

Thinking about suicide: Contemplating and comprehending the urge to die

LIZ SHEEAN INTERVIEWS DAVID WEBB

In 2006, DAVID WEBB completed the world's first Ph.D. on suicide by someone who has attempted it. Prior to this, David worked in the computer industry as a software developer and university lecturer. In his recent book, *Thinking about suicide: Contemplating and comprehending the urge to die*, he highlights how the suicidology literature has studiously ignored the voice of those who experience suicidal feelings. In fact, the whole field of research seems to never talk to those it claims as its subjects. Webb rejects the dominant medical model that claims suicide is caused by some notional mental illness. Instead, he proposes an understanding and a conversation (community enquiry) that



can allow rather than stifle the terrible feelings, and creates a space for these feelings to be experienced in a different way. How much do we know about the experience of despair that can lead to suicide? How can we understand and make any successful interventions if we cannot understand the first thing about this experience of despair? Not by medicalising it, but really trying to understand both how it feels and what it means. Webb has explored his own experience of being suicidal through phenomenology, and has found his own solution in a form of spirituality—the need no longer to struggle to live, but to accept and embrace life.

Thank you for an eloquent, sensible and important contribution to the literature on suicide. Your book is invaluable for anyone with an interest in the human condition, to say nothing of distressed human beings. You say that the 'fundamental flaw' at the core of contemporary thinking about suicide is the failure to understand suicidality as it is lived by those who experience it. Can you tell us more about this?

When I first started looking at the literature of suicidology, what struck me immediately was how absent the actual suicidal person was from this literature. There is very little of what I now call the 'first-person voice' of suicidal people who know suicidal feelings 'from the inside'. I remember

feeling that all these experts seemed to be looking at people like me through the wrong end of their telescope, so that we were almost invisible specks on the distant horizon. This is still largely the case, and I argue that you cannot hope to understand any human experience, not just suicidality, if you ignore what it means to those who live those experiences. And for this you need to hear directly from those who have the lived experience, there's no other way of getting this important information.

In mental health in general, the participation of consumers in research, policy development and service delivery is still largely tokenistic here in Australia, despite claims to

the contrary. I've just returned from the UK where they take the 'first-person voice' much more seriously than we do here. In suicidology and suicide prevention, however, the UK is probably almost as bad as we are here where the 'first-person voice' is virtually absent.

I maintain that any efforts to prevent suicide must begin with an understanding of what suicidal feelings mean to those who live them. And for this, we need to hear directly from suicidal people themselves. There's no other way. I found it extraordinary that the experts in the field regard this as unimportant, which is part of what prompted my Ph.D.

You describe suicidality as a 'crisis of the self'. This is in stark contrast to the current thinking that views suicidality largely in terms of mental illness. What makes the 'crisis of the self' view more useful?

Seeing suicide as a crisis of the self is a better starting point for understanding suicide than the prevailing mental illness approach for several reasons. First of all, the 'self' is the 'sui' in suicide, both the victim and the perpetrator of any suicidal act, which should make it a core concept for suicidology. Second, thinking of suicide as a crisis of the self is closer to the lived experience of suicidal feelings. And third, this perspective automatically raises important questions that currently are largely ignored by suicidology, in particular who or what is this 'self' that is in crisis?

Thinking of suicidal feelings as a crisis of the self is also a more useful starting point for any therapeutic help for the suicidal person. Our sense of self is much more than just the biology of our brains. Modern biological psychiatry, which unfortunately is still the dominant influence in mental health today, sees us as little more than biochemical robots. But our sense of self includes the psychological mind, the spiritual soul, and also our social and cultural contexts and histories. The self is an inherently holistic concept that cannot be reduced to just the biology of the brain. If you want to help the suicidal person then you need to attend to the whole person, which modern psychiatry is incapable of doing.

You speak of suicidal feelings as being worthy of respect. In fact, you invite suicidal people to honour and respect their suicidal feelings as real, legitimate and important. Isn't this dangerous? What do you mean by this?

I invite all people, not just suicidal people, to honour and respect suicidal feelings as real, legitimate and important for the simple reason that they are real, legitimate and important to those who live these feelings. Anything less is false and a denial of not only the person's feelings but of the person themselves, given that such feelings go to the very heart of our

sense of self. To contemplate ending your life is significant and worthy of respect, both by the person having those feelings and anyone around them. I would go further and say the

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suicidal crisis is a noble, indeed sacred, crisis that should be approached with gentle reverence by all who encounter it.

This has to be contrasted with the current knee-jerk reaction to suicidal people, which is fear and panic and also, far too often, lots of negative judgements. This in turn leads to either denying the person's suicidal feelings through one of the many common myths around suicide, such as 'it's just attention seeking behaviour'. Or if we are believed, then the most likely reaction will be to pathologise our feelings with a medical diagnosis, often with lots of shaming, and then try to stop, control or suppress them by whatever means possible. This is not only another denial of the person, but also includes the risk of being locked up and quite possibly drugged against our wishes, which suicidal people would prefer to avoid—just like everyone else. It's really no wonder then that we are very careful about to who we might disclose suicidal feelings.

Yes, suicidal feelings are dangerous, there's no escaping this. But I say that society's current response to suicide is more dangerous than what I'm proposing, which is really nothing more than some simple respect for the very significant feelings a suicidal person is having.

I do, however, urge my suicidal soul-mates not to act on these feelings—that is, to neither suppress nor indulge these feelings. There is a space between suppressing and indulging these feelings where you can meet them and engage with them meaningfully. If you're able to spend even a little time in this space, then it can also be a

space from which healing can begin, probably by first talking with someone about it. And anyone invited into this space should feel honoured and privileged, even though it can be scary.

But first we must acknowledge these feelings, which should be done with gentle respect for our pain rather than with society's poisonous, shaming and shameful taboos.

From the times that you were suicidal, tell us about your experiences of the efforts of those who tried to help you and give you advice? From these experiences, what advice would you give to helping professionals?

I sought help from quite a few people from a variety of the helping professions. Mostly it was not very helpful, and a few times it was distinctly harmful. The obviously harmful ones were the psychiatrists who deceived me into taking quite inappropriate and dangerous drugs. But the scariest one was a psychiatrist who did not try to drug me, but rather set out to break my spirit, as if I was some wild brumby, presumably in order to re-mould me into someone more to his liking. Fortunately, I escaped his influence after about ten sessions. One other really harmful experience was not with a psychiatrist, but a drug and alcohol counsellor at a residential rehab who said my talk of suicidal feelings was 'bullshit', and that I needed to focus on my real problem which was drug addiction. Like the psychiatrists who see only mental illness, and therefore the need for medical treatment, this fellow saw only addiction—the old line about 'if the only tool you have is a hammer then everything looks like a nail'.

The 'talking therapy' counsellors I saw were not so harmful, but neither were they particularly helpful. For

instance, one psychologist I saw for about a year was terrific in many ways, but in the end it all felt like a 'dance on the surface', which I later realised was because that was *exactly* what it was—a psychological dance with the mind that could not reach into the depths of my spirit where the real crisis was to be found and, ultimately, resolved.

One notable exception was a woman I saw intermittently throughout the four years I struggled with my suicidal urge. She claimed no particular expertise as a crisis counsellor (or a drug counsellor), but she was magnificent in that she allowed all of me—all my pain, all my madness, all my confusion—to be present in every session with her. She also never feigned false empathy when my thoughts or behaviour were baffling to her, which is another hazard often encountered. Instead, she had an extraordinary capacity to just 'be with' and 'bear witness' to my pain, without judgement, without false empathy and without trying to 'fix' me.

So my short list of do's and don'ts for the helping professions would be—don't bully, don't shame, don't deceive or coerce, don't feign false empathy, don't judge, and try to resist the urge to fix or cure your clients. More importantly, do respect the suicidal person and their feelings. Do be honest, including about your own fears when working with suicidal people (though please don't make your client become your therapist, which happens disturbingly often). Do allow the 'whole person' into your time with them. Do allow us to tell our stories uncensored by your professional prejudices. And, do cultivate the capacity to be with and bear witness to another's pain, even if you find it difficult or incomprehensible.

Although you are clearly reluctant to give advice, what advice would you give to people who are suicidal?

You're right. When someone approaches me directly to tell me of their suicidal feelings, which sometimes happens, the first thing I say is that I'm not a therapist or counsellor of any kind so if it's advice that they're looking for then I'm unable to help. So far the reaction to this has been "Thank God for that, I've had it up

to here with therapists", a sentiment that I understand very well.

This is not altogether the cop-out that it might sound like because I have already indicated what I regard as the most important advice of all—to respect and honour suicidal feelings. Except when talking directly with a suicidal person, I try to do this rather than just say it. If anyone discloses their suicidal feelings to me, I first of all thank them, maybe with a hug, and try to acknowledge the big step that is being taken just to share these feelings with another person. It's obvious, though needs to be said, that

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these occasions occur because I speak publicly about my own suicidal history, which makes people feel safer and more comfortable about approaching me. But it is still a courageous step to take, which I try to acknowledge.

I then say that I'm happy to hear a little of their story and, if they're interested, to share a little of my own. From there, we might have a conversation, which I do not call therapy or counselling and is not at all about me giving advice. Typically, people are just relieved and pleased to be able to talk a little about their suicidal feelings, knowing that they won't be judged or, indeed, advised on what they should do. Some advice might occasionally arise during these conversations when, for instance, we talk about some of the options that might be available for that particular person. But this is really the person themselves using the conversation to help them figure out their own best advice.

When it comes to the myths about suicide you distinguish between popular myths and professional myths. Can you tell us more about these and why you view the professional myths as the most dangerous?

There are many myths about suicide, most of which are due to fear, ignorance and prejudice. The popular myths are those that are common

in the general community, such as 'suicide attempts are attention seeking behaviour, or 'just' a cry for help'. These are unfortunate, and indeed dangerous, but also understandable, given the misinformation around suicide. But it is the myths we find among suicide prevention professionals that I regard as more dangerous.

The most dangerous professional myth is the one that underpins and undermines the entire discussion of suicide and suicide prevention, which is that suicide is caused by mental illness. If you look at the literature you will see that there is no evidence

at all to support this assertion, only medical assumptions and prejudices. It's another case of 'if the only tool you have is a hammer then everything looks like a nail'.

Let's be very clear on this. Suicide occurs when a person takes a deliberate, cognitive, psychological decision to kill themselves. It does not occur because of some biological malfunction of the brain. A suicide attempt can certainly have medical consequences, not only death but also serious injury, but it rarely, if ever, has a biological, medical cause.

The great danger of this myth is that if we blame suicide on some notional medical illness then we fail to look deeper for the real causes of why an individual chooses death rather than life. This medicalisation of suicide is blind to the psychological mind, the spiritual soul, and the social and cultural contexts behind a person's decision to die. It is the single biggest obstacle to progress in suicide prevention.

You say that we need a broad community conversation on suicide, to bring it out of the closet as a major public health issue. What form would this conversation take, and what would it achieve that is not being achieved already?

The critical change needed to make any progress with suicide prevention

is a change in community attitudes towards suicide. This requires a broad and ongoing community conversation. This conversation is required to break the toxic silence around suicide, and to move away from shaming suicidal feelings to respecting them. It is also important to expose the many myths, especially the medical myths, which sustain the fear, ignorance and prejudices around suicide. A 'whole of community' conversation is required because it is clear that this conversation cannot be left solely to the professional experts.

The leadership and energy for this conversation has to come from the community itself. It is essential that this conversation is not led and controlled by medical doctors, as is the case today. It is a conversation that needs to take place in the home and at work, at the coffee shop and the pub, as well as in seminars and conferences and also, importantly, in the media where the current media guidelines for reporting on suicide are another example of professional misinformation.

We need to be cautious though. We need to acknowledge that we are not very good at having this conversation currently because we are at the very beginning of it. We all have much to learn, and many conversations are required if we are to become more skilful at talking about such tricky and delicate issues. We must be gentle as we fumble forwards. But silence is no longer an option.

Out of this conversation will emerge what I believe is the real hope for suicide prevention, which is what we might call 'mentally healthy communities'—except I prefer to talk of psychosocial wellbeing rather than mental health and illness. I am sceptical about achieving significant reductions in the suicide toll through suicide prevention programs that focus solely on preventing already suicidal people from killing themselves, important though this is. The real hope for reducing the suicide toll is to prevent suicidal feelings arising in the first place—a community-wide promotion of psychosocial wellbeing, rather than the current 'ambulance at the bottom of the cliff'. Paradoxically, this community conversation must

begin with respect for suicidal feelings as real, legitimate and important.

A second story told in the book is of you struggling with, and beating, drug addiction. Your book is not only invaluable reading for people who are suicidal and those who aim to help them, but could also be invaluable for anyone who is battling an addiction... Recently, I was in a hospital emergency department with a thirty-year old woman who was desperate to gain admission to a detox unit because she was terrified that she might harm herself if she was discharged. The psych nurse told her he was 'not convinced' that she would harm herself. What would you say to that?

We hear stories like this all the time and they sicken me and make me weep. You virtually have to be standing in a pool of your own blood before our public mental health system will take you seriously. This is usually blamed on a lack of funding, which is

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true enough, but it's also the expensive misuse of the little funding that does exist. I would not want more funding for just more of what we currently have because our public mental health system is a very dangerous place for suicidal people. It really is a complete shambles.

On the drug addiction, I don't actually think of myself as 'beating' it, like in conquering it. It was more the case that I just learned that life was better without the drugs—I'm still trying to learn this about tobacco. I was perhaps a classic case of self-medicating my pain with illegal drugs, so it was perhaps easier for me in some ways because my drug use was not intimately tied up with my social life as it is for many drug users. But one of the problems with my drug use was that everyone, including myself, felt that I had to get off the drugs before I could attend to the other issues, such as my suicidality. It took four years to

learn that I was never going to get off the drugs without first attending to my suicidal pain.

You describe having become aware of a 'constant sadness' that had been with you for much of your life. Can you tell us more about how you came to view this as a 'divine discontent' and how you reached your 'solution'?

When I came out the other side of those four years, I could look back and see that the sadness that had overflowed into suicidal feelings had always been with me. I still can't say exactly why and I don't say that this sadness has gone now. But the sense of liberation I felt when I finally let go of my urge to die made me see that I didn't have to let this sadness rule how I lived. I was sort of set free of its hold on me rather than losing it altogether. I then read somewhere about 'divine discontent' and found that I understood what this meant.

I now say that I am grateful for my suicidality because it propelled me to finally meet myself fully for the first time in my life. This set me free and I cannot imagine being where I am today without my suicidal history—so I'm very grateful because I'm very pleased to be where I am today. When I say this, though, I feel I must also say that I do not advocate suicidality as a spiritual practice—it is dangerous and I do believe there are better, less dangerous ways to 'find yourself'. And by the way, I don't think of this as a 'solution'—which sounds too much like the silly idea that I'm 'cured'—any more than growing up is a solution or cure for being young.

If you could be a social policy maker what would you do? What role would you give to traditional medical interventions and medication?

The first and most urgent priority is to put an end to a mental health system

that is based on force. The primary source of the so-called stigma around mental health, which should be called discrimination, is our current laws that make second-class citizens of people labelled with a psychiatric diagnosis. Everyone knows this and no-one wants to risk losing their freedom because society judges them to be crazy. These laws underpin and poison every aspect of our mental health system in ways that go far beyond just those who are made involuntary patients under these laws. They are also not based on any reasonable justification but are quite obviously, when you examine them, entirely about controlling people who society finds disturbing, and not at all about the care and treatment of distressed individuals.

Once again we see that it is fear, ignorance and prejudices—and also vested interests—that drive mental health policy, rather than the real evidence of what people really need at times of extreme psychosocial distress. Good intentions are not sufficient—indeed the road to mental health hell is truly paved with good intentions.

But we now encounter a rather nasty ‘chicken or the egg’ problem. We will not get rid of these harmful laws until alternatives to force are developed and expanded, but this will not occur while we continue to rely on force. So an equally urgent priority is to create safe spaces where distressed people can take some time out and attend to their issues with appropriate supports. I like the word ‘sanctuary’ to describe these places, but ‘asylum’ in the true meaning of the word is good too. The critical word though is that these must be safe spaces, which means that medical treatments must not be allowed to be forced on people without their consent. Very few safe spaces exist for people experiencing serious psychosocial distress. Alongside abolishing the laws that create the current unsafe spaces, we need to create more of the safe spaces that people are crying out for.

The role for traditional medical interventions and medication in these sanctuaries would be as just one of many possible supports available, along with counselling, education, life-skills training, so-called alternative therapies such as acupuncture and massage, exercise including things like yoga and

dance, and also, very importantly, peer support. Some of these medications can be useful for some people at times of intense crisis, but only with consent and with close, careful and sensitive

silence as simply nowhere else to go. And I finally met myself for the very first time. My mind arose from and subsided into this silence, the mind came and went, but the silent self

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medical supervision. And only very rarely, if ever, do people need to take these medications for long periods or for the rest of their lives, as so many of us are told.

Your book describes how spirituality was the key to your own personal recovery. Can you say something about this and, in particular, the implications for the helping professions in their work with their clients?

The key to my recovery was when I finally let go of my attachment to my mind as central to my sense of self. I suspect this may sound a heresy to many of your readers as I think the prevailing view, at least in most western societies, is that our sense of self is primarily psychological, that it is primarily a mental sense of self, that our minds are the foundation of our sense of self. I think that’s the view of most people in the general community and it’s also found in most of the academic and professional thinking about our concepts of self. I believed this too until June 1999 when, at the weary old age of 44, my suicidality taught me otherwise.

My path to a spiritual understanding of my sense of self came mainly through yoga, which I have been doing for many years, though not very diligently I must add. But it was only during my years of suicidal struggles that I learned about some yoga teachings that said ‘the self cannot be found in or by the mind, but rather can only be found in the silence of a truly quiet mind in which all thoughts are completely absent’. I struggled with this idea for quite some time until, propelled by my suicidality and utterly exhausted, I finally surrendered to this

remained. I learned that I was not who I thought I was, that Renee Descartes was close but not quite right—I learned not that ‘I think therefore I am’ but that ‘I am therefore I think’. And I also learned that the mind can be a wonderful servant but a shocking master. Most of all I discovered that at the innermost core of my being, at the very heart of myself, indeed my self itself, was this bottomless lake of silent stillness. And in this silent stillness I found peace, the peace that I had been yearning for all my life. I felt like a complete dope when I also saw that this silent inner peace had been *with* and *within* me all along, but I had failed to notice it. I felt like a dope again when I also saw that my failure to notice this source of all that I am was also a key factor in my suicidality. But it didn’t matter. All I could do was laugh. Oh, and my suicidality (and drug addiction too) then immediately became absurd so that I simply let go of them, almost effortlessly, like a snake shedding a no longer useful skin.

I am obviously passionate about these teachings that set me free, but I am not at all evangelical about them. I also do not propose them as some universal panacea for suicidal feelings. One of the most frustrating things during such difficult times is people who insist that what worked for them will also work for you. Spiritual zealots can also be a big pain in the butt. Please also note that the spirituality that I speak of is not at all religious. I was raised an atheist and remain an atheist today. But I do feel that biology and psychology are not sufficient to completely explain and understand the self, or more precisely our sense of self. I sometimes wish that I had

another word than spirituality for this 'something else' because it is so off-putting to so many people. But I've not found one yet, though consciousness is close (but has other problems).

This is just my own personal story but many people who experience a mental health crisis often speak of their difficulties in spiritual terms. Spiritual values and needs and spiritual ways of knowing, in many different guises, are frequently very important to many people for their sense of self. They can also be a potential source of great healing, as they were for me. The helping professions, however, are not

trained in how to engage in meaningful dialogue around spiritual ways of knowing. On the contrary, their training typically forbids or paralyses them from entering into such spiritual conversations. David Tacey at La Trobe University aptly describes this as the 'spirituality gap'. As a way forward, I think we can look to what we've done in recent years around being more sensitive to cultural diversity, and how we have learned to communicate more effectively with people whose cultures are different to our own, sometimes *very* different. For instance, I don't understand religious spirituality, or

the faith-based belief in a supernatural God, but these days I'm at least able to have a meaningful conversation with those who do. Although spiritual ways of knowing almost by definition take us beyond the merely rational mind, this does not mean that we cannot talk sensibly and rationally about spiritually. We must first reclaim our inherent spiritual wisdom from its current exile, where it has been banished by scientific prejudices, and reassert it as a legitimate and significant voice in the important community conversations we need to have about our sense of self—and suicide.

AUTHOR NOTES

DAVID WEBB has served on the board of the *World Network of Users and Survivors of Psychiatry* (WNUSP) and is International Representative for the *Australian Federation of Disability Organisations* (AFDO), representing both organisations at various UN forums on the *Convention on the Rights of Persons with Disabilities* (CRPD). Along with his Ph.D. and the book from this research, '*Thinking About Suicide*', David's other writings about suicide and the rights of people who experience psychosocial distress can be found at the companion website: www.thinkingaboute suicide.org

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