Suicide AND Lifting

Issues in Prevention and Postvention

Marilia Coutinho

Ronin Institute

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How to cite this book:

Coutinho, M. *Suicide and Lifting: Issues in Prevention and Postvention*. Ronin Institute, 2020.

Coutinho, Marilia.
Suicide and Lifting / Marilia Coutinho, Ronin Institute. 1e. 2020
215 pages cm. –
Includes table of contents.
ISBN 978-0-9986229-0-3 (digital publication)
DOI 10.5281/zenodo.4022849
Suicide-sociology. | Suicide-psychology. | Suicide-prevention. | Lifting weights as prevention - suicide.
NON-FICTION / Sociological. | NON-FICTION/ Public Health/ General. |
1. Suicide. 2. Lifting. I. Title.

Cover art by Laerte Coutinho and cover by Lena Coutinho

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This book is the edited version of web content published by the author at the Elitefts.com website.

This book is dedicated to

The hopeless and the helpless

To those that provide hope and help

To the non-conformist, atypical and deviant

And to those who love and support them

To the Mad

And to those who embrace, study and support madness

To those with the means and the courage to confront mainstream psychiatry

To those that battle it from the inside

And to those that resist it from the outside

To Aaron Swartz and to those keeping his legacy alive forever

To the billions who died of suicide because societies gave them no choice

To all those who refuse to normalize the constant flow of premature and avoidable deaths

To those that fight the suicide-conducive social conditions to transform society

And to Egbert, because I promised to make his death matter

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Foreword

By Peter Beresford

This book is important and worth our attention for a number of closely connected reasons. First, it is written by someone who identifies as a 'suicide attempt survivor' so enables us to draw on invaluable but still under-rated and devalued 'lived experience'. Second, it seems to start with few assumptions and rest on few fables – instead it sets out some helpful correctives to damaging conventional wisdoms in this field. Third, it connects with the emerging international-survivor led discipline of Mad Studies, which in my opinion offers the most hope for rethinking and renewing our understanding of madness and distress since the scientists first got to work and condemned so many to the dehumanizing aspects of the psychiatric system and associated 'big pharma' as well as an unhelpful preoccupation with chemical and mechanical 'solutions' to the emotional and psychological ills that go hand in hand with being human. Fourth, as the author rightly says 'it is of paramount importance to include psychiatry survivors and suicide attempt survivors' movements in any and all conversations about suicide, from surveillance, through prevention, and into care'. Fifth and finally, this book can only be helpful through its commitment to the belief that suicides 'are social acts shared by society', rejecting simplistic assumptions that 'suicide is an individual act, resulting from an individual pathology'.

But there is one more unexpected association which this book brings center stage; that is how (power) lifting and strength sports may help our understanding in this life and death context. Now I've thought a lot about madness, distress and self-destruction and I've seen women and men struggle with massive weights on my TV and been amazed at their achievements, but I've never put these two phenomena together. I am glad that Marilia Coutinho has and I am especially glad, as she puts it, that this 'back burner' activity had the chance to come to the front of her agenda with the unpleasant accident of Covid-19 making her ill. This gave her the chance to develop her thoughts and put pen to paper on a subject which, as she tells us, she is uniquely qualified to explore as 'an insider in both roles'.

Now let me be candid about where I am coming from in writing these opening words. I spent 12 years as a user of state/public mental health services in the UK; some of them helpful, some the absolute opposite. That experience was also coupled with being reliant on the welfare benefits system, which was also part of all that was negative about my experience of distress. Sadly

though as the years have gone by, that system where I live, has got more and more harsh and unpleasant.

All these experiences set me on the track of becoming involved in the psychiatric system survivors' movement, trying to make more sense of my own situation and working with others with similar experience to try and bring about change through our own 'user' or 'survivor' led organizations. For me this has especially been through the disabled people's and service user organization Shaping Our Lives (https://www.shapingourlives.org.uk).

Over these years I saw too many friends and colleagues die ostensibly at their own hands, as well as learning more about the broader pain and loss such premature exits from this earth resulted in. I became more and more interested in social approaches to understanding mental distress, madness and people taking their own lives.

One breakthrough moment for me came when I had the good fortune to visit an exhibition about the life and work of Vincent Van Gogh in Paris. Vincent has become a cliché of medical and popular understandings of madness, self harm and suicide. But this exhibition was very different. It drew on the work and understandings of the French actor and writer Antonin Artaud, himself a psychiatric system survivor. Like van Gogh he was ultimately to end his own life and he also experienced ECT among other 'treatments'. In 1947 he argued that the Dutch master's work so disturbed society that it shunned his art and led to his despair and suicide. He concluded that van Gogh was a man 'suicided by society'. Artaud dismissed crude psychiatric assessments of van Gogh that even now continue to obscure his life and work. Instead what he offered was a pre-figurative 'social model of madness and distress' (https://www.basw.co.uk/system/files/resources/basw_103307-2_0.pdf).

It really is time to explore madness, distress and suicide through a fresh lens, particularly that of psychiatric system survivors themselves. This book helps us in this task. Marilia Coutinho rightly explores new relationships and in doing so highlights the importance of adopting an inter-disciplinary approach. That's why I hope lots of people will have the chance to read her words and to take the opportunity it offers to think afresh about issues of madness, life, death, suicide and of course power lifting.

Peter Beresford OBE is Emeritus Professor of Social Policy at Brunel University London and Co-Chair of Shaping Our Lives the national service user and disabled people's organization.

Preface

A book on suicide and lifting has been one of my backburner projects for years. My backburner projects are always the best ones. Why they remain on the backburner is not an original story: important, in-depth intellectual projects are intimidating. Some are more, some are less intimidating and this one was a lot. The refusal of the involved scientific disciplines to talk to each other and engage in interdisciplinary knowledge production and action left me in a permanent state of self-doubt: did I read enough on the major items? Did I pick up on the context of each contribution? How am I going to navigate this Babel with elegance and respect for all parties involved? Finally, what original contribution do I have to offer?

Since 2005, I assumed lifting and strength sports had a suicide protective effect. After all, most sports do. I was, myself, an international elite, world record-breaking powerlifter until 2017. Warm-up area conversations during powerlifting world championships strengthened my belief. Evidence about flow in sports and its benefits for mental wellbeing were the foundation of my contribution's originality: like several other activities and sports, lifting would be suicide-protective due to the lifter's chance of experiencing flow.

A few years back, however, a disturbing piece of evidence showed up on my weekly literature review on the subject: the only published studies about suicide and strength sports measured higher suicide rates as compared to the general population, falsifying my hypothesis. The suicide and lifting project remained tightly stored on the backburner even longer.

The disturbing studies were conducted in two Scandinavian countries: Sweden and Finland, discussed in Chapter 10. They were carried out by different teams, 14 years apart. Comparing suicide rates among strength and power athletes with those of the general population, for the same cohorts, period, and sociocultural setting, they were significantly higher. The disturbing part is not only the higher-than-general-population suicide rates but the fact that other sports where suicide rates were studied showed the opposite trend: lower suicide rates compared to the general population. No other study was conducted about suicide in strength sports and I believe it is unlikely there will be any, for methodological and interest-related reasons: most strength and power sports are not collegiate, Olympic, or professional sports where health indicators are closely monitored.

A couple of months ago, a combination of factors got me into writing a “lengthy article” about the subject: it’s the final year of the 2013-2020 World Health Organization Comprehensive

Mental Health Action Plan (2013), which includes suicide prevention; the deaths of despair issue has been on the news more than never before, and with the COVID-19 pandemic I finally found myself with time to pick up where I left off several times in the past.

Like thousands of other people, I became seriously ill late in March and my column article deadlines were waived by Elitefts, where I write a column. My length limit was also waived: I could go beyond my three-thousand-word average article length. When I picked up the suicide and lifting article again, still sick or recovering, I was soon at seven thousand words. My literature review folder had about 130 items (now close to 400) and the more I expanded it, the more holes I saw in the story that I needed to tell. Although I never underestimated the complexity of the issue and the inconsistencies in most previous approaches, it was much more complex than I presumed at first. I also discovered many new promising perspectives that I was unaware of before. Finally, I found and connected with the customer/user/survivors movement.

The more I read recent research articles or books on suicide, the more convinced I was that the resistance to engage in interdisciplinarity from the involved sciences was not the only reason why it remains elusive. Deeper and deeper into this rabbit hole, I realized that the more we study the microphysics of suicide, the less universal proposed models look, and the more diverse its manifestations. The more I observed the recent rise in suicide rates in previously low-risk populations, the more I came to believe that the results of Academia's inability to cross-talk and solve problems in an interdisciplinary manner were deadly.

The only thing in common to all behaviors classified as suicides may be that they are deaths caused by deliberate self-destructive action against oneself. One of the first things that called my attention as I delved into the literature was the idea of a self-destructive continuum where suicide would be one sub-type. This idea was adopted by early day psychoanalysts, psychiatrists by profession (Chapter 3). The thousands of reports, peer-reviewed articles, and news stories about "deaths of despair", defined as those caused by suicide, accidental or undefined substance overdoses, and liver failure, ignore that early contribution. When they include these causes of death under the "death of despair" umbrella, they are reinventing the self-destructive psychoanalytic continuum wheel.

After seven years of the WHO's Comprehensive Mental Health Action Plan, we can all agree that there was important progress on surveillance, and more studies were conducted to test models about suicide conducive as opposed to suicide preventive or protective factors. However, this seems to be as far as we go unless there are major changes in the relation between knowledge production agents, and in the institutional power structure. More specifically, unless we

challenge, at the institutional level, mainstream psychiatry's logically fallacious assumption that most suicides are caused by mental illness because suicide, according to it, is a manifestation of mental illness, we are stuck in an incommensurability dilemma. This is called a tautology.

As a society, we need to go beyond the assumption that suicide is an individual act, resulting from individual pathology. We need to admit that many, if not most suicides are associated with social pathologies and as such, they are social acts shared by society.

To do that, it is of paramount importance to include psychiatry survivors and suicide attempt survivors' movements in any and all conversations about suicide, from surveillance, through prevention, and into care. As mainstream psychiatry continues to disqualify their patients as interlocutors, let alone collaborators in the production of knowledge about mental suffering and wellbeing, knowledge brokers become essential players in any action concerning suicide (Chapters 4 and 5).

Today, interdisciplinarity and co-production of knowledge with lived experience movements is not just a desirable intellectual attitude but a moral imperative. I decided, first as a joke, then as a science educator, and finally with this book to take upon myself both the role of "interdisciplinarian" and knowledge broker in this knowledge intersection. Two factors make me confident enough for that: I am an insider to both roles. My educational background ranges from chemistry to philosophy (as epistemological extremes): my undergraduate training includes chemistry, biochemistry, and evolutionary biology. My post-graduate training covers organic chemistry, ecology (Master's degree), philosophy, sociology, and political science (Ph.D.). This background has never been an institutional advantage to me and I learned the hard way that enthusiasm with inter and transdisciplinarity was mostly lip service. Departments still favor single-discipline tracks. With this and other projects developed with and within independent scholar organizations (the Ronin Institute and Institute for Globally Distributed Open Research and Education (IGDORE)), it has finally become an advantage. The second factor is that I am a suicide attempt survivor and I carry the sequelae to remind me of that. The neurodiversity movement’s motto of “nothing about us without us” resonates with me very strongly. I will build bridges across disciplines and from them into the “outer world”, whether they are used or not during my life span. I can see some bridges under construction already and I hope soon there will be many crossers.

As is frequently the case, there was the last drop that triggered my response to all this: I decided to turn a "lengthy article" into a book to be published and freely distributed in two months because the last suicide that happened in my immediate social circle pushed me to walk the

extra mile. Not only Egbert's death but the negative reactions to it prompted the urgency to write and publish this book.

This book was written with different audiences in mind. It addresses scholars from all the disciplines involved in suicide research and action and it addresses potential gatekeepers such as coaches, teachers, community leaders, spiritual leaders, and civil rights movement leaders, especially customers/users/survivors' movements. Along the construction of the argument about why lifting has the observed atypical and ambivalent effect on suicide probability, I made calls to action and reaction. That wasn't as easy as it seems. There are long segments of text about important disciplinary or inter-disciplinary issues where I suspected that the lay reader would fail to envision practicality. The "takeaway textboxes" were inserted for this reason. In this sense, this book talks directly to potential gatekeepers, less so to movement leaders and indirectly to fellow scholars.

I hope that gatekeepers find the content useful, that the movement leaders see themselves acknowledged, appreciated, and embraced as fellow knowledge producers and that my colleagues understand (and hopefully support) the call for opening up their disciplines' boundaries.

This book is published under the Ronin Institute for Independent Scholarship, to which I am proud to belong. It is a great match: the Ronin Institute is committed to “reinventing academia”. I am aware that the calls to academic action made here can hardly be accomplished in traditional institutions. Now, for the first time, we have an organization where these steps can be taken. I am grateful beyond words to all the Ronin Institute people who welcomed, supported and embraced my projects.

Some people were critical to making this project happen. The first is my significant other, who doesn't share all my views on suicide or my argument about suicide and lifting, did something more important than agreeing with me: he believed that I needed to write this book to move on and that I needed to move on. He offered his full support. He was the one who told me about Egbert's death on an unforgettable Saturday, the day after he died. He saw me spiraling down the imaginary lost opportunities tunnel and was there as I came back bearing dark gifts.

Phillip Shotts, intellectual property attorney and a man of beautiful words, elegant ideas, and a powerful friendship told me: "you can't undo his death but you can make it matter". Since that June 17 when Phillip and I talked, I committed to making Egbert's death matter.

This work was a somewhat a hybrid family endeavor: the book cover was designed by Lena Coutinho, and the art was done by Laerte Coutinho, both my sisters. Laerte was the person to tell me that this book had to be written because it was essential. As a transgender woman and activist, she is no stranger to mental suffering and discrimination. My daughter, clinical psychologist Melina Bertholdo, has been supportive of the book in many ways. First, by being supportive of me in confusing and painful moments. Second, by helping me contextualize psychoanalysis's role in our understanding of suicide. I wish we had more time for this.

None of this would have happened if Sheena Ledham, my editor at Elitefts and autism specialist, hadn't given me an enthusiastic green light to pursue the project. Dave Tate, Elitefts owner, has offered me support, freedom, and a platform on which to explore my projects during the past four years.

Something tells me that this is just the beginning of a much longer journey. Because this is just an intuition, I don't know where this road will take me, who I will meet in the way, and for how long we will walk together. However, I must believe in a positive outcome for all the problematic issues revealed with this project. This is called hope and it is what keeps us going (Chapter 9).

Reading guide

Writing to such different audiences as gatekeepers, other scholars, lived-experience movement leaders and a general readership concerned with public health and suicide is a challenge. One of the first concerns I have addressed is to avoid the use of any jargon. After all, to promote interdisciplinarity, one has to negotiate common terms to even start a conversation. To integrate the contributions of lived-experience movements, even more critical terminology negotiation must take place. A conversation between psychiatrists, as unconventional as they may be, with lived-experience movement leaders who question the validity of psychiatric nosology, is a first very hard step to take.

If the reader is someone dealing with their own suicidal challenges, a jargon-laden book would be of very little use.

The book was written in a certain order for the sake of the argument but it can be read according to the order that best satisfies the reader's needs. Here are some suggestions for different types of readers.

For gatekeepers:

I am assuming a loose form of Quinnett's gatekeeper concept, used on Chapter 5 ("Can we predict and prevent suicide?"), in "The Window of Opportunity", as "people who may be strategically positioned to identify distress in the community and could be trained as gatekeepers" (Quinnett 2013). These would be all those mentioned by Quinnett minus lived-experience movement leaders. They are at a qualitatively different situation concerning the identification of red flags and their interest in the topics covered by this group. Gatekeepers are coaches, teachers, community leaders, spiritual leaders, and civil rights movement leaders. For this reading guide, anyone in the above positions, or anyone with the interest and the curiosity to learn about preventing suicide at the grassroots level is a gatekeeper.

I suggest you read the next three chapters, "Introduction", "Let's Talk About These People" and "What is Suicide and How Can We Classify it" and then, unless you are inclined to an in-depth exploration, skim through the green text-boxes until you reach "Can we predict and prevent suicide?" In this chapter, read the first topic ("The Window of Opportunity"). "Stigma and the Law" is particularly important and from there you can follow the green text-boxes until you reach the chapter about "Lifting, Mental Well-being, and Mental Suffering".

Even if you are not implementing a lifting-based program at your community, this chapter should provide you with insight about potentially helpful and unhelpful components of any program or environment and ways to promote the first and mitigate the latter.

The green text-boxes are summaries or takeaways of a larger segment. Through them, you can decide to read the whole topic or chapter or move on.

For scholars:

Whatever your field is, there's a chance you may be frustrated with the lack of depth into it. My point here was to use the outlines of each to highlight the interdisciplinary gaps as a bas-relief or a negative photograph of a landscape. Moreover, I wanted to stress the need for a social, rather than purely individual approach to suicide and mental suffering in general. There are an environmental chicken and a phenotypical egg. Getting our eggs from the grocery store for years may have had an impact on younger generations of scholars who may not be familiar with who laid that egg.

I especially invite you to read the chapter on "Lifting, Mental Well-being, and Mental Suffering" and appreciate how the absence of interdisciplinary and critical approaches to suicide makes it difficult to make sense of data and to devise policies. . The idea that many times, if not most of the time, we are proposing approaches that will "probably work" based on by-proxy data and concepts tested in other conditions is far from optimal. That's what we have to work on, though. This is as close as I get to a call to action to test approaches and programs.

For lived-experience movement leaders:

I hope you feel inclined to read the book cover-to-cover. I am one of you and although there is not a single paragraph about my experience in this book, I am convinced you will recognize the identifying marks of a survivor-author. Other readers probably won't and they will only learn the author is a survivor because I mention it at the Preface. I know that we look at reality differently and we identify hidden elements that are not visible to those who haven't got skin in the game, who haven't been out there, and exposed the things we are supposed to never talk about and also the non-neutral nature of knowledge construction.

For some of you, there may be chapters about issues you are too familiar with. Everything except the first ten topics and the chapter on lifting, proper, is related to the history of lived-experience movements. There are still the green text-boxes and you may choose to skip them or not.

For someone in mental suffering and/or dealing with your own prevention or postvention:

I would like to suggest that you consider this book as a collection of resources that you can go back and explore as frequently as you need. You can skim through the green text-boxes and decide where you want to read more. Depending on where you are in your process, I would go directly to the end of the book, on Chapter 9, “What Suicide is Not”, Chapter 13, “False Beliefs” and then back to Chapter 10, “Hope”.

After that, even if you have never lifted in your life and are not familiar with the strength gym culture, I would go to Chapter 10, “Lifting, Mental Well-being, and Mental Suffering”. There are several items that you will recognize as similar to other sub-cultures that you are familiar with.

1

INTRODUCTION: WHO LIFTS THE BARBELL AND WHO DOES THE BARBELL LIFT

Is lifting weights something that can help people struggling with suicide – whether experiencing extreme mental suffering or having just survived a suicide attempt? Can it help vulnerable populations protect themselves from suicide conducive factors? Is there something about lifting weights or about lifting weights with others that can help these people out of their dark cave of despair or confusion?

Evidence suggests that it can be both positive and negative.

It is my mission with this project to delve into the most relevant scientific disciplines where suicide was studied, the customers/users/survivors' movements of mental suffering people, and try to bridge the gaps between them. Only then it will be possible to understand in which circumstances lifting can be a positive and in which it can be a negative influence over the suicidal person.

The first step to answering the question in the first line and developing the argument is to establish what we are talking about. If a common definition cannot be found, it's important to understand why and what working assumptions to use.

Deep down, we don't know what the disorders associated with mental suffering are. At the mechanism level of things, depression, anxiety, personality disorder, or autism remain elusive. We have symptomatic descriptions and typologies but we don't know what causes them or even if they are one thing or many that look alike. In science, there is an important distinction between association and causation. For example: in 1850, Ignaz Semmelweis observed a high ***association*** between puerperal death and physicians not washing their hands before a delivery. In 1862, Louis Pasteur, often referred to as the "father of microbiology", supported the germ theory of disease. However, actual evidence that germs ***caused*** infections that led to death came only in 1876 with Robert Koch's discovery of the anthrax bacillus (Schlich 2012, Blevins & Bronze 2010). That is a classic example in the history of science and if we move back, there were lay theories about disease based on associations as well. Unfortunately, that's not the case with behavioral or mental phenomena. Psychiatrists may have names and some consistent associations concerning a certain behavior but they have no clue about what is causing the patient's suffering. Yet, they have to do something about it and so do we. Suicide falls exactly into this category.

Critical psychiatrists, and psychiatric researchers, have been insisting on this knowledge insufficiency in recent years. Most of them suggest a more comprehensive approach including societal-level mechanisms (Stein et al 2013). They point out that psychiatry is struggling more, not less, to provide prevention, treatment, and prognosis (McGorry et al 2006). Nosology, or the classification of diseases, is harder in psychiatry than in almost any other medical field. Is a certain behavior a discrete clinical condition? Is it an arbitrary segment along the dimensions of human functioning (Widiger et al 2005)? The DSM-5 (Diagnostic and statistical manual of mental disorders) and the ICD-11 (International Classification of Diseases 11th Revision) are works in progress in terms of diagnostic guidelines, far from the effectiveness needed on the front-line battle with mental suffering, whether it is a disease or not.

Although most scholars believe that suicide is preventable, they also agree that we are still failing in our attempts to prevent it. Not only that, but there is a major concern with the constant rise in suicide rates in the past decades in certain social segments - for example, among military veterans, young adults, and middle-aged white males in the USA. Several countries have

experienced a rise in suicide rates and have felt the need to promote applied research towards the development of preventive measures.

I believe that the failure to effectively promote suicide prediction and prevention is the interdisciplinary wall of silence. Suicide, as an object, lies at the intersection of many disciplines: sociology, psychiatry, psychology, anthropology, law, toxicology, urban planning, political science, and management, to name a few. By not actively engaging in interdisciplinary work, we end up not even agreeing about the definition of suicide. And that is just to mention the sciences. An even thicker wall exists between all social institutions, science included, and the (surviving) victims. Knowledge and questions don't cross this wall. Surviving victims of suicide are not only the suicide attempt survivors, who, if not carefully listened to, have a high chance of repeating the attempt and succeeding. Suicide victims are also surviving relatives, friends, and whole communities.

A suicide is not only an individual act of medical consequences. It is also, and often mostly a social act of social consequences and a manifestation of social pathologies.

Something has been changing in the interdisciplinary and community-based direction. Recently, the number of publications on social aspects of suicide as well as those attempting to bridge the scientific gap are growing. Timidly but steadily. One of the reasons for this is that there is an institutional push from way up the health science and policy hierarchy: the World Health Organization.

On May 27th, 2013, during the 66th World Health Assembly, consisting of Ministers of Health of 194 Member States, the World Health Organization adopted an almost decennial mental health action plan. As pointed out by Saxena and collaborators on *The Lancet* (WHO 2013, Saxena et al 2013), as a result of many years of debate, the WHO moved away "from a wholly medical model", incorporating approaches developed throughout the world towards "community-based care". White and Sashidharan have called it a "more nuanced" approach (White & Sashidharan 2014).

The plan's four major objectives are: more effective leadership and governance for mental health; the provision of comprehensive, integrated mental health and social care services in

community-based settings; implementation of strategies for promotion and prevention; and strengthened information systems, evidence, and research. We all agree on this: the previous model was either not helping or making things worse. If a strengthened evidence-based information system in integrated mental and social care services at community-based settings grows roots, maybe we will be able to promote suicide preventive conditions and avoid suicide conducive conditions.

What does that mean in practice? For starters, it means going back to the classics, such as Durkheim (1897), and updating the model by collecting modern data on suicide. Other important measures are to identify the bottlenecks to prediction and prevention, such as heavy religious influence combined with a non-mandatory autopsy, leading to sub-notification of suicides (Ohayi 2019, Dine 2019); theocratic laws punishing suicidal individuals (Arensman 2017); or inability to force health insurance companies to cover self-inflicted injuries which are the first red flags for suicide risk, making the bulk of these important signs for prevention invisible (Chapter 6).

Most of all, though, it is important to use the available research and theory to create a few practical guidelines for decision-makers, community leaders, and individuals in a supervising position: teachers, coaches, and, why not, co-workers and friends. We will have qualitative change in perspective that can lead to actual prevention when we reframe the responsibility for suicide towards the collective rather than the individual. While individual choice must be respected, such as "rational suicide" or euthanasia, and suicide-risk dissociative or psychotic states must be dealt with by others because the victim is not equipped to assess reality, the bulk of suicides are determined by social variables that can be changed.

Bullying, domestic abuse, discrimination, social isolation, and intolerance are associated with suicide. A lifting gym or training environment that welcomes these behaviors is conducive to suicide while those that oppose them may be preventive of suicide.

My argument is that lifting may have either a positive (preventive) or negative (conducive) influence on the suicidal person or the suicide survivor: it depends on the social setting where lifting takes place. Only by examining different approaches and concepts involving suicide can we provide any useful guidelines.

Considering that the best predictor of individual suicide is hopelessness, my other challenge is to find the common thread of how hope is lost and gained back.

2

LET'S TALK ABOUT THESE PEOPLE

Before we examine the different conceptual tools developed to study and intervene on suicide, I will introduce you to a few cases that I observed, directly or indirectly. This is an exercise that anyone can do and will probably reveal overlooked surprises because that is the advantage of memory: it provides distance. Aaron Swartz, Egbert (not his real name), my bipolar cousin, my schizophrenic friend, my terminal muscular dystrophy professor, the department outcast, the foreign grad student, child psychology pioneer Bruno Bettelheim and, ironically, Sigmund Freud himself died of suicide. These deaths have only one thing in common: the decision and active measures that led to death were made by the victims. Everything else is different.

On January 11, 2013, Aaron Swartz ("Aaron Swartz" 2020) died by suicide. Aaron was a normal, happy child prodigy who grew up to be one of the major figures in the activism for free access to information. Among other things, Aaron was a co-founder of Creative Commons, Open Library, Demand Progress, Reddit, and received several awards for his web inventions. He was a friend of knowledge, science, and believed in the power of the internet to bring social justice.

In late 2010 and 2011, Aaron downloaded a large number of academic journals from the MIT network while at MIT. Powerful companies had been hunting Aaron for a while and on a joint federal and state action, he was charged and prosecuted ("UNITED STATES DISTRICT COURT DISTRICT OF MASSACHUSETTS" 2011) with the help of JSTOR ("JSTOR Swartz Evidence All Docs" 2010), MIT and other organizations. The Federal Government decided to make an example out of Swartz by punishing him to the full extent of the law and some. Even with the help of the community, Aaron's personal and family resources were exhausted. As nine new charges were added to the lawsuit, his parents were getting a second mortgage on the house. At this point, Aaron realized that they had no chance since the prosecution was determined to not negotiate. The corporate and government political war against him was hurting his family and his causes. He ended it all by hanging himself.

I remember as if it was today. Like others in the scientific community, I was struck by pain and anger. On that day I wrote four letters: to the Office of the Attorney General, to Carmen Ortiz,

Massachusetts Attorney General, and chief prosecutor, to the MIT and to JSTOR. In each one of them, I wrote, in no uncertain terms, that Aaron Swarts was forced to commit suicide by them and that they had blood on their hands. Carmen Ortiz was the object of a petition signed by 60,000 people demanding that she step down ("White House Must Respond to Petition to Remove U.S. Attorney in Aaron Swartz Case" 2013). Carmen was ambitious and ruthless. She was Obama's choice for Massachusetts democratic governor candidate. With Aaron's death, her career was over. She tried teaching for a while and joined a law firm living in the lowest possible profile. She will never have a political career or hold public office again, and she probably looks over her shoulder to this day and for the rest of her life. Aaron's death resulted in a legal probe but nothing came out of it ("Aaron Swartz' Death Fuels MIT Probe, White House Petition to Oust Prosecutor", 2013).

Aaron died of suicide but the public perception was that of a murder. He became a martyr of all the noble causes he championed. His self-sacrifice seems to have significantly influenced the history of the Open Access movement ("Scientific Reports Overtakes PLOS ONE As Largest Megajournal" 2017, "History of the Open Access Movement" 2020). As of May 2018, there were 1.4 billion works licensed under the various Creative Commons licenses ("State of the Commons" 2020).

The dirt that came out concerning corporate interests after the suicide intimidated the MIT, JSTOR, and all the big academic publishing companies. The MIT denied involvement, JSTOR, whose involvement became public, offered their full library to open access (which they canceled years later).

Aaron died on January 11, 2013. On June 4, Research Gate ("Bill Gates, Benchmark And More Pour $35M Into ResearchGate, The Social Network For Scientists – TechCrunch" 2013) closed Series C financing arrangements for $35M from investors including Bill Gates. In September 2013, Academia.edu ("A Social Networking Site is Not an Open Access Repository" 2018) raised $11.1 million from Khosla Ventures, True Ventures, Spark Ventures, Spark Capital and Rupert Pennant-Ream. The growth of PLOS (Public Library of Science), a nonprofit open-access science, technology, and medicine publisher, follows a similar timeline ("PLOS" 2020).

I suspect that Aaron's thoughts as he hung himself were only to protect his family and escape the torture of a trial with a pre-established result. It was strictly impossible to envision a positive outcome in the future which is the definition of hope (Chapter 9). He couldn't predict the social consequences of his death. However, martyrdom often promotes social change. In this case, it did.

Egbert was a shy boy. Hard worker on his job, at school, and at the gym, where he lifted. He showed signs of mental suffering early in his teenage years but only got help when he was an adult and educated himself on the matter. He talked to me about his issues. Like so many in his condition, he was easy prey for manipulative types who frequently dragged him deeper and deeper in the circle of drug abuse and depression. He received poor mental health assistance and had few people to talk about the discomfort of mood-stabilizing drugs, particularly lithium. He felt sick and, as so many, discontinued and resumed pharmacological treatment again and again.

Like most successful suicides, Egbert rehearsed his: I knew of at least three attempts. As is the rule on self-inflicted wounds, he duct-taped them as best as he could because there is no medical coverage for that. It didn't work well, he bled publicly and one would assume that his need for help was obvious. About a month later he was found dead from an overdose of something I was never told.

Also like so many suicidal patients, the month before his final and successful attempt, he seemed calm, in control, and publicly encouraged all his social networks to openly talk about suicide. That was the last red flag. He was 23 years old when he died of suicide.

Egbert was a white middle-class young man from an American Midwest state. His social environment was predominantly evangelical, with heavy drug users, unsupportive of educational pursuit and part of these people were "gym cultists": bullies, contemptuous of anyone who was not a strength athlete, group-thinkers.

I never knew my cousin. My parents told me he was a mathematical genius like at least two of his siblings, except even more so. One of his siblings has all the features of the savant. He's an adorable man with some cognitive impairment. He found his place in society because he communicates well: mathematical challenges are obvious to him and he managed to make people see them that way. He became an amazing private math teacher and leads a simple, supervised life. The cousin who died of suicide had violent mood swings, scary euphoric and psychotic episodes, and depression. One day he shot his mouth, missed the brain, did not die immediately, and crawled to his parents' room (suicide ambivalence). He died minutes after that, leaving a nonsensical suicide note. All I know about this note is that he cheered his favorite soccer team as a good-bye.

In college, I met several people who died of suicide. The first was one of our buddies. He had been diagnosed with schizophrenia but his family was neglectful. He abused recreational drugs

and we didn't know what psychiatric medications he took. His episodes could happen in the middle of a class or during a party. One day he jumped into an unprotected elevator well at the students' dorm. We were confused, felt guilty, and have never talked about it.

A couple of professors died of suicide. One was at the end stages of muscular dystrophy. He was brilliant, funny, somewhat cynical, and caring. I miss him. Another was a young and promising woman back from her postdoc abroad. She was an international authority on her subject, extremely committed to causes in a world that only made sense to her as a crusader. She was hired in one of the less productive, most mediocre, and ethically questionable departments of the university. During a couple of months, other faculty members treated her with passive aggressiveness and made her feel like an outcast. Suddenly, her demeanor changed, and she plunged into what looked like depression or a longing for something lost. Months passed and again, suddenly she changed into a calm and polite person, apparently conformed with the circumstances. She was found many days after her death by suicide because of the smell from her apartment. In her office, she left neat piles of books with instructions to return to the library or donate. She had worked all her life to make a difference in the world as a scientist. What should be her long-term professional life stopped making sense to her.

As I recall it, the graduate student from Chile wasn't so unlike the young female professor. He obtained a scholarship to work on his dissertation in one of the best laboratories at one of the best departments in the world. I was an undergraduate research assistant then. He was the poster child of enthusiasm and belief in the power of science to improve the world. After a few months, he hadn't made friends. The pathologically competitive environment created clicks of graduate students according to academic accomplishment and the student from Chile wasn't accepted in any of them. They weren't particularly interested in changing the world. Nobody invited that student for Christmas and his body was found after New Year's day as neighbors called about the smell.

Sigmund Freud, founder of psychoanalysis and one of the founding fathers of psychology died on September 23, 1939, from a lethal morphine dose administered by his doctor Felix Deutsch. Freud suffered from inoperable cancer of the jaw and his "contract" with Deutsch established that when pain and suffering became unbearable, that the friend should help him die. It is assumed that it all happened according to Freud's plans for a dignified death. However, up to this day, there are doubts about that (Gifford 2017). Another prominent psychologist, Bruno Bettelheim, ended his life through asphyxiation with a plastic bag in 1990 when the suffering from his degenerating health after a stroke became unbearable (Finn 1997).

My point with these examples is to show how multi-faceted suicide is in practice and how each one of us might already know someone who died of some type of suicide.

How were Aaron's mind and brain when he hung himself? I'm sure it would be possible to detect abnormal activity and a very disturbed state of mind. But his motivation for the act was instrumental and altruistic. My college friend and my cousin experienced reality through the lens of psychosis. The negligent family environment my friend lived in and the strict religious one my cousin had may or may not have been strong factors in their deaths. The two scientists may or may not have been chronically depressed but what we do know is that their suicides happened in the context of a dramatic erosion of meaning in their lives. Freud and Bettelheim were ill and in pain. It is possible that Freud passed in complete peace, a transcendent man satisfied with having left the world a wiser place and, of course, enjoying the simultaneous fading out of pain and life. Bettelheim survived the horrors of the Dachau and Buchenwald concentration camps where he was brutally treated, suggesting PTSD. He struggled with depression for a long time. Still, he left extraordinary contributions to the wellbeing of others. Bettelheim died in isolation and misery, under growing harsh criticism. He didn’t pass in peace or with pain relief. Egbert was diagnosed and medicated for bipolar disorder and depression. It’s hard to overlook the fact that he fits perfectly in the demographic that currently manifests the phenomenon of “deaths of despair”. He was immersed in a social circle that is struggling with a historical thinning of life purpose and meaning added to grim perspectives of life choices for personal development.

3

WHAT IS SUICIDE AND HOW CAN WE CLASSIFY IT

There no consensus in the definition of suicide. The minimum common denominator is "death resulting from intentional measures taken by the individual".

The stigma and taboo about suicide come from different institutional sources and historical threads but the result is the same: we can't seem to have an organized public conversation about it. There is no consensus on what suicide is – whether because the sciences can't agree on a definition, or because in most countries (even those officially secular), the law reflects religious views that end up punishing individuals who attempt suicide, or because every cultural niche expresses in its own way contempt and hate towards those who either die or almost die of suicide, or finally, because the voices of the victims are silenced.

If we don't agree on what suicide is, how can we predict and prevent it? Even if we decide to fall in line behind the mental health initiatives, grudgingly embracing the mental illness approach to suicide, how do we know where to look? Whether certain behaviors should be considered pathological or not is as much a medical as a philosophical choice (Canguilhem 2012). What defines a behavior as pathological? Dysfunctionality in life? Suffering?

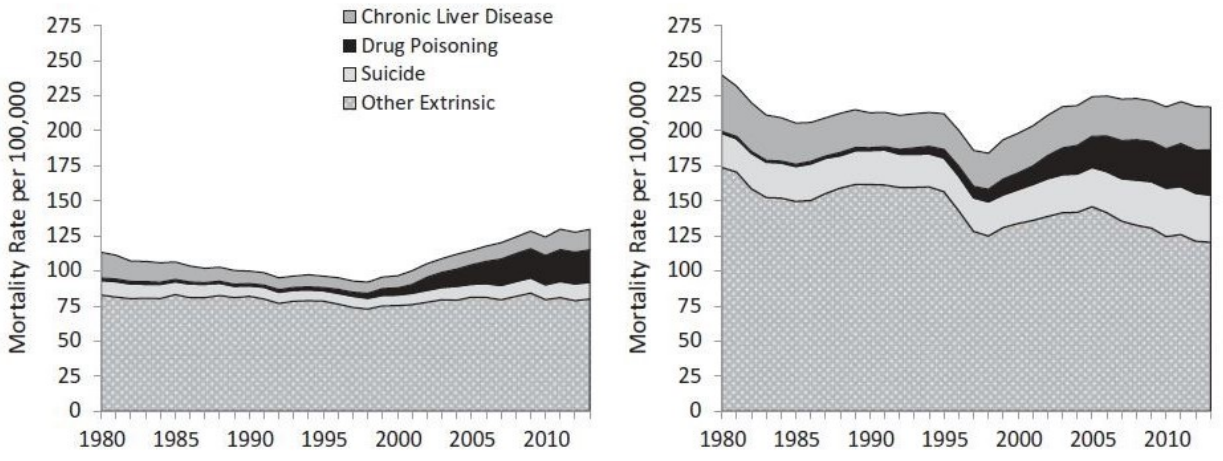
Several conditions considered as mental illnesses and listed on the DSM-5 don't cause suffering. A serial killer, who may have several co-morbidities besides one of the Cluster-B personality disorders, won't walk into a psychiatrist's office and ask to be treated because he is in pain.

Quite the opposite: he gets sexual pleasure out of inflicting pain in others. Yet, it is a consensus that serial killers and mass murderers have a mental illness.

PTSD is a big enigma (Hendin & Haas 1991, McKinney et al 2017, Brake et al 2017, Locci & Pinna 2019, Brake et al 2019): nobody knows what exactly causes it except that trauma is a pre-condition. On several individuals, trauma can irreversibly alter not only the behavior but the brain structure itself. It causes extreme suffering and is highly associated with suicide.

A confounding factor today is the increase in drug overdose deaths (figure 1). There is evidence that a good part of "unintentional drug overdose deaths" are suicides (Bohnert & Ilgen 2019). As we will see, Freud and other authors discussing suicide with a psychoanalytic perspective classified long-term self-destructive behaviors as suicides. If we add the questionably "unintentional drug overdose deaths" and long-term self-destructive behaviors (Menninger 1938) such as drug and alcohol abuse (Suokas & Lönnqvist 1995), suicide will account for much more than the share of deaths than it does today (table 1).

Figure 1. Mortality rates for U.S. white women and men, 1980-2013



Source: Masters et al 2017. Mortality rates for US white women (left) and men (right) aged 45-54 from “extrinsic” causes of death, 1980-2013. Original source: NCHS, Multiple Cause-of-Death Files (1980-2013); CDC, Bridged-Race Population Estimates (1990-2013); and Census Bureau, Quarterly Population Estimates (1980-1990). Note: Mortality rates estimated at age 50 years.

Table 1. Rates of Death from Suicide and Overdose in the United States, According to Year

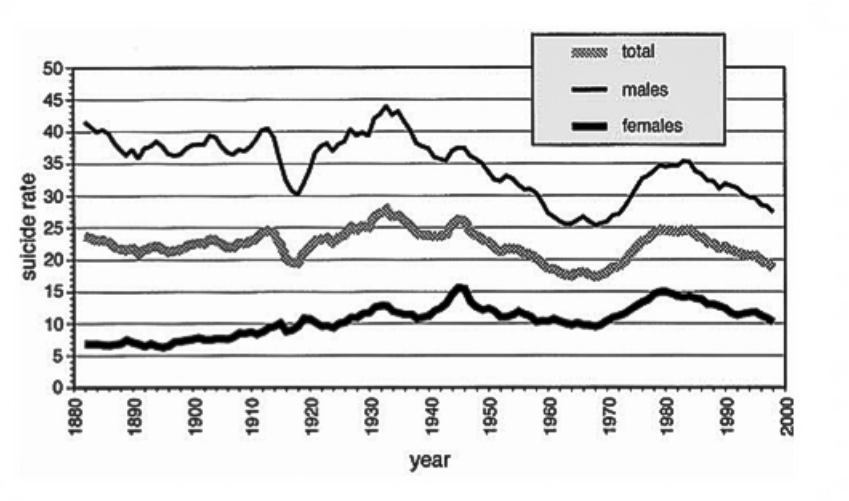
Cause of Death	Age-Adjusted Rate per 100,000 Americans																	
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Suicide	10.4	10.7	10.9	10.8	11.0	10.9	11.0	11.3	11.6	11.8	12.1	12.3	12.6	12.6	13.0	13.3	13.5	14.0
Intentional overdose	1.2	1.3	1.4	1.3	1.4	1.4	1.5	1.6	1.6	1.6	1.7	1.7	1.7	1.6	1.6	1.6	1.5	1.5
Intentional overdose involving opioids	0.3	0.3	0.4	0.3	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Unintentional overdose	4.3	4.7	5.8	6.5	6.9	7.7	9.0	9.6	9.9	10.0	10.4	11.3	11.2	11.9	12.8	14.5	17.8	19.7
Involving opioids	2.2	2.4	3.1	3.4	3.6	4.0	4.8	5.0	5.3	5.5	5.7	6.3	6.4	6.9	7.9	9.3	11.9	13.5
Suicide and unintentional overdose combined	14.7	15.4	16.8	17.2	17.9	18.6	19.9	20.9	21.5	21.7	22.5	23.6	23.8	24.6	25.8	27.8	31.3	33.7
Involving opioids	2.5	2.7	3.5	3.7	4.0	4.5	5.2	5.5	5.9	6.0	6.3	6.8	6.9	7.4	8.5	9.8	12.5	14.1

Source: Bohnert & Ilgen (2019). Categories were determined on the basis of the codes of the *International Statistical Classification of Diseases and Related Problems, 10th Revision*, that were obtained from death records. Suicide deaths were those with an underlying cause of death coded as X60 through X84, Y87.0, or *U03. Unintentional overdose deaths were those with an underlying cause of death coded as X40 through X45. Deaths involving opioids were those with multiple causes of death codes recorded as T40.0 through T40.4 or T40.6. Data were obtained from the Centers for Disease Control and Prevention.

The self-destructiveness continuum, of which death by hanging, shooting, asphyxiation, and other means identified as suicides would represent a point in the intention scale (Firestone & Seiden 1990, Maltsberger 2008, Henderson 1976) raises questions about what effective suicide prevention is. If the behaviors characterized by self-neglect and self-destructiveness are placed under the suicide umbrella, then we're possibly talking about the first cause of death in modern industrial societies. The methodological problem is where to draw the line and provide guidelines as to at which point self-neglect and recklessness are red flags for suicide (or a long-term suicide taking place).

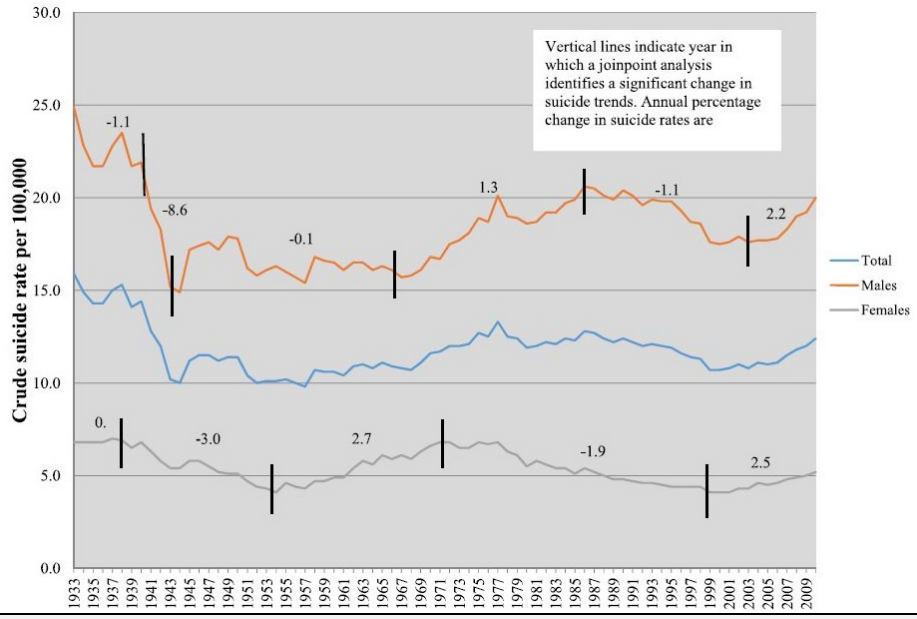
There are several things that we do know about suicide, many of them already pointed out by Durkheim (1897) and his followers. We know suicide is a stable phenomenon in a given society and that the best predictor of suicide rates is the previous year's suicide rate within that social group (figures 2, 3 and 4). Rates change slowly and when there is an abrupt change it is correlated with dramatic disruption in society (figure 5).

Figure 2. Suicide rates (deaths per 100,000) by sex, Switzerland, 1881-2000 (rough rates, 5-year moving averages)



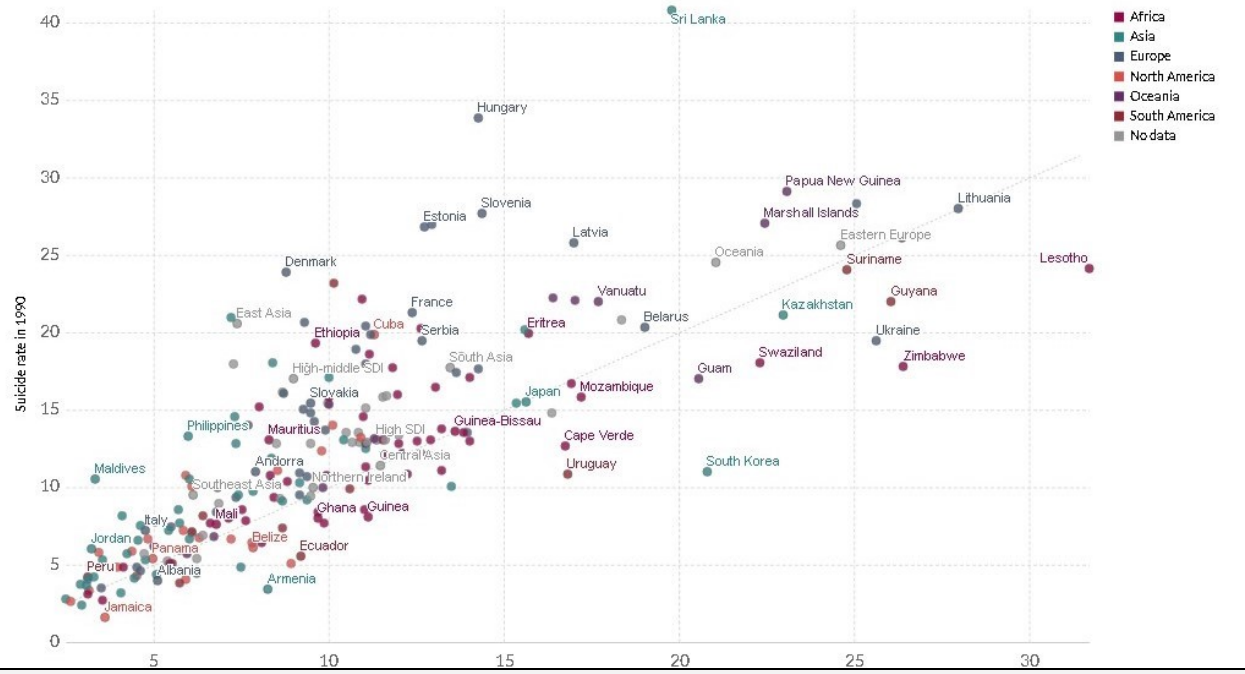
Source: Ajaccio–Gross et al (2006)

Figure 3. US crude suicide rates, overall and by sex 1933-2010



Source: Phillips 2014. US crude suicide rates, overall and by sex 1933-2010. Original Source: US National Center for Health Statistics (http://mypage.iu.edu/~jmcintod/SuicideStats.html)

Figure 4. Suicide rate in 1990 vs. 2017.



Source: "Suicide Rate in 1990 Vs. 2017" 2020. Original Source: IHME, Global Burden of Disease. OurWorldInData.org/suicide.

Even the recent increases in suicide rates among certain segments of American society, among traditional societies disrupted during colonization or among former Soviet countries after the fall of the Berlin Wall, are slow if compared to a transmissible pathogen epidemic such as COVID19.

Suicide rates are high as compared to other causes of death even at present sub-notification levels.

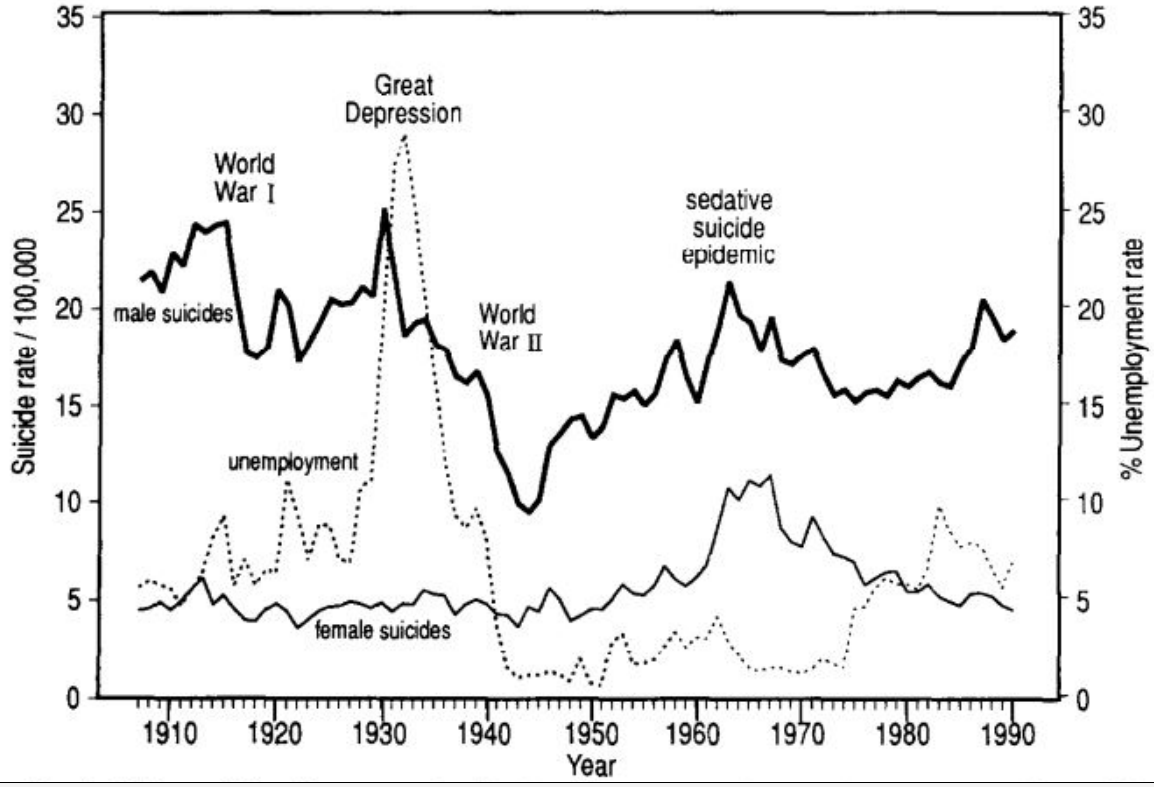
Changes in suicide rates are comparatively slow.

Positive changes in suicide trends also take a much longer time than mitigating measures effects directed at other causes of death.

Phillips (2014) suggested that the (slow) changes observed in American suicide epidemiology can be attributed to "weakened forms of social integration and regulation among postwar cohorts". As a predominantly social phenomenon and unlike a transmissible pathogen, suicide

rates vary according to cohort, sex, ethnicity, income strata, religion, region, and, of course, trauma, abuse (physical, emotional, and sexual), economic inequality and insecurity.

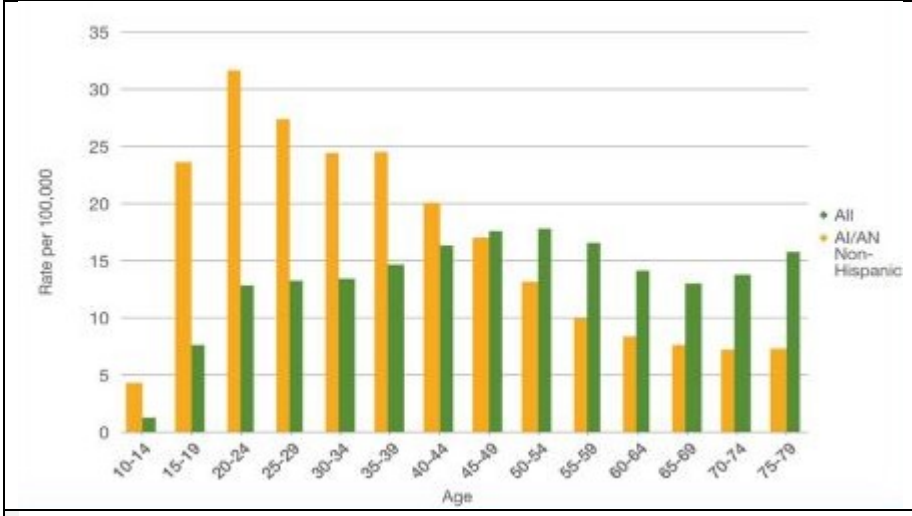
Figure 5. Male and female age-standardized suicide rates and unemployment rates, 1907-1990



Source: Morrell et al 1993.

When we break up epidemiological data by social segment, specific high suicide rate trends become visible. For example, the disproportionate suicide rates among young native Americans: in an overall suicide rate chart they are invisible because of the relatively small size of their population (figure 6).

Figure 6. Suicide Rate by Age for American Indian/Alaska Native Compared to United States (Average 200-2013).



Source: Substance Abuse and Mental Health Services Administration 2017. Original source: Suicide Prevention Resource Center (SPRC): http://www.sprc.org/basics/scope/disparities

Suicide impacts different social groups differently. However, it is always one of the major causes of death. Suicide rates are high and have been high for a long time.

Suicide is the hidden face of brutality, oppression, inequality, abuse, rape, bullying, and mental illness, the latter being frequently also the result of those social factors.

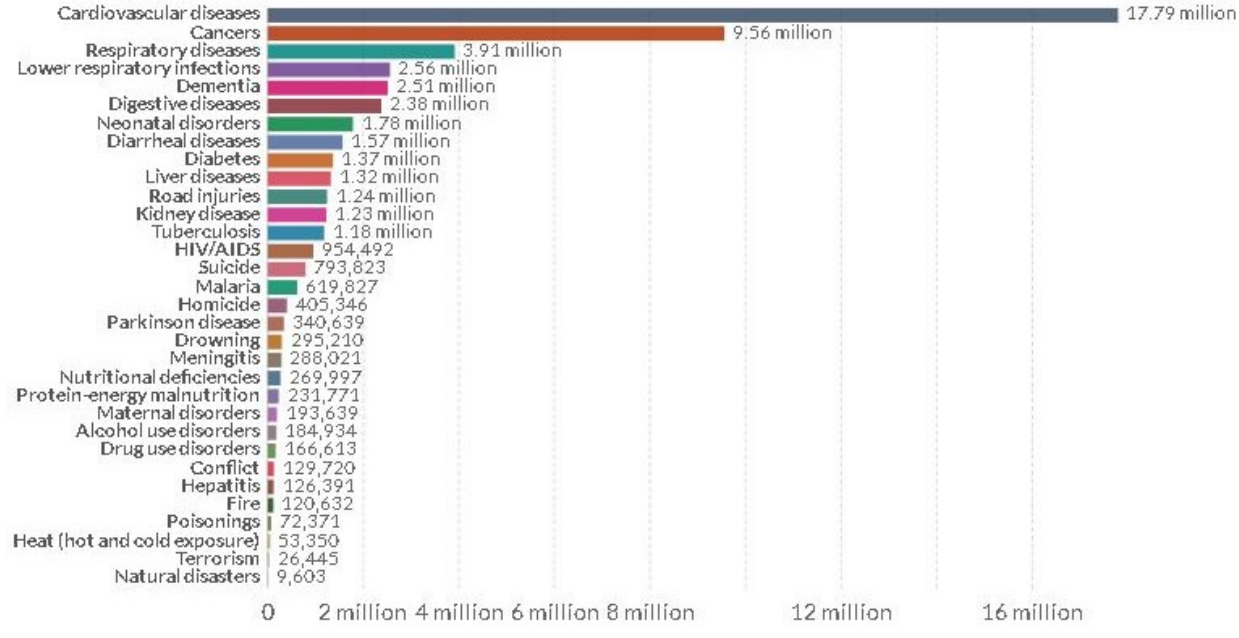
The challenge has always been with us and we have failed to deal with it. Whether it is because of the oppressive forces of religions, theocracies, or normative (reproachful) pathologization, suicide has been and still is a major killer and the single undeniable manifestation of hopelessness and despair in our societies.

During the past many thousands of years of human history, we have been trying to de-normalize suffering, cruelty, oppression, violence, and murder. In the Middle Ages half of the children died before one year of age, infectious diseases could have catastrophic incidence in the form of epidemics and wipe out from 10-60% of whole nations and hunger was a major killer until the beginning of this century. The reason why we should face the suicide challenge seriously is that

many of its determinants are manageable. Suicide may have never been dealt with seriously because it is still normalized: something that happens to people who are born "sick in the head". It is not.

If we look at the chart of the leading causes of death for 2017 (figure 7), all the non-accidental causes receive significant research and treatment funding, and there is a genuine belief that they can be decreased. The difference is that society still sees those who die from these causes of death - malignant neoplasms, heart disease, diabetes, and chronic lower respiratory disease – as victims whereas suicide is predominantly considered “their fault”. It is not (table 2).

Figure 7. Number of deaths by cause, World, 2017



Source: "Suicide" Our World in Data 2020. Original source: IHME, Global Burden of Disease.

Table 2. Leading Causes of Death in the United States (2016)

	Select Age Groups							
Rank	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Unintentional Injury 847	Unintentional Injury 13,895	Unintentional Injury 23,984	Unintentional Injury 20,975	Malignant Neoplasms 41,291	Malignant Neoplasms 116,364	Heart Disease 507,118	Heart Disease 635,260
2	**Suicide 436**	**Suicide 5,723**	**Suicide 7,366**	Malignant Neoplasms 10,903	Heart Disease 34,027	Heart Disease 78,610	Malignant Neoplasms 422,927	Malignant Neoplasms 598,038
3	Malignant Neoplasms 431	Homicide 5,172	Homicide 5,376	Heart Disease 10,477	Unintentional Injury 23,377	Unintentional Injury 21,860	CLRD 131,002	Unintentional Injury 161,374
4	Homicide 147	Malignant Neoplasms 1,431	Malignant Neoplasms 3,791	**Suicide 7,030**	**Suicide 8,437**	CLRD 17,810	Cerebro-vascular 121,630	CLRD 154,596
5	Congenital Anomalies 146	Heart Disease 949	Heart Disease 3,445	Homicide 3,369	Liver Disease 8,364	Diabetes Mellitus 14,251	Alzheimer's Disease 114,883	Cerebro-vascular 142,142
6	Heart Disease 111	Congenital Anomalies 388	Liver Disease 925	Liver Disease 2,851	Diabetes Mellitus 6,267	Liver Disease 13,448	Diabetes Mellitus 56,452	Alzheimer's Disease 116,103
7	CLRD 75	Diabetes Mellitus 211	Diabetes Mellitus 792	Diabetes Mellitus 2,049	Cerebro-vascular 5,353	Cerebro-vascular 12,310	Unintentional Injury 53,141	Diabetes Mellitus 80,058
8	Cerebro-vascular 50	CLRD 206	Cerebro-vascular 575	Cerebro-vascular 1,851	CLRD 4,307	**Suicide 7,759**	Influenza & Pneumonia 42,479	Influenza & Pneumonia 51,537
9	Influenza & Pneumonia 39	Influenza & Pneumonia 189	HIV 546	HIV 971	Septicemia 2,472	Septicemia 5,941	Nephritis 41,095	Nephritis 50,046
10	Septicemia 31	Complicated Pregnancy 184	Complicated Pregnancy 472	Septicemia 897	Homicide 2,152	Nephritis 5,650	Septicemia 30,405	**Suicide 44,965**

Source: "NIMH » Suicide" 2020. Original source: CDC.

People who die of suicide are victims of suicide. This is why it is time to denormalize death by suicide.

Worldwide, suicide kills more than malaria, homicide, hunger, or war (figure 8).

Figure 8. Summary of Suicide Trends

Summary

- Globally 800,000 people die from suicide every year – that's twice the number from homicide.
- Suicide is one of the leading causes of death in young people.
- 1.4% of global deaths in 2017 were from suicide. In some countries, this share is as high as 5%.
- Suicide rates are typically higher for older individuals.
- Globally, the suicide rate for men is twice as high as for women. In many countries this ratio is even higher.
- Suicide rates from firearms are particularly high in the US – 60% of deaths from firearms result from suicide.
- Self-poisoning from pesticides have had a large toll, particularly in low-to-middle income countries. Bans on some pesticides have been effective in reducing suicide rates.

Source: "Suicide" Our World in Data 2020.

4

APPROACHES AND TYPES OF SUICIDE

Suicide is the self-directed lethal act that results in death. The intentionality, the self-awareness and consciousness, and the motivator for the act (whether economic duress, pain, self-sacrifice, mental illness, or a state of overwhelming hopelessness resulting from a given social context or pathology) are as varied as the suicide forms.

There is a global unprecedented increase in suicide rates overall and more so in specific groups. The mantra of "mental illness" repeated in chorus a million times to explain the rise in suicides and rampage shootings is worn, old, and useless. Human behavior has been swinging between two extremes since it became a subject of scientific interest and even before that ("it's all determined by external causes, it's all nurture", versus "it's all determined by internal causes, it's all nature"). Ideas such as "the apple never falls far from the tree" have been available since time immemorial to explain violence, cheating, theft, and suicide. "Some people are just born that way" (an "all nature" example). The idea of the intrinsically benign human nature that becomes corrupted by society has also been around (an “all nurture” example). The idea of the “noble savage” has been entertained since ancient times (Dudley 1972).

Pre-scientific ideas of suicide

Sometimes the past is not in the past. Most of our society is scientifically illiterate and shares ideas and values concerning suicide inherited from ancient beliefs crystallized in religions. Kay Jamison, an academic leader in suicidology, has mapped traditional conceptions about suicide in her books, most detailed in "Night falls fast: Understanding suicide" (Jamison 2011). Abrahamic and even polytheistic reincarnationist religions strongly object to suicide, which for these cultures represents a major transgression of divine codes. For this reason, traditionally

people who died of suicide were not even buried in holy ground. Even many legally secular countries deny treatment to patients with self-inflicted injuries resulting or not from suicide attempts ("Despite Law, Health Plans Refuse Medical Claims Related To Suicide." 2014). This is a situation where modern institutions are still contaminated with pre-scientific prejudices and ideas.

Why does this matter now? Because many of the people who will handle a suicidal person in distress still espouse these ancient damaging beliefs. Their interaction with the suicidal person may increase their feelings of hopelessness, shame, and guilt, and farther push them into taking their lives.

There is no consensus as to whether suicide grew in prevalence or not as it crossed different forms of social disapproval. All the written records we have correspond to societies that had already developed social classes or casts, with intra-societal oppression, patriarchal organization, female oppression, forced marriages, rape, and slavery. In other words, all the social pathological determinants of suicide were at work. Durkheim suggests that social disapproval of suicide increased as more emphasis was placed on individual dignity. Marra and Orrù (1991) disagree and argue otherwise. Recent studies about the association between forced marriage and suicide among women with no psychiatric diagnose (Saxby & Walter 2013) suggest that this is an important clue: many of the forces identified by the social sciences and psychology as conducive to suicide were present or could be provided during episodes of endemic war.

The Medicalization of Madness, Suicide, and the Asylum Culture

When madness was added to the menu of subjects under the domain of medicine, deviant behaviors were pathologized. This is the other thread that informs much of the modern views on these behaviors today, including suicide. Reclassifying them as a disease did not reduce the

stigma and discrimination. On the contrary, it led to the "Great Confinement". From the Renaissance to the modern age, Foucault argues, those considered mad, originally tolerated, were increasingly excluded from society until complete confinement in the modern age. They were then institutionalized, "treated", punished, and tortured with the justification that those were the methods to reverse their moral weakness (Foucault 1988).

Why does this matter now? 1. because the strong emphasis on natural and individual causes for suicide (mental illness) and its public representation as a deficiency and a weakness are some of the most serious enemies of suicide prevention; 2. Because society still disqualifies those diagnosed as mentally ill from decision-making and self-assessment; 3. Because a mental illness diagnosis is an important foundation for discrimination.

Psychiatry's first patients were the deviant and the undesirable. In the XVIIIth century, they were blamed for their condition. Assuming that they caused it justified the methods used to force them to revert to normality, or "cure" them. Instead of a moral flaw to be punished, these deviants carried an illness to be cured. The illness, however, was their fault, which made their treatment an actual punishment. No cruelty was spared to cure the insane.

In the case of suicide, it meant submitting individuals who survived a suicide attempt to extreme forms of torture instead of sentencing them to death as theocracies did.

Durkheim and the sociology of suicide

Suicide has been defined and judged for a very long time and there are written records of it since ancient times. It has been systematically studied only recently. The first empirical study and scientific conceptualization of suicide are attributed to Émile Durkheim (1897). Eghigian (2018) pointed out that Durkheim's work might have been more the product than the trigger in the scientific study of suicide since at least one contemporary author adopted a methodologically

similar approach: Enrico Morselli, author of Suicide: An Essay on Comparative Moral Statistics (1881). That is the nature of scientific inquiry: it is always a product of the intellectual context.

Durkheim's suicide typology relies on his model about integration in the social group's "conscious collective" which we could roughly relate to our modern concept of predominant culture in a complex society. The conscious collective is the set of values, beliefs, moral and ethical standards, and forms of reasoning prevalent in a given social group.

Integration can be understood as either having a place in the social group's structure and functioning or sharing cultural references.

We could think about somebody with weak or no social ties (having no family or being estranged from one's family, no stable employment or school, no community of shared interests) or with a weak or loose self-referenced symbolic system (no shared ethical or moral system, no shared beliefs over which to build expectations and goals, or shared descriptors of reality). We've all met thousands of them. We just don't see them.

Considering integration and regulation, Durkheim identified four types of suicide:

1. Egoistic suicide is a response to a state of loose or no ties to any social group, resulting in a sense of not belonging. In the integration spectrum, this would be the pathological social condition of no integration. Meaninglessness and hopelessness are associated with this condition and are both conducive to suicide.
2. Altruistic suicide would be the exact opposite: the level of social integration is so holistic that individuals see themselves as less important than the group. Durkheim considered that this would be a social scenario not conducive to suicide except for self-sacrifice as in the military. Much has been discussed concerning this with the advent of suicide bombers.
3. Anomic suicide is the result of extensive cultural disruption so that the moral regulatory system is practically absent. Individuals lack the substrate to build expectations from life and self-expectations.

4. Fatalistic suicide would be the result of a social scenario opposite to the former: a rigid system exerting oppressive discipline over individuals may lead to a state of hopelessness that results in suicide.

In this perspective, suicides are manifestations of social pathologies: for example, societies that fail to offer routes of integration to its members, societies that have been deeply disrupted by internal or external conflict, disintegrating ethnic groups or tribes under the excessive regulation with oppressive discipline. They would result in egoistic and fatalistic suicides, respectively.

Bullying, for example, may reflect the absence of moral and ethical regulation and the result is an increase in suicide among the outcasts. Children, still evolving their integration in the social group, if left unsupervised, tend to manifest anti-social and damaging behaviors. It is no surprise that there is a strong association between suicide and bullying victimization (Kim & Leventhal 2008, Bauman et al 2013, Koyanagi et al 2019, Hinduja & Patchin 2019). Alternatively, among adults, when authority figures do not enjoy trust and respect, violent abuse among the group's members may take place as a form of power dispute. Violence of this type is frequently inspired by shared beliefs from other, external social groups or ideologies and takes the form of bullying, assault, or murder. Suicide rates increase in such situations. They could be seen as anomic and fatalistic suicides respectively.

We can think about school environments in which adults do not enjoy true authority and trust. The students may then engage in violent and immoral behaviors disapproved by the school's nominal authorities, expecting no reprimand. Similarly, we can think about abuse in the military where bullying, rape, and other forms of abuse take place despite being strongly, but not effectively, disapproved by the command (Monteith et al 2019, Gross et al 2020). The relationship between abusers and victims in both cases frequently reflect power relations in the major society: victims will frequently be women, ethnic minorities, gay or transgender people, the poor, the deviant, the "mad", or those who don't share the dominant religion.

Suicides among indigenous populations that experience violence and disruption in their encounter with European colonizers (or the major society) have been documented. We would think that these suicides could be interpreted as egoistic or anomic since both belonging and regulation are compromised with cultural disruption. Hamlin and Brym (2006) suggest that Durkheim’s model is insufficient to provide a proper interpretation of preliterate (traditional) societies. They studied the Guarani-Kaiowá indigenous Brazilian society, one of the most suicide-prone groups in the world. According to the authors, the inclusion of cultural and social-

psychological considerations resolves Durkheim's model insufficiency. The rates compiled in their study make any other "suicide epidemic" pale in comparison (table 3).

Table 3. Characteristics of Suicide Among the Indigenous Peoples in Mato Grosso do Sul, 1991-1995 and 2001-2003 (n=230)

Rate (per 100,000 population)	
Total rate, 1995	75
Total rate, 2003	128
Average annual rate in the most suicide-prone settlement (Pirakua)	324
Average annual rate in second most suicide-prone settlement (Porto Lindo)	208
Average annual rate in third most suicide-prone settlement (Panambizinho)	148
Propinquity (in km)	
Maximum distance between settlements in rectangle	267
Between Pirakua and Porto Lindo	267
Between Pirakua and Panambizinho	155
Between Porto Lindo and Panambizinho	197
Age	
Average age of suicide	21
Percent of suicides under age 19	53
Percent of suicides under age 33	91
Gender	
Male to female gender ratio under age 17	0.9
Male to female gender ratio over age 16	2.7
Male to female gender ratio, total	1.6
Method	
Percent by hanging	90

Source: Hamlin and Brym 2006. Original source: compiled from Ministério da Saúde (2003, 2002, 2001) and Instituto Socioambiental (1995). "These data undoubtedly exclude suicides among Guarani who are either isolated (living far from government offices) and dispersed (who refuse to leave their ancestral lands and live on reservations). Nonetheless, we believe they are sufficiently comprehensive to establish the broad patterns that interest us."

What Hamlin and Brym's work seems to suggest is that a model that attributes a more significant role for culture as a causal explanation for suicide and accepts multi-causal suicides has better explanatory power. The Guarani-Kaiowá mass suicides are highly specific in method, age, and most of all, actual motivation. For the Guarani- Kaiowá, leaving the "Land of Evil" in the quest for the "Land without Evil" is a cultural (social) imperative. The search, turned inevitable and permanent by the violent contact with Brazilian society, involves an attempt to reach an individual state of lightness or transcendence. It involves food restriction, singing, dancing but ultimately, as the state of mind known as nhemyrõ is achieved ("a mixture of ferocity, anger, despair, and sadness" which drives a "diffuse aspiration toward transcendence"),

death by self-strangulation. According to Hamlin and Brym, a thorough consideration of a group's culture solves the apparent contradiction in Durkheim's model by which equal states of anomie cause different suicide rate responses.

Unfortunately, the similar phenomena of young suicide clusters among North American Native Americans has not received such a detailed cultural analysis (table 4). The emerging picture is one of generic, unpredictable, Durkheimian anomic suicides.

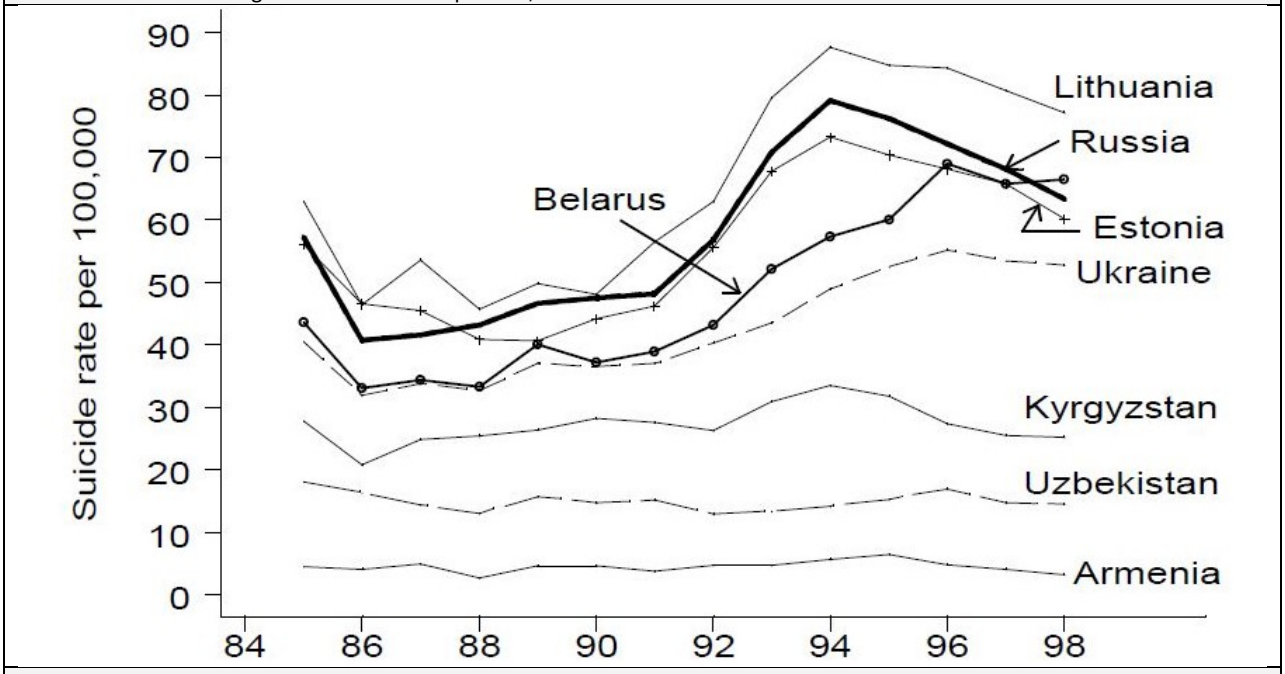
Table 4. American Indians/Alaskan Natives Risk Factors for Suicide Clusters

Individual	Male Adolescent or young adult Alcohol use (acute and/or chronic)
Family	Exposure to family member suicide Unstable family relationships or home life Parental unemployment Parental alcoholism
Community	Exposure to friend suicide Loss of traditional ways within the community Personal tie/connection to one of the prior cluster victims (imitation)
Environmental	Closed, rural, isolated community High levels of poverty or unemployment Lack of resources and/or fragmented services

Source: Substance Abuse and Mental Health Services Administration 2017

The same can be said about studies of other social groups displaying a rapid increase in suicide rates. One example is the increase in suicides immediately after the fall of the Berlin Wall and the end of the Soviet Union in former socialist countries (figure 9). The author considers economic (hyperinflation, unemployment) and sociologic (family disruption, changes in the labor market) factors but not cultural ones (Brainerd 2001). The fact that the suicide "epidemic" in a group of former socialist countries preferentially affects older males suggests that this cohort was more sensitive to the post-1990 cultural disruption.

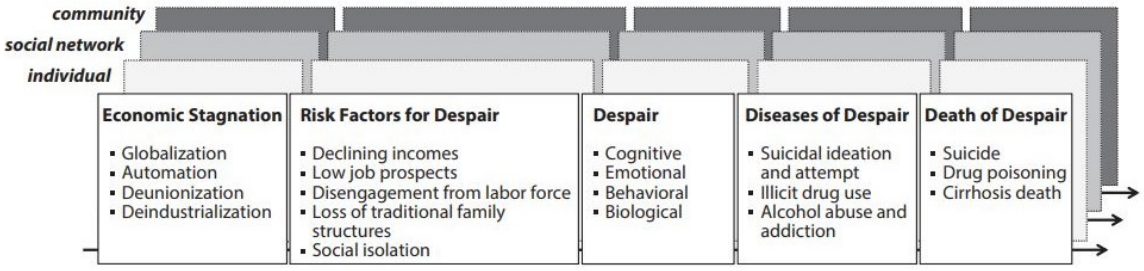
Figure 9. Suicide rates per 100,000 between 1985-1998 in former socialist countries



Source: Brainer 2001.

It is not surprising that the recent increase in suicide deaths among "non-Hispanic American whites of low education", known as "deaths of despair", has far from a consensual interpretation: although most authors focus on economic factors affecting the psychological wellbeing of this population (Scutchfield & Keck 2017, Shanahan et al 2019, Cherlin 2018), there are those who simply dismiss it as a reflex of an increase in cheap illegal opioids in the black market (Botelho et al 2017). The latter reflects poor methodology since by now it is clear to scholars that deaths by suicide, by drug overdose and by alcohol-abuse-related liver disease are all associated (figure 10). These three suicide methods share a pattern of self-destructiveness that must be interpreted.

Figure 10. Potential Moderators of Pathways: timing of economic stagnation, sociodemographic group, sex, previous adversity, vulnerability/protective factors.



Source: Shanahan et al 2019

If cultural factors combined with social disintegration are driving deaths of despair among "middle-aged non-Hispanic American whites of low education", wouldn't those be expected to affect their children as well? Yes, and they are: younger "non-Hispanic American whites of low education" are dying of suicide proportionally more than other ethnic groups in the same cohort except for Native Americans, which by far lead suicide rates among the young (Han et al 2018).

Why does this matter? Because the factors that are driving these people to suicide are frequently the same ones that lead them to the gym. Sometimes lifting and being part of the gym environment will turn them away from suicide and sometimes won't. The factors are at work all the same. The difference may be what happens inside the gym.

A social group's coherence or homogeneity depends on the extent to which its members share cultural items (Abrutyn et al 2018): language, values, beliefs, world views, and explanations. In complex industrial countries, the larger society has low coherence and is usually highly heterogeneous. In fact, the modern nation-states (countries) are not "a" society, but a legally integrated collection of societies. For this reason, individuals will seek smaller cultures that exist inside the larger society, especially in urban environments. They will usually inherit part of their belonging and value system from their family. As individuals grow into adulthood and personal

autonomy, they tend to adopt new symbolic items and, frequently, new belongings (new social groups). For example, they may question the family's religion and church community but they will share the same ethical standards as their parents. They may not be with their parents and siblings every day but they still share weekends and holidays. One of the adults may take up their father's profession and will be the manager at "Robertson and Sons" welding and plumbing, or the next Dr. Robertson at Robertson Family Practice. This is the absolute most favorable scenario: there is quasi-perfect social and cultural belonging, and smooth social continuity.

We can think about someone born into poverty, with the father out of the picture, an abusive uneducated alcoholic mother, living in an abusive adult environment. He or she grows up with no social expectation, loose (contradictory, ambivalent, or ambiguous) moral values and soon drops out of school. The closest thing to a coherent social group is the local gang. Before long he or she is in the prison system where there is absolutely no space for personal choice in belonging or action.

Alternatively, we can think about someone born in a formerly colonized country shattered by war, their family is murdered and the closest thing to a social group is the warlord's organized crime unit.

Between the two extremes, there is an infinite array of cultural scenarios, social integration, and regulation.

Freud and psychology

The other path that leads us away from the predictive self-fulfilling mental disease understanding of suicide in psychiatry ("if it is a suicide, then there was a mental disorder") is to be found, ironically, in psychology. The starting point is naturally Sigmund Freud. Freud himself died of suicide, a type which today we would probably classify as “rational suicide” since it was a well-planned action for when everything else failed on his fight against cancer, and pain made his life unbearable.

The main concept from which Freud’s model of suicide stems is the “death drive”. The “death drive” itself is an elaboration over the “pleasure principle” by which Freud introduced a foundational tension in human existence, forever at work in the unconscious.

The pleasure principle is foundational to all of Freud's work. It refers to the human instinct to permanently seek pleasure and avoid pain. In Freud's early work, the pleasure principle explained the construction of individual life purpose. In contrast to it was the principle of reality. While the pleasure principle would generate a permanent drive for self-gratification, the cognitive assessment of the external world and its restraints would oppose it. The reality principle would confer man the ability to defer gratification. Behavior would be a result of the tension of these two foundational principles (Freud, "Formulations on the two principles of mental functioning.", 1911).

Based on that, Freud hypothesized that suicide was frequently the expression of the repressed destructive drive towards an external element. Because it is repressed, the destructive drive is turned towards the individual himself, resulting in suicide or other self-destructive outcomes (Freud, "Mourning and melancholia", 1918, in the History of the Psycho-Analytic Movement, Papers on Metapsychology and Other Works, 1957). For that reason, some of the relevant motives identified by psychoanalysts for suicide are anger, resentment, or hate.

The elaborated version of the death drive as the tensional principle in dynamic opposition to the pleasure principle appeared later, on Freud's "Beyond the Pleasure Principle", from 1920, and later on in "Civilization and its Discontents", from 1929 (Freud 2015a and b). The death drive encompasses destructive as well as regressive forces, fantasies about a return to the womb, or to a state free of tension (Soreanu 2017).

According to this perspective, all human beings exist within the unconscious tension between the "erotic (or life) drive" and the death drive. All humans: not only the sick ones, not only the bad ones. Moreover, if it weren't for that tension, according to Freud, we wouldn't have Civilization. We wouldn't even have the earliest manifestations of human culture because all of it is a result of the sublimation of those fundamental drives (or instincts) into useful or productive action. In this view, guilt and "neurotic repression" is the price we all pay to share the love and belonging that society may only bestow on those who relinquish their drives.

Why does this matter? Because if all individuals have the same unconscious tensional structure, we are all capable of happiness, creation, and transcendence, as well as hopelessness, darkness, and destruction (self-destruction or destruction of others). Suicide takes place when something disturbs this balance.

Karl Menninger (1938), an influential American psychiatrist, listed many behaviors that, according to this model, are attenuated forms of suicide: chronic drug abuse, unexplainable life choices that lead to ruin or reckless exposure to risks. They would be suicidal actions without the willingness to embrace agency or responsibility for the outcome. The farther into denial, the less death looks like suicide: for example, strange accidents or unexplainable diseases. As we've seen, these behaviors can transform into one another and a heavy drug user may, at one point, deliberately overdose.

As later elaborated by Menninger, suicidal motivation is necessarily made of three different independent intentions: to kill, to be killed, and to die. These are three very different actions in intent and purpose. To kill someone is a pure expression of aggression and destruction regardless of to whom it is directed. Killing is highly associated with poor executive function, which is the neural mechanism of impulse control (Bredemeier & Miller 2015, Paschall & Fishbein 2002). Being killed is a much more passive act and not an uncommon predominant component in violent death ("suicide by cop"). Dying is the complete absence of action and total passivity. Suicide involves the full spectrum that goes from complete agency (I kill) to having someone with agency doing something to the person (someone kills me), to the absence of action (death happens to me).

The feelings associated with each act are anger, resentment, and guilt which feed into each other in a destructive spiral that eventually results in death by suicide. There is little consensus about what emotions comprise the suicidal state. Anger, sadness, self-loathing, resentment, and guilt are usually identified, interacting, and evolving into one another. Perceived wrongdoing, adversity, or thwarting may lead to unendurable resentment. Resentment may encompass hate as related to revenge or envy and hostility towards someone or something. Repressed resentment is directed inward and may overtax the individual's resources for assimilation, resulting in suicide. We go back to the idea that unmastered self-destructive impulses either

insufficiently directed outward or insufficiently gratified by external opportunities result in self-destructive action.

The most significant contribution of psychology to the understanding and intervention over suicide was to blur the line that separates the "normal" from the "pathological". With this, a road to suicide prevention by manipulating suicidal forces and components in each person becomes possible.

The shattering of the self is considered, by some psychoanalysts, the point of no-return in the self-destructiveness progression. Maltsberger argues that the suicidal self, as a sub-structure of the ego, can become frail and vulnerable to powerful destructive forces. Not only it is under attack from the superego but the ego itself undergoes failure and disarticulation of self-representation. The individual is injured at the core of their identity. At this point, there is no more control over the "affective flooding": anguish, self-loathing, anger, aloneness sweep through the mind and cause excruciating pain. When the helpless self gives in to hopelessness it begins to break up (Maltsberger 2004, 2008).

Other theories of suicide

Several other theories of suicide offer to bridge the path between a specific context for suicidal intent and a successful attempt (table 5).

Table 5. Three theories of suicide positioned within the ideation-to-action framework

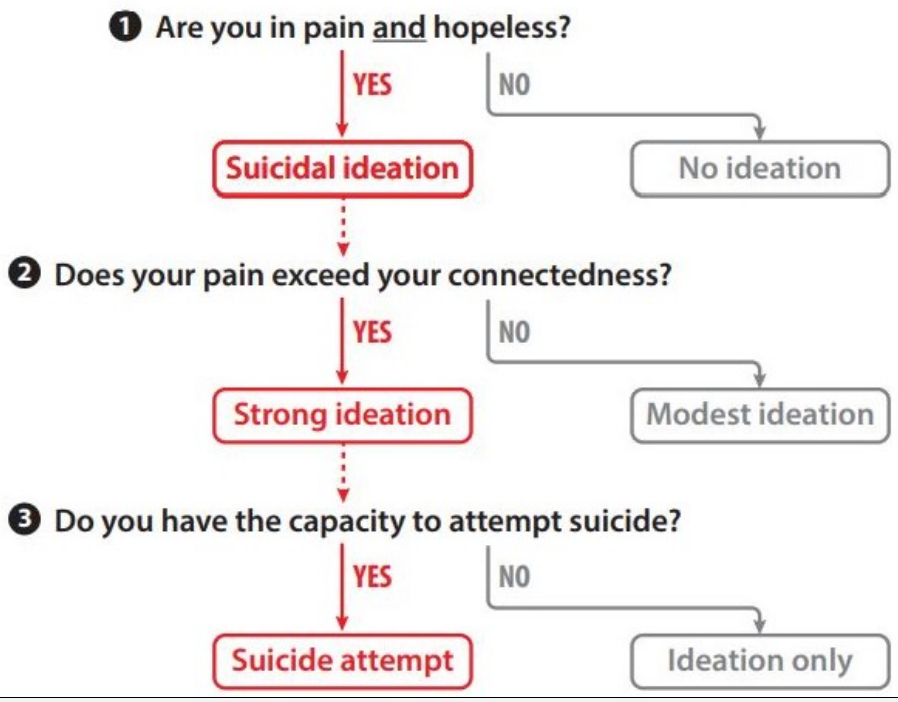
Theory	Main factors causing suicidal ideation	Main factors causing progression from ideation to attempts
Interpersonal (Joiner 2005)	Perceived burdensomeness and thwarted belongingness	Acquired capability for suicide
Integrated motivational-volitional (O'Connor 2011)	Defeat and entrapment (facilitated by threat-to-self and motivational moderators)	Capability, impulsivity, planning, access to means, imitation, and other volitional moderators
Three-step (Klonsky & May 2015)	Combination of pain and hopelessness, especially when pain exceeds connectedness	Dispositional, acquired, and practical contributors to increased capacity for suicide

Source: Klonsky et al 2016.

To kill, to be killed and to die, the three basic motivators proposed by psychoanalysis, are contradictory and hard to orchestrate. It makes sense that suicides are rehearsed and preceded by non-lethal self-inflicted attacks (figure 11). According to the interpersonal theory of suicide, individuals must first develop the capability for suicide by overcoming fear of death and reluctance to suffer self-inflicted pain (George et al 2016).

Here is an important fact for those in any position of identifying suicidal risk or helping a suicidal person: they have probably tried it before. Also, despite some disagreement, there is a larger consensus over the fact that there is a progression from suicide ideation to suicide completion.

Figure 11. The three-step theory (3ST) of suicide



Source: Klonsky et al 2016

Data from public statistics show that among those with suicidal ideation, 15.6% will make an attempt within the following year while 31.8% will progress to an attempt at some point in their lifetime. Most of these attempts (60%) happen during the first year after the onset of suicidal ideation. One of the determinant factors for this is the development of a suicidal plan, doubling its chance. Among those who attempt suicide, an estimated 16% will make a second suicide attempt within the following year. Completed suicides are distributed as follows: about 2% during the following year, 5% after 9 years, and up to 13% detected after 37 years (O'Connor et al 2013). Significantly, a prior suicide attempt is the single most important risk factor for suicide in the general population (WHO "Preventing suicide" 2014). From these admittedly incomplete and sub-notified data, some practical guidelines can be inferred:

Suicide is rehearsed and there is a progression between suicidal ideation and completion. If someone shares hopelessness with you, you have a red flag. They may be hurting themselves in more or less obvious ways. Visible self-inflicted injuries are a serious red flag and this person is not seeking attention: they are rehearsing their death by suicide. The single most important risk factor for suicide is a previous suicide attempt.

Suicide, like other non-transmissible causes of death, is something that evolves slowly, most likely taking years. The original determining elements are usually lost in a person's history.

When the first red flag is raised there is the highest chance of helping the suicidal person. Maybe you (and the social network) can directly prevent the progression by providing "fixes" to social pathological factors that resulted in that suicidal behavior. Maybe you cannot: if suicidal behavior is a result of chronic untreated pain, for example, someone else has to be mobilized to help.

The documented progression from suicidal ideation to completion also led a group of cognitive researchers to propose that suicidal thoughts are the primary antecedents of suicidal behaviors (Nock et al. 2008). The self-loathing emotion, strongly related to the feeling of hopelessness, may be a result of perceived failure (the thought "I failed", "I am a failure"), usually failure to meet some standard. Suicide often comes to mind immediately after failure (Chatard & Selimbegović 2011).

From experiencing a situation or event (lack of professional opportunities, poverty, social disruption, social oppression, abuse, etc.), to becoming increasingly conscious of them and producing a thought (through more rational or more irrational thought processes), and finally verbalizing them may be fast if pre-conditioned ("I am a failure" following failing a task), or very slow ("I am worthless", "I am shameful" following many years of abuse).

Verbalized suicidal thoughts can come disguised as jokes or comments embedded in layers of context. For example:

"Not worth it. I'd never be approved anyway"

"Such a nice house. Not for me, I'll never have one"

"I didn't pass. It was a waste of my parents' money. I'm not worthy of them, I'm a total failure and a burden"

"You need to fail? I can do that for you, it's my specialty"

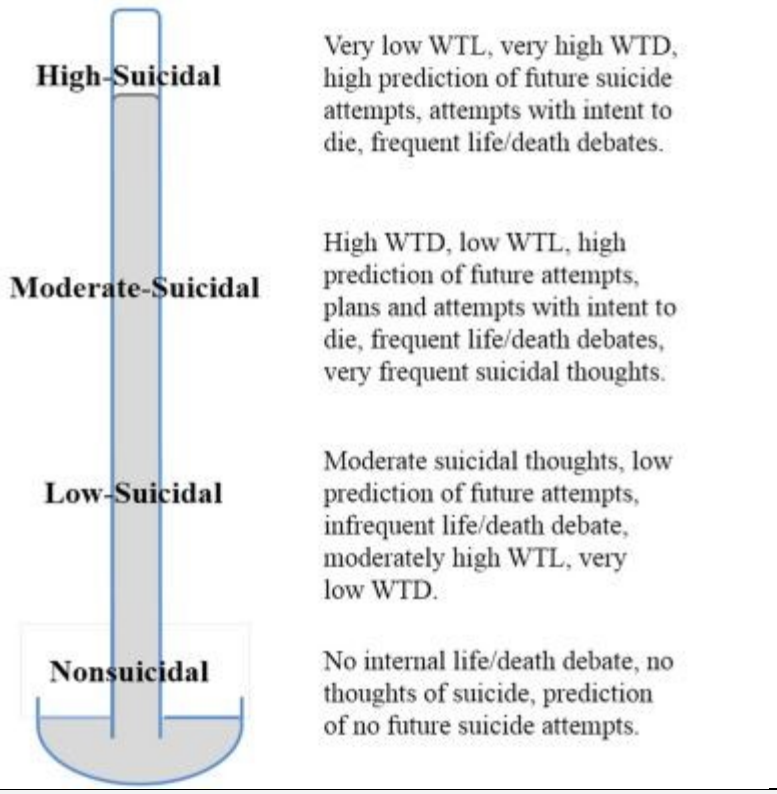
"I don't think we should continue. It's a waste of your time, I'm clearly not making any progress. I never had any talent anyway"

"I think I'll just change my name, put on a hat and shades and disappear after this"

Understanding a person's sense of belonging and social integration, their lived experience of oppression and regulation, the importance of repressed negative emotions, and the cycle of negative emotions and self-destruction can help you identify red flags before the suicidal behavior becomes more serious.

According to the different combination of the studies and theories introduced here, different suicide risk assessment instruments and scales were elaborated. They have been validated through a series of tests (figure 12). The result is some variation of the "suicide risk barometer" (Harris et al 2015).

Figure 12. The suicidal barometer model



Source: Harris et al 2015. The suicidal barometer model with descriptions of suicidality levels based on item response theory analyses. WTL=wish to live, WTD=wish to die.

These instruments have pretty straightforward questions such as “have you been thinking about suicide lately?” Some suicidal individuals won’t admit to such thoughts and others are stuck in a dark ocean of suppressed emotions. Emotional suppression and invalidation are highly associated with suicidal behavior (Kaplow et al 2014, Yen et al 2015).

They may just want to escape all the bad memories, the bad context, the bad feelings, and emotions.

The escape theory of suicide

The escape theory of suicide is one of the results of interdisciplinary projects. Integrating and building over more recent contributions from social-psychology, escape theory is significantly influenced by the original Durkheimian propositions. The main assumption from which escape theory builds its causal arguments is that individuals' most important motive to attempt suicide is to escape from self (Baumeister 1990, Chatard 2011). Escape happens in a deconstructed state, not unlike that described by Maltsberger (2004, 2008). As a result of the desire to escape from the self, suicide would involve a six-step progression:

1. Major failure-related disappointment - a discrepancy between the standard and reality is very important here although external problems (or a combination of both) can be a cause
2. Self-blame, negative implications about the self
3. Aversive state of high self-awareness (feelings of inadequacy, incompetence, guilt)
4. Negative feelings and affect (self-loathing, self-hate)
5. A state of cognitive deconstruction as an escape from the painful trajectory. As attempts to escape are insufficient to divert the aversive thoughts and feelings, more attempts to escape and numbing the pain are made.
6. Cognitive deconstruction conducive to suicide, such as a lack of inhibitions, rejection of meaning, and irrationality

This six-step progression is a decision-tree structure: at each step, something can happen that will lead to an outcome other than suicide. A decision tree is a flowchart-like structure. Each node represents an attribute test and two options may result. “Decision” tree doesn’t mean an actual decision, but a route among two or more possible ones.

That means not only that at each step the individual has the potential to reinforce their inner resources or the opposite. It also means that at each step, there is an opportunity for suicide prevention. Since at each step the individual is increasingly trapped inside their irrational process, increasingly isolated from others and less communicative, there is a chance to interfere and empower the individual towards the "other" road: the one that doesn't lead to suicide.

An environment that handles competition positively and constructively, confronting perceptions of failure with more nuanced appraisals of the situation are suicide preventive. A destructive and hostile competitive environment can be conducive to suicide. That is when the sports community must assume responsibility for what kind of environment it is promoting.

The rational suicide

Rational suicide is a controversial concept. First, a significant part of the medical and scientific community assumes that, by definition, if there is suicidal behavior it is determined by mental illness. If the individual is interrupted in a suicide attempt, it is automatically assumed they are not competent to make decisions and their autonomy is taken from them. They will be hospitalized or controlled by other adults at home. Suicide prevention policies include detaining and hospitalizing all suicidal agents caught in the suicidal process.

Critical psychiatrists, suicide researchers, and even official public health organizations assume that there might be a much larger proportion of rational suicides than it is assumed.

With the present surveillance tools, health policies, and prevalence of mainstream psychiatry's tautological assumption that if it is a suicide attempt, then it is irrational, driven by mental illness, rendering the agent legally incompetent, we don't know the proportion of rational suicides.

Biel (2019) assumes that not only euthanasia patients but other suicidal agents are rational and competent and that policies should reflect this assumption. Once the rationality and competence of an apprehended patient are established, they would not be subjected to forced hospitalization or post-treatment.

It still begs the question of how to determine the rationality of suicidal action. If detailed planning is adopted as a criterion for rationality or competence, it still doesn't mean that suicide is the only option for that individual: it means that, without significant action from third parties, it is.

Some authors have been pointing out the competence of suicidal agents for decades (Mayo 1986). Others observe that the suicidal agent might be rational and competent, as many elderly individuals. However, their decision to die is derived from the social context which they cannot change (Dzeng & Pantilat 2018).

With better data providing a realistic picture of suicidal acts predominantly contextualized in a scenario of inescapable and excruciating chronic pain, or social circumstances that promote isolation and no prospect for improvement, the understanding of rational suicides may provide suicide prevention stakeholders with a better understanding of helpless situations (as opposed to just helpless individuals) and of the social circumstances that need intervention.

As for the individual, although impulsive acts with a window of opportunity call for intervention, their autonomy should always be respected. The response to individuals expressing the wish to die must be framed by the concepts of understandability and respect (Clarke 1999).

Euthanasia or physician-assisted suicide is legal in the Netherlands, Belgium, Luxembourg, Colombia, and Canada. Physician-assisted suicide, excluding euthanasia, is legal in 5 US states (Oregon, Washington, Montana, Vermont, and California) and Switzerland. Public support for euthanasia and physician-assisted suicide in the United States has plateaued since the 1990s, ranging between 47% and 69% (Emanuel et al 2016).

Still, most of the literature about rational suicide is concerned with showing that they are actually irrational, a research agenda that borders the irrational. It is irrational to find irrationality on the wish to die of someone forced to live under unbearable conditions and even worse, force them to continue to live.

Sometimes, a cigar is just a cigar. Freud died of suicide because of all the options available, it was the only one that beat living in excruciating pain. Many suicides among the elderly are rational. Pain, inability to maintain minimum living standards and dignity, hunger, or any other extremely debilitating condition with no perspective of change leads to rational suicide.

Bohnert and Ilgen (2019) claim that "pain causes alterations in the neurocircuitry related to reward, which results in vulnerability to suicide and potentially to riskier use of opioids. This biologic mechanism is supported by epidemiologic data that have shown that chronic-pain diagnoses are linked to suicide". This line of inquiry is not helpful. There is no need to appeal to reward neural mechanisms to explain rational suicide from chronic pain: there is a point in which the scale balancing enduring pain and meaningful experiences in the world tilt towards death. Living just stops making sense. Maybe for this reason chronic pain suicides are such a

controversial subject. At this point, the decision is nobody's business except the person deciding to live or die.

Efforts to prevent suicide come hand in hand with de-pathologizing it. The high association between a positive diagnostic of mental illness and suicide doesn't tell us anything about the chicken and the egg. Mental illness is highly associated with negative environmental conditions (Mulder et al 1998, Amone-P'Olak et al 2018, Curran et al 2016). It is also tautological because suicide is considered an expression of mental illness, and because we don't know which came first: if the negative environmental conditions chicken or the mental illness egg. (Baumeister 1990).

The natural corollary to the assumption that suicide may be competent and rational is that it must be respected if so. This opens two cans of worms: the euthanasia debate, where ethics and health scholars face the religious stonewall, and chronic pain.

Chronic pain is associated with suicide (Petrosky et al 2018, Racine 2018). There has been a dramatic increase in chronic pain sufferers denied pain treatment after the radical anti-opioid measures adopted by the CDC (Sade 2020, Pergolizzi et al 2019). The war on opioids and the questionable interpretation of epidemiologic data are a result of many other factors beyond what is known as the "opiate crisis" (Jones et al 2018).

Without a health care system that adopts a comprehensive approach to treatments and interventions and addresses patients' needs, individuals will self-medicate. Chronic pain patients, estimated in approximately 25 million people in the USA, have always self-medicated. If not with alcohol, with laudanum; if not with laudanum, with poppy tea, if not with poppy tea, with opium. Since prescriptions with indefinite refills for opiate pain-killers became available, they have been self-medication's first choice. That happened long ago. However, the "opiate scare", or the acknowledgment that the number of individuals addicted to prescription drugs was very high, is recent. It became a political platform issue after the late 1990s ("The Opioid Crisis" 2020). The first federal measures started in 2000 in the USA. The increase in synthetic opioid-related deaths was exposed as an "epidemic". It was depicted as the natural progression from prescription opioid use for a "legitimate" reason to drug abuse and overdose death ("The Opioid Crisis" 2020, Lisa & Halverson 2018). Several emotion-laden stories reached the mainstream media. Conveniently, the fact that the majority of deaths are by street drugs, heroin and fentanyl in particular ("Where Does Fentanyl Come From?" 2020, "Fentanyl Has Taken over America's Drug Market" 2018), was and still is omitted.

As more restrictive measures were adopted to limit the access of individuals to legal opioids, the more the opioid-related deaths increased. A simple look at the charts and a google search for "opioid-crisis-smuggling-fentanyl" is enough to understand its structure (ironically even in DEA official documents: US Drug Enforcement Administration 2018): China's fentanyl smuggling is a high investment for the Triad and the first notorious Transnational Criminal Organizations' (TCOs) consortium operation. Fentanyl is produced in China, transported to Mexico, where the Cartels manage distribution in the USA. The more restrictive the measures, the more clients for the black market. As of now, fentanyl overdoses are the leading cause of drug-related death.

The measures adopted by the CDC and other agencies are sloppy, excessive, violent, and unscientific (Pergolizzi et al 2019, Kertesz et al 2019). Opioid addiction is bad but untreated pain is even worse. The number of suicides related to the official measures adopted by the government to combat the "opioid epidemic" is high (Kline 2019). First, a good part of the opioid overdoses are suicides but end up as "accidental overdoses" in the public records. Second, untreated pain is a high-risk factor for suicide and it is rational to try to die if life is reduced to excruciating, unending pain. Third, people who never had access to the recreational black market are pushed in its direction out of an urgency to control their pain. These naïve drug users are typical victims of drug overdose: neither the Triad nor the Cartels are known to apply precise quality control on their merchandise and someone might end up ingesting 80mg of oxycodone when they only tolerate 20mg.

That's a picture where everything is wrong: while the majority of people being prescribed opioids for pain up to the mid-2010s were older than 45 with a large portion over 65 yrs, opioid-related deaths affect younger users (Samet & Kertesz 2018). With so many restrictions, stigmatization of opioid users ("legitimate" or not), and treatment denial, this demographic is experiencing an increase in suicides. The younger and middle-aged adults are dying "deaths of despair" that involve drug overdoses, alcohol, and liver damage. With the aggravated social factors driving this demographic to suicidal behavior, more of them will seek out a welcoming black market with powerful drugs. With increased deaths, the regulatory agencies adopt even stricter control over health providers. Pain clinics are shut down ("Why I Am Closing My Pain Practice" 2018). Many Family or General Practice physicians don't prescribe opioids anymore. Drug companies are sued. It is a strange scenario where everybody seems to be losing and that is hardly the case in a market economy.

But someone is not losing. We know that the TCOs are profiting from this state of affairs. However, they never operate alone. Someone else is also happy: whoever negotiated with the

TCOs to squeeze out legal opioid prescriptions and gear people in pain in their direction. It's not a person. It's a whole malfunctioning regulatory system.

If we go back to the original question as to whether opioid pain-killers should be prescribed long term to patients suffering from chronic pain, the unbiased answer is "yes". Not only that, but it must be done within the public health system where low-income individuals can be seen and benefit from affordable medication (Christo 2020, de Leon-Casasola 2013).

How should we see suicide among chronic pain patients? What if they rationally decide that they can't enjoy life anymore with that pain and decide to die (as so many of them do)? Were these deaths preventable? Should they be prevented?

I leave you with the questions.

The pharmacological revolution

The "pharmacological revolution" happened during a short period in which a new approach to deviant or atypical behavior, cognition, and emotion was adopted. This new approach was based on the assumption that those atypical or deviant behaviors were pharmacologically treatable illnesses of neurologic origin. It started in 1950 when the drug chlorpromazine was employed as an anti-psychotic. This is still the dominant approach in psychiatry although intellectual (lack of causative explanations), ethical (hyper or incorrect medication), and practical (failure to solve problems at the individual and social level) discomfort with it has always been a matter of contention for critical psychiatry.

By the sheer weight on social representations of suicide and other so-called deviant behaviors, it's imperative that we take an in-depth look at mainstream psychiatry rather than scientific standards (the scientific study of suicide began with sociology) or its chronology, since the

historical continuity between pre “Pharmacological Revolution” psychiatry and post 1950s psychiatry is at least questionable (Baumeister & Hawkins 2005).

Before World War II, psychiatry had the intellectual structure inherited from asylum psychiatry where it was practiced (Scull 2011), something increasingly less acceptable that resembled some sadistic form of pseudo-science. At the same time, physicians who specialized in psychiatry were seduced by psychoanalysis, which offered a complex model of human behavior and a code of ethics. Under psychoanalysis, patients were human beings at an unfortunate point in the psychic structure spectrums. Psychoanalysis-based psychiatry was called "the dynamic approach" in the USA where it was dominant for decades (Menand 2020, Tuck 2014).

Eventually, the pharmacological "paradigm" (Healy 1987) became hegemonic in psychiatry and any psychiatric intervention. For over half a century, behavior, cognition, and emotion were psychiatry's legitimate objects of study and power. Wherever possible, the idea of a mind issue was substituted by the idea of a brain issue. The social and psychological approaches presented here not only lost importance and reach but were actively disqualified. Psychotherapy was at best "adjunct therapy" and the mind, an unnecessary construct.

Psychiatry grew from a small and marginal specialty in medicine to a major one as the public and private spending on mental health, especially psychiatric drugs, grew exponentially.

This new and pharmacologically fortified psychiatry was employed, again and again, as a political weapon to silence dissent (Perlin 2006) and to disqualify behaviors by devouring everything and regurgitating it as pathologies (Breggin 1983).

The “Pharmacological Revolution”, or “modern psychopharmacology” began in 1950 with the synthesis of chlorpromazine. It is not a coincidence that the first version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) was published in 1952.

Until today, psychiatry is the only medical specialty where nosological entities are vague and ambiguous (Smolik 1999). The violent “medicalization of cognition, emotion, and behavior, and the interpretation of subjective variables as 'normal' or 'abnormal' in the context of society and culture” (Kawa & Giordano 2012) created a conflict between a powerful medical practice with less than optimal understanding of causal mechanisms, and all other sciences, not to mention social movements. If there is no consensus as to what is mental illness, there is even less so concerning treatment, where pharmaceutical companies’ aggressive pill-pushing strategy is not veiled.

There are many factors holding psychiatry in this “intellectual dark age”. Most of them boil down to social control (Conrad 1992) and profit-based institutional control (Frank et al 2005).

What the World Health Organization and local country initiatives are now trying to at least dilute, if not break down, is psychiatry's monopoly over suicide: its definitions, research, treatment, and prevention – or, rather, its overwhelmingly predominant pharmacological and pathologizing approach. As pointed out by Kawa and Giordano (2012):

> *Translated into over twenty languages, referred to by clinicians from multiple schools, as well as by researchers, policy-makers, criminal courts, and third-party reimbursement entities, the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) enjoys a nearly hegemonic status as the reference for the assessment and categorization of mental disorders of all types - not only in the United States but increasingly in Europe and more recently Asia.*

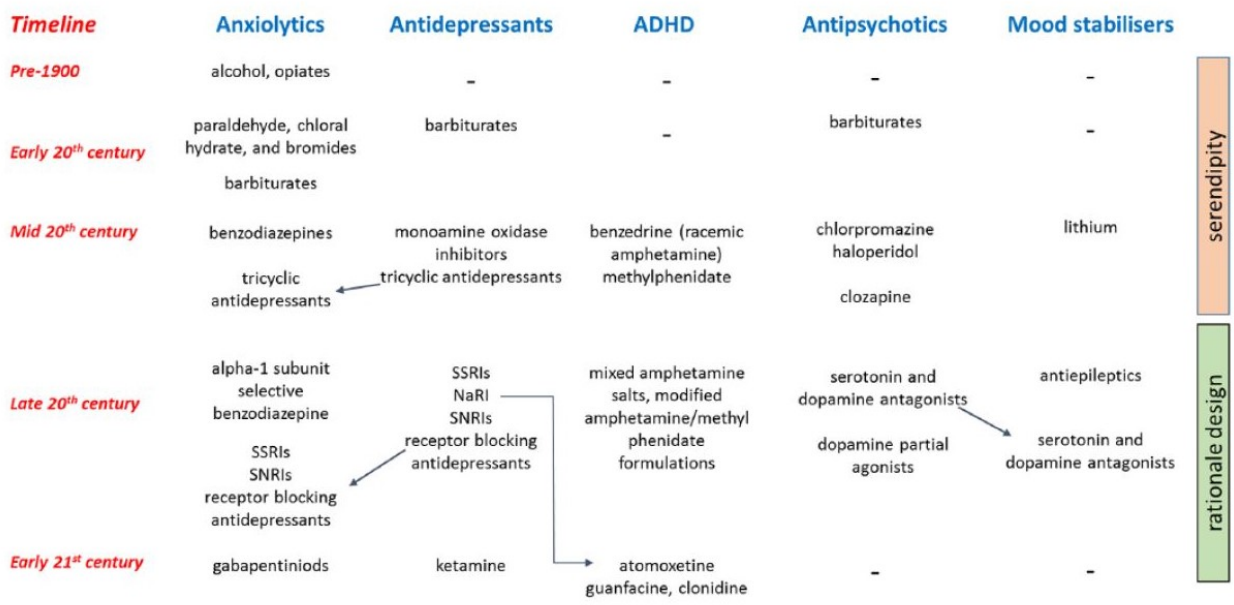
Up to very recently and still in great part nowadays, it didn’t matter how inconsistent and flawed a psychiatric nosological category was: psychiatry and the DSM are not about accuracy but about power. Things such as the circular understanding of suicide as pertaining to mental illness have been contentious issues for years. If suicide is considered a manifestation of mental illness, then it is tautological to diagnose its cause as mental illness: by definition, the cause of suicide will be mental illness (Baumeister 1990) and by now we know it is much more complex than this.

In studies about the relations between science and its major society, we frequently talk about the "market pull" versus "science/technology push" to explain the dynamics of technological innovation (Godin & Lane 2013, Choi 2018). In the case of psychiatry and pharmacological (technological) innovation, there is a strong interrelated market and policy pull, and a weak science/medicine push, especially because it has nothing to push. The imbalance is so gigantic as to have psychiatry exist for years with the conceptualization of several mental disorders based on possibly spurious drug reactions. Mood disorders are considered serotonin dysfunction disorders when there is not a thread of causal evidence in this direction. Even now, there are attempts to rename mental disorders according to their assumed (but never supported by evidence) molecular mechanism or to "develop of a pharmacologically valid psychiatric nosology” (Ban 2006 and “NBN New Knowledge, New Nomenclature" 2020). The absurdity of supporting the "amine hypothesis of mood disorder" is so abnormal that Healy suggested it

played a (Kuhnian) paradigmatic role of psychological nature since it was irrefutable in practice (therefore, weak or unscientific according to the reader's epistemological preference).

The first psychoactive drugs of the pharmacological revolution were discovered by chance while the substance was being investigated for an unrelated condition (figure 13). For example, Charles Bradley observed an improvement in behavior among ADHD (attention deficit hyperactivity disorder) children while treating some of these patients for severe headaches with Benzedrine (racemic amphetamine). Lithium salts, to this day a standard treatment for bipolar mania or mood swings, were found to sedate guinea pigs in 1949 by John Crade (Robinson 2018).

Figure 13. History of the development of the major classes of drug used in psychiatric disorders



Source: Robinson 2018

Robinson (2018) discerns two periods of drug discovery and psychopharmaceutical innovation: the serendipity and the rational design periods. From the point of view of neurologic and psychiatric research and conceptualization of diseases, we are still in the dark: because a certain substance altered the behavior of a sample of individuals (clinical trial) more or less significantly if compared with controls, the research target became "what does this drug do in the brain". Drugs do a lot of things everywhere but the first studies pointed to an effect over free amines (serotonin, dopamine, and norepinephrine). The mechanism of mood disorders was announced as a pathologically altered chemical balance of free amines but it was not a true mechanistic

scientific discovery: it was at best an association. There is an association with serotonin availability in certain inter-synaptic spaces and an observed change in behavior in a certain percentage of the samples, usually with a significant standard deviation.

Psychopharmacology grew and evolved along this path in which the discovery of all the major classes of psychoactive drugs preceded a detailed knowledge of their biochemical targets or mechanisms of action. The drug determined the concept of the disease mechanism. Drugs shape the cultural understanding of psychiatric disease, mental illness, or, who knows, atypical behavior, cognition, and emotion (Braslow 2019).

The astonishing success and status enjoyed by psychopharmacology do not reflect more effective pharmacological treatment and better drugs. It doesn't reflect a better understanding of disease mechanisms or even its nature. The most common word in the new publication titles in any psychiatric newsletter is "association". It is as if the community is overwhelmed with significant and spurious associations and can no longer spare resources and attention to causes and mechanisms. The overwhelming success of psychopharmacology is a result of several factors, at the center of which is pharmaceutical marketing and changes in health policy (Braslow et al 2019).

Several players, private and public, shape the policy response to the market trends (figure 14) and vice-versa (Frank et al 2005).

Figure 14. National expenditures on psychotropic drugs

	1987	1992	1997	2001
Nominal spending	$2.77 billion	$3.83 billion	$9.04 billion	$17.83 billion
Percentage of mental health spending	7.7%	7.2%	12.8%	21.0%

Source: Frank et al 2005. Original source: Coffey et al. 200, Mark et al 2005

For post-WWII psychiatry equipped with its new pharmacological tools and the dark inheritance of the asylum culture, suicide is the manifestation of individual pathology reflected on social suffering. Patients are still deprived of any right to speech since, by definition, they are "rationally impaired" even if they are not psychotic or dissociative. Individuals experiencing the

descent into suicidality and self-destruction are torn between crying for help and defending themselves from psychiatry. Thousands of years of punishment of the suicidal and the "atypical" shape our reaction to "suicide intervention". We carry an immemorial terror of the "stain of madness" not only because of the stigma but because of immediate consequences.

5

CAN WE PREDICT AND PREVENT SUICIDE?

The easy answer to both questions is "yes". However, our ability to predict suicide is not unlike the way we can predict hurricanes or tornadoes: we know it will hit a certain large area and we have probabilities associated with the impact, the location, and even the day and time. We can predict that in a certain community the risk of suicide is high and there is a chance that 5-11 individuals die of suicide in the following 12 months. We still can't predict who, when, and how. We can prevent suicide by bold and aggressive strategies at the community level and we have a high chance of preventing a certain percentage of at-risk people from dying of suicide. We still don't know who and how it will happen.

On its first publication after the adoption of the Mental Health Action Plan ("Mental Health Action Plan" 2013), the WHO affirmed: "suicide is preventable" (WHO "Preventing Suicide, a Global Imperative" 2017). Yet, actual data on suicide prevention is non-existent. The strategy is unarguably consistent and supported by indirect data but there is not a single implemented program documenting the success of one or another prevention strategy. The WHO cites an American research agenda data as evidence that suicide can be prevented by strategies that involve heavily relying on psychotropics, antipsychotics in particular and post-attempt psychotherapy (National Action Alliance for Suicide prevention "A prioritized research agenda" 2014). The 9% estimated reduction in 5 years of intervention in the United States pales in

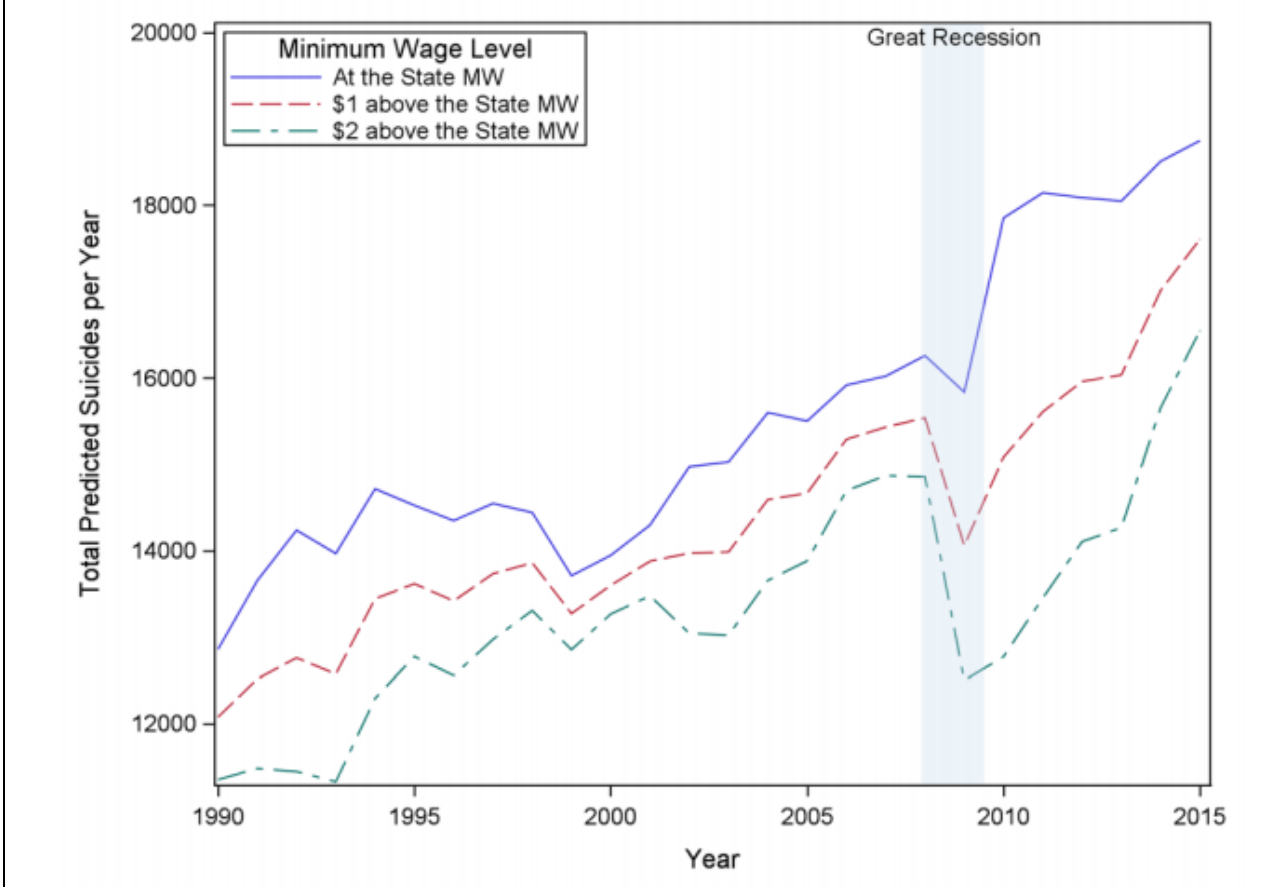
comparison with the national overall increase and the significant increase in certain ethnic groups and cohorts (Canner et al 2018, Shiels et al 2017). Moreover, in a recent study about suicide re-attempt in a cohort of suicide attempters, Irigoyen and colleagues affirmed that there was no evidence that pharmacological treatment prevented suicide (Irigoyen et al 2019).

What we know concerning specific interventions and changes in suicide rate is related to societal conditions. The closest we have to a high-impact preventive measure is minimum wage increase: Kauffman and colleagues (2020) found that a dollar increase in the minimum wage was related to a meaningful 3.4% decrease in suicide mortality for those of lower educational attainment (figure 15 and 16). Minimum wage policy protects against suicide in the USA (Ahern 2020).

Figure 15. Effect on suicide rates of the interaction between minimum wage and unemployment

Source: Kaufman et al 2020. Effect on suicide rates of the interaction between minimum wage and unemployment. Minimum wage levels are expressed in US$2015. estimates are for all 50 US states and Washington, DC models include the difference between state and federal minimum wage is US$2015, state and year fixed effects, state unemployment rate, and the interaction between the minimum wage and unemployment. Modeled unemployment rates run from the 5th to 95th percentile for state-months (3.0%–9.4%).

Figure 16. Total predicted suicides among US adults aged 18–64 years with a high school education or less at different minimum wage levels over time and varying unemployment rates.



Source: Kaufman et al 2020. Total predicted suicides among US adults aged 18–64 years with a high school education or less at different minimum wage levels over time and varying unemployment rates. Minimum wage levels are expressed in US$2015. estimates are for all 50 US states and Washington, DC models include the difference between state and federal minimum wage in US$2015, state and year fixed effects, state unemployment rate, and the interaction between the minimum wage and unemployment.

There are global interventions that have not been considered by any suicide prevention program: for example, the effects of climate (Nicole 2020). Burke et al (2017) identified that suicide rates rise 0.7% in US counties and 2.1% in Mexican municipalities for a 1oC in increase in monthly average temperature. The authors project that unmitigated climate change could result in a combined 9-40 thousand additional suicides across the US and Mexico by 2050, representing a change in suicide rates comparable to the estimated impact of economic recessions (Burke et al 2017). Carleton studied the relationship between warming and suicide, controlling for social-demographic variables, and found that a 1oC increase in a single day causes over 70 more suicides. The author estimates that warming over the last 30 years is responsible for 59,300 suicides in India, accounting for 6.8% of the total upward trend (Carleton 2017, Stack 2017).

These trends correspond to two preventive measures that can only happen at the highest levels of political decision-making: the minimum wage is determined at the federal level in most countries and initiatives to mitigate climate change are necessarily international.

Establishing a quantitative global goal in suicide prevention as proposed in the WHO Mental Health Action Plan 2013-2020 (WHO "Mental Health Action Plan" 2013), where the WHO Member States have committed to work towards the global target of reducing the suicide rate in their countries by 10% by 2020, may or may not be realistic but certainly doesn't reflect any measurable action. As demonstrated by the WHO three years into the plan, the global decrease in suicide in the previous decade was not far from that (WHO, "Preventing Suicide" 2017). In the period between 2000 and 2012, the global population increased and the absolute number of suicides decreased by approximately 9%. However, among the 172 Member States with populations of over 300.000, the 2000–2012 change in age-standardized suicide rates ranged from a decline of 69% to an increase of 270%. The average 9% decrease has little meaning if the standard deviation is this large.

Unless great strides are made at the global level towards secularity (controlling the negative religious influence concerning the acceptance of the LGBT community, over deviant behavior and over suicidal behavior itself), decreasing economic inequality (controlling the negative impact of poverty, unemployment, food insecurity), strengthening democracies (controlling the negative impact of oppression, discrimination, persecution, and intimidation), the best a global suicide prevention program can aim for is promoting universal consensus over the risk factors for suicide and a global commitment to surveillance.

Without actionable data, there is no action.

Documented advances within the scope of the WHO Mental Health Action Plan (WHO “Mental Health Action Plan” 2013) were on surveillance, according to Ella Arensman, President of the International Association for Suicide Prevention (IASP), Director of Research at National Suicide Research Foundation, Department of Epidemiology and Public Health, University College Cork, Ireland, and WHO Collaborating Centre for Surveillance and Research in Suicide Prevention, Cork, Ireland (Arensman 2017).

Adequate surveillance and, more than that, a social agreement on the necessity of preventing suicide will be the biggest challenges. As pointed out by the WHO (WHO, "Preventing Suicide" 2017), the mere acknowledgment that suicide deaths are preventable is not enough to make it a priority in several countries. It should be no surprise that decision-makers in non-secular, or, worse, fundamentalist countries, not only will not implement the most important actions towards prevention but will continue to work against it. In most countries, suicide is still stigmatized and it will be hard to gain social support for something most individuals came to believe is a "sin" or a "biological inevitability". In non-secular countries, surveillance itself is virtually impossible: the majority of suicides will go unreported and the attempts, unseen. Registering a suicide is a complicated procedure involving several different authorities, often including law enforcement. Most families, if given the alternative, will deny an autopsy and will not accept suicide as a cause of death. The real uphill battle we, as a society, will have to fight to promote prevention and support those in mental suffering is *cultural change*.

Arensman (2017) suggests the following necessary components for a successful prevention plan: Surveillance, Restricting Access to Means, Media, Training and Education, Treatment, Awareness, Stigma Reduction, Postvention, Crisis Intervention and Access to Services (Arensman 2017).

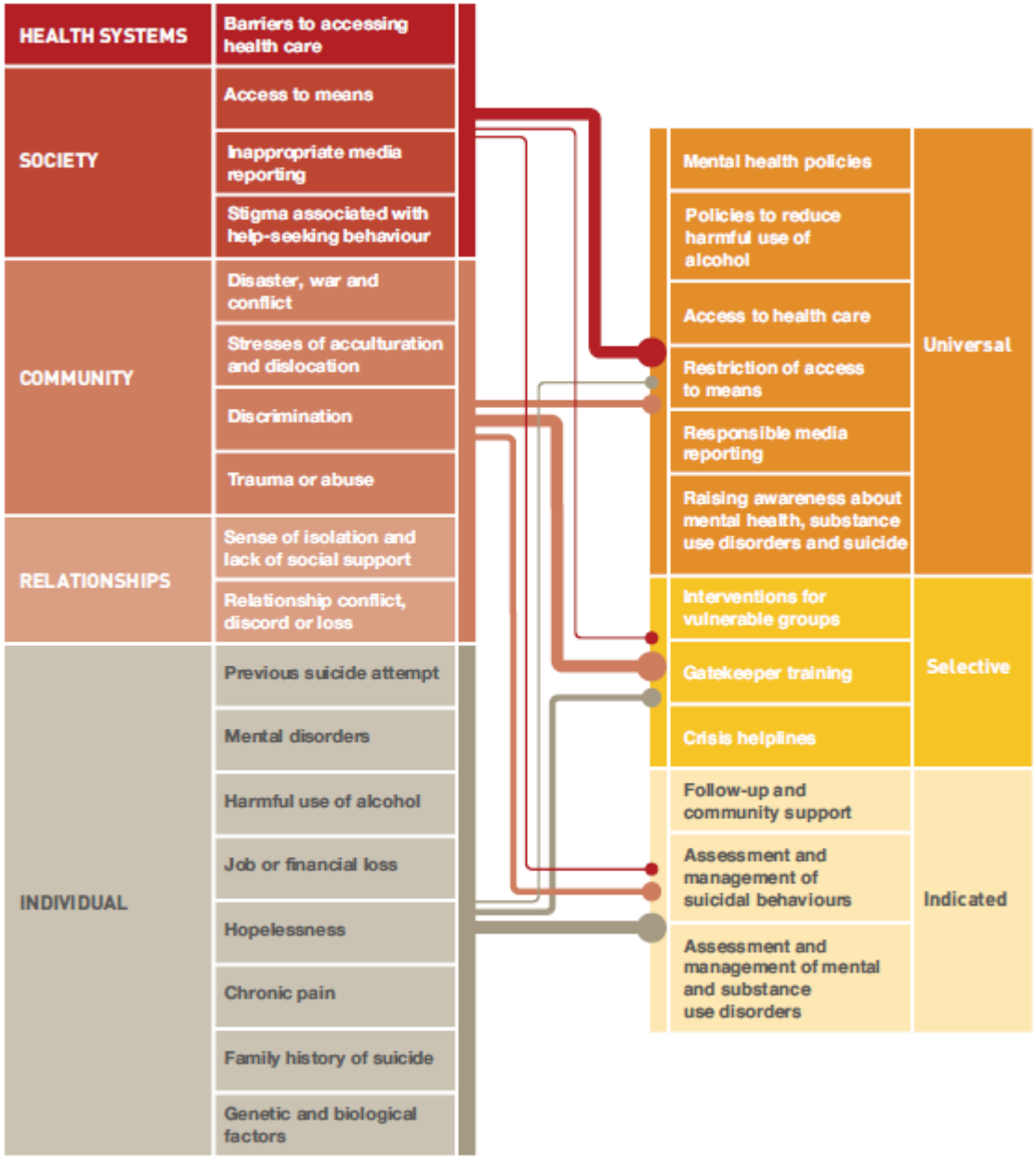
According to the WHO (WHO, "Preventing Suicide" 2017), evidence-based interventions for suicide prevention are organized into three types of intervention (figure 17 and 18):

“Universal” prevention strategies, which are designed to reach an entire population (removing barriers to care and increasing access to help, strengthening protective processes such as social support, and altering the physical environment).

“Selective” prevention strategies targeting vulnerable groups such as persons who have suffered trauma or abuse, those affected by conflict or disaster, refugees and migrants, and persons bereaved by suicide.

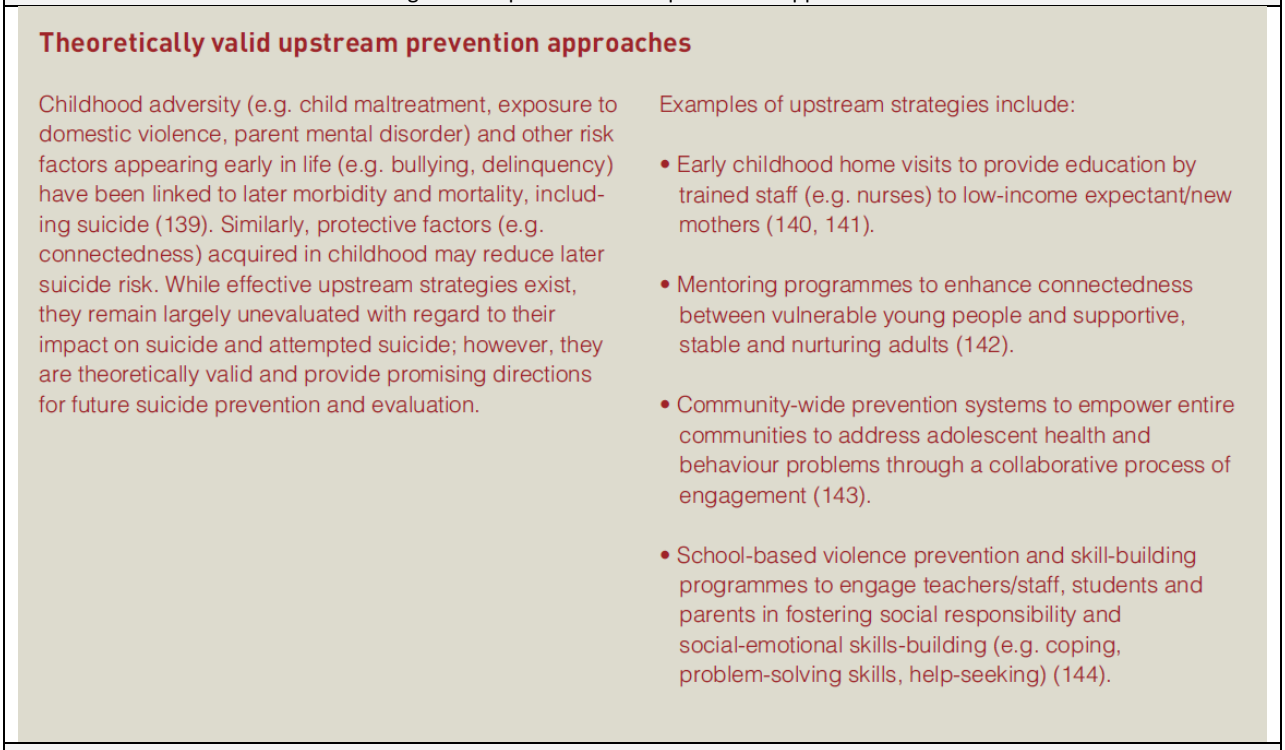
“Indicated” strategies targeting specific vulnerable individuals with community support, follow-up for those leaving health-care facilities, education and training for health workers, and improved identification and management of mental and substance use disorders.

Figure 17. Evidence-based interventions for suicide prevention



Source: WHO, Suicide Prevention, 2017.

Figure 18. Upstream suicide prevention approaches



Source: WHO, Preventing Suicide 2017.

Why does this matter? The suicide-risk individuals that will either show up at the gym or may be coaxed there by a supportive program are the result of all the negative things that already happened before you met them. There is nothing you can do about their abusive stepfather, about the bullying that victimized them through high school or about their post-traumatic syndrome secondary to traumatic brain damage due to a grenade in Afghanistan. There is still room for prevention at the community level. The guidelines outlined by the WHO are useful.

Sometimes, community-level and local programs are as good as it gets and they can be very good. As individuals, are all impotent concerning the macro-level determinants of suicide. However, they all explode at the community level. Frequently, the at-risk individuals are perceived as such when they are at the last stages of the suicidal progression. That's where personal contact with them can push them one way or the other.

Considering that the WHO Mental Health Action plan (2013) is the best that the very limited interdisciplinary consensus and the political agreement could achieve, it is important to point out that:

At the macro-level, no suicide prevention can be effective without:

- ***Postvention (continued care after successful prevention of a suicide attempt, given that the single most important determinant of suicide is a previous suicide attempt)***
- ***Legal protection of suicide attempters***
- ***Public health care for self-harm and suicide attempt victims***
- ***Aggressively attacking stigma and taboo***
- ***A public conversation about suicide that includes survivors and/or is survivor-centered***
- ***Important measures to combat economic inequality, unemployment, discrimination and free access to public health resources***
- ***Dramatically changing policies concerning vulnerable groups (abused individuals, refugees, and migrants, Indigenous peoples, prisoners, Lesbian, gay, bisexual, transgender and intersex (LGBTI) persons)***
- ***A proper policy concerning chronic pain treatment***

The window of opportunity: social network and the public conversation

Assuming the suicidal person was already victimized by negative social factors, which greatly determine the manifestation of psychopathological negative factors, and considering that there are impulsivity and ambivalence forces at play, how much time do we have to stop an ongoing suicide process? In the majority of suicide attempts, successful or not, the actual suicidal process is too short to interfere with except by chance. What else can this information help us with? The more lethal the means, the lower the chance of successful prevention during the window of opportunity.

Except with rational and psychotic suicides where the typical suicidal ambivalence may either not happen or be managed differently, how long does it take for a victim to mentally engage and perform a suicide attempt? And how long does it take between deciding to go through with suicide and performing the act? The answer is, unfortunately, a very short time.

Most people can recall a movie or even real-life video-taped situation in which a person stands at the edge of a cliff, a bridge or a building roof, hesitant, with an expression of pain and confusion on their face. A short hesitation period and ambivalence are the rule. In some of the positive outcome cases, someone manages to engage the victim and distract them. Is distraction the most effective means of dissuading someone from jumping?

There is no consensus about what kind of approach works in that critical state especially because even the suicidal people that are not mentally ill are in a neurologically different state in which they don't seek help, tend to reject it, and have unpredictable reactions (Wilson 2017).

Suicide intervention involves an effort to understand another person's psychic world. We need to be able to put ourselves in that person's situation as they experience ambivalence, the alternating desires to die and to live. That is not easy but much harder is to understand the experience of projecting one's death. Regardless of how rational and altruistic a suicidal act is, it is always a fully experienced transition between existing and not existing. The human mind

cannot conceive inexistence. We can imagine several futures including fictional ones but we cannot imagine not existing. Not existing means not imagining anything and not having a mind to feel or think. Death is lonely and weird and mysterious.

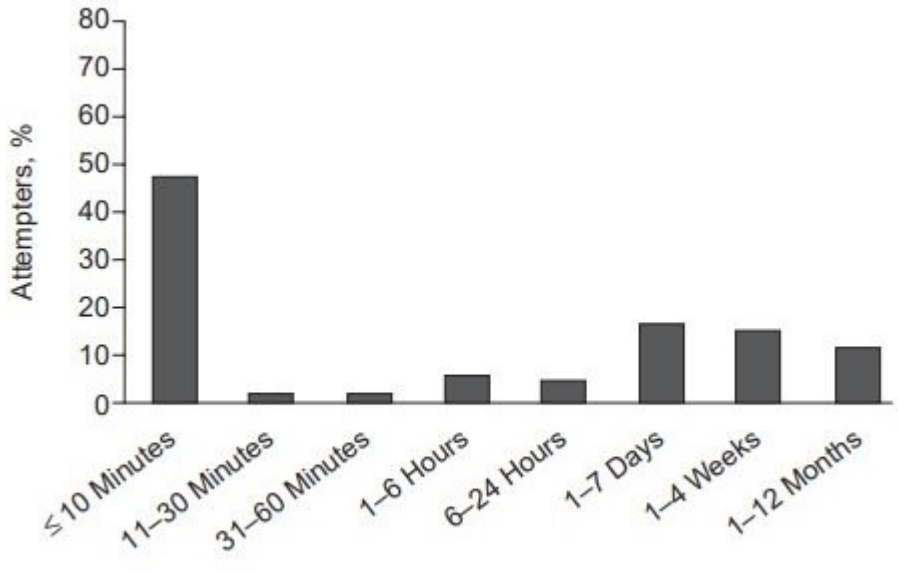
The suicidal process is described as consisting of three phases (Deisenhammer et al 2009):

1. Consideration: suicide is considered as a possible solution to current problems and/or suffering.
2. Ambivalence: the confrontation between self-destructive and self-preservation forces
3. Decision making: the actual accomplishment of the suicidal act

Studies carried out in Austria and in India resulted in similar observations (Deisenhammer et al 2009, Kattimani et al 2016). Kattimani and colleagues carried out a three-year study with 347 suicide attempt survivors. As in Deisenhammer and colleagues' study before (figures 19, 20 and 21), the analysis was based on the suicide process as reported by survivors:

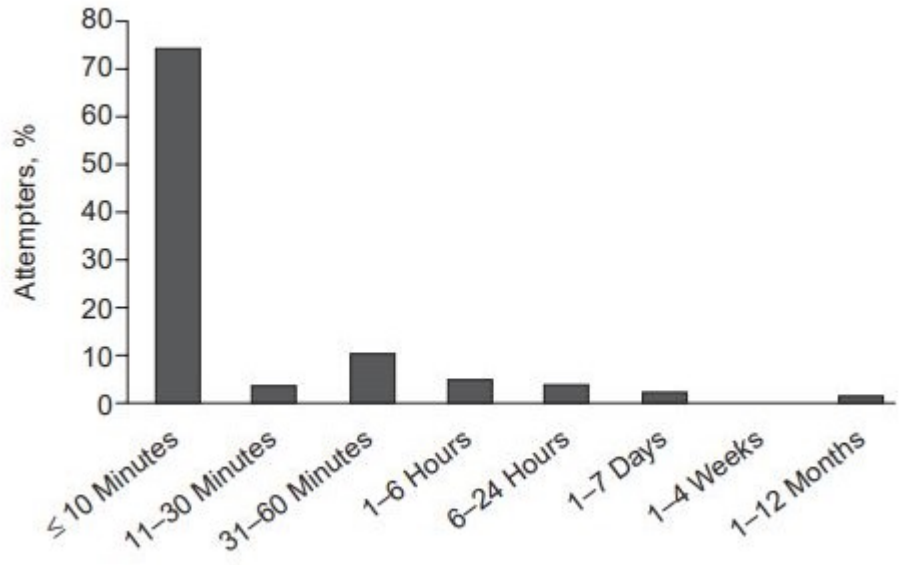
1. First quartile had 96 (30.1%) subjects (suicide process time up to 5 min)
2. Second quartile had 71 (22.2%) subjects (suicide process time 6 min to 30 min)
3. Third quartile had 77 (24.1%) subjects (suicide process time 31 min to 120 min)
4. Fourth quartile had 75 (23.5%) subjects (suicide process time of >120 min or 2 h). B

Figure 19. Time between first occurrence of a thought of suicide and suicide attempt



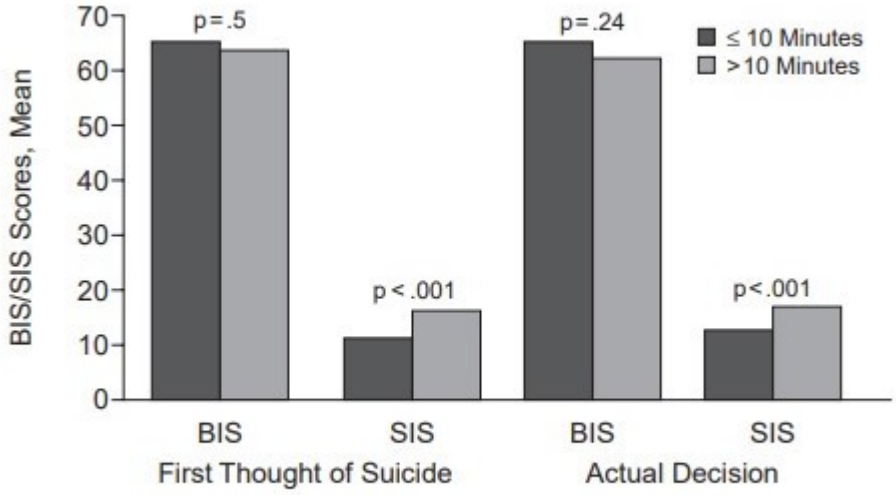
Source: Deisenhammer et al 2009

Figure 20. Time between decision to commit suicidal act and attempt



Source: Deisenhammer et al 2009

Figure 21. Impulsiveness and suicide intent scores related to the length of the suicidal process



Abbreviations: BIS = Barratt Impulsiveness Scale, SIS = Beck Suicide Intent Scale.

Source: Deisenhammer et al 2009

Suicide prevention focuses on the longer duration suicidal processes or longer duration phases. Realistically, if the red flags were not identified until the decision-making moment, and if the person is alone, as is statistically the most likely scenario, there is nothing to do.

The FBI developed a methodology for more effective interventions in the suicidal crisis of another individual to be implemented in police suicide prevention (Quinnett 1998, 2013). Quinnett believes that suicidal communications are a window of opportunity for trained Gatekeepers to intervene. QPR stands for “questioning”, “persuade” and “refer”. This methodology gets us as close as possible to the decision-making moment.

Even though all or most suicidal individuals display red flags and direct or indirect cries for help, there is a point in which they withdraw and engage in the suicidal process. All suicide theories, as different as they may be, suggest the same thing. According to Quinnett, any person can be trained to develop awareness about suicide, enhancing surveillance of others in possible distress. This leads to the potential detection of observable suicide warning signs. Once detected and recognized as symptoms of distress, the gatekeeper can then apply the three-step intervention.

The Gatekeeper doesn't need to be a psychologist. Quinnett lists at least 25 classes of people who may be strategically positioned to identify distress in the community and could be trained as QPR Gatekeepers: family members, friends, neighbors, co-workers, colleagues, teammates, office supervisors, squad leaders, foremen, academic and resident advisors, caseworkers, pharmacists, veterinarians and many others (Quinnett 2013).

The first case described by Quinnett (1998) was an intervention by the shift supervisor on a police officer's suicidal crisis. The supervisor identified the crisis based on something the victim said and probably his demeanor. He then asked the officer if they could talk somewhere else and manifested both awareness and concern. The language was important: being non-judgmental, non-invasive, and non-demanding allowed the supervisor to question the action without trying to force the officer into doing anything. He was able to persuade the officer to see a psychologist and to promise to not do anything until they did it. The officer was defensive at first. He didn’t want to give up his badge and gun, and he didn’t want to be seen as "crazy" or incapable. All these things were dealt with.

Why does this matter? First, because Quinnett's methodology doesn't depend on what theory of suicide is more accurate. It addresses detection and intervention regardless of causes or the potential victim's mental health. Second, because it includes all of us in suicide prevention and provides us with tools. The key here is to show how we are all part of the suicidal context and we can all be part of the solution.

The moral of the story here is that once the suicidal process is initiated, there is a limited chance of preventing the act. However, even among those in the suicidal process, an intervention can be initiated by watchful individuals.

The revolt of the madmen

Among the victims of all the major causes of death and disability, psychiatric patients are the most deprived of rights and benefits. Punishment and deprivation of rights are two of the worst enemies of suicide prevention.

The long history of rejection and punishment of the "deviant" and "atypical" is a dark and dirty one. The unspoken social hatred against non-conformity, especially from the powers that be, was bestowed upon these people systematically, according to different sets of beliefs and theories, and also different forms of constraint and torture. For centuries, they could not collectively speak, let alone react. The medicalization of everything promoted by psychiatry, and its service to institutions seeking to get rid of the unwanted deviant, created the conditions for this forgotten oppressed group to organize for the first time.

They created a union and a movement.

There are thousands of national and international patient advocacy organizations. Most started as an initiative of patients who sought each other to solve practical problems and empower themselves in the disadvantageous relation with the health care system (providers, insurance companies, hospitals, drug companies, and research organizations). Several of them grew powerful enough to be coveted and finally co-opted by the drug industry (McCoy et al 2017).

In most of these cases, patients or patients' families were victimized by a certain disease and received an inadequate response from the health care system. Maybe they found themselves with a rare disease diagnosis and reached out to other patients' or their families. Their affinity is based on their relationship with the disease. The disease affected their bodies and in a certain way provided the common interest between patients and their families, researchers, physicians, and policymakers. Despite possible mutual distrust, they can all agree that they want to treat breast cancer, or prevent diabetes, or understand muscular dystrophies.

Psychiatry, psychiatric illnesses, and psychiatric patients are different. There used to be little or no common ground between mental health patients and psychiatry. There was no decision-making conversation, whether about prevention, treatment or research. Patients were not offered the opportunity to provide input in their diagnosis. Psychiatric diagnostics are based on an analysis of behavioral symptomatology – not on blood tests or clinical images. There is a large room for subjectivity and arbitrary judgment if compared with other diseases and specialties.

Patients were rarely offered any option concerning their treatment. They were frequently violently constrained (involuntary hospitalization). Until today, this type of treatment strategy may happen as a result of an agreement between the family and “authorities”, and hospitalization may still be indefinitely maintained. In the end, the power of life versus one’s minimal citizen’s right to autonomy lies in the subjective hands of the mental institution’s high-ranking professionals, all of which must be psychiatrists.

These same authorities, in agreement with families or not, could suppress a patient’s “undesirable” behavior through lobotomy or electroshock therapy until the 1970s (Stickings 2019, Moore 2019).

Understandably, mental health patients have built their organizations and movement because they were victimized by the health care system through mainstream psychiatry. While other activists call themselves "breast cancer survivors", "HIV survivors" or "myeloma survivor", the forcibly treated "deviant" or "atypical" patients created the "psychiatric survivors movement". It

was not a movement for the patients surviving a disease but for the patients who survived the trauma of psychiatric treatment.

Due to the violence and suffering imposed on "atypical" individuals or those undergoing mental suffering, frequently with involuntary hospitalization, psychiatric patient advocacy is unlike any other patient advocacy movement and organization. Instead of organizing just to better treat their disease, like other patient organizations, psychiatric patients organized to defend themselves from psychiatry itself: it is an anti-iatrogenic damage movement.

The origin of the psychiatric patients' movement in the 1970s is contextualized in the momentum created by the civil rights movement, and in the rise of new forms of psychiatric abuse during the 1950s and 1960s. These involved involuntary psychiatric treatment methods including lobotomy and electroshock therapy, which were brought to light by former or "escaped" patients, by the press and by the movie industry ("Mental Health and Survivors Movements" 1973).

More or less parallel to the pharmacological revolution, psychiatry adopted other forms of radical intervention on behavior: lobotomy, for example, was introduced after Egaz Moniz won the Nobel Prize of Physiology for the therapy in 1949. By 1950, the surgery was performed in 286 hospitals in the United States and, by 1951, an estimated 18,000 patients had undergone the operation (Braslow 1999). In his case study of a California state hospital, Braslow framed the introduction of lobotomy in the hospital in a particularly unfavorable relation between physicians, staff, and patients. There were 11 physicians for 4000 patients in this hospital (Stockton) and at this point, the focus was order and control rather than treatment. Not unlike its asylum precursors, physicians applied a variety of technologies to maintain order: electroconvulsive therapy, hydrotherapy, mechanical restraints, and chemical restraints (such as barbiturates and hyoscine). Electroconvulsive therapy (ECT) was introduced in 1934 by Hungarian neuropsychiatrist Ladislas J. Meduna. It took long for modifications in the protocol to be introduced, making the treatment less painful and less damaging to the patient's cognitive functioning (Write & Bruce 1990, Hirshbein 2012). Until then, ECT was extremely painful and

caused permanent brain damage in many cases. Lobotomy was seen as an alternative to ECT. According to Braslow, between March 1947 and June 1954, physicians performed 245 lobotomies on 232 patients in Stockton. They abruptly terminated their lobotomy program with the introduction of the antipsychotic drugs reserpine and chlorpromazine in 1954. Chlorpromazine is the famous Thorazine featured in most movies staged in psychiatric wards in the 1950s and 1960s. The scenes where patients on the run are finally subdued by two strong nurses and given a shot that makes them go limp show the efficiency of the new drug. Mental hospital scenes of patients in a quasi-vegetative state realistically show the effect of Thorazine. Below are Thorazine commercials from 1955 showing how the drug industry (Smith Kline & French Laboratories then) appealed to authoritarian attitudes in American society: docility and obedience from the "different/disturbed", female compliance, and family order (figures 22 and 23). Two other adds portray a young child and a menopausal woman "pacified" by Thorazine.

Figure 22. Original Thorazine add showing the controlling power of Thorazine in the institutional setting

"disturbed wards have virtually disappeared"[1]

Many hospitals have found that

THORAZINE*

- makes patients accessible and receptive to psychotherapy
- reduces or eliminates the need for restraint and seclusion
- improves ward morale
- speeds release of hospitalized patients
- reduces destruction of personal and hospital property
- reduces need for shock therapy and lobotomy
- increases capacity of hospital to serve more patients than ever before

'Thorazine' is available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

Smith, Kline & French Laboratories, Philadelphia

1. Overholser, W.: in Chlorpromazine and Mental Health, Philadelphia, Lea & Febiger, 1955.
*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

Source: "See How Thorazine" 1955.

Figure 23. Original Thorazine add promoting the drug's virtue in controlling family-disruptive mental and emotional disturbance

Source: "See How Thorazine" 1955.

The perfect storm in the war for social control through brain intervention happened in the 1950s and 1960s: as loud and messy suppressive technologies such as early ECT and older drugs were abandoned, lobotomy, anti-psychotics, antidepressants, and other powerful psychotropics were widely used. Civil rights movements constituted the breeding ground for the "deviant or atypical" people's movement, including those in extreme mental suffering. These movements were taking place everywhere, from the US to several European countries, and they were growing intellectually more robust. The widespread use of psychiatric hospitals to lock up political dissidents was increasingly documented and revealed. Psychiatric drugs were tested on Viet-Nam soldiers (Kamienski 2016). It was not hard to connect the dots: the mind is the ultimate bastion of autonomy. Therefore, the most coveted item for social control. At the same time that the controlling side of the equation was playing free and loose with victims' health, Nixon launched the infamous "war on drugs", now known to be expensive, ineffective and a tool to perpetuate systemic racism (Rolles & McClure 2009, Rosino & Hughey 2018).

It is not surprising that as soon as the movement took off, it had strong radical components. Some of the founders believed that psychiatry was one of the means of class social control. Unionizing and fighting psychiatry would be analogous to workers fighting employers through their unions. These activists' objective was social transformation. Since there wasn't a consensus about the movement's ultimate goals, it was agreed that sharing the same views on society would not be a requirement to join it. The one basic foundation was to defend the dignity of mental patients ("Today in London's Radical History" 1973, "Mental Health and Survivors Movements" 2020).

The founding of the Mental Patients Union is today considered a landmark in the movement. There is a continuity line connecting the pioneering actors and institutions of the 1960s to today's organizations and movements. However, much more was happening during that period. Between 1969–1970, the Insane Liberation Front (ILF) was organized in Portland, Oregon, by a small group of people including Howie The Harp (homeless advocate), Dorothy Weiner (union organizer), and Tom Wittick (political activist/organizer). The short-lived ILF influenced several initiatives in North America, including the founding of the Mental Patients Liberation Project, in 1971 and the Mental Patients Liberation Front, in 1976 ("Mental Patients Liberation Front" 2020).

Legal representation, communication and the sharing of relevant information were critical to advancing the movement. The Bazelon Center for Mental Health Law was founded in 1972 by a group of lawyers and mental health professionals ("Bazelon Center for Mental Health Law"

2020). The first edition of the Madness Network News was published in 1972 ("Madness network news" 2020, "Cynthia Miller Papers, 1973-1995" 2020). Madness Network News' contributors included patients, ex-patients, and sympathizers, especially mental health workers.

The call to found an organization was shared through what came to be known as “the fish pamphlet” ("The Need for a Mental Patients Union." 2020, Cresswell 2009, Spandler 2006).

Figure 24. The fish pamphlet

Source: Cresswell 2009

The fish-on-the-hook was borrowed from psychiatrist Karl Menninger and represents the individual "hooked" to a difficult situation. The individual's behavior is a manifestation of their attempt to free themselves from an oppressive, binding situation. The full text by Menninger is this:

> *'When a trout rising to a fly gets hooked on a line and finds himself unable to swim about freely, he begins a fight which results in struggles and splashes and sometimes an escape. Often, of course, the situation is too tough for him.*
>
> *In the same way, the human being struggles with his environment and with the hooks that catch him. Sometimes he masters his difficulties; sometimes they are too much for him. His struggles are all the world sees and it usually misunderstands them. It is hard for a free fish to understand what is happening to a hooked one (reproduced in Cresswell 2009)*

At this time, anti-psychiatry activists (participants on the controversy from within psychiatry) and "psychiatry survivors" (patients and ex-patients) shared not only a goal but were brothers-in-arms.

In 1973, the Mental Patients Union was founded to "oppose psychiatric oppression" ("Today in London's history" 1973, "The Need for a Mental Patients Union" 2020) with over a hundred people in the founding meeting. It is considered the beginning of the organized psychiatric survivors' movement in Britain and it was preceded by two years by the Scottish Union of Mental Patients, established by mental patients at Hartwood Hospital in July 1971 (Gallagher 2017, "Scotland the Brave" 2020). Gallagher's careful work with Scottish sources has shed light on the significance of all psychiatric patients' movements, including anti-psychiatry and deinstitutionalization approaches. He demonstrated how the interplay between top-down social and governmental practices and bottom-up resistance and action by patients resulted in a robust social movement.

The founding meeting was successful in several ways. It was held at the Paddington Day Hospital in West London, known to adopt humane methods, including psychotherapy. National Health Service authorities wanted to close it. The patients demand that Paddington Day Hospital stay open was met ("Today in London's history" 1973). They wrote and voted on a "Declaration of Intent of the Mental Patients Union". It began with: "We proclaim the dignity of society's so-called mental patients. We challenge repressive psychiatric practice and its ill-defined concepts of 'mental illness'".

According to participants, some demands couldn't be agreed on such as the abolition of mental hospitals. Other demands remain unaddressed to this day. They are the disrespected rights of mental patients such as the right to refuse a certain therapy, the right to privacy, and the right of not being held against their will.

Why does this matter? Patients and ex-patients have dealt with disagreement among them since they decided to take their destinies in their hands with the creation of the Psychiatric Survivors Movement. It is not necessary to agree on everything to take action. It is not even necessary to be in the same organization. Their goal was to defend their autonomy and self-determination rights (dignity). Everybody could get on board with that. If we agree that suicide rates have always been too high and that suicidal people deserve a chance of not dying by suicide, it's enough to start changing for the better. We must agree on our respect for the victims, though.

It was the American root in the Mental Patient's Liberation front that evolved into today's international psychiatric patients' rights organizations such as Mind Freedom International and World Network of Users and Survivors of Psychiatry (Minkowitz 2012, "Implementation manual for the United Nations Convention on the Rights of Persons with Disabilities" 2008, McDonnell 2014). Like the WNUSP, Mind Freedom has been recognized by the United Nations Economic and Social Council as a human rights NGO with Consultative Roster Status. Judi Chamberlin, who wrote the foundational book "On Our Own: Patient-controlled Alternatives to the Mental Health System" (1978), introduced her work as a platform, speaking on behalf of psychiatric patients and ex-patients:

> *This is a book about psychiatry and alternatives to it, written from a patient's point of view. For too long, mental patients have been faceless, voiceless people. We have been thought of, at worst, as subhuman monsters, or, at best, as pathetic cripples, who might be able to hold down menial jobs and eke out meager existences, given constant professional support. Not only*

> *have others thought of us in this stereotyped way, we have believed it of ourselves. It is only in this decade, with the emergence and growth of the mental patients' liberation movement, that we ex-patients have begun to shake off this distorted image and to see ourselves for what we are- a diverse group of people, with strengths and weaknesses, abilities and needs, and ideas of our own. Our ideas about our "care" and "treatment" at the hands of psychiatry, about the nature of "mental illness," and about new and better ways to deal with (and truly to help) people undergoing emotional crises differ drastically from those of mental health professionals. (Chamberlin 1978)*

Judith Chamberlin became a pioneer on psychiatric survivors' movement not only by sharing her experience as an involuntary mental hospital inmate but by pointing out that certain skills and knowledge could not be obtained in any other manner except by direct experience. During her years of hospitalization in the late 1960s, she not only witnessed psychiatric abuse but acquired an accurate perception about the dehumanization of the psychiatric patient ("faceless and voiceless subhuman monsters and pathetic cripples").

As soon as she was discharged, she joined the Mental Patients Liberation Front, in 1971, and became associated with the Center for Psychiatric Rehabilitation at Boston University. That affiliation facilitated her role as co-founding member at the Ruby Rogers Advocacy and Drop-in-Centers as well as the National Empowerment Center, of which she became a director. These two centers are support organizations run by ex-patients. It seems to have been clear for her then, and later to others, that allies were welcome but the movement and representations had to be organized and ruled by patients and ex-patients only.

By the late 1980s, there were several psychiatric survivors' grassroots movements. They decided that they needed an independent Coalition. In 1988, the Support Coalition International (SCI) was formed and renamed as Mind Freedom International in 2005, with David W. Oaks as its director. Many of the founding members, like Chamberlin and Oaks, go back to the early days of the Psychiatric Survivors Movement in the 1970s. In 1991, at the biennial World Federation for Mental Health conference in Mexico, the World Federation of Psychiatric Users was formed. In 1997 it changed its name to World Network of Users and Survivors of Psychiatry (WNUSP).

SCI's first public action was to stage a counter-conference and protest in New York City, in May 1990. The counter-conference was “counter” to the American Psychiatric Association's annual meeting, at the same time and directly outside the APA's venue. The obvious message of

demanding that their representatives be not only listened to, but negotiated with and prioritized was heard, ignored by many, and accepted by few.

Chamberlin (1978) was not alone. Linda Morrison, with "Talking back to psychiatry: The psychiatric consumer/survivor/ex-patient movement" (2013), Robert Whitaker, with "Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill" (2001) have raised their voices and documented psychiatric abuse and epistemological flaws along with other writers from the movement.

Along this journey, patients and ex-patients parted ways with mental health professionals that had defended the same principles and participated in the organizations. Frustration and a perception of ineffectiveness justified that separation during the 1980s (Chamberlin 1990).

There were two moments in which academics were “insiders” (or quasi-insiders) to psychiatry survivors movements: in the beginning, through their interactions with anti-psychiatry, and in the 2000s, with the emergence of “Mad Studies” in tandem with the *Mad Pride* movement.

The final note in the survivors’ movements chapter is about the suicide attempt survivors’ movement. In line with all the predecessors of customers/users/survivors’ actions, from the earliest psychiatry survivors movement to now, suicide attempt survivors understood that they had a unique and indispensable perspective on suicide and that they must be heard.

DeQuincy Lezine has described the movement’s visibility as starting in the mid-2000s: the 2005 First National Conference for Survivors of Suicide Attempts, Health Care Professionals, and Clergy and Laity, co-sponsored by the Organization of Attempters and Survivors of Suicide in Interfaith Services (OASSIS) and the Suicide Prevention Action Network (SPAN-USA); the National Suicide Prevention Lifeline’s 2007 Attempt Survivor Advisory Summit Meeting, and SAMHSA’s 2010 Building Bridges: Suicide Prevention Dialogue with Consumers and Survivors (Lezine 2014, Carey 2014, “OASSIS” 2020).

Dese’Rae L. Stage created the project “Live Through This” (2020) and as a result of its impact, she and a group of others launched the Attempt Survivors initiative in 2013. It was meant to be a collection of the information needed by people in the wake of their suicide attempts, created by survivors, for survivors (“Attempt Survivors” 2020).

Mad Pride

The Mad Pride movement is an offshoot of the early psychiatry survivors' movement. In a sense, it represents some of the natural developments from it, not that different from other minority movements: to claim the stigma and subvert it. Mad Pride is about confronting mainstream psychiatry and the role it plays in protecting the status quo. Mainstream psychiatry continues to be engaged in a pathologizing effort that makes any and all non-conformist behavior the object of persecution, diagnosis, and treatment. In doing so, it disqualifies the deviant as interlocutors and dehumanizes the patient. Conditions, which are ways of existing, when pathologized by psychiatry, become *things* that people *have* and it changes these people into less-than-human. Mad activism rejects the concept of conditions as mental illness, and, as a consequence, it challenges psychiatry's identity as a medical specialty. The movement exposes the normative nature of psychiatric judgments (far more normative than any other scientific or science-based practice), the explanatory limitations of psychiatric theories (low empirical value), and the classificatory inaccuracies that beset the discipline (logical fallacies and other shortcomings, Rashed 2020(a)).

The Mad Pride movement was formed in 1993 as a response to local discrimination against people with a psychiatric history living in boarding homes in the Parkdale area of Toronto, Ontario, Canada. Much like its predecessors and allied movements, such as Mind Freedom, Mad Pride fought for the rights of customers/users/survivors of psychiatric health care. The difference is that instead of just claiming health care users' rights, they confronted the stigma by embracing the slurs. Like gay-rights activists before, who reclaimed the word queer as a badge of honor rather than a slur, these advocates proudly call themselves mad (Glaser 2008). As mentioned before, words have power (Torrey 2011). By claiming to be rightful members of society, mad people challenged all negative and demeaning preconceptions about a wide and heterogeneous group of people. I've been calling them the deviant or atypical in this book because that is all they have in common: their behavior can be different enough to be tagged to their identity.

The Mad Pride movement is the prototypical identity politics movement: atypical and deviant individuals are attributed a burdensome identity by society since time immemorial (Rashed 2019 (a) and (b), 2020, Farber 2012, Corrigan et al 2011). Like gay people, mad people have two choices: to deny their identity and compromise with mainstream institutions for the “lesser evil”, or to confront all institutions with the power of mobilization to force stigma and prejudice

out of dominant discourse. Even better: to force several scientific disciplines and one medical specialty, psychiatry, to recant and de-pathologize their identity. “We are mad” means challenging everything: the notion of mental illness, the prerogative of medical specialties and other social institutions, including families, to overpower them in any social situation, and also to claim specific identity rights.

The movement was launched a few years before the release of the book “Mad Pride: A celebration of mad culture” (Curtis & Dellar 2000). Both Curtis and Dellar were early members of the movement. In an interview, Rob Dellar explained the many items in the Mad Pride platform and their realistic perception of mainstream psychiatry’s shortcomings. One important problem was the way that drug companies were interacting with the mental health sector. "The government was encouraged by the media and one or two maverick charities to put forward legislation that increased coercion of people with mental health issues," he said (Abraham 2016).

Mad Pride, more than its predecessors, was about identity. The original movements were concerned with immediate needs, such as guarantees for the protection of their civil rights. This agenda is still very much present and justified by abuse. However, once some rights were conquered the chief issues became defending them against permanent threats from mainstream institutions, advancing identity recognition, and rights to special requirements.

Considering the tremendous power derived from thousands of years of the most violent attacks against non-conformists, of specialized institutions for detaining and separating non-conformists from the major society, of torture methods and murder, Mad Pride can be considered successful in its tactic of forcing the acknowledgment of the "mad amongst us".

It is impossible to predict how far it will go, whether the movement will be successful in forcing society to repress and criminalize attacks on non-conformists (bullying) and guaranteeing their right to live life without fear. The immense majority of mad people still hide because in all but a few places, being mad is punished, legally or not, or simply quenched by excluding the mad from job applications, from public service, from advanced education, and from family rights. However, a path for political action which includes suicide prevention has been successfully outlined by the movement. The voices of the mad now have to be heard, even if with a limited reach, even if still not with equal legitimacy (Cohen 2020).

The neurodiversity movement

The question for those that have and those that still haven't (and hopefully never will) been in the receiving end of a psychiatric diagnostic is: how do they want to be addressed? There is a lot in a name (Reaume 2002, Minkowitz 2012, Torrey 2011). The difference between "lunatic", "patient", "psychiatric survivor", "client", "customer" and "partner" is the difference between: a. completely stripping the individual of their humanity ("lunatic"); b. interacting with the individual as long as they agree to compliance as opposed to pro-activity ("patient"); c. an enemy who succeeded in surviving psychiatry's damaging attack ("psychiatric survivor"); d. the recipient in a service-providing system controlled by the service provider ("client"); e. the recipient of service according to an officially regulated contract ("customer"); and f. a colleague with a skill and knowledge set that are needed for treatment, prevention, research and policy decisions ("partner").

How the "non-conformist", "deviant" or "atypical" people choose to be addressed has an impact on the social representation of their condition with players beyond medicine. "Mad Pride" is an attempt to separate the term "mad" from the notion of pathology. The "neurodiversity movement" made important advances and is campaigning for their right to not be pathologized.

"Neurodiversity" is a term associated with the branch of the civil rights movements derived from the early days of psychiatry survivors' movements, like Mad Pride. It represents the "neuro equality" platform of those diagnosed with neurological or neurodevelopmental disorders: first, it is a challenge to the still prevalent tendency to pathologize all phenotypes associated with neurological or neurodevelopmental disorders (e.g. Autism Spectrum Disorder (ASD)). Second, it rejects the ranking of individuals' interests and needs according to the mainstream understanding of properly functioning cognitive capacities (Fenton & Krahn 2007).

Steven Kapp edited a book about the autistic community's "stories from the frontline" (Kapp 2020) featuring what the neurodiversity movement is today. The book also outlines the key actions that defined the autism rights branch of the neurodiversity movement since it organized into a unique community over 20 years ago. It is the first book about a mental condition fully written by authors with a positive diagnostic for that condition. This is also known as "lived experience" knowledge and is considered indispensable for effective co-production of knowledge that includes all stakeholders on a given subject or problem.

Autistic activists have been at the vanguard of the neurodiversity movement and today, for most people, "neurodiverse" means "in the spectrum". Their motto, however, represents all non-conformists, deviants, and atypical people: "nothing about us without us". Kapp describes the motto as an expression of standpoint epistemology: a standpoint position "claims that authority over knowledge is created through direct experience of a condition or situation. Standpoint epistemology is related to the idea of lay expertise, which is discussed extensively in the sociological literature" (Russel in Kapp 2020, p. v).

Autism activism is several decades old. Its first organization, Autism Network International (ANI), was founded in 1992. The term neurodiversity was coined in 1998 by Judy Singer on Martijn Dekker's mailing list InLv. The movement matured towards the cross-disability rights movement and the term incorporated its political dynamic (Kapp 2020, p2).

Although the neurodiversity movement has little institutional and leadership overlap with Mad Pride or psychiatric service customers/users/survivors, they share important features: 1. The demand for autonomy and inclusion rights; 2. The demand to be co-participants in the production of knowledge and policies about their conditions; 3. The origins of the movement being in great part a response to existing stigma; 4. The shift to an identity-politics type movement as a result of concocting their identity by and for themselves. This is relevant in the broad discussion about suicide because society's resistance in agreeing with these demands has been a cause for poor prevention policy outcomes and disrespect for millions of individuals' civil rights.

An important (unanswered) question introduced by the neurodiversity movement is the extent to which certain differences inherent to their condition represent actual disadvantage to navigate society's institutional structure, social demands, and securing their livelihood. While the mad person within the Mad Pride or customers/users/survivors' groups is not defined by the movement as including those who will always need specific social assistance, the neurodiversity

movement assumes that part of those they represent fit into the general description of a disabled person.

That is an internal contradiction that doesn't have an easy solution. Embracing the "neurodiverse", as opposed to "neurological disorder patient" label, is empowering, stresses the demand for autonomy and rejects pathologization. The demand for special rights and assistance tells another story. They are not just different: they have a disadvantage or a disability. We can argue that some of these conditions can create a disadvantage or an advantage (or both). Indeed, a significant sub-group or neurodiverse individuals are gifted because and not despite their condition. Companies that value this type of talent are making adjustments to their workplace accommodations to absorb them (Austin & Pisano 2017).

The logical sequence to the question is: what are we going to do concerning the fact that many of these different individuals have no way of living an autonomous life in society as it is, regardless of whether this is a problem that wouldn't exist in a hypothetical different society? They are different and they may be, as many are, significantly gifted compared to a neurotypical person. Still, there are issues in our modern social life that they might not be able to handle, making them deserving recipients of public service. Legally, they are disabled.

Disabled means incapacitated. It used to mean “legally disqualified”. *Dis* is a word-forming particle from Latin which means lacking or opposite of. Able is also a word of Latin origin which means "apt".

Therefore, being neurologically “different” in a neurotypical dominated society can be harmful not only because of stigma but due to lack of special care.

The public acknowledgment concerning the international burden of neurological disabilities is recent ("World report on disability 2011" 2011, "Neurological disorders: public health challenges" 2006). It is estimated that about one billion people worldwide suffer from neurological disorders and that 6.8 million people die annually from these disorders. The numbers are staggering: about 13% of the world population lives with a neurological disability. From the history of the neurodiversity and consumers/users/survivors' movements, besides an important volume of academic publication, we know that the needs of this population were not only neglected, but they were stigmatized and often punished.

Legal rights for neurodiverse people have been conquered recently and in a few countries. There is a long way to go (Math et al 2016).

Possibly the greatest contribution of the neurodiverse movement to suicide risk people is the energetic demand of diversity acceptance. Being perceived as different (non-conformist, deviant, or atypical) frequently makes the individual vulnerable to bullying and other forms of social violence. Shame and confusion for being different as well as accumulated failures according to social standards are highly associated with suicide. The neurodiversity movement forces acceptance, an acceptance that society never willingly gives.

In the basement of the Bureau International des Poids et Mesures (BIPM) headquarters in Sevres, France, a suburb of Paris, there lies a piece of metal that has been secured since 1889 in an environmentally controlled chamber under three bell jars. It represents the world standard for the kilogram, and all other kilo measurements around the world must be compared and calibrated to this one prototype. There is no such standard for the human brain. Search as you might, there is no brain that has been pickled in a jar in the basement of the Smithsonian Museum or the National Institute of Health or elsewhere in the world that represents the standard to which all other human brains must be compared. Given that this is the case, how do we decide whether any individual human brain or mind is abnormal or normal? To be sure, psychiatrists have their diagnostic manuals. But when it comes to mental disorders, including autism, dyslexia, attention deficit hyperactivity disorder, intellectual disabilities, and even emotional and behavioral disorders, there appears to be substantial uncertainty concerning when a neurologically based human behavior crosses the critical threshold from normal human variation to pathology (Armstrong 2015).

“Hear them out” - the problem of inclusive prevention and treatment: co-production of knowledge

From the early Psychiatric survivors' movements to today's neurodiversity movement, psychiatric patients have been fighting to be included in the dialogue about "deviant", "atypical" or "diverse" behavior, cognition, and emotion as capable and equal interlocutors. They want to participate in the definition of what is a mental or neurologic illness and how to deal with their behaviors, including suicide.

The first time mental patients screamed their platform was in the early 1970s in England ("Mental Patients Liberation Front” 2020). This is what they demanded then, in a clear list of 24 items:

Mental Patients Union Demands taken from the *Declaration of Intent* of April 1973:

We Demand

1. The abolition of compulsory treatment i.e. we demand the effective right of patients to refuse any specific treatment.
2. The abolition of the right of any authorities to treat patients in the face of opposition of relatives or closest friends unless it is clearly shown that the patient of his own volition desires the treatment.
3. The abolition of irreversible psychiatric treatments (ECT, brain surgery, specific drugs)
4. Higher standards in the testing of treatments before use on us.
5. That patients be told what treatments they are receiving are experimental and should have the effective right to refuse to be experimented on.
6. That patients be told what treatments they are receiving and what the long-term effects are.
7. Also the abolition of isolation treatment (seclusion in locked side rooms, padded cells, etc.)
8. The right of any patient to inspect his case notes and the right to take legal action relating to the contents and consequences of them.

9. That the authorities should not discharge any patient against his will because they refuse treatment or any other reason.
10. That all patients should have the right to have any treatment which we believe will help them.
11. That local authorities should provide housing for patients wishing to leave hospital and that adequate security benefits should be provided. We will support any mental patients or ex-patients in their struggle to get these facilities and any person who is at risk of becoming a mental patient because of inadequate accommodation, financial support, social pressures, etc.
12. We call for the abolition of compulsory hospitalization.
13. An end to the indiscriminate use of the term 'mental sub-normality'. We intend to fight the condemnation of people as 'mentally subnormal' in the absence of any real practical work to tackle the problem with active social understanding and help.
14. The abolition of the concept of 'psychopath' as a legal or medical category.
15. The right of patients to retain their personal clothing in hospitals and to secure their personal possessions without interference by hospital staff.
16. The abolition of compulsory work in hospitals and outside and the abolition of the right of the hospital to withhold and control patients' money.
17. The right of patients to join and participate fully in the trade union of their choice.
18. That trade union rates are paid to patients for any work done where such rates do not exist.
19. That patients should have recourse to a room where they can enjoy their own privacy or have privacy with others, of either sex, of their own choosing.
20. The abolition of censorship by hospital authorities of patients' communications with society outside the hospital and in particular the abolition of telephone and letter censorship.
21. We demand the abolition of any power to restrict patients' visiting rights by the hospital authorities.
22. The right of Mental Patients Union representatives to inspect all areas of hospitals or equivalent institutions.
23. We deny that there is any such thing as 'incurable' mental illness and demand the right to investigate the circumstances of any mental hospital patient who believes he or she is being treated as incurable
24. We demand that every mental patient or ex-patient should have the right to a free second opinion by a psychiatrist of the patient's or Mental Patients Union representatives' choice, if

he or she disagrees with the diagnosis and that every patient or ex-patient should have the right to an effective appeal machinery.

The first publications by the Psychiatric Patients Moment was not a cry for help anymore but a loud demand to be heard. For too many centuries, perhaps millennia, the “madmen” were silenced and censored. From then on, a central battle would be to make sure everybody in society heard them.

In the beginning, they were heard, and, more than heard, interpreted and spoken for by the antipsychiatry and other early critical psychiatry movements. Their legacy today is small and marginal to the project of incorporating consumers/users/survivors in knowledge production. The most open approaches in psychiatry that can still be considered mainstream are far from incorporating patients in knowledge generation (Smith et al 2020, Baklien & Bongaardt 2014, Mezzich 2007).

Mental health consumers/users/survivors' movements are not much closer to being an equal (or at least empowered) player in mental health policy than at the beginning of the movement. The difference, however, is that now they can't be ignored.

Studies about the interface of science, technology, medicine, and society have documented a relatively recent trend of change in the way scientific knowledge is produced. Shutting sciences into the Ivory Tower, letting it cook for some years, and then collecting the applied results in the form of technology and medicine doesn't correspond to the reality of science production today, if it ever did. We have figured that out a couple of decades ago. Science is much more "porous" than previously believed and we think it has always been so. Since around the 1970s, the "pores" were big enough and scientific production pulverized through different institutional settings that the non-scientific actors in science production became the focus of research. Science was responding to problem-solving situations in a less disciplinary and more inter (or trans) disciplinary manner in these alternative institutional settings (Gibbons et al 1994, Latour 1987). The first studied cases of specially created structures to mediate the negotiation of interests and transference of knowledge, still unidirectional, were technology transfer agencies in research institutions. These agencies facilitated and managed the transformation of a piece of empirical research into proprietary knowledge that could be legally protected, licensed, and commercialized (Comacchio & Pizzi 2012, Kidwell 2013). This is also where the figure of the “knowledge broker” was first identified (Berbegal-Mirabent et al 2012, Hargadon 1998). That's the agent responsible for making sure knowledge crossed the scientific disciplinary barrier. This barrier exists to keep everything that is legitimate science (production, reproduction, and

sanction) inside and everything else outside but now we know that this barrier is porous. The knowledge broker was then, at first, the class of agents (or organizations) that makes sure scientific knowledge follows an efficient path through the barrier, into "society at large".

It became clear that this was not a one-way street and other things besides demands and market needs leaked from the outside into the protected scientific environment. There has been a lot of resistance from science against these “things from the outside”. Today, there is more acceptance about this traffic of ideas. It is also more accepted that, as much as the figure of the “interdisciplinarian” is needed to facilitate productive inter, trans and cross-disciplinary work, knowledge brokers are needed to facilitate the inflow of “items” from stakeholders to science.

The first concern about science' s permeability was to promote the most effective negotiation between industry, policy-makers, academic and other research organizations, and other power-invested stakeholders. Knowledge brokering was first and foremost the translation of science into formats that could be used by these external agents into the market.

It worked well on technology producing fields and the agents responsible for developing and commercializing these products. It also worked with government decision-making bodies.

Still, each participant had the same role as before and scientific knowledge production continued to be as esoteric and field-contained as before.

Health and environment presented new problems, still unsolved. Although traditional knowledge about bioactive compounds has fed mainstream medicine from its origins, the discovery of traditional medicine and its use of bioactive compounds unknown to science created another type of knowledge flow: biopiracy (Shiva 2016). Biopiracy, or the forcible appropriation of indigenous knowledge and the native organisms used to produce the coveted products, is a non-collaborative co-production of knowledge in which only one party benefits from the interaction.

Medicine, an assumed science-based social practice, has been impermeable to patients until they figured how to exert political pressure and force their concerns to be taken into consideration. Medicine came into the spotlight for all its flaws and was attacked by science, a conflict that generated the "seal of quality" known as "evidence-based medicine", by policy-makers, legislators and regulatory organisms, whose political gains and interests require medicine to comply with their demands and by strong patient advocacy organizations (Eddy 2011, "Evidence-based medicine. A new approach to teaching the practice of medicine" 1992). Even though in time, the most robust patient advocacy organizations were flipped by strong

economic powers in the health industry, at first they showed physicians that patients had the power to influence medical practice by their organizational power over politicians and legislators and also by directly forcing physicians to respect them.

Mainstream psychiatry, however, is immune to most of this. Its promiscuous relation with the drug industry is beyond brokering: there is no line separating the two. Even with empowered critics from the inside, mainstream psychiatry is structured in a way that makes interdisciplinary dialogue and practice difficult and frequently impossible. Several definitions for the same phenomenon are not only different between the sciences and psychiatry: they are incompatible. This is the branch of psychiatry that will not negotiate with patients.

The modern dissenters in psychiatry have a different relationship with consumers/users/survivors' movements from that of early critical psychiatry. They have still not gone far beyond expressing allegiance and separating themselves from their mainstream colleagues, a disagreement that has more academic than policy consequences. They haven't yet managed to be effective knowledge co-producers with consumers/users/survivors.

From the patient movements presented in the previous chapter, organized to defend themselves against psychiatry, promoting a public representation of psychiatry as motivated by oppression and power, anti-scientific or just plain evil, we are now observing the rise of new strains of survivors organizations with a much deeper understanding of co-production of knowledge.

All health prevention initiatives depend on adherence by those victimized by whatever needs to be prevented. The only way to implement suicide prevention initiatives is to hear what suicide-risk and suicide survivors have to say. To prevent suicide, society must grant individuals' right and autonomy to take their lives. Prevention becomes, then, the mitigation of suicide social determinants and the institutionalized offer of alternative options to death.

To “hear them out”, it is frequently necessary to kick their relatives and relations out of the room and away from the at-risk individual, and to exclude organized religion from the conversation about suicide.

> *An international team of users and survivors of psychiatry, led by Tina Minkowitz, participated actively in the negotiations at the United Nations (UN) in New York from the first session of the Ad Hoc Committee in August 2002 through the adoption of the completed text on December 13, 2006. The Ad Hoc Committee was a unique process for all of us. We seized a historic opportunity and accomplished something basic and fundamental that has changed the human rights landscape for us and for all people with disabilities. (“Implementation manual for the United Nations Convention on the Rights of Persons with Disabilities." 2008)*

Realistically, the co-production of knowledge in psychiatry is not in the foreseeable future. Some significant steps forward have been taken, such as the recognition of consumers/users/survivors' movements in a consultative capacity. This is by no means a linear path.

> *The NSUN letter was signed by more than 100 individuals, as well as organizations from more than 20 countries, including Argentina, Peru, India, Chile, Columbia, Japan, Kenya, Estonia, and Hungary (**nsun.org.uk, 2018a**). It said there was little or no involvement of user-led organizations in planning the event, in a blatant breach of the UN Convention on the Rights of Persons with Disabilities (**UN, 2006**). (Beresford 2018)*

Meanwhile, other collaborative initiatives involving several marginal segments – marginal to academia, marginal to the major society, deprived of basic human rights – emerge. Side by side with indigenous psychologies and other post-colonial co-constructed bodies of knowledge, knowledge about mental health is slowly crawling into forbidden spaces. It has already grown roots into Academia and, in a few countries, even “infiltrated” health care organizations.

> *This article argues that civil mental health laws operate to constrict how people think, understand, and speak about psychosocial disability, madness, and mental distress. It does so regarding views and experiences of mental health service users and psychiatric survivors (users and survivors) and*

their/our accounts of disability, madness, and distress, such as those articulated by the emerging field of Mad studies (Beaupert 2018)

6

ANTI-PSYCHIATRY, POST-PSYCHIATRY AND MAD STUDIES

Evidence strongly suggests that the manner with which mainstream psychiatry has dealt with suicidal people is counter-productive. Its refusal to engage the victims of mental suffering in the decision-making process has just aggravated the stigma and victims' social isolation. Since the 1960s, alternative approaches have emerged from within psychiatry with the potential to act in a suicide protective manner. It is important to know their main ideas and consider them a resource available to all those involved in suicide prevention.

No other medical specialty has such a disturbed, extreme and at the same time intimate relationship with their patients than psychiatry. It has been the inflictor of pain, the torturer of non-conformists, the dehumanizer of the undesirable, and the instrument to quench dissent. It has done all that against its victims' will, in support of itself and the political status quo. It has denied a voice to the deviant and atypical by pathologizing their minds, their behavior, and their speech.

The primordial reason for that is the nature of scientific and technical knowledge in modern society, established as the rightful and monopolistic holders of legitimate truth. This power is what made science socially indispensable. Despite resistance, rejection, and even destructive attempts from society, today dangerously visible in science denialists movements and governments, the world will turn to science for verdicts and solutions: what is causing the new disease? Will the meteor crash into Earth? How can the most destructive bomb be made? How

do children learn? Science still holds the power to provide the answer, albeit temporary in its truthfulness. Medicine as a technical practice that relies on science's sanction has the ultimate power to declare what is normal and what is pathological.

When that power is combined with a political agenda, the consequences can be, and often are, deadly.

It is no wonder that psychiatry has been the most hated of all medical specialties. It has also been one the most powerful, despite having the least empirical value amongst them. Fear and hate often work in a feedback loop. The more one fears to be officially labeled as "mad", the more they will hate those empowered to provide the label.

Mainstream psychiatry has been efficient in dehumanizing and disqualifying the thoughts and words of their voluntary and involuntary patients. However, psychiatrists understood that they couldn't go on ignoring the survivors' movements, especially after the World Health Organization gave them consultative status. The coercive authority of psychiatry has been exposed and the genie cannot be put back into the bottle.

Psychiatry has been challenged since its early days. A movement of patients and ex-patients, self-identified as survivors of psychiatric torture, has gained structure, a platform, and momentum much later, in the wake of the American civil rights movement.

When consumers/users/survivors' movements were validated and joined by critical psychiatrists themselves, in an intellectual movement that was known as antipsychiatry, mainstream psychiatry could no longer ignore them. They had to respond and defend themselves.

The anomalous status of psychiatry among medical specialties is acknowledged both by critics and "critics of the critics" (Nasrallah 2011, Desai 2005). One could argue that they should be addressed as "psychiatry's defenders" but that's hardly the case. They are involved in defending themselves against the several robust waves of intellectuals, mostly from inside psychiatry, that have brought to light the specialty's intellectual shortcomings, its political and economic agenda, and its lack of ethics.

The "critics' critics" arguments are typical of a political campaign: first, they lump together all their challengers, highlight the ones that lack legitimacy, such as Scientology or right-wing movements, and attempt to discredit "criticism" as a homogeneous and unsupported trend. That tactic did not work. There is no continuity between pre-1960s conflicts and post-1960s

movements, or any relationship between Scientology and the Mental Patients Union, for example.

Psychiatry's shortcomings were irreversibly exposed. Antipsychiatry morphed into other intellectual schools. Psychiatry survived.

Antipsychiatry

The story I am telling about how society has handled mental suffering, non-conformism, deviation, and atypical individuals, which includes suicidal individuals, is a long sequence of different forms of abuse, torture, and coercion. It is, up to very recently, the history of society's institutions created to get rid of the unwanted and unbelonging. Political science, as the discipline concerned with power relations in society, provides as much of the explanatory framework to understand the history of psychiatry as the several meta-sciences (history, philosophy, and social studies of science and medicine). From its origin up to the late 1940s and early 1950s, psychiatry was a marginal field of medicine, devoid of scientific status, while tropical medicine, infectious disease medicine, cardiology, endocrinology, and immunology collected all the accolades. Psychiatry was medicine's poor cousin, and psychiatrists, not much more than prison wardens and torturers, cogs in the wheel of the war against dissent.

The advent of psychoanalysis, and its adoption by a non-negligible number of psychiatrists, shook the specialty's status quo in the 1930s and 1940s, driving the first wedge into psychiatry and attracting brighter and more compassionate minds to it.

The real fracture, though, started with anti-psychiatry. The movement that came to be known as anti-psychiatry was developing since the early 1950s but the term "anti-psychiatry" was coined by David Cooper in 1967. Cooper was a South African-born psychiatrist and theorist who fled his home country for being an anti-apartheid activist. Once established in London he became involved with alternative institutional and treatment strategies for schizophrenia and other mental afflictions.

He was not alone – not inside psychiatry, not among social movements and not as an intellectual. The voices of challenge and change in psychiatry had to come from the inside and they did (Crossley 1998). It was inevitable. At this point, there was already enough of a critical mass of reformist psychiatrists to constitute an intellectual movement: Thomas Szasz, Giorgio

Antonucci, R. D. Laing, Franco Basaglia, Theodore Lidz, Joseph Berke, Morton Schatzman, Leon Redler, and Silvano Arieti networked intensely for decades, frequently until their deaths.

Like other schools of thought that challenged mainstream psychiatry (generically known as "critical psychiatry"), anti-psychiatry attacked the specialty's diagnosis frailty, the lack of scientific foundation, its equally unsupported nosology, its harmful treatments, the dehumanization of patients and its social and political use to silence dissent. Unsurprisingly, anti-psychiatry is depicted by detractors as an unreasonable opposition to science and progress. Another important tactic adopted by detractors of psychiatry's reformist movements is to divulge alternative (false) histories in which critical psychiatrists were featured as part of anti-science and far-right extremist trends when they were actually at the opposite end of the ideological spectrum.

Unlike other critics of psychiatry from before or after, anti-psychiatrists questioned the foundations of psychiatry itself: its purpose, its nosology, the concept of mental illness, and the very distinction between madness and sanity (Crossley 1998, Ralley & Dumolo 2012).

Anti-psychiatry's intellectual supporters outside medicine were some of the brightest minds of the time, such as L. Ron Hubbard, Michel Foucault, Gilles Deleuze, Félix Guattari, and Erving Goffman.

The most important support it had, though, came from the psychiatry survivors' movement. It was one of the first occasions in which scientists and physicians looked outside their field and up to the end-user of their expertise for intellectual collaboration. It was the first manifestation of co-production of knowledge where science/medicine outsiders were – at least in theory – equals in the collaborative effort.

This was not easy, and arrangements changed in time. At some point, the movements closed their doors to non-patients and established boundaries. It was still fine to cross the boundaries and cooperate but survivors/patients decided that their voice needed to come from independent organizations where all shared similar lived experiences. That was and still is their most precious asset since the acknowledgment that nothing can substitute personal lived experience was growing in different corners of social life.

Some aspects of the early stages of the movement explain the widespread perception of radicalism and lack of practical application. Frequently, important steps in the history of ideas are marked by violent ruptures with the previous paradigm and its sociocultural context. Sometimes, the radical strikes from that beginning stain the perception of the movement for a

long time. Cooper critically deconstructed the nuclear family model in several occasions, including his foundational book *Psychiatry and Anti-Psychiatry* (Cooper 1967) and later on *The death of the family* (Cooper 1974). He advocated an alternative social organization, the commune, free from the rigid roles of father and mother, of monogamy, of contractual marriage, of the traditional binaries (passive-active, homosexual-heterosexual), where true therapy could take place. Therapy was seen as the process of ridding oneself of internalized family ghosts. Madness was seen as both a resistance and a sign of the repressive nature of the traditional family (Chapman 2016).

That was too counter-cultural for the delicate tastes of the medical establishment as well as the major society. Cooper's contribution towards a subject-centered approach to mental suffering, his criticism of mental institutions, and his pivotal role in the dialogue with survivors' movements ended up underrepresented in the histories of this period.

As is often the case, the founder of a movement is devoured by its own. Cooper was relegated to the role of an anomaly in the larger movement of critical psychiatry. R.D. Laing's son and biographer, Adrian, argues that there was only ever one anti-psychiatrist: Cooper (Chapman 2016).

The second icon of anti-psychiatry, or maybe not, according to his son, is Ronald David Laing (Crossley 1998). R. D. Laing was a Scottish psychiatrist known for opposing treatment (or, rather, control) methods adopted in mental institutions during the early 1960s. Two important points made by Laing align him with other critical psychiatrists: first, his belief that psychiatric nosology was inadequate. Second, the belief in a subject-centered approach to mental suffering. He and other critics of mainstream psychiatry favored a much heavier role for the social environment in mental suffering.

Whether Laing himself claimed to be part of the anti-psychiatry movement or not doesn't change the fact that he was the architect of its core ideas.

Laing was a prolific writer and his books exerted significant influence over the younger generation of psychiatrists as well as intellectuals from other fields, and patients. Mainstream psychiatry's reaction to his popularity was negative:

> *Bright young schizophrenics, like bright young people generally, are interested in reading about their condition. From the vast and varied selection of literature available to them, they appear to show a marked preference for R. D. Laing's The Politics of Experience (1967). The present*

> *authors, like other members of the ``square'' older generation, are of the opinion that they know what is best, and that this book is not good for these patients (from Siegler et al., 1969, p. 947, in Crossley 1998).*

Crossley (1998) believes that three overlapping elements characterize Laing's impact: a proto-scientific revolution (which, according to the author, failed), a shift within left-wing politics, and the emergence of the 1960s' counter-culture. Laing invested much effort in changing clinical practice and theoretical constructs within psychiatry. Unlike other critical psychiatrists, he insisted on reform rather than a substitution of psychiatry. For example, Laing suggested that schizophrenia is a label and that the patients' particular behavior reflected a family phenomenon. Laing's criticism of mainstream psychiatry evolved into a more political approach, clearly pointing out that it was in the nature of mental institutions to dehumanize and invalidate the patient as a human being. That didn't help him gain popularity in mainstream psychiatric institutions or journal outlets, pushing him away from the field itself and more into the counter-cultural social movement. Convergence with other movements into an anti-family, pro-commune perspective, and Laing's experimentation with LSD, obstructed his potential impact on psychiatry at that point.

The third prominent name in anti-psychiatry (who, like Laing, denied belonging to the movement) is Thomas Stephen Szasz, a Hungarian-American academic, psychiatrist, and psychoanalyst. Unlike other critical psychiatrists –those identified with anti-psychiatry as well as those who chose other labels – Szasz was not a radical political reformer. He is known for challenging the notion of mental illness itself and psychiatric diagnosis. Much like modern critical psychiatrists, he pointed out that there were neither serological, genetic markers nor image evidence to corroborate the diagnostic of mental illness. Szasz was a firm opponent of involuntary psychiatric treatment and institutional commitment.

Szasz's critical approach to mental illness was one of the first systematically elaborated and published (Szasz 1961). He maintained his maintained this point of view all his life, having participated, in 2001, in the Russell Tribunal on Human rights in Psychiatry held in Berlin. The majority verdict claimed that there was "serious abuse of human rights in psychiatry".

These three figures, currently recognized as foundational to the anti-psychiatry movement, networked intensely with each other and with several other psychiatrists, intellectuals, and movement leaders. As they disagreed more and more, they finally grew apart (Roberts & Itten 2006).

Is anti-psychiatry dead? Evidence shows that it gained prominence at the same time as some of its protagonists were pursuing different projects and identifying with other labels. Detractors seem eager to proclaim the death of critical veins inside psychiatry and declare them anti-scientific, or ideological sparks from the past. Some authors consider that the movement never died: it just stopped being anything related to psychiatry or psychiatrists. Instead, it would be now an outsider movement with no allies inside psychiatry (Nasser 1995, Whitley 2012). Anti-psychiatry's legacy is claimed by the new social movements and preserved in initiatives such as the Anti-psychiatry Coalition ("The Antipsychiatry Coalition" 2020). At the same time, it is vehemently rejected in mainstream environments. According to Rashed (2020(b)), accusations of "anti-psychiatry" connections are used to silence legitimate criticism of psychiatry as well as to disqualify mental health activism.

Post-psychiatry

As anti-psychiatry lost some of its impact on psychiatry and medicine in general, and as customers/users/survivors' movements were recognized by the WHO in an official consultative capacity, critical perspectives continued to evolve. The best structured of them is known as "post-psychiatry".

The term 'post psychiatry' was coined by Campbell in 1996 in an anthology of first-hand experience essays about mental distress (Campbell 1996). The term was derived from the shared idea that a new psychiatry was needed for a postmodern world.

Bracken and Thomas (2001) outlined post-psychiatry in their article "Postpsychiatry: a new direction for mental health". The authors are aligned with the government's change of direction concerning mental health policies in Britain. A new ethos informed it, one that commanded attention to the links between poverty, unemployment, and mental illness. Policy guidelines focused on disadvantage and social exclusion. To satisfy the new policy approach, a new kind of psychiatry and a new deal between health professional and service users (the "consumers" and "psychiatry survivors" of the early days) had to emerge.

Bracken and Thomas published their foundational article in 2001, the year of UK's general election, following a period of Labor Party control. The election was the last to date in which any government has held an overall majority. Possibly, it was also the last time innovative social policies such as the outlined mental health guidelines could be implemented. It was the

beginning of the future, a future in which the relations between science and society would take the expected step forward into problem-focused, interdisciplinary and co-produced knowledge. Sadly, it was not but they couldn't know it then.

John Armstrong Muir Gray, then director of the National Knowledge Service and Chief Knowledge Officer to the National Health Service, among other policy positions, said:

> *"Postmodern health will not only have to retain, and improve, the achievements of the modern era but also respond to the priorities of postmodern society, namely: concern about values as well as evidence; preoccupation with risk rather than benefits; the rise of the well-informed patient" (Bracken & Thomas 2001).*

Bracken & Thomas were faced with a larger problem when it came to psychiatry: although the specialty survived anti-psychiatry and other powerful intellectual and political challenges, the improvements called for by the UK government would be much more extensive. The challenge now would be to uncouple psychiatry from all the shortcomings extensively analyzed and revealed by former and present social movements.

The goals of post-psychiatry would be to advance psychiatry into a context-driven approach, an ethical, rather than technological orientation, where service users could be involved in shaping the culture and values of the working teams, as well as reframing the relation between medicine and madness, rethinking and repurposing the politics of coercion. If and when society was faced with the need to remove an individual's freedom due to their mental disorder, this decision should no longer be the monopoly of psychiatry.

Backlash and antagonism were expected. In a critical article against post-psychiatry, Kecmanovic (2009) adopted the old tactic of misrepresenting the contender's claims to confront and disqualify them. Kecmanovic didn't seem to settle for one or another interpretation of postpsychiatry's perspective on diagnostic to disagree with. First, he claimed post-psychiatry rejected any diagnostic procedure. For Kecmanovic, its proponents would then be campaigning for deprofessionalization, depsychiatrization, and demedicalization of psychiatry. He moved on to claim that post-psychiatry promoted collaborative diagnosis involving the care provider and the user (patient). The fact that the two claims are not logically compatible didn't stop him from continuing his deconstructionist quest. He portrayed post-psychiatry as relying exclusively on an analysis of the social context in which the user/patient manifested symptoms. Kecmanovic couldn't make up his mind as to whether he accused post psychiatry of ignoring symptoms or of

negotiating the nature of the symptoms with the user/patient. The same logical inconsistencies characterize the rest of his criticism of post-psychiatry. His arguments may have some value but unless they are cleaned of their many logical flaws, from the most *red herring* fallacies to other informal and formal ones, there is no possible debate. This type of response, when internal to a scientific field, can only be properly comprehended if contextualized. In this case, the fallacious criticism of post-psychiatry is a defensive strategy from mainstream psychiatry. The argument's structure is composed of an introduction where the contender is described as having some merit and then a long diatribe about how it is illegitimate because the "good premises" were pushed too far.

Contrary to Kecmanovic's claims that post-psychiatry failed to address mainstream psychiatry's most relevant challenges, authors from different countries believe that post-psychiatry has been able to provide positive and practical answers to them as well as a much needed theoretical and philosophical ground. Harangozó (2019), from Hungary, Stupak, and Dyga (2018), from Poland and Korolenko and Shpiks (2016), from Russia, pointed out how postpsychiatry's approach resolves the problem of misdiagnosis and produces better treatment results.

Democratic psychiatry and political psychiatry

Besides post-psychiatry and anti-psychiatry, other critical branches of the specialty include alternative or democratic psychiatry, founded by Italian psychiatrist Franco Basaglia, political psychiatry, founded by French West Indian psychiatrist Ibrahim Frantz Fanon, and radical psychiatry, founded by French-born American psychotherapist and writer Claude Michel Steiner.

Democratic psychiatry, introduced by Franco Basaglia in Italy (Foot 2014), is at the foundation of the "Trieste model" of public psychiatry, considered by the WHO one of the most progressive and efficient in the world. Like anti-psychiatry, its origin goes back to the radical challenge of mainstream psychiatry from the 1960s. In 1974, Basaglia implemented an alternative approach to psychiatric care based on the centrality of the suffering person as opposed to a diagnosed disorder. Trieste has been a collaborating center of the WHO for four decades to disseminate its model and practical guidelines across the world.

Portacolone et al (2015) described the attempt to translate the Triste model to San Francisco through a collaboration between the Department of Mental Health in Trieste and the

department of Psychiatry at the San Francisco General Hospital, an institution affiliated with the University of California in San Francisco (UCSF). The agreement was signed in 2006 by Dell'Acqua and Okin, then chief of psychiatry of the San Francisco General Hospital. The authors concluded that obstacles outside the scope and power of the implementing team made the translation impossible.

The obstacles stem from both the demographic characteristics of San Francisco and the American Health Care system. Unlike Trieste, San Francisco is a city marked by extreme economic inequality, a thin and insufficient social safety net, homelessness, and widespread drug abuse. More than that, the American private-centered health care system made it impossible to adopt more inclusive and efficient mental health programs. The sociopolitical and demographic context in the USA was much less hospitable to reform and the intellectual environment equally unfavorable: psychiatric institutional values were much less challenged, anti-stigma efforts on which social inclusion depends were less extensive, and all in all, the experience showed the world that psychiatric reform towards overall better service to those in mental suffering depends on a combination of favorable factors that goes way up to the societal and government levels.

Political psychiatry was founded by Frantz Fanon, a French West Indian psychiatrist and anti-colonial political activist from the French colony of Martinique. Fanon was strongly critical of psychiatry as it was practiced in the colonies, inseparable from the oppressive empire-colony relations. He exerted influence on Franco Basaglia's work in Italy and remains, to this day, a reference in mental health service for ethnic minorities in central as well as in peripheral countries.

As those he inspired and critics before him, Fanon emphasized the flaws of mainstream psychiatry concerning its neglect of the social context in which mental suffering is manifested. Also like other critical psychiatrists, Fanon suggested that patients benefit from a community-based approach instead of institutionalized care.

Fanon's main contribution to psychiatry is his confrontation of a model based on the exclusion of the patient, in which their identity is defined by their otherness and the assumption that their discourse is incomprehensible in essence (Menozzi 2015).

Mad Studies

Allies to mad people – the non-conformists, the atypical, the neurodiverse, the deviant, the unwanted – also come from the social sciences and the humanities. *Mad studies* refer to a field of scientific inquiry that integrates users/consumers from its inception. It is a close cousin, for example, of indigenous psychology, a movement in psychology that advocates not only a subject-centered approach to mental suffering but the co-production of psychological knowledge with traditional cultures.

Mad Studies is a field of inquiry but not just that: it is a field of praxis. It is a field of knowledge defined by co-production between users, scholars, and activists (not necessarily exclusive categories). Menzies et al (2013) define it as an interdisciplinary and problem-focused field.

Mad studies represent an attempt to maintain and promote the growth of the alliances created in the wake of the psychiatry survivors' movement. Items of the early agenda are present but some have become increasingly problematic, such as the fast psychiatric pathologization of behaviors: with each new patented substance, a new disorder is inserted in the DSM or expanded to include children, for example.

In this sense, "Mad", as a noun, refers to all the categories of non-conformists, deviant and atypical individuals whose behavior, thoughts, and emotions disturb the conveniently medicalized definition of sanity. Mad doesn't mean "they who have a disorder" but rather "they who have been rejected by major society through mainstream psychiatry through nosologic labels conveniently organized to satisfy the status quo and the pharmaceutical industry".

Castrodale (2015) defined "Mad Studies (as) a growing, evolving, multi-voiced and interdisciplinary field of activism, theory, praxis, and scholarship."

Richard A. Ingram coined the term “Mad Studies” at the First Regional Graduate/Undergraduate Student Disability Studies Conference at Syracuse University on May 3, 2008. He had been a senior research fellow in the School of Disability Studies at Ryerson University. Ingram presented the paper which named the new discipline/field two months before being subjected to psychiatric confinement (Ingram 2016).

As Ingram described the coming together of Mad Studies, he pointed out that there was method in their madness. However, there must also be Mad in their method. Ingram believed that this

was a new form of producing knowledge and if it is incorporated in academia, it should shake it up as academia reinvents itself:

> *"The ultimate horizon that I would hope for would, therefore, be that if Mad Studies does enter academia that it unsettles all academic disciplines: That is what it should do because universities are the place of reason. If Mad Studies achieves its objectives, it needs to have as part of its end goal the shaking up, the disturbing, of all forms of academic knowledge" (Ingram 2016).*

Ingram predicted Mad studies' impact on academia as one that would constructively force open seals that obstruct the cross-talk with multiple stakeholders and also the incorporation of "outsiders"' knowledge. He also predicted an almost complete impermeability of psychiatry to Mad studies (Ingram 2016).

While I don't think he is wrong in predicting impermeability, Mad studies are growing roots in traditional academia, and as it does, so does the (expected) criticism against it. The deliberate choice of terms, beginning with Mad and madness, was an attempt to challenge and out psychiatry and its stigmatizing lexicon "rather than devalue those of us who have been subordinated by the two" says Beresford (2019).

Mad studies is a field or discipline for "engaged academics", as outlined by Cresswell and Spandler (2013), which entails its own contradictions. Especially in this field of "psychopolitics", a term coined by Sedgwick (1982) and elaborated on by Cresswell and Spandler, where participants' identities are permanently questioned, given their deep engagement. Many such academics share the identities of institutional scholars, activists, and also consumers/users of mental health systems.

How academia will interact with this new interdisciplinary discipline or field is unpredictable although I suspect the fate of this interaction is highly dependent on what happens at the political level in each society. In other words, if the executive, judiciary and legislative powers are less hostile to inclusive practices, Mad studies might flourish.

7

STIGMA AND THE LAW

Words carry cultural baggage. We call it "theory-ladenness". The idea that an observational term may be "loaded with theory" comes from epistemology and the philosophy of science. When Thomas Kuhn argued that two paradigms were "incommensurable" he was referring to the fact that observational terms were theory-laden by different sets of assumptions, becoming non-translatable (Kuhn 1962). The "paradigms" that Kuhn proposed as integrated systems of conceptual models and practices for the functioning of science constitute complete world views.

In the 1950s and 1960s, Thomas Kuhn, Norwood Hanson, Paul Feyerabend, and others questioned the objectivity of observation since, according to them, one cannot use observational evidence, expressed by a term, without committing to the theory where that term acquires its semanticity. The more controversial the theory and the higher the number of competing models, the lesser the epistemic value of the observation and the term (Bogen 2009).

That is true for all observational terms: they are all dependent on an integrated system of semanticity like a language or a culture. Certain terms will be used less controversially both among scientists and between scientists and whoever they are in dialogue with, outside of science. Examples:

Table 6. Observational expressions and their contexts		
Term or observation	**Form of observation**	**Conceptual model**
This is a Diptera larvae, not a worm	Naked eye	Modern taxonomy, strongly related to the evolutionary synthesis; not accepted by religious lay persons. However, at certain levels, taxonomy is not controversial even for them.
Here is your gallbladder stone.	Naked eye following laparoscopic extraction of the gallbladder	Modern anatomy and physiology; uncontroversial concepts of digestive anatomy and functioning
I am observing global warming at play. These unprecedented wildfires are produced by the climate change dynamic.	The wildfire can be observed with naked eyes. Different cultures will call it "fire". What the climate scientist "saw" was a manifestation of global warming. Global warming is observed through mathematical modeling of longitudinal temperature records (of the atmosphere, of the soil, etc), of atmospheric gases and satellite imaging.	Climatological modeling of climate change based on modern geological and climatological consensus about climate variation. Although there is a level of consensus characteristic of "normal science" (Kuhn 1962), a significant part of the lay population refuses to accept the scientific explanation.
This is a brain tumor. We still don't know if it's benign or not.	Image analysis (MRI, CT scan)	Modern neuroanatomy.
This is borderline personality disorder	Observation based on an interview with the patient and possibly information from the family. Observation is considered epistemically weak or of low value (an observation that does not contain a lot of reproducible uncontroversial content).	Models about mental disorder and a nosology manual (DSM-V).
He is cognitively disabled. He is in the spectrum.	Subjective observation based on either talking to the person, teachers, and family or analyzing videotaped situations in class.	One chosen model about atypical behavior. Not consensual.
This is schizoaffective disorder and it is causing suicidal behavior.	Subjective observation of the person's body language, silence, speech and situation (standing over the edge of a high building)	Highly controversial. Several meaningful informing indirect observations were not obtained (social, ethnic, and even medical).
She is mentally ill, previously diagnosed, and taking psychotropic medication and her testimony should not be considered.	Second-hand observation (no observation).	Someone else's interpretation and application of the DSM-V. A model concerning the reliability of a person's statements. The objective of the observation was to disqualify the witness.

"Mental illness" or "disorder" is now not only controversial but ideologically and politically laden (Torrey 2011). The mere fact that suicide prevention is coordinated as a part of a "mental health" initiative is controversial. Several parties with a vested interest in suicide prevention programs would rather see it as a stand-alone social program. "Mental illness" became a problematic term and it will remain so as long as the evident epistemological flaws on psychiatric nosology remain. It is theory-laden by more than one theory.

I will adopt the nomenclature that most accurately respects the reality of the phenomena and interdisciplinary nature of related knowledge. I will refer to the condition in which suicidal people are as "mental suffering" – not illness, not disease. By the same token, the condition in which individuals find themselves with a low probability of dying of suicide will be referred to here as "mental wellbeing".

The suicidal state of an individual is a mental health problem. And a social network and community resources problem. And a support network and welfare problem. And a macroeconomic problem. And an educational problem. And a political problem. And a legal problem. Finally, certainly, a legislative problem because if the laws aren't changed, all suicide prevention program investments are significantly wasted.

For the moment, let’s just hold this thought: the United States is the only country that doesn’t have a national public health system, where there is private monopoly in the health industry and health care, and that this is the reason why it is from hard to impossible to enforce laws or create laws that are consistent with science rather than with corporate profit. The fact that things that must be necessarily free of cost and readily available are not so in the US may be associated with suicide spikes in certain regions or social groups.

As the literature reviewed here demonstrates, the one greatest predictor of successful suicide is a previous suicide attempt. If suicide attempt victims are not immediately offered free multi-disciplinary health care, the health care system becomes a suicide-conducive force.

Suicide attempts belong in the same category as snake bites, reproductive health, and non-transmissible disease screening: either it is free-of-cost, efficient and government-controlled, or society, through its institutions and corporations are one of the factors in the increase in morbidity and mortality from these conditions.

There are a few pieces of legislation that could protect the suicide attempt victim: under federal rules from the Health Insurance Portability and Accountability Act — HIPAA — employment-based health plans (now extended to individual insurance plans) cannot discriminate against a particular person by denying eligibility for benefits or charging more because they have a specific medical condition (Andrews 2014). These are all private health insurance plans and the companies that provide them have an exorbitant power to shape the laws to their needs. For example, they are entitled to specify what kinds of injuries they want to cover and which ones they don't. These are the so-called source-of-injury exclusions. That's where they can specify that if the injury is self-inflicted, the victim is not eligible for coverage from the health plan that

ultimately they pay for (employment benefits are not gifts). Health insurance companies do not have to justify the denial of service. Finally, both insurers, health providers and employers hiring an employer-based health care program for their company are protected by federal law on denying service based on their religious beliefs or their conscience ("Conscience Protections for Health Care Providers" 2018, "Department of Health and Human Services" 2018). In other words, there is very little legal regulation over health care providers or insurers in the US: health insurers will cover what they want and health providers will provide whatever they want (Koons & Tozzi 2019).

There are two publicly funded programs in the US: Medicare ("What's Medicare" 2020) and Medicaid ("Medicaid" 2020). Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and People with End-Stage Renal Disease. It is still health insurance, it is not public health, it may involve a premium and out-of-pocket expenses. About 43% of Medicare patients had out-of-pocket expenses exceeding their assets (Renter 2014). Medicaid is a health plan for low-income people who qualify, depending on the percentage of the State's poverty income that the person can document, besides other issues. Medicaid covers suicide attempts and self-inflicted injuries (Coursolle 2020). Medicare doesn't (Renter 2014).

There are around 9% of uninsured Americans as of 2018, far better than the 18% before the implementation of the Affordable Care Act in 2014. However, suicide attempts, the most important event in a suicide prevention program remains an unsolved problem since most people will avoid medical attention and insurers will fight not to pay the related health claim (Gallup 2019).

Finally, if the victim does receive medical treatment for a self-inflicted injury, they may expect that their privacy will be violated since the health care provider is legally entitled to contact several individuals related to the victim, including those that may have played an important role in the negative factors leading to the suicidal state ("US Department of Health and Human Services" 2014). What happens after that, depending on whether there was police involvement or not, varies.

The United States is not the only country where suicide prevention faces a legal brick wall: among WHO member states are 25 countries where suicide is currently still criminalized and an additional 20 countries where, according to Sharia law, suicide attempters may be punished with jail sentences (Arensman 2017). In nine African countries, suicide is criminalized and suicide attempts are prosecuted and penalized. At this point of international suicide prevention

efforts and the first global program reaching its end, an internal conversation is called for in every country. The argument in favor of keeping suicide criminalized is usually the expected anti-scientific and theocratic discourse: "suicide is inherently evil, immoral, or sinful; therefore, continued legal prohibition and judicial sanctions are defensible" (Adinkrah 2016). There is no reliable data on suicide or suicide attempts from these countries.

The Catalonia Suicide Risk Code Epidemiology (CSRC-Epi) study represents one approach to suicide prevention through surveillance, evaluation, and care offered to suicide attempters or victims of self-inflicted injury. The study takes into account that there is an unknown proportion of suicide attempters who do not contact healthcare services, and emphasizes that the study is limited by that (Mortier et al 2020).

Countries with no well-structured national public health system and private monopoly in health care and the health industry, such as the US, have a structural economic and policy obstacle to implement a successful suicide prevention program. Theocratic countries where suicide and suicide attempt are criminalized are at an even more unfavorable position to make any progress in this direction (Mishara & Weisstub 2015). However, even secular democracies with national public health systems such as Greece, Ireland, Italy, and Portugal face important obstacles for a suicide surveillance and prevention program: their strong religious traditions (Orthodox and Catholic). Suicides are usually registered as “undetermined” or “accidental” deaths. Pritchard and colleagues (2020) conducted population-based studies and compared them to test whether there was any significant difference in patterns of suicides, undetermined deaths, and accidental deaths between these four Western countries and 21 predominately Islamic countries. They found that for the Western comparator countries, the average suicide rate was 66 per million people, the average undetermined death rate 56 per million, and the average accidental death rate 58 per million, yielding a suicide: UnD + AccD odds ratio (OR) of 1.73. The average values for the other three groups were as follows: less-traditional Islamic countries, suicide rate, 31 per million; UnD+AccD rate, 101 per million; suicide: UnD+AccD OR = 3.3. Former USSR countries: suicide rate, 61 per million; UnD+AccD rate, 221 per million; suicide:UnD+AccD OR = 3.6. Arabian Gulf states: suicide rate, 10 per million; UnD+AccD rate, 76 per million; suicide:UnD+AccD OR = 8.6. Middle Eastern and North African countries: suicide rate, 6 per million; UnD+AccD rate, 151 per million; suicide:UnD+AccD OR = 25.2. Mortality patterns in the Islamic countries were significantly different from Western comparator countries.

What we learn from this is that legal impediments to suicide prevention, such as the US virtual impunity of monopolistic private health corporations, determined not to cover suicide attempts

and self-inflicted injury, or the Muslim countries' criminalization of these acts, are just part of the problem. Of course, access to free, public, and efficient health care is associated with lower suicide rates (Holliday 2018). However, deeply ingrained stigma, usually coming from religious traditions, can make it hard to seek help after a failed suicide attempt and also hard to register suicide deaths.

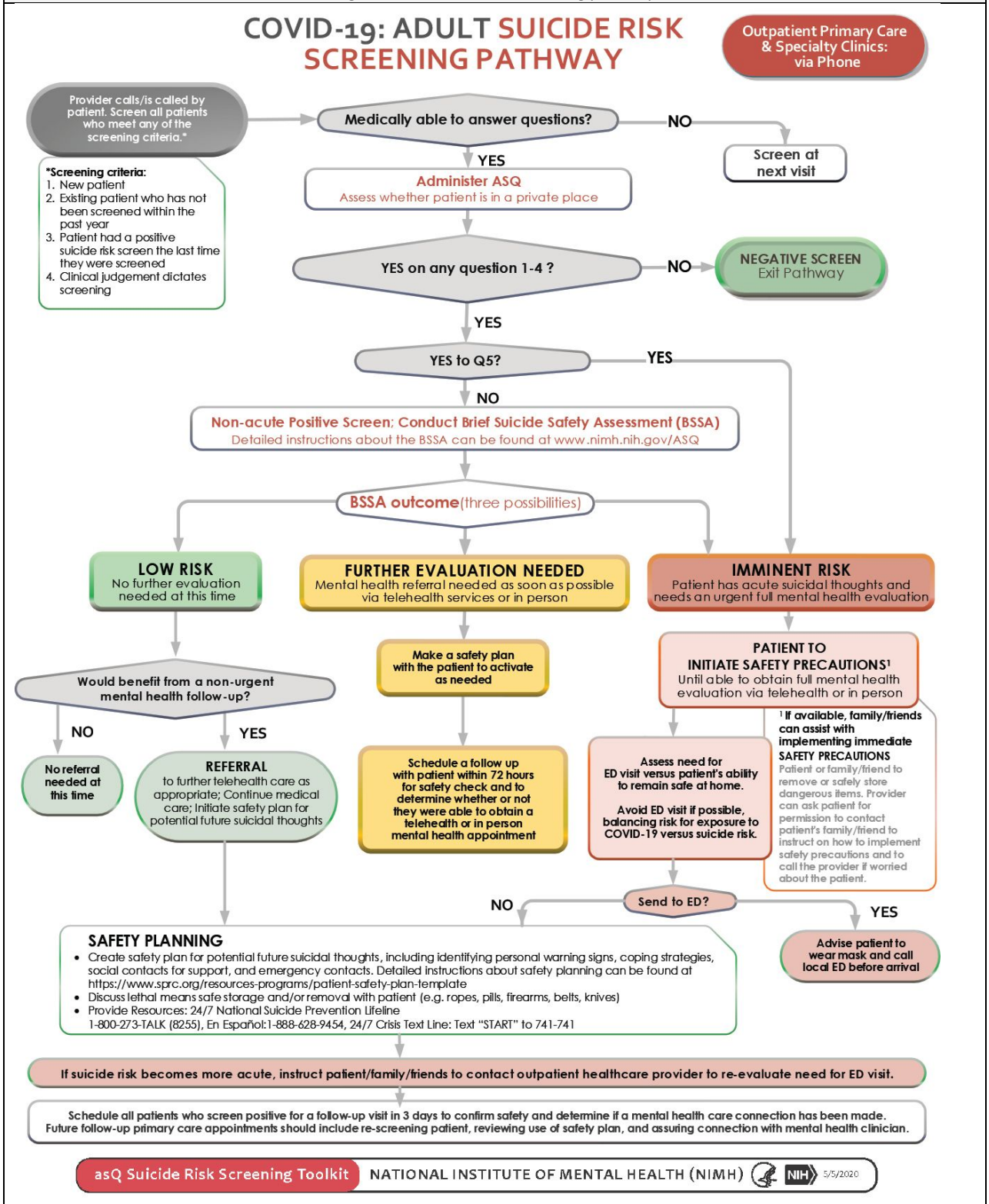
Stigma goes much deeper and wider than anachronic or flawed legal systems. Fighting the stigma associated with madness was a platform item of all the psychiatry survivor movements up to now. Mental health laws are instruments to perpetuate stigma by removing power and agency from the service users. The stigma associated with the cognitive, behavioral, or emotional deviants or atypical (mad people) is much more destructive than the stigma associated with most other conditions within major societies. Mad people in the health care system are discriminated against and treated with cruelty by health care providers themselves to this day (Bates & Stickley 2013).

An example of how stigma and legal problems can hinder surveillance and prevention is Pao and colleagues' (2020) proposal that a universal suicide screening be implemented in all hospitals. Their reasoning is solid: the majority of people who died by suicide visited a health care professional months before their death. According to the authors, the medical providers who assisted these patients are in a privileged position to detect suicide risk. They cite the successful initiative at the Parkland Health and Hospital System (PHHS). The authors seem aware of how patients might react to the several questionnaires imposed on them: they introduce a “less threatening step” to lower the defenses of patients who might feel they are being treated in a punishing way.

Patients don’t just “feel they would be treated in a punishing way”: they know it. Several people with power in that specific medical structure would decide to screen them for something that can brand them with stigma and several potential catastrophic outcomes. Clearly, Pao and colleagues didn't take the time to talk to psychiatry survivors' movement representatives or they would know that.

Their initiative flowchart shows an agile decision-making system:

Figure 25. Suicide adult screening pathway



Source: Pao et al 2020.

Unless the legal issues involved in the suicidal process and the stigma are addressed, the chances of this program to work are small.

These are typical (personal communication, anonymous) dialogues with suicidal patients in hospital settings (HP=hospital personnel; P=patient):

HP (turning the patient's wrists and observing slash scars): we should get you some help with this…

P: That's unnecessary. It's healed.

HP: I mean mental health help. You seem to have hurt yourself.

P: No, you're wrong. These were accidents.

HP: Seems like you are very much accident-prone.

P: whatever. Accidents. Nothing else.

HP: I have to report this injury and you can only leave the hospital with a family member.

P: You are not. This was an accident.

HP: this was not an accident and you know it.

P: Fine. Call the police. I see five irregularities here. I will report you.

HP: It's probably not an infection. Your bloodwork shows elevated liver enzymes. This one here… it suggests you might be drinking more than you should. Or maybe also taking something to calm you down?

P: No, don't worry. You collected the blood the morning after a party at my mate's house. That's all.

HP: Are you sure you don't want to talk to one of our mental health people?

P: No, I'm feeling great. Just tired.

This is practicing sly normality (Mills 2014) or camouflage (Schneid & Raz 2020). It's a skill that most people can develop when they are overpowered by social actors capable of punishing or destroying who they represent: an ethnic minority, a political clandestine opposition, or the non-conformist, deviant or atypical. In societies that punish the Mad and persecute those with overt self-destructive behavior, many learn to "pass" as "normal", even if "normal" exists as much or as little as madness. It doesn't matter because sly normality or camouflage is not about understanding the oppressive "other": it's about surviving by looking like them.

Even patients who are not used to lying will lie to any authority that broaches this sensitive topic. In places where they may be criminalized or involuntarily hospitalized, they will do whatever it takes to hide the evidence of suicidal behavior. In the US, they will lie to avoid a hospital bill and also because they don't know where the information will end.

A five-decade-old psychiatry survivors' movement exists because there are actual reasons to fear psychiatric probing and treatment. Unless the mental health and psychiatric establishment give up their overbearing and inflexible denial to work with "the other side", represented by survivors organizations, this line of screening and prevention has a small chance of making a dent on suicide surveillance and prevention.

Why does this matter: 1. Because without a legal reform that makes it mandatory for health providers and insurance companies to provide care to suicide survivors and victims of self-inflicted wounds, any suicide prevention attempt is strongly incomplete; 2. Because health care professionals must be trained and/or selected based on their emotional health and immunity to suicide stigma; 3. Because those responsible for suicidal people who act on their prejudice and discriminate the victims should be held accountable and punished. Only then we can hope to reach the first steps on true suicide prevention.

8

“THERE WAS NOTHING YOU COULD DO” x “I SHOULD HAVE…” (SUICIDE PREVENTION/PREDICTABILITY)

As agreed by suicide prevention task forces, scholars, and some customers/patients, suicide is preventable. However, no matter how ideal a society is in implementing a comprehensive suicide prevention program, some suicides will still happen. The reason that suicide is not altogether preventable like measles is that it is a stochastic event: someplace, sometime, given certain uncontrolled circumstances, there will be a known probability that someone will die from suicide even in the ideal optimal scenario. And being crystal clear on this, the ideal scenario, if it ever is to exist, is so far into the future that none of us will see it in our lifetimes.

We are stuck with high suicide rates that we can and should try to decrease according to contextual strategies designed by teams of stakeholders. We agreed suicide is preventable but what proportion of suicides we will be able to prevent is not possible to estimate.

The tragedy of uncertainty and unpredictability strikes at the individual level. No matter how many gatekeepers we have and how well we manage to instill awareness in society at large, Chuck, Pablo, and Annika will still die of suicide. Chuck was your student, Pablo was your friend and Annika was your sister.

It gets worse: even the suicidal person, aware that after two attempts they are much more at risk to die at the third, aware that the states of mind conducive to their suicide is impulsive and short-lived, aware that they generally choose to live despite their deep mental pain, even this

person may not be able to prevent their own suicide. Most of us tried the check-ins with chosen supervising friends, we tried self-support groups, we tried mood-checking-systems but the truth is that when suicidal people engage in the suicidal process, there are neurological alterations that make all these measures unlikely (Wilson 2017). The more the suicidal person avoids seeking support, the more likely the suicide (Benatov et al 2020).

What happens to the teacher, the friends, the health care providers, the co-workers, the gatekeeper, and the positive family elements? They become vulnerable members of the community (Pitman et al 2017), they must be watched, supported, and followed in their efforts to make sense of their loss for as long as necessary. This process, or "suicide bereavement", is different from "natural bereavement" (coping with the loss of someone to natural causes). Individuals immediately affected by someone's death by suicide, who we will call "suicide secondary victims", are estimated to be 6 to 28 per successful suicide. The total number of secondary victims just in the US is around 3-5 million (Cvinar 2005). Siblings, parents, and peers are at a much higher risk of developing major depression and PTSD (Brent et al 1995, Brent et al 1993a). After all we've discussed about the controversial nature of psychiatric diagnostics, whether it is a "real" major depressive state or just "looks a lot like major depression" (Brent et al 1993b) doesn't matter: the self-destructive risk is the same. As Andriessen and colleagues (2017) suggested, suicide exposure goes far beyond the family context and research and support must cover all the affected. Suicide affects the professionals involved with the victim. It is estimated that 22–39% of psychologists and 51–82% of psychiatrists experience at least one patient suicide in the course of their career although these numbers are uncertain. That's not a small rate. In the aftermath of a death, many of these professionals are taken by a sense of guilt and failure. Some of them question their professional and personal adequacy. As Kelleher and colleagues (2014) pointed out, these people, too, need special attention and given space and opportunity to elaborate their loss, a loss that happens at many levels.

Cvinar (2005) explained that suicide bereavement is "different" but also warned against the paucity of studies and proper methodology in the matter. One of the aspects in which suicide bereavement may be different is that family secondary victims may be subject to stigma and discrimination. Stigma is correlated with shame. The feeling of shame affects the secondary victims' ability to interact with society or, as so frequently recommended, to "move on". It also affects the relationships within the family unit and the result may be complete isolation of the bereaved during the post-suicide period. With shame comes blame – self-blame and finger-pointing as well, which may lead to a vicious cycle of accusations, remorse, and anger. How

much of this cycle of isolation and family tragedy is a consequence of the family members' perception of society's reproach and how much is actual discrimination is unknown.

Some things are quite specific to suicide secondary victims: stigma, blame, search for meaning, and being misunderstood. Even if the primary victim left a suicide note, coming to terms with that person's suicide may take years or it may never happen. A certain level of search for meaning in loss happens in every death. Natural deaths might be easier to come to terms with. Violent deaths create permanent cycles of hypothetical questions. If the victim was killed in a car crash, some family members will spiral down in "what if" scenarios even when reassured everything was completely random. Family members of murder victims rarely overcome the trauma. Sometimes it seems better to embrace the tragedy, create an organization and devote all one's energy to preventing other crimes than to "moving on".

This is all different with suicide. The medicalized version of suicide is more benign to family members because it's easier to dismiss it as losing the genetic lottery. The primary victim was just born "wrong". It's sad but it's nobody's fault. That's false for the majority of suicides and we know it: neglect, sexual abuse, bullying, social isolation due to war or migration, oppressive treatment are all highly associated with suicide, which, we now know, may have multiple causes.

Most families will deny as much as possible that the death was a suicide and when they can't, they will hold on to the mental illness explanation as a drowning man to whatever floats. Deep inside, many feel it can't be that simple.

With a multi-factorial approach to the primary victim's suicide, it is everybody's responsibility. Dealing with the loss in this realistic way may exorcise the ghost of doubt but it requires a lot of work. It involves transforming the inevitable guilt into a sense of social responsibility, accepting it as a result of ignorance and social circumstance. This is not easy and frequently it is not even possible.

Another difference between suicide bereavement and natural death bereavement is that the suicide might be replicated in what is commonly called "suicide contagion" (Poland et al 2019, Pitman et al 2017). Contagion is not well or consensually understood. Epidemiological data simply shows that those directly related to a suicide victim have a higher suicide attempt and completion probability right after the first suicide. Because of an alarming increase in suicide rates among Army personnel but not Air Force or Navy between 2005 and 2009, a well-funded study project was launched. The results from this initiative have been harshly criticized for methodological reasons and because they failed to generate actionable data. The studies,

however, strongly suggested clustering and contagion: suicide attempts from 2004 to 2009 tended to cluster in Army units in which prior suicide attempts had occurred (Hoge et al 2017). The problem, like with so many other issues in suicide studies, is that the concept of contagion is not clearly defined or consensual. Other studies seem to corroborate the contagion hypothesis (Hom et al 2017).

In all suicide clusters that deserved a follow-up study, it was unsurprisingly found that the victims had a previous mental illness, diagnosed or not. However, as Baumeister (1990) pointed out long ago, this is a tautological statement: since suicide is assumed to be a manifestation of mental illness by mainstream psychiatry, mental illness will be found and diagnosed. This is scientifically discommendable.

The truth is that we don't know what this phenomenon represents. We don't know whether the secondary victims are overwhelmed with sadness and identify with the primary victim, thus replicating their behavior. We don't know whether it is overwhelming guilt and if it is, we don't know why. We don't know if it's guilt out of failure (to save the primary victim or in any way prevent the suicide) or guilt out of potential fault (of having been mean or in any way negatively acted against the primary victim).

Survivor's guilt is another ill-defined term in psychiatry that refers to the guilt of having survived a fatal situation where others died. It was first described in psychoanalytic publications about Holocaust and Hiroshima survivors. In a study among PTSD patients at a UK traumatic stress clinic, Murray (2018) reported that 90% of the patients who had survived where others had died had feelings of survivor guilt. Surviving a fatal traumatic event was associated with higher levels of suicidality. Awareness of survivor guilt was associated with more severe PTSD.

The peers of a suicide victim can feel that they were spared that death and they may devolve into sharing it.

Why that matters: first because you will probably find yourself in the group of those impacted by suicide at some time in your life. The closer you are to the suicidal person, the stronger the impact. The more ambivalent the relationship, the more dangerous. Suicide bereavement is different from natural death bereavement. You shouldn't underestimate that impact and it's a good idea to seek help while you can still consider it. Second, because you might find yourself in the position of observing a social group experiencing the impact of suicide and you can promptly act to assist the group.

The "what if" thoughts are torturing and endless. The cycle of regret and powerlessness results in exhaustion and depression. Hopefully, there will be some closure later.

In cases of excessive mental suffering, as the first account from Kay Jamison on “Night falls fast” (1999) or other refractory cases of bipolar disorder or depression, the patient’s death by suicide may be a relief on their loved ones. If they fought together with and for the victim with all the tools available to them and nothing gave the victim any relief from that suffering, their death may be less ambivalent although not less sad.

9

WHAT SUICIDE IS NOT

These are claims that have been more or less elaborated on “lay theories” of suicide. “Lay theories”, in this context, are prejudicial assumptions made by anyone with no lived experience or technical knowledge. They are not just false but damaging. Also, they tell a lot about who is voicing them. Finally, they strongly adhere to the perspective of suicide as an individual problem, unrelated to social context. If they stray away from the purely individual account of a suicide it will be to blame the victim’s family or social circle.

- An act of selfishness: it is common to hear lay individuals accuse the suicide victim of being selfish and not thinking about "anybody else". What they mean is that the primary victim was unable to project their continued existence into a future in which the unbearable mental suffering and even the external problems maintaining it would have a more positive outcome. Sometimes, what makes a suicidal individual postpone the suicide are the people who would become secondary victims to their death. When all hope is gone and the pain – whether physical or mental – is intense enough to quench other thoughts, they kill themselves. Finally, one of the common aspects of suicidal thinking is the victim's belief that they are worthless, a burden to everyone who loves them, and that everyone will be better off when they are gone. In that sense, appealing to a suicidal person's "sense of responsibility to their family", or to "think about your children" can push them faster into the suicidal process since it intensifies the feeling of guilt and inadequacy.
- A sin: the idea that having sex before marriage, marrying a person of the same sex, abusing drugs, or killing oneself are sins are religious beliefs, not truths. Religion has a dark history with victims of mental suffering. Organized religions were chief perpetrators of torture on deviant, atypical, or suffering individuals. If the suicidal person is obsessed with the idea of sin, someone familiar with this issue should be engaged. Several religious leaders or priests have a much more benign understanding of suicide and could be of help. Anything that either intensifies religious guilt or drastically confronts the victim's beliefs is dangerous. The

victim is in a fragile condition, their self is shattered, and they don't need an atheist to deprive them of a few beliefs they are still trying to juggle.

- A weakness: the value-laden "weakness versus strength" claim is related to all the bad things in social life. It is unsupported by evidence of any type. However, it is foundational to any form of oppression: the oppressor is justified because, by definition, they are stronger. Being seen as physically weak by children from our industrial societies is reason enough to be bullied; being seen as mentally or cognitively weak (and it doesn't matter if other terms are institutionally used, such as cognitive disability or impairment) is a reason for pity or contempt; any behavior that deviates from a given moral norm is considered a weakness or a character flaw. Poverty or life difficulties, in general, are systematically judged a weakness since the dominant view is that it is always the result of poor life choices. A suicide victim is frequently said to be someone who wasn't strong enough to face life challenges. There is not a shred of validity to any of these claims. They are just false beliefs based on the moral of oppression.
- Unmanly: we frequently hear that someone was not "man enough" to handle problems and if the suicide victim is male, that is a frequent response. Again, this is just an expression of a false set of beliefs derived from an oppressive (and bigoted) moral system.
- A character or personality flaw: a favorite one in the prejudiced menu is "mental toughness". Suicide victims would be not mentally tough enough. Mental toughness is the object of empirical research and theorizing. The concept is not consensual, and measuring tools still not sufficiently adequate. A study about the relationship between mental toughness and suicidal ideation among military police was carried out by Smith and colleagues (2016). The psychometric properties of the Mental Toughness Psychological Skills Profile (MTPSP, a scoring questionnaire), and its association with suicide ideation, were evaluated in a sample of active-duty U.S. Air Force Security Forces personnel, a subpopulation especially vulnerable to suicide risk. The MTPSP is comprised of factors which were independently correlated with general distress, somatic anxiety, positive affect, presence of meaning in life, search for meaning in life, positive self-bias, social support sources, and suicide ideation. The Confidence factor was the only one that had a significant association with suicide ideation when all five factors were considered simultaneously but was fully mediated by social support. Self-confidence may be associated with reduced suicide risk because those individuals tend to report higher social support.
- A crime: it is a crime only where the law is based on religious principles and not on a system of rules to best regulate the actions and interactions of the members of society. That would

be a theocratic legal system and there is nothing rational about it. It exists to ensure the dominant religion remains dominant. Suicide cannot be typified as a crime in a properly secular society.

- Cowardice: this claim is based on the assumption that, first, any adversity must be faced (and not avoided or eliminated) and any suffering must be endured. If one chooses not to, it represents a lack of courage in this perspective. For the cowardice claim to be true, we must also assume those two assumptions to be true (any adversity must be faced and all suffering must be endured). We know that they are false. This lay theory may lead to the assumption, too, that the suicide victim is scared or intimidated by something and that they are escaping from it through death. That is not consistent with any study about the suicidal mindset. The dominant feelings do not include fear. The suicide victim's state of mind is dominated by hopelessness which actually provides the necessary courage to ignore the pain and the disturbing inability to conceive inexistence.
- Laziness: the laziness claim is comparable to the weakness or sin claims. It refers to the need to push all the determinant factors on anyone's suicide back to the victim. The laziness claim is also a child of the naïve individualist lay theory, where success or failure are a matter of good choices and determination. There is abundant evidence that this not the case, ever, not even within a specific cultural and income group. This claim also assumes that the suicide victim offends society in several ways: first, they are losers in the competition of life. Second, they don't embrace their failure to work harder: they drop out of the game because they are too lazy to play it. Suicide victims are frequently exhausted and maybe withdrawn due to depression. They are not lazy.
- Cheating: the cheating claim is directly related to the laziness one. Life is a game and it has rules. Winners win because they are just naturally better, make better moves (choices), and are determined. Losers lose because they make bad choices. That is a reflex of that society's moral system: a hierarchical and oppressive one where winners dominate losers. Losers are the object of contempt but suicide victims are far worse: they cheated by dropping out of the game. This game has a rule against not playing it, which is illogical but a large part of every society shares it.
- The apple that doesn't fall far from the tree: that's the only claim that involves anybody else except the suicidal individual. All the claims in lay theories carefully protect society from any responsibility for the suicide death. This one shifts the responsibility for the suicide to the victim's family, which is then stigmatized and ostracized if the community shares this belief strongly enough. According to this belief, the victim's sinful, weak, or criminal behavior is

consistent with their family's nature. The family is not blamed for inducing the victim to suicide but rather for existing and producing an offender such as the victim.

10

HOPE

Hopelessness is considered the state of mind most correlated with suicidal intent, even more so than depression. Hope is the state in which the individual can conceive of a future in which a positive outcome to their problems can happen. By directing attention to the future, hope delays self-destructive action. Hopelessness obliterates the expectation of a future. Goal and purpose are related concepts but they are not equal to hope.

Hopelessness and despair

“Deaths of despair” are on the news on an almost daily basis. Among the dictionary definitions of “despair” are “the complete loss or absence of hope” and “the feeling that there is no hope and that you can do nothing to improve a difficult or worrying situation". The etymological roots of the word "despair" are the combination of the Latin particle "de" (down from) and the word "sperare” (to hope). The dictionary definitions of hopelessness include “a feeling or state of despair; lack of hope”, “the feeling or state of being without hope”.

These deaths of despair, that include suicides (by all methods), substance overdose not-ruled-as-deliberate, and liver failure, are deaths of "loss of hope". According to psychoanalysis, they are all suicides (Menninger 1938). They are undeniably deaths resulting from self-destructive behavior.

Table 7. List of the first 10 news items with the expression "deaths of despair" in the title, collected on July 30, 2020		
Outlet	**Title**	**Date**
International Monetary Fund	Divided by Degrees: Angus Deaton on how More Americans Without B.A.'s are Dying of Despair	7/30/2020
BBC News	Deaton: Slow 'disintegration of working-class America'	7/29/2020
Detroit Metro Times	Michigan sees an increase in opioid abuse as a result of coronavirus-related despair	7/28/2020
Washington Post	'Deaths of Despair' soared in Trump country. It may be getting worse.	7/23/2020
Shepherd Express	Deaths of Despair and the Future of Capitalism (Princeton University Press), by Anne Case and Angus Deaton	7/16/2020
The Dialog	In wake of COVID-19, many people will suffer what are known as 'deaths of despair' — Elise Italiano Ureneck	7/15/2020
Washington Business Journal	Viewpoint: Scour for signs of 'depths of despair'	7/10/2020
The Brookings Institution	Charts of the Week: Racial wealth gap, COVID-19, deaths of despair	7/10/2020
The Journal Record	Facing a future of 'deaths of despair'	7/10/2020
Psychology Today	Attendance at Religious Services and Deaths from Despair	7/8/2020

There is still little consensus about whether despair and hopelessness are synonymous or if they are being used with the same meaning in research. More objective definitions and cross-talk would be beneficial since there is a body of published research that only employs the term "hope" and "hopelessness" and another that uses "despair". I will assume here that they are synonymous and, therefore, "deaths of despair" are "deaths of hopelessness".

What is hope

Hope is diversely defined as a mental state, an emotion, a feeling, an attitude, or a cognitive response to reality that projects a positive solution to present distress in the future. The importance of hope in suicide is that when it exists, the individual can cope with the stressors. In the absence of hope, it becomes harder and harder to handle problems without a perspective of improvement. Eventually, the person may no longer be able to cope and engages in self-destructive behaviors to escape the pain.

Hope is broadly defined as the ability to envision/feel that there is a solution in the future to current problems or psychic pain. Hope has many implications for the individual. To start with,

there is a future to expect. For this reason, hope supports social connection and belongingness, both considered essential for social integration since Durkheim (1897). As a corollary, hope also implies the belief in the possibility of being rescued as opposed to being abandoned (Goldblatt 2017). Indirectly, hope also favors trust, a pre-requisite for accepting help.

What exactly is hope remains elusive or not consensual. Whether it is a cognitive appraisal of reality (therefore, a thought), an emotion, a feeling, or a propositional attitude, is unclear (Crane 2009, Halevy 2017, Milona 2020). Goldblatt (2017) defines hope as a mental state (Putnam 1992). In this mental state, a desire is directed toward the future: the desire for a positive outcome. As such, it supports a positive resolution to psychic pain. The reason why hope is so significant in suicide prevention is that by connecting the victim to the future positive resolution of pain, it postpones self-destructive action. In other words, hope is what halts suicide but also what buys time for more substantial hope.

We could say that, at the individual level, prevention starts with "a little hope".

"Hope theory" is part of the line of psychology called "positive psychology". In cognitive terms, hopeful thought is the belief that there are pathways to desired goals combined with the ability to become motivated to seek them. As a cognitive component, hopeful thought would then be able to drive the emotions and well-being of people (Snyder et al 2002).

Whether hope is the emotional antecedent of cognitive response, vice-versa or the response itself will remain a topic of controversy in and between the sciences. However, the controversy is immaterial to the role of hope and its absence in suicidal behavior. Everyone agrees that it is intimately connected with suicide, with few exceptions (like Mendonca & Holden 1996).

Hope is not faith, hope is not wishful thinking and hope is not denial. Hope is not goal, purpose, or motivation either. Hope is the ability to believe and focus on a positive outcome in the future. Not just believe but believe enough to be mobilized. Sometimes, just mobilized enough to ***not*** move in the direction of the suicidal act.

It's not hard to connect the dots and figure out that if hopelessness is a more powerful correlate of suicide than depression, suicide intent itself, or any other indicator, measuring hopelessness could be the most valuable tool to identify suicide risk. It also doesn't involve asking the patient: "Have you had thoughts of suicide in the past two weeks", to which most suicidal people would quickly reply: "absolutely not". If a health care provider talks about suicide with a potential victim who is a stranger to them, the chances of identifying suicide risk are small. If a gatekeeper or someone in the community engages the potential victim in a conversation that involves the future, there's a chance: the future is absent from their language.

The future tense is less used in the speech of hopeless people:

- Where are you going to be on Christmas?
- Christmas is always at Molly's parents' house

- I don't really care about New Year's celebrations

- Will you go to Greg's retirement party?
- I don't know.

- What are your career plans now?
- Next week is my dissertation defense.
- I heard it's all set for you to be in Yale in August
- I guess so.

- I love you very much and I have always been proud of you.
- What do you mean? I didn't even finish school! Shit's gonna get real in two years!
- Right.
- And you're going to be there with me
- I am always on your side. No matter what, you will make it.

Suicide feels like a solution to chronic problems:

- How's the job search? Pete wanted to share some suggestions with you.
- It's all figured out, don't worry.

- We need to talk: your ex-wife's lawyer has contacted me and she did not agree. She has other demands as well.
- This is not going to be a problem.
- How so?
- Trust me: it won't.

It is also evident that hope is a protective factor concerning suicidal desire. One of the reasons why hope is possibly the most important protective factor is another dominant feature in suicidal behavior: ambivalence. Ambivalence is present on suicidal behavior right to its final outcome. It is the alternation of the desire to die and to live. The one factor that can tilt the scale in favor of life is hope (Goldblatt 2017).

With so many approaches to hope and suicide, it's a good idea to reach back to the pioneers. Edwin S. Shneidman is considered one of the fathers of contemporary suicidology. Shneidman considered that suicide was caused by "psychache", or psychological pain (Leenaars 2010), which I have been calling mental suffering. Suicide takes place when the pain becomes unbearable, beyond a subjective threshold for enduring such pain.

Shneidman's listed ten commonalities in his definition of suicide in the article "A Conspectus for Conceptualizing the Suicidal Scenario", in 1992.

I. The common purpose of suicide is to seek a solution.

II. The common goal of suicide is cessation of consciousness.

III. The common stimulus in suicide is intolerable psychological pain.

IV. The common stressor in suicide is frustrated psychological needs.

V. The common emotion in suicide is ***hopelessness-helplessness***.

VI. The common cognitive state in suicide is ambivalence.

VII. The common perceptual state in suicide is constriction.

VIII. The common action in suicide is egression.

IX. The common interpersonal act in suicide is communication of intention.

X. The common consistency in suicide is with lifelong coping patterns (Leenaars 2010)

For Shneidman, hope was the common emotion underlying the suicidal act, contrary to the cognitive approach of hope theory. It makes sense that an unbearable state of psychache calls for a solution. The solution is the cessation of consciousness while for the escape theory of suicide the solution is escaping, suicide being the last stage of escaping.

Regardless of which conceptual approach we choose, there is always a threshold after which all other coping mechanisms are insufficient and suicide is the only visible solution. It seems appropriate to assume that whatever else defines this threshold, the loss of hope is the strongest component.

Shneidman also proposes ten commonalities of suicide prevention:

1. A program of support of suicide-prevention activities in many communities throughout the Nation.

2. A special program for the "gatekeepers" of suicide prevention.

3. A carefully prepared program in massive public education.

4. A special program for followup of suicide attempts.

5. An active NIMH program of research and training grants.

6. A redefinition and refinement of statistics on suicide.

7. The development of a cadre of trained, dedicated professionals.

8. Governmentwide liaison and national use of a broad spectrum of professional personnel.

9. A special followup for the survivor-victims of individuals who have committed suicide

10. A rigorous program for the evaluation of the effectiveness of suicide-prevention activities (Leenaars 2010).

Although there is little consensus about what hope is, there is some agreement that it is associated with the ability to set goals and engage in goal-oriented action. Long term goals, on the one hand, and purpose (an all-time type of goal) are associated with better coping mechanisms, the existence of a social network, and stronger social ties and resilience. Purpose is what gets people to hang on even when external conditions are unfavorable. How long can any individual hang on to their purpose or if everybody has a breaking point (the threshold) is unclear.

The body of research on suicide and how it is associated with environmental stressors suggests that at extremely uncertain and unfavorable conditions where the individual is socially isolated and detached, or where their original culture is disrupted to a point of leaving the individuals without a value system or even an identity, the threshold will be achieved by many people because of said social conditions.

Apparently, a reason to live (involving intrinsic and extrinsic motivation and goals) is much more significant than a reason not to die.

Shanahan and colleagues (2019) propose that developing tools to identify detrimental conditions through multidimensional conceptual mapping is critical in suicide studies. They suggest that such studies should provide the tools to identify the pathways to despair and from that to premature death. They should also help to identify the sub-groups more vulnerable to the negative impacts of economic, cultural, and social disruption. According to the authors, and I agree, only then can we envision preventions and interventions that might be effective. Whether they will be or not depends on the larger political and cultural conditions.

Where does hope come from?

If hopelessness is such a strong correlate to suicidal behavior, understanding how to restore lost hope becomes imperative at all levels. If you are a gatekeeper, it is important to identify hopelessness and also to have some tools to help the vulnerable person restore lost hope or start their journey of hope reconstruction.

Studies about hope, the psychology, and the philosophy of hope, ironically take hope for granted. It was only when the absence of hope was associated with self-destructive behaviors that the ontological issue became a question. From most of the literature on hope, one concludes it is there as a default setting, just as most human behavior is goal-oriented.

The question is how to restore hope when it is lost.

Goldblatt (2017) suggests three pathways towards hopeful engagement with the suicidal patient. These are (1) relational coping, (2) symptom management, and (3) link to a core identity. Goldblatt concluded that hope was strongly correlated with the formation of a caring interpersonal relationship. The more “empathic time” the caretaker spent with the suicidal person, the more favorable was the reconstruction of their hope. That required a proactive role from the caregiver in engaging and forming a relationship with the otherwise withdrawn patient. Hope is related to the construction of a meaningful connection and conveying acceptance, which can trigger a trust response from the patient. Hope may return when there is a process of reparation to previous attacks that led to injuries to the ego. Goldblatt proposes that symptom management is indispensable for the victim to tolerate the ongoing suffering when psychic pain is decreased. The final step to the recovery of hope is re-integrating the shattered self and a new connection to the victim’s core identity.

Hope recovery (and loss) are culturally contextualized. Holt and Reeves (2001) described how they developed a definition of hope for the Dominican Republic rural village where they conducted their study. That was done through an ethnographic analysis (in ethnonursing practice). It resulted in a concept of hope as "an essential but dynamic life force that grows out of faith in God, is supported by relationships, resources, and work, and results in the energy necessary to work for a desired future. Hope gives meaning and happiness" (Holt & Reeves 2001).

Gibson (2019) adopted the term “respair” to describe the rise of hope in social theory and its implications for anthropological thought and practice. Respair refers to the return of hope after a period of despair at a societal level. It highlights the relation between hope and its "others": despair, disappointment, and waiting. These others to which hope is an alternative are not the only concepts associated with hope from an anthropological perspective. These associated concepts include anticipation, desire, disappointment, doubt, faith, fear, optimism, among others. Gibson and the authors she reviewed were mostly concerned with shared hope, how it can be construed as a social good (whether an asset, capital, or currency).

The approach is relevant for suicide prevention programs considering that the most effective interventions are at the community level where grassroots movements grow. Questions such as what is collectively muting hope and what can foster it are relevant in this level of intervention.

That brings us to the question of where is the locus-of-hope and how we can manage it in ways that suicide variables are affected. Wagshul (2019) observed that of the three suicide pre-conditional factors according to the interpersonal theory of suicide, two are reduced by increased hope (thwarted belongingness and perceived burdensomeness). The third one, acquired capability for suicide, seems to be increased by hope, which makes little sense. We have a hint that hope is not one but several related phenomena from the anthropology contributions. Wagshul (2019) then suggests looking at Bernardo's (2010) locus-of-hope construct. Bernardo (2010) developed his model within Snyder's (Snyder et al 2002) cognitive approach to hope as an individual difference variable, a trait-like disposition for two types of hope cognitions, agency and pathways. He proposed an extension of this approach by conceptualizing locus-of-hope. Research on hope theory offered the empirical foundation for this thesis: individual-focused agency and pathways have been shown to be associated with positive goal-directed cognition and actions. However, studies on conjoint agency, endogenous social agency, proxy, and collective/shared agency suggest that goal-directed cognitions may involve goals and actions of other people. In this sense, hope may lie not only in one's own plans and capabilities (internal locus-of-hope) but in those of others (external locus-of-hope). According to Bernardo (2010), individual differences in the four locus-of-hope dimensions are correlated with individual differences in individualism and collectivism. Individualism and collectivism, according to this school of thought, are cultural attributes: cultures can be more individualistic, placing goal setting and seeking at the individual level, or more collectivistic in their pursuit of goals and happiness. Different social theories place a heavier emphasis on one or the other according to their models. In today's globalized world, although pure types may be found, the rule is that different societies will tend more to one or another end in the individualism-collectivism gradient. Bernardo used the Auckland Individualism and Collectivism Scale to correlate to his locus-of-hope dimension measures.

To test his locus-of-hope hypothesis, Bernardo modified the original Dispositional Hope Scale developed by Snyder and colleagues (1996) adding eight new items constructed for each of the three external locus-of-hope subscales: external-family, external-peers, and external-spiritual. Consistent with the original scales, four items referred to agency and four to pathways. Bernardo hypothesized that individualism (but not collectivism) would predict internal locus-of-hope while collectivism (but not individualism) would predict both external-family and external-peer locus-of-hope. He also predicted a relation between collectivism and external-spiritual locus-of-hope. The test studies included 268 students (127 females, 141 males) from three sectarian universities (2 Catholic and 1 Protestant) ranging from 16 to 21 years.

Based on Bernardo's (2010) categories, Wagshul (2019) designed a study to understand the discrepant results about suicide factors and hope. Data from a sample recruited online (N = 193; 88.6% aged 21–49; 59.1% men; 80.3% white) were analyzed to isolate the effects of external locus-of-hope on acquired capability for suicide, controlling for depression, demographic variables, and internal locus-of-hope. The results confirmed that internal locus-of-hope positively predicts acquired capability for suicide and demonstrated that external locus-of-hope has the opposite effect.

Wagshul (2019) concluded that interventions designed to raise one's level of externally located hope have the potential to deter suicidal individuals from actualizing their plans. That is not as simple as it sounds. First, what the study shows is not that external locus-of-hope directly lowers acquired capability for suicide. It just shows that, statistically, the likelihood of possessing acquired capability for suicide is lower in a person who has external locus-of-hope than in a person without that quality.

The studies highlighting locus-of-hope are an important tool in considering suicide surveillance and suicide prevention. That doesn't mean they are easy to incorporate in a surveillance or prevention design. Understanding that hope is culturally contextualized and construed complicates rather than simplifies the task. Or, rather, pushes prevention farther away from mainstream psychiatry and suggests that anthropology, social work, other community programs, and customers/users/survivors groups may be indispensable tools.

Whether the locus-of-hope is predominantly internal or external for a given at-risk community, restoring hope must happen at the intersection of the individual and the community levels.

When approaching a disturbed and potentially suicidal person, acquiring some information about their cultural origin, types of culturally established expectations and shared values is important. That doesn't mean conducting an ethnographic interview: it means attempting to understand where that person places their hope. That can be critical to take protective steps and know how and who to refer the person.

11

LIFTING, MENTAL WELL-BEING, AND MENTAL SUFFERING

We reach the final and directly applied part of this book: can lifting help a suicidal person out of suicide risk? If so, what are the conditions to make this possible? Can it be harmful to the suicidal person?

The short answer is yes to both. Since my goal is to prevent unnecessary suicides and help suicidal people and suicide survivors recover, it is important to examine both the conditions that can make lifting a suicide-protective activity and those that can make it a suicide-conducive one.

The reason for this book is that unlike other physical activities and sports, lifting (and strength sports in general) has been shown to be associated with higher than average suicide rates, as compared to certain studies' demographic. There is a small number of studies about suicide and lifting (and strength sports in general), and the data suggest a negative effect. While studies are abundant about the suicide-protective effect of sports in general, there are no more studies about suicide and lifting besides the ones considered here.

Based on by-proxy and anecdotal data, I believe lifting can be one of the most powerfully protective activities concerning suicide. However, we have to make sense of data on the contrary and which factors may contribute to negative or suicide-conducive effects. Also based on anecdotal data and anonymous communication, these factors are unfortunately present in many lifting environments.

It is our moral obligation as a society to combat any socially derived suicide-conducive factor. While the choice to live or deliberately stop living must be respected, conditions in which this is less of a choice and more a result of extreme mental suffering due to a negative environment or history have to be confronted and changed.

If I am right and lifting can be so powerfully protective, then the imperative to identify and eliminate suicide conducive factors is even more important.

For this reason, I will divide this item into three parts: first, I'll list the effects that make lifting a suicide protective activity. Second and based on the previous list, I'll examine the necessary conditions to favor those effects, therefore promoting a suicide protective activity and environment. Third, I'll examine how lifting can be harmful and suicide-conducive.

Can lifting help a suicidal person out of suicide risk?

Lifting can help a suicidal person for five reasons:

1. ***There is abundant evidence that solitary physical practices involving partial sensory tunneling and conducive to flow can promote altered states of consciousness that ultimately lead to mental well-being.***
2. ***Mind-body integration / anti-fragmentation force.***
3. ***Excellent promotion of inter-organ cross-talk and recovery of physiological homeostasis and well-being.***
4. ***Simple, uncomplicated and problem-oriented social interaction.***
5. ***A concrete way to exercise regulatory behavior in an otherwise chaotic life, slowly recovering self-sufficiency and autonomy. Moreover, hope, the one factor most highly associated with suicide prevention, can only be cultivated in a goal-oriented life.***

Probably yes for five reasons:

1. **There is abundant evidence that solitary physical practices involving partial sensory tunneling and conducive to flow can promote altered states of consciousness that ultimately lead to mental well-being.**

In simple terms, flow is a state of complete absorption in a task, resulting in several sensory, cognitive, and emotional temporary alterations. This concept is particularly useful when considering the potential beneficial effects of lifting for the vulnerable person. There is a broad literature about the advantages of mindfulness and meditation practices for mental wellbeing. These practices share a common mental attitude and neural correlates with any skillful and autotelic (rewarding in and for itself; auto= self, telos=goal) task done in a dedicated manner: focus. A certain type and level of focus can produce an altered state of consciousness and specific neural responses. It is no wonder that the creator of the term and first conceptualization of flow, Mihaly Csikszentmihalyi (1975) studied several sports activities for his pioneering work.

Flow research as it has been outlined by its pioneers is part of Positive Psychology's agenda (Nakamura & Csikszentmihalyi 2002). Positive Psychology is a domain of psychology founded and named by Martin Seligman. It refers to the scientific study of the "good life", or "eudaimonia": the positive human experiences that result in happiness and welfare, or a meaningful life. That is where my claims about not only flow but self-regulated behavior's positive role for vulnerable individuals come from. They come from an approach dedicated to the study and provision of guidelines to obtain all the things that the suicidal victim has lost: a meaningful life, hope, and happiness.

Nakamura and Csikszentmihalyi (2002) start their chapter asking what constitutes a good life and they answer:

> *Viewed through the experiential lens of flow, a good life is one that is characterized by complete absorption in what one does. (Nakamura & Csikszentmihalyi 2002, p. 108)*

If intrinsic motivation or involvement in autotelic activity explains several aspects of a good life, it makes sense that one of the most important symptoms of depression is the loss of interest in everything and the inability to be interested and obtain pleasure from anything.

The conditions for the flow experience include:

> • *Perceived challenges, or opportunities for action, that stretch (neither overmatching nor underutilizing) existing skills; a sense that one is engaging challenges at a level appropriate to one's capacities*
>
> • *Clear proximal goals and immediate feedback about the progress that is being made (Nakamura & Csikszentmihalyi 2002, p. 109)*

Given these conditions, individuals may enter a state with the following characteristics:

> • *Intense and focused concentration on what one is doing in the present moment*
>
> • *Merging of action and awareness*
>
> • *Loss of reflective self-consciousness (i.e., loss of awareness of oneself as a social actor)*
>
> • *A sense that one can control one's actions; that is, a sense that one can in principle deal with the situation because one knows how to respond to whatever happens next*
>
> • *Distortion of temporal experience (typically, a sense that time has passed faster than normal)*
>
> • *Experience of the activity as intrinsically rewarding, such that often the end goal is just an excuse for the process (Nakamura & Csikszentmihalyi 2002, p. 109).*

The flow state is sensitive to any change in the balance of the conditions it requires or the dynamic system constituted by the person and the environment. The concept of *emergent motivation*, as one that emerges as a response to *proximal goals* produced by the interactional dynamic system, is important. Given enough time to experience flow, emergent long-term goals can take shape (Nakamura & Csikszentmihalyi 2002, p. 110).

While the vulnerable individual is engaging in the task of reassembling their shattered self, of establishing a relationship with society in which they may start to build a meaningful life, lifting provides the goal and feedback structures that may elicit the flow experience.

From each autotelic lifting experience, however imperfect it may be, the individual comes out with a more structured self. The self becomes organized around goals (Locke 2002) and this is what lifting is providing: goals tailored to the skills, attention, and energy.

Flow is also determined by how much attention can be devoted to the task. The vulnerable person usually has little control over the wave of negative intruding thoughts that demand and monopolize their attention. However, it is not possible to share the attention on not falling during a squat with anything else. And then comes another squat, and then another.

Little by little, squats reclaim back the individual's attention control.

With more attention control, the more chances the person has of experiencing flow. The more experienced they get, the more the person will engage in the activity. From each experience, they emerge with an increased ability to enjoy goal-oriented activities and to focus on goals. Since the flow state is intrinsically rewarding, it stimulates the individual to replicate them and to expand that state to other fields of life.

The appreciation for goal-setting and goal-oriented action is an acquired attitude. Squat by squat, the individual re-acquires the ability to live a meaningful life.

Studies suggest that the ability to experience flow is nearly universal. It may not be easy and the frequency in which individuals experience flow varies significantly. It is easier for those with an *autotelic personality*, defined by a general attitude of life enjoyment and tendency to engage in things for their own sake (Nakamura & Csikszentmihalyi 2002, p. 112). That is the exact opposite of our vulnerable individual. However, if they are at the gym with the intention of lifting something, the hardest and most taxing task was performed successfully: to be there to do something for the fun of it.

Flow theory has informed psychotherapy for over two decades in the most diverse cultural settings, with positive results (Nakamura & Csikszentmihalyi 2002, p. 112).

On a cautionary note, the concept of flow is immersed in scientific uncertainty: there are no causal explanations for the state. There is still a limited understanding of what factors are associated with flow and how they influence the state (Swann 2016, Swann et al 2018, Weber et al 2016).

The type and number of brain network phenomena taking place during the flow state, or during the transition between flow states and other states is unknown. They may be relevant to explain the results observed (Huskey 2016, Huskey et al 2018).

I suggest that the simplicity of movement, the subjectively perceived levels of complexity (the more proficient the lifter, the more technical complexity they perceive), the nested goals based on the most simple of all (moving from point A to B and back to A), and the simple feedback inherent to lifting may increase the chances of a vulnerable individual with a shattered self to reclaim their ability to control attention, to enjoy setting goals and to engage in a goal-oriented autotelic activity. Flow and psychoanalytic theories support the hypothesis. There is a small set of published studies showing that strength training can have "mindfulness" effects (Vernon 2018) and others suggesting that it can alleviate PTSD symptoms (Whitworth et al 2019).

In other words, it makes sense and many of us can tell stories that fit my narrative but we will only know for sure after this hypothesis is systematically tested with adequate interdisciplinary scientific methodology. Since the exact nature of flow is uncertain, this will probably not happen soon.

2. Mind-body integration / anti-fragmentation force

Sadly, mind-body integration has become a catch expression for new age scammers. That is unfortunate considering that the state of fragmentation of a suicidal shattered self includes perceptive and cognitive distortions that affect the individual's self-representation. That involves the perception and representation of their own bodies. That is one extreme aspect of body alienation, as if the body was external to the self, "someone else's body".

Restoration of balance in self-perception and self-representation involves reclaiming that body as their own. The body should become something that "I am" and not something that "I have" (and may have lost).

Lifting is particularly suited for this endeavor since the motor tasks involved require heightened levels of self-perception. As one learns, automates and improves their lifting skills, proprioception, and kinesthetic awareness increase. Proprioception is the biological phenomenon of being aware of one's body position and movement. This information is generated by mechanosensory neurons called proprioceptors (Tuthill & Azim 2018). Kinesthetic awareness involves proprioception and refers to the individual's awareness and control of their body in the environment, relative to that environment (Ramstrand et al 2019).

The idea that emotions are reflected in unconscious or involuntary motor patterns is not new (Shatan 1963). The more immersed in psychic pain, the less the mind responds to feedback

information from the rest of the body. The mind can develop stunted or inadequate responses and it may feel like the body belongs to someone or something else.

Lifting is a safe and efficient way of providing the mind with simple and discreet proprioceptive information and generates kinesthetic awareness. Many other forms of physical activity or body practice can promote the same result, and maybe, for some people, they will be preferable to lifting. However, for an individual depleted of energy, mental organization, and executive functions, the task of skillfully moving a steel rod from point A to B and then back to A may be an optimal way to stimulate all aspects of conscious motor task execution.

Collective sports certainly promote higher levels of kinesthetic awareness since the player must integrate a great deal of information from the environment with proprioceptive information. If the suicidal individual is trained in collective sports and if they are willing to engage in it, it will promote “mind-body integration” too. However, for many individuals consumed by mental suffering to the point of having a shattered self, simple tasks that can be pleasurably executed with more and more skill may be what does the job.

3. Excellent promotion of inter-organ cross-talk and recovery of physiological homeostasis and well-being

Until a few years back our understanding of the endocrine “organ cross-talk” was limited to three “axes”: the hypothalamic-pituitary-gonadal axis (HPG axis, involving the hypothalamus, the pituitary gland, and the gonadal glands), the hypothalamic-pituitary-adrenal axis (HPA axis or HTPA axis, involving the hypothalamus, the pituitary gland, and the adrenal) and the hypothalamic-pituitary-thyroid axis (HPT axis, involving the hypothalamus, the pituitary gland, and the thyroid). They are still important (Hoermann et al 2015, Duntas 2016, "Hypothalamic-Pituitary-Gonadal Axis" 2020, Klein 2003, Smith & Vale 2006, Plotsky et al 1998). However, our current understanding of endocrine, paracrine, and autocrine regulation is incredibly more complex.

Endocrine regulation involves hormones produced in endocrine glands that act at tissues remote from the glands; paracrine regulation involves many peptides released by nonendocrine cells that act on nearby cells, and autocrine regulation involves substances that act on the cells producing them (Welle 1999).

The new players in endocrine, paracrine, and autocrine regulation involve the exercising muscle, the adipose tissue, the gut, the gut microbiota, and other combinations. The resulting image is of a network of interconnected organs and functions involving the whole body.

Of all the new axes, the one that matters the most for us here is the skeletal muscle-brain axis (or skeletal muscle-brain-liver-adipose tissue axis) which provided a new understanding about exercise-induced adaptation. The first revolutionary idea was that not only the adipose tissue but also the muscle manifest endocrine activity. (Delezie & Handschin 2018).

The contracting muscle secretes myokines, protein hormones which can exert autocrine, paracrine, and long-distance endocrine effects (Severinsen et al 2020). The muscle tissue is an important node in the body network cross-talk. However, it must contract to play its beneficial moderating function. The inactive muscle behaves differently (Delezie & Handschin 2018, Pedersen 2019).

All these advances have brought us to a much more integrated understanding of organic functions. The several brain networks have shown to be all connected in what is known as connectome ("Human Connectome Project" 2020, Sporns et al 2005). The set of secreted proteins and peptides into the extracellular space or retained intra-cellularly is now known as secretome and includes cytokines, myokines, growth factors, insulin and so many other signaling molecules (Uhlén 2019). Biological networks are networks of networks: genetic, metabolic, signaling, and neural networks are interconnected.

It all starts by promoting regular contraction of the large muscles of the body in an integrated manner. Nothing accomplishes this role better than power and strength compound movements. Lifting is one of the activities that promote just that.

4. Simple, uncomplicated and problem-oriented social interaction

A vulnerable or at-risk individual's social interaction carries damaging patterns for years. They are either socially isolated and disconnected, exhausted and withdrawn from oppressive relations, or severely hurt and traumatized by social relations from their past. This individual tends to update the damage in any subsequent damaging social interaction to the point that they can't handle it anymore. The mental organization of social interaction is too draining and confusing. Although it is important for their safety that they maintain and increase the number of meaningful and more profound social interactions, it is also important to have an opportunity

to explore them with the least pressure. The simple exchange they might engage at the beginning of their lifting journey, concerning what bars to use, who's the best person to give some input on their bench press or their clean, and an offer to spot them while squatting can be quite enough for the week. They can explore being appreciated and useful by helping someone with a hand-off or joining a group that needs loaders. The problems to be solved are simple, codified and so are the tools to participate. They don't involve all the things that got distorted during years of living under mental suffering.

This may be their first positive tour out of complete social isolation or perverse social interactions.

5. **A concrete way to exercise regulatory behavior in an otherwise chaotic life, slowly recovering self-sufficiency and autonomy. Moreover, hope, the one factor most highly associated with suicide prevention, can only be cultivated in a goal-oriented life.**

Humans can display different types of behaviors. Some behaviors are automatic, requiring little conscious control. Others are self-regulated by executive functions. Executive functions are a set of neurologically orchestrated cognitive processes through which the individual may exert control over their own behavior. Self-regulated behavior is critical to achieving a goal. It is also important in avoiding potentially harmful situations. Self-regulation includes selecting, monitoring, and facilitating some behaviors while inhibiting others. Repressing an impulse, for example, is an inhibitory control over behavior (Coolidge and Wynn 2001).

The automatic or prepotent response is pre-codified and is triggered by a stimulus (Diamond 2013, Hofmann et al 2009, Plutchik 2001). The executive system overrides the prepotent response. The prepotent response may be an impulse or a conditioned response.

Unsurprisingly, both integrated neural functioning and endocrine function are compromised in suicidal individuals. Impaired executive function is a characteristic of suicidal individuals and the suicidal act (Bredemeier & Miller 2015, McGirr et al 2010).

The suicidal individual – whether at risk and/or having survived an attempt – has either given up trying to set goals, an increasingly harder and meaningless task for them, or they are barely recovering this ability. Also, despite ambivalence, suicide happens, and more often than not, it is the result of impulsive behavior.

All the tasks ahead of a suicidal individual are inter-related: they must recover hope and hope is intimately related to goals. Hope can be cultivated in goal-oriented lifestyles. Self-sufficiency and autonomy depend on goal-oriented behavior.

Even though the neurological propensity for several behaviors, including self-regulated ones, is genetically determined, it is also developed like a skill.

Lifting involves, at the same time, very simple and codified tasks with standardized objects, and extremely complex skill improvement. From a simple act of pressing a bar to the acquisition of skills and improvement of the snatch movement, lifting covers the whole spectrum of simplicity to complexity in goal-oriented, self-regulated behavior (Stone et al 2013).

Self-regulated behavior is present from the moment a novice touches the bar with the intention of learning or executing a simple barbell movement to the training program of an Olympic Weightlifting Olympian.

Being able to decide, plan, and execute a lift is a big step on a long road of autonomy construction or recovery.

All the five factors described here can make lifting an optimal strategy for preventing suicide or recovering suicidal people. The indirect evidence I used here suggests so. A few published studies suggest that strength training has positive emotional, cognitive, and behavioral benefits for both healthy subjects and those suffering from depression or another diagnosed disorder (O'Connor et al 2010, Gordon et al 2017). As much as my arguments concerning lifting here may sound compelling, they are hypothetical, based on by-proxy or anecdotal evidence. It is important to emphasize that they have not been tested with actual suicidal individuals in a lifting environment.

Conditions to make lifting a suicide prevention or recovery strategy:

1. **A relaxed, tolerant, and unintimidating environment.**

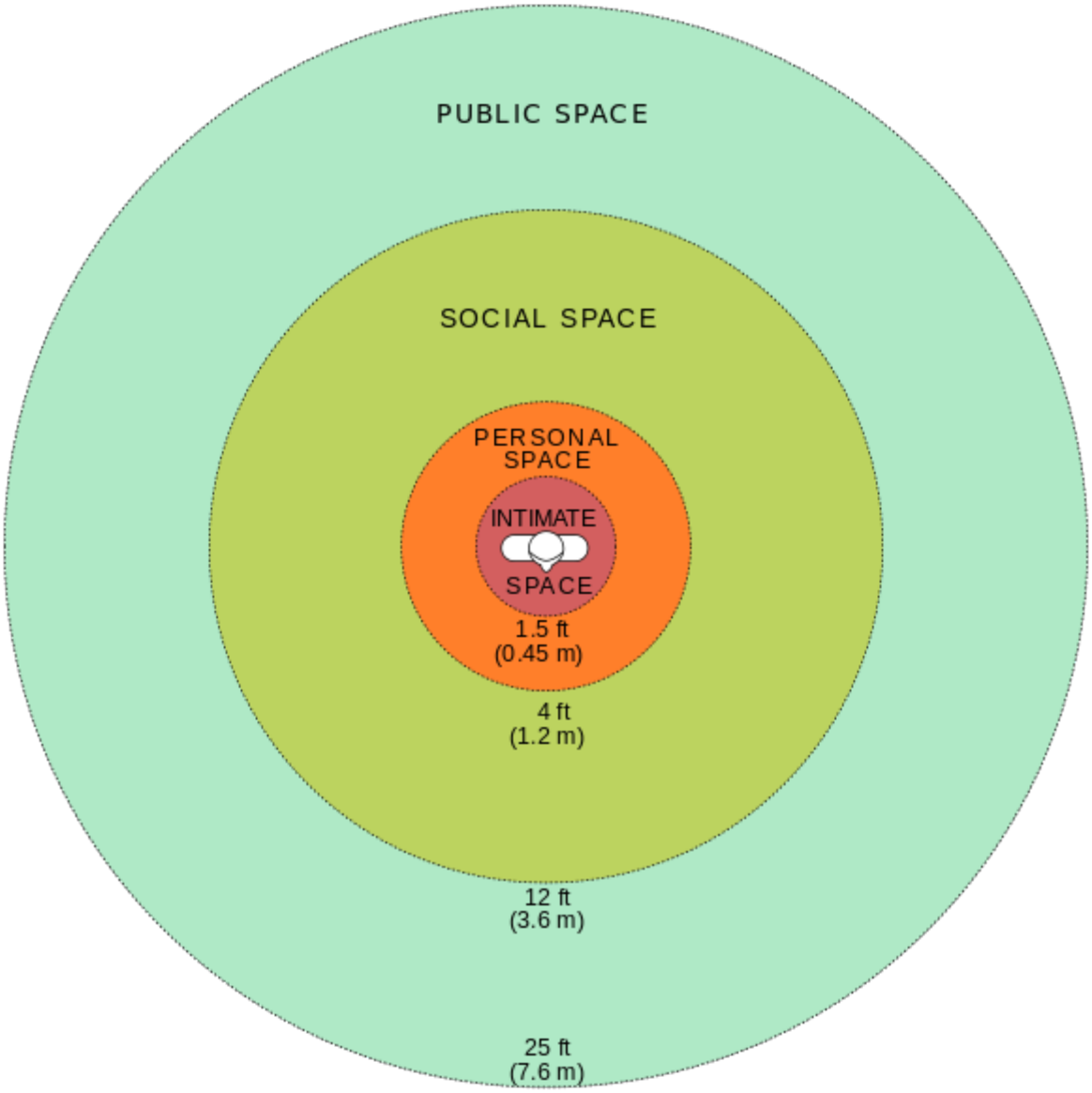
That is not as hard to achieve as it may seem and it doesn't require "counter-intimidation". Even among adolescents, where counter-intimidation and repression measures are necessary, the

greatest predictor of bullying behavior is the perception of approval by the most influential individuals (Steinfeldt et al 2012). Many of the most influential leaders in the strength sports are the right people to do that. Caring and mature gym owners can provide a safe environment for vulnerable people. They will probably be able to come up with their own strategies to help these people. How much the vulnerable person will be willing to share is unpredictable, not to mention hypothetical. A suicide-risk person or someone surviving a suicide attempt can be invited to share their "special needs". They probably don't know what these needs are nor do they see themselves as deserving any care. The work at the gym begins by making it possible for the person to accept that they deserve care and respect. The rest is a long, often endless path towards self-integration.

2. A training environment that protects the personal and intimate space.

A person at risk of suicide or recovering from a suicidal period has shattered boundaries (Maltsberger 2008). Without boundaries, none of the nurturing items above can take place. Space is both tangible and intangible, both cultural and physical. Around the person, there are concentric spheres from the most internal (the intimate space) to the most external (the social space). The respective distances vary according to context, including culture. This is a representation based on Hall's (1966) model:

Figure 26. Diagram representation of personal space limits



Source: Diagram representation of personal space limits, according to Edward T. Hall's interpersonal distances of man, showing radius in feet and meters. Inspired by Reaction-bubble.png by Libb Thims ("File: Personal Space" 2020)

The vulnerable person has problems with one or more spheres of space. The multi-layered, non-verbal form of interaction that shapes relationships with spaces and people (Hall 1966, Holmes and Spence 2004) has been disruptive for the vulnerable person.

The chance that this person has experienced violent interactions resulting in an invasion of their intimate space is higher than that of the general population, or the other people at the gym. Trauma survivors frequently develop an alarm reaction to being too close to strangers (or even acquaintances) and a dislike of being touched.

There might be issues with the built environment which is the separation from a more protected to the least protected environment: the public space (Reynald & Elffers 2009).

The ideal situation is a somewhat protected area, like a rack, for example, that forms an imaginary and symbolic temporary home. Given the dynamic of most gyms, it is not difficult to accommodate a vulnerable person's need for a protected intimate and personal space with the exception, possibly, of peak hours. Peak time at a gym is not the best time for the vulnerable person to be there. It can take a while to rebuild a system of possible interactions with others.

3. **The protected personal and intimate space must allow the survivor to explore the deep focusing lifting motor/body practices that are conducive to the silent periods of relief and reorganization.**

Experiencing flow states, as discussed above, is a highly desirable outcome of lifting for the vulnerable person. When or whether at all this person will be able to experience it doesn't depend on the external conditions alone or even chiefly. However, external conditions can impair or promote the flow experience. The requirements for a flow-conducive environment are simple: a protected area, if possible the same one at every training session, the negotiated physical distance from others, and silence.

4. **Silence.**

Whatever sound the survivor needs must be chosen by them and must not be disturbed by the outside environment. Providing this "sensory bubble" is not rocket science: a power cage and no loud ambient music provide just that. Suicide survivors are usually quiet people that don't demand anything although they should be supervised.

The controversial training sounds that some gyms prohibit are not the problem here. The constant bang sound of someone deadlifting at the gym or the clanging noise of everything else can be an issue for someone not familiar with them. Experience shows that, from toddlers to training-naive older people, once they are told what to expect, display no fear or annoyance. Someone talking loudly is much more of a stress trigger than a lifting grunt.

Silence refers to two things: the first is the absence of unwanted loud ambient music. Unwanted loud music is a physiological stressor (Fink 2019, Goodman 2012, Kurshumlia & Kurshumlia 2019, Wong 2018). The second is that trauma victims may have a strong reaction to it. The third

is that loud ambient music is a form of interpersonal violence, a non-declared intention to force others to submit by making them listen to the music chosen by whoever wants to exert power. That can have damaging effects on the vulnerable person. If it just dissuades them from ever coming back, it's one lost opportunity to help this person. If they lack even that much ability to react and reject what feels uncomfortable to them, it's worse: they may return to an environment where they are being violated and spiral down into their habitual self-destructive pattern that should be prevented.

5. **A balance between self-organization freedom and a gradual and gentle coaxing back into discipline.**

If the survivor achieves a few moments of peace by repeatedly doing sets of three drop snatches, it is best to leave them alone. A lifting-knowledgeable friend or coach should be aware of the possible detrimental effects of too much repetition of a single compound movement and carefully suggest introducing other items to their repertoire.

6. **A balance between welcoming the survivor with a caring and attentive approach and overwhelming them with excessive worries. Over-anxious family members or friends may not be the best choice for lifting partner to a survivor.**

The survivor or at-risk individual must perceive a caring attitude in others. Too much attention, especially anxious attention, however, may be counter-productive. It is impossible to know what each vulnerable individual needs in terms of attention and care. Showing that they are welcome and they belong in that environment is the first step to learning as they go.

7. **A balance between letting the survivor choose their way at the gym and integrating them in social activities.**

The at-risk individual arriving at a gym comes with a baggage and the gym is not the place for a psychotherapeutic reconstruction of this past. They may be averse to socializing (at first or always) or they may crave interaction. Whatever it is, they are on a journey to recover (or build from scratch) their autonomy and self-sufficiency. Integrating them is something that must be considered according to this. The friendly social group is not there to substitute the vulnerable individual's decisions but rather to engage them in decision-making.

8. **A positive perspective on strength, on the lifts, and on competition. That means not pulling the survivor into a power hierarchy.**

Examples are phrases that put abilities and anatomical features in perspective ("Bodybuilding Motivational Quotes For Weightlifting" 2019) such as:

"Biceps are like ornaments on a Christmas tree." - Ed Coan. It is a funny phrase and it also makes a point: for that athlete, biceps volume is not relevant. It is not a competitive advantage and the person doesn't really care about biceps aesthetics.

"Just remember, somewhere, a little Chinese girl is warming up with your max." - Jim Conroy. This phrase is useful in many ways and not only to the vulnerable person. First, it expresses, in the form of a joke, a fact that most people who study sports talent screening know: nothing beats China in terms of the volume of the talent pool. Therefore, there is a probability larger than zero that somewhere a little Chinese girl is warming up with your max. What does that mean? First, it means that no matter how good anybody is today, chances are that, in time, there will be someone better. It doesn't make any accomplishment better or worse. It just puts "accomplishment" and "success" in perspective. That perspective is favorable to suicide-prevention because it gently opens the argument to the importance of intrinsic motivation. We want our vulnerable person to enjoy their lifting experience regardless of Jeff's numbers or the qualifying total table. Why? First, because lifting should be fun by and for itself. Second, because somewhere, a little Chinese girl is warming up with your max.

"My old routine was McDonald's on the way to the gym, coffee during my workout, Burger King and Copenhagen post-workout." - Dave Tate. We can probably agree that this is not the best nutrition advice. Some folks can strongly react to it and present a long list of nutritional capital sins such as trans fats, the percentage of high glycemic index carbohydrates and they may not be wrong. However, if the priority is to produce a positive, tolerant, and relaxed environment, there's nothing like showing that the leaders in this activity are human. They like junk food, for example.

"Fortunately, there is a solution, and it's not performing multiple sets of whatever cable Kegel exercise is being pushed as "The Answer." Just a little hard, smart, basic work." - Jim Wendler. This is not only true but compassionate. There is a dialogical context in this phrase. Wendler is responding to something said, done, or a cultural habit in the training world. What he is saying without resorting to the authority argument is that there is no need for difficult and extremely strenuous work. Just a *little* hard, smart, basic work. Not a lot – a little. And a little is as much as our vulnerable person can do if they are engaged and enjoying their lifting.

The authors of these phrases are leaders in the strength sports. Whether the environment will be positive and protective to the vulnerable individual is highly dependent on the leaders' attitudes. A study conducted at the Georgian Weightlifting Federation in Tbilisi, Georgia, showed that: "although Olympic weightlifting remains stereotypically hypermasculine, coaches compliment female weightlifters' technique as superior to men's and train their athletes to integrate masculine "nature" and feminine "culture" in the expression of physical strength. In doing so, coaches do not instill fully formed subjectivities but manage embodied forms, using exclamatory cues to disaggregate the athlete into action, affect, and anatomy" (Sherouse 2016).

Can lifting be harmful to the suicidal person or conducive to suicide?

1. **Whereas participation in collegiate sports is associated with lower than average incidence of suicide, participation in strength sports is associated with a higher than average incidence. This is an associative evidence. We have no idea about causation.**

A Swedish study with a political/moral agenda and hypothesis concerning the causational relation between testosterone analog use as PED (performance-enhancing drug) and suicide produced an unsuspected result. Lindqvist and colleagues (2014) revealed a previously undetected association: among those active in wrestling, powerlifting, Olympic lifting, and the throwing events in track and field when the suspicion of AAS (androgenic anabolic steroids) use was high, between 1960-1979, in the cohorts between 20-50 years, there was an excess mortality of around 45% if compared with the general population. The overall mortality rate wasn't increased comparing these athletes and the general population. The data analysis suggested that a higher mortality in some cohorts and from some causes compensated for a lower mortality in others. Elite athletes live longer and this is not news (Lemez & Baker 2015, Garatachea et al 2014). These elite athletes had lower mortality rates for cardiovascular disease and cancer, as identified in other studies (Garatachea et al 2014, Lindqvist et al 2014). What the Swedish study revealed was that, among these athletes, the suicide rate was 2-4 times higher when comparing former athletes in the cohorts between ages 30-50 with the general population.

The authors' conclusion is fallacious: according to them, strength and power athletes between 1960-1979, when anti-doping testing was not enforced, would have died of suicide as a consequence of their AAS abuse, as opposed to athletes from other sports who, as a corollary to the authors' hypothesis, didn't abuse AAS. First, there is no evidence that strength and power sports have or had higher AAS use than any other sport (Baron et al 2007, Sullivan 2013). Informally, "it is known" that the power and strength sports are not the highest ranking when it comes to the use of testosterone analogs. It should be obvious that it is impossible to obtain a reliable estimate on AAS illegal use among any social group, whether Olympic athletes, non-Olympic athletes, or just random people. The more money and power are involved, the more sophisticated and widespread will be the means of obtaining a negative test result (Alquraini & Auchus 2018), including bribery (Maennig 2002, Dimant & Deutscher 2015). Second, despite an abundance of published peer-reviewed articles of varied methodological strictness (Thiblin et al 1999, Trenton & Currier 2005 as examples of very poor methodology), there is no evidence of an association between AAS use and suicide.

Despite no evidence in favor of the AAS-suicide link hypothesis, it seems to have been important enough to deserve other studies in Scandinavia, preceding Lindqvist group's. Pärssinen and colleagues investigated premature mortality among Finnish powerlifters suspected of having used AAS (2000). Finnish male powerlifters who competed at top levels during 1977–1982 were selected as the study group. The mortality during the 12-year follow-up was 12.9% among the powerlifter group versus a 3.1% mortality in the control group. Needless to say, quantitative analysis with these numbers and “samples” is not scientifically adequate. However, the fact that 3 out of the 8 powerlifter deaths were of suicide while at the control group, 4 out of 34 deaths were suicides is an observation of interest.

This is an example of interesting facts with a flawed hypothesis (good data and bad science): there is an increased suicide rate among power and strength athletes in Scandinavia according to these two controversial studies. The conclusion that “it is probably attributable to AAS abuse” is not only empirically flawed but also logically wrong. There are many more variables that could be associated with suicide and were not measured. Sports are tiny cultures and that’s where we have to look.

The suicide rate among "other sports" (those that are not power or strength sports) is significantly lower than the general population controlling by cohort and cultural environment. Sports participation appears to be a protective factor against suicide among collegiate athletes. Within this population, males have higher suicide rates than females and African-Americans

have a higher suicide rate than Caucasians. The highest suicide rates were among male football players (Rao et al 2015). Sports participation seems to be protective against suicide in most contexts and social groups (Rao & Hong 2016, Colin 2012).

There are other exceptions to the protective role of sports besides strength and power sports. Minority high school females seem to be more at risk if they participate in sports than other groups, controlling for age and sex. There is no explanation for the observed phenomenon but it is hypothesized that they are more frequently victims of bullying (Lester 2010, 2017).

Suicide rates among strength and power sports out of the collegiate environment were never studied again after the Scandinavian studies. We have no idea if the higher suicide rates observed among those countries' strength athletes is similar to other countries. What I know is that the suicides that I have encountered, like that of Egbert, which I described before, were not identified or entered in the public record as suicides. In his case, there was a careful agreement to call it an "accidental overdose" in public or in written communication. All the people who were close to him had witnessed the result of his previous suicide attempts including bleeding on a competitive platform from profound unhealed wrist cuts. There is no excuse for anybody to deny that suicide. Yet, that's what was done. His body was not autopsied and now he is another entry in the statistics of "accidental drug overdoses".

Whether the Scandinavian studies represent a universal trend or not will probably never be tested. These data, anecdotal information, and my own observation suggest there is a chance of negative, suicide-conducive conditions manifesting in the strength sports. They can be identified at the "strength gyms", in social media communication and post-competition comments.

2. **In a large number of strength gyms, intimidation, strictly hierarchical, aggressive inter-personal relations are tolerated. Bullying is not only tolerated but frequently stimulated. Bullying is strongly associated with a higher incidence of suicide among vulnerable populations.**

Bullying and intimidation are forms of inter-personal violence (Coutinho 2018).

Bullying includes all forms of non-lethal violence perpetrated over victims to establish and maintain a power structure (social hierarchy). In our complex society, there are several small sub-cultures where behavior is uncodified, unruled, and where bullying is practiced.

Legally, equal members are “peers”. High school classmates, gym members, or same rank co-workers, for example. Bullying is therefore also referred to as “peer abuse” (Bennet 2006).

Intimidation is any behavior that conveys to the intimidated party that they must comply. In the gym context, it means that there is an unspoken and unwritten code that establishes a hierarchy, a set of values, and accepted behaviors. This unspoken code is enforced through intimidation.

The association between bullying and suicide has been documented (Kim & Leventhal 2008, Hertz et al 2013). Most studies are concerned with the suicide risk associated with childhood and adolescent school bullying, whether immediate death risk or long-term deteriorating mental health ending in suicide. Bullying among adults is harder to study but workplace bullying is a reason for concern and a demand for more research (Lutgen 2018, Conway et al 2017).

One never knows how vulnerable to suicide a person is because vulnerability is a result of their life history, always opaque to strangers. Bullying is, then, stochastic suicide inducement: the bully doesn’t know when, where or who will commit suicide as a causal result of their actions but there is a certain probability that it will happen.

Bullying at gyms is part of what is known as the "gym culture". A closer look shows that there isn't "a" gym culture but rather several such cultures. The gym culture of a fitness/bodybuilding-oriented gym is different from that of some CrossFit boxes, which are different from our "strength gyms" (the "underground", "old school" strength training gym). Commercial gyms take measures to avoid bullying and the formation of actively dominant clicks by establishing contractual clauses against aggressive and intimidatory behavior. These rules can make

competitive strength training harder since competitive preparation requires a long time using a single rack or bench. Lifters training at commercial gyms cannot force their way to a rack or to their favorite barbell. In some commercial gyms, lifters manage to beat the rules (or settle an agreement with the owner) by training together and monopolizing equipment for longer than it would be acceptable. Sometimes there is no agreement. Tension builds up and eventually either the lifting crowd dominates, bullying other members out of the equipment they want (or just bullying them to enforce compliance) or they get kicked out of that gym.

Subtle acts of bullying may not be verbal but not less eloquent for that reason: eye-rolling, shaking one's head with a smirk after a contemptuous stare at the victim, strategically making the victim's way through the gym hard or physically blocking their access to some equipment. In actual strength gyms, there can be a hierarchy in the access to equipment. A low ranking or unwanted gym member may have difficult access to some of the racks or some of the bars. If they are not soon adopted by a higher-ranking member or behave subserviently for some time, they might never get accepted, their time at the weight room will be marked by anxiety, hyper-vigilance, and finally disgust. That's how intimidation serves two purposes: getting rid of those who won't abide by the non-written rules and clearly signaling to those who want to be accepted that it is a hierarchical structure and they are expected to behave accordingly.

At this point, we have no way of conducting a study about intimidation at strength gyms. Unlike commercial gyms, where we can always find disgruntled customers willing to speak, especially if given the benefit of anonymity, this does not happen at strength gyms. Individuals who left strength gyms in an atmosphere of either animosity or disaster will not speak out.

Whether or not a negative atmosphere will emerge and dominate a strength gym is hard to predict since it depends less on the strength athletes present than on leaders and followers that constitute the community. Studies conducted about the athletes show that negative personality traits may be prevalent, such as intolerance, authoritarianism, narcissism, bigotry, and homophobia (Darden 1972, Rubinstein 2003). That doesn’t mean that they set the unspoken code of conduct or value system. They are a part of it.

We have a few by-proxy sources of evidence: two documentaries, intimidatory expressions extracted from forums or reported by anonymous sources, resentful expressions about situations where the strength gym culture doesn't prevail, and "motivational quotes" taken from the internet.

There were few documentary movies about the strength training or strength gym environment ("Power Unlimited" (2007) and "Westside vs. the World" (2019) being the most realistic). Most of the content is highly positive, supporting a nostalgic narrative about the "good old days", true for most interviewed people. Both documentaries provide a glimpse or some indirect evidence about a darker side of the strength culture. In the movie "Westside vs. the World", one of the first members of the gym, who is portrayed as a social outcast, enjoys a period of belonging and acceptance in that tiny lifting universe. However, he cannot keep up his performance nor his dominance and dies of an overdose. The spectator is left with the suspicion that it may have been a suicide and with no doubt about the victim's self-destructive behavior. Some beatings described in interviews sound like hazing. There are stories about people making huge sacrifices to be accepted by the "inner sanctum". Some claim, decades later, that it was all worth it. Others don't share this view. Intolerant behavior coming from beloved members of a community can sound perfectly innocent and even entertaining.

The movies help us understand how bullying acts in the strength gym culture could be harmless, including for those who were bullied. Unlike a high school, where the victims cannot run away from their tormentors, a gym member can just leave. In these high-performance strength training gyms, most of those who did not agree with the unwritten and unspoken rules and hierarchy did not stay, which explains why the ones interviewed decades later remember those days as the best of their lives.

We have no idea how many people trained in less positive environments ended up with the deadly end of the intimidation rope. As I have discussed above, we will never know. We are left with the disturbing Scandinavian numbers and anecdotal accounts about negative bullying experiences.

Table 8. Intimidatory phrases taken from forums or contributions from people who will remain anonymous	
Phrase	**Meaning**
"If I see anyone at this rack after 5 PM a 45 will go flying over your head"	You must respect the ***hierarchy*** of authority/strength; You will be ***punished*** if you don't ***submit*** to them.
"No, you can't: this is for men only" (directed at a man)	Men are superior to women; You will only be ***accepted*** as a man when you reach an unwritten level of ***accomplishment***; Unless you reach that level, you are ***denied an identity.***
"Hey, [gym owner], can you get rid of the pussy posers? They are taking up space"	Individuals who do not "play by the book" of hierarchy, values, and accomplishment are ***not welcome***
"What is this supposed to be, a squat or a hiccup?"	You don't qualify for joining us
"I need this rack in 20 minutes. This is my squat day"	There is a hierarchy; I am above you and that gives me the ***right to take from you whatever I want*** at the gym; You must accept being ***abused***.
"The physical therapy guy" (loud enough so that the man lifting "light" weights according to the standards of the community can hear)	You are ***pathetic and ridiculous***, therefore, inadequate and not acceptable
"If he's under 200lbs he's not a man" or "if he's under 200lbs he should be competing in the women's division"	The unwritten code establishes morphological and aesthetic parameters. If you don't meet them, you are ***not acceptable***.
"Quit being a pussy"	"Pussy" is a derogatory slang term for the vagina and a metaphor for ***coward*** men; You must accept being ***abused***.
"Quit being a bitch"	"Bitch" is a derogatory slang term for a female dog and can mean a mean woman, an unreliable woman, a submissive male or a ***male who complains***; You must accept being ***abused***.
"Get your hips down unless you want to take it in the ass"	A graphic disapproving comment (homophobic expression) and command about the lifter's hip position during anything except the bench press; You must accept being ***abused***.
"Every time you lift you become less of the pussy that you are"	You are ***worthless*** (homophobic expression) but you ***can become one of us*** if you lift.
"Find the switch for your testicles and flip it to the on position"	You are ***worthless*** (homophobic expression) but if you ***manage to change***, you can become one of us
"Has a testicle ever come into contact with your family tree other than in the alley behind a gay bar?"	You are ***worthless*** (homophobic expression)
"If you were half the man your mother was this would not be a fucking problem"	You are ***worthless*** (homophobic expression)
"This is a gym, not a fucking dance class, lift like a god damn man"	You are ***worthless*** (misogynist expression)
"Hey, pencil neck! Move your ass so a real man can use that machine!"	You are ***worthless*** (misogynist expression)
"Shouldn't you be in the step class with the other ladies?"	You are ***worthless*** (misogynist expression)

The bold and italic marked words and expressions from the extracted messages above show that the "gym culture" and the "strength gym culture" specifically may be potentially dangerous for vulnerable individuals. These phrases were taken mostly from American gyms but also from other countries, which shows a certain universality about the "strength gym culture". Some were witnessed interactions sent to me in the condition of anonymity. The target of the verbal abuse

felt intimidated and complied at that moment. I don't know if they remained at the gym or left but I have no reason to think these interactions did not happen.

We could summarize all the messages in one statement: there are "us" and there are the worthless "others". If you are worthless you will take abuse. You will comply with our rules and change yourself to conform to our standards if you want to stay and be accepted.

Table 9. Examples of strength gym culture members complaining about how they are treated outside strength environments (expressions taken from internet strength forums)
"I just feel now a days any gym that is not a hardcore dungeon like gym you will be immediately ostracized for lifting heavy using bands and chalk."
"I would say find a more hardcore gym."
"To keep it short some butthurt pussy slackjawed phaggot complained to the front desk and we were told to keep it down."
"I really hate this mindset of people acting like they aren't preventing us from training but they want us to do it quietly. GRRRR! We train, we lift and we eat. When we walk through the doors of a gym we are coming not to socialize but to wage war on the weights. We come in to ROAR, because that's what BEASTS do. WE roar and we conquer the machines."
"They kept staring at me every time I squatted. Then the manager said I was making them uncomfortable. I asked why, he said I was staring at them. I was staring?"
"When going for maximal weights atmosphere makes a HUGE difference. At school we have our own power room with metal blasting, ammonia in the air and dudes hitting each other, it is fukin AWESOME!!! The commercial gym I go to in the summer plays soft music and is filled with pussy phaggots benching 135 for half reps."

Some famous motivational phrases (either attributed to celebrities or anonymous) express the same values. They are all factually (and sometimes logically) false.

Table 10. Motivational phrases from the internet		
	Why they are incorrect	**Why they are dangerous for vulnerable or average individuals**
"The last three or four reps is what makes the muscle grow. This area of pain divides a champion from someone who is not a champion."	The most updated research in sports science does not support this claim.	A vulnerable individual is exhausted to a level that other people cannot imagine. Providing them with a declaration of failure may push them down the self-destructive ladder.
"If you think lifting is dangerous, try being weak. Being weak is dangerous."	Facts show that danger is associated with intent and access to lethal means, not any subjective strength or weakness.	If dealing with individuals already harassed by the pressure of a success that they don't understand, haunted by the idea of weakness and failure, this idea can be felt from slightly to very upsetting.
"The successful warrior is the average man, with laser-like focus."	This is incorrect on all levels, starting from war history to neuropsychology.	Nobody should be fed the dangerous illusion (and lie) according to which they will become a "warrior" (or exceptional individual) if only they can master focus.
"You must expect great things of yourself before you can do them."	Expectations are not associated with success. Realistic expectations combined with several other parameters may be.	Most people and all vulnerable people struggle with false widespread assumptions about expectations, determination, and success. Since failure is a specifically critical issue for vulnerable people, false assumptions about it can be lethal.
"A champion is someone who gets up when they can't."	This is logically fallacious.	Vulnerable people frequently struggle with feelings of inadequacy and incompetence. They may also be on an escape stage in which flirting with death through high-risk behavior is increasingly more frequent. The idea underlying this motivational phrase may encourage a vulnerable person to ignore their limits,

		use pharmacological help to cross them, and crash.
“What hurts today makes you stronger tomorrow.”	False. This is a variation of the "no pain, no gain" motto where the pain was usually what is known as "delayed onset muscle soreness" (DOMS). DOMS is harmless but pain is not: pain is a signal and must be interpreted.	The path toward re-integration only makes sense to the victim. They need to enjoy the actions to enjoy the process. When they build a goal-oriented strategy for themselves, they will decide if something uncomfortable makes sense. Until then, generalizations work against the process.
“If something stands between you and your success, move it. Never be denied.”	Unrealistic and conducive to a sense of failure and defeat. It is also morally reproachable: everyone will be denied many things. Several of these denials are irreversible.	The idea may reinforce feelings of ineptitude and an obsession with their failure to achieve some externally defined success standard.
“Success is walking from failure to failure with no loss of enthusiasm.”	False: that is not how self-regulated behavior and executive functions work.	The vulnerable person may be escalating their response to failure to a holistic perception of complete inadequacy. A message about resilience in the face of multiple failures experienced or perceived as the only outcome leads to a moral judgment about the person who can no longer stand the pain of repeated (real or perceived) failure.
"Tough times don't last. Tough people do"	False. There is no support from reality that tough times don’t last (tough times have been known to last all the time available to several groups of living beings and even societies: some lasted too long and everybody died). There is no support in reality that tough people last. The history of warfare illustrates the opposite: the most physically capable people went to war and died young at higher rates than the physically less capable who didn’t go to war.	The two claims can have catastrophic effects. The suicidal state includes social isolation and feelings of aloneness and not being capable of communicating with others. They may perceive their whole life as a tough time, especially if it includes abuse. Telling them that hard times don’t last only makes them feel more separated and confused. Telling them that tough people last when they have lived with suicidal ideations for years is one extra push in the direction of self-destruction and escape.
"Don't wish it were easier. Wish you were better"	Unsubstantial, rhetorical. The comparative adjectives require a definition of skill/effort requirement of the task and of quality of skill or ability. They have no semantic content without it, playing, instead, a role in moral judgment: "if you are struggling at anything it means you aren't good enough".	The idea of not being good enough is frequently the center of the suicidal mindset. It should not be emphasized. It has to be deconstructed.
"You have to be at your strongest when you're feeling at your weakest"	This usually means that all the things that comprise excellence should be optimal for the person to have tools to handle extreme difficulty ("feeling your weakest"). This is neither true nor false. It is a rhetorical claim or passing of judgment.	One thing is to explore the idea that it's good to be well prepared for difficult times, although it's not always possible, and another one to color it with moral judgment. It's good to be well prepared. People who are well prepared are not stronger or better.
"Strength does not come from physical capacity. It comes from an indomitable will"	It is factually wrong.	Poetic license or not, insistence on an “indomitable will” is a reminder, to the victim, of their bent or broken will.
"Pain is temporary. Quitting lasts forever"	It is factually wrong in both instances.	This aphorism contains two different sources of harm: invalidation and cognitive dissonance. For someone experiencing a painful life for a long time, the assumption that "pain is temporary" is either mocking or invalidating them. The false statement that "quitting lasts forever" may enhance the victim's pain concerning failure (frequently related to quitting).

"Come in the gym like you're going to war"	In literal form, that advice is illegal. The metaphor is just socially dangerous and psychologically damaging.	The victim may have some trauma involving conflict. Mentioning war can have unsuspected results.
"There is no strength without struggle"	False.	That's the opposite of the idea one needs to convey to a victim about lifting: that it's like going to war, that it's a struggle and that it's painful. That is the life they need some silence from.
"Push yourself because no one else is going to do it"	False: all people are pushed by somebody or several people. Prescribing a hypertrophied super-ego ("push yourself") is dangerous advice.	The victim probably cannot handle more negative interactions and demands they fail to meet. They don't need pushing.
"The wolf on the hill is not as hungry as the wolf climbing the hill"	A metaphor about goal-oriented behavior, not necessarily true of all collective goal-oriented tasks.	There are several messages. The message concerning the "need to stay hungry", always intensely pursuing a goal, is inadequate for most people. Most people struggle with too many demands-turned-goals that compete for their efforts. In this process, the victim is not even close to the hill, let alone concerned with the efficiency of climbing or competing with others.
"You are the only one who can limit your greatness"	False.	Unrealistic and threatening claims can be damaging.
"The worst thing I can be is the same as everybody else"	Factually absurd and morally reproachable: all people are equally singular and there is no social sameness. Morally, it is a call to despise all "other" humans.	A victim can be experiencing a profound sense of isolation. They don't need more isolation.
"Strength is the product of struggle. You must do what others don't to achieve what others won't."	Factually incorrect.	Encourages an unhealthy attitude towards competition for the average and the vulnerable person.
"Hustle until you no longer have to introduce yourself"	Nonsensical. It claims that if you "hustle" you will become famous. The verb "to hustle", in American English, means obtaining something by forceful action, persuasion, or fraud.	Encouraging the average person to participate in unruled, possibly illegal actions is a bad idea. Encouraging vulnerable people to do so is even worse since competitive violence in an unruled universe can be lethal for them. That's where the worst in human interaction is manifested.
"No one cares about your problems. Work harder"	The first claim may be true. If it is, the advice is irresponsible.	The whole point about improving social and individual health is to strengthen networks where people care and help solve each other's problems. A vulnerable individual is borderline to exhausting their resources. They don't need to be told that nobody cares about their problems.
"You don't always get what you wish for. But you always get what you work for"	Factually false.	Both the average and the vulnerable individuals are used to working for something and not getting it. That is the rule rather than the exception. Lying about this can push them to conclude that they are, indeed, worthless and inadequate.
"The pain of discipline is nothing like the pain of disappointment"	"Selling" discipline as something painful is a marketing strategy. Discipline is not painful. Discipline as "disciplehood", being a disciple to learn something from a knowledgeable person, is supposed to be interesting and pleasurable. Discipline as a more rigidly ritualized behavior is frequently a source of relief as automatic behavior is much less exhausting than self-regulated behavior.	The insistence on pain to a whole population that handles mental (and sometimes also physical) pain all the time is not only counter-productive but dangerous.

"Discipline is just choosing between what you want now and what you want most"	That's closer to the concept of self-regulated behavior by which one can operate with the expectation of delayed reward.	Insisting that a person must have better self-regulated behavior is counterproductive and dangerous since it may highlight their shortcomings. Out of legal context, commands such as “you must do this”, “if you don’t do this you will suffer/be punished” just make people feel inadequate.
"Successful people are not gifted; they just work hard, then succeed on purpose" / "Self-belief and hard work will always earn you success" / "Success is what comes after your stop making excuses."	Again, the dangerous lie about the self-made man: any social and economic database demonstrates that the variables most strongly associated with success are not talent, intelligence, determination, or hard work. The strongest predictor of academic achievement is socioeconomic status; the strongest predictor of financial wellbeing is also wealth ("Georgetown University Center on Education and the Workforce" 2019, Abrams & Kong 2012)	One of the most dangerous lies both to the average and vulnerable individuals: most of the time, the causes of failure to achieve any level of success are not in the individual but rather on structural societal factors. Knowing this gives them a better (because realistic) chance of pursuing their goal and succeeding in it than believing the false narrative according to which it is all on them.
"I’m using your hate as my fuel"	This is neither true nor false, just an emotional statement meaning something on the line of “I acknowledge that you (adversary, sports fans) hate me and because you do, I will work even harder”. It doesn’t make sense.	Each person handles the realization that they are hated differently. It is never a positive contribution. To stimulate engaging that hate, especially in the form of rumination, is unhealthy.
Source: "20 Fitness Motivation Quotes" 2017, "Bodybuilding Motivational Quotes For Weightlifting” 2019		

The final consequence of a hierarchical and bullying environment is segregation and cult mentality. For our vulnerable individual, segregation, and, ultimately, exclusion, if taking place at the beginning of the gym experience, is still the safest option. Remaining in the group, playing the "carrot and the stick" game for acceptance in a cult-like social structure is by far the worst outcome in the interaction with the "strength gym".

3. **The cult environment: whereas in the beginning, the survivor with a shattered self may feel that the "us against the world" mentality, the entitlement, the inflated collective positive self-representation and the collectivism of a cult environment are comforting, on the long run they will deepen internal fractures, social difficulties, and in the end, hopelessness.**

This item is about the damaging effect of a cult environment. While the cult-like strength gyms exist, there is an increasing number of strength gyms founded on opposite assumptions, embracing tolerance and a role in the major society.

Cult is one term used for "sect". Sects or cults are self-segregated social groups within the major society. They are usually the result of frustration concerning the difficult access to power in the major society. Religious, political, ideological, or philosophical cults/sects are defined by their perception of complete separation from the major society. How this perception is achieved

among a large number of people is an object of controversy. Mind control, brainwashing, coercive persuasion are concepts that refer to an observed phenomenon: cult members who still have family and other relationships become withdrawn and unwilling to interact with them; their worldviews are tautological and increasingly discrepant with reality; if confronted, the confrontation is seen as proof of the cult's conspiration theories. There are several theories about how such profound transformations in a subject's belief system and behavior can be produced. They all involve extreme forms of manipulation. There is no doubt that they are negative for the subject but they do not necessarily involve overt violence. Well known writings about them include "Captive minds, captive hearts", by Tobias and Lalich (1994), and Hassan's "Freedom of Mind" (in Hassan 2018).

Some examples of leaders and their cults are Jim Jones (Jonestown Guyana), David Koresh (Branch Davidians), Stewart Traill (The Church of Bible Understanding), Charles Manson, Shoko Asahara (Aum Shinrikyo), Joseph Di Mambro (The Order of the Solar Temple a.k.a. Ordre du Temple Solaire), Marshall Heff Applewhit (Heaven's Gate) and Bhagwan Rajneesh (Rajneesh Movement).

According to Navarro (2012), who studied psychopathic cult leaders with the FBI, their beliefs are not different from any other sect, expressed as the leader's "ideas": everyone else outside the cult is "the enemy", "wrong" or "lost" and the cult worldview is illuminating. There is an irresistible allure to the cult, gang, or sect. Usually, it is the promise of an identity and a purposeful life. In the strength gym environment, the identity part is not hard. There are two problems: first, the allure of embracing a purposeful life is an illusion. There is no visible purpose outside the group's immediate existence. There is no grand, top-level goal projected in the future. Second, the new identity is strongly shifted towards collective approval and goals and leaves no space for inter-individual diversity. The vulnerable person is frequently "different".

Susceptibility to being recruited by a cult or gang has a high overlap with the characteristics of the suicidal state: a history of abuse, a shattered self, intolerable mental suffering, social isolation, lack of belongingness, and socioeconomic hardship (Curtis & Curtis 1993). This person is easily vulnerable to accepting a new culture and playing a submissive role in it.

The cult provides this new identity, this new way of thinking about themselves and others, including in-group identification and out-group rejection (Ward et al 2001). Demeaning others increases the group's self-esteem (Branscombe & Wann 1994). Inter-group threats and the correspondent out-group responses increase group cohesion and outward conflict (Riek et al 2006). In the case of strength gyms, the threats are usually amplified. The types of inter-group

threats identified in the literature include: realistic threat, symbolic threat, intergroup anxiety, negative stereotypes, group esteem threat, and distinctiveness threat.

The two important aspects of the strength gym culture are reacting to negative stereotypes, and to group esteem threats, and defending their distinctiveness marks. Strength gym culture members' video-taped and broadly divulged attempts at getting kicked out of commercial gyms are a clear manifestation of the group's need to reinforce their self-esteem while acknowledging (and mocking) their negative stereotype ("Planet Fitness Throws Out a Powerlifter" 2016, Bonvechio 2013).

Certain strength gyms, which can also self-identify as underground gyms, dungeon gyms, warehouse gyms, or old school gyms may constitute actual cult headquarters. Members are usually proud that their gym has no non-cultists ("pussies", "the mediocre", "normal people", “normies”, "weak", "soft") and they may be proud of the intimidation tactics used to make outsiders feel unwelcome and leave.

Very few of them are strength/lifting clubs, a place where a couple of friends get together to lift with the equipment they crowdfunded to purchase and legally closed to non-members. Most strength gyms are small business opened to the public (but not really). They are not "strength sports training centers": they are a gym or health club in the fitness industry.

It's a tense relationship. Strength gym talk (including the omnipresence of "motivational" memes, phrases and even people) is a permanent attempt to reinforce the belief that they are not an "ordinary gym", that they have nothing to do with the fitness industry, that they don't share the same values, aesthetics, equipment or environment maintenance. Several such gyms used to take pride in being unclean, in not having heating and air conditioning, and ignoring any regulation concerning indoor sound loudness.

Their message is that they may look like a gym but they are far from what an outsider to the “world of strength” would expect from a gym.

Group cohesion is based on certain core beliefs:

- We are qualitatively different from “other people”, we are physically and overall stronger than they are, we are mentally tougher, grittier and more resilient
- Unlike “the others”, we are capable of completing a routine regardless of how we feel
- Others can’t understand our values. Our values are morally superior to the “others”’ values.

- Others can't understand us and all communication attempts are futile
- We are brave while the "others" are cowards
- We don't think others look good and they don't think we look good: we can only appreciate each other

Below is a list of phrases collected from five different newsletters subject lines along the past 5 months. They were shuffled and classified according to six content items.

Table 11. Verbatim sentences obtained from strength sports newsletters and social media

	We against the world / they are out to get us / we are better than them / we are special	**Misogyny**	**You can become one of "us"**	**Weak X Strong**	**War metaphors**	**Violence/ domination/ success**
The Makings Of A Good Wife						
Stone Lifting: As A Ritual Initiation For Modern Men.						
Strongman Rules 1-5: "How To Be A Strong Man In A World Full Of Weaklings."						
Lose Yourself To Find Yourself						
Training like a Gladiator						
The Price of Hesitation						
Get TOUGH & Fight Back						
they're all LIARS!						
Weak Men vs Picking Up Dog S--t?						
When You Need to Get Tougher, Do This (NO Barbell)						
We TRAIN on Holidays vx Those Who TALK About it						
Why Men Need to Be Around Men						
What TOUGH People REALLY Do?						
Warlord Aesthetics						
Training to get TOUGH vs Pretty Boy Bodybuilding						
Man UP Monday						
RANT - WEAK People Hate STRONG People						
It's Getting DANGEROUS Out There						
We are NOT Common Folk						

The STRONGEST Men Always Trained Like This						
How to achieve THE Warrior Mindset						
Desperation is WEAK						
You Need To Read This: Fatigue is a LIAR						
When Monsters Trained in Dungeon Gyms						
Always be Ready to Burn it ALL Down						
Fight Club Physique						
Weakness is a Crime + 2 Exercises to become a BEAST						
Us vs the Pink Dumbbell Society						
NO Time for These WEAK 'At Home' Workouts						
Man is Supposed to be STRONG						
Stop Asking for Permission to be a Man						
Authenticity and Masculinity						
The Line between Bad Boy Rebel and Bitch Boy Loser						
The Rise of Trainwreck Women						
Some People Do NOT have the GUTS						
It takes ARMS to Be a MAN OF ACTION (but Don't open if you're a b*tch)						
The Tao of Bro-The Right Mindset						
How To Destroy Your WEAK Excuses						
Holiday Training Tips To DOMINATE						
How to be a Leader & Achieve More Success						
Strength and Self-Respect						
You vs Them						
Why Some People are Weak and Some are STRONG						
Attack Your Training & Your Life						
Monday Motivation - Rage Against Being 'Normal'						
Training to be						

Dangerous + 20 Rep Squats						
Are you too soft to achieve your goals?						
When are you gonna become the man you're meant to be?						
Get TOUGH or Get Destroyed - Life Ain't Easy!						
How to Fight the War on Mediocrity						
If You're Not Tough, You are F--ED :(						
The 'Seek & Destroy Workout`						
How to Get Built Like a SPARTAN						
Drunk Single Moms						
On the Nature of Good and Evil						
Redflags and Femnazi Firestorms						
Dungeon Gyms, Garage Gyms & Old School Strength						
Finding Your Authentic Self						
The War on Men						
Be A Man: Leave Your Mother's Home						
Show No Weakness, Men.						
We Are The Generation Of Lost Boys						
I Love Pain						
How To Find Out If You Are A Balanced Male						
No Trophies For The Weak (Only Sour Grapes)						
Lifestyles Of Strong & Wealthy						
Everyone's Afraid Of Imaginary Bullsh*T						
Why "Nice Guys" Always Finish Last						
Behind Your Anger Is Your Power						
Do NOT Join the Celebration of WEAK Men						
Conspiracy: Is the Govt Trying to Make us Weak?						
The SOFT American (No Matter Where You Live)						

Finding your design						

Table 12. Social Media statements from some strength training leaders
"...scared sheeple just doing what they are told, pathetic..."
“And this continued until one day, the husband walked into his bathroom and came face to face with a naked man. See, this is the kind of stuff that happens to men who don't work on themselves”
“What Strong Men do In the Face of Tough Decisions. As men, we carry the responsibility of tough decision making.”
“(My wife) appreciates when I make decisions. She likes to follow my lead.”
“#1 Rule For Real. Strong. Men. The sun was beating down on that hot, 97 degree day. (…) That, or there's just an excess of effeminate men out there. To be a successful entrepreneur, you have to be a successful man. #1 thing that constitutes a real man is his ability to get sh*t done whether he feels like it or not”
“There’s nothing but straight facts in this here tweet, ladies. I’ll eat my food and the food your skinny-fat boyfriend couldn’t finish.”
“Let's do what the racist blm tells us! We're self hating cucks! Because I've never seen a safe black neighborhood or city and they kill each other by the dozens every week but let's support that behavior!”
“Black square is pretty beta, dude”

More than intimidation and bullying, which, depending on the survivor’s recovery stage, may just drive them away, the cultist atmosphere is conducive to suicide. Cults are the opposite of social integration.

4. The distortion of identity construction and the dangerous pursuit of a purposeful life.

Why would an individual end up in such an environment? Some can innocently end up there: a friend invited, there were beer and girls and they kept returning. That's not unlike the way religious or ideological cults grow. A friend invites someone to play basketball. Once there, the kid realizes that it's a community center and there is a powerful adult who is emulated by all youngsters. He has some funny ideas. If the kid has a healthy family environment, is engaged and committed in their academic life, and has a functional social network, he probably won't return. The kids that keep going back are the ones that don't have a protective social environment and may be deep into social isolation and meaninglessness.

12

HOW FAR DOWN THE RABBIT HOLE DO YOU WANT TO GO?

Whether you are a scholar, a community reference, a social movement leader, or a family member, there is a lot at stake concerning how far down the rabbit hole of suicide understanding and prevention you are willing to go. There is no easy choice. There is a reason why major players in our societies invested so much in silencing the "mad". Siding with them and confronting everything else is a tough choice.

If I achieved any goal with this book you are probably feeling frustrated with the extent of our ignorance about suicide and our impotence in relieving mental suffering, demonstrated again and again by the prevalence of suicide. That's part of my goal: to advance in the understanding of a problem and advance solutions to it, it is necessary to confront ignorance and ineffectiveness. You may also feel uncomfortable about the uncertainties involving suicide prevention and management of at-risk situations. Not only uncertainties but complex ethical questions.

The deeper we go into this rabbit hole, the more uncomfortable it gets. Discomfort comes from the nature of the subject itself, from impotence but also because most of the time we reach uncertainty or controversy, and from there, multifurcations. Which path is the most productive one? Decision quality depends on many factors in a fine balance. Having several options or alternative approaches can be a positive factor in decision-making. However, there is an optimal number of alternatives after which decision-quality decreases because processing power is insufficient. Unfortunately, suicide studies and practice usually present us with a higher-than-

optimal number of alternatives. That requires more tools to evaluate the alternatives from the decision-maker standpoint. Some alternatives are easy to dismiss but most of them are not: no matter how inadequate they are, they may offer relevant contributions. Optimal decision-making is also associated with optimal information quantity and quality. That is where the concept and agenda of evidence-based practice (medicine, nutrition, social work, among many others) come from. Too little information is a bad scenario that requires the decision-maker to resort to by-proxy data. The smaller the quantity and the lesser the quality of the information, the harder it is to find adequate by-proxy data. The core data about suicide rates in the strength sports and gyms is frustratingly limited. To make it worse, there is no hope to obtain more data in the foreseeable future. This whole book involved an effort to find as much by-proxy data as possible, and to throw the widest-reaching net to collect different and complementary conceptual approaches. Hopefully, this will improve analysis and decision-making.

Interdisciplinarity is critical for the understanding and prevention of suicide. Dealing with insular disciplinary cultures in this context is unnerving. Integrating the social sciences, psychology, psychiatry, neurology, epidemiology, public health, public policy, and other disciplines is no longer an option: it is an obligation since there is no progress on the matter without it. Yet, there are still fields, mainstream psychiatry being the paradigmatic example, that are almost impermeable to negotiating interdisciplinary work and knowledge production.

If the cross-talk between scientific disciplines is full of obstacles, the cross-talk with consumers/users/survivors, the only groups that can provide the essential lived experience knowledge, is practically non-existent. It doesn't help that this is the one road for co-production of knowledge that remains disqualified by the sciences, involved institutions, other stakeholders, and society at large. In short, nobody wants mad people participating in this discussion with any decision power.

This is one of the most uncomfortable academic rabbit-holes I have crawled into.

Once into this rabbit hole, one cannot avoid political decisions. Can we agree about the rights of the deviant and atypical populations as well as the rights of those in extreme mental suffering? Some rights, such as proper care for self-harm patients, so that they feel comfortable enough to share what is happening with no fear of punishment, are hardly controversial in intellectual terms. However, secularism and theocracy are not mutually exclusive in practice: several legal restrictions on health care coverage to self-inflicted injury victims are originally religious. There is some gaslighting with the pre-condition issue (the insurance company won't cover self-inflicted injuries because they are a psychiatric pre-condition). That is also fallacious: it's an

injury, whether it's caused by a vertigo-caused domestic accident, incompetent use of a knife, or slashing one's wrists. The problem with slashing one's wrists it that there's an unspoken and unwritten agreement that it's immoral and "wrong".

But how do we deal with other demanded rights, such as euthanasia? After years of activism, some countries and some states in the US approved euthanasia with hard requirements for application. Still, perfectly rational individuals with no hope concerning their psychic and physical pain will be institutionalized if caught in the act of attempting suicide.

We have no answer to that. No matter how deep we dig into the literature, it will come down to an ethical decision that each one of us needs to make as a professional.

Suicides are rational decisions more frequently than they are officially registered as. It is also true that no matter how rational the person is, they will be in an altered neurological state during the suicidal process. I defend the legalization of euthanasia and simplification of procedures so that anyone who needs assistance to die can obtain it. But who is “anyone”?

In epistemology, after rejecting an approach through systematic critique, it is always wise to check where the paths that leave that crossroad lead us. Epistemological recklessness is destructive because the problem is not to go deep but to go deep in the wrong hole and not find your way back (Collins 1992, Dascal 1991).

Consistent scholars will usually adopt positions that are throughout coherent. The defense of autonomy and self-determination is a principle to several movements and schools of thought. I don’t recommend a blanket application of this principle, however, because I am not confident about how much of an individual’s decision was made *by* them or *for* them. An individual trapped in an oppressive situation in your society (whoever you are), within anybody’s reach and ability to confront the oppressors, deserves suicide prevention. When suicide prevention is a signal to the hopeless and helpless individual that there is proactive willingness to interfere with the external cause of their mental suffering, I believe it is legitimate and it should be done. It is showing hope to the hopeless and offering help to the helpless.

Training people in communities to be gatekeepers, people who will watch for signs of distress, hopelessness, and helplessness, is important. A significant part of egotistical suicides happens because the victim has become disconnected. They become part of the invisible crowd and their death will be just another entry on public health data. Maybe not even as suicide. This is a fact. Our reaction is our choice: these suicides are happening to people who became invisible. Nobody talks to them and nobody pays attention to them. The gatekeeper can pay attention to

those that are becoming invisible. Adopting a systematic program to reach out to the invisible people is a political decision and we are all part of it.

In the list of people whose suicides I described in chapter 2, I would volunteer to babysit the Chemistry graduate student during the Christmas Holiday until we could set therapy for him, for example. The department could have been mobilized and a cascade of resources made available. Who knows? We could have been looking at a future Nobel Laureate or the father of three little kids sailing their life over the Ocean. Nobody had the babysitting choice because there was no surveillance in place. The faculty member who lost her faith could have been helped. Arriving in Latin America at that time, in Academia, was tough. There were all sorts of obstacles to productive research and teaching – from laboratory supply import to library quality. Landing in a mediocre department that selected the pettiest and most frustrated scholars during decades of complicity is a disaster waiting to happen. These colleagues were passive-aggressive bullies. Someone could have seen that. I could. A gatekeeper could. She just needed to be geared back to the path of hope, a hope she had already elaborated and committed to.

Would my cousin have found a way to live with the “psychache” caused by his severe form of what seems to have been bipolar disorder? Would the intervention of secular gatekeepers have helped then, when there was nothing except lithium to offer to these patients? I don’t know. Could my classmate have used a little more empathy from us and a proactive intervention from a university gatekeeper? I don’t know that either but it would have given him a chance of a better choice. And what is a better choice? Given my principles, it is a more autonomous and conscious choice. Several schizophrenic patients lead reasonably happy lives with supportive families and communities.

There is no prevention to those people living with extreme pain or disability who need some assistance to leave life with dignity. The other side of suicide prevention is legalized and quality euthanasia.

My greatest pains on that list are Aaron Swartz and Egbert. The first one is Aaron. Aaron had to be a martyr to turn an important wheel of the civil rights movement. I don't see any way in which anyone could have fought the forces that drove him to that decision. The federal government, acting on behalf of corporate publishers, had not only destroyed Aaron's life but was moving forward to destroy his mission and his family. It is painful to realize how pathetically small we are in face of the destructive social forces capable of creating a suicidal trap.

The second pain is Egbert. If I was the gatekeeper, when and where would I intervene? I don't know. I had direct contact with that boy and had no idea of what kind of mental suffering he was going through. When I still coached him, I showed him how to improve his lifts. That was easy because he was a natural talent. After I left the gym and he opened up to me about medication issues, an obvious sign that things were beyond bad, I didn't know what he needed to hear. A gatekeeper needs to have a specific type of contact with the victim. While avoiding pressure and judgment, the gatekeeper must have synchronous interaction (on ground or video-conferencing) to detect the level of urgency or the nature of the distress.

There certainly was something there that I missed and that's when we fall into the "what if" spiral. Egbert is a case in which I can see many opportunities for prevention. A local gatekeeper could have figured how to help young Egbert out of his early life traumas; a school gatekeeper could interpret his negative social interactions and helped him out of them; a community worker could work with that boy to build a hopeful mindset and accept help where he needed.

We failed Egbert as a society by not identifying red flags way back into his childhood.

The questions we all eventually ask ourselves, whether we are scholars, teachers, family members, or coaches are: how deep am I willing to go? Into which holes? What position should I take concerning extreme forms of mental suffering where no treatment seems to help? Should I refrain from interfering in the decision to die made by a friend who genuinely tried all possible approaches to their "psychache" with no success? There are only bad alternatives: lifelong mental hospital confinement or more aggressive therapeutic approaches. Our ethics can tell us not to interfere. Our emotions may try to take over. What about emotionally close people? An elderly parent dealing with excruciating chronic pain? What if they ask for our help to die with dignity? Suppose their arthritic hands can't do it. Do we understand death well enough to know what to do?

These are exercises that each professional involved in suicide (prevention or research) or person willing to be a gatekeeper has to engage with more than once.

Are we, as scholars, willing to point out the epistemological flaws in mainstream psychiatry that led to tautological clinical statements and unsupported policies? Are we willing to confront medicine, force them into interdisciplinarity and, even harder, to force them into accepting to produce knowledge as equals with their patients? The skeptical question being: can we or will we ever be able to do it, considering their century-old carved space in society as a medical

specialty and, most of all, the enormous multinational pharmacological investment on "treating the mad"?

Are we, as citizens of a Civilized world, willing to name and demand change at each oppressive or abandonment situation we see as “suicides in the making”? Because that is what they are, that is why suicide is one of the major causes of death but is hardly handled as something important. Suicidal people are seen as people who don’t matter so much.

How much are we willing to invest to provide visibility and humanity to the invisible people who slip through the cracks of our networks? How much help are we willing to provide to the helpless and hope to the hopeless? How much are we willing to be defeated more than to be successful?

There is a lot of soul searching to do as we stare into the rabbit hole or into the abyss.

13

FALSE BELIEFS (LAY THEORIES) ABOUT SUICIDE AND THE RIGHT ANSWER

Shneidman's fables and facts (Leenaars 2010):

FABLE: People who talk about suicide don't commit suicide.

FACT: Of any ten persons who kill themselves, eight have given definite warnings of their suicidal intentions.

FABLE: Suicide happens without warning.

FACT: Studies reveal that the suicidal person gives many clues and warning regarding his suicidal intentions.

FABLE: Suicidal people are fully intent on dying.

FACT: Most suicidal people are undecided about living or dying, and they "gamble with death," leaving it to others to save them. Almost no one commits suicide without letting others know how he is feeling.

FABLE: Once a person is suicidal, he is suicidal forever.

FACT: Individuals who wish to kill themselves are "suicidal" only for a limited period of time.

FABLE: Improvement following a suicidal crisis means that the suicidal risk is over.

FACT: Most suicides occur within about three months following the beginning of "improvement," when the individual has the energy to put his morbid thoughts and feelings into effect.

FABLE: Suicide strikes much more often among the rich – or, conversely, it occurs almost exclusively among the poor.

FACT: Suicide is neither the rich man's disease nor the poor man's curse. Suicide is very "democratic" and is represented proportionately among all levels of society.

FABLE: Suicide is inherited or "runs in the family."

FACT: Suicide does not run in families. It is an individual pattern.

FABLE: All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.

FACT: Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, he is not necessarily mentally ill.

14

TAKEAWAYS

I hope the main takeaway you get from this journey across different scientific disciplines and traditions is that if we strip ourselves from the thousands of years of fear, turned hatred, turned intolerance against those who hurt themselves, we may get closer to empathizing with them. And if we go a little deeper and appreciate the weight of the social environment on that person's suffering, on the role of social pathology – a disease of society – on suicide, we may understand that it could happen to any of us. Given the right circumstances and the right push, anyone can die of suicide. That's a terrifying thought but it is required to make us take action. Suicide is preventable but can only be prevented if we understand that we are part of the equation. Ignoring the problem is action. Bullying or condoning bullying is a huge action. Standing up against bullying and against intolerance is also action. We can choose to go on being part of the problem or we can choose to be part of the solution.

1. Suicide is a consequence of many possible things and mental illness is just one of them. All of them can be minimized.
2. Strength training is conducive to mental well-being
3. Cultist environments and bullying are highly associated with suicide and mental suffering in general
4. Environments that accept and encourage bullying are actively promoting mental suffering and perhaps suicide
5. Be responsible, whether you are a gym owner, a coach, an athlete, a gym member, or the elusive "influencer": you can either be the problem or the solution. There is nothing in between.
6. Above all, educate yourself about the nature of suicide. If you recognize individual or social red flags, act: either contact someone or, if you are prepared, intervene.

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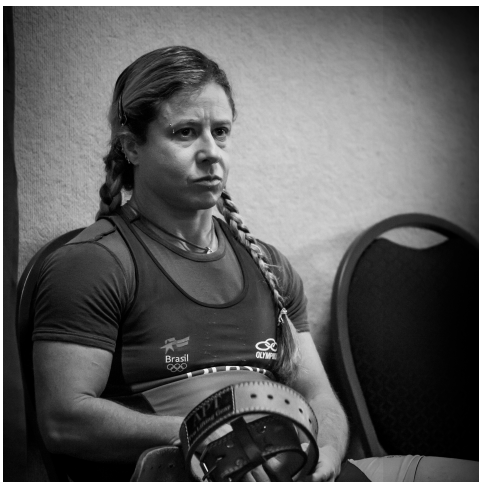
About the author



Marilia Coutinho is an independent scholar with a multi-disciplinary background: she earned her Ph.D. in sociology of science after an M.S. in chemical ecology and a B.Ss. in biology. Her alma mater is the University of São Paulo. Her past research and publication range from molecular parasitology to designing institutional technology transfer agencies. She has conducted research and taught at the University of São Paulo, University of Florida, Virginia Polytechnic Institute and State University, University of Brasilia and today she is affiliated with the Ronin Institute for Independent Scholarship. She has been a PAHO/WHO fellow and was the principal investigator in projects that took her to four different continents. She was also a fellow, principal investigator and, today, an activist in defense of the major Brazilian science and technology agencies. Marilia has always been an athlete and in the past decade she won several world titles in powerlifting. This experience was instrumental for her research and writing on exercise science and sports psycho-sociology. She currently lives in the US.