of victims of attempted self-extermination in a semi-arid state in Brazil and one of the data collected by this analysis is related to the use of alcoholic beverages by some victims who attempted suicide and the same point that about almost 10% of those assisted had this information confirmed by their family members and/or clinical exams. It is estimated that this number is higher since this data was not collected from all patients due to emergency procedures that demanded agility and priority to help the victim and, therefore, the exact result of the survey carried out by the group was compromised. (Oliveira et al, 2020).

A study points out the association between the use of psychoactive substances with mental disorders and suicide, the direct relationship between these three factors reveals the emergence of psychiatric disorders from the use of psychoactive substances, leading the individuals in the sample to abuse and dependence of them, culminating in the attempt of self-extermination. This study also points to evidence that in some cases, the use of these substances may be a consequence of the comorbidity of the mental disorder. Also in this Ceara it is important to emphasize the existence of a possible accelerated evolution, between the use of chemical compounds and

self-destructive behavior, among people who have diagnoses of depression, social phobia, bipolar disorder, anxiety, schizophrenia, personality disorder and post- -traumatic, both for isolated diagnosis and for multiple disorders, with the greatest recurrence when it comes to depressive disorder (Monteiro, 2020).

The work mentioned above also points to the emotional and behavioral state of individuals when consuming one or more psychoactive substances. Its use or abuse impairs the ability to judge and assess critically, thus becoming vulnerable and susceptible to acting impulsively, affecting problem-solving skills, actions that corroborate with an inability to contribute and interact in groups, generating isolation social, reducing personal credit and discouraging family support (Cantão, 2017).

These behaviors and consequences directly contribute to psychological distress, harming the individual's mental health, leading to suicide. The current scenario of preventive actions, the practice of tangible strategies and the role of the manager and health professional point to the limitation that exists in Brazil with regard to suicide and public health (Silva, 2018).

TRAUMA AS ONE OF THE SUICID FACTORS

The attempt at self-destruction is on the spectrum of suicidal behavior and needs to be understood in a complex way as it interacts with several factors. One of the factors that may be associated with this ideation/attempt of self-healing is PTSD (Post Traumatic Stress Disorder), which is very common in cases of domestic violence suffered by some women and pronounced in the vast majority by their partners within their home, and that this becomes a mark that causes some functional damage to its victims, such as depression, low self-esteem and loss of autonomy (Neto *et al*, 2020).

PTSD resulting from events with a high degree of stress, such as domestic violence, pandemics, accidents, catastrophes, among others, can compromise the quality of life of an individual and/or a large group and this can lead to disastrous consequences. Each subject reacts differently to adverse situations, some being more capable than others of being resilient, in any case, the discussion of a study points out professional intervention and psychoeducation as an alternative to combat suicide attempts as a result of this disorder, therefore, it generates knowledge about this diagnosis and with it, a better adherence to PTSD monitoring (Neto et al, 2020).

Studies carried out since the beginning of the COVID-19 pandemic, highlight new experiences arising from the moment (social isolation, grief, facing new situations) and the consequent connection with the emotional and behavioral destabilization caused in the global population, being predictable, the development of this stress in many of the individuals who go through this period with significant personal losses (Silva *et al*, 2020).

Preventive control measures, necessary during the pandemic, such as social isolation, which has the functionality of separating people, in order to reduce their contagion, significantly resulted in the increase of some personality disorders and, with this, increased suicide rates around the world. Psychological changes, such as anxiety and depression, were scored as the most relevant in the period in question. However, the short period of analysis on the topic demands additional studies regarding the recognition of risk factors for suicidal behavior and demands the development of specific management and coping strategies, in order to minimize the impacts caused by this scenario (Silva et al, 2020).

In a cross-sectional study carried out with 644 women aged 18 to 49 years in Recife, it concluded that there is a higher risk of suicide attempt in women who had PTSD (Post Traumatic Stress Disorder) and were not religious adherents. Religiosity/spirituality has great importance in a process of resignification, as the search for these, for many, can provide an apparatus for coping with adverse situations in life that contribute to the elicitation of traumatic and dysfunctional behaviors. Some researchers point out that spirituality/religiosity works as a great motivator, being a source of hope and an impulse to give new meaning to someone's historicity, changing the meaning of life and death of these (Monteiro, 2020).

PREPARATION OF HEALTH PROFESSIONALS FACING SELF-EXTERMINATION ATTEMPTS

Professionals in the Family Health Strategy (ESF) are constantly faced with suicidal behavior in the work environment, since autochiria behavior is considered a public health problem. In this sense, Almeida & Verdana (2020) investigated the relationship between professional training and the attitudes of Primary Health Care workers towards suicidal behavior. The study was attended by 65 health professionals from different categories, such as physicians, nurses, community health agents, nursing technicians, dentists and oral health assistants, all components of 06 ESF teams in a municipality in the state of Minas Gerais Brazil. Data were obtained through the self-application of a sociodemographic questionnaire and the Questionnaire of Attitudes towards Suicidal Behavior - QUACS (Almeida e Verdana, 2020).

According to the authors, both personal characteristics and professional training showed a relationship with the attitudes taken, that is, with the *praxis* of health workers in the face of suicidal behavior (p.7). Much of the self-perception of caring capacity was linked to training and reading material about suicide, also a great part of the negative attitudes were related to a lower perception of caring capacity, as well as the presence of more condemning attitudes (Almeida e Verdana, 2020).

According to the WHO (2009), in the recommendations for the prevention of suicidal behavior, the promotion of training for professionals who work directly with self-destruction demands, such as first responders, military personnel and firefighters, is one of the strategies for the previous identification of elements of risk for suicide attempts, since they are the first to have contact with people who are at risk of death. Other resources taught are the identification of symptoms and signs of mental disorders, in addition to ways of restricting the general public's access to lethal means, understanding the integrality of mental health service institutions offered and the means by which the individual can access them. it (WHO, 2009).

Following the line of recommendations, Almeida and Verdana (2020) state that it is essential to promote the process of continuing education and encourage empathetic, positive and secure attitudes among health professionals who face the issue of suicide in their work environments, since such promotion and encouragement are characterized as relevant factors in the prevention of suicidal behavior and in the reduction of negative attitudes of professionals towards it, attitudes that are closely associated with the harmful unpreparedness for the care of the person at suicidal risk (Almeida e Verdana, 2020).

Some of the means used around the world to prevent autoquiria is the administration of public policies that aim to limit access to firearms, poisons to extinguish pests and the construction of obstacles that prevent

high precipitation, such as bridges and cliffs. According to Gunnel (2017), who carried out an investigation into restrictions on the sale of pesticides versus the occurrence of suicides in some countries, he was able to point out that such difficulties imposed in the acquisition of these toxics made autochyria rates reduce (Gunnell, 2017; WHO; 2009).

For patients who attempted suicide, the treatment is different, as it is necessary to be concerned about the type of assessment that must be performed and how the treatment will be with this individual who is in great suffering. It's a call for help, a suicide attempt, a warning sign. It names the behavior that deserves diagnosis and therefore the professional, whether a psychologist, psychiatrist or even another qualified professional, who is faced with this patient must investigate the situations, causes, reasons and review the attitudes and behaviors of self-extermination in relation to the suicidal behavior. Building therapeutic bonds is an important point for acceptance, adherence, and reduction of the conflicting feelings that the patient has at that time, in addition to understanding and maintaining respect for the patient's emotional condition, the context of life and motivation to attempt a suicide; in addition, a position of acceptance without moral and religious judgment is essential in these cases. The myths that permeate suicidal attempts or behaviors must not be taken into pause during the patient's assessment and management, not questioning and thinking that the suicide attempt was the way the patient found to manipulate those in his life, to not leading and leading to stereotyped clinical behaviors, in addition to stigmatizing the patient already in conflict and placing him in a situation of shame or anger for not having managed to self-destruct and continue to abuse himself. Suicidal behavior has a great emotional impact on the health team, which can trigger feelings of harassment or pity, leading the team to treat this phenomenon with great disregard. Adequate support is important, as it tends to mobilize the patient to find strength for a change of life (WERLANG; BOTEGA et al. 2004, pp. 123-128).

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