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Editorial / Monograph

Editorial for Special Issue on Understanding and Prevention of Suicidal Behavior: Humanizing Care and Integrating Social Determinants

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ABSTRACT

Background: Suicide is a preventable public health and social problem. Suicidal behavior is a complex and multifactorial phenomenon whose characterization, assessment, prevention, intervention, and postvention require a comprehensive approach focused on the meaning in a person's life and ttheir suffering in their biographical, social and cultural context. It is an extraordinarily variable phenomenon over time and highly dependent on contextual elements. **Method:** This editorial includes the social determinants of this phenomenon, key aspects linked to the dehumanization of healthcare settings, the problems of iatrogenic harm in universal prevention programs for schoolchildren and adolescents, and good clinical practices collected in the scientific literature. **Results:** The editorial highlights the importance of research for the prevention of suicidal behavior from any intervention level, whether educational, community, social, or health, as all are involved in prevention. **Conclusions:** The goal is to help improve the biographical circumstances of people with suicidal behaviors and the meaningfulness of their lives. This must be done through a collective scaffolding in which the most vulnerable can ask for help when they need it, as well as guide themselves towards life circumstances worth living.

Editorial del Monográfico "Comprensión y Prevención de la Conducta Suicida": Humanización de los Cuidados e Integración de los Determinantes Sociales

Palabras clave:
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Recomendaciones con apoyo empírico

RESUMEN

Introducción: El suicido es un problema de salud pública y social prevenible. La conducta suicida es un fenómeno complejo y multifactorial cuya delimitación, evaluación, prevención, intervención y posvención, requiere un enfoque comprensivo focalizado en el sentido vital y el sufrimiento de la persona en su contexto biográfico, social y cultural. Se trata de un fenómeno extraordinariamente variable en el tiempo y muy dependiente de elementos contextuales. **Método:** Este editorial incluye los determinantes sociales de este fenómeno, aspectos clave vinculados a la deshumanización de los entornos sanitarios, los problemas de daño iatrogénico en los programas de prevención universal para escolares y las buenas prácticas clínicas recogidas en la literatura científica. **Resultados:** Se resalta la importancia de la investigación para la prevención de la conducta suicida desde cualquier ámbito de intervención, ya sea educativo, comunitario, social o sanitario, pues todos están implicados en la prevención. **Conclusiones:** El objetivo es ayudar a mejorar las circunstancias biográficas y el sentido vital de las personas con conductas suicidas. Esto debe realizarse mediante un andamiaje colectivo en el que los más vulnerables puedan pedir ayuda cuando la necesiten para orientarse hacia vidas que merezcan la pena ser vividas.

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Suicide is a major health and social problem and, as this *Special Issue* of Psicothema illustrates, it is not one that can be dealt with easily. Suicide is largely preventable. International specialists discuss the new data and future research directions in the field of suicidal behavior. Together they outline a multifaceted view of suicidal behavior toward preparing a multi-sectorial, data-driven public health approach aimed at improving overall population mental health, humanizing care, and integrating social determinants, while specifically targeting those with the greatest vulnerability. The result is a rich collection of 10 papers by 65 authors from several countries. As Franco et al. (2021) expressed, preventing suicide is perhaps the noblest of public health goals. They approached the subject on its sheer multi-dimensionality, from theory to practice, from reasons to live during a suicidal crisis (Besch et al., 2024) to the role of fearlessness about death (Andreo-Jover et al., 2024), from adolescents (López-Fernández et al., 2024) to older adults (Torres et al., 2024), from psychometric tools (Joyce et al., 2024) to ecological studies (Jimenez et al., 2024), and from people experiencing homelessness (Calvo et al., 2024) to family communication (Buelga et al., 2024) or psychological autopsy (Caro-Cañizares et al., 2024).

O'Connor & Nock (2014) defined suicide as the act by which a person intentionally ends his or her own life. More than one in 100 deaths result from suicide. It is estimated that more than 700,000 people globally die by suicide each year (almost 10 per 100,000 population). Suicide is the 17thth leading cause of death across the lifespan and is ranked as the fourth leading cause of death among people aged 15-29 (World Health Organization [WHO], 2021). More alarmingly, actual suicide rates may be even higher than reported owing to stigma, misclassification, and limited surveillance systems. Furthermore, almost 80% of global deaths by suicide occur in low and middle-income countries, but less than 15% of suicide-related research is conducted in those settings, whereby much less is known about the epidemiology and etiology of suicidal behavior (Lovero et al., 2023).

Conceptually, suicidal behavior is a complex and multifactorial phenomenon whose delineation, assessment, prevention, intervention, and postvention require a comprehensive approach focused on the individual's life meaning and suffering in their biographical context and, therefore, social and cultural (Al-Halabí & Fonseca-Pedrero, 2021, 2023a; García-Haro et al., 2018; Hawton & Prikis, 2017; Stack, 2021). According to Coppersmith et al. (2023), approximately 9% of the population has suicidal thoughts at some point in their lives. In the case of the adolescent population, this percentage would rise to around 20% (Fonseca-Pedrero et al., 2023; Lim et al., 2019). However, from a public health perspective, the field of suicidology has reasonably been more concerned with suicide. But suicide deaths are only part of the story, with up to four times as many suicide attempts for each death. The personal, family, and social cost of such phenomena is undeniable. Nevertheless, recently Jobes et al. (2024) have highlighted the need to consider suicidal ideation as a primary research target. Alleviating such thoughts would reduce suffering and improve the quality of life for many people, even with a functional or instrumental component of such thoughts aimed, in most cases, at dealing with the feeling of being desolate.

We are, therefore, faced with a phenomenon characterized by the presence of great existential suffering and intolerable psychological pain in which a person, in a given circumstance, decides to take their own life. It would be more of an existential drama than a symptom of a supposed "mental illness" or an "intrapsychic breakdown" that needs to be "cured". A diagnostic or linear interpretation (i.e.,a Brain-Centric Model of Suicidal Behavior) would not be appropriate (Kleiman et al., 2017; Hawton et al., 2022). The distress leads to such complex paths that, at times, the determination to die due to suicide, as contradictory as it may seem, can be instigated precisely by the fear of death. Chiles et al. (2019) note that in a suicidal crisis, it is likely that a person will experience emotional or physical pain that he or she believes is "intolerable", "inescapable", "interminable". According to these authors, pain is viewed as intolerable if it exceeds one's defined threshold; pain is viewed as inescapable if one does not see any solutions to the problem causing the pain; and pain is viewed as interminable if one believes that it will never change on its own accord.

Human Suffering is not a Mental Disorder

Beyond the complexity and multifactorial nature there are two basic and disjunctive positions in the scientific literature on suicidal behavior that are reflected in the social and clinical landscape: (1) A primarily individual-endogenous and diagnosis-centric conceptualization (Boldrini et al., 2024; Sun et al., 2024); (2) A contextual-functional (Chiles et al., 2019) or contextual-phenomenological-existential approach (Al-Halabí & Fonseca-Pedrero, 2023a; Al-Halabí & García-Haro, 2021; García-Haro et al., 2018, 2020).

Unlike the diagnosis-centric approach, the contextual approach would be transdiagnostic (with a common core to the suffering of people, whether in the presence or absence of one or more diagnostic labels), psycho(patho)logical (ontological continuity between "normal" and pathological psychological experience), and multisectoral (not limited to the health field, but extending to all social and community areas and institutions). The biomedical model of mental health takes nosographic diagnosis as a (biological) explanation for suicidal experiences and behaviors. Although the presence of a mental disorder (usually depression) and suicidal behavior may correlate, the diagnosis is never the cause (García-Haro et al., 2020; Pridmore, 2015), nor does it explain why a person thinks about or attempts suicide (O'Connor, 2011). Instead, the contextual-functional-existential model advocated in this *Special Issue* takes both the diagnosis and suicidal experiences and behaviors as what needs to be explained. To do this, it establishes as a starting point the phenomenological-behavioral (biographical) scale of the person's lived world and the problems they encounter in their circumstances, that is, life's problems. Suicidal behavior is plural and diverse, extraordinarily variable over time, personal, and highly dependent on contextual elements (Coppersmith et al., 2024; Kleiman et al., 2017). Thus, it would fit with the figure of existential drama, following Pérez-Álvarez (2019) proposal to understand psychological problems as social dramas. The meaning of this drama lies in the action-decision capacity of a person who, in a given circumstance, decides to take their own life.

Dehumanization and Mental Health: Toward Re-Humanization

Recently, Jenkins et al. (2023) have focused on the dehumanization experiences suffered by people with mental health difficulties or problems, proposing a new association of this phenomenon with death by suicide. Thus, the authors include as sources of meta-dehumanization interactions with society, professionals, institutions, and the media, which would impact self-dehumanization and stigmatization of these people with difficulties. Meta-dehumanization may also occur within the clinical context, from interactions with healthcare service providers, staff, and clinicians. Experiential accounts suggest that people in clinical settings can feel like both an object that needs fixing or a child lacking independence. Unfortunately, research suggests that healthcare staff dehumanize "psychiatric patients" more so than general hospital patients, perhaps suggesting additive dehumanizing experiences for those with mental health problems (Jenkins et al., 2023).

Therefore, even those circumstances that have traditionally been considered risk factors in longitudinal correlation studies could have another interpretation related not so much to the diagnostic label as to the added difficulties in their life through problems in interpersonal relationships (including mental health professionals). Again, suicidal behavior would be rooted in life circumstances and not in the diagnosis per se. These questions the usefulness of diagnostic labels as reliable predictors of suicidal behavior and as a basis for psychological treatment. New knowledge paradigms emphasize this idea that the prediction of suicide risk is not valid, so continuing to rely on it as a prevention strategy is an impossible equation that is frustrating for both professionals and people seeking help (Berman, 2018; Coppersmith et al., 2024; Hawton et al., 2022). It is necessary to consider specific protocols for the rehumanization of services and care from professionals and society as a whole, beyond merely health care (Jenkins et al., 2023). Consequently, classical risk factors (Turecki et al., 2019) and even their accumulation, demonstrate very low specificity and poor predictive power and, above all, do not explain why some people die by suicide and others do not (Franklin et al., 2017). A risk factor is not necessarily a causal factor, but rather a variable that systematically precedes an outcome. To guide preventive strategies and complement knowledge derived from the study of risk factors, which are more characteristic of epidemiological models, psychological models of suicidal behavior, also known as Ideation-to-Action Theories of Suicide, have emerged (Klonsky et al., 2018). This new generation of psychological models of suicidal behavior holds that the transition to action does not occur due to an increase in the intensity of ideation, but is guided by its own or different parameters (Joiner, 2005; Klonsky et al., 2021; Klonsky & May, 2015; O'Connor, 2011; O'Connor & Kirtley, 2018; Van Orden et al., 2010). Additionally, it should be noted that language is a vital issue in suicide prevention. Professionals must avoid perpetuating the stigma (and self-stigma) suffered by people with these types of experiences, with particular involvement of the media or the public exposure of personal narratives (Braun et al., 2023; Kirchner & Niederkrotenthaler, 2024; Niederkrotenthaler et al., 2022).

Beyond the Healthcare System: Recovering Social Determinants of Mental Health

People exposed to unfavorable social circumstances are more vulnerable to mental health difficulties and problems (Kirkbride et al., 2024). Recently, Pirkis et al. (2023) have argued for the need to focus on the social determinants associated with death by suicide and other suicidal and self-harming behaviors. These authors present a model that articulates how such social determinants interact with individual risk factors. Social factors are modifiable and, therefore, open a unique window of opportunity not only for suicide prevention but for psychological well-being. This model, based on the WHO's conceptual framework (2014), provides a multitude of social determinants or influences that impact suicidal behavior and self-harm, identifying strategic targets that should be incorporated into national suicide prevention plans (Pirkis et al., 2023): macroeconomic factors, public and social policies, laws, social values, or coverage of the national health system, among others. All of these depend on government decisions. The individual risk factors that interact with the previously described social factors would encompass demographic, contextual, family, or clinical aspects. Among both groups of factors, those related to socioeconomic status (education, employment, occupation, and income) are of particular importance. These strategies take the form of interventions in universal, selective, and indicated prevention, involving intersectoral actions that must be undertaken not only by the health sector but also by other sectors beyond health. Similarly, this model also emphasizes the importance of data monitoring on the impact of policies and other interventions, as well as strengthening the empirical evidence on their effectiveness. This implies collecting data to determine what interventions are being implemented, with which populations, and with what results.

Suicidal behavior prevention strategies include intervention levels in the social, community, interpersonal, and individual spheres (Pirkis et al., 2023; Platt et al., 2019; WHO, 2014). With timely, evidence-based and often low-cost interventions, suicides can be prevented. For example (Walsh et al., 2022), school-based suicide prevention interventions were associated with a 13% reduction in the likelihood of suicidal ideation (odds ratio [95% confidence interval] = 0.87 [0.78 - 0.96]) and a 34% reduction in suicide attempts (odds ratio [95% confidence interval] = 0.66 [0.47 - 0.91]). It is also interesting to consider the population attributable risk, an indicator representing the proportion of cases of a disorder in a population that can be attributed to a risk factor. Thus, for example, if a 100% effective intervention for suicidal ideation (considered as risk factor) is implemented, 33% of total suicides in adolescents could be avoided (Castellví et al., 2017).

Universal prevention is aimed at the entire population to raise awareness about the phenomenon of suicidal behavior, sensitize and reduce stigma, eliminate barriers to access to health care systems, promote help-seeking, mitigate the impact of crises, and enhance protective factors such as social support and coping skills. Some examples are universal school programs (Díez-Gómez et al., 2024), limiting population access to potentially lethal means, or providing guidelines for the media to offer responsible coverage. Suicide prevention and treatment plans, strategies, or protocols should not be just campaigns to detect and suppress "symptoms,"

but should help people in crisis face the real problems and dilemmas that life presents to them firsthand, providing them with the necessary individual and social resources. It is, therefore, a community and general approach (Al-Halabí & Fonseca-Pedrero, 2023a). Selective prevention is aimed at specific groups that are more vulnerable because they are in difficult situations or have few supports or resources, such as the prison population, homeless people (Calvo et al., 2024), victims of violence, migrants, drug users (Fonseca-Pedrero & Al-Halabí, 2024), or women during the perinatal period (Al-Halabí et al., 2021), among others. Finally, indicated suicide prevention strategies are aimed at people who show manifestations of suicidal behavior and who are, therefore, particularly vulnerable. Psychological treatment is, accordingly, a form of indicated prevention (Al-Halabí & Fonseca-Pedrero, 2023b). People with suicidal behaviors who need it should be properly referred to mental health professionals for a correct assessment and approach through specific psychological therapy, case management, frequent follow-up, skills training, or support groups. The scientific literature supports the use of psychological treatments such as cognitive-behavioral therapy and dialectical-behavioral therapy. Both treatments have been shown to have superior effects to usual care in reducing suicidal ideation and attempts through randomized clinical trials (National Institute for Health and Care Excellence [NICE], 2022). It is also worth noting that non-professional accompaniment, support, and surveillance of loved ones, and the daily contact and care of close ones can also play an important preventive role, either per se or in collaboration with the therapeutic approach.

As it is multisectoral, suicide and suicidal behavior prevention does not rely solely or mainly on mental health services, which would constitute only the indicated prevention of suicidal behavior, as mentioned above. Multiple institutions are more likely to come into contact with these people: educational centers, social services, primary care, companies, residences, prisons, media, or social networks, which must have specific prevention programs or strategies.

Regarding Universal School-based Programs for Suicide Prevention: Primum non Nocere

There are numerous studies that support that psychological interventions prevent mental health problems (Fonseca-Pedrero et al., 2023). In general, school mental health services seem to find a small to medium effect (g = 0.39) in reducing mental health problems. Previous work has found that effect sizes for universal, selective, and indicated interventions are g = 0.29, g = 0.67, and g = 0.76, respectively (Sánchez et al., 2018). A systematic review found that universal interventions in educational settings that targeted the entire classroom significantly reduced the odds of Suicidal thoughts and behaviors in young people by up to almost two-fold compared to those receiving no treatment (Kiran et al., 2024). However, and without detracting from the relevance of these studies, there is still a need to obtain a greater scientific corpus in the field of mental health promotion and prevention in the educational contexts, particularly when it comes to suicidal behavior in adolescents (Casares et al., 2024; Fonseca-Pedrero et al., 2024).

It is also worth noting that there is sufficient body of knowledge indicating that some school mental health interventions can cause iatrogenic harm (Foulkes & Stringaris, 2023). According to these authors, the potential benefits of school interventions can also be their weaknesses. This is particularly relevant for universal programs where all students are exposed to the same content. Thus, some adolescents might learn strategies or information that are irrelevant to them or, worse, that can actively cause harm. Such would be the case of increased internalizing "symptoms" compared to the control group found in some studies included in a meta-analysis on anti-bullying interventions (Guzman-Holst et al., 2022). It is also important to consider that there may be subgroups of adolescents who will experience harm from the interventions and that such an outcome may be masked when results are averaged (Montero-Marin et al., 2022). Although these types of results may seem surprising, there is already a well-established body of literature showing that public health interventions can cause harm to a group of people, including adolescents (Bonell et al., 2015; Hayes & Za'ba, 2022; Lilienfeld, 2007). In this scenario, Foulkes & Stringaris (2023) propose as an explanation that a relevant mechanism could be that interventions inadvertently encourage adolescents to reflect on and attend to negative thoughts and emotions. Similarly, if adolescents are encouraged to label their negative thoughts and emotions with "psychological or psychiatric labels," terminology common in school interventions, this could lead to changes in self-concept (e.g., "I have anxiety") and changes in behavior (e.g., avoidance) that ultimately increase distress and other discomforts during adolescence.

Furthermore, Foulkes and Stringaris (2023) also point to another possible relevant mechanism to explain iatrogenic harm, which would consist of the peculiar characteristics of development during adolescence. Adolescents are especially susceptible to peer influence, and precisely, interventions in schools are usually carried out in groups. This can facilitate adolescents influencing each other regarding negative moods and learning problematic behaviors from each other (sometimes known as "deviancy training"). Therefore, it is a reasonable hypothesis to think that encouraging adolescents to discuss negative thoughts, feelings, and behaviors in group settings (common in school programs) could lead to an increase in these experiences (Foulkes & Stringaris, 2023).

The panorama is not simple, but it cannot continue under the widespread assumption that mental health interventions are beneficial for all adolescents, nor can the possibility that some people may suffer harm as a result of such initiatives be ignored. The mechanisms by which this occurs are still not well known, but it seems reasonable to think that having well-evaluated quality work is at least a primary condition and a necessary starting point (see, for example, the demonstrated efficacy in preventing suicidal behavior in schoolchildren from the multicenter controlled and randomized study by Wasserman et al., (2015). Studies evaluating such interventions should report cases of deterioration and other adverse effects, as occurs with clinical trials. They should even have a plan for what to do with adolescents who are harmed by these sessions. Only in this way can the science of prevention and health promotion reach a satisfactory level of maturity.

Good Clinical Practices: A Move From a 'Risk-Focused' to a 'Safety-Focused' Culture

Suicidal behavior is plural-diverse and dynamic-fluctuating-interactive, extraordinarily personal, variable over time, and highly dependent on contextual elements (de Beurs et al., 2024; Kleiman

et al., 2017). Considering all this, assessment and intervention are inseparable processes, with the moment of assessment being especially crucial for the person to feel they are in a safe, trustworthy environment where they will not be judged (Zortea et al., 2020). This will favor help-seeking and engagement in the therapeutic process, which is a fundamental element for reducing suicidal ideation.

The clinical interview is the best method of assessing suicidal behaviors and cannot be separated from the intervention. It is not only about providing feedback to the person but also about reaching a shared vision that allows them to regulate their emotions and, from there, contemplate alternative solutions to death. Hawton et al. (2022) propose the formalization of an approach that relies on investing time in gaining therapeutic alliance rather than ticking boxes, leveraging this alliance to uncover unmet needs and identify modifiable risk factors, and building a collaborative care plan as the therapeutic assessment unfolds. A thoughtful, patient-centered assessment will take time and elicit substantial information, which can become unwieldy if not well organized. Here, reasons for living, life meaning, or connectivity deserve special mention. There is abundant research questioning the usefulness of predictions about imminent suicide risk and pointing to the difficulty of doing so accurately (Hawton et al., 2022). This issue of how to assess suicidal behavior is crucial, as it relates to one of the major advances in research in recent years. In the words of Mughal et al. (2023), we cannot miss the opportunity established by the guidelines of the new NICE (2022): it is time for psychological and social assessment, not risk assessment. This guidance clearly states that all people who have self-harmed should receive psychological and social care. The assessment should be carried out as soon as possible by a trained mental health professional to identify the circumstances of the episode and the person's strengths and needs. This assessment should be conducted with a sense of hope and optimism and should never be delayed or overlooked. As Mughal et al. (2023) point out, moving from a "risk-focused" culture to a "safety-focused" culture is a challenge for everyone, particularly for public services. But it is necessary to emphasize the therapeutic benefit of comprehensive and thorough assessments, rather than approaches that reduce individual experience to a risk category. All of this, of course, must be done through basic care values such as empathy, compassion, and non-judgmental attitudes. These care values also include self-care for professionals, both in the healthcare and social fields.

The review of the scientific literature allows us to state that psychological interventions are effective in reducing suicidal ideation and suicide attempts in the medium and long term. For the adult population, cognitive-behavioral therapy is the intervention that has received the most attention from researchers (Al-Halabí & Fonseca-Pedrero, 2023b; NICE, 2022; Turecki et al., 2019). Several meta-analyses and systematic reviews support that this therapy can reduce the presence of suicidal behaviors in adults, regardless of the diagnoses they have received (Sher & Oquendo, 2023; Witt et al., 2021).

The scientific literature is also consistent in showing that dialectical behavior therapy can reduce suicidal ideation, suicide attempts, and self-harm in people diagnosed with borderline personality disorder (Al-Halabí et al., 2024; Oud et al., 2018; Witt et al., 2021). However, there is no consensus on this when systematic reviews or meta-analyses examine its effectiveness regardless of the sample's diagnosis or the length of follow-ups. Nonetheless, there is consensus that this psychological therapy provides support and validation of people's suffering while promoting change strategies. Finally, the clinical intervention known as Collaborative Assessment and Management of Suicidality (CAMS) has received empirical support, although it has not yet reached the level of recommendation of the previous two treatments (Santel et al., 2023).

On the other hand, the brief intervention with the most empirical support for responding to suicidal crises is Stanley and Brown (2012) safety plan (Nuij et al., 2021; Stanley et al., 2018). The safety plan is a collaborative intervention that should complement any therapeutic process (NICE, 2022). The scientific literature suggests that this intervention is a beneficial tool to help the person reduce suicidal ideation in the short term and to be prepared for difficulties and risky situations, instilling hope in episodes of vulnerability and increasing their safety. Also, the so-called caring contacts is an intervention that was evaluated several decades ago and refers to the usefulness of the routine of sending brief and non-demanding messages that express concern and emotional support during follow-up to those who have been discharged from clinical care (Comtois et al., 2019; Inagaki et al., 2019).

Lately Rudd et al. (2022) published a narrative review of randomized clinical trials conducted in recent decades that provide a set of simple and effective clinical strategies for people with suicidal thoughts and attempts. The authors state that these strategies can (and should) be integrated into clinical practice regardless of theoretical orientation or intervention context (naturally, there would be some variations between a healthcare center, primary care, mental health, or emergency services). Thus, the scientific literature supports clinical recommendations around five domains outlined next:

- A process of informed consent and an initial dialogue emphasizing the importance of personal and shared responsibility as part of an effective collaborative treatment process.
- An explanatory model that helps the person understand the function of their suicidal behavior, enabling them to use regulation and self-care skills, rather than merely conceptualizing suicide instead of a symptom of a mental disorder or other diagnosis.
- A proactive approach to identifying and overcoming barriers to receiving assistance and to facilitating overall treatment adherence.
- The development of a specific plan for management of future crises or suicidal episodes.
- A specific plan for safe storage and limiting access to lethal means.

The Whole is Greater Than the Sum of its Parts

From a social and ecological perspective, multicomponent, multilevel, and complex interventions address the social determinants of suicidal behavior at multiple ecological levels. In high-income countries, complex interventions for suicide prevention are effective in reducing suicide rates compared to individual evidence-based strategies. This concept refers to the complexity of the intervention rather than a complex intervention. Although the combination of strategies within complex interventions has

gained importance in addressing the multifaceted nature of suicide, little is still known about what works, for whom, and what the underlying mechanisms of change are that enable the replication of effective programs and translate them to other settings and real-world contexts (Krishnamoorthy et al., 2022, 2023). An example of intervention could be Optimizing Suicide Prevention Programs and their Implementation (OSPI-Europe), which has five levels of interventions targeting suicide prevention (Harris et al., 2016). These include training for primary care (level one) and community-based (level three) professionals; a public health campaign (level two); support for patients and families (level four), and reducing access to lethal means (level five).

Complex interventions highlight the need to explore the interactions between their components. However, this has not yet been fully achieved in complex psychological (or behavioral) interventions (Harris et al., 2016). In this regard, two general aspects can be highlighted:

(1) Synergistic interactions (whether at one or several levels) achieve a greater impact than the sum of the effects of the interventions carried out in isolation. An example would be inviting press professionals to cover the start of an activity (e.g., a prevention program) and subsequently having the media show interest in the program's effectiveness.

(2) Catalytic interactions (whether at one or several levels) are those that stimulate additional activities that add value to the planned activities but are external to them. They occur when different levels of intervention, or even the program as a whole, act as catalysts to stimulate related activities carried out by people or organizations outside the intervention teams. An example could be initiating suicide prevention training through the launch of a public awareness campaign, which then stimulates complementary activities developed by professionals with a shared interest in suicide prevention (e.g., training courses).

It is extremely interesting to analyze and understand the potential synergistic effects of multilevel interventions, as well as to provide an estimate of the effect size of suicide prevention interventions. In this regard, Hofstra et al. (2020) found a significant effect of suicide prevention interventions on deaths (d = -0.535) and suicide attempts (d = -0.449). As for the synergistic effect of multilevel interventions, a significantly greater effect was shown related to the number of levels of the intervention. Interventions incorporating a single level found a small effect size (d = -0.3), while two-level interventions had a moderate effect size (d = -0.5) and larger in three-level interventions (d = -0.8). These findings allow public managers to make informed decisions and highlight the added value of prevention activities that should be included in planning and how they could be maximized. Future research should focus on multilevel interventions due to their greater effects and synergistic potential. It is noted that the combined effect of two (or more) intervention components is greater than the sum of the two parts provided in isolation. As the famous axiom says, it seems clear that the whole is greater than the sum of its parts.

Everyone's Business: An Opportunity not to be Missed

In this *Special Issue*, the reader will find scientific evidence on the social and psychological factors involved in preventing suicidal behavior in various populations. However, isolated strategies do not make a real impact in reducing the overall rates of this human phenomenon. Thus, prevention policies and programs are needed. All these actions must be framed within the need to implement a true national strategy for promoting mental health and social well-being that goes beyond the healthcare system. It would involve developing multisectoral policies, plans, and actions based on coordination, cooperation, and shared responsibility.

On the other hand, suicidal behavior is still not well analyzed or understood, and myths and taboos remain significant barriers to its prevention (WHO, 2014). Its delimitation, classification, etiology, prevention, approach, and postvention is a difficult task with no an easy solution. There is room for improvement. It is essential to emphasize the reduction of stigmatization, promoting psychoeducation that reduces myths and false beliefs related to mental health and suicidal behavior, as well as raising awareness and seeking help whenever necessary. In any case, no book or article, no matter how comprehensive, can predict all the contingencies a psychology professional will have to deal with when faced with the task of helping people with suicidal behavior. Consequently, we need to be flexible and, above all, understand why we do what we do.

This highlights the importance of research to achieve good professional competencies and specific training and education in managing suicidal behavior from any intervention level (educational, community, social, or health), as all are involved in prevention. Such competencies must include scientifically backed choices, without forgetting the importance of a kind and empathetic attitude. Note that the professional help proposed here does not focus so much on deactivating a typical psychopathological diagnosis (depression, personality disorders, etc.) or repairing "broken" mechanisms. The aim is to help improve the existence of people struggling to stay afloat in the face of the harassment of death wishes. This must be done through a collective scaffolding in which the most vulnerable can ask for help when they need it, as well as orient themselves towards life circumstances worth living.

Author Contributions

Susana Al-Halabí: Conceptualization, Writing - Original Draft, Writing - Review & Editing. **Eduardo Fonseca-Pedrero**: Conceptualization, Writing - Original Draft, Writing - Review & Editing.

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The authors declare that there is no conflict of interest.

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