LETTER

Towards a person-centered, mind-oriented model of suicide

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Accepted for publication: 25 May 2012

To the Editor

Many studies on suicide identify several risk and protective factors associated with suicidal behavior. These factors can been divided into several categories: socio-demographic, socio-cultural and relational (which include the role of life stressors), clinical and neurobiological [1-8]. Current psychiatric models of suicidal acts have tried to integrate statistically significant findings obtained in epidemiological, clinical and neurobiological studies in holistic frameworks.

Mann's stress-diathesis model of suicidal behavior [9,10] is widely used by researchers and clinicians. Mann [9] first proposed a basic model based on Monroe and Simons theory of stress-diathesis [11]: patients with a low threshold (e.g. impulsivity as a "trait") for suicidal behavior who experience a trigger (e.g. "state-dependent" conditions as major depressive episodes and/or stressful life events) are at high risk for making a suicide attempt. He enriched that model with new assumptions [10]: "objective" states (such as depression, psychosis and/or life events) interact with "subjective" state and trait conditions to trigger suicidal acts. With regard to "subjective" conditions, hopelessness, perception of depression and/or suicidal ideation, may lead to suicidal planning. Finally, another "subjective" condition, impulsivity, related to serotonin dysfunction and influenced by alcoholism, smoking, other substance abuse and/or head injury, would interact with suicidal planning and lead to suicidal acts or to aggression. A few years later, Mann included the role of the reactivation of cognitive patterns [8] as another crucial factor in his model. Some authors such as Oquendo [12] and Turecki [13] have enriched Mann's model with concepts.

However, among other theoretical and methodological limitations, those models only describe general, mainly neurobiological, behavioral, "objective" patterns, but fail to give an adequate explanation of both individual suicidal behavior and of the specific "mind" process that leads to suicidal ideation and, in the end, to suicidal acts. In fact, when we are confronted by suicide, we need more than general, behavioral, "brain oriented", "objective" patterns that are usually poor in explaining each individual suicidal act. For instance, Hitler's suicide (he committed suicide before being caught by his enemies) and Primo Levi's suicide (a writer, a Holocaust survivor, that committed suicide many years after the Second World War) may be indistinguishable from the point of view of risk and protective factors (depression, hopelessness, war exposure, etc) but are clearly not identical from the individual's, "subjective" (phenomenological) point of view.

Moreover, most variables taken into account are "measured" according to the scientific methodology. However, although it may be useful to "quantify" the "magnitude" of each factor "qualitative" analysis is needed for a better comprehension of suicidal acts. Let's use a metaphor [14]. If we want to understand why a book we like (e.g. a best-seller) is important for us, we cannot reduce our comprehensive model to a statistical analysis of the number of chapters, paragraphs, words and letters the book contains. These data will tell us something interesting about the book but little about why it is important not only for me/us but also for many other readers. Of course, if we eliminate the "quantitative" composition of the book, we will not be able to feel and think what we feel. We need the physical support to read a book. We need to incorporate a "qualitative", person-centered approach to achieve a wider comprehension of human phenomena (i.e. suicide).

A new view on suicidal behavior should be taken into account in Psychiatry in order to combine neurobiological ("*brain-centered*") and behavioral patterns of suicide risk with a comprehensive, phenomenological, person-centered, *"mind" oriented* approach to the meaning of each individual suicidal behavior.

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