Addressing Suicide: a commentary

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In an article to appear in the Journal of Alternative Medicine Research in January 2022 (Shahtahmasebi S, & Pridmore S (2022) *Addressing suicide: the final nail in the mental illness coffin, J Altn Med Res; forthcoming*), we presented a selection of case stories told by those who survived serious suicide attempts, and argue that they survived suicidality by addressing suicide through changing the focus from a medical definition of suicide to life experiences. This commentary provides a brief summary of the key points.

Introduction

The problem with New Zealand and global suicide prevention strategies is the medicalisation of suicide. This means that mental illness is assumed from the outset. There are two major flaws with this assumption. First, strategies based on such an assumption have failed to *prevent* suicide because they dictate waiting for mental illness to manifest before intervening. In other words, the strategy is merely the ambulance at the bottom of the cliff. Second, the assumption of mental illness, combined with the ambulance at the bottom of the cliff policy means the intervention will only address mental illness (which may or may not exist) and physical injuries, thus, ignoring suicide altogether.

Suicide has been medicalised since the early nineteenth century without evidence. yet, supporting evidence in the form of psychological autopsy type studies was offered over a century later in the late 1950s. However, these studies are substantively and methodologically flawed and the evidence has been discredited and disproved (Hjelmeland, et al, 2012; Shahtahmasebi, 2005). A major source of bias in the data, often ignored, is the general mind-set that suicide is caused by mental illness. As a result, suicide cases are automatically assumed to be mentally ill, and vice versa. For example, in a coroner's inquest into the death of an adolescent, who was reported to have been a happy and popular person with no sign of any health problems and no evidence of mental ill-health, the family GP testified: "I am desperately sad we had no insight into his mental health problems and so were not able to prevent this tragedy." And conversely, a long sufferer of mental illness had come to believe she was going to die by suicide because of her mental illness diagnoses ((Vee, 2020); personal emails).

Current suicide prevention strategies' refusal to address suicide has led to several adverse outcomes. The first and second negative outcomes have been the failure to halt the overall increasing suicide trends, and prevent unnecessary deaths. The third and fourth are the absence of vision and innovative thinking. This stagnation has resulted in invoking zombie policies; strategies that provide "more of the same" every year but with more lives lost at higher financial costs. Fifth, suicide research has not progressed beyond mental illness, and our understanding and knowledge of suicide has been hindered.

Case stories reflect our inability to understand and help prevent suicide. Between one-quarter and one-third of all suicide cases sought psychiatric intervention, yet, went on to complete suicide.

However, there is some evidence to suggest that addressing suicide rather than an automatic mental illness assumption may be more effective in stopping suicide.

Some case examples

In her book (Vee, 2020), Vee expresses a strong long held belief that she was going to die by suicide because of her mental illness diagnoses. Until recently, her suicidal ideation and mental illnesses were treated as one ((Vee, 2020); personal emails). She is highly critical of the psychiatric services in particular the treatment she received every time she sought help with her suicidality. In recent years, she was assigned a new therapist who focused on her life experiences. Now, she believes that her suicidality is not the result of depression; her suicidal ideation has shifted from active ideation to a passive form; the therapist has succeeded in showing her that someone cares. Vee believes that a mental illness approach to suicide is inappropriate: -

> "I have been thinking about the idea that psychiatry doesn't really address suicidal ideation, …"

Claire Freeman became a tetraplegic at the age of seventeen in a car accident when her mother fell asleep while driving her to an interview (https://www.nzherald.co.nz/nz/tetraplegic-model-claire-freeman-speaks-out-against-euthanasia-after-once-planning-to-end-her-life/AOVGFHVLVXN6Q3XAMQVXLK7DN4/), attempted suicide a total of six times. Shockingly, she claims that after her fourth attempt the psychologist and psychiatrist suggested euthanasia in Switzerland where it is legal. She planned her journey to Switzerland but ironically it was a medical emergency that brought about a change in focus in her life. A corrective surgery gone badly wrong which led to further disability helped her reflect on her life and face her demons:-

> "The amazing thing was the sleep. I think that was a really big thing, not being able to do anything, just lying in bed thinking about life."

She admits that her suicidality was not because of her broken neck and her disability as the psychologists/psychiatrists saw, she simply did not have the skills to cope with the massive changes in her life.

> "…it was just, 'Of course she wants to die, she's in a wheelchair, she's in pain.'"

Other examples, also publically available, are the accounts of Kevin Hines and Ken Baldwin who in separate incidents jumped off the Golden Gate Bridge in San Francisco and survived. (https://abc7news.com/golden-gate-bridge-suicides-suicide-survivors-jump-survive/2010562/).

Although the media framed the interviews as a mental illness experience, the two subjects' stories reflect lived experiences. Both subjects mention their mental illness, but they emphasise their personal issues, including experiencing problems with communication with family and friends, feelings of being a burden on family, and being useless.

Again, as in previous cases, they did not wish to die. For example, Kevin Hines explains that despite being in despair he made a pact with himself: if one person asked him if he was OK, he would tell them everything and ask for help. But no one did.

As soon as they had jumped off the bridge, they regretted their decision. Ken said, 'When I wanted to live the most, I was probably going to die'; and Kevin said that suddenly all his problems were solvable, and he regretted his decision as soon as he jumped.

Discussion and conclusion

Psychiatry has claimed ownership of the suicide problem for a couple of centuries now. Two centuries of experience show an increasing overall suicide trend, scant suicide data, lack of progress beyond mental illness, and a lack of insight into suicide. As a result, psychiatry preaches mental illness as the cause of suicide but practises something completely different about suicide. It is not surprising that suicide prevention policy makers offer the same zombie policies that are "more of the same" every year at much higher costs. Yet, in New Zealand and globally suicide prevention strategies are still based on mental illness.

What is astounding is the willingness of politicians, policy makers, researchers and the public to continue to bury their heads in the sand and allow more people to die unnecessarily.

The above cases provide further evidence of the harm that a lack of suicide discourse has. For example, none of the above cases really wanted to die but saw death as a valid option to their problems. They all attempted suicide unsuccessfully – is this why euthanasia was recommended to one case, and the others were expected to attempt before help was forthcoming? Clearly, a well-developed suicide discourse would have led to a more informed communication between Claire Freeman and the psychiatrist/psychologist, and would have enabled Kevin Hines and Ken Baldwin to communicate with their family and friends.

Without a suicide discourse, Kevin Hines and Ken Baldwin did not know how to ask for help. In Kevin's case he placed all his hope on a member of the public to intervene when he made a pact with himself that he would seek help if one person enquired how he was. Neither the passing public nor Kevin himself were able to communicate – as a result Kevin jumped off the bridge, fortunately he survived. Many do not survive to tell their stories.

In the case of Vee, as in previous cases suicide discourse is limited to mental illness. Over the years she has been diagnosed with at least five mentally ill conditions since her childhood. In her forties she began to believe that because of her mental illness diagnoses she was certain to

die by suicide. However she had a terrible experience every time she sought help from psychiatric and mental health units/hospitals for her suicidality. She would have been helped if she had attempted or if she had attempted suicide or had an active plan to kill herself.

If, in the above examples, the subjects' suicidality had not been addressed none of them would have been alive today to tell their stories. The tragedy is that they all had to suffer, but be fortunate enough to survive suicide attempt(s). Change of focus in life can be implemented through life experiences and throughout life. In other words we do not have to wait for suicidality to manifest in order to intervene, but in cases "suicide" must be addressed rather than seeking a mental illness diagnosis.

For example, during 2010-16, suicide was addressed through a series of youth suicide prevention workshops. These workshops were designed to empower communities at grassroots to talk about suicide by providing them with relevant and appropriate information (Shahtahmasebi, 2013). Youth suicide reduced drastically in the communities that took part. One of the comments from suicide survivors (parents who had lost a loved one to suicide) was that if they had received the information provided at the workshop their loved one would probably still be alive.

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