

A View on Suicide Prevention from the Perspective of Positive Psychotherapy: Towards an Integrated Paradigm



Maksim Goncharov

MD, PhD, psychiatrist, psychotherapist,
Master Trainer of Positive Psychotherapy
(Moscow, Russia)

Email: maqsimgoncharov@gmail.com

Received 01.12.2025

Accepted for publication 23.12.2025

Published 23.01.2026

Abstract

Suicide is a profound indicator of personal and societal distress. This article argues that the limited effectiveness of existing prevention strategies largely stems from the dominance of a reductionist, biomedical paradigm that marginalizes the psychological dimension of human suffering. To address this gap, the article proposes integrating a salutogenic (health-oriented) approach with Nossrat Peseschkian's model of life balance as a methodological foundation for prevention. We contend that effective prevention requires a paradigm shift towards psychological health, the cultivation of a help-seeking culture, and the systematic integration of psychotherapeutic practices into general medical care. Practical recommendations are offered to bridge the current divide between biological and psychological approaches, advocating for a balanced, person-centered model.

Keywords: suicide prevention, Positive Psychotherapy, integrated treatment, salutogenic approach, life balance, psychosomatics, reductionism, existential loneliness, verbalization

Introduction

Even though suicide is a frightening, profound, and universally troubling issue that has accompanied humanity throughout its entire existence, no effective key to resolving it has yet been found. Broadly speaking, all existing views and approaches have not produced significant results. Perhaps they are inadequate, or perhaps they simply have not been widely disseminated or implemented. In any case, we are still in the stage of identifying valuable ideas that may later be implemented.

I would like to share my perspective as a practicing psychotherapist, informed by 28 years of clinical experience, including serving as head of a suicidology department and maintaining a private practice. This article is also a result of my preparation for an international conference on suicide prevention. I deeply believe that suicide prevention is a vital social and psychological issue, and current strategies require critical re-evaluation.

The core premise of this article is that the role of psychology in understanding and preventing suicide is significantly underestimated within the prevailing medical model. Considering that a substantial proportion of diseases and presentations in healthcare are psychosomatic in nature, psychology is central to their development and resolution. Unfortunately, modern medicine often views the human being primarily through a reductionist, biological lens, offering predominantly physical and chemical treatments. This fundamental gap between understanding disease and understanding the person leads to an underestimation of psychological individuality. While reductionism has been extraordinarily successful in combating infections and in surgery, it is catastrophically inadequate when dealing with existential pain and chronic distress, which are at the heart of suicidal crises.

Methodology

2.1. The persistent challenge of suicide and the need for a new perspective

Even though suicide is a frightening, profound, and universally troubling issue that has accompanied humanity throughout its entire existence, no effective key to resolving it has yet been found. Broadly speaking, all existing views and approaches have not produced significant results. Perhaps they are inadequate, or perhaps they have not yet achieved sufficient dissemination and practical implementation. In any case, we are still in the stage of searching for valuable ideas that may later be implemented.

I would like to share my perspective as a practicing psychotherapist, informed by 28 years of clinical experience, including serving as head of a suicidology department and maintaining a private practice. This article is also a result of my preparation for an international conference on suicide prevention. I deeply believe that suicide prevention is a vital social and psychological issue, and current strategies require critical re-evaluation.

The core premise of this article is that the role of psychology in understanding and preventing suicide is significantly underestimated within the prevailing medical model. Considering that a substantial proportion of diseases and presentations in healthcare are psychosomatic in nature, psychology is central to their development and resolution. Unfortunately, modern medicine often continues to view the human being primarily through a reductionist, biological lens, offering predominantly physical and chemical treatments. This fundamental gap between understanding disease and understanding the person leads to an underestimation of psychological individuality. While reductionism has been extraordinarily successful in combating infections and in surgery, it is catastrophically inadequate when dealing with existential pain and chronic distress, which are at the heart of suicidal crises.

2.2. The psychological anatomy of suicidal despair

Suicide is always a tragedy. Underlying every suicide is profound suffering that often remains invisible. Suicide is an indicator of deep distress, and a high suicide rate in a country reflects serious societal dysfunction.

Let us look behind the façade of suicidal behavior. If we generalize, suicide emerges from

a very specific psychological state characterized by:

1. Unbearable suffering.
2. A sense of hopelessness.
3. Loneliness and isolation.

In other words, it is a state of deep crisis and despair. No matter how we classify it, suicidal behavior is perhaps the most dramatic cry for help. When a person decides to end their life, it means their loneliness has become far more excruciating than we imagined. This is not a poetic metaphor but a clinically and existentially accurate observation.

The Russian philosopher Nikolai Berdyaev once said: "A person never denies life itself; he denies the moment in life that makes it unbearable."

Loneliness here is an existential catastrophe, not merely the absence of company. Suicidal loneliness reflects the collapse of all meaningful connections that give life its sense. Suicide is seen not as a desire for death but as the only imaginable way to stop unbearable pain.

People do not begin thinking about death spontaneously. The decision forms slowly and agonizingly, permeating the entire consciousness. The individual remains in internal conflict for an extended period (Peseschkian, 1977; Shneidman, 1993).

Voluntary death is only the most vivid form of suicidal behavior. Drug addiction, alcoholism, risky behaviors, and gambling can also be understood as forms of self-destructive behavior or delayed suicide.

If we want to be effective in suicide prevention, we must stop viewing suicide as a single tragic point. We must see the entire life trajectory leading to that point. Addiction and risk-taking behaviors are suicide whispering, stretched over months and years.

Discussion

3.1. The therapeutic relationship and verbalization as core preventive mechanisms

Every psychotherapist knows that each disorder has its own dramatic history. When I meet a patient with suicidal tendencies, we begin to build rapport. As the patient gradually allows me into their experiences and personal narrative, trust grows, and self-disclosure deepens. Eventually, I gain the opportunity to see their subjective suffering, understand its roots, and uncover their active conflicts, family

concepts, and internal contradictions (Goncharov, 2024; Peseschkian, 1987; Wolberg, 1967).

Gradually, if all goes well, we discover new sources of support, build a new relationship with the self, and strengthen the personality by developing new qualities. Notice that all this becomes possible only through deepening our therapeutic relationship.

Everyone who practices psychotherapy knows that when everyday problems and conflicts are suppressed rather than spoken about openly, this leads to psychological and psychosomatic disorders. Silence is fertile soil for mental illness and psychosomatics (Peseschkian, 1987).

Essentially, this observation suggests that if people could openly share, speak, and seek help, many problems could be avoided. "One person reaching out to another for help is the greatest phenomenon in humanity," wrote Lewis Wolberg (1967, p. 242).

This is perhaps the most essential social skill we should teach children: "If you are struggling, ask for help." If children learn to seek help, we will solve half of their future problems immediately.

Thus, a key conclusion for prevention is that we need more psychological expertise. People must have both the opportunity and the willingness to talk about their problems.

Yes, talking is not yet a solution. But it is no longer a secret. It is pain that has been shared – and shared pain is half pain.

Verbalization is a form of psychological hygiene. Suppression is toxic. During both individual and group therapy sessions, I hear touching and dramatic stories and secrets. Often, people speak about something for the first time in 20–30 years. This is something they desperately need. Through this, they experience relief. We are full of secrets; some crush us, suffocate us, and prevent us from living. We need to address these secrets promptly. And doing so requires a safe, specialized environment – often through tears and pain – but it is necessary.

3.2. The crisis of the biomedical paradigm and the case for integration

I am a physician, but I believe that a human being is far more psychological than biological. Our ability to choose and make decisions is

psychological in nature. Behind every choice stand values.

Values are not universal; they are culturally conditioned. Cultural values are also psychological (Goncharov, 2024; Peseschkian, 1987).

Despite suicide being a socio-psychological problem, it is handled primarily by medicine. The issue is that biological medicine and psychological medicine still exist in parallel as competing concepts, with only a very formal dialogue between them.

The main achievement of modern medicine is pharmaceuticals. There are pills for everything. Medicine often views a person as though nothing beyond physical and chemical processes exists. Yet if we treat people only as physical bodies, we cease to perceive them as human beings. This model focuses on the objective qualities of the diseased organism but cannot grasp subjective individuality. Excluding the subject from medicine creates a background in which the patient's personality becomes invisible (Peseschkian, 1985).

We can describe Shakespeare's Hamlet at the physical-chemical level – ink on paper – or at the biological level – as visual perception. But such a description gives us nothing for understanding tragedy, conflict, or character. For that, we need literary analysis and psychology.

Medicine has achieved tremendous success in treating infections and surgical conditions, but has accomplished virtually nothing in treating chronic disorders. The prevalence of chronic illness continues to rise. Medicine offers effective solutions for acute problems but has little to offer in chronic ones. Chronic disorders are a way of life, and lifestyle is psychology.

Medicine still largely relies on the pathogenic approach – physicians understand pathology well but understand little about health. The salutogenic, health-oriented approach remains mostly theoretical rather than practical (Antonovsky, 1979).

3.3. Towards a balanced, integrated treatment model

It is crucial to clarify that critiquing biomedical reductionism does not dismiss biological factors or pharmacological treatments. In acute suicidal crises, medication can be life-saving by reducing overwhelming anxiety, agitation, or depressive psychosis, creating a

window of stability where psychotherapy can begin (Rutz, 2004). The problem is not biology itself, but the dominance of a purely biological framework to the exclusion of the psychological. Effective suicide prevention requires an integrated model where pharmacotherapy manages acute symptoms and biological vulnerabilities, while psychotherapy addresses the underlying psychological, existential, and relational causes of suffering. They are complementary, not competing, strategies.

3.4. The paradox of the physician: illustrating the system's failure

Let us look at physicians themselves. Today, doctors have access to the most advanced technologies, medications, and procedures. But does this make the physician population generally healthier than others? Obviously not. Physicians are certainly not champions of happiness. They, too, die by suicide. Worse, the risk is higher than in the general population.

Male physicians die by suicide 1.4–2.3 times more often than other men. For female physicians, the situation is even more dramatic: their suicide risk is 2.5–4 times higher than that of women in general. Medicine is one of the few professions where the suicide risk for women exceeds that for men.

In the United States, 300–400 physicians die by suicide each year – equivalent to losing an entire medical school annually (Davis et al., 2021).

This large 16-year study confirmed elevated risk and showed that physician suicide rates are about 32–40 per 100,000 – far higher than in the general population.

Why is this happening? Why do doctors not benefit from their advantages? Because over 80% of all diseases are psychosomatic, and over 90% of doctor visits are related to stress or psychology. Physicians are psychologically illiterate and trained only in biological symptom control. And they cannot help themselves.

But there is good news. According to a study on professional satisfaction, 99% of psychotherapists report that their work is meaningful and helpful. 95% are satisfied with their profession. 91% would choose psychotherapy again (Beerheide, 2018). German studies show that psychotherapists are the most satisfied professionals. Perhaps because psychotherapists can help not only clients but

also themselves. Psychotherapy is the only profession in the world in which personal development and internal harmony are mandatory components of training (Peseschkian, 2016).

Psychotherapy is a deeply human method. It leverages a person's strengths and helps them apply all available resources. A psychotherapist genuinely wants the client's life to improve. They study the client's life, identify what is not working and what should change, and explore how to make those changes.

A healthy therapist's personality helps restore the patient's personality, whose disorders are rooted in unhealthy relationships of the past. We build relationships that have healing power, offering love and acceptance (Goncharov M., 2014; Goncharov M., 2024; Гончаров М. 2024).

Of course, I am referring primarily to humanistic and psychodynamic methods, in which relationships are central, not to procedural approaches.

Psychiatric and psychotherapeutic education differ greatly. Psychiatric training centers around diagnosis, pathology, and treatment – highly academic and rational. Psychotherapeutic training emphasizes self-knowledge, relationship-building, emotional understanding, and personal harmony – the main working tool.

Positive Psychotherapy and the Life Balance Model: A Practical Framework for Prevention

Suicide prevention is complex and multifaceted. A comprehensive approach is essential.

Our task is to become a bridge across the abyss of loneliness – back to life, connection, and hope. The most powerful tool in prevention is not technique, but our humanity, our approach, and our personal example.

For effective suicide prevention, we may need to acknowledge the priority of the psychological over the somatic. Lifestyle – ultimately determining somatic health – depends on psychology. Prioritizing psychological health involves no risk.

Everyone knows the term iatrogenesis – harm caused by incorrect medical actions. However, we need salutogenesis – patients “catching” health from doctors. Physicians must themselves become examples of healthy living in every sense. This means doctors must be trained in life balance, well-being, conflict management, and

psychological competence – and apply these skills in their own lives.

All of this revolves around the concept of life well-being – the ability to initiate, maintain, and develop a high quality of life despite ongoing challenges. Well-being is, above all, a mindset, a life philosophy, a system of beliefs. It is a meaningful lifestyle filled with relationships, purpose, and care.

To achieve this, one can practice life balance. My dear teacher, Prof. Nossrat Peseschkian – German psychiatrist and psychotherapist of Iranian origin, founder of Positive and Transcultural Psychotherapy (1977) – said: “A healthy person is not the one who has no problems, but someone who can deal with them.” He developed a clear, simple, culturally sensitive model of four basic life spheres that underpin well-being.

These are the spheres of body/health, achievement/work, relationships/contact, and meaning/future (see Fig. 1) (Peseschkian, 1987). They encompass all fundamental human needs.

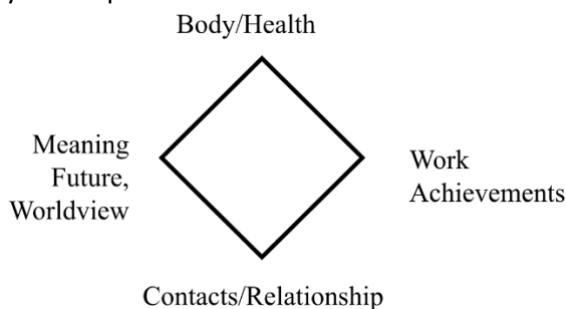


Figure 1. The Four Life Domains by N. Peseschkian (1987)

Put simply, to maintain a good quality of life, one must be able to:

- look and feel healthy, enjoy life, rest, and recover;
- be competent professionally and work within working hours;
- have a healthy social environment and maintain friendships;
- possess clear meanings, life goals, hobbies, passions, and sources of joy.

In other words, keeping all four life spheres in balance and harmony ensures well-being. Any long-term imbalance inevitably leads to problems in the deficient spheres (Goncharov M., 2024; Peseschkian, N., 2016).

The problem is that modern society is excessively focused on achievement. People tend to work too much and raise their children with the same value orientation.

Parents are often more concerned with academic performance than with their child’s ability to form friendships, dream, or create. This leads children to build their self-esteem exclusively on achievements and to become psychologically dependent on them: “I must be strong and successful”; “I must solve my problems myself”; “To be loved, I must succeed.”

Such self-concepts lead to high stress, vulnerability, and dependency on achievement. Character deformation inevitably affects future quality of life. A child may learn to study or work well but remain unable to live fully, enjoy life, or find meaning beyond performance (Goncharov, M., 2024; Пезешкиан, X., 1998).

Furthermore, to prevent the accumulation of psychological pain, children must be taught to build relationships and seek help when needed.

They must grow up with a sense of authorship of their own lives, in an environment that encourages and celebrates their creativity. This gives them an active, creative attitude toward life and the ability to overcome difficulties, fostering a sense of “I am not alone.”

Conclusion

Our task is not to wait until a person collapses under the weight of unspoken pain. We must build bridges across the abyss of their silence. We must create a culture in which caring for mental health and speaking openly about difficulties becomes the norm.

Verbalization is not just words. It is the act of giving form to the chaos of inner pain. It transforms toxic emotional energy into constructive dialogue (Goncharov M., 2024).

Adults must set an example for children by seeking help. It does not matter what problems you have – what matters is how you resolve them. Speaking about problems is a sign of strength and maturity, not weakness.

Given the high prevalence of psychosomatic disorders, psychotherapists – not enthusiasts but trained professionals – should consult patients more frequently, both at the nosological and pre-nosological levels.

Psychotherapy must be popularized. Visiting a psychologist or psychotherapist is as essential to health as visiting a dentist.

We must build a culture of seeking emotional help and make it as accessible as possible.

To translate this vision into practice, the following integrated recommendations are proposed:

1. Integrate Psychotherapeutic Principles into Medical Education: Training for all physicians must include core competencies in psychological self-care, life balance models (such as Peseschkian's), basic counseling skills, and recognition of psychosomatic distress. This aims to combat psychological illiteracy and enable doctors to model wellbeing.
2. Implement Systemic Psychotherapeutic Consultations in Primary Care: Make brief psychotherapeutic assessment and intervention a standard part of general medical practice to address problems early, reducing the path from psychological pain to somatic symptom or crisis.
3. Promote a Salutogenic Public Health Strategy: Shift public discourse and prevention programs from a purely risk-focused (pathogenic) model to one that actively promotes psychological skills: help-seeking, emotional literacy, conflict resolution, and life balance from childhood.

4. Foster Formal Collaboration Between Psychiatric and Psychotherapeutic Services: Develop clear clinical pathways that ensure patients receive combined pharmacological and psychotherapeutic treatment where indicated, based on a holistic, person-centered assessment.

5. Destigmatize and Normalize Psychological Help-Seeking: Public campaigns should frame engaging with psychotherapy as a proactive and wise investment in overall health, equivalent to maintaining physical fitness.

In conclusion, suicide prevention ultimately requires a paradigm shift from a reductionist, biologically-dominated model to an integrated, salutogenic one. By embracing the psychological essence of human suffering, leveraging the healing power of relationships and verbalization, and applying practical frameworks such as the life balance model, we can build a culture of connection that actively fosters resilience. The most powerful tool in prevention remains our collective humanity and our commitment to seeing the whole person.

References

1. Antonovsky, A. (1979). *Health, stress, and coping*. Jossey-Bass.
2. Beerheide, R. (2018). Zwischen Kümmerer und Burn-out [Between Caring and Burnout]. *Arztemonitor*. URL: <https://www.aerzteblatt.de/archiv/aerztemonitor-2018-zwischen-kuemmerer-und-burn-out-0232164b-e29e-4bf6-9095-8f5142729e12>
3. Davis, M. A., Cher, B.A.Y., Friese, C.R., & Bynum, J.P.W. (2021). Association of US Nurse and Physician Occupation With Risk of Suicide. *JAMA Psychiatry*, 78(6), 1–8.
4. Goncharov, M. (2024). *Actual Capabilities in Positive Psychotherapy: What Personality Consists of*. Wiesbaden: WAPP Press, 2024.
5. Goncharov, M. (2025). The Conflict Model of Positive Psychotherapy. In: Messias, E., Peseschkian, H. (eds) *Positive Psychiatry, Psychotherapy and Psychology*. Springer, Cham.
6. Peseschkian, N. (1987). *Positive Psychotherapy. Theory and Practice of a New Method*. Springer-Verlag.
7. Peseschkian, N. (2016). *Positive Family Therapy*. Bloomington, USA: AuthorHouse. (first published in 1986, Springer-Verlag, Berlin, Heidelberg (Germany)). Peseschkian, N. (1987). *Psychosomatics and Positive Psychotherapy*. Springer.
8. Rutz, W. (2004). Suicidal behaviour: comments, advancements, challenges. A European perspective. *World Psychiatry*, 3(3).
9. Shneidman, E. S. (1993). *Suicide as psychache: A clinical approach to self-destructive behavior*. Jason Aronson.
10. Wolberg, L. R. (1967). *The technique of psychotherapy (2nd ed.)*. Grune & Stratton.
11. Гончаров, М. А. [Goncharov, M. A.] *Эмоциональная защищенность и безопасность в практике психотерапевта [Emotional security and safety in psychotherapy practice]*. Москва: ИОИ, 2024. [in Russian]
12. Гончаров, М. А., Фролов, П. С., Шишова, Е. О., Шишов, М. В. [Goncharov, M. A., Frolov, P. S., Shishova, E. O., Shishov, M. V.] (2014) *Почему психотерапевт лучше дружеской «жилетки». 33 совета по использованию своего психотерапевта [Why a psychotherapist is better than a friendly “shoulder to cry on.” 33 tips for using your psychotherapist]*. Москва: АСТ. [in Russian]
13. Пезешкиан, Х. [Peseschkian, H.] (1993). *Основы позитивной психотерапии [Fundamentals of Positive Psychotherapy]*. Архангельск: Изд-во АГМИ. [in Russian]
14. Пезешкиан, Х. [Peseschkian, H.] (1998). *Позитивная психотерапия как транскультуральный подход в Российской психотерапии [Positive Psychotherapy as a transcultural approach in Russian psychotherapy]: дис. ... д-ра мед. наук : 14.00.18. Санкт-Петербург. [in Russian]*