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SUICIDAL BEHAVIOUR: PSYCHOLOGICAL, SOCIAL, AND EXISTENTIAL DETERMINANTS AND THEIR IMPLICATIONS FOR PREVENTION

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Abstract

Introduction. Suicidal behaviour is a major public-health concern shaped by interacting psychological, interpersonal, social, cultural, and existential factors. Explanations based solely on psychiatric diagnosis or a single adverse event fail to capture the pathways from distress to suicidal ideation and from ideation to action.
Aim. This narrative review synthesises selected psychological, psychodynamic, existential, and sociological approaches to suicidal behaviour, identifies clinically relevant protective factors, and examines the bioethical tension between suicide prevention and socially legitimised forms of assisted dying.
Materials and methods. A focused narrative search of peer-reviewed literature and citation contexts was conducted and updated in July 2026. Searches addressed the main psychological, interpersonal, social, protective, and end-of-life concepts considered in the review. Systematic reviews, meta-analyses, recent empirical studies, official statistics, and seminal theoretical works were prioritised. Evidence was synthesised thematically without quantitative pooling.
Results. Psychological pain, hopelessness, burdensomeness, thwarted belongingness, defeat, and entrapment are important but non-specific correlates of suicidal ideation. Additional volitional factors influence progression to action. Narcissistic vulnerability may increase risk when shame, humiliation, affective dysregulation, and interpersonal rupture converge. Meaning, social support, treatment, physical activity, and some forms of spiritual engagement may be protective, but their effects are context-dependent. Assisted-dying practices must be distinguished by agency, intention, capacity, clinical indication, and safeguards.
Conclusions. Effective prevention requires coordinated clinical, relational, and population-level responses that reduce psychological pain, restore connection and realistic hope, and strengthen accessible mental-health, social, and palliative care. End-of-life policy should preserve conceptual clarity and monitor the effects of changing eligibility criteria without replacing empirical scrutiny with either alarmist or dismissive rhetoric.

Keywords: **psychache, hopelessness, thwarted belongingness, social integration, meaning in life, assisted dying, palliative care**

INTRODUCTION

More than 720,000 people die by suicide worldwide each year, and suicide was the third leading cause of death among people aged 15-29 years in 2021 [1]. In Czechia, 1,561 deaths were classified as suicide in 2024, corresponding to 14.3 deaths per 100,000 inhabitants. This represented an increase of 308 deaths compared with 2023. The Czech Statistical Office cautions that much of the increase reflected a new validation procedure using police and health-information data, through which some deaths initially recorded as accidents or events of undetermined intent were reclassified [2]. The 2024 figure should therefore not be interpreted as a straightforward year-on-year change in behaviour.

Suicidal behaviour develops through a dynamic interaction of biological vulnerability, psychological pain,

psychiatric symptoms, interpersonal experience, social conditions, cultural meanings, and access to support. Contemporary models also distinguish the emergence of suicidal ideation from the transition to an attempt: factors that explain why a person thinks about death do not necessarily explain why, when, or whether that person acts [3]. This distinction limits simplistic causal accounts and supports layered prevention across clinical, relational, institutional, and population levels.

The original theoretical core of this article connects suicidality with love, meaning, narcissistic vulnerability, and social integration. These perspectives remain valuable when interpreted carefully and placed alongside empirical research. Philosophical concepts must not be converted into clinical labels, and suicidal persons should not be characterised as morally deficient or inherently oriented towards death. In many crises, the wish expressed is primarily a wish to end intolerable suffering rather than an unambiguous wish for non-existence [4].

AIM

The article aims to synthesise psychological, psychodynamic, existential, and sociological accounts of suicidal behaviour; identify relevant protective factors and implications for prevention; and briefly examine the ethical boundary between suicide prevention, assisted dying, and other end-of-life practices.

MATERIALS AND METHODS

A focused narrative review was undertaken. Targeted searches in the scite scholarly literature and citation index were supplemented by official World Health Organization, Czech, Dutch, Belgian, and Canadian sources. Search concepts combined terms relating to suicide and suicidal ideation with psychache, hopelessness, belongingness, narcissism, family support, spirituality, physical activity, euthanasia, physician-assisted suicide, palliative sedation, and voluntary stopping of eating and drinking. The search was updated in July 2026.

Priority was given to systematic reviews, meta-analyses, recent empirical work, and official reports published primarily between 2015 and 2026. Older works were retained when foundational to the theoretical framework. Sources were included when they directly informed a claim or provided clearly identified contextual evidence. Because the article is a narrative rather than a systematic review, the synthesis does not estimate pooled effects, assess publication bias, or claim exhaustive coverage.

RESULTS

Psychological and interpersonal mechanisms

Shneidman's concept of *psychache* describes intense psychological pain associated with experiences such as loss, rejection, humiliation, guilt, loneliness, or perceived worthlessness. Subsequent research supports a robust association between psychological pain and suicidal thoughts and behaviour, although prospective evidence is less extensive than cross-sectional evidence [4]. Hopelessness is another well-established predictor: a person may experience the future as closed and suffering as permanent, even when alternatives remain objectively available [5].

Interpersonal theories add perceived burdensomeness and thwarted belongingness to this account. Their explanatory value is supported across diverse samples, but meta-analytic findings also show that the proposed interactions are not uniformly predictive and should not be treated as a deterministic formula [6]. The integrated motivational–volitional model further places defeat and entrapment in the pathway to ideation, while exposure to self-harm, access to means, acquired capability, impulsivity, and past behaviour may influence progression from ideation to action [3]. Risk assessment must therefore address both current suffering and the factors that make action more likely.

Clinical ambivalence creates an important opening for intervention. A person can simultaneously seek relief, fear death, hope to be found, and feel unable to imagine change. Effective care combines direct assessment of suicidal intent and access to means with treatment of psychiatric and physical conditions, collaborative safety planning, continuity of contact, and practical action on social stressors. Moralising responses are counterproductive because they add shame without reducing pain or entrapment.

Narcissistic vulnerability and suicidal dynamics

Narcissism is heterogeneous. Grandiose traits, vulnerable narcissism, and narcissistic personality disorder should not be conflated, and most people with narcissistic features do not attempt suicide. A 2024 systematic review nevertheless found sufficient evidence to consider clinical and subclinical narcissism in the assessment of suicide-related outcomes, while emphasising variation in definitions, measures, populations, and study quality [7]. Adolescent research likewise links pathological narcissism with suicidal ideation and behaviour, particularly through emotion-regulation difficulties and interpersonal vulnerability [8].

Psychodynamic accounts help interpret how shame, humiliation, rejection, loss of status, and collapse of an idealised self may become intolerable. When external validation has become central to self-cohesion, an interpersonal rupture can activate self-hatred, rage, emptiness, or dissociative detachment [9, 10]. Grandiose fantasy may then function defensively rather than indicate stable self-confidence. These formulations are clinically useful as hypotheses about a person's experience, not

as substitutes for individual assessment or evidence of inevitable risk.

Love, biophilia, and meaning in life

Fromm's contrast between biophilous and necrophilous orientations describes value relations to life, growth, control, and destruction [11]. It should not be used to classify a suicidal person as someone who «loves death». Such an interpretation would overlook psychological pain and reproduce stigma. A more defensible use of Fromm is preventive: relationships based on care, mutual recognition, and responsibility can strengthen a person's capacity to value both others and the self. In *The Art of Loving*, love is presented as an active practice involving knowledge, concern, responsibility, and respect rather than passive sentiment [12].

Frankl's existential approach similarly treats meaning as a concrete orientation towards relationships, responsibility, work, creativity, or a chosen stance towards unavoidable suffering [13]. Meaning-centred approaches should not romanticise suffering or imply that a suicidal person has failed to find the correct purpose. Their clinical relevance lies in reopening possibilities that constricted cognition has rendered invisible and in helping the person identify reasons for living that are personally credible.

Social integration, anomie, and contemporary conditions

Durkheim demonstrated that suicide rates vary with social integration and regulation, distinguishing egoistic, anomic, altruistic, and fatalistic patterns [14]. Although his typology cannot explain individual cases on its own, it remains useful for connecting personal distress with isolation, economic disruption, rapid normative change, excessive control, and loss of social position. Contemporary pressures – including precarious work, debt, discrimination, violence, abuse, family rupture, and online comparison – may intensify vulnerability through several pathways rather than through a single social cause [1].

Family and social relationships require equally careful interpretation. A systematic synthesis identified perceived family support and connectedness among the protective factors associated with lower suicidal behaviour, while noting limitations in the evidence and variation across groups [15]. Family life also constitutes a legally protected sphere in European human-rights law, reflecting its institutional significance, although legal protection itself is not evidence of a causal health effect [16]. Public-health research on migrant integration further illustrates how family, education, and culture interact with access, belonging, and health [17]. These findings support culturally responsive prevention without idealising every family or assuming that family contact is safe in contexts of abuse or coercion.

Protective factors and implications for prevention

Protective factors operate cumulatively and contextually. Social support, reasons for living, coping skills, access to responsive care, supportive educational and work environments, and reduced access to lethal means can interrupt different stages of the suicidal process [1, 15]. Physical activity is associated with lower suicidal ideation in meta-analytic evidence, but intervention data remain limited and mixed; exercise should therefore be offered as a potentially helpful component of care, not as a replacement for clinical treatment [18]. Czech and Slovak research has also connected movement with spirituality, meaning, and beliefs about vulnerability, but did not directly test suicide outcomes [19].

Religious, spiritual, and meaning-making resources are similarly heterogeneous. A recent systematic review and meta-analysis found that some dimensions, including the personal importance of religiosity, may be protective, whereas negative religious or spiritual struggle and a distressing search for meaning may accompany greater suicidality [20]. A larger meta-analysis also concluded that religion should be considered alongside, rather than instead of, other risk and protective factors [21]. Clinicians should therefore explore what a belief system means to the individual instead of assuming either benefit or harm.

At service level, prevention depends on coordination between healthcare, social services, schools, workplaces, families, and crisis systems. Research in social-service organisations highlights the organisational importance of structured project management, resourcing, and adaptation to service context [22]. Education also matters: aesthetic and narrative experience can make embodied, affective, and existential aspects of illness and dying more perceptible to health professionals and can complement biomedical and ethical reasoning [23].

DISCUSSION

The reviewed perspectives converge on a central proposition: suicidality is neither reducible to diagnosis nor adequately explained by social adversity, personality structure, or loss of meaning in isolation. Psychological pain and hopelessness help explain suicidal desire; interpersonal disconnection, humiliation, and entrapment explain important pathways; and volitional factors help explain why only some people move from ideation to action. The same multidimensional understanding applies to protection. Connection, meaning, physical activity, spirituality, and family support can help, but none is universally protective or sufficient without accessible, evidence-based care.

Fromm and Frankl add a language of value, relationship, and responsibility that is largely absent

from risk-factor lists. Their contribution is strongest when it deepens attention to lived experience rather than moralises it. Durkheim, in turn, prevents an exclusively individualised reading of distress. Together, these approaches support prevention that addresses both the person and the conditions in which hope, belonging, and agency become possible.

Suicide prevention and assisted dying: a bioethical tension

A normative asymmetry deserves explicit discussion. Non-assisted suicide is ordinarily approached as a preventable public-health outcome, whereas euthanasia or physician-assisted suicide is defended by part of society as an autonomous, humane response to otherwise intolerable suffering. In the Czech debate, dignity, autonomy, vulnerability, political language, and the availability of palliative care remain central and contested; Czech law does not currently recognise a constitutional right to euthanasia [24]. The contrast cannot be resolved by terminology alone, particularly when psychological pain, loneliness, perceived burdensomeness, and fear of dependency may appear in both suicidal crises and requests for assisted dying.

Conceptual distinctions nevertheless matter. In euthanasia, a clinician administers the life-ending medication; in physician-assisted suicide, the eligible person performs the final act using medication supplied or prescribed for that purpose [25]. Palliative sedation uses proportionate medication to relieve refractory suffering by reducing consciousness and is defined by a therapeutic intention rather than an intention to cause death [26]. Withdrawal of a burdensome or non-beneficial medical treatment, including clinically assisted nutrition and hydration, should not be described as simply «withholding food and water»; comfort feeding, mouth care, the clinical benefits and burdens of artificial support, consent, and the underlying disease must be considered separately. Voluntary stopping of eating and drinking refers to a decisionally capable person's deliberate refusal of oral intake in order to hasten death and raises its own contested questions about professional support [27].

The «slippery slope» concern should neither be declared proven by every rise in case numbers nor dismissed automatically as a fallacy. An empirical version asks testable questions about changes in eligibility, interpretation, safeguards, and affected groups over time. Eligibility and practice have broadened in some jurisdictions. Dutch law permits euthanasia when statutory due-care criteria are met for medically grounded suffering that may arise from somatic illness, psychiatric disorders, dementia, or multiple geriatric syndromes; 219 notifications in 2024 primarily concerned psychiatric disorders [28, 29]. Belgium extended its euthanasia law to minors in 2014 and had recorded seven cases involving minors by 2025 [30]. Canada removed the requirement that natural death be reasonably foreseeable in 2021, while eligibility based solely on mental illness remains excluded until March 2027 [31]. These developments demonstrate legal and practical extension, but they do not by themselves establish coercion or failure of safeguards.

Evidence remains contested. Earlier comparative research found no disproportionate impact on several conventionally defined vulnerable groups in Oregon and the Netherlands [32]. Conversely, analysis of Dutch psychiatric cases identified disagreements among physicians and difficult judgements about capacity, irremediability, and treatment refusal [33], while more recent Dutch and Belgian literature documents continuing growth and debate around assisted dying on psychiatric grounds [28]. The appropriate response is sustained empirical monitoring, transparent reporting, protection against subtle pressure on people who feel burdensome, and genuine access to mental-health, social, disability, and palliative services. Assisted dying must not become a substitute for care that is unavailable, unaffordable, or poorly coordinated.

CONCLUSIONS

Suicidal behaviour emerges from interacting psychological, interpersonal, social, cultural, and existential processes. Psychological pain, hopelessness, burdensomeness, thwarted belongingness, defeat, and entrapment are clinically important, while progression from ideation to action depends on additional volitional factors. Narcissistic vulnerability may heighten risk when shame, humiliation, affective dysregulation, and relational rupture converge.

Prevention is most credible when it combines timely clinical care with continuity of contact, family and social support where safe, practical reduction of stressors, restricted access to lethal means, and opportunities to rebuild meaning and agency. End-of-life debates require precise distinctions among suicide, assisted suicide, euthanasia, palliative sedation, treatment withdrawal, and voluntary stopping of eating and drinking. Changing eligibility criteria should be monitored critically and transparently, with equal attention to autonomy, vulnerability, and the availability of high-quality care.

Perspectives for further research. Prospective studies should examine how psychological pain, narcissistic vulnerability, family connectedness, spirituality, and social conditions interact across the transition from ideation to action. Comparative research should also evaluate whether changes in assisted-dying regulation affect suicide-prevention practice, perceived burdensomeness, trust in healthcare, and access to palliative and mental-health services.

COMPLIANCE WITH ETHICAL REQUIREMENTS

This narrative review used publicly available scholarly, legal, and statistical sources and did not involve human participants, animals, or identifiable personal data. Ethics committee approval and informed consent were therefore not required.

Study Limitations. This narrative review is selective and interdisciplinary. It does not provide a systematic risk-of-bias assessment or pooled estimates, and several foundational concepts predate current empirical standards. Findings on protective factors are often observational, culturally variable, and vulnerable to reverse causality. The end-of-life comparison is intentionally concise and cannot replace a dedicated legal or bioethical analysis.

Statement on the Use of Artificial Intelligence Tools. During preparation of the Czech-language source manuscript, generative artificial intelligence tools were used only to a limited extent. ChatGPT (OpenAI, USA) was subsequently used to assist with translation into academic English, language harmonisation, and final editing. The authors critically reviewed and revised all artificial-intelligence-assisted output, verified the references and factual claims, and take full responsibility for the content of the manuscript.

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The authors declare no competing interests.

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Резюме

СУЇЦИДАЛЬНА ПОВЕДІНКА: ПСИХОЛОГІЧНІ, СОЦІАЛЬНІ ТА ЕКЗИСТЕНЦІЙНІ ДЕТЕРМІНАНТИ І ЇХНЄ ЗНАЧЕННЯ ДЛЯ ПРОФІЛАКТИКИ

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Вступ. Суїцидальна поведінка є серйозною проблемою громадського здоров'я, що формується у взаємодії психологічних, міжособистісних, соціальних, культурних та екзистенційних чинників. Пояснення, зведені лише до психіатричного діагнозу або однієї несприятливої події, не відображають переходу від страждання до суїцидальних думок і від думок до дії.
Мета. Узагальнити психологічні, психодинамічні, екзистенційні та соціологічні підходи до суїцидальної поведінки, визначити клінічно значущі захисні чинники та розглянути біоетичну напругу між профілактикою самогубств і суспільно легітимованими формами асистованого помирання.
Матеріали та методи. Проведено цільовий наративний пошук рецензованої літератури та контекстів цитування, оновлений у липні 2026 року. Пріоритет надавався систематичним оглядам, метааналізам, сучасним емпіричним дослідженням, офіційній статистиці та основоположним теоретичним працям. Дані синтезовано тематично без кількісного об'єднання результатів.
Результати. Психологічний біль, безнадійність, відчуття себе тягарем, порушене почуття належності, поразка та пастка є важливими, але неспецифічними корелятами суїцидальних думок. Перехід до суїцидальної дії залежить від додаткових вольових чинників. Нарцистична вразливість може підвищувати ризик за поєднання сорому, приниження, афективної дисрегуляції та розриву стосунків. Сенс життя, сімейна й соціальна підтримка, доступ до лікування, фізична активність та окремі форми релігійної або духовної залученості можуть мати захисне значення, однак їхній вплив залежить від контексту. Евтаназію, асистоване лікарем самогубство, паліативну седацію, припинення клінічно асистованого харчування і гідратації та добровільну відмову від їжі й пиття необхідно розрізняти за суб'єктом дії, наміром, здатністю ухвалювати рішення, клінічними показаннями та правовими гарантіями.
Висновки. Ефективна профілактика потребує поєднання клінічних, реляційних і популяційних заходів, які зменшують психологічний біль, відновлюють зв'язки та реалістичну надію і забезпечують доступність психіатричної, соціальної та паліативної допомоги. Політика наприкінці життя має зберігати поняттєву точність і прозоро оцінювати наслідки зміни критеріїв доступу.

Ключові слова: **психічний біль, безнадійність, порушене почуття належності, соціальна інтеграція, сенс життя, асистоване помирання, паліативна допомога**

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