An Anthropology of Suicidology

Abstract

The academic and professional discipline of suicidology, with its roots in sociology, psychology and psychiatry, represents the 'collective wisdom' of our understanding of suicidality and suicide prevention. But an examination of the broader cultural contexts of the discipline shows that some significant voices are being marginalised or excluded from its discourse. This anthropological look at suicidology reveals that it is predominantly the power and influence of psychiatry that is responsible for the shallow, narrow and inward-looking culture in suicidology today. In particular it is psychiatry's obsolete commitment to an objective biomedical model of suicidality that denies the legitimacy of these other voices. Of particular concern is the stark absence from the discipline of the first-person voice of the lived experience of suicidality.

Introduction

The initial motivation for my PhD was the question: "Why is my experience of suicidality absent from suicidology?" When I first looked at the literature of the academic discipline of suicidology, which defines itself as the science of self-destructive behaviour, I could not find my story anywhere in this 'collective wisdom' on suicide and suicidality (i.e. suicidal thoughts, feelings and behaviour). Was my story peculiarly unique to me? I didn't think so then and still don't.

The 'method' of my research is not to attempt any generalisation from a sample size of one, especially when that one is myself. Rather, my thesis examines the formal knowledge of suicidology in the light of one individual's lived experience of suicidality. That is, the 'data' of my research is the formal knowledge of the discipline, and the first-person story becomes the analytical tool – a prism, if you like, through which this data is examined. This exercise reveals significant gaps in suicidology, which then suggests how and why the discipline is unable to describe or explain my lived experience of – and recovery from – persistent suicidality.

One of these significant gaps is simply the dearth of first-person accounts of suicidality in the literature and discourse of suicidology. This absence of any substantive *phenomenology of suicidality* is the critical flaw behind the two other major gaps revealed by my research. First, perhaps the most fundamental concept of the discipline is that of the self

– the 'sui' in suicide, both victim and perpetrator of any suicidal act – but it is rarely discussed in the literature. Second, and not unrelated, the spiritual dimension of suicidality, so central to my own recovery, is virtually absent from suicidology.

This paper looks at how and why these three aspects of suicidality – the lived experience of suicidality, concepts of the self, and spirituality – are so neglected by the discipline. To do this, it looks at the discipline of suicidology as a community with a culture. Like any culture, it has its participants, institutions and processes. It has historical and cultural contexts, values and beliefs, and forums and modes of discourse. There are power structures with rules and influences that regulate and determine what is allowed – and not allowed – into this discourse. To understand why my story is absent from our collective wisdom on suicide requires an anthropology of suicidology.

The Discipline of Suicidology

The origins of suicidology can be traced to Emile Durkheim's social analysis of suicides in Europe in the late 19th century. In *Le Suicide* (Durkheim 1952 [1897]), he proposed a taxonomy of four basic types of suicide based on social relationships. Although these categories are still discussed, Durkheim's most enduring legacy is the ubiquitous epidemiological studies that dominate the literature of suicidology today. It was not until the late 1950s that a psychologist, Edwin S. Shneidman, coined the term 'suicidology' and went on to become the first president of the American Association of Suicidology (AAS). Shneidman attributes suicide to psychological pain – which he calls *psychache* – arising from frustrated or thwarted psychological needs (Shneidman 1996, 2002).

Along with sociology and psychology, psychiatry is the third, and today the most influential, of suicidology's 'parent disciplines'. This is not the psychoanalytic psychiatry of Freud with his concept of a death instinct or *thanatos* (Freud 1963 [1917]) or Menninger's notion of *Selbstmord*, or self-murder (Menninger 1966 [1938]). And it is certainly not the Jungian psychiatry of James Hillman, one of the few authors to consider the yearning, spiritual soul in his *Suicide and the Soul* (Hillman 1973). Psychiatry today is dominated by the biomedical model of 'mental illness'. The two pillars of this psychiatry are the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV 1994) and *biological psychiatry* for the treatment of these disorders, which usually means psychopharmacology or drug therapies.

While acknowledging these origins and three parent disciplines, suicidology is its own academic and professional discipline, defined in the *Comprehensive Textbook of Suicidology* as "the *science* of self-destructive behaviors" (Maris et al 2000 p 62). One of the aims of this science is the search for risk factors for suicide – e.g. gender, age, marital or employment status etc. These are the ubiquitous epidemiological studies, mentioned earlier, which dominate the literature of the discipline. The two major journals of suicidology are *Suicide and Life-Threatening Behavior (SLTB)*, published by the AAS, and *Crisis*, published by the International Association for Suicide Prevention (IASP), based in Europe. A brief survey of recent years shows that roughly two-thirds of the refereed articles in *SLTB* and more than half those in *Crisis* are epidemiological studies. These studies are important for targeting suicide prevention programs to 'at risk' populations, but they have yielded only weak predictors of suicide in individuals because of the many demographic variables and low baseline percentages. Despite this extensive search for risk factors, we find that "one of the strongest predictors of suicide is making a previous suicide attempt" (Beautrais 2004 p 1).

It is at this individual, personal level that psychiatry exerts its influence on suicidology. There is a widespread myth based on the biomedical model of the DSM and biological psychiatry, though challenged by people like Professor Shneidman, that the mental illness of depression is the major cause of suicide. Professor Robert Goldney, an Adelaide psychiatrist and internationally prominent suicidologist, uses a "real estate analogy" to assert that the key to suicide prevention is "depression, depression, depression" (Goldney 2003 p 87). Shneidman and others challenge Goldney's assumptions as relying on the pseudo-science of the DSM, which Shneidman criticises as having "too much specious accuracy built on a false epistemology" (Shneidman 2001 p 5). It is evident from his own words in his *Crisis* article that Goldney makes the serious error of confusing correlation with causation. The symptoms of 'depression' (defined in the DSM *solely* in terms of symptoms) are symptoms that are also frequently seen in the suicidal. But to regard depression as a *cause* of suicide is to assume uncritically the "false epistemology" of the DSM and tantamount to claiming that the flu is caused by a runny nose. Unfortunately, this is the predominant view in suicidology today.

The second pillar of modern psychiatry, biological psychiatry, also relies on the pseudo-science of the DSM but goes a step further and locates the supposed illness in the biology of the brain. This is the 'chemical imbalance of the brain' school of psychiatry and the basis of the psychopharmacological therapies – i.e. drugs – that have become the first line of treatment for 'depression' and other psychiatric disorders. One prominent suicidologist,

Ronald W. Maris, is endorsing this approach when he jokes – or is he only half-joking? – that we could perhaps "put Prozac (or the SSRI of your choice) in every major city's water supply. You know, like fluoride." (Maris 2003 p 5). There is a growing controversy around these medications because of the risk that they can actually trigger suicidality. The Food and Drug Administration (FDA) in the US has recently required a 'black-box warning' on the labelling of SSRI anti-depressants and the UK has banned them for children. Despite this, these drugs remain the recommended treatment for depression, which is erroneously claimed as the primary cause of suicidality.

The Wider Suicide Prevention Community

There is a wider community with an interest in suicide than just the formal academic discipline of suicidology. Whether these other participants are considered part of suicidology or as the context in which suicidology is practised is perhaps a moot point. To appreciate this cultural context of suicidology, we can use the following description of a discipline by the historian/anthropologist Greg Dening:

> *In fact the disciplines are sets of individuals, socially related, differentiated in status and power. They offer their own systems of social control which sanction some forms of behaviour and reward others. They develop norms and value systems. They have mythologies which legitimate their structures and belief systems. They have rituals which re-enforce them. They have socialising and induction processes which not only impose acceptable measures of conformity, but like all such effective socialising processes objectify and internalise the limits of behaviour so that to the socialised they appear good, just and rational. The disciplines are established in a social environment. ... Finally, like all social entities, their present life is conditioned by their past. The past offers them a paradigm within which acceptable forms of evidence, acceptable questions, acceptable criteria of judgments, acceptable languages of communications and acceptable modes of transmission from one generation to another, have a cultural and social form*. (Dening 1973 p 674)

We could use this description to explore the social and cultural relations between the three parent disciplines of suicidology and see that, despite its roots in sociology and psychology, psychiatry clearly has the dominant influence in status and power in suicidology today. We would also see how the "mythologies" of psychiatry, namely the DSM and biological psychiatry, "impose acceptable measures of conformity" and determine "the

acceptable forms of evidence" etc. We could look at the editorial committees of the discipline's journals (as well as what they publish) and the keynote speakers invited to its conferences and see again that psychiatry dominates suicidology today. And we could see who exercises the most influence on governments and receives the rewards of subsidies and grants … and once again it is apparent that the medical model of psychiatry dominates.

But it is the wider suicide prevention community – the broader cultural context of suicidology – that I wish to explore in the light of Dening's description of a discipline. In the programs of suicidology conferences, keynote and invited speakers will typically be psychiatrists, with the occasional psychologist and, even more rarely, sociologists. Some of these may present the latest demographic data from the inevitable epidemiological studies, but these may also come from government public health bureaucrats or other population studies experts. You will probably also see keynote presentations from 'suicide survivors' or survivor organisations (see below for what these terms mean in suicidology). But it is in the 'back room' presentations at these conferences where you find representatives from the wider suicide prevention community.

Two communities that have some presence in suicidology are the *psychosocial* and substance abuse services. These are both important because they are often in the front-line of dealing with suicidal people. But both these services are less oriented to the biomedical model of psychiatry, focusing on disability or addiction rather than mental illness, and recovery and rehabilitation rather than medical treatments. Given that the 'comorbidity' of substance abuse with suicidality is frequently mentioned in the literature of suicidology, as is psychosocial disability, suicidology would benefit from a greater contribution from both these fields. Little of this occurs, however, primarily because of the exclusive influence of psychiatry and the biomedical model.

Another group with higher suicide rates are those suffering from complex trauma. Childhood sexual abuse is beginning to get some attention as trauma that often manifests later in life as suicidality. But it is not only childhood trauma that is evident in the suicide statistics. Soldiers returning from war are also disproportionately represented in suicide statistics, as are victims of crime and domestic violence. These people often get a psychiatric diagnosis of Borderline Personality Disorder. In her keynote address at a recent national conference of mental health consumers, Merinda Epstein showed how this psychiatric label represents one of the most stigmatised and neglected areas of mental health (Epstein 2004). There are some services that specialise in these areas but they have even less of a presence in

suicidology than the psychosocial and substance abuse services. Again, this is primarily due to the exclusion from suicidology of non-biomedical approaches to suicidality.

One community within suicidology that is well represented are those known as 'suicide survivors'. When I first encountered this term I thought it meant people like myself who had survived a suicide attempt. But it actually refers to the bereaved, those who have lost a loved one to suicide. This is an important community, not the least because such survivors are known to be at higher risk of suicide themselves, and attending to this unique form of grief is known within suicidology as 'postvention'. These survivors regularly feature among the keynote and invited speakers at suicidology conferences and there is often a major stream looking specifically at the issues of these survivors – indeed the annual AAS conference regularly has its own parallel survivors conference.

Other stakeholders in this wider suicide prevention culture include governments, who look to suicidology for guidance on suicide prevention policies and programs, and the media. The strong influence of psychiatry and medicine on governments is again evident in the massive public subsidies for medical treatments compared with relatively negligible support for psychosocial, substance abuse and trauma recovery programs. And the media, which has a vital role to play if suicide is to come out of the closet as a public health issue, is constrained by severe guidelines from suicidology on how to talk about suicide (see www.mindframe-media.info).

What's Missing?

When I first looked at the literature of suicidology I was struck by the stark absence of first-person accounts of the actual lived experience of suicidal thoughts and feelings. There are a few exceptions to this, most notably Edwin S. Shneidman who includes some (brief) first-person accounts in his work and asserts that:

> *the keys to understanding suicide are made of plain language; that the proper language of suicidology is lingua franca – the ordinary everyday words that are found in the verbatim reports of beleaguered suicidal minds* (Shneidman 1996 p viii)

The psychologist David Jobes calls this lived experience of suicidality "the phenomenology of suicide – studying different kinds of suicidal states, what they mean [i.e. to the person who experiences them] and how suicidality can differ among individuals" (Jobes 2003 p 2). But although Jobes is an Associate Editor of *SLTB*, remarkably little of the phenomenology of suicidality appears in the literature of suicidology.

When you do occasionally hear first-person accounts of suicidality at suicidology conferences, only rarely will they be from keynote or invited speakers. My own experience of these conferences is primarily the annual conference of Suicide Prevention Australia (SPA), which sees itself as the peak NGO in Australia on suicide prevention. These conferences have not been happy experiences for me. Little effort is made by the conference organisers (or governments) to encourage and support 'survivors' (such as myself) or other mental health 'consumers' (sic) to attend and participate in these conferences. We are tolerated, often patronisingly, sometimes suspiciously or fearfully, but rarely genuinely welcomed.

The 2004 SPA conference, for instance, made no public call for papers but had only invited speakers, none of whom were suicidality survivors or even mental health consumers. Nor were we represented in any of the conference streams or expert panels, or even recognised as stakeholders in the conference objectives. Until we protested, that is, and a workshop by mental health consumers was belatedly and hastily included in the program. At the conference itself, there was a stark contrast between the invited 'experts' and the back-room workshop participants, many of whom lived in and worked in communities identified as high-risk, such as indigenous peoples, middle-aged and rural men, and our own group of mental health consumers. With a conference theme of the future research agenda for suicidology, the experts spoke largely of the need for 'evidence based' research as defined by the narrow, medical criteria of what constitutes valid evidence. Participants in the workshops, in contrast, spoke of a more whole-of-person and whole-of-community approach to suicide prevention. It was also noticeable, and noted, that very few of the invited experts stayed to attend the final session of the conference when the feedback from the workshops was presented to the full conference.

Even more than the largely absent first-person voice, the most striking gap in the literature of suicidology for me, given my own recovery through spiritual enquiry, is the exclusion of spirituality. There is a recognised 'spirituality gap' in mental health. Many who struggle with mental health difficulties, including suicidality, speak of their struggles in spiritual terms, but our doctors and counsellors are professionally incapable of engaging in conversations about spiritual needs or values (Tacey 2003 p 199). In the last decade or so, we have seen spirituality emerging as a lively topic in the discourse on physical illness, especially around acute, chronic or life-threatening illnesses. A notable example of this discourse within sociology is the work of Catherine Garrett, who defines spirituality as "best

understood as that which gives ultimate meaning to people's lives" (Garrett 2002 p 61). Given that mental health crises, and in particular the crisis of suicidality, challenge our deepest sense of self and personal meaning, I find it curious that we see even less discussion of spirituality in mental health, and especially so in suicidology, than we do in physical health.

I should note that the 2003 conference of SPA had a theme of *Finding meaning to sustain life: The place of spirituality in suicide prevention*, which was a bold and welcome initiative by SPA. But again, this conference was a disappointment. The invited speakers were drawn entirely from those who spoke of spirituality from a religious perspective, with the important exception of a couple of Aboriginal speakers who spoke of indigenous spirituality. I have no criticism of any of these individual speakers, but the failure to recognise non-religious spirituality in the conference program made me feel invisible, yet again, at this conference. More than this, the failure to include non-religious spirituality represents a major stumble at the very first hurdle we face in any discourse on spirituality – that is, to distinguish between religion and spirituality. I should also note that SPA is perhaps more inclusive of the first-person voice, as well as spiritual ideas, than its international counterparts. If we look at the programs and proceedings of other suicidology conferences – such as those of the American Association of Suicidology (AAS) or the International Association of Suicide Prevention (IASP) – the absence of the first-person voice and spirituality is even more stark than at SPA conferences.

The third and last major gap in the discourse of suicidology is closely related to the previous two. There is very little discussion in suicidology on concepts of selfhood. The discipline seems content to assume the various – and varying – notions of selfhood from its three parent disciplines. This is despite the fact that, firstly, these varying perspectives have been of only limited usefulness for understanding suicidality, but secondly and more importantly, it is necessary for a sub-discipline to define its core concepts according to the contexts of the sub-discipline. Suicidology has not done this. A rare exception in the literature is David Bell who asked, "Who is killing what or whom?" (Bell 2001). Bell looks at this important question from a psychoanalytic perspective, but other interpretations are needed, including the various spiritual perspectives that I am calling for. Suicidology, however, chooses to remain largely silent on this line of enquiry.

Why These Gaps?

It is difficult to point to the absence of something in the literature of a discipline and perhaps it takes fresh eyes even to see that something is missing. As a survivor of my own suicidality, these gaps in suicidology jumped out at me when I first looked at the literature. My subsequent research has only reinforced this perception. Elsewhere I have proposed an Integral Suicidology, based on the Integral Model of American philosopher Ken Wilber (Wilber 2000a, 2000c), as a framework for bringing self, soul and spirit into suicidology (Webb 2003). But part of the argument to open suicidology's doors to the full depth and breadth of the suicidal crisis is to ask not only why these gaps exist in the first place but also, how they are sustained?

Following Dening's description of a discipline, the first part of the answer to these questions is given by suicidology itself. The major suicidology text quoted earlier that defined the discipline as "the *science* of self-destructive behaviors" (their italics) goes on to assert that "surely any science worth its salt ought to be true to its name and be as objective as it can, make careful measurements, count something". Furthermore, "*suicidology has to have some observables*, otherwise it runs the danger of lapsing into mysticism and alchemy" (Maris et al 2000 pp 62-3). It is this obsolete commitment to an outdated, positivist notion of science that renders suicidology blind to the invisible, unmeasurable interiors of the lived experience. This is particularly evident (with every pun intended) when we hear the arguments for 'evidence based' research and practice, as we did repeatedly from the experts at the 2005 SPA conference. The criteria for what constitutes valid evidence in these arguments are essentially those used for medical experimentation, with the randomised control trial (RCT) held up as the 'gold standard'. While RCTs are essential for testing new and potentially dangerous drugs, they are inappropriate and indeed mostly useless for researching holistic approaches to mental health, especially when the object (or is it the subject?) of enquiry is the personal meaning of the lived, human experience. Or the desperate absence of meaning, as is so often the case with suicidality.

On the question of spirituality, the same text gives a clear indication of its very deliberate exclusion by suicidology. The only mention of spirituality is found in the preface where the authors acknowledge "the immense intellectual and spiritual debt that we all owe to our mentors and friends" (Maris et al 2000 p xx). Here the authors acknowledge spiritual values and needs in the writing of a book, but find no other occasion to mention them in the

650 pages of their *Comprehensive Textbook of Suicidology*, which is still the primary reference for the discipline, at least in the US.

To fully explain these gaps, and particularly how they are sustained, we need to look further than just the ideological prejudices of positivist science. It is here that Dening's understanding of a discipline as a culture becomes so important, which is why I've chosen to look at suicidology conferences where suicidologists meet as a community and where many of the cultural practices and rituals that Dening alludes to are apparent. It is at these gatherings that we find the "sets of individuals, socially related, differentiated in status and power" and the "systems of social control which sanction some forms of behaviour and reward others". We find "mythologies which legitimate their structures and belief systems", most notably in suicidology today the mythologies and belief systems of modern psychiatry. The selection of keynote and invited speakers, together with the scheduling of the 'back-room' presentations and the control of questions from the floor, act as "socialising and induction processes which impose acceptable measures of conformity". But most of all, these gatherings, along with the editorial control of the literature of a discipline, determine the "acceptable forms of evidence, acceptable questions, acceptable criteria of judgments, acceptable languages of communications", all of which, as Dening points out, "have a cultural and social form".

These cultural and social forms are the gatekeepers to the discipline. And always with gatekeepers, we need to be mindful of who and what is being excluded as well as who and what is being allowed into a discourse. In the discipline of suicidology it is quite clear that amongst the excluded are the first-person voice of the lived experience of suicidality, any meaningful discussion of subjectivity and our sense of self, and the relevance of spiritual values and needs. Furthermore, it is the cultural and social forms of medicine, and in particular of modern psychiatry, with its narrow criteria of what constitutes valid evidence that is the weapon used to exclude these voices. The struggle to broaden the agenda of suicidology is, as Dening's definition suggests and theorists like Foucault make explicit, a cultural and political power struggle. If the discourse is restricted solely to evidence that can be 'proved' by randomised control trials, then these gatekeepers will never allow into the discipline other vital evidence that is invisible to these methods but which from my experience, and my research, is essential for a better understanding of suicidality.