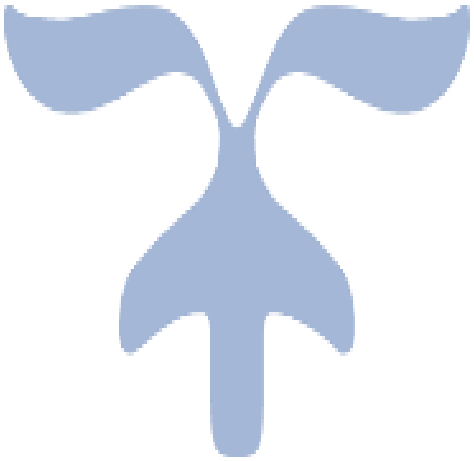
Why We Fail to Prevent Suicide

The Blessings of Tragedies



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Typically, the literature review highlights themes discovered from research that is a narrow or specific aspect of a particular subject. The research done for this project does not follow this model. Neither the approach for the research nor the presentation of it are the widely accepted practices that everyone is accustomed to and expects from a research paper that starts with the reason for it. This research was done by a mother hurting from her son's completed suicide. It started as a desperate attempt to understand her own personal failure to prevent his death when she and two other members of her family had received formal suicide prevention training, all of them were together with her son the immediate days prior to his death and no one was able to stop it. Thus, the topic of the research was overly broad and all of it was aimed at answering this one question: Why we failed to prevent his suicide.

The understanding of this experience required an examination of it from several different perspectives, including death in American society, sociology of suicide, psychology of suicide, current practices in suicide prevention, critiques of those practices, ADHD as a link to suicide, and sharing experiences to prevent suicide. Themes emerged within each of these categories that will be discussed individually in this review. Sources also required careful consideration to make the citations and literature easily associated with their perspectives for discussion that is readily available to the reader, altering the expected format for a paper.

Death in American Society:

There are three main themes within this research that is important to point out as it relates to understanding this failure to prevent suicide[1]. The first is life and death are not opposites but are the same side of the coin. Life cannot continue to exist without death and death can't happen without the occurrence of life. The second is avoiding death does not promote life. American society widely practices death avoidance. Adults shelter children from attending funerals and experiences of death. We avoid saying dead, died, or dying with terms like the eternal sleep, passing on, passing away, and referencing it as a loss. We make our dead look like they are just sleeping. Every time we attempt to avoid death we miss out on a life experience. The third is death is not something to fear but is a tool to use that makes life sweeter and richer. We don't keep children from crossing the road forever. Eventually, we teach them how to mitigate that risk, to cross the street safely so they can experience the most out of life. We learn to mitigate the risks of death in our activities to gain the most out of the experience of life. The practice of death avoidance, our attitudes and feelings about death are deeply woven into the fabric of our society that they aren't questioned and most of us would never consider studying death in society because of it.

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Curtin, A. (2017). The Absurdity of Denial: Staging the American Way of Death; New Theatre Quarterly, 2017, Vol.33(2), pp.125-142 [Peer Reviewed Journal]33(2), 125-142.

The ideas presented in the perspective of death are represented in all relating references. The textbook is from a 2016 study of death course I took at UMM - DeSelper, L. A., & Strickland, A. L. (2015). The Last Dance Encountering Death and dying (Tenth ed.). New York: McGraw-Hill Education

DeSelper, L. A., & Strickland, A. L. (2015). *The Last Dance Encountering Death and dying* (Tenth ed.). New York: McGraw-Hill Education.

Thompson, Neil; Allan, June; Carverhill, Philip A ; Cox, Gerry R ; Davies, Betty ; Doka, Kenneth ; Granek, Leeat ; Harris, Darcy ; Ho, Andy ; Klass, Dennis ; Small, Neil ; Wittkowski, Joachim; The case for a sociology of dying, death, and bereavement; Death Studies, 15 March 2016, Vol.40(3), pp.172-181

Sociology of Suicide:

Emile Durkheim is at the center of the research examining the sociology of suicide. He was a French sociologist and one of the founders of Sociology as academic discipline. In 1897, he wrote a book titled *Suicide*, it was the first methodological study of a problem occurring within the of society that was addresses from the social contexts of society. It was a case study of suicide that provided an example of what the sociological monograph should look like. His research is over a century old, yet he is either referenced in current research or his work is the basis for research being done today. His work has been highly criticized for using aggregate statistics to explain individual behavior as an ecological fallacy. Supporters, however, are quick to point out that his conclusions identify specific groups with higher rates; men over women and soldiers over civilians are just two examples that hold true today. His work was a holistic approach to understanding suicide, as it impacts specifics groups, that was never meant to explain individual behavior.

This micro-macro relation in Durkheim's work is still an area of contention for sociologists today. Some authors like those who wrote the article, *Durkheim, Social Capital and Suicide Rates Across US Counties,*[2] is an expansion of Durkheim's work. They even write in this article:

"Sociologists are long accustomed to believing that suicide rates reflect underlying levels of social integration and cohesion. We are probably right about that. The durability of the Durkheimian theory is hugely impressive. Carefully crafted, problem-oriented sociological research can provide strategies for change that can contribute to the sense of collective efficacy that communities need to solve their most pressing social problems, of which suicide is often one."

They later write:

"Our research works to link Durkheim's classic study with modern social capital research and connect it to the social phenomenon Durkheim was interested in studying."

Others like *Toward a Cultural-Structural Theory of Suicide: Examining Excessive Regulation and Its Discontents*[3] recognize the Durkheim's contribution to this research but claims

"It fails to account for a significant set of cases because of its overreliance on structural forces to the detriment of other possible factors."

Their research provides "a new cultural-structural theory of suicide that examines when and how culture plays a role in fomenting vulnerability to suicide in some places or collectives. By thinking about the cultural dynamics of excessive regulation, we offer a more powerful theoretical model for suicide that supplements the structure-heavy Durkheimian theory."

They recommend that more studies are needed to understand the role culture plays to understand the roles of meaning and identity in suicidality. The main point from Durkheim and subsequent sociology studies is that when addressing suicide and suicide prevention psychology-based studies are not enough. Culture and the societal factors of sociology contribute to not just

[2] Recker , N. L., & Moore, M. D. (2016). Durkheim, social capital, and suicide rates across US counties. Health Sociology Review, 25:1, 78-91. doi:: 10.1080/14461242.2015.1101703

[3] Abrutyn, S., & Mueller, A. S. (2018). Toward a Cultural-Structural Theory of Suicide: Examining Excessive Regulation and Its Discontents. Sociological Theory, 36(1), 48–66. https://doi.org/10.1177/0735275118759150

understanding suicide but the necessity of mitigating these factors as important strategies in preventing suicide.[4]

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Mueller, A. S., & Abrutyn, S. (2016). Adolescents under Pressure: A New Durkheimian Framework for Understanding Adolescent Suicide in a Cohesive Community. American Sociological Review, 81(5), 877–899. https://doi.org/10.1177/0003122416663464

Wray, M., Colen, C., & Pescosolido, B. (2011). The sociology of suicide. Annual Review of Sociology, 37, 505-528.

Psychology of Suicide:

This is the most well-known perspective of suicide. Countless studies have been done to understand the psychology of suicide. This search retrieved 63,247 peer-reviewed items, compared to only 20,763 peer-reviewed items retrieved from the sociology search. This isn't that surprising given that psychology is the study to understand individuals, and suicide is an individual choice of action based in one's own perceptions of life.

Sensation and perception[5] is a field within psychology that is noteworthy. Each of us has our own threshold for pain, our own sensations of the intensity of that pain, and our own perceptions as to the cause of our pain. We also know that there are various types of pain such as emotional, mental, and physical. We also have our own capacity for coping with the amount

[4] Mueller, A. S., & Abrutyn, S. (2016). Adolescents under Pressure: A New Durkheimian Framework for Understanding Adolescent Suicide in a Cohesive Community. American Sociological Review, 81(5), 877–899. https://doi.org/10.1177/0003122416663464

[5] Yantis, S., & Abrams, R. (2017). Sensation and perception (Second ed.).

of pain experienced with varying levels of effectiveness[6]. Each of us will react and respond to life events in our own way with our own interpretation of the event and meaning within our own lives. Thus, the more stress events cause us and the more of these experiences there are within close session the more our ability to cope with those stressors is drained. Injuries, mental illness, and physical conditions contribute additional stress with each additional diagnosis draining our ability to cope with life even more[7]. Individual differences in the values of quantity of life over quality of life also increases one's risk of suicide when the perceptions of these stressors overwhelm the individual. Someone who values quality of life more will be affected more negatively by the stress of life and be more of risk for suicide. Mental disorders cause pain and decrease the quality of life just the same as a chronic physical illness. Just as not everyone with a terminal physical illness seeks out the right to die, not everyone with a mental illness seeks out suicide. [8]

Two very distinct and dominant schools of psychology thoughts and theories are nature and nurture. Nature is the part of us we can't change, such as genetic influences and body chemistries. Nurture from this perspective is the individual factors of environment and the effects of those individual factors on the individual. Over time the field of psychology has come to accept the use of nature and nurture to explain human behavior instead of it being one or

[6] Bement, M., Weyer, A., Keller, M., Harkins, A., & Hunter, S. (2010). Anxiety and stress can predict pain perception following a cognitive stress. Physiology & Behavior, 101(1), 87-92.
[7] Racine, M. (2018). Chronic pain and suicide risk: A comprehensive review. Progress in Neuropsychopharmacology & Biological Psychiatry, 87(Pt B), 269-280
[8] Ahmedani, B., Peterson, E., Hu, Y., Rossom, R., Lynch, F., Lu, C., . . . Simon, G. (2017). Major Physical Health Conditions and Risk of Suicide. American Journal of Preventive Medicine, 53(3), 308-315
Verrocchio, M., Carrozzino, D., Marchetti, D., Andreasson, K., Fulcheri, M., & Bech, P. (2016). Mental Pain and Suicide: A Systematic Review of the Literature. Frontiers in Psychiatry, 7, 108.

the other. Nature and nurture are still trying to be understood, focusing on the extent of their connection and how they are interconnected.

An important point to note comes from the subfield of social psychology. Theorists in this field recognize the social influences on individuals within groups. They understand that the group has power to influence individual behavior in both positive and negative ways. They also understand that the individual impact on the group will be either positive or negative. They are still trying to understand the mechanisms of their interconnections, the influences of and on these interconnections, and the ability for manipulation, much of which isn't found in the realm of psychology, but instead sociology. [9]

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E. David Klonsky, Alexis M. May, and Boaz Y. Saffer (2016) Suicide, Suicide Attempts, and Suicidal Ideation Annual Review of Clinical Psychology 2016 12:1, 307-330

Bement, M., Weyer, A., Keller, M., Harkins, A., & Hunter, S. (2010). Anxiety and stress can predict pain perception following a cognitive stress. Physiology & Behavior, 101(1), 87-92.

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Ngwena, J., Hosany, Z., & Sibindi, I. (2017). Suicide: A concept analysis. Journal of Public Health, 25(2), 123-13

Verrocchio, M., Carrozzino, D., Marchetti, D., Andreasson, K., Fulcheri, M., & Bech, P. (2016). Mental Pain and Suicide: A Systematic Review of the Literature. Frontiers in Psychiatry, 7, 108.

Racine, M. (2018). Chronic pain and suicide risk: A comprehensive review. Progress in Neuropsychopharmacology & Biological Psychiatry, 87(Pt B), 269-280

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Ahmedani, B., Peterson, E., Hu, Y., Rossom, R., Lynch, F., Lu, C., . . . Simon, G. (2017). Major Physical Health Conditions and Risk of Suicide. American Journal of Preventive Medicine, 53(3), 308-315.

[9] Aronson, Wilson,, Akert, & Sommers. (n.d.). Social Psychology (9th ed.). Pearson.

Lindh, &., Beckman, K., Carlborg, A., Waern, M., Salander Renberg, E., Dahlin, M., & Runeson, B. (2020). Predicting suicide: A comparison between clinical suicide risk assessment and the Suicide Intent Scale. Journal of Affective Disorders, 263, 445-449

Zadravec, T., Grad, O., & Soéan, G. (2016, May 1). xpert and Lay Explanations of Suicidal Behaviour: Comparison of the General Population's, Suicide Attempters', General Practitioners' and Psychiatrists' Views. International Journal Yantis, S., & Abrams, R. (2017). Sensation and perception (Second ed.). of Social Psychiatry, p.282-303

An Understanding of the Psychology and Sociology Connection:

Societies are nothing more than a larger group of people. Understanding sociological factors through the lens of psychology allows for individual meaning of sociological experiences to be understood from the individual perspective impacting a society. The nurture of psychology includes sociological factors that need to be understood by those in the field of psychology to understand the societal impact on the individual. Neither the nature of individuals as represented by psychology nor the nurture of them as represented by sociology are a vacuum of independent forces representing opposites of a coin for understanding human behavior. They are in fact the same side of the coin. Societies wouldn't exist without individuals coming together to create them with individual and species survival dependent upon the societies that are created. This makes it essential the study and evaluation of both perspectives be used in suicide prevention, research, and studies.

An article in the *European Journal of Social Theory* titled *Socioeconomic Inequalities of Suicide: Sociological and Psychological Intersections*[10] even states:

"Current theorization in mainstream suicide research is limited by its failure to engage with enduring, yet vitally important sociological debates regarding structure and agency, nature and culture."

[10] Chandler, A. (2020). Socioeconomic inequalities of suicide: Sociological and psychological intersections. European Journal of Social Theory, 23(1), 33–51. https://doi.org/10.1177/1368431018804154

Thus, understanding suicide from perspectives of both sociology and psychology is vital if we are going to prevent it.

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Steven Stack & Augustine J. Kposowa (2016) Culture and Suicide Acceptability: A Cross-National, Multilevel Analysis, The Sociological Quarterly, 57:2, 282-303, DOI: 10.1111/tsq.12109

ADHD, Impulsivity, and Suicide:

Three core symptoms of ADHD are hyperactivity, impulsivity, and inattention. Additionally, the inattention component of ADHD includes a lack of focus and a lack of concentration on tasks of little interest to the individual while exhibiting a hyper-focus on things that are incredibly important and/or interesting to this individual. [11]This hyper-focus may be exceedingly difficult to break and possibly borders on being obsessive, if not an obsession in of itself.

The studies done to understand the link between ADHD and suicide are increasingly showing that those with ADHD are at a higher risk of suicide than those with other mental disorders, including depression. This is contributing to the characteristic of ADHD that includes a lack of impulse control and the high occurrence of co-morbidity of other mental disorders in those with ADHD.

[11] Stickley, A., Koyanagi, A., Ruchkin, V., & Kamio, Y. (2016). Attention-deficit/hyperactivity disorder symptoms and suicide ideation and attempts:

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Balazs, J., & Kereszteny, A. (2017). Attention-deficit/hyperactivity disorder and suicide: A systematic review. World Journal of Psychiatry, 7(1), 44-59.

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Chou, W., Liu, T., Hu, H., & Yen, C. (2016). Suicidality and its relationships with individual, family, peer, and psychopathology factors among adolescents with attention-deficit/hyperactivity disorder. Research in Developmental Disabilities, 53-54, 86-9

Forte, A., Orri, M., Galera, C. et al. Developmental trajectories of childhood symptoms of hyperactivity/inattention and suicidal behavior during adolescence. Eur Child Adolesc Psychiatry 29, 14

Furczyk, K., Thome, J. Adult ADHD and suicide. ADHD Atten Def Hyp Disord 6, 153–158 (2014).

Rimkeviciene, Jurgita; O'Gorman, John; De Leo, Diego How do clinicians and suicide attempters understand suicide attempt impulsivity?, A qualitative study Death Studies, 15 March 2016, Vol.40(3), pp.139-146 [Peer Reviewed Journal] ps://doi.org/10.1007/s12402-014-0150-1

Suicide Prevention and Its Critiques:

The vast majority of these studies to understand suicide focuses on either the risks of suicide as it applies to specific individuals to identify those most at risk of suicide, or to understand the risk that some factor poses to individuals. The article *Looking to the Future: A Synthesis of New Developments and Challenges in Suicide Research and Prevention*[12], states that the "USI (Universal, Selective, Indicated) prevention model forms the basis for all of the suicide prevention activity worldwide."

USI is the universal model setting the standard that all countries and organizations follow in addressing suicide. Suicide is studied, understood, and prevented worldwide from this one model of the same approach explaining all the similarities across organizations as they all

[12] Rory C. O'connor, & Gwendolyn Portzky. (2018). Looking to the Future: A Synthesis of New Developments and Challenges in Suicide Research and Prevention. Frontiers in Psychology, 9, 2139.

promote the same suicide prevention strategies and the research being from the same approach. It also explains the almost impossible difficulty of finding anything differing from this. The article continues to state that[13]

"despite its use as an overarching framework, it is obvious from the research literature that there are extensive gaps in our knowledge about what works to prevent suicide and how the different levels of intervention (USI) interact. However, there have been recent efforts to investigate the synergies between the different components of suicide prevention strategies (Harris et al., Given that suicide rates continue to rise in some countries (e.g., in the United States), perhaps it is time to reconsider whether a paradigm shift, rather than a 'more of the same' approach to suicide prevention is required."

The USI focus is on the risks of suicide combined with our cultural practices of death avoidance to mean the more of the same approach that is used in suicide prevention is from the understanding that suicide is a cause of death with research aimed at understanding those most at risk of it and preventions aim at those posed with the highest risk of suicide. Exhaustive studies trying to understand the correlation between mental illnesses and suicide that have repeatedly failed to draw that conclusion. Depression is the most widely associated with an increased risk of suicide and it is the easiest to associate with it. The problem is Depression has the same risk of suicide as any other mental health diagnosis except for ADHD which is its own discussion. The lack of correlation between mental disorders and suicide is supported by the article titled, *Suicide, Suicide Attempts, and Suicidal Ideation*[14] as it goes on to explain that,

"It is often stated that over 90% of individuals who die by suicide have mental disorders (Bertolote & Fleischmann 2002). However, it is also true that the overwhelming majority of individuals with mental disorders—more than 98%—do not die by suicide (Nordentoft et al. 2011 2016)."

[13] Rory C. O'connor, & Gwendolyn Portzky. (2018). Looking to the Future: A Synthesis of New Developments and Challenges in Suicide Research and Prevention. Frontiers in Psychology, 9, 2139.
[14] E. David Klonsky, Alexis M. May, and Boaz Y. Saffer (2016) Suicide, Suicide Attempts, and Suicidal Ideation Annual Review of Clinical Psychology 2016 12:1, 307-330

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Jaff Brodsky, B., Spruch-Feiner, A., & Stanley, B. (2018). The Zero Suicide Model: Applying Evidence-Based Suicide Prevention Practices to Clinical Care. Frontiers in Psychiatry, 9, 33.

Donna Holland Barnes, P. (2014). Suicide Prevention Efforts Aren't Working. Here's Why. Psychiatric Emergenciese, D. (2014). Preventing suicide in all the wrong ways. Center for Health Journalism.

Sharing Experiences to Prevent Suicide:

Typically, research does not include personal experience and the idea of sharing one's own personal experiences is a huge taboo. Personal experiences are considered to be subjective as it only happens to the one with the experience and the only applicable interpretation, understanding, and meaning for it is theirs. While this is true, it doesn't decrease the value of our experiences in research. Experiences provide research with an application for it and examples of it from life. Additionally, there are countless shared experiences among humans. Relating our own experiences in life to our research provides greater insight for understanding both the experience and the research, providing greater perspectives and insights for both deeper understandings and for better research.[15]

[15] Hawton, K. (2001). Studying survivors of nearly lethal suicide attempts: An important strategy in suicide research. Suicide & Life-threatening Behavior, 32(1), 76-84
MacLean, S., MacKie, C., & Hatcher, S. (2018). Involving people with lived experience in research on suicide prevention. Canadian Medical Association. Journal, 190, S13-S14.

Additionally, one of the prevention strategies USI endorses is sharing suicide survivor experiences. During the research of suicide prevention, studies done to understand the importance of sharing the experiences as either a survivor of someone that completed suicide or survived an attempt were discovered. These studies are included because experiences aren't only the basis for this project but is the heart of it and all the outcomes from it.

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Important Notes of the Lit Review:

- The schools of both psychology and sociology recognize the importance of the other in suicide prevention but fail to understand the other from its own perspective that is then applied through its own lens.
- Sociology and psychology are a complex connection of interwoven connections, the studies of which need to be interconnected to fully understand humans, human behavior, and their societies.
- Deeply embedded cultural practices influence all aspects of society, including the approach for solutions to societal problems that may make them less effective.
- ADHD association with suicide is largely unknown and recognized among the public, including mental health providers.

- The USI has hindered the exploration of suicide prevention and research from any other perspective than the one offered as a cause of death.
- Personal experiences have a role in research, especially in suicide prevention

The last bullet point is the focus for continuing this discussion as I will be sharing my own life experiences pertaining to suicide. The validity of sharing experiences will be found in your own reaction to it at the end as combining these points turn a tragedy into a blessing.

My Personal Experiences and ADHD:

As previously mentioned, this research was the result of a mother's experience as a survivor of her son's suicide. There is another type of suicide survivor which is as a survivor of attempted suicide. This research, project, and the outcomes from it are very personal to me. It represents my journey after my son completed suicide and my road to find healing and acceptance. However, this isn't my only type of suicide survivor. I am also a survivor of multiple suicide attempts with ADHD.

These experiences provide insights into not only the research but also provide deeper understandings of the prevention strategies and ways for improving those strategies from a different perspective than most researchers and suicidologists, as most of them live outside the world of suicide. I live in a much different world as suicide has been identified as my "normal" brain pathway. It is my hope that by sharing my story as it relates to the research to offer a deeper understanding of suicide for those that make a living studying it to consider as they move forward in their own research and in our prevention strategies for it.

I grew up with wonderful parents and it was the perfect storm of circumstance that caused my first thoughts of suicide to occur in elementary school. During the summer before I began first grade, my family moved to a small rural town with only one high school. My father had just been hired to be the new high school principal. The year was 1979, before ADHD was known as such. Instantly, when school stated that fall, I had a new identity. That morning, when I got on the bus for the first time, everyone knew who I was as I just learned that I was the principal's daughter. High school students are huge when you are in the first grade and I didn't know any of them, making this a scary experience. It wasn't just the kids on the bus that knew me as the principal's daughter. My classmates, other kids at school, and by the end of semester, I realized that was how I was known even to people in the community. In this small town, everyone knew me as the principal's daughter, and each had their own expectations for me. Unknown at the time, I suffered from severe ADHD that made it impossible for me to meet any of these expectations. This emphasized my feelings of failure with devasting consequences.

It was in second grade that I had my first thoughts of suicide. It came after being exposed to the concept of heaven in Sunday school and a discussion of what it was like. I couldn't stop dwelling on the idea that if it is so great there, why must we suffer here. School was becoming harder and I was struggling more both academically and socially. Thoughts of suicide grew both in frequency and in intensity as I got older and school become harder.

My first suicide attempt occurred in middle school. My parents immediately got help for me. I was diagnosed with major depression and anxiety. Treatment consisted of medication, and individual cognitive behavioral therapy. The medications were useless, and I briefly felt better after venting in therapy.

High school was an overwhelming nightmare. The dynamic of my father's position was the most influential on my behavior and the relationships between myself, teachers, and other students, impacting our father-daughter relationship. My increasing academic struggles and normal teen-age angst led to anorexia-type behavior, self-harm, increased suicide ideation, and another attempt requiring hospitalization. I was then diagnosed with border-line-personality disorder and bi-polar. I wasn't even 18 years of age. I was prescribed cocktails of drugs that failed to provide relief[16].

My young adult years were periods of contradictions between normalcy and chaos with another attempt that led to an extended hospital stay, rounds of electric shock therapy, and stronger drug cocktails as doctors convinced of their own diagnoses blamed me for treatments not working and I was dismissed. I learned to play the game of these mental health providers. I told them what they wanted to hear instead of the truth by claiming I felt happy without experiencing suicidal thoughts and in a few days I was released.

My desperation to feel "normal" led to horrible decisions and an abusive marriage that took five years for me to escape and resulted in two kids. My youngest child was only four months old when the divorce was finalized. This led to a move, starting a new job, returning to college, my oldest starting kindergarten, and another change in jobs. All this combined with my son's birth, the divorce, and the death of a grandmother that made me experience all of life's greatest stressors in a period of 11 months. My grandmother's death was the final straw that led to another suicide attempt and hospitalization.

[16] When ADHD first became known, it was believed to only effect boys and not girls. This led to my misdiagnoses and treatment failures.

This hospital stay was different than my previous ones. My previous experiences all had an air of suicide as a phenomenon in the discussions and therapy. This was the first time I received an understanding for the attempt by doctors and staff. Instead of being some phenomenon that occurs, this attempt was viewed and discussed more as an understandable "normal" reaction by anyone who had gone through this experience. It would be years before another attempt is made, but the thought is always there.

The experience of having ADHD varies based on the symptoms experienced and the intensity of those symptoms. I wasn't diagnosed and treated for ADHD until my late thirties. I was treated instead for misdiagnoses that didn't help. The two most common misdiagnoses for ADHD are bi-polar and borderline personality disorder, both of which I received. Additionally, I experience extreme impulsivity, inattention, and the hyperactivity of ADHD. My emotional variances are because I am extremely reactive to the external factor of life experiences. The entirety of this project and all components within it all resulted from hyper-focus. My interpersonal relationships have been impacted and influenced by ADHD and impulsivity. ADHD was the single greatest factor impacting my childhood, made worse by my father's career and position in the community.

Relating and Connecting the Research to My Personal Experiences:

Typically, factors of suicide ideation in children are thought of in terms of disadvantaged children or the factors contributing it. My childhood experience shatters these popularly held understandings. My childhood experience in these terms was beyond amazing. I had adoring

and supportive parents who provided me with every available opportunity. In fact, from these perspectives it is impossible to understand my suicide ideations and attempts.

The sociology research claims that more studies are needed to understand the role culture plays in understanding the roles of meaning and identity in suicidality. My childhood experiences serve as an example of this helping to explain it. It wasn't the factors of family life or greater society that contributed to my attempts. It was very specifically my role as a principal's daughter in an exceedingly small town, which means something different to everyone, which serves as the basis for the expectations of behavior, appearance, and conduct. I was never just Julie or a student. It was always "the principal's daughter" with its associated images and expectations that came before Julie in every interaction. ADHD in of itself didn't cause the suicide ideations, nor was the academic impact in of itself. It was the impact ADHD had on my academic performance as it related to everyone's expectations for a principal's daughter that was detrimental to my well-being. Change any factor: if my father wasn't the principal, if we lived in a city, or there was another high school in the community, each changes the meaning altering the impact.

Even if all the expectations for a principal's daughter remain constant, however, just changing the meaning everyone has of "a principal's daughter "alters the experience of being one. If the meaning is one that as their friend they can influence benefits on your behalf, that person is going to associate and interact differently than if the meaning is they will influence you to be in trouble if you are friends. The latter interactions unchecked will be acts of rejection and bullying contributing to suicidal thoughts and actions. The understanding of a factor contributing to suicide is not going to be found in studies of that factor. These understandings

are only going be found by understanding the meaning, or possibilities of meanings, that factor has to the individual, the people around them, the influences it has on these relationships and interactions, the resulting impact as experienced by the individual, and the meaning that impact has within their lives that the current approach in suicide prevention makes far more complicated.

It is through psychology and this research that we are provided with the deeper understanding of meaning as an individual experience through understanding the impact of an experience to the individual. Psychology allows us to examine the individual psychological influences of given factors to understand the meaning of them. This only matters in the current paradigm approach with data suggesting the need for a shift.

Additionally, my years of receiving and using suicide prevention strategies along with in-depth discussions from other survivors allow for discoveries of gaps in their practical use that is otherwise unavailable in research. A major one being in the use of contracts by clinicians and the use of feelings/emotions survey questionnaires in hospital settings. These are great tools from the perspective of research that is laughable in practical use, so let me explain.

I have received in-patient mental health care from a variety of hospitals in numerous states. Naturally, some are better than others, but they all share common elements that are counterproductive in treating mental health patients. One is the element of being locked up and stripped of personal freedoms, some of which is necessitated by patient safety that requires re-evaluation in the execution. The lack of patient autonomy on these units jeopardizes the required care they desperately need. No one likes being in a hospital, but most

physically ill patients won't leave until they are better. The majority of patients in a mental health unit are there voluntarily. It only takes one day for my focus to turn from getting well to getting released as the lack of control I feel over the situation becomes too stressful. Once release becomes the patient's focus, the surveys/questions used to evaluate a patient's mood and suicide risk are uncreditable. The stress of the stay increases the longer it continues with the patient's well-being in the balance. There are individual differences for this, but the one-fits-all approach in mental health care is a huge failure. Hospital mental health units need to adjust the treatment of patients as prisoners through provisions for autonomy.

Once a clinician knows my history of suicide ideation and attempts, they immediately request my signature on a contract stating I won't attempt suicide while receiving care. I will refuse to sign. This is immediately followed with a threat of hospitalization, to which I reply I will leave. This immediately changes the tone and I am asked why I refuse to sign such a contract. The answer is simple: it is my choice to make and once made, signed or not, the contract won't stop me. This answer is Immediately followed with a question of how I am supposed to know if you are safe and the answer is you don't and that is not why I am here. I am here to receive help and by being here you know I am serious. The rest is a relationship of trust between mental health providers and their patients.

I experienced two hospitalizations after my son's death, highlighting the problems in mental health care. After failing for months to get an appointment, the hyper-focus finally got the better of me. Appointments are prioritized to those who received a hospitalization or a court order to receive treatment. Instead of being proactive to prevent the requirement for either, the system is reactive requiring such an event to receive treatment.

The second instance of meaning-based example is more recent. The two people I turn to in time of a crisis are my husband or my mother. There has been a rift in the relationship between my parents and husband. My parents informed me extremely late the last night of a visit with them that they were not comfortable in my home because of some hostilities towards them and would no longer be coming to visit me at home. My struggles with ADHD and the associated experience as their child severely strained my relationship with my parents, with every effort to repair it being made. Thus, I was devastated and deeply hurt. I couldn't go to either of the people I normally turn to as they were the cause of the problem. The thoughts of suicide immediately started upon returning home. It was all I could think about and dwelled on it constantly. Exactly one week later an attempt was made. Even when alone, and no one expected to be there, someone always intervened during the attempt to prevent me from completing. This was the first and only time I self-intervened after an attempt to prevent completion. It was an empowering moment to know it wasn't what I really wanted to give me more control of my suicidal thoughts.

A required fundamental shift in suicide prevention rests in understanding the one in control of the act and who is ultimately responsible for it. Death studies provide an understanding for these misunderstandings and the inherent practice of death avoidance in suicide prevention. The primary focus of formal suicide prevention training is stopping someone else from doing it. The language used during training is someone else and never you. The strong emphasis on the risk associated with brain disorders contributes to the stigma of those disorders while providing a false sense of security when a diagnosis is not present. Clinicians, let alone anyone else, are not always able to distinguish any changes in mood or behavior. The focus on others in

prevention and training places the responsibility of the act on someone who doesn't control it. Then if the act is completed the expectation is for survivors to believe they weren't responsible for it. Unbearable survivor guilt is the natural outcome from these trainings. Current suicide preventions are great supportive measures for someone contemplating suicide and for some that is enough, but the rising suicide rates across demographic boards is evidence that more is needed. Additionally, there are no public warnings of suicide associated with ADHD and its increased risk over depression. Even as more people are being affected by suicide, automatically increasing the awareness of it, programs aimed at suicide prevention continue to focus on raising awareness.

Perspective of Current Suicide Prevention Strategies:

Currently, suicide is understood, studied, and prevented from the standpoint that suicide is a cause of death with prevention centered on the act. Studies aim at understanding this cause, the factors contributing to it, and over-all preventions with more specific preventions aimed at those most at risk of it. It focuses on preventing the act; completely overlooking the risk of one aspect of suicide, which is as a risk to life.

Proposing A NEW Perspective for Suicide Prevention:

Understanding suicide as a **risk to life instead of a cause of death** serves as paradigm change of approach as who's at risk and preventions aimed at those most at risk focusing on preventing the act of suicide are no longer considerations. In this approach, everyone is at risk of suicide, with life and the promotion of life at its center. This means understanding the external sociological factors contributing to this risk to eliminate and mitigate those factors, building

individual resilience to those factors, and empowering those that control the act with the ability to self-prevent it. Under this approach, suicide prevention is aimed at preventing the contemplation of suicide, instead of just the act of it, by focusing on life and the choice to live the easier and better option.

A New Suicide Prevention Program:

Understanding suicide as a risk to life, and the complete absence of availability of anything from this approach, led to the creation of a new three-point suicide prevention program now titled Dream to Live. The first point of the program is a parental child development guideline of coping skills. It starts at age 0 and goes through age 18, offering developmentally appropriate coping strategies and ways parents can encourage this development throughout childhood. The second and third points are both worksheets. The second is a self-inventory of coping strategies that identifies the ones that work best. It uses a stoplight to self-identify a crisis. The third point is creating a crisis action plan. It serves as an icebreaker to start these difficult conversations between loved ones so they can work together to create a plan of action should a crisis occur.

Transforming my research obsession into my passion, I created a website to promote the grassroots organization I founded to make the Dream to Live program available for free to everyone. KYVO is the name of this organization serving as a platform for promoting Dream to Live as its mission. That mission is to change the understanding of suicide as a risk to life and to empower individuals that control the act with the ability to self-prevent it through a clear focus on life and the choice to live as the easier and better option.

The Blessing of the Tragedy:

My worst personal tragedy is my son's suicide. It shook me to my very core and I would do everything to have him here. Yet, if he were here this research and these outcomes would not exist. It took his death for me to recognize the failure of suicide prevention training and the importance of Dream to Live and KYVO. It is his death that is the fuel for my passion to prevent suicide that makes him a part of everything I am doing with KYVO. He gave new meaning and purpose to my life, making it far more rewarding, and in turn I gave meaning and purpose to his life that he couldn't give to himself. KYVO is an intertwining connection of both our lives and a shared bond that was created from death, strengthened in life, to be unbreakable through our blessing to each other that will hopefully be a greater blessing for others. The experience of a tragedy is energy-fueled. That energy turned inward is a path to self-destruction. My son provided a way for me to turn that energy outward to discover the blessing of his life within mine that even through death makes me both lucky and proud to be his mom. I couldn't ask anything more of a son as our shared purpose continues to bring us closer together as mother and child.

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