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Prevenção do suicídio na escola na perspectiva da Teoria Interpessoal-Psicológica do Suicídio: uma revisão de literatura

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Resumo
O suicídio é um tema já analisado por diferentes frentes da ciência e da sociedade e sobre o qual não há consenso ou respostas definitivas – algo próprio de um fenômeno tão complexo. Na esfera educacional, o tema ganhou relevância pelo crescente número de tentativas e mortes por suicídio na população infanto-juvenil. Assim, por meio da pesquisa bibliográfica e revisão de literatura, este estudo objetivou relacionar a Teoria Interpessoal-Psicológica do Suicídio com a temática da prevenção no ambiente escolar. Esta teoria indica que o pertencimento frustrado, a percepção de ser um peso, e a capacidade para autoagressão são fatores que ao interagirem entre si compõem risco aumentado para o suicídio. Conclui-se que a Teoria Interpessoal-Psicológica do Suicídio pode contribuir para um olhar embasado em uma teoria aplicável: o pertencimento e a percepção de que a própria vida vale são construtos psicossociais que indicam amplos caminhos para a prevenção no contexto educacional.

Palavras-chave: Educação em saúde. Saúde mental na escola. Suicídio na adolescência. Formação de professores.

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Suicide prevention at school from the perspective of the interpersonal-psychological theory of suicide: a literature review

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Abstract
Suicide is a theme already analyzed by different fields in science and society, and about which there is no consensus or definitive answers - something that befits such a complex phenomenon. In the educational sphere, the theme has gained relevance due to the growing number of suicide attempts and deaths among children and teenagers. Thus, through bibliographic research and literature review, this study aimed to relate the Interpersonal-Psychological Theory of Suicide to the prevention issue in the school environment. This theory indicates that thwarted belongingness, self-perception as a burden, and the acquired capability to self-harm are factors that when interacting with each other constitute increased risk for suicide. We conclude that the Interpersonal-Psychological Theory of Suicide can contribute to a view based on an applicable theory: belongingness and the perception that one's own life is worth are psychosocial constructs that indicate broad paths for prevention in the educational context.

Keywords: Health education. Mental health at school. Suicide in adolescence. Teacher training.

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La prevención del suicidio en la escuela desde la perspectiva de la teoría interpersonal-psicológica del suicidio: una revisión de literatura

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Resumen
El suicidio es un tema ya analizado por diferentes frentes de la ciencia y la sociedad y sobre el que no hay consenso ni respuestas definitivas, algo propio de un fenómeno tan complejo. En el ámbito educativo, el tema ha cobrado relevancia debido al creciente número de intentos de suicidio y muertes por suicidio en la población infanto-juvenil. Así, mediante la investigación bibliográfica y la revisión de la literatura, este estudio tuvo por objetivo relacionar la Teoría Interpersonal-Psicológica del Suicidio con el tema de la prevención en el ámbito escolar. Esta teoría indica que la pertenencia frustrada, la percepción de ser una carga y la capacidad de autolesión son factores que al interactuar entre sí conforman un mayor riesgo de suicidio. Se concluye que la Teoría Interpersonal-Psicológica del Suicidio puede contribuir a una visión basada en una teoría aplicable: la pertenencia y la percepción de que la propia vida vale la pena son constructos psicosociales que indican amplias vías de prevención en el contexto educativo.

Palabras clave: Educación para la salud. Salud mental en la escuela. Suicidio en la adolescencia. Formación de profesores.

Introduction

Suicide is a significant public health issue worldwide and has increasingly drawn the attention of health authorities in various parts of the globe. Despite the growing number of studies on suicidal behavior in recent years, further investment in this field of research is still necessary (BOTEGA, 2015; HAWTON; SAUNDERS; O'CONNOR, 2012; WORLD HEALTH ORGANIZATION [WHO], 2014).

In Brazil, approximately 11,000 people take their own lives each year. Among the population aged 15 to 29, suicide ranks as the fourth leading cause of death (BRASIL, 2017a). The Brazilian mental health care model has focused more on intervention than on prevention, which impacts the planning and funding of actions and projects in this area (SCAVACINI, 2018). Furthermore, the significant regional variation in suicide mortality rates across Brazil underscores the need to assess local characteristics when planning public policies for mental health promotion or suicide prevention initiatives.

Law No. 13,819, dated April 26, 2019, establishes the National Policy for the Prevention of Self-Harm and Suicide in Brazil (BRASIL, 2019) but has yet to be regulated. Despite the significance of this policy, additional initiatives are necessary. In order to contribute to the understanding of suicidal behavior, this work presents the Interpersonal-Psychological Theory of Suicide (JOINER, 2005), which is not widely disseminated in Brazil (LYRA, 2018; PLUTARCO, 2019), and discusses it as a theoretical foundation for preventing youth suicide in the educational context.

The perspective adopted in this work is biopsychosocial, viewing suicidal behavior as a behavioral process that requires the involvement of various actors and social fields for its prevention. This spans from the state and its public policies, including the training of personnel in health, education, public safety, social security, and other areas, to the community and individual levels (BERTOLOTE, 2012; BOTEGA, 2015; JOINER, 2005; SCAVACINI, 2018; WHO, 2000, 2006, 2014).

Suicidal Behavior: What Are We Talking About?

Suicide is a phenomenon present in all regions of the world and has been understood through various religious, moral, and cultural lenses, making it a subject of interest across

multiple fields (BERTOLOTE, 2012). The field of study focused on suicide is known as suicidology. This area is characterized by more questions than answers, and the ability to predict suicide today is not significantly better than it was 50 years ag (O'CONNOR; KIRTLEY, 2018).

Conceptually, suicide is the deliberate and intentional act of causing one's own death, regardless of the motivation or whether it is impulsive or planned (BERTOLOTE, 2012; BOTEGA, 2015; WHO, 2014). The Ministry of Health indicates that self-inflicted injuries and suicidal behavior are "complex and multifactorial phenomena, with social, economic, cultural, biological factors, and personal life history as determinants" (BRASIL, 2017b, p. 10). Understanding suicide as a public health issue, despite being an individual expression, has allowed the topic to be placed on the national and international public agenda (BERTOLOTE, 2012).

Suicidal behavior is commonly viewed as a continuum ranging from suicidal ideation to attempts, which may culminate in completed suicide (BOTEGA, 2015; PINHEIRO, 2015; WERLANG; BORGES; FENSTERSEIFER, 2005; WHO, 2014). The intentionality of the act and the clarity of the person committing it should not be overestimated in the broader understanding of this phenomenon (BOTEGA, 2015). Suicidal ideation encompasses both fleeting thoughts of a desire to die and fixed ideas about ending one's life (BOTEGA, 2015). Regarding suicide attempts, although there are no official records, they are estimated to exceed the number of deaths by suicide by at least tenfold (BOTEGA, 2015).

At this point, it is important to note that when discussing suicide, expressions like "commit suicide," "suicidal person," "successful suicide," and their variants should be avoided, as they carry a pejorative connotation that associates the act with crime or sin, implies a fixed trait rather than behavior, and entails an inappropriate moral judgment that may relate suicide to an "act of courage." Such language can increase the risk of contagion, as will be explained further. Instead, it is recommended to use expressions like "die by suicide," "take one's own life," "attempt suicide," "completed suicide," "kill oneself," and their variants.

Suicidal behavior has been framed in terms of risk and protective factors, with studies more commonly correlating risk factors (BOTEGA, 2015). Benincasa and Rezende (2006, p. 94) define risk factors as "elements with a high probability of triggering or being

associated with the triggering of an undesirable event, not necessarily a causal factor," arguing that harmful health behaviors can be mitigated through educational policies. Protective factors, on the other hand, are personal or social resources that lessen or neutralize the impact of risk factors.

Linked not only to the risk of death, suicidal behavior is associated with multiple factors social, economic, cultural, biological, and personal that can also trigger other dysfunctional behaviors or contribute to the development of mental disorders. Joiner (2005) and Botega (2015) suggest that suicidal ideation and previous attempts are the most significant risk factors for suicide, even when considering differences between individuals with ideation and those who die by suicide (ARAÚJO; VIEIRA; COUTINHO, 2010). Mental disorders, social isolation, family conflicts, unemployment, and physical illnesses are other widely noted risk factors in studies (VAN ORDEN et al., 2010). As it pertains to epidemiological correlation, the lists of risk and protective factors presented in the literature should be viewed as indicative rather than exhaustive or diagnostic.

While the association between suicide and mental disorders is high, other variables are involved in suicidal behavior (WHO, 2006, 2014; BRASIL, 2021). Even though mental disorders are significant risk factors for suicide, they should not be considered in isolation or used as the sole criterion for risk assessment. After all, not everyone with a mental disorder exhibits suicidal behavior, and conversely, individuals without mental disorders also attempt suicide and die by suicide (VAN ORDEN *et al*., 2010).

Thus, suicidal behavior is understood through a biopsychosocial health approach, regarded as a complex human behavioral process that is multifactorial and multidetermined, in which biological, psychological, social, cultural, economic, and gender factors, among others, interact in the development of the phenomenon (BOTEGA, 2015; BRASIL, 2017b; HAWTON et al., 2012; JOINER, 2005; WHO, 2014). In this sense, it is essential to move beyond the biomedical perspective that tends to view this phenomenon solely as a result of mental disorders. Nor is it merely an individual issue, as is commonly believed in public perception. Each death by suicide also speaks to the collective, the conditions of existence, and the shared world, as we are relational beings.

omprehensions about Suicide: From Durkheim to Joiner

Émile Durkheim (1897/1987) was the first to develop a comprehensive systematic model of suicide, asserting that suicide rates reflect the mental health level of a population. Based on the analysis of suicide rates in several European countries, his theory focused on the relationship between the individual and society. According to Durkheim, within each social group, there is a specific tendency toward suicide that cannot be explained "either by the organic-psychic constitution of individuals or by the nature of the physical environment... it necessarily depends on social causes and constitutes, in itself, a collective phenomenon" (DURKHEIM, 1897/1987, p. 127).

Based on this understanding, Durkheim established four social types of suicide: 1) egoistic: in which individuals exhibit low integration within their social group, resulting from excessive individualization; 2) altruistic: contrary to egoistic suicide, altruistic suicide occurs when an individual, being overly integrated into society, sacrifices their life for it; 3) anomic: characterized by the way the individual is connected to society and how it regulates individuals in a maladaptive manner. Unemployment and divorce, among other situations where individuals experience loss and lack of perspective, are examples of this type; and finally, 4) fatalistic: in contrast to anomic suicide, this occurs when there is a high level of societal regulation over the individual, a high degree of submission to rules, where there is no expectation of change examples of this type would include the suicides of prisoners and slaves. Durkheim's work has faced much criticism for overemphasizing society at the expense of individual aspects, but his contribution to the study of suicide is undeniable.

Years earlier, Karl Marx (1846/2006, p. 23), while evaluating the role of social and economic organization in suicide, stated that the number of suicides "should be considered a symptom of the inadequate organization of our society." He argued that while misery is the main cause of suicide, being present across all classes, it is impossible to indicate a single determining cause for suicide or to assume that experiences, feelings, or temperaments are the same for everyone (MARX, 1846/2006).

Although Marx's text is not particularly significant in suicidology or even within Marxist literature (ARAÚJO et al., 2010), it is evident that both Marx and Durkheim, from different perspectives, recognize a social determination of suicide and emphasize that this phenomenon is not unnatural; rather, it is intrinsic to human society.

While the cited theories leaned towards the social aspect of suicidal behavior, the alienists (the term used for psychiatrists at the time) of the early 19th century shifted the blame for self-inflicted death to the individual. By associating "suicidal tendencies" with an individual's predisposition to exaggerate their suffering in difficult life situations, they reinforced the religious approach that viewed melancholy and the propensity for suicide as morally condemnable, categorizing them within the realms of madness and illness (MINOIS, 2018; SCAVACINI, 2018).

In the 20th century, Sigmund Freud presented a psychodynamic explanation for suicide through the death drive, which opposed the life drive in cases of suicide (MINOIS, 2018). Simultaneously, other theories were developed, indicating the complexity of this act. Beginning in 1980, starting with Edwin S. Shneidman's cubic model of suicide in 1985, at least 12 theoretical models about suicide began to emerge, pointing to various factors that lead to suicidal ideation and behavior (O'CONNOR; PORTZKY, 2018). These explanatory models advanced the differentiation between suicidal ideation and attempts and death by suicide, as well as the analysis of the conditions or factors associated with this transition, enabling the development of applied studies and the planning and evaluation of more effective interventions at all levels of prevention (O'CONNOR; PORTZKY, 2018). The Interpersonal-Psychological Theory of Suicide, which will be described next, is one of these models (JOINER, 2005; VAN ORDEN *et al*., 2010).

The Interpersonal-Psychological Theory of Suicide

The Interpersonal-Psychological Theory of Suicide, elucidated in Thomas E. Joiner's book Why People Die by Suicide (2005) and updated by Van Orden et al. (2010), is a comprehensive model that frames the ideation-to-action process, distinguishing factors associated with suicidal ideation from those related to the execution of a suicide attempt or completed suicide (JOINER, 2005). Historically, theories of suicide did not specify the conditions that differentiate ideation from attempts and deaths by suicide. Therefore, the main innovation and contribution of the Interpersonal-Psychological Theory of Suicide lies in its formulation of this framework and its identification of the psychosocial

characteristics involved in the development of suicidal behavior (O'CONNOR; PORTZKY, 2018).

Building on the knowledge produced by theorists such as Émile Durkheim, Edwin Shneidman, Aaron T. Beck, Roy Baumeister, and Marsha Linehan, along with propositions from economics and genetics, Joiner (2005) presents the Interpersonal-Psychological Theory of Suicide based on empirical evidence. The theory posits that people die by suicide because they can (are capable of) and because they want to (VAN ORDEN et al., 2010). It distinguishes three factors that, when combined, significantly increase the risk of developing suicidal behavior (BECKER; FOSTER; LUEBBE, 2020; JOINER, 2005; LYRA, 2018; PLUTARCO, 2019; VAN ORDEN et al., 2010). These factors are: 1) thwarted belongingness, which indicates an experience of isolation, loneliness, and disconnection from others; 2) perceived burdensomeness, which refers to the feeling of being a burden to others or to society; and 3) acquired capability to self-harm, which is the learned ability to self-harm through repeated exposure to painful and/or fear-inducing experiences that lead to habituation to pain or fear. The first two factors are related to ideation, while the last is understood as a condition for the transition from ideation to attempt, which may or may not result in death.

Regarding the third factor, without dismissing genetic or neurobiological aspects, Joiner (2005) argues that the capacity for self-harm is learned and acquired through life experiences. This is because, evolutionarily, natural selection processes have shaped the fear system (escape/avoidance) for the defense and preservation of life (VAN ORDEN et al., 2010). Thus, this "capacity for suicide" relates to direct or indirect exposure to situations of violence and self-harm, such as self-injury without suicidal intent and previous suicide attempts, as well as other experiences that lead to habituation and increased tolerance to physical pain and reduced fear of death (JOINER, 2005; VAN ORDEN et al., 2010). A history of accidents or medical treatments that lead to repeated exposure to pain, a lifestyle with exposure to risks like drug use, a history of physical or sexual abuse, and certain mental disorders such as anorexia nervosa and borderline personality disorder which are associated with self-harm behaviors are additional examples.

Furthermore, the planning and preparation for suicide (such as imagining one's suicide or progressively taking preparatory actions) can also lead to habituation through

cognitive processes and mental imagery, serving as another way to acquire the capacity for self-directed violence (VAN ORDEN et al., 2010). Joiner (2009) highlights this learning as one of the fundamental, though not sole, factors in the execution of a suicide attempt and completed suicide. However, this acquired learning and capacity for suicide does not result in the desire to die. For that, interaction between the first two factors is necessary, as will be described next.

According to Joiner (2005, 2009), the desire to die by suicide arises from the experience of thwarted belongingness - feeling lonely and alienated from others - and the perception of being a burden - the idea that "it would be better for everyone if I were dead." These are two distinct but related constructs. For the youth population, for instance, impoverished family relationships seem to significantly contribute to the development of suicidal behavior (HAWTON et al., 2012). Furthermore, there is a certain difficulty in distinguishing between the desire to die and the desire to temporarily escape an intolerable situation or state of suffering (BOTEGA, 2015; HAWTON et al., 2012). This distinction has been observed by the author of this work during interactions with adolescents and young individuals presenting suicidal ideation in a school setting.

Belonging is a dynamic cognitive state influenced by intra- and interpersonal factors, involving frequent interaction and the constant presence of reciprocal care in relationships. It can be thwarted in situations of rupture of significant relationships, such as those with family, friends, or other individuals (JOINER, 2005; VAN ORDEN et al., 2010). In experiences of isolation, loneliness, or rupture of meaningful relationships, there are usually interpersonal difficulties that may be explicit or not to the others involved. Examples of situations where feelings of non-belonging can develop include parental separation, migration, and psychological violence. This is a dynamic experience that can change over time and across relationships, and it is based on the observation that social isolation is one of the strongest and most reliable predictors of cases of ideation, attempts, and completed suicides (VAN ORDEN *et al*., 2010).

The perception of being a burden to others encompasses two dimensions of interpersonal functioning: 1) beliefs that the "self" is so flawed that it becomes a responsibility for others, and 2) affectively charged cognitions filled with self-hatred (VAN ORDEN et al., 2010). This perception can be related to low self-esteem, a sense of lack of control over life events, frustrations regarding performance in different areas of life, and

feelings of guilt and shame. This sense of "burden" may not be perceived by others, as it is an experience felt by the individual. The significant difference between parental expectations and a child's or adolescent's perception of their possibilities, unemployment, and the presence of physical illnesses are situations closely related to this aspect, which can be exacerbated in the presence of depressive episodes (JOINER, 2005). Like thwarted belongingness, the perception of being a burden is also a dynamic cognitive state and a dimensional phenomenon, varying over time and according to relationships (VAN ORDEN et al., 2010).

From a prevention perspective, when any of the three factors in the Interpersonal-Psychological Theory of Suicide are substantially reduced, the risk of suicide is consequently diminished. However, considering that the acquired capability for suicide is not easily changed, it is the psychosocial factors that prevention and intervention can effectively target (JOINER, 2009), and these are areas where the educational context can contribute.

Suicide Prevention in the Educational Context

Suicide prevention actions within the school environment are not limited solely to this topic; they encompass any actions that relate to reducing risk factors and strengthening protective factors, targeting students, professionals, and even the community. For example, schools can implement initiatives aimed at promoting self-esteem, self-efficacy, and cognitive flexibility, while simultaneously reinforcing emotional bonds within the support network so that students have someone to turn to when they struggle to cope with their problems. Social skills behaviors intended to resolve and prevent interpersonal issues while maintaining social relationships can also be developed within schools in a cross-cutting manner (PEREIRA et al., 2018). These skills contribute to enhancing interpersonal relationships, assertive communication, and practicing empathy.

Additionally, feeling capable and competent specifically in the sense of contributing to something or someone can be very protective (JOINER, 2005). There are various psychosocial aspects with which schools can assist. Encouraging cooperative relationships among students and between students and teachers, fostering autonomy by supporting the student, promoting self-awareness and understanding of their relationships, self-care, and

self-esteem, as well as being attentive to social isolation, bullying, violence, or harassment, strengthening relationships with families, recognizing warning signs as risks rather than "just phases of adolescence," and teaching socio-emotional skills, problem-solving strategies, coping mechanisms, and help-seeking behaviors are some of the possibilities (PEREIRA et al., 2018; WHO, 2000, 2006).

Regarding programs, projects, or actions for suicide prevention in the school context, Joiner (2009) highlights the promotion of belonging strategies as successful interventions. An example of such strategies is identifying at-risk students and implementing actions that foster their sense of belonging within the community (peers, adults, family, and others). For this purpose, Pinheiro (2015) argues that school staff must have at least a basic understanding of how to identify warning signs of suicidal behavior and what actions to take in response. Numerous resources are freely available online that provide this knowledge (see, for example, ASSOCIAÇÃO BRASILEIRA DE PSIQUIATRIA [ABP], 2014; PRADO, 2019; WHO, 2000, 2006). Particularly among the youth population, these signs are often overlooked by family members, educators, and even healthcare professionals, who may dismiss them as "teenage crises" or "attention-seeking behavior." Consequently, many young people only receive help when they face high-risk situations or when there are recurring attempts often resulting in serious health consequences.

Specifically for the youth population, Hawton et al. (2012) recommend the following prevention strategies: training programs focused on skills and psychological well-being in schools; gatekeeper training (e.g., for teachers and peer groups); mapping to identify individuals who may be at risk; encouraging help-seeking behavior; promoting online sources of help; reducing stigma associated with mental health issues and seeking help; conducting psychosocial interventions for adolescents at risk of suicide (e.g., adolescents with depression, those who have experienced abuse, children who have run away from home); providing psychosocial intervention for adolescents engaging in self-harm; and improving mental health systems in terms of access and quality of services, particularly in underdeveloped or developing countries.

Training school professionals to identify students exhibiting suicidal behavior, teaching students how to assist their peers with problems, and implementing actions that promote mental health while reducing stigma regarding mental illnesses are effective for suicide prevention. Furthermore, educating individuals to debunk myths about suicide,

along with observing warning signs and knowing how to seek help, is crucial for community-level prevention. Clarifying how to assist someone vulnerable, teaching how to listen attentively and empathetically (i.e., being present, approaching authentically), and elucidating ways to cope with a suicide attempt or the grieving process are also important, as pointed out by the World Health Organization (WHO, 2006).

Bertolote (2012) notes that educational and informational programs in schools that focus on promoting competencies and reinforcing social skills have demonstrated effectiveness and are relevant strategies for suicide prevention - aligning with the psychosocial aspects of the Interpersonal-Psychological Theory of Suicide. However, the author also cautions that there is evidence indicating that school programs solely focused on warning signs of suicide can be harmful when they adopt an inappropriate approach. For instance, highlighting lethal methods or addressing the topic in a stigmatizing or romanticized manner, which is not educational and fails to provide information about alternative help, can be detrimental (BERTOLOTE, 2012).

The best approach to suicide prevention is through collective and intersectoral work, in collaboration with community agents (WHO, 2000). Therefore, it is essential to extend beyond the confines of psychiatry and psychology, involving the training of nurses, social workers, educators, community agents, and others to identify, manage, and appropriately refer individuals at risk of suicide.

This multisetorial and transdisciplinary intervention is acknowledged as a challenge for the reality of public schools in Brazil. This is due to factors such as the organizational structure available in schools, the number of professionals, the demands and workload, the lack of qualified training (or adequate information) to address this issue or other related mental health topics, and even the culture and organization of the school. These variables need to be identified so that the difficulties can perhaps be minimized, allowing the school to become a protective space for life. Furthermore, one of the most critical aspects of suicide prevention is identifying and recognizing which students are suffering and at risk of suicide (WHO, 2000).

In their analysis of the literature on factors associated with suicidal behavior in children up to 14 years old, Sousa et al. (2017) conclude that family conflicts, school-related problems including bullying and poor academic performance, impulsivity, and depression are associated with an increased risk of suicide in childhood. Conversely, they

highlight that when these or other vulnerability factors related to the child's life history are identified and the child receives appropriate care and treatment, there is a lower risk of developing suicidal behavior. The authors also note that it is common for children to express their desire to die in the days and months leading up to a suicide attempt, often through notes. They cite cases where farewell letters were written in school activities submitted to teachers, with two of them being grammatically corrected by the teachers but receiving no psychosocial follow-up from the school.

This analysis of childhood suicide and its recommendations regarding attention to direct or indirect verbal manifestations of the desire to die, as well as the emergence of interest in death and changes in behavior, also applies to adolescents and young adults. In summary, any change that affects the adolescent's performance, attention span, or behavior should be taken seriously.

Given the time they spend with students, teachers are often good sources of information regarding their students' mental health issues. Therefore, when observing signs of suicidal behavior, school professionals can listen to and support the student or seek assistance from the school's pedagogical team. When appropriate, referring the student to the Psychosocial Care Network and informing their parents or guardians can contribute to ensuring the student receives appropriate assessment and support. Furthermore, upon returning to school after being away for health treatment, it is crucial that the student is welcomed back in a supportive and appropriate manner (WHO, 2000).

There are various materials that extensively list the most common warning signs related to suicidal behavior (see, for example, World Health Organization (2000, 2006); Brazilian Psychiatry Association (2014); and Prado (2019). For the sake of conciseness, we will not reproduce them here. We recognize the relevance and immense utility of these materials, but we also emphasize that this is not an exhaustive list, reminding that each student is a unique individual who may not display any of the listed signs, which reinforces the need for active and non-judgmental listening.

In common understanding, there is a belief that asking about suicidal ideation can induce the act, which is why, even when there is suspicion, it is often common not to inquire. However, studies show that asking about suicidal ideation does not increase the risk. On the contrary, it can actually contribute to prevention by allowing for the necessary management and care (HAWTON et al., 2012; WHO, 2000). Borges and Werlang (2006)

emphasize that the presence of suicidal thoughts in adolescence does not necessarily mean that there will be a completed suicide. However, when these thoughts are related to affective disorders, especially depression, identifying and assessing risk is an important prevention strategy, necessitating that family members, friends, teachers, and health professionals remain vigilant to the behaviors and feelings of adolescents.

Baggio, Palazzo, and Aerts (2009) highlight the school as a strategic location for suicide prevention, noting that patterns of relationships and risk behaviors are also reproduced by students in this environment. The possibility of promoting and protecting students' health lies in the early identification of risk situations to prevent worsening. The authors indicate that adverse family relationships, isolation, peer aggression, and depressive symptoms are factors related to the prevalence of suicidal planning among adolescents, emphasizing the importance of teachers in identifying these issues and addressing them with young people (BAGGIO et al., 2009). Furthermore, school failure is also seen as both a risk factor and a warning sign.

It is considered that the organization of teaching work, approval and retention criteria for students, assessment of learning, and the school climate and culture are critically important. They are also related to the production of mental health and emotional suffering among professionals and students. Therefore, changes in school culture aimed at the psychological well-being of the school community can be significant and contribute to reducing stigma surrounding mental illness and encouraging students to seek help (BORGES; WERLANG, 2006; HAWTON et al., 2012). Given the increase in cases of attempts and deaths from suicide among children and adolescents in recent years and the fact that suicide can be prevented (BORGES; WERLANG, 2006; BRASIL, 2017b; WHO, 2014), it is necessary to plan and develop actions for preventing suicidal behavior within the educational context.

The studies presented support the findings of Joiner (2005) and Van Orden et al. (2010) in their exposition of the Interpersonal-Psychological Theory of Suicide by highlighting the need for promoting healthier interpersonal relationships, help strategies, and psychoeducation. Thus, it is essential to critically rethink educational practices and the school environment that contribute to competitiveness and individualism, so that instead of promoting or exacerbating suffering, the school becomes a space for the development of

students in the processes of socialization, belonging, and the recognition that their lives are worth more than their death.

Final considerations

The nuances of suicidal behavior are not necessarily visible, but they are real and deeply painful demanding a consistently attentive and humane perspective, as well as active and interested listening. For a complex and multifactorial phenomenon like suicide, simple or isolated responses are not possible. The socioeconomic, cultural, psychological, biological, and clinical aspects involved in suicidal behavior require a challenging choice about the vantage point from which to view this phenomenon, ensuring that important information is not overlooked and that the topic is neither unintelligible nor overly simplistic. However, this should not hinder the pursuit of ways to understand and intervene.

The Interpersonal-Psychological Theory of Suicide can contribute to a perspective grounded in an applicable theory: the constructs of belonging and the perception that one's life has value indicate broad pathways for prevention in the educational context. Viewing suicide as a complex human behavior rather than a disease (or as resulting from a mental disorder) implies perceiving the individual not as a potential "suicidal person," but as someone who is suffering and who can and deserves access to alternative ways of coping with that suffering.

Given the gap in Brazilian academic production that presents a biopsychosocial perspective on suicide prevention in the school environment, this work suggests that within the complex web surrounding suicidal behavior, there is also the necessity, possibility, and potential to act in prevention through various psychosocial variables related to the desire to die. However, this review also has limitations as it does not systematically encompass works from other theoretical perspectives. Furthermore, it was written prior to the COVID-19 pandemic, meaning that the specificities and challenges of the pandemic context, as well as any new research that may have emerged during this interim, have not been considered.

In summary, contemplating suicide prevention involves thinking about life, its forms, and its conditions. Not only does Brazilian suicidology need to advance in studies on

prevention and postvention related to the school environment, but practices that promote mental health within the school community also need to be consolidated, evaluated, and more widely shared within our context.

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