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SUICIDE AND MENTAL DISORDER: A NECESSARY CRITIQUE

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Este artículo analiza desde una perspectiva crítica y reflexiva la asociación entre suicidio y trastorno mental. Se debate el dato de la Organización Mundial de la Salud que dice que el 90% de los suicidios se deben a un trastorno mental. Se concluye que la asunción acrítica de este dato conlleva: 1) una confusión entre un factor de riesgo y una causalidad psiquiátrica, 2) una idea reduccionista del suicidio y la conducta suicida vistos como un "síntoma", una evolución "natural" o incluso como un trastorno mental en sí mismo, y 3) finalmente, supone una anulación del núcleo íntimo del fenómeno suicida que es la capacidad de decisión-acción de una persona-en-un-contexto. Estas conclusiones ayudarían a pensar el suicidio más allá del enfoque biomédico y del factor diagnóstico.

Palabras clave: *Trastornos mentales, Psicopatología, Suicidio, Intento de suicidio, Factores de riesgo.*

This article analyzes, from a critical and reflexive approach, the relationship between suicide and mental disorder. The figure provided by the World Health Organization reporting that 90% of suicides are due to a mental disorder is debated. It is concluded that an uncritical acceptance of this figure implies: 1) a confusion between a risk factor and a psychiatric causality, 2) a reductionist idea of suicide and suicidal behavior seen as a "symptom", a "natural" evolution, or even as a mental disorder in itself, and 3) finally, it involves the cancellation of the intimate nucleus of the suicidal phenomenon that is the decision-action capacity of a person-in-a-context. These conclusions help us to think about suicide in a way that goes beyond the biomedical approach and the diagnostic factor.

Key words: *Mental disorders, Psychopathology, Suicide, Suicide attempt, Risk factors.*

A father and his son are traveling by car. They have a serious accident. The father dies and the son is taken to hospital because he needs a complex emergency operation, so a renowned doctor is called. However, upon entering the operating room the doctor says: "I can't operate on him. He's my son." How is this possible? Sometimes cognitive biases are involuntarily activated that prevent solutions from being reached. In the previous case, it would be a gender bias, because while the renowned doctor is the boy's mother, some readers will have difficulty reaching this conclusion. Other times scientific biases are activated that lead to partial conclusions, if not directly false or self-serving ones, as is the statement that more than 90% of people who commit suicide suffer from a "mental illness".

The quote that says that 90% (or more) of suicides are due to a mental disorder is widely accepted (WHO, 2014). This figure comes from studies of "psychological autopsies" (Hjelmeland et al., 2012). It refers to a medical-psychological investigation of the possible causes of death of a person when these causes are not clear.

In recent years, several authors have questioned the reliability and validity of psychological autopsies due to their numerous and serious methodological deficiencies and analytical biases (Hjelmeland & Knizek, 2016; Hjelmeland et al., 2012; Hjelmeland & Knizek, 2017; Pouliot & De Leo, 2006; Shahtahmabesi, 2013). By way of illustration, selection and confirmation biases are indicated. These consist of finding and confirming what is sought, respectively. They usually seek to confirm the existence of three things: a history of mental disorder, previous attempts, and substance use. This option would lead to overestimating the proportion of mental disorders in suicides and misunderstanding the relationship (often causally) between psychopathology and suicide. If the existence of problematic life contexts that could be helped were traced, perhaps these would be found to be present in 100% of cases. It has also been observed that when autopsies are used with a qualitative-narrative approach, the role of mental disorders decreases significantly and other factors that better illuminate suicide appear (Hjelmeland, 2016; Hjelmeland & Knizek, 2016; Hjelmeland et al., 2012; Hjelmeland & Knizek, 2017). On the other hand, the fact is questioned that many interviewees are close relatives who may need the attribution to a "mental illness" as a way to better endure grief.

Given this figure of 90%, so widespread in the literature and media, it is worth proposing a critical analysis. The criticisms, when there are any, naively assume a univocal sense of the figure and simply point out that not all suicides have a psychiatric

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basis. But the most important thing is not questioned; that a risk factor (statistical association) and an explanatory factor (Franklin et al., 2017) are being confused, with the danger that this entails (Hjelmeland & Knizek, 2017; Pridmore, 2015), since a myth is being encouraged: suicide equals "mental illness". More specifically, it is a myth present in the psychiatric literature since Esquirol and rehabilitated in our day by official academic psychiatry. Thus, it is justified that the best suicide prevention strategy is the indirect route; through the reduction and control of the diagnostic factor: early detection and treatment of mental disorders, especially depression (Mann et al., 2005), which is, in short, a diagnosis-centric and pharmacocentric strategy. On the other hand, investment in the study of mental disorders is justified (Pridmore, 2015; Shahtahmabesi, 2013) to the detriment of other factors that are equally or more important in suicide, such as psychological, contextual, existential, and social factors. And, above all, to the detriment of the study of protective factors.

The diagnosis-centric approach refers to the attempt to cluster the explanation-understanding of psychological suffering and of unusual or problematic experiences around discrete categories of disease according to the diagnostic systems used, ICD/DSM, currently in crisis (Allsopp et al., 2019; Deacon, 2013; Timimi, 2012, 2013, 2014), and the fact that mental health care today revolves around the control of the symptoms of these diagnoses.

The objective of this article is to analyze, from a critical and reflexive perspective, the data that state that 90% of people who commit suicide suffer from a mental disorder. Three critical considerations are presented: 1) the meaning and tautology of the figure, 2) the biomedical naturalization of suicide, and 3) the conceptual confusion about what suicide is and what it is not. The article closes with the main conclusions.

MEANING AND TAUTOLOGY OF THE FIGURE

Although the connection between suicide and mental disorders is well established, its meaning is not. A simplistic relationship is counterproductive. What does it mean that 90% of people who commit suicide suffer from a mental disorder? Just thinking about this briefly, it can be seen that the interpretation is neither univocal nor simple. Staying with the superficiality of the figure is misleading. There are statements that hint at more than the evidence authorizes. That (A) 90% of people who die by suicide had or could have had a mental disorder, does not mean that (B) 90% of people with mental disorder commit suicide, or that (C) the diagnostic factor is the "cause" of 90% of suicides. Indeed, the vast majority of people with clinical problems neither commit suicide nor attempt to do so. Obviously, (A), (B), and (C) are three different things. We believe, however, that many readers will have concluded and even memorized in a "natural" way that the figure under discussion affirms the second statement and even the third one. This would have operated a cognitive-social bias that places mental disorders at the explanatory center of suicidal behaviors. In fact, the biomedical model of mental health, installed as a computer program in our individual and social way of thinking, based on nosological diagnoses, and ultimately in the brain or genes (Pérez-Álvarez, 2011), shines in our days as a complete and sufficient explanation of any human behavior. This brightness dazzles rather than illuminates the phenomenon it is wished to study. De-activating this bias is a challenge today. It could be said that it is one of the tasks of our time.

1. First, mental disorder is neither a necessary nor sufficient condition for suicide. The fact that there is a relationship between psychopathology and suicidal behavior does not authorize the conclusion that psychopathology is the "cause" of suicide, as stated, explicitly or implicitly, on account of a biomedical naturalization of suicide (Insel & Cuthbert, 2015). A risk factor is confused with an explanatory factor (Franklin et al., 2017), and even more, this confusion is spread as a "truth" through the media; a social institution that is characterized by the fact that by informing about reality, it creates meanings and realities. See the following press release: "More than 90% of suicides in minors are due to a mental disorder" (Mayordomo, 2019, p.23). These questions are often confused even among critical authors with the alleged "psychiatric causality" of suicide (León Pérez, Navarrete Betancort, & Winter Navarro, 2012). The previous news article began with this enigmatic statement: "Suicides are the second cause of death in adolescents—after traffic accidents—but the first medical cause."
2. The fact that many people with terminal and oncological diseases think about suicide or take their own lives (Calati et al., 2018; Diaz-Frutos et al., 2016), does not mean that suicidal behavior is a symptom of cancer or that cancer "causes" suicide. It means rather that suicide is an extreme-situation option that opens up in the face of contexts of tragic suffering, as is the case here of the imminence of death or anticipating terrible agony. Here, cancer functions as a precipitating factor of suicide. Even more so if it is experienced as an irreversible loss of the life plan or as a burden for others. Specifically, this circumstance seems to have been the motivation of the suicide of the well-known actor Robin Williams, or of the euthanasia writing of the poet Juan Goytisolo, this form of suicide being classically known as "rational suicide" (Siegel, 1986). It is understood that it is possible to comprehend this, from a second-person perspective, in terms of life balance (satisfactions/burdens that life gives me). Based on the biomedical model, this subgroup of suicides does not have a psychopathological basis. This is the other side of suicide; the 10% that is complementary to the 90%.
3. The fact that the diagnosis of depression is a long shadow that accompanies suicide behavior does not mean that the clinical "condition" is the relevant variable to understand the suicide "scene" or "act": a 70-year-old man had been diagnosed with depression since he turned 50; he is diagnosed with cancer with metastasis and after a few days he commits suicide. Question: Did he commit suicide due to having depression? A woman suffers gender

violence by her partner. She develops a mood disorder that leads her to take medication. After a few months she separates from her partner and suffers a new aggression with death threats to her children, she enters a state of crisis and attempts to commit suicide by taking medication. Was depression the cause of the suicide attempt? A final example: if a person uses alcohol as a disinhibitory element to "dare" to perform the suicidal act (or consumes alcohol as an emotional analgesic), that does not mean that alcohol is a cause or precipitant of suicide or suicidal behavior, nor would it be correct to conclude that psychotropic drugs are the cause or a risk factor for suicide because they are used (as is often the case) in drug self-intoxication. This would be a case of confusing a consequence with a cause.

4. It is interesting to note that within the diagnosis-centric model, the explanatory mechanisms by which a given diagnosis "causes" suicidal behavior have not been studied. It is said that "pathological suicide" is suicide that is "caused" by a "mental illness", without providing more information. This is important, as there are numerous phenomenological and existential nuances that should be placed on the canvas, which is already rather impressionist. Indeed, the following are not the same, 1) the desire to escape from intolerable suffering aggravated by the meaning of chronicity and stigma attributed to a "mental illness" (bipolar disorder), 2) the desire to die after a state of demoralization and hopelessness that clouds any positive prospects for the future (depression), 3) the escape response to imperative voices that incite a person to throw him- or herself out of the window (schizophrenia), or 4) impulsive self-destructive behavior after an affective loss or rejection (borderline disorder), etc. It is not enough to verify that there had been a psychiatric diagnosis, as if the relationship between mental disorder-suicidal behavior were causal, linear, evident, and univocal.
5. Finally, although psychopathology is a risk factor, it is not the only one. There are other risk factors; among them the history of child sexual abuse and maltreatment (Angelakis, Gillespie, & Panagioti, 2019; Beghi, Rosenbaum, Cerri, & Cornaggia, 2013) and psychosocial factors (Baca-García et al., 2007). Among the latter, we should highlight: hopelessness, impulsiveness, perfectionism, cognitive styles and biases, lack of support, etc. (O'Connor & Nock, 2014). Also, let us not forget the social determinants (education, working conditions, housing, and economic income) (Estruch & Cardús, 1982; Fernández de Sanmaned et al., 2018; Navarrete Betancort, Herrera Rodríguez, & León Pérez, 2019) and existential and cultural conflicts (Hjelmeland & Knizek, 2016; Rendueles, 2018). The insistence on overstating the importance of the diagnostic factor to the detriment of others that are equally as or more important, has in our opinion more of an ideological and interest-based sense, than a scientific, evidence-based one. These interests include commercial-economic, professional-corporate, and social-political ones (Deacon, 2013).
6. However, with the figure of 90% we wish to point out the tautology according to which whoever attempts to commit suicide or thinks about it, by the act of doing so, has a mental disorder that is the "medical" cause of this suicidal behavior. The DSM-5 (APA, 2013) moves in this tautological direction which suggests, within the disorders that require further study, a new diagnosis: "suicidal behavior disorder". Its manifestation or fundamental and only symptom is the suicide attempt. Suicidal behavior is attributed to a "mental illness," whose existence is inferred retrospectively precisely because of the presence of suicidal behavior. As some informants say: "nobody knew I was sick." As inferred from the diagnostic criteria of this manual, this suicide attempt must be guided by the intention or expectation of killing oneself. If not, the authors of the DSM-5 recommend not making the diagnosis. The same can be said about "non-suicidal self-harm disorder"; it not only defines the behavioral topography but also the meaning or purpose of the self-injurious behavior. However, this manual does not give any clue about what is really important in our opinion, namely: how is the existence or not of suicidal intent evaluated when the person him- or herself may have difficulty accessing his own intentional content or motivational mechanisms?

THE BIOMEDICAL NATURALIZATION OF SUICIDE

The figure of 90% does not originate from any place or perspective, but from a theoretical *a priori* that should be explained. It refers to the biomedical naturalization of suicide. Naturalization is the process of converting every human issue, whether problematic or not, into a positivist-naturalist issue, detached from the socio-historical and cultural conditions where these human issues take place and make sense, placing their center of analysis and study in biomedical materiality and preferably in the brain or the genes. Suicidal behavior would be understood as either a "symptom" or clinical manifestation of a mental disorder (referring here to depression and borderline personality disorders), either as a "natural" consequence, complication, or evolution of a "psychiatric illness" (referring to "resistant depression"), or even as a mental disorder in itself (see the DSM-5 proposal for "suicide behavior disorder", included in the conditions for future study section).

This naturalization of suicide has no scientific evidence, beyond having countless nonspecific biological correlates. Perhaps the death of a dog that stops eating after the decease of its owner is the closest thing to a "natural" complication or evolution from an endotymic disorder to a (suicidal?) death by starvation. In any case, the similarity of this canine death with the suicide of a human subject diagnosed with depression is totally artificial. To those who defend the thesis of animal suicide, it is worth asking: do animals have ideas of suicide?

To deepen this criticism of the naturalization of suicide, let us look at the following quotation that deals with bipolar disorder. "Suicide is one of the symptoms that can occur in the episodes of the disease and, therefore, patients and family members should be given the corresponding information

about its management. It is important that they are able to conceive of suicide as a symptom of the disease, the episodes of which are limited in time, and *not as a voluntary decision pertaining to the individuality of the subject*. Therefore, psychoeducation, both of patients and relatives, is essential" (Reinares Gagneten et al., 2004, p.191). The italics are ours. To reduce the suicidal act to a mere involuntary symptom, unmotivated outburst, raptus, or short-circuited act, is to distort its most essential meaning, which is the intentionality-of-wanting-to-take-one's-own-life. Intentionality and symptomatology are two concepts that belong to different ontologies. If there is intention-for, then, it is difficult for it to be a "medical-symptom-of"; and the opposite: if it is a "symptom", one cannot think that it is intentional, unless we decide that the genes, cells, or molecules of the organism pilot the biographical life, make decisions, and carry out existential stock-taking. The following quote could be situated in this reductionist line: "It is a very dangerous fallacy (the thesis of rational suicide is being criticized): it is like saying that someone dies freely from hepatitis or cancer" (Suárez, 2010). It means that suicidal behavior has the same entity as a medical symptom like any other, such as thirst to diabetes, sweat to a fever or tremors to Parkinson's. In other words, suicide would be thought of as a body movement rather than as a psychic act. Or in terms of Castilla del Pino (2010): "an abehavioral act" rather than a behavioral one. However, as the philosopher and psychiatrist Jaspers said, suicide is not to depression what fever is to infection (Jaspers, 1959).

The paradox of the biomedical model of suicide consists of first describing the suicidal behavior in phenomenological, first-person terms, as an intentional-act-of-killing oneself, and then, trying to prove that such intentionality does not exist, because in reality "psychiatric illnesses are illnesses of freedom" which ultimately invoke abnormal biochemical, neurobiological, and/or genetic-hereditary mechanisms. Furthermore, this occurs without clarifying that genetic is not synonymous with hereditary; see the role of epigenetics (López-Otín, 2019). This biomedical logic of suicide is not only criticized for being reductionist and mechanistic but also for being dangerous. It carries the risk of diluting or deactivating any psychological and contextual analysis (social or political) involved in the suicide crisis, since it places the center of explanation-understanding on damaged mechanisms of the intra-subject-materiality, including here the supposed "heritability" of suicide. This way of thinking about suicide (pathophysiological reduction without subjectivity, social context, values, or theory of the subject), provides fertile ground for privacy monitoring practices (propagation of detection scales and risk estimation in the different services, alarm codes, etc.), preventive pharmacological treatments, and ultimately, restrictive interventions, or possibly directly harmful ones, such as involuntary admissions, mechanical containment, or electroconvulsive therapy (ECT); which, incidentally, would increase stigma and discrimination.

From our experience in clinical contexts, suicidal ideas and attempts are not so much associated with "symptoms" or with nosological diagnosis (depression, schizophrenia, etc.), but with a blanket of contextual and existential factors such as: 1) dealing with problematic life contexts without success or without hope of a way out, 2) the experience of repeated failure of coping strategies, including support systems, 3) the demoralization associated with the semantics of psychiatric diagnosis ("brain-genetic-chronic-disease-like-any-other-that-requires-continued-medication"), the connotation of which, loaded with stigma, is paradoxically fostered by certain professional sectors that claim to combat stigma in mental health, and 4) the side effects of treatment, which, when experienced in the first person in body and soul, can prevent or interfere with moving forward with evolutionary tasks, values, or the life plan.

To see some of these issues in detail, an example is presented.

The literature profusely cites the example of the American writer Ernest Hemingway, diagnosed with various mental disorders, to illustrate the connection between psychopathology and suicide. However, this same literature fails to say that a few months before, and until a few days prior to his death, the Nobel Prize for Literature was treated intensively at the Mayo Clinic with ECT and medication. It is said that at the beginning he improved a lot and that shortly thereafter he worsened seriously, carrying out several failed suicide attempts, which meant he was admitted again (without his consent) and he received more electroshock sessions (Baker, 1974; Martin, 2006). Although it is not said anywhere, it may be considered that this worsening had to do not so much with the "natural" evolution of the supposed mental disorder but with the ECT itself, since this modality of help (especially in the early 60s) produces significant memory loss and cognitive impairment after its administration (Johnstone, 1999; Read & Bentall, 2010; Read, Cunliffe, Jauhar, & McLoughlin, 2019). Indeed, it is known that after receiving ECT, his memory—and his ability to write—was seriously limited. He complained, crying, to his doctor that ECT had destroyed his talent and that he could not write any more (Sandison, 1998). This situation, along with others (the death of his friend Gary Cooper, the Cuba-US conflict, and the FBI surveillance) sank him further and it can be inferred that he ultimately approached the precipice of suicide. Only in this sense is what Martin says, that "biological factors contributed to his suicide" (Martin, 2006), true. This (purposeful) omission of the negative effects of ECT is important in order to better understand the circumstances of his suicide, since it is known that writing was his main antidote to alleviate the numerous physical injuries and psychological problems he suffered throughout his life, in addition to a poorly accepted deterioration associated with old age (Baker, 1974; Martin, 2006; Yalom & Yalom, 1971).

This hypothesis, regarding the harmful effects of electroschock as a factor involved in the suicide process, is especially relevant in those people who place artistic creation as the meaning of their lives. It is known that the rupture of the self with its life project (identity crisis or crisis of the self) is an important risk factor in suicide (Castilla del Pino, 2013). With

this, we wish to point out two questions: 1) that attributing the "cause" of suicide to the "symptoms" or the diagnostic factor may be an approach that is too simplistic, and 2) that there are treatments that are so aggressive, so disabling that, whilst they put an end to the most terrible "symptoms", they also leave behind a dark shadow of collateral damage that is not negligible. They can leave people with such a degree of deterioration and disability that, although they are without "symptoms" ("sleeping well, no appetite problems, stable mood", etc.), they take them away from the most valuable part of their lives, and place them, without realizing it, on the edge of the abyss. As if living were just breathing.

The American writer William Styron had better luck. According to an autobiographical novel (Styron, 2018), after suffering a deep depression with suicidal ideas, he found in a psychiatric admission the solution to his extreme situation. A context of maximum protection and release of responsibilities, the trial of different pharmacological treatments, and occupational therapies contributed, according to his own confession, to his clinical improvement, it being difficult to determine the differential weight of each of these elements in his final evolution. A certain placebo effect associated with admission is not ruled out, since, as recognized by the author himself, the suicidal ideas disappeared within a few days of admission. Perhaps the experience of care is decisive in getting out of the suicidal crisis beyond the biochemical effects of medication. Thanks to this rapid improvement, he was able to avoid ECT, and—it could also be ventured—perhaps suicide as well.

As it is verified many times in the clinic, the important thing, as we say, is not so much the diagnosis itself but the interferences that both the "symptoms" and the side effects have of certain treatments in the pragmatics and meaning of individual life. See among the side effects extrapyramidal difficulties, memory impairment, or affective alterations induced by certain neuroleptics. It is these effects that often prevent, complicate, or limit moving forward with the life plan or with a values-based-life. They feed and encourage the lack of control over one's life, demoralization, despair, and hopelessness. This is why it is not strange that, in patients diagnosed with schizophrenia, "depressive symptomatology" (especially the most cognitive experiences: undervaluation, hopelessness, etc.) is the variable most related to th e risk of suicide (Gracia Marco, Cejas Méndez, Acosta Artiles, & Aguilar García-Iturrospe, 2004). The fact that what is important is not the diagnosis itself but the functional interferences, can be verified without difficulty in the case of numerous famous writers and artists who chose to commit suicide (Virginia Woolf, Vincent Van Gogh, Ernest Hemingway, David Foster Wallace, etc.) It could be said that for all of them (Virginia Woolf confessed this), death was a better option than the alternative of living a life without the possibility of working (reading, painting, or writing).

In conclusion; it is necessary to think about suicidal crises and behaviors from the perspective of a complex and meaningful interaction among the circumstance experienced (problematic life contexts, dramas), the diagnosis (set of symptoms and signs), the self-project (guiding principles that give meaning to identity, life, and the future), and the help received (therapeutic relationship, interventions, and treatments). This all has very important implications for care and prevention. Invalidating treatments that exacerbate the rupture of the self with its life plan and a poor or directly threatening therapeutic relationship, are—from this perspective—facilitating elements of suicide, and therefore, factors to take care of in the helping process, beyond symptomatic reduction. It is necessary to reorient the professional help not only towards the control/avoidance of "clinical symptoms", but also towards strategies for the creation and acceptance of them, so that their effects do not crystallize in executive obstacles; or vice versa: help the person to move forward, despite everything, carrying the bad-feeling and limitations in their backpack. It is understood that mental health is not only the elimination of symptoms of distress, but also functional recovery and improvement of the quality of life. It would be necessary to "return to things themselves" (Husserl), which in our field would be *people-there-in-the-world-going-on-with-their-lives* (Heidegger-Ortega). In this sense, it would be beneficial to work on fundamental and decisive issues such as the following: contemplating the frustration of expectations and the mourning for the loss of the self-plan, building a new life meaning according to the new possibilities, accepting the loss of cognitive capacity and the inability to work, creating the more/less continuous need for pharmacological treatment (when necessary), working on the experience of loss of control over life and the need for help (especially in the elderly), and managing social stigma and self-stigma. These issues are completely ignored in the suicide protocols, focused on the diagnostic factor, and require psychotherapy training for the clinician. Not surprisingly, for all the above a specialized psychotherapeutic intervention is required.

CONCEPTUAL CONFUSION

Let us now look at some implicit conceptual confusions surrounding the 90% figure. It refers to the lack of discrimination between the death of a person who in the midst of a "psychotic crisis" jumps out of the window fleeing from imperative hallucinatory voices and that of a person who under the pressure of a diagnosis of chronic depression decides to end his/her life leaving a farewell note. According to the biomedical model, both are examples of "pathological suicides." However, the question arises: what suicidal similarity exists between a death that is unwanted and not sought, and a death that is wanted and planned? For someone to commit suicide without wanting to (in the case of the psychotic crisis) is a contradiction. Back in 1897, Durkheim (2004) warned of the need to make this distinction. The attribution of suicidal behavior to the domain of a "disease-like-any-other" (pathophysiological reduction) or to the domain of a subject-in-context (the reasons or rationalizations, always ambivalent or dilemmatic, to want to take one's own life is discussed here. This way of confusing facts that are so different and distant from the clinical and existential point of view obscures in our opinion the

understanding of the phenomenon of suicide. If there are no elements to reconstruct *a posteriori* the intentionality and willingness to desire death (subjectivity), it should be questioned whether it is really suicide, even if there was a mental disorder. For our part, we defend, as do most experts and forensics, that in the suicide phenomenon there must be enough data to reasonably infer or deduce the suicidal intent of the act. If not (and here the farewell note would play a fundamental role, although not only or always), it could be something else; see defenestration in people diagnosed with schizophrenia. These suicides without intentional involvement are often called "pseudosuicides."

In the same vein, the most important classification and diagnostic manuals also note the aspects of intentionality. ICD-10 (WHO, 1992) includes "intentionally" self-inflicted suicide and self-harm. As mentioned earlier, the DSM-5 (APA, 2013) talks about "suicidal behavior disorder." In the definition of attempted suicide, suicidal "intention" is included, or it is said that the subject intends to cause his own death. The problem is that it does not indicate how this intent is to be evaluated. It excludes those acts that are initiated during a confusional syndrome (criterion D) and those that are carried out for a political or religious purpose (criterion E). These two criteria are of interest, since DSM-5 would admit medical interpretations, on the one hand, and religious-political ones, on the other, of suicidal behaviors. It is thus a complex issue and saying that there are suicides of political-religious "motives", suicides of medical "causes", and pathological suicides, further obscures the understanding of the suicide phenomenon.

On the other hand, it should be remembered that the WHO defines suicidal behavior as the act of a subject deliberately and intentionally taking their own life (WHO, 2014).

Now, as is known in psychopathology, the intentionality or functionality with which an act of behavior operates in a context is often independent of the awareness of it by its protagonist and, therefore, it would be impossible for the subject to verbalize if he or she were to be asked about it. Furthermore, intentionality is not always deliberate or reflective, nor is it a matter of all or nothing, but rather a dimensional process or field, with gray areas. It can be seen as a continuous dripping into a glass; sometimes it overflows and then a self-destructive act is "impulsively" executed. However, we believe that the existence of farewell notes or letters is, in the absence of other indicators, the best external indicator of suicidal intent. In an old study, it was found that the existence of a farewell letter produced the highest statistical index for frustrated suicide and the second highest for consummated suicide. On the other hand, in suicide attempts or the equivalent it was insignificant (Rojas, 1978). This does not mean that the reasons or rationalizations written on the paper are the "truths" of suicide.

We have reached a sufficient height from which to see that it is not so much the behavior itself, that is to say its topography or behavioral materiality (taking poison or jumping through a window), or the final result (death or life), but the intention that a subject pursues by executing a certain behavior, which defines the "essence" of suicidal behavior. Maintaining the intentionality criterion is essential to discriminate between a suicide and an accident. There is nothing intrinsic to suicidal behavior that says, "this is a suicidal act" (except perhaps for hanging). If, on the contrary, the criterion of the final result of death is taken, the mistake could be made of labeling as suicide things that are not. Human behavior is always contextual. The "same" behavior, such as throwing yourself out of a window, can have different meanings-functions depending on the context; for example: 1) checking one's ability to fly (a 4-year-old boy who is playing Superman), 2) in response to auditory hallucination (a person diagnosed with psychosis who hears imperative voices urging him to jump), 3) as a desperate way to escape a fire (when a building is in flames and there is no escape), 4) to escape an unbearable shame (after an eviction or disclosure of a sex video), 5) to escape persecutory guilt or avoid a prison punishment (after killing an ex-partner), or 6) to shorten an agonizing and irreversible future (after receiving the news of a terminal illness). Are they all suicidal behaviors and the same kind of suicide? If a biochemical-genetic or personality-psychological analysis were carried out, would there be one same core result, or would several profiles be found? All of this has important epidemiological, clinical, and research implications. It could be that things and cases that are not suicide, and/or at least not in the same way, are being recorded as suicide. In order to have valid data, it is important to go beyond the observable behavior and the diagnostic category (descriptive-statistical-generic-abstraction) and enter the lived experience or the "life space" (Lewin, 1978) of the person at risk of suicide, which is their concrete individual life. It is a question of seeing the reality from the first-person perspective of the protagonist, although for this, information from nearby people must also be collected so that, from there, from inside and from outside, one would be able to discriminate better whether we are strictly facing a suicidal phenomenon, and, of course, to understand it. It is interesting to introduce, albeit briefly, Lewin's notion of "living space"; it refers to the person and the context, as it exists psychologically for that person, that is, to his intimate construction of the world, "at a given time", which includes a "contemporaneity principle" according to which the perspective of the present integrates both the past and the future (Lewin, 1978).

So, entering the person's lived or constructed world, at any given time, would be the equivalent to the process of psychopathological evaluation of imputability in the forensic field. In the absence of a "medical autopsy" that verifies whether the cause of death was suicide or not (which is absurd, since biology does not inform intentions), a study of "psychological autopsy" would be required—or rather "psychobiographical"— although this autopsy will never be free of reliability issues.

CONCLUSION

The 90% figure, taken superficially, without the necessary

criticism, activates a series of cognitive biases, which are already institutional (cultural), and that should be discussed. First, a risk factor is confused with a psychiatric causality and points towards a clinical, tautological, and self-evident sense of the suicidal act (suicide is a consequence of suffering from a suicidal behavior disorder). Second, suicide and suicidal behavior are understood as a "symptom", a "natural" evolution or even a mental disorder in itself, which ultimately refers to biochemical, neurological, and genetic-hereditary alterations yet to be deciphered. Suicide, from this biomedical point of view, would then be a thing that happens to the subject and not a behavior that he or she performs in a dramatic circumstance with a meaning. In phenomenological terms, we would talk about a sense of ownership but no sense of agency. Finally, the 90% figure nullifies or undermines the intimate core of suicide, which is the decision-action capacity of a person-in-a-context. Or, in other words, the analysis of suicide as it primarily and really is; a dilemmatic-intentional-behavioral-contextual phenomenon in which many factors are interwoven: cultural, social, existential, psychological, clinical, and biological. These conclusions open the way to thinking about suicide beyond the biomedical approach and the diagnostic factor.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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