I tried to kill myself when I was 14. It wasn’t the first time. My psychiatrist had just upped my Prozac, a whole lot of unresolved early childhood trauma had flared up at puberty, and the baseline sadness and confusion I felt mushroomed into an overwhelming desire to die. The thoughts wouldn’t leave me alone:
Everything I could think of circled back only to suicide. I wrote out a suicide note and made an attempt. I won’t go into the horrors of waking up alive in an emergency room where the staff was clearly annoyed they had to deal with me and my “attention seeking” behavior. (I have written about this elsewhere.)

I won’t go into the indignity of being involuntarily locked up, time after time, until I satisfactorily convinced the staff that I wouldn’t harm myself or attempt suicide again. (I was lying.) The system taught me to lie, to hide my suicidal feelings in order to escape yet another round of dehumanizing lock-ups and “treatments.” I can safely say that not once did I feel seen or heard in the various settings I was committed to over the years. Generally, I felt more like an object to be diagnosed, dosed, and kept alive against my will.

My champions generally came from outside the mental health system. Mr. Harris (no relation), my high school Honors Comp teacher, came to visit me in the psych ward after an attempt. I was embarrassed to let him see me like that, but I was also secretly happy he showed up. He didn’t see me through the lens of diagnosis or deficit or as a “suicidal patient.” He saw me as a gifted writer, and encouraged me to keep writing. Mr. Harris literally shined the very first light that helped me to journey out of suicide and back to life. (Believe that you, one human being, can make that much of a difference in someone’s life. He did, with no special “training” or “expertise.”)

When I was 25 years old, I made the decision to be “out” as a person with a psychiatric history and past suicide attempts, and entered the world of mental health activism/advocacy. My first real job in the field was in 2008 with a small suicide prevention non-profit. I was hired specifically for my lived experience; but everywhere I went, the only voices that seemed to matter were those of the MDs, the PhDs, or the “suicide survivors,” family members who had lost loved ones to suicide. While these voices are certainly important and we owe much to the grassroots suicide survivor movement for raising awareness about suicide, I wondered why there didn’t seem to be any interest in hearing the perspectives of people like me, who had survived suicide attempts. I resigned from my suicide prevention gig after eight months, not because I believed people’s hearts were not in the right place but because I instinctively felt the prevailing approach was inadvertently making the problem worse. I also couldn’t continue to do grants stewardship for one of their funders, Eli Lilly, whose drugs had caused myself and others to be more suicidal.

I was troubled by the master narrative of suicide prevention, which is all about “promoting help-seeking behaviors,” ostensibly for some underlying, untreated mental health condition. Okay, so let’s say someone heeds the suicide prevention call and gets into treatment. What kind of help will they receive? Likely, a diagnosis, some pills that they may or may not be told they need to take for life, and a discharge. Furthermore, at least one study indicates that “the risk of suicide is higher during the period immediately following discharge from inpatient psychiatric care than at any other time in a service user’s life.” I would argue that this is not only due to lack of follow-up upon discharge, as the study asserts; it is also because most mental health care systems and providers don’t know much about promoting hope and well-being after a suicide attempt. Suicidology experts concede that the training most mental health professionals receive regarding suicide is “woefully inadequate.”
What I have noticed about suicide prevention is that despite all the brains, money, and good intentions being poured into it, it doesn’t seem to be working. I recently attended a research progress meeting at the National Institute of Mental Health, where NIMH director Dr. Thomas Insel shared some very disturbing trends. He showed a chart comparing mortality from stroke, heart disease, AIDS, and leukemia from 1990 to 2010. In every single case, there have been noticeable, impressive decreases in mortality over this time period. Most striking is that AIDS, which was once an almost-certain death sentence, is now seen as a “Chronic Manageable Disease.” The decrease in mortality stops when we come to rates of suicide, which remain largely unchanged over the very same time period. Why isn’t the suicide rate going down?

Here in the United States we spend more per capita but have overall poorer health outcomes compared to other similarly wealthy nations. As Robert Whitaker argued in Anatomy of an Epidemic, more and more people are being permanently disabled by mental health conditions – at an alarming rate. Mental health/substance use issues (especially depression, anxiety, and other conditions) are among the leading contributors to chronic disability in the United States, according to a 2013 JAMA study. Consider the Global Burden of Disease Study 2010, which is the largest study of its kind looking at mental health and substance use worldwide from 1990 to 2010. Since 1990, the “global burden of disease” attributable to mental health conditions and substance use, as measured by the number of Disability Adjusted Life Years (DALYs), rose 36 percent worldwide. The studies’ authors attribute this rising “global burden” to age and population growth. Now, I’m no public health expert, but these results do beg the question: Why aren’t people getting better when it comes to mental health-related conditions? Robert Whitaker has much to say about this, including the dominance of the medical model approach and the indiscriminate and often irresponsible over-prescribing of psychiatric drugs. Remember that people diagnosed with severe mental health issues die, on average, 25 years younger than the general population.

These statistics suggest something is fundamentally wrong when it comes to our national and global approach to suicide. What has been missing from the suicide prevention puzzle? The voices of people who have intimately known what it feels like to want to die. Even today, if you took a straw poll of suicidologists to see if there is value in our voices and perspectives, I believe that few would see it. Ironically, this perspective is at odds with the views of Dr. Edwin Shneidman, largely considered to be the founder of suicidology, who viewed the perspectives of people with lived experience of suicide as critically important. He wrote in The
Suicidal Mind (1996): “the keys to understanding suicide are made of plain language…the ordinary everyday words that are found in the verbatim reports of beleaguered suicidal minds.” You would never know this to attend today’s suicidology meetings, which are much more concerned with studying statistics about people who have completed suicide, rather than talking to those of us who are still alive. David Webb, author of Thinking about Suicide, defines suicidology’s current prejudices against the first-person voice of survivors as “scientism,” or the belief that only the third-person, or scientific/medical, narrative is what matters. It is this very scientism that the suicide attempt survivor must challenge head-on.

I myself was at first very reluctant to engage with a field that didn’t seem to value my perspective, as it caused me to re-experience traumatic memories of being silenced and suppressed by mental health professionals in the past. But the good news is that the dominance of scientism in the suicide prevention world is slowly eroding. For years, people like Eduardo Vega, Heidi Bryan, Mark Davis and DeQuincy Lezine have been lone voices trying to get the entire suicide prevention field to see the importance of the attempt survivor perspective. In large part due to their hard work, and allies and champions within the American Association of Suicidology, it looks like a new Suicide Attempt Survivor Division of AAS is on the verge of becoming a reality.

My hope is that the voices of suicide attempt survivors will not only be taken seriously within AAS, but that their “lived expertise” will come to drive all research, policy, health care priorities and community responses to suicide. In the last few years, there are a growing number of suicide attempt survivors who are willing to speak out and challenge the status quo. Live Through This, created by Dese’Rae Stage, features the images and stories of people who have attempted suicide. The American Association of Suicidology has launched a blog, run by journalist Cara Anna, which features over 60 distinct voices of people with lived experience of attempting suicide. I don’t agree with every perspective I read on that website, but it is exciting to me that so many people are now willing to publicly break down the taboos around being “out” as a person who has struggled with suicidal feelings and attempts. Like the HIV/AIDS movement in the 1980s and 1990s we are a highly stigmatized group; but I also believe that, like the HIV/AIDS movement, we have the power to change attitudes and demand change with our advocacy voices.

The most heartening development for me was a recent historic summit sponsored by the National Action Alliance for Suicide Prevention, which sought to bring together its Suicide Attempt Survivors Task Force, as well as members from its Clinical Care and Intervention Task Force, launching a new Zero Suicide initiative. (Click here and here for some reports on the event, from an attempt survivor and clinician perspective, respectively.) For the first time, I was able to sit in a room with clinicians and feel that my voice was not only heard but valued and respected. I was able to say things that I didn’t feel safe saying if I wanted to keep my suicide prevention job in 1998. I was able to say that “safety” in the context of my treatment was always a euphemism for coercion, and that well-intentioned efforts to keep me “safe” caused only more harm and trauma. Cara Anna said that “treatment should never feel like punishment” and I emphasized that “forced treatment has no place when it comes to mental health or suicide.” Melodee Jarvis talked about “celebrating our stories of survival.” Tom Kelly said, “I’m a person. I’m not a lost cause.” These are sentiments and concerns that have heretofore not been uttered in mainstream suicide prevention meetings. We have a long way to go to see a grassroots movement of suicide attempt survivors that will be able to influence the way suicide is understood and responded to on a national and global scale, but this dialogue was an encouraging beginning.

What Can You Do?
Tell Your Story. If you are a suicide attempt survivor, or someone who lives with suicidal feelings, I encourage you to “come out–” if and only if you feel ready. Write a blog post; create a video; send a selfie to

http://www.madinamerica.com/2014/03/six-ways-can-really-help-prevent-suicide/
#todayistandup on Instagram; do whatever you can to break down the scary walls of silence and shame around this issue. Share what system and social responses hurt you and added to your suicidal burden; tell us what gives you hope; and explain how you cope and stay alive in an often-hostile world. Tell us about the relationships that helped bring you back to life. We need your wisdom and your vision. The more of us who speak out, the more power we will have to end discrimination and effect the radical changes we want to see in how suicidal people are treated. Our voices are needed everywhere to shift the perspective from a narrow medical model, deficit-based approach, to a holistic, strengths-based, community-wide suicide response.

Join sasurvivors@googlegroups.com, the international Suicide Attempt Survivor discussion list. I started this list several months ago to promote respectful dialogue among suicide attempt survivors, to get politically organized, and to share resources and information. Lots of great ideas are being generated there, such as the need for an independent advocacy network of suicide attempt survivors (which is coming soon!) as well the need for a national survivor-run 24/7 chat/text service to support people experiencing thoughts of suicide. We need your energy and support to bring these and other hopeful ideas to fruition.

Join the #SPSM (suicide prevention social media) chats on Twitter. I have participated in a few of these, and it’s a great way to influence the conversations and bring a lived experience perspective. People on Twitter constantly bemoan the lack of survivor and advocate voices in these conversations, so please get on Twitter for some respectful dialogue and to share your ideas. Find me tweeting about suicide and well-being @leahida, and follow @beyondmeds, @aboutsuicide, @unsuicide, and @lttphoto for a start.

Learn How to Be an Ally/Practice eCPR. I recently had the pleasure of co-presenting (with Will Hall) a workshop on a public education campaign we are developing called “Emotional CPR for People with Suicidal Feelings” at the Tools for Change conference in San Francisco (#tfc2014). In the workshop, we talked about why current, fear-based responses to suicide only drive the problem, and how we can all practice responding from a place of hope and belief that healing is possible. People told us that they appreciated eCPR’s use of role plays, which we used to contrast the typical fear-and-liability-based response with examples of open-hearted, curious responses that honor the person’s profound pain with respect and dignity.

Make a commitment to be a part of the solution. For too long, we have been told that community members must leave it up to the professionals to deal with suicide. As a result, we as a society are “illiterate” when it comes to suicide. Not only do we not know the signs, we generally have no idea how to respond in a way that’s actually helpful. But we can and should each be prepared to play an important role in supporting someone through a suicidal crisis. If we truly want to make change, we can’t leave it solely up to the police or the clinicians (who, as we saw earlier, mostly do not have a clue as to how to respond to suicide). We must all learn how to listen and how to truly connect (the “C” in Emotional CPR). We must learn to honor the suicidal experience as a deeply human problem, a universal problem, a “crisis of the self,” as David Webb so eloquently puts it, and to do much better than a severely limited medical model that locates suicide in faulty biology or genes. Understanding suicide as a medical issue/biological disorder only breeds the current state of fear, misunderstanding and discrimination. Understanding suicide as a human struggle is naturally de-stigmatizing and generates authentic compassion.

Create Safe Community Spaces. For too long we have been told that we cannot speak openly about suicide, that we will somehow spread it via “contagion.” That advice demonstrates complete ignorance. We must create truly safe spaces everywhere, where people can speak honestly about suicide without fear of coercive interventions. We can all be a Mr. Harris and go beyond the approach of simply preventing someone from dying by any means possible (even if it kills them), and instead practice supporting them, in a spirit of respect and collaboration, to find reasons to live. Forget just “preventing” suicide. Together, let’s create real
I believe that by returning to the humanistic roots of suicidology, elevating the first-person experience to its former centrality, and creating safe, culturally respectful spaces to unload our suicidal burdens, we just may have a chance of reversing our global epidemic of suicide and distress.

* * * * *

Speaking Truth to Power: Leah writes about holistic, community-based approaches to support those experiencing emotional distress and extreme states; storytelling as a vehicle for personal liberation, human rights, and social justice; and connections between creativity, activism, spirituality, and social change.

This entry was posted in Blogs, Coercion, Community, Depression, Featured Blogs, Psychiatric Drugs, Recovery/Empowerment, Rethinking Psychiatry/Medical Model, Suicide, Trauma/Distress and tagged Alternatives, complete mental health recovery, emotional distress, Human Rights, mental health advocacy, suicide, suicide attempt, Suicide Attempt Survivors by Leah Harris. Bookmark the permalink.
Six Ways You Can Really Help Prevent Suicide | Mad In America

Related Posts:
- Opening the Dialogue: Can Families and Survivors Heal Together?
- Classism in Disguise
- A Breakthrough for Suicide (Attempt) Survivors at the AAS
- May Your Psychache be Minimal
- We Are All Adam Lanza’s Mother (& other things we’re not talking about)

4 thoughts on “Six Ways You Can Really Help Prevent Suicide”

1. Stephen Gilbert on March 14, 2014 at 1:24 pm said:

Thank you for suggestions about things that we all can do to help one another so that suicide doesn’t have to become the option that frees us from overwhelming distress and misery. This is much more
proactive than anything the “mental health system” ever does for people. All they want to do is drug us to the gills and numb us to our issues and distress while never once helping us with anything practical that might enrich our lives to the point that we would rather live than die.

I was held in a private hospital before I was sent to the state hospital. A number of us were there due to issues of suicide. A number of us would gather every afternoon and talk about our “stuff” and in essence we did group therapy for one another. The staff of the “hospital” told us to not talk about “suicidal stuff” and became angry with us when we continued to do so. Those afternoon gatherings were the beginning of my finding balance for my life once more. That private hospital charged people $1,000 per day and we had to do our own therapy about our own suicidal issues! Of course, they were all too happy to try to drug us to the gills and make us numb.

Log in to Reply

2. **Steve** on **March 14, 2014 at 2:24 pm** said:

Leah, I always get a little worried when I read an article about suicide prevention, because I used to supervise at a volunteer suicide hotline and watched the changes over time as we got farther and farther away from a trauma-based, human-interaction focused model to the dominant medical model we see today. Most of the writing, including from the AAS, are about knowing the signs and getting “treatment.” And you are right, there are almost no voices from survivors of suicide attempts, or of the ham-handed interventions that are supposed to help.

I was so impressed by what you had to say, as it completely reflects my own experience as a counselor and a person who has at times struggled with suicidal feelings. Your emphasis on being present for the person and not judging him/her for having his/her feelings, which in my experience are almost always very understandable given their experiences, is exactly what the mental health world as a whole needs to hear. I am so glad you’ve found your voice and helped others find theirs. I really do believe this is the only way the mental health world will reform – when those who have to suffer through its “helpful” interventions stand up and say NO MORE!

Thanks for a moving and inspiring article!

— Steve

Log in to Reply

3. **Darby Penney** on **March 14, 2014 at 5:36 pm** said:

Leah, thank you so much for telling your story, which echoes the experiences of so many of us who have been shamed, blamed, and forced to accept “treatment” that didn’t meet our needs because we wanted to die. One would hope that the so-called “helping” professions would react with compassion to people who are in such despair that the only escape they can see is to end their lives. And the public seems to have absorbed these ideas – people say things like how selfish people are who complete
suicide, or how “unfathomable” it is that someone would want to die. Those of us who have been there understand and our insights would be valuable to the field if they would only listen. I’m so glad you are out there saying this to people who need to hear it!

Log in to Reply

4. **Laur** on **March 14, 2014 at 6:52 pm** said:

I have experience on crisis hotlines, where we are required to follow a very specific protocol if someone even MENTIONS suicide. Again, this can be in a very often-hand way and not something they are serious about. We are still required to ask them very specific questions about their suicidal ideation (even if it is almost non-existent). In many cases, this means de-railing the conversation a caller would actually LIKE to be having—which is often regarding the issue that puts suicide in their mind in the first place.

In the mental health professions, protecting your own ass is always of utmost importance. It may not even be something you want to do, but if you work for an organization or agency, this may be a mandatory part of your job.

For social workers, this mandatory repeating means saying things (as a social work teacher did in class): “Don’t share anything about [your own] childhood abuse if you don’t want me to report it.” Is it just me, or is this model a really odd way to conduct human relationships?

Log in to Reply

Leave a Reply

You must be [logged in](http://www.madinamerica.com/) to post a comment.

Support MIA

[Click here](http://www.madinamerica.com/) to join in support of Mad In America.

Our ongoing operations are funded entirely by the [support of our readers](http://www.madinamerica.com/).

Resources

Our [Service Directory](http://www.madinamerica.com/) includes a large list of practitioners and programs who support psychiatric drug withdrawal, along with other alternative communities and local resources.

Our [Resources Page](http://www.madinamerica.com/) provides useful links for people looking for alternatives to conventional, drug-focused care.

Our [Calendar](http://www.madinamerica.com/) provides information on upcoming events.
Your Meds

Research and report drug side effects on RxISK.org.