Self-destruction and self-exclusion: the suicide in the rural areas of Rio Grande do Sul – Brazil*

Auto-destruição e auto-exclusão: o suicídio nas áreas rurais no Rio Grande do Sul - Brasil

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Abstract

This paper deals with suicide in rural areas of Rio Grande do Sul, Brazil, considering the relation of this phenomenon with the advance of the capitalism in the countryside. This change has been creating new living and working styles and, besides, processes which lead to illness. Among these processes, suicide becomes a reality as a process of self-destruction and self-exclusion. These are sociopathologies of the development which are created in demonstrations of mental illness, depression and suicides, driven by a model of development imposed in the rural area through the economic incentive and, also, through all the economic speech carrying a project of hope. It is about the social and economic systems acting as generators of precariousness, human, familiar and psycho-philosophical costs, desocialization processes, self-generated alienation and self-cleaving, showing that it is increasingly necessary to think about the relation between the social and the individual in life and death processes.

Keywords: Suicide, Rural areas, Sociopathologies.

Resumo

Este artigo trata da questão do suicídio no meio rural no Rio Grande do Sul, Brasil, a partir da articulação deste fenômeno com o avanço capitalista no meio rural. Este último tem produzido novas formas de vida e trabalho e, ademais, processos de adoecimento. Entre tais processos ganha corpo o suicídio enquanto processo de autodestruição, de autoexclusão. São as sociopatologias do desenvolvimento que se constituem em manifestações de doenças mentais, depressão e suicídios, alavancadas por um modelo de desenvolvimento imposto ao meio rural através da incitação econômica e, ademais, por todo um discurso econômico portador de um projeto de esperança. É o sistema social e econômico agindo enquanto gerador da precariedade, de custos humanos, familiares, psicofisiológicos, de processos de dessocialização, de alienação autogerada, de clivagem de si apontando que se deve, cada vez mais, refletir sobre a relação entre o social e o individual nos processos de vida e morte.

Palavras-chave: Suicídio, Áreas rurais, Sociopatologias.

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Introduction

Émile Durkheim, over 100 years ago researched the suicide and its rates in France, England and Denmark. In this research, the author asserted that while suicide was a solitary act, the causes had significant links to various social factors. He said that suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result (Durkheim, 2000). Then, dealing with the issue of self-destruction through suicide means dealing with the human, life and how it has been put in risk. Life, in some aspects, has been severely attacked. However, the shield over it does not allow us to see what is happening in this "no man's land", in these areas where death arrives slowly and starts carrying with it one after the other.

Three people die every day by suicide in Rio Grande do Sul (Brasil, 2013). Is it possible to think about this situation as something normal? Would that be naturally expected to happen? Considering this situation normal and acceptable and lacking ethical indignation not rarely prevents that violent practices are questioned but, also, that these practices continue being considered normal, regular, within the pattern, as "it has always been" or, then, seen as something banal, as well stated by Arendt (1999), being considered part of daily life. Similarly, this issue reminds Butler (2005) when she asks: what is life? What makes a life count as life while others does not? How is it possible that some lives are more visible than others? The capitalist advance in rural areas has developed new lifestyles, especially through the new working options. These changes bring along with them processes of self-exclusion, self-destruction. Thus, what is rural is increasingly becoming "not rural" anymore, what leads to a propitious space for death in its different shades. Therefore, this brief chapter carries in its heart the horror to the omission, the "leave it as it is" idea, the complacency, the intended indolence whose action/lack of action hides the fact that death by suicide is happening in the rural areas, but which is also happening everywhere. Such deaths agitate, disrupt and, because of the, talking about this issue points to the visibility of some phenomena that are hidden in the shadows and continue facing us, testing our souls, staring at our eyes, in their deepest dimension (Couto, 2012).

Suicide: brief comments about it

According to what was estimated by the World Health Organization (WHO, 2010), 815,000 people committed suicide worldwide in 2000, and ten to twenty times more people attempted suicide. This implies that in every 40 seconds a person dies by suicide in the world and that in every three seconds, on average, there is a suicide attempt. This situation also indicates that more people die by suicide than, for example, in armed conflicts, traffic accidents and other violent kinds of deaths. The rates in different countries vary a lot and the highest figures can be found in the Eastern European

countries. Considering the age of the victims, in fatal cases as well as in attempts, it is possible to notice that there is age precociousness, which in countries like Canada, is between 15 and 24 years old. It is noticeable that the rates are increasing worldwide, both in males and in females, varying from country to country and, also, with similarity in rates within similar ethnic groups. The suicide rates, in global terms, seem to be rising in indigenous groups around the world such as in the case of Australian, Chinese and North American tribes.

The suicide among indigenous populations, according to a survey conducted by the World Health Organization (WHO), is associated, among other things, to poverty and dependence on alcoholic beverages. However, statistics are compiled in differently ways in the analyzed countries and it is not uncommon to find different figures regarding to suicide depending on the agency that performed the survey and how the data was recorded. The highest suicide rates are concentrated in European countries, especially in Eastern Europe, in countries which share similar historical background and similar socioeconomic characteristics: Estonia, Latvia and Lithuania. Other countries with high suicide rates are: Russia, Hungary and Finland. Outstandingly, when Europe is not being considered, the high rates were observed in island countries, such as Cuba, Japan and Mauritius (Meleiro, Mello-Santos & Bertolote, 2004).

WHO talks about a number of risk factors that can lead to suicide or suicide attempts, which are considered as non-fatal suicidal behavior. The suicidal behavior would have a large number of causes that can be classified as psychiatric or biological factors, events in someone's life that may have precipitated the suicidal act and also factors indicated as environmental and social. Among the last cases mentioned, there are: Loss of employment, of religious ties and socioeconomic conditions. In the World Report on Violence developed by WHO, some differences were found in suicide rates in rural and urban areas. The report indicates that the rates are higher in the rural areas and among farmers. Besides the difference in suicide rates in urban and rural areas, the report shows significant variations regarding to the methods used to perform the suicidal act. Considering the factors identified as common to increase the suicide rates among the people who live in rural areas, the report described the isolation and, therefore, difficulty to detect the warning signs of the phenomenon. Also, the limited access to resources related to health and low educational levels were also mentioned as determinant factors (WHO, 2011).

The data presented in the report indicates the increase in the suicide rates in different European countries, especially Germany, in moments when the economic recession and unemployment were taking place. The figures tend to grow in the same proportion that the social disintegration increases, observed

through the growth of unemployment rates and when there is low social protection and economic crisis. Thus, the suicidal behavior seems more frequent among unemployed people than among the ones who are employed, mainly considering the ones who lost their jobs suddenly. All the information bellow presented was obtained in studies carried by the WHO, organization that, in 2002, promoted a wide spread regarding to this issue and discussed about it, considering it a public health problem, shown in the report about mental health.

Suicide is also analyzed by the Pan American Health Organization (PAHO), international organization which deals with public health and which acts as WHO's Regional Office for health in America. The rates are calculated also by 100.000 and the years when the data were collected were 2003 to 2005. Hence, for this organization, in Brazil the death by suicide rate is 5.7, in Argentina it is 8.2, in Chile it is 7.1, in Paraguay it is 6.2 and in Uruguay it is 16. Notice that the number found in Uruguay is really high if compared to the other countries. Besides, the suicide rate found for the countries which are part of the Southern Cone was 8.1 (PAHO, 2010). In 2000, WHO published the Manual for Suicide Prevention aimed at professionals who deal with health. The document was part of the sources aimed at specific social groups and professional and was specifically relevant for suicide prevention. It was developed to be part of the *Suicide Prevention* (SUPRE), the international initiative from the World Health Organization (WHO, 2010) to prevent suicides. In this manual it is possible to have access to many questions related to suicide, for example: The international dimension of the phenomenon, the relation between suicide and physical and mental diseases, the socio-demographic and environmental factors, the approach, the way to identify who is in risk of committing suicide, how to guide people who are in risk, among other. The objective was to spread the discussion about this important issue and adapt, according to the local conditions, the manual itself and the guiding foreseen on it, having a pattern on WHO's policies to prevent suicide and facing this issue nationally. During the same period, the event *I Seminário Nacional de Prevenção do Suicídio* (I National Seminar for Suicide Prevention) in Porto Alegre, Rio Grande do Sul, took place. It was a moment when the public who attended the event discussed about prevention strategies. Among the main strategies, it was mentioned the population's access to psychiatric treatment through the public primary care units of the *Sistema Único de Saúde* (Unified Health System in Brazil), *Programa Saúde da Família* (Family Health Program in Brazil), specialized mental health services and, finally, emergency care units and emergencies rooms (Brasil, 2012).

According to Brazil's Ministry of Health, the mortality rate by suicide in the country is 4.5 per 100,000 inhabitants, but the southern states reach rates twice as high, as is Rio Grande

do Sul, where the rate is 9.8 per 100,000 inhabitants (Brasil, 2012). To help the suicide rates to decrease, as well as the suicide attempts and the damage associated with the suicidal behavior (traumatic impact of suicide in families, communities, schools, workplaces) the institution *Coordenação de Saúde Mental* (Department of Mental Health) presented the plan *Estratégia Nacional para Prevenção do Suicídio* (National Strategy for Suicide Prevention). Thus, through Ordinance 1.876, the guidelines of this policy were presented, which has as objective, in addition to reducing mortality by suicide, also working in the training of health professionals, following up of the survivors and those who attempted suicide (Brasil, 2011). To be able to do that, some actions are in progress, such as: Creation of working groups formed by representatives of some departments of the Ministry of Health, universities and civil organizations; publication of the National Guidelines for suicide prevention; creation of the logo *Amigos da Vida* (Friends of Life), which identifies the National Strategy; organization of the previously mentioned event I National Seminar for Suicide Prevention (2006); launch of the project *Comviver* (2006), in Rio de Janeiro; launch of the publication *Referências Bibliográficas Comentadas Sobre Suicídio* (Commented Bibliographic References About Suicide) (Brasil, 2012); and, finally, DVD release of the I Seminar for Suicide Prevention. Later, the actions led to the regulation of the National Guidelines and to the development of what is called *Plano Nacional para Prevenção do Suicídio* (National Plan for Suicide Prevention). The Guidelines that will orientate the National Plan have already been developed and discussed about, however, the Plan is not available yet. They were created through the Ordinance 1.876, from August 14, 2006, establishing, therefore, the national suicide prevention, as already mentioned, in all the federal units, taking into account the three levels of the government.

Finally, since 2006, the World Health Organization has published several documents that deal with the suicide prevention in some places, related or not to some specified professional categories. They are kind of orientation guides and manuals to be used as prevention in the work environment by prison officers, doctors and general practitioners, general press, elementary and middle school professionals, groups of people who survived suicide attempts, counseling professionals and workers. Suicide is a serious public health problem, and Brazil is among the ten countries with the highest number of deaths. Besides, the socioeconomic changes which are in progress result in the probability of a substantial increase in rates of suicide mortality in the coming years (Rocha, 2007).

These brief comments can illustrate how close the issue of suicide is of all the people, everywhere in the world. In Brazil, the average suicide rate, as previously mentioned, varies from 4 to 6 deaths per 100,000 inhabitants. However, in Rio Grande do Sul, the annual rate

goes from 8 to 10 deaths per 100,000 inhabitants (Viana, Zenker, Sakar & Escobar, 2008). Talking about the profession of these people who commit suicide, it is possible to highlight the farmers, because this occupation shows high rates of suicide and depression, which is identified as the most frequently observed disorder among victims, along with schizophrenia and personality disorders (Viana *et al.*, 2008). There is still the prevalence of hanging as the most common method to commit suicide, especially in the southern states of the country (Rio Grande do Sul, Santa Catarina and Paraná). In a similar study, Lovisi, Santos, Legay, Abelha & Valencia (2011) work on an epidemiological analysis of suicide in Brazil from 1980 to 2006. The study mentioned that from 1980 to 2006 Brazil had had 158,952 cases of suicide. The national average rates of mortality by suicide have been growing, moving from 4.4 to 5.7 deaths per 100,000 people, causing a growth of 29 % during the years that were analyzed. Socioeconomic adversity and lack of social support would increase the risk of suicide in vulnerable populations. This would be the case of people with a history of previous suicide in the family, mental disorders (especially depression) and anxiety, and comorbid conditions such as use and/or addiction to alcohol or drugs (Lovisi *et al.*, 2011). Nevertheless, besides the already known factors such as depressive disorders and use of or addiction to alcohol or drugs, there was the need to carry out in-depth investigations which could discuss also social, economic and cultural aspects. Such aspects may influence suicidal behavior and the prevention would need to be, because of that, more exhaustive and multi-sectorial, including issues related and unrelated to health, taking into account the diversity and specificity of different populations (Lovisi *et al.*, 2011).

Nowadays, there are many studies dealing with suicide in its different aspects. Suicide manifests itself as an undeniable and deeply significant phenomenon in all societies. It is a clear symptom of the struggle between the men's passions, their biological grounding and the social forces of their surroundings (Chavez-Hernández & Leenaars, 2010). The new theories and perspectives that try to deal with the issues involving suicide today propose that the study of suicidal act should incorporate multiple factors that have been unnoticed for a long time, trying to understand and prevent the phenomenon. Thus, two contributions are considered to be central: The first is the disbelief on the assumption that only psychiatric patients would be likely to endanger their own lives themselves. The idea presented is that not all people who think about committing suicide are psychotic, just as not every psychotic would think about attempting a suicide (Chavez-Hernández & Leenaars, 2010). Another aspect is about the difference between the suicide that really happens and the suicide attempt. This assumption would imply in understanding that the studies about suicide should not focus only in the person's death,

but also, consider the moment when it was planned, its ideation and the material and written traces that have been left (Chávez-Hernández & Leenaars, 2010). As well stated by Bastos, analyzing the factors which are present in the suicidal act separately would be as implausible as defending that the air we need to breathe keeps being the same if we separated the oxygen from the substance that feeds our lungs (Bastos, 2009). So, suicide would be a complex event that occurs between personal and social life. However, the relation of this phenomenon with work has been studied only contemporaneously, still in an incipient way, especially from the 90s on, when this issue unsettled the European community. As an example, there are the studies developed by Dejours & Bègue (2010) when debating about suicide and its close connection to work. The authors point out that the suicides in the workplace mostly increased from the 1990s on, as part of a scenario of human suffering and deterioration of labor relations (Dejours & Bègue, 2010).

According to these authors, suicides, always covered by a cloak of silence, started, in France, being disclosed in public areas, alerting people about this important issue, focusing mainly in those which happened in large companies like *Renault*, *Peugeot* and Électricité *de France* (Dejours & Bègue, 2010). In agriculture, the suicides had already been observed, what led to considering this field of work as vulnerable and care demanding. To Dejours and Bègue (2010) there would be still some difficulty in determining the suicides in rural areas in their relation with work, as this is a sector of the economy where the work and living spaces mingle (Dejours & Bègue, 2010). Taking that into account, they affirm that, despite the statistical difficulties of the suicide problem, "a single case of suicide would be already very serious, showing the deep degradation of the overall human and social matter of work" (Dejours & Bègue, 2010). Hence, the public policies should be urgently reviewed, contemplating this new scourge, considering that only one suicide in the workplace would already indicate that the mutual help and solidarity conduct were being banned from the habits and routines of working life, where, instead of it, the motto of every man for himself would be the rule. The breakdown or disintegration of the solidarity or the social ties at work deserves a special attention, because when a worker kills himself because of work, it means that the whole work community would probably have also been in a suffering situation.

According to the authors, such degradation could be measured by the "[...] privilege granted to the management, to the detriment of labor" (Dejours & Bègue, 2010), when the management process does not seem to be dependent on the work itself. The new management methods would be destabilizing what is collective, stimulating the pursuit of individual goals. Thus, people would be alone, because the productive restructuring leaves each person on his/her own. This same relation is mentioned by Santos, Siqueira & Mendes (2010)

when they talk about the suicide attempts among bank employees within the context of productive relations nowadays. For them, the analysis of suicide nowadays instigates, more and more, the debate about the intervention of the work organization in the worker's decision about committing suicide. This means that the management practices, which are increasingly more perverse, used on the contemporary work organization, may be influencing the worker's subjectivity, giving an even stronger evidence that it is necessary to make the labor relations more humane. Suicide is, in this sense, "a serious and scathing complaint of what is experienced in the workplace: competitiveness, pressure, humiliation, threats and attacks, imposed individualism, loneliness, lack of companionship, fear and lonely suffering" (Barreto & Venco, 2011). For the authors, work both builds and ruins individuals, it can cause damage and harm to their health. Not rarely would such negative effects be irreversible, because they "impose psychological distress seen as despair, agony, hopelessness, loss of efficiency at work, lack of freedom, displeasure, feeling of emptiness and worthlessness, suicidal ideation and, subsequent, death by suicide" (Barreto & Venco, 2011).

Such analysis has also been made by Orellano (2005), in its research about the relation between suicide and work, or, to be more specific, the lack of it. Argentina is the chosen scenario and the process of productive restructure is the starting point. The crisis that happened in the eighties, the stage of internationalization of the economy characterized by globalization and deregulation of financial markets, caused many undesirable effects. Among these effects is the drop of the overall life quality, the drop in economic welfare. Moreover, the population's health was affected with new physical and mental conditions emerging, tracing a new profile of individual vulnerabilities. The study showed a relation between the social events of different magnitudes that ended up leading the people to specific actions related to their subjective natures. Among such actions suicide must be mentioned as a social pathology. However, there would be also the perspective that social institutions could deal with the social disintegration process that would be happening, notably denouncing the new business methods that culminate in human degradation. People increasingly become only numbers, and it is easy to replace them at any moment, even if they reach the goals proposed by the companies (Santos *et al.*, 2010). It is, then, possible to conclude that there is a close relation among mental disorder, illness and the working history of the individuals. This means that the different kinds of management of the working organization are likely to be considered as vectors of disease, depression and suicide attempts. The difficulties faced during work end up becoming a burden on the person's life, becoming part of the personal field. "In short, work becomes a prison, dominating completely the person's psyche" (Santos *et al.*, 2010).

The phenomenon of suicide, once restricted to the countryside in France, seems now to have its limits expanded, affecting the tertiary, industrial and service sectors (Dejours, 2008). This is also noticed by Merlo (2011) when he states that psychological distress originated from the work may be manifested in several ways, including suicide (Merlo, 2011). The author remarks that the profile of the patient's diagnoses during appointments at *Ambulatório de Doenças do Trabalho do Serviço de Medicina Ocupacional do Hospital de Clínicas de Porto Alegre* (clinic of labor diseases of the occupational medicine service of Clinical Hospital from Porto Alegre) has been changing. It is increasingly noticeable cases which involve psychological suffering. Thus, suicides in the workplace are considered a relatively new issue, mainly due to difficulties in establishing the relation between this phenomenon and work: "suicide that occurs in the workplace leaves little doubt. What we live today in the workplace are pathologies of loneliness." Besides, as mentioned by Merlo (2011), in the Brazilian scenario we must make an effort to make this issue visible, considering it represents the failure of the person's defenses to resist against suffering (Merlo, 2011).

In the end, it is believed that suicide cannot be explained only by individual motivations (Dias, 1991). While these motivations would be important, they would not be the only ones, but also related to social factors that transcend the limits of personal life and rely on forces which are external to the person, like values and the same cultural patterns of a specific society, as a more interactive and dialectical phenomenon of suicide. So, this issue would imply on a structural analysis of the principles and mechanisms regarded to where the modern society is. Therefore, suicide would be multi-determined by factors that can only be learned from the focus on a subject that is part of a society, establishing an exchange (Dias, 1991). Thus, psychological, biological, social, cultural and economic factors make suicide a complex phenomenon that has been the fourth leading cause of death for people between 15 and 44 years old around the world (Brzozowski, Soares, Benedet, Boing & Peres, 2010). Also, it is estimated that by the year 2020 about one and a half million people will have committed suicide and that from 15 to 30 million people will have attempted suicide (Brzozowski *et al.*, 2010).

In such a way, self-inflicted violence occupies a prominent place as a social problem that cause impact on worldwide public health and suicide rates work as indicators for the analysis of social change, especially those which weaken and have a bad effect in some individuals, causing them to give up their lives (Cavalcante & Minayo, 2004). Suicide can be considered as a global self-aggressive act, performed by the people themselves, in a conscious way, when they believe that this choice would lead, in an efficient and adequate way, to the expected result (Cavalcante & Minayo, 2004). Even

though, deaths by suicide certainly do not embrace all the deaths that result from self-destructive processes, considering that besides the suicidal acts, there are references to suicide equivalents which include certain deaths by accidents and homicides, in addition to chronic self-destructive processes that could end up as death by natural causes (Barros, 1991). Regarding to that, there are difficulties intrinsic to the self-destruction process and several studies pointed out the hypothesis that common causes and triggering processes could exist as part of the database of violent deaths, including deaths by suicide, homicide and accidents and even natural deaths, such as neoplasia, myocardial infarction and liver cirrhosis. In fact, society today faces a historical period characterized by intense transformation of values and customs and people are confronted daily with situations involving violence (Werlang, 2006).

Among these situations there would be the self-inflicted violence, interpersonal and social violence, which could be physical, sexual or psychological and even the privations and the negligence that all together show how the measures against violence are increasingly urgent (Werlang, 2006). As well stated by Minois (1995), nowadays the intellectuals are dealing less and less with the issue of suicide and when they do it, it happens because of the pressure brought by the statistics. "Suicide kills more than road accidents: there is a victim every fifty minutes and this number is constantly increasing" (Minois, 1995). The author also states that the consequences of suicide have not changed over time, suggesting that this is a phenomenon that blames on the social organization, which is criticized for its failure to ensure happiness to its members. Moreover, during the time suicides have been observed, it was possible to notice that it is also a phenomenon related to social classes: there are ways to die which are more and less noble. The mistreatments over the corpses have always existed for those who are less fortunate. The ones who had better conditions would feel the tolerance, but for the "ordinary", "only with some rare exceptions" (Minois, 1995), the majority of cases involving suicide was related to excessive physical, moral or emotional suffering. People would kill themselves due to the suffering and the punishment, the "judicial savagery" would slowly start being rejected and madness would come into play as a kind of escape. People shut up, and this attitude ends up transforming the suicide in a taboo issue (Minois, 1995).

Suicide in rural areas of Rio Grande do Sul

Rio Grande do Sul is the Brazilian state which has the highest rates of death by suicide if compared to the other states. This position allows us to think about some specific conditions in the state, particularly those related to the rural sector, and, in addition, ponder about the Municipal Mortality Rate by Suicide (MMR-S) in Rio Grande do Sul, which has been growing while the general population rates decrease and the rural population rates increase. This is

the table made available regarding to the last ten years of deaths by suicide analyzed in the State. The small towns and villages with significant rural population tend to increase their suicide rate compared to the ones with a higher urban population. This finding is important to illustrate the movement that the phenomenon of suicide has followed in the recent years. The table below shows the thirty towns whose MMR-S is among the highest in the state:

Considering the thirty towns mentioned above, it is possible to observe that in only seven of them the rural population is not higher

Table 1. The higher MMR-S in Rio Grande do Sul state (2000-2010)

Number	Town	Urban Population	Rural Population	Total Population	MMR-S
1	Sério	530	1,751	2,281	61.37
2	Cristal do Sul	931	1,895	2,826	46.00
3	Nova Boa Vista	578	1,382	1,960	45.91
4	Santo Antônio do Planalto	1,233	754	1,987	45.29
5	Poço das Antas	861	1,156	2,017	44.62
6	Sete de Setembro	494	1,632	2,126	42.33
7	André da Rocha	496	720	1,216	41.11
8	Campos Borges	2,006	1,488	3,494	40.06
9	Boa Vista do Sul	391	2,387	2,778	39.59
10	Campina das Missões	2,188	3,929	6,117	39.23
11	Sinimbu	1,437	8,630	10,067	35.76
12	Canudos do Vale	411	1,396	1,807	33.20
13	Alecrim	2,165	4,880	7,045	32.64
14	Coqueiros do Sul	904	1,553	2,457	32.56
15	Forquetinha	465	2,008	2,473	32.34
16	David Canabarro	1,912	2,771	4,683	32.03
17	São José do Herval	867	1,337	2,204	31.76
18	Lagoa dos Três Cantos	807	791	1,598	31.28
19	Linha Nova	416	1,208	1,624	30.78
20	Doutor Ricardo	693	1,337	2,030	29.55
21	Marques de Souza	1,545	2,523	4,068	29.49
22	Roca Sales	6,602	3,685	10,287	29.16
23	Agudo	6,894	9,835	16,729	28.69
24	Ponte Preta	512	1,238	1,750	28.57
25	Presidente Lucena	1,511	974	2,485	28.16
26	Herval	4,523	2,234	6,757	28.11
27	Tiradentes do Sul	2,098	4,363	6,461	27.85
28	Vale Verde	882	2,371	3,253	27.66
29	Dois Lajeados	1,563	1,717	3,280	27.43
30	Marcelino Ramos	2,722	2,412	5,134	27.26

Source: Built by the authors from data obtained from The Brazilian Institute of Geography and Statistics (IBGE) and DATASUS.

than the urban population. In the 23 remaining locations, it is perceived the rural population has a significant presence in the total population. In any case, they are all cases of small populations, whose totals vary from 1,200 inhabitants to a maximum of about 16,000. This detail is important as it makes possible pondering about the current conditions in rural areas, which may impact on the MMR-S.

As a matter of fact, it must be acknowledged that the countryside is not the same anymore. The countryside is not necessarily synonymous of what is primarily agricultural. It has been used, not rarely, as a place of residence. Sometimes families combine the agricultural activities with other activities not necessarily related to food production. The firewood cutting and aviaries are some examples. In this case, it is also noticed the relation with the industry: the small farmers are, more and more, becoming part of a bigger system and their relation with the industry shows this change. This is a tiny glimpse, *a look through the crack* of this "new" rural world that emerges: The natural economy, little by little, is being wiped out. The peasant or small farmer is almost an endangered individual.

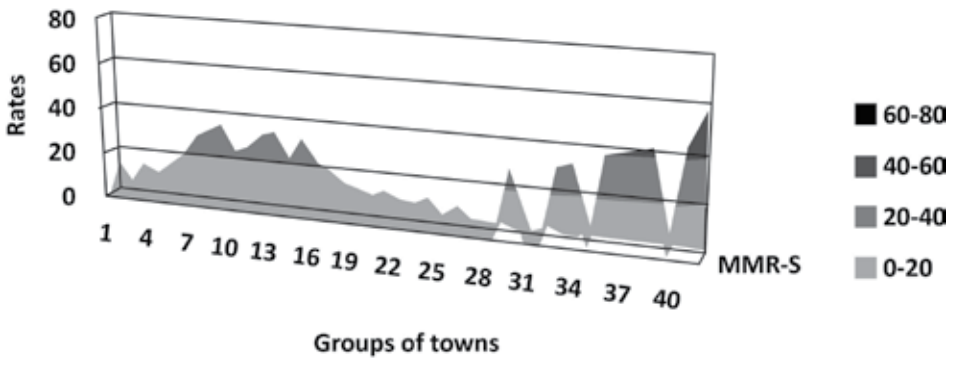
Table 2. Average MMR-S in Rio Grande do Sul state/100,000 (2000-2010)

Number	State	Urban Population	Rural Population	Total Population	MMR-S
1	Rio Grande do Sul	9,102,241	1,593,291	10,695,532	10.078

Source: Built by the authors from data obtained from The Brazilian Institute of Geography and Statistics (IBGE) and DATASUS.

The table above shows the average mortality rates by suicide in the State, from 2000 to 2010. The average MMR-S is 10.0/100,00 to 498 cities analyzed. As it was previously mentioned, the MMR-S increases in the same degree that the total population decreases and, within it, the rural population increases while the urban population does not. The graph below illustrates the distribution of the MMR-S in the State in relation to the towns which are part of it. The small towns of the state tend to have higher MMR-S than the bigger towns, with prominent urban populations.

Figure 1. Division of the MMR-S in Rio Grande do Sul



Such changes can impact on people's lives. We must consider the arrival of non-agricultural activities in rural areas, since these activities change the common pattern of the space, under capitalist auspices, regarding to the farmer's ways to be and to do things. This is the change Salmona (1994) talks about when she talks about the cleavage of identity. The small farmer is already a foreigner in his world. And if he is not feeling it yet, it seems that the path to get to it is not going to take too long. Besides the cleavage of personality, there is an increase in physical and psychological work-related load, especially when there is the combination of work with industry. The way how people make things has changed. It is the economic incentive being part of family lives, the industrialization of the countryside, where the process of "deruralization" starts taking place, confirming what Hervieu (1996) said: rural will no longer be a synonym of food production, *this slogan will be gone*.

Thus, this (dis)integration is happening: the families are becoming pluriactive and the combination between the agricultural and non-agricultural work in the countryside is becoming the same thing. In this context the wage is taking the countryside, through other non-agricultural activities which are made by residents of the rural areas. This is the contradiction: while there are alternatives to generate income, the non-agricultural activities undermine the farmer's identity, cleaving it, impoverishing his culture and techniques. The isolation, the issues involving the health loss, the impossibility to exercise and practice activities daily are issues that also need to be considered. The rural, in this sense, has become a space of precariousness, a precariousness that entails the loss of social objects, both the real and idealized ones: there is a real loss of health, work, social status, importance of the nuclear family, financial, family and social ties and emotional bonds. There is also fear: fear of running out of work, of not being recognized, of becoming socially invalid. Slowly, this loss gradually shows signs of the difficulties to live, signs of being unable to live. Tomorrow is no longer seen as a project: There is no future perspective and, therefore, *it is better to be dead*. Thus, the self-exclusion is becoming real, self-generated alienation takes shape: the dullness, the self-closeness that does not allow anymore dreams. These people stop dreaming. This social precariousness leads to the loss of trust: Firstly, the loss of self-trust.

They stop believing in the ability to make things happen, to make things work, to be able to achieve. After, trust in others also disappears: they do not represent a shelter anymore. Finally, the future remains broken-down. There are no social ties established that can counterbalance the sense of loneliness which is experienced. In fact, there are two processes that are intersecting: the ones provided by the new ways of life brought by capitalism in the countryside, which affected more than the economic dimension, changing also the identities and previous lifestyle, leading to a

precariousness context; a heightened precariousness, inciting the loss of confidence. Thus, economic incentive and social precariousness cause social suffering which, in its worst representation, may be leading to suicidal practices. The precariousness is not only related to situations of real loss, but also to the possibility of losing, feeding the agony related to losing the job, the ability to work, health, money, home. Finally, what can be noticed is an increase in the MMR-S in locations where there is a significant rural population. This fact can be related to the changes in the rural areas around the world nowadays, what makes us question ourselves what is actually rural in the countryside. This scenario of a rural area that is not so rural, is the place of insecurity, it is the prospect, the specific context in which the instability is being developed, leading to social distress. This, in turn, in its enhanced form, has led to the self-exclusion process, materialized through suicide. This is the context of the "new rural" that has been taking place under the trend of capitalist modernization in the countryside.

The sociopathologies of the development and of the economic incentive

The precarious social space which has been described is where some sociopathologies caused by the violence of the economic and technical procedures imposed on rural households through the modernization process can be found. The *development sociopathologies* are manifested as mental illness, depression and suicide, boosted by a model of development imposed on rural areas through economic incentive and, also, through an economic speech which carries a project of hope (Salmona, 1994). In this context, more than the self-destruction processes related to the social, there would be also processes of cultural and technical impoverishment. These two, by their turn, would not be harmless. What are the human costs of the modernization process of small family enterprises? How does the modernization or intensification of work is dealt with by families, by the social groups? These are some of the questions outlined by Salmona (1994) in order to study the social costs that could be linked to an economic incentive, which can cause diseases to the body, mind, family and family group, in a broader sense.

The human cost, in that respect, would be related to people's losses: psychic, relational, social and identity loss. Thus, there would be human costs arising from the development and economic incentive processes, which could be classified into three types: a) psychophysiological costs; b) relational and familiar costs and, c) human costs of structural origin. Among the psychophysiological costs we must highlight, first of all, issues regarding to the physical and psychological diseases and the accidents related to the kind of work that is performed. They would be, in that matter, linked to the time and the volume of work performed. However, there is an increase of nervous fatigue, caused by the management processes that sneak in, in rural areas, and, also, by anxiety and concern regard-

ing to the new kinds of management of agricultural business. At the core of this type of psychophysiological cost related to the economic incentive, there would be an impoverishment process of personal identity, which would lead to symptoms of an identity cleavage.

There would also be an autonomy of the self-image, an autonomy of the self-representation, case when the worker would represent himself as an segmented self, cleaved, as the work performed would be beyond his capacity. Lastly, in the same context, there would be a process of self-generated alienation, in which the farmers would close themselves in the silence and loneliness, not expressing their aggressiveness, their feelings, anymore. Here is where the process of desocialization can be found attached to a high volume of work and to a strong self-destruction desire, in a movement called self-generated alienation. Castel (2003) uses a term disaffiliation which, to talk about a state or situation of privation to recount experiences, trace trajectories and explain processes. The analytical grid which he uses to explain the phenomenon of social disaffiliation, while revealing the various constitutive phases of the social exclusion process, brings to some different social zones: social integration zone, individualization zone, vulnerability zone, exclusion zone, assurance zone. He talks that the core of the social issue today is the existence, again, of the useless to the world. This is a paradox. It took centuries of sacrifice, suffering and enforcement –the force of laws and regulations, coercion of necessity and also hunger– to be the civilization of work that is required under the wage condition. Now all seems that is gone.

Then, this desocialization movement would happen even counting on the family and neighbors presence. Such alienation mechanisms would be linked to different factors in a work that becomes more and more unbearable to the person, to a heavy psychological and physical load, insolation, disease, and, finally, a strong desire to destroy himself. The family and neighbors presence would not minimize or stop such a pathological phenomenon.

More than the psychophysiological costs, there would also be the relational and familiar costs, as previously mentioned. Not uncommonly is there more than one generation being part of the same group of family farmers. Thus, sometimes, the family members face exploration situations of other members of the family unit, of the work group, especially in moments when there is a change of working methods and/or management, besides, when there is a change of the work pace developed on the property. The increase in workload, the pressure and also the embarrassment, accentuate the conflicts which already exist within the working group, causing new conflicts that lead to physical and nervous fatigue. In the groups analyzed by Salmona (1994), the conflicts between people from different generations are accentuated when there are modernization

processes or reorganization of activities in rural areas. In this respect, there is a whole group of trials ranging from increasing the time spent working to giving up holidays, weekends and even vacation time, increasing the cases involving depression and aggression among members of the family group. In this context the impoverishment of family relations takes place, along with the previously mentioned desocialization process.

During the development of modernization and economic incentive processes, there is an increase in the mental and physical work-related load and, especially, an exorbitant increase of nervous fatigue linked to the changes in working activities, gender division of labor, the increasing rates of surveillance, control and management of the rural development. It is also in the family core that Tabary (2007) observes the growth of an increase in the number of divorces. The crises the couples face have led increasingly to this practice. In other words, the social and economic difficulties are leading to family crises for couples that make their living with small farming production (Tabary, 2007). The weakness among couples advances to the same extent than the life projects are set apart: will they stay in the countryside or move, change the lifestyle they have? The familiar cost is, not rarely, the disruption of affective and loving relationships (Tabary, 2007).

Lastly, there are human costs of structural origin, namely, the pathogenic effects produced in the family groups which engage in projects of individual or group development. Such effects would be caused both by the functioning of the agricultural bureaucracy as by the modernization process itself, by the injunctions suffered through the regulating of the groups or families and, moreover, the brutal contact with an algorithmized knowledge (Salmona, 2002) conveyed by the economic structure, especially the one related to the organization and dissemination of the activities to be done by farmers when they opened the doors to the processes of modernization. Then, we can ask: Would be the farmers the new useless these days, as told us Castel? The economic incentive processes induce to a number of cultural, relational, physical and psychological negative effects, which cause, in their turn, paradoxical messages, producing situations of double embarrassment. The causes of these negative effects could be avoided, since the mechanisms of impoverishment and deterioration could be noticed in case of changes or quick transformations in the economic environment. The economic incentive would be, then, the leading force of the modernization processes that are conducted by the State. Those factors brought by new kinds of management of the agricultural work, were articulated to a process of diffusion of new technologies or technological innovations in the agricultural environment, making possible to verify the human and social costs that the process of modernization left behind: The full destruction of family units, the physical and psychological illnesses, the famil-

iar illnesses, the cleavage of personality. These issues became dominant among families.

Thus, the hopelessness becomes real and depression and suicide are the main consequences of the development policies and working conditions that are taking place. The processes of modernization have implications, especially in rural areas, which are being analyzed. The work performed, the work conditions and transformations lead to suffering and they have affected greatly the mental health of the rural population, causing morbidity. This process brings another process along with it: the brutal acculturation, which affects even young people living in the countryside and which has been crucial when dealing with depression and suicide in rural areas in the last twenty years (Salmona, 2002). So, the economic development beyond the changes in several dimensions of the personal and family life, causes changes in the way of being, seeing and thinking about the world, and such circumstances have caused suffering. The incitative policies carried by the State, noticeable in the French case, but which can be considered an inspiration to what is lived today in Rio Grande do Sul, have led to a tiredness: tiredness of the progress. The process of modernization which small farmers are exposed to, the march which they are forced to be part of, has led them to ask themselves the type of "development" that is ongoing. What happens in the rural world is a big change through the mechanization, the great use of chemical products, the informatization. All these "revolutions" within the agricultural world work have contributed to the increase of the working accidents, the illnesses, the depression, health conditions, but, mainly psychological health problems (Salmona, 2007). The issue which takes place is, then, that the rural world has led to the production of morbidity. The advance in the capitalism range in the last fifty years would have brought a kind of "shade" under the rural societies, if they are compared to the urban world. The new kinds of agricultural production had changed the rural world, however, the impacts to the population's health were not studied in such a deep way as in the urban (Salmona, 2007). The entrance of the capitalism in the private space of the farmer's families would be one of the deterioration elements of the family itself. The urban employees are not attacked directly in the nuclear family by the development agents, however, when we talk about the family farmers, this entrance happens straightly and, not uncommonly, with supervision and follow up. The private area is, then, invaded, filled, and this intense entrance in the private space shows one of the differences between the rural and urban workers. This is an important issue to be observed, since a great number of suicides happen in the rural areas. In order to show the suicide issue among farmers, Wachter (1987), trying to identify an etiology of suicide and movement around the "map" of these deaths in some other areas of France. The author points out that there are some "suicidogenous" zones which have a special kind of familiar structure: They are marginalized

and socially relegated families, having their members isolated. These groups build, within themselves, feelings of loneliness and despair, motivating some "self-destruction pathologies", such as alcohol addiction and suicide. However, there would be more than that. In the contemporary moment of territorial and social path of suicide, the author notes that this is circumscribed in some fixing points: In the lower levels of the social hierarchy, among workers, farmers, employees who earn their own salary, social categories in which members have little or no chance of social mobility. In such a way, this lack of mobility is intertwined with the territorial or even residential inertia and the perpetuation of this social condition can lead to affective flams, but, at the same time, can generate feelings of disappointment, despair, resentment, frustration. The intensity of such feelings can end up being manifested through violent acts. According to Wachter (1987), in social inertia context and with the ordinariness of lifestyles, these shall be seized as social losses. The sense of social and spatial relegation doubles in a tragic dimension, since the fragile family institutions no longer perform their role of making people feel safe and protected. So, in order to escape from this situation, of the fixedness of this social situation, one possibility is self-destruction. To such a degree, suicide would be a pathology from the grounding and, at the same time, from the grounding which affects the groups that are in a situation when there is a lack of perspective.

Conclusions

Dealing with issues involving suicide constitutes an acceptance of the overlap between individual and social, a complex interrelationship between psychological and social, biographical and contextual, structural and casual. As said Durkheim, suicide is individual, however, the causes are social and, we may add, complex. It is also important to highlight that the feeling of suffering, origin of the self-destruction processes, is indeed a part of human existence, however, nowadays, its limits are preventing from living and, moreover, are acting against everything that ruins life. Suffering has been followed by a retraction from social relationships and by a lack of perspective about the future. The horizon gets blurred and carries no possibility of action, what leads to a sense of social worthlessness, shame and self-blame. Those who suffer are prevented from acting against what makes them suffer: they are "frozen", self-excluded; they no longer feel the body, the thoughts. They lose or fear the loss of the social objects, become self-alienated, make themselves inactive, refuse to care, refuse relations, leave their own self. They lose their subjectiveness, psychologically excluded, looking only for their own way to "leave the self" and the death of the self. This does not come out of nowhere, it comes from social and economic organization that invades bodies, minds, family relations, community relations. It is the social and economic system, acting as a generator of the precariousness, of the human, family and psychophysiological costs, of the

process of desocialization, of the self-generated alienation, of the self-cleavage. Moreover, this articulation of social and individual can contribute to highlight the situations of violence, domination and injustice that the human being is submitted to. Choosing such an extreme factor between the social and the individual through suicide means bringing a little light to the invisibility of some mental processes that, often, are blurred. It allows, as well, reporting the offensive face of modernization processes, especially those related to the "development" of the agricultural world. It also gives the chance to report the situations of loss of hope, dreams, confidence caused by a political, social and economic model whose dynamics has led to different destruction processes.

References

Arendt, H. (1999). *Eichmann em Jerusalém: um relato sobre a banalidade do mal.* São Paulo: Companhia das Letras.

Barreto, M. & Venco, S. (2011). Da violência ao suicídio no trabalho. En M. Barreto, N. Berecheim & L. Pereira, *Do assédio moral à morte de si*: *significados sociais do suicídio no trabalho* (Capítulo 9). São Paulo: Matsunaga.

Barros, M. (1991). As mortes por suicídio no Brasil. En R. Cassorla, *Do suicídio*: *estudos brasileiros* (Capítulo 3). Campinas: Papirus.

Bastos, R. (2009). Suicídios, psicologia e vínculos: Uma leitura Psicossocial. *Psicologia USP*, *20*, 67-92.

Brzozowski, F. *et al.* (2010) Suicide time trends in Brazil from 1980 to 2005. *Cadernos de Saúde Pública*, 26, 1293-1302.

Butler, J. (2005). *Giving an account of oneself.* New York: Fordham University Press.

Cavalcante, F. & Minayo, M. (2004). Organizadores psíquicos e suicídio. En M. Prado, *O mosaico da violência*: *A perversão na vida cotidiana* (Capítulo 8). São Paulo: Vetor.

Castel, R. (2003). *As metamorfoses da questão social: Uma crônica do salário*. Petrópolis, RJ: Vozes.

Chávez-Hernández, A. & Leenaars, A. (2010). Edwin S. Shneidman y la suicidología moderna. *Salud Mental*, 33, 355-360.

Couto, M. (2012). *A confissão da leoa*. São Paulo: Companhia das Letras.

Dejours, C. & Bègue, F. (2010). *Suicídio e trabalho*: *O que fazer?* Brasília: Paralelo 15.

Dejours, C.(2008). Novas formas de servidão e suicídio. En A. Mendes, *Trabalho e Saúde*: *O sujeito entre emancipação e servidão* (Capítulo 2). Curitiba: Juruá.

Dias, M. (1991). O suicida e suas mensagens de adeus. En R. Cassorla, *Do suicídio*: *Estudos brasileiros* (Capítulo 5) (2nd ed.). Campinas: Papirus.

Durkheim, E. (2000). *O suicídio*: *Estudos de sociologia*. São Paulo: Martins Fontes.

Hervieu, B. (1996). *Los campos del futuro*. Madrid: Ministerio de Agricultura, Pesca y Alimentación.

Lovisi, G. *et al.* (7 de Septiembre de 2011). *Análise epidemiológica do suicídio no Brasil entre*

1980 e 2006. Recuperado de http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1516-44462009000600007&lng=en&nrm=iso

Merlo, A. (2011). Entrevista 01. En M. Barreto, N. Berechtein & L. Pereira, *Do assédio moral à morte de si*: *Significados sociais do suicídio no trabalho* (Capítulo 1). São Paulo: Matsunaga.

Ministério da Saúde do Brasil (23 de Junio de 2010). *MS*. Recuperado de http://portal.saude.gov.br/portal/saude/cidadao/visualizar_texto.cfm?idtxt=25605

Ministério da Saúde do Brasil (23 de Abril de 2011). *Portaria 1.876 de 14 de agosto de 2006*. Recuperado de http://dtr2001.saude.gov.br/sas/PORTARIAS/Port2006/GM/GM-1876.htm

Ministério da Saúde do Brasil (12 de Mayo de 2012). *MS*. Recuperado de http://portal.saude.gov.br/portal/arquivos/pdf/levantamentobibliografico.pdf

Ministério da Saúde do Brasil (Junio 15 de 2012). *Datasus. MS*. Recuperado de http://www2.datasus.gov.br/DATASUS/index.php?area=0205

Minois, G. (1995). *História do suicídio*: *a sociedade ocidental perante a morte voluntária*. Lisboa: Teorema.

Orellano, M. (2005).*Trabajo, desocupación y suicidio*: *Efectos psicosociales del desempleo*. Buenos Aires: Lumen.

Rocha, F. *et al*. (2007). Suicídio em Belo Horizonte entre 2004 e 2006. *Revista Brasileira de Psiquiatria*, 29, 190-191.

Salmona, M. (1994). *Souffrances et résistances des paysans français*: *Violences des politiques publiques de modernisation économique et culturelle*. Paris: Editions L'Harmattan.

Salmona, M. (2002). *Les champs de la souffrance. Agriculture: Entre contrats & contrôles*. Recuperado de http://www.agrobiosciences.org/IMG/pdf/acte8e_univ_marciac.pdf

Salmona, M. (2007). *Dépressions et suicides dans le monde des petite paysans*. Recuperado de http://www.orspere.fr/IMG/pdf/C033164_Rhizome_28.pdf

Santos, M., Siqueira, M. & Mendes, A. (Junio 11 de 2011). *Sofrimento no trabalho e imaginário organizacional: Ideação suicida de trabalhadora bancária*. Recuperado de http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-71822011000200017&lng=en&nrm=iso

Santos, M., Siqueira, M. & Mendes, A. (2011). *Tentativas de suicídio de bancários no contexto das reestruturações produtivas*. Recuperado de http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1415-65552010000500010&lng=pt&nrm=iso

Tabary, J. (2007). *Néo-ruralité et souffrance psychosociale*. Recuperado de http://www.orspere.fr/IMG/pdf/C033164_Rhizome_28.pdf

Viana *et al*. (2008). Prevalência de suicídio no Sul do Brasil, 2001-2005, Rio de Janeiro. *Jornal Brasileiro de Psiquiatria*, 57, 38-43.

Wachter, S. (1987). Éta: Décentralisation et territoire. Paris: L'Harmattan.

Wang, Y., Mello-Santos, C. & Bertolote, J. (2004). Epidemiologia do suicídio. En A. Meleiro, C. Teng & Y. Wang, *Suicídio: Estudos fundamentais* (Capítulo 6). São Paulo: Segmento Farma.

Werlang, B. (2006). Comportamentos Violentos. En B. Werlang & M. Oliveira, *Temas de Psicologia Clínica* (Capítulo 2). São Paulo: Casa do Psicólogo.

World Health Organization (10 de Junio de 2010). *Prevenção do suicídio: Um manual para profissionais da saúde em atenção primária*. Recuperado de http://whqlibdoc.who.int/hq/2000/WHO_MNH_MBD_00.4_por.pdf

World Health Organization (11 de Febrero de 2011). *World Report on Violence and Health*. Recuperado de http://whqlibdoc.who.int/hq/2002/9241545615.pdf