A Breakdown: 3 Suicide Prevention Myths

By Jennifer Tirado, Alternatives to Suicide Network Coordinator

September is Suicide Prevention month. Around this time of year, we are bombarded with messages that while helpful in some ways, can be harmful in others. In this piece, we will look at three major myths about Suicide Prevention that are widely held and promoted.

Myth 1: Hospitalizing someone who is suicidal is always the best way to support them.

Hospitalization can be helpful in that it can get someone away from any imminent danger, get them access to resources, and allow them time away from their usual routine. However, as those of us may know from lived experience, being on an Inpatient unit also involves being behind locked doors, having valuables locked up and out of reach, being surveilled and relying on others to take care of our belongings for us. We are taken out of our normal lives and while this can be a relief to some, it's not helpful for everyone. A study done by the Journal of American Medicine (June 2017), suggests hospitalization can fuel feelings of trauma for some individuals. This is due to many factors but the key point is the loss of control when going into an inpatient setting.

Another matter to keep in mind is when someone is hospitalized they are being contained for a short time only, and will need to be released eventually. When this happens, their suicide risk can be elevated not only during their hospital stay but for a long time after.

There's evidence that this method of support can exacerbate traumatic memories that people carry with them; the very experiences that influence suicidal feelings in the first place.

One major alternative are Peer Respites, a model that is seeing a new wave of interest and advocacy among the peer community in our state. There are many examples of peer respites in several other states. The most notable is Afiya, in neighboring Massachusetts. States such as New York, Pennsylvania, Washington, and about a dozen more all have their own peer respites. Unlike a hospital setting, a true peer respite allows people the freedom to come and go as they please. Instead of clinical white walls, people have living rooms, kitchens and their own bedrooms, access to staff support and resources – as well as their freedom. The more we talk about these models and advocate for them in Connecticut, the more awareness we can bring to them.

Truth: While traditional hospitalization may help some people, it may also come at a devastating cost to others. Peer respites are well worth exploring as an alternative when someone is in crisis.

Myth 2: Talking about suicidal thoughts openly with others who have similar experiences can "trigger" someone into being more likely to end their lives.

This is a misconception that always seems to come up. Some people fear any talk of suicide is dangerous and should be avoided at all costs. Even professionals worry that someone talking about it can bolster motivation in completing the act. This is an unfortunate myth and always reminds me of what people used to think of Alcoholics Anonymous when it was first developed. People did not think addicts could recover in peer-based community. In fact, some even thought that bringing people with this same

problem together will only make them want to do it more. We soon learned that this couldn't be further from the truth. These days, AA meetings are often promoted in the clinical world.

There is so much shame and stigma around the issue of suicide that many people are afraid to talk about it openly. They may not want to be seen as negative, they may be deeply embarrassed by having these feelings at all, especially if they also carry the responsibility of being a clinician or a parent.

This is ironic considering the value of community in many peer and recovery models. Feelings of isolation is one of most common shared experiences of anyone who's struggled with suicide. Often times those of us who with suicidal thoughts are told we're selfish for even considering it. As mentioned above, if someone does talk about it, it's almost always treated as something that necessitates emergency and possible hospitalization. The potential consequences of these tactics are enough to silence anyone, even if they're in the midst of intense pain.

In "Alternatives to Suicide" groups, people often experience relief at being able to speak to the experience with openness in the presence of others who understand.
Burying the shame only makes it more likely that the act will be completed. In groups, we often say, "when someone is talking about suicide, they're not doing it".

In Alt2su groups, we normalize these feelings. We tell people that they don't need to feel embarrassed or ashamed. We acknowledge life is tough sometimes; that these feelings make their own kind of sense, even when others don't understand.

Truth: Having a space to talk openly about suicidal feelings among people who are understanding and empathic, can be cathartic to someone struggling and may give them a greater sense of community.

<u>Myth 3: Suicide should be treated as the problem of one sick person, something that is affecting them alone.</u>

These feelings go far beyond one person with mental health struggles in the moment. Suicide is a societal issue and it's endemic. And when there are discrepancies in access to resources and equity, we see a rise in suicide rates. Suicide is often spoken of as a "death of despair". Often what causes a human being great despair are societal roadblocks that are systemic and can feel, or be, impossible for someone to get beyond.

We need to take a more collective view. As a culture, we take this issue beyond individuals who are too often construed to be "the problem" in and of themselves; objects in dire need to be "fixed". We will see that addressing suicide is something all of us can share; something all of us can talk about. Suicide is about far more than a psychiatric experience, as many of us are taught. It's an issue that hits at the heart of the "Existential": the challenges we face every single day as human beings. As we consume more prescriptions, suicide rates haven't gone down. Something isn't working and as a society, it's imperative that we think of those who are slipping through the cracks. It's not just an issue for sufferers, supporters, clinicians, or even peers. It's something we all have to take into consideration, even in the day-to-day ways we treat each other.

Truth: The issue of suicide is societal, systemic, and belongs to all of us – whether or not we are touched by it directly.

We know this isn't an easy topic to discuss and some of these truths may seem controversial to many. We urge folks who want to be supportive to take a look at different ways of being present for someone struggling. We are not saying that traditional models never work or should be stopped, we are discussing other possibilities that might serve a greater diversity of people than we have before.

If you'd like to learn more about a Harm Reduction approach to suicidal thoughts, urges, or feelings, please check out Connecticut's Alternatives to Suicide network. If you'd like to know more about the research behind this article, please check out the work of the Wildflower Alliance, the organization that developed the Alt2su model in 2008.

Citations:

- Journal of American Medicine: June 2017
- JAMA Psychiatry: https://pubmed.ncbi.nlm.nih.gov/28564699/
- Afiya: https://wildfloweralliance.org/afiya/#:~:text=An%20opportunity%20to%20rest%20and,peer%20respite%20as%20you%20desire.
- Research compiled by: Wildflower Alliance training curriculum: "When Conversations turn to Suicide"
- Peer respites | Washington State Health Care Authority