Editorial: is adolescence an illness of the mind or an apprenticeship of life experiences

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Acknowledgement – Special thanks to Dr Cassidy whose multiple reviews of this editorial finally pointed me to some evidence supporting my long-running notion that in order to prevent suicide, suicide prevention strategies must address 'suicide' instead of mental illness.

This editorial argues that suicide prevention strategies will be more responsive when suicide rather than mental illness is addressed. Lived experiences are more relevant and appropriate to addressing suicide than seeking to diagnose a mental illness which may or may not be present, in order to stop a suicide. A scenario is presented in which when 'suicide' was addressed the case survived, whereas multiple suicide attempters who time after time were treated for a mental illness and then subsequently died by suicide.

It cannot be denied that suicide has always occurred regardless of regions, ethnic groups and across time (Pridmore & Pridmore 2020a; also see archives of DHH). Historically, the portrayal of suicide in literature has been the inevitable solution to dire circumstances, or, poetically, as a demonstration of the extent of love between two people, i.e. life without one another is not worth living or too hard to contemplate (Pridmore & Pridmore 2020b, Pridmore & Rostami 2020, Pridmore et al. 2019, Pridmore 2018). As such, society was conditioned to accept suicide as an inevitable or a normal reaction to [perceived] hopeless circumstances. This perception is still valid. In dedicating his book, the Sealed Box of Suicide (Tatz et al. 2019) to his great uncle, the late Colin Tatz remembered him as a poet who sold chicken feed but was a poor book-keeper, who sadly committed suicide because he misread his healthy credit column as a debit.

Before the medicalisation of suicide, literature promoted suicide as a result of despair or unbearable circumstances – at the same time it implicitly promoted the uselessness of suicide as a solution. If only Mark Anthony and Cleopatra, Romeo and Juliet, and the late Colin Tatz's great uncle had waited to confirm the circumstantial evidence before taking their own lives, then life may well have been different.

As has been repeatedly discussed in DHH (e.g. see Pridmore & Pridmore 2020b, Pridmore & Rostami 2020, Pridmore et al. 2019, Pridmore 2018), we can make two major conclusions; firstly, suicide has never been viewed as an illness of the mind but as a reaction to dire circumstances (also see Tatz 2019), secondly, literature's portrayal of suicide, poetic or otherwise, implicitly warns society that suicide does not solve problems, on the contrary it complicates circumstances further. The implied conclusion from such literary stories is that society needs to be more attune with its own vulnerability and develop resilience to protect its population from adverse events.

Indeed, such notions are clearly evident from a review of those who survived a serious suicide attempt. For example, the account of two suiciders, Kevin Hines and Ken Baldwin,

who jumped off the Golden Gate Bridge in San Francisco and survived (https://abc7news.com/golden-gate-bridge-suicides-suicide-survivors-jump-survive/2010562/), are quite revealing and illuminating. In this interview the suicide attempts are presented as the result of mental illness.

Since the medicalisation of suicide we have been conditioned to ditch the literary reasons for suicide in favour of a mental illness which is automatically assumed when a suicide occurs and vice versa (Shahtahmasebi 2005), even when there is no evidence.

There is an urgent need to, at least, consider an alternative analysis of suicide in relation to lived experiences rather than automatically assuming mental illness as the cause of suicide. for example: -

Firstly, both survivors talked about their perceived life problems. Secondly, they both expressed their profound regret as soon as they had jumped. Thirdly, they referred to the ironies of life: that as soon as they left the bridge they instantly regretted their decision and appreciated their lives. Indeed Ken said 'When I wanted to live the most, I was probably going to die'. Fourthly, they implied that there had been a lack of dialogue with family and friends they expressed their desire to have had talked to their family and friends. Fifthly, Kevin Hines's account where he described that he thought he was a burden on his family and that he was useless – is a feeling not unfamiliar to adolescents (Omar et al. 2018)!

This is consistent with other accounts of suicidal behaviour. Some individuals who have been diagnosed with a mental illness may develop suicidality, at least in part, due to the emphasis on mental illness as the cause of suicide. In some cases suicidality may develop some years after a number of mental illnesses have been diagnosed. In such cases, suicidality is often manifested after taking prescribed medications, e.g. see Vee's story (Vee 2020). In her book, Vee listed how she had been diagnosed with a number of psychiatric conditions since childhood. Her suicidality manifested much later into adulthood and after taking prescribed medication. Vee clearly did not want to die for the main reason that she seeks medical help as soon as suicidality manifested itself - but because of her mental illness diagnoses she had come to believe that she would die by suicide. However, she found mental illness services were lacking and indifferent to her needs, and were unequipped in dealing with suicidality unless a serious attempt was made – she found non-medical and community approaches were more relevant (personal correspondence).

Kevin's account does not suggest mental illness as the cause of suicidality – despite the fact his thought processes were influenced by despair he was in favour of living rather than dying - he made a pact with himself; if one person asks him if he is O.K. he would tell them everything and ask for help. But no one did. Finally, someone approached him pulled out a camera and asked him to take her photo – he took the photo, then he jumped. But he regretted his decision as soon as he jumped.

The flip side of the coin is that someone did talk to him so why was Kevin unable to take the opportunity and start a conversation?

The truth is that, globally, the medical model of suicide prevention and media have taken humanity out of suicide – under this model, no one, other than those psychiatrically trained, can talk about suicide (Shahtahmasebi 2018a & b) – and as a result no suicide discourse has been developed. Therefore, people are too afraid or do not know how to approach suicidal

people or what to say to them. Conversely, suicidal people are afraid to say how they feel or do not know how to seek help because they are worried that they will be referred to a psychiatric unit and/or be labelled as mentally ill.

As a result, suicidality; the persons' real life experiences and state of mind are unwisely dismissed and ignored in favour of finding symptoms that might fit a mental illness diagnosis.

The video of the interview with Kevin Hine and Ken Baldwin is a great example of a dismissive society. The two suicide survivors share their life experiences to warn people that suicide is not a solution to life's problems. However, their accounts of 'lived' experiences in relation to suicide are dismissed as mental illness by making a reference to the two men's mental illness diagnosis. This unnecessary linking of life experiences to mental illness is the result of a conditioned society to view and accept human behaviour, including adolescent development, as a medical problem (Pridmore & Rostami 2020).

The automatic assumption that suicide is the result of a mental illness has been a huge stumbling block in developing suicide prevention strategies. For this reason, suicide survivors (including family and friends of suicide victims) who become advocates of suicide prevention pressure their governments to invest and commit more resources for mental illness services.

The mental illness approach has persistently failed to reduce suicide rates, there is over a century of data pointing to the fact that this approach does not work. Why do we, as taxpayers, want to invest even more resources in this way? It defies logic/wisdom but the main reason is that we, the tax-payers, are not allowed to *know* of or provide any alternative strategies.

A suicide prevention approach at grassroots (Shahtahmasebi, 2013b) dignifies people's feelings and emotions, and acknowledges their experiences in order to inform the development of prevention strategies.

It is a great shame that policy makers have buried their heads in the sand; it is a great shame that the media is blind and deaf and irresponsibly promotes a failed prevention policy.

Conclusion

In the video mentioned above, the two suicide survivors regretted their action as soon as they jumped – in this way they unwittingly addressed suicide. It was not a psychiatric intervention that made them realise that their life problems were solvable despite their diagnosed mental illness. So suicidality was addressed and resolved. They are still alive and are advocates for suicide prevention. On the other hand, those suicidal cases who were treated for mental illness multiple times, died by suicide (see a selection of cases in Shahtahmasebi 2008, 2005; and Shahtahmasebi & Smith 2013b). Surely, this proves that suicide and mental illness are two different phenomena.

A mental illness approach cannot prevent suicide because it waits for a mental illness to develop or a suicide attempt before intervening – this is not prevention but intervention. If a mental illness has developed then the suicidal person has to wait a long time for a psychiatric intervention and help (Shahtahmasebi2013b). On the other hand the majority of suicide cases are successful in their first attempt – and are then labelled as mentally ill without any solid

evidence. And the remainder of all suicide cases who did seek psychiatric intervention still went ahead and killed themselves. So why should a potential suicidal person seek help from mental illness services? Perhaps because this is the only intervention available – the alternative being suicide.

References

Omar, H. & Shahtahmasebi, S. (2018) Making it to adulthood: why do we miss the warning signs? Dynamics of Human Health (DHH), 5(1): http://journalofhealth.co.nz/?page_id=1510.

Pridmore Saxby, Pridmore William. (2020a) Suicide in Writing Across Time and Place. In Said Shahtahmasebi and Hatim A. Omar (Eds) The Broader View of Suicide. Eds. Cambridge Scholars Publishing: Newcastle upon Tyne 2020. 42-70.

Pridmore, Saxby.; Pridmore, William. (2020b). Suicide in stories from the Middle East (8-12th century). DHH, 7(2): https://journalofhealth.co.nz/?page_id=2153

Pridmore Saxby. & Rostami, Reza. (2020) Suicidal behaviour disorder: a bad idea. In Said Shahtahmasebi and Hatim A. Omar (Eds) The Broader View of Suicide. Eds. Cambridge Scholars Publishing: Newcastle upon Tyne 2020. 265-279.

Pridmore, S., Pridmore, W. & Shahtahmasebi, S. (2019). Suicide triggers in *Les Misérables.* DHH; 6(2): https://journalofhealth.co.nz/?page_id=1834

Pridmore, Saxby. (2018). Jesus, Socrates and suicide prevention. Dynamics of Human Health (DHH), 5(3): https://journalofhealth.co.nz/?page_id=1627

Shahtahmasebi, S. & Omar H. (2020) "A Broader View of Suicide". Cambridge Scholars Publishing, Cambridge, UK.

Shahtahmasebi, S. (2018a) What does a statistician know about suicide and suicide prevention? Dynamics of Human Health (DHH), 5(1): http://journalofhealth.co.nz/?page_id=1512.

Shahtahmasebi, S. (2018b) Only psychiatry: a strategy void of substantive theory and statistical concepts. Dynamics of Human Health (DHH), 5(2): http://journalofhealth.co.nz/?page_id=1574.

Shahtahmasebi S (2013a) De-politicizing youth suicide prevention. Front. Pediatr. 1:8. doi: 10.3389/fped.2013.00008, URL: http://journal.frontiersin.org/article/10.3389/fped.2013.00008/abstract.

Shahtahmasebi, S. and L. Smith (2013b). "Has the time come for mental health services to give up control?" J Altern Med Res **6**(1): 9:17.

Shahtahmasebi, S. (2008) Can suicide be quantified and categorised? In Leo Sher (Ed.). Internet and Suicide. Nova Science Publishers, Inc. pp373-390.

Shahtahmasebi, S (2005) Suicide in New Zealand. *TheScientificWorldJOURNAL* (2005) 5, 527–534.

Tatz, Colin and Simon Tatz (2019). The Sealed Box of Suicide. Zug, Switzerland: Springer.

Vee, Janet (2020) Watching Myself Be Borderline: A Smart Sufferer Says How It Started And How She Survives. Outskirts Press. Parker, USA.