Thinking (Differently) About Suicide

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It is appropriate to start a talk like this with some story-telling. Stories are important because they are the main way that we share our personal thoughts and feelings with others. But story-telling is more than just giving others a window into the silent, invisible interiors of our subjectively felt experiences. In order to tell our stories we must first *find* our voice, which requires that we reflect on our experiences and, as best we can, make some sense of them. Only then can the words – or the music, the paintings or the dance – be expressed and shared with others.

The story I want to tell today is not one about my own personal experience of persistent suicidal feelings, though this will be mentioned occasionally. Rather, the story I want to tell is of my enquiry into suicide after I stopped being actively suicidal in the late 1990s. This story is one of looking back on my unexpected survival in order to try and make sense of what I'd been through. It is also a story that investigates not only my own personal thinking about suicide but also what the society I live in thinks about suicide. In particular, my story investigates the academic discipline known as "suicidology" – i.e. what the experts in suicide prevention think about suicide.

Suicidology – A Survivor Perspective

When I first looked at the literature of suicidology I struggled to find my own experience of being suicidal in this vast database of expert knowledge on suicide. I found myself thinking that whoever all these experts were talking about, it was certainly not me, and I wondered whether my personal experience of suicidal feelings was somehow uniquely peculiar to me. I didn't think so then and think this even more so these days. As I continued to wade through this literature, I realised that the actual suicidal person was remarkably absent from all this expert knowledge. It was like these experts were looking at people like me through the wrong end of their telescope so that we were little more than almost invisible dots on the distant horizon.

The suicidal urge to die only passed for me when I finally attended to the spiritual crisis that lay at its heart, so I was looking in the literature of suicidology for any discussion of spirituality. I guess I was not too surprised to find spirituality virtually prohibited and banished from the academic discipline that claims to be the scientific study of suicide. But I was surprised – indeed stunned and appalled – to see that the first-person voice of suicidal people was also almost totally absent. This was made all the more stark by the strong presence within suicidology of those bereaved by suicide, which is another important – but very different – first-person voice on the experience of suicide.

My investigations led me to conclude that there's several reasons why the first-person voice of suicidal people is largely absent from suicidology, none of them good. I'll mention just a couple. First, many experts hold the view that people who survive a suicide attempt can tell us little, if anything, about those who succeed in killing themselves. Some pedantically argue that suicide by definition requires a dead body so survivors, such as myself, cannot tell us anything useful about successful or "real" suicide attempts. This attitude represents a slightly sanitised version of the common prejudice that the only genuine suicide attempt is a successful one. This is not only offensive to people like me, it is also contradicted by the hard quantitative data so loved by these very same experts, which show that most suicides are preceded by at least one unsuccessful attempt.

But the main reason, I believe, why suicidology pays so little attention to the suicidal person is that suicide is considered irrational madness so that, almost by definition, such people cannot contribute anything useful to the rational, scientific study of suicide. This is just one of numerous examples of how suicidology uses its scientific pretensions to exclude not only the spiritual and the subjective but also anything that it deems to be irrational. I think this also suits many suicidologists very nicely because many of them really do not want to have any real contact with actual suicidal people.

Some notable exceptions (dissenting voices) within suicidology

I must mention a couple of notable exceptions within mainstream suicidology who do give genuine attention to the actual suicidal person. The first is Professor Edwin S. Shneidman, a pioneer in the field who was the founder and inaugural President of the American Association of Suicidology in the early 1960s. Shneidman put the suicidal person at the centre of his study of suicide, saying that:

> *the keys to understanding suicide are made of plain language … the ordinary everyday words that are found in the verbatim reports of beleaguered suicidal minds* (1996, p viii)

He then coined the term *psychache,* which he defined as psychological pain due to thwarted or distorted psychological needs, as the basis for his central idea that "every case of suicide stems from excessive psychache". Psychache is conceptually very different to the (notional) medical illness of depression, which Shneidman saw as the dominant but unhelpful influence in suicidology in recent decades:

> *No branch of knowledge can be more precise than its intrinsic subject matter will allow. I believe that we should eschew specious accuracy. I know that the current fetish is to have the appearance of precision – and the kudos and vast monies that often go with it – but that is not my style. Nowadays, the gambit used to make a field appear scientific is to redefine what is being discussed. The most flagrant current example is to convert the study of suicide, almost by sleight of hand, into a discussion of depression – two very different things.* (2002, p. 200)

Professor Shneidman sadly died in 2009, age 91, lamenting the current medical dominance of the academic discipline that he helped to establish. Fortunately, there are a few dissenting voices within modern suicidology that carry his legacy forward. In particular, the Aeschi Group, named after the Swiss village where they meet every two years, is a group of eminent suicidologists who challenge the dominant discourse in suicidology today[1]. Like Shneidman, they put the suicidal person at the centre of their study of suicide and regard what we say about our suicidal feelings –

[1] www.aeschiconference.unibe.ch

in our own words – as the “gold standard” for understanding suicide. I regard the Aeschi Group as the *only* innovative, critical and creative voice within mainstream suicidology today.

Suicidology is Part of the Problem

By the time I completed my PhD I was convinced that suicidology is part of the problem rather than the solution in our efforts to prevent suicide. Let me say this again in rather stronger language – suicidology currently contributes to rather than reduces the suicide toll. In order to justify this serious accusation, I now want to look at the two biggest obstacles I see in suicide prevention. This will take our story here beyond academic suicidology into the politics of suicide, but we must keep in mind that suicidology occupies a critical role in this politics.

Suicidology is part of the problem - Stigma

The first major obstacle to suicide prevention is typically called stigma, though it should be called by its correct name, discrimination, which immediately takes us into the political realm. Suicidology, along with the wider suicide prevention industry, regularly highlights stigma as a central issue, but at the same time fails to see the stigmatising effects of its own attitudes and practices. A couple of examples of this have already been mentioned, but there are plenty of others, in particular the pathologising and medical labelling of suicidal people.

But what typically fails to get mentioned in the discussion of stigma is that its major source is the mental health laws that make second class citizens of suicidal people. These laws not only discriminate against and stigmatise the suicidal individual, they are also the legal foundation of mental health systems based on depriving people of their liberty and then forcing unwanted medical treatment upon them. Suicidal people, like everybody else, do not want to lose their liberty and be assaulted by medical violence so we find that mental health services are being deliberately avoided by the very people they are supposed to help. At the very least, this contributes to the suicide toll by failing those in need of help with their suicidal feelings. But even worse, some suicidal people who do make contact with mental

health services are finally pushed over the edge into suicide by the violence they encounter from these services. And even worse again, detention and medical violence can actually trigger suicidal feelings in people who have never previously been suicidal.

For some years I have been asking the suicide and other mental health experts in Australia whether our mental health laws help or hinder suicide prevention. In particular, I ask them for any evidence that detention and forced treatment actually helps prevent suicide. There is in fact no scientific evidence for this for the simple reason that there has been no research into this critically important question. I then point out that if detention and force were to be evaluated by the criteria of medical research, which is not unreasonable given that they are claimed to be life-saving interventions, then the lack of any evidence on either their efficacy or safety would mean that they would simply not be permitted. Despite this, everyone maintains the status quo assumption that force is necessary. But I say it contributes to the suicidal toll which, in the absence of proper scientific studies, is supported by the little evidence[1] that does exist along with basic human rights principles that violating people's human rights is harmful.

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[1] I know of no studies that examine the efficacy and/or safety of involuntary hospitalisation and/or forced treatment for the purpose of preventing suicide. There are some studies that look at the efficacy and safety of community based involuntary treatment, which are worth mentioning even though suicide prevention is not one of the variables investigated:

a) "Compulsory community and involuntary outpatient treatment for people with severe mental disorders (Review)" by Kisely SR, Campbell LA, Preston NJ, Cochrane Collaboration (2011) concluded that there is "little evidence that compulsory community treatment have a positive effect on outcomes such as hospital admissions, length of stay or compliance with medication".

b) "International experiences of using community treatment orders" (2007), commissioned by the UK Department of Health and undertaken by the Institute of Psychiatry, King's College, University of London, is perhaps the most exhaustive review of the evidence on the efficacy and safety of community based involuntary treatment. The first dot-point in its Executive Summary states "It is not possible to state whether community treatments orders (CTOs) are beneficial or harmful to patients" (p 7). The report is available online at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072730

Another study worth mentioning is "Do nations' mental health policies, programs and legislation influence their suicide rates? An ecological study of 100 countries" by Burgess et al, published in the Australian and New Zealand Journal of Psychiatry (2004). The objective of the study was "To test the hypothesis that the presence of national mental health policies, programs and legislation would be associated with lower national suicide rates." The results, however, were that "Contrary to the hypothesized relationship, the study found that after

Suicidology's persistent silence on discriminatory, stigmatising and harmful mental health laws represents a tacit acceptance of status quo assumptions that contribute to rather than reduce the suicidal toll. Suicidology is part of the problem of the stigma of suicide.

Suicidology is part of the problem - Medicalisation

The second major obstacle to suicide prevention is found at the heart of these mental health laws, which is the medicalisation of suicide. A suicide attempt can have medical consequences, including death, but it is never caused by a medical illness. What causes suicide is a *decision* to kill yourself – a psychological, cognitive decision, not some biological medical terminal illness. It may be that an unbearable medical illness is a factor leading to that decision, but it is not the illness that kills you.

The medicalisation of suicide has arisen alongside the emergence of biological psychiatry as the dominant influence in mental health over the last 30-50 years. A massive global public relations campaign has convinced most people, at least in western countries like Australia, that most suicides are caused by the medical illness of Depression[1]. This has occurred even though the scientific status of Depression as a genuine medical illness is hotly contested. But even if you accept Depression as a medical illness, it is not a terminal illness. Depression does not *cause* suicide. The most that can be said is that there appears to be some correlation between

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introducing mental health initiatives (with the exception of substance abuse policies), countries' suicide rates rose". The authors then speculate on why they got this unanticipated result and clearly further investigation is required, but it is surprising that such an alarming result does not appear to have been followed up anywhere in the world.

[1] A recent example in Europe of medical dogma dominating suicide prevention can be seen in a current document from the EC-led European Pact for Mental Health and Well-Being – Wahlbeck K. & Mäkinen M. (Eds). (2008). Prevention of depression and suicide. Consensus paper. Luxembourg: European Communities – which asserts that "Suicide is primarily an outcome of untreated depressive illness". Although many people do believe this to be true, many others do not, so it is extraordinary to see a statement like this in a document that claims to be a "Consensus Paper".

depression and suicide, but it is a serious mistake to confuse correlation with causation.

More realistically though, the medical label of Depression represents nothing more than an indication of emotional distress, which may be due to a wide range of causes – physical (biological), mental (psychological), relational (social/cultural) and/or spiritual. Blaming suicide on the notional medical illness of Depression leads to some dangerous consequences, such as the misguided view that suicide can be prevented by medical treatment, in particular by treatment with antidepressants. It is time that the massive antidepressant experiment of the last 20-30 years is declared a failure, at least for suicide prevention. Another harmful consequence is that we now know that psychiatric labelling stigmatises, rather than destigmatises as was hoped, those of us who experience extreme emotional distress or other disturbing states of consciousness (Pescosolido et al, 2010). But the most serious consequence of blaming suicide on the medical illness of Depression is that if we believe that Depression causes suicide then we fail to look for the real underlying reasons for why a person chooses to die rather than to live.

Suicidology's embrace of Depression as the primary causal explanation of suicide comes not from any good science but is demonstrably due to medical ideological dogma. Suicidology is part of the problem of the inappropriate and excessive medicalisation of suicide.

The Politics of Suicide

The close interrelationship between suicidology and the politics of suicide is now apparent. Driven by fear and ignorance and prejudice, society continues to panic in response to suicide and seeks to contain and control suicidal people. The state then calls upon the medical profession as a willing accomplice to provide a justification for the use of force under the guise of medical treatment. A little scrutiny reveals that this is not based on science or any rational argument but rather on ideological dogma. Suicidology is part of the problem, rather than the solution, in our efforts to prevent suicide.

Alternatives to (medicalised) Suicidology

Looking for alternatives to suicidology's current thinking about suicide, the first step is to reconceptualise how we think about suicide. We can begin by reinvigorating Shneidman's concept of psychache, but I think we can take it even further.

Suicide as a crisis of the self

Suicide is best understood as a *crisis of the self*, rather than the consequence of some notional mental illness. I say this for several reasons. First of all, the self is the 'sui' in suicide, and both the victim and the perpetrator of any suicidal act. It should be the most important concept in the study of suicide but suicidology gives it remarkably little attention.

Second, thinking about suicide as a crisis of the self is much closer to what it feels like to live with suicidal feelings. The starting point for the study of suicide should be what suicidal feelings mean to those who live them – the first-person knowledge of those who know suicidal feelings "from the inside".

Third, any reasonable concept of the self will automatically be a more holistic approach than the current shallow medical approach that reduces us all to biochemical robots. Our sense of self encompasses not only our physical, biological being but also the mental, social, cultural, historical and spiritual aspects of our being.

Thinking about suicide as a crisis of the self also goes a long way towards breaking the stigma of suicide. We all have our own personal sense of self. We have all had times when our sense of self has felt challenged, wounded or in crisis in some way or other. This may not necessarily have been a suicidal crisis but the experience and knowledge of a self in crisis is something that we all share and are familiar with. This automatically breaks down the "them-and-us" thinking that lies behind much of the stigma around suicide so that there is no longer a them-and-us, only us.

"Mentally healthy" communities

Another conclusion from my research is that real progress in reducing the suicide toll will not come through interventions with actively suicidal people. These interventions are important for those individuals, and I'll say more about this soon, but I doubt that this approach will yield really significant reductions in the overall numbers. Rather, the key to suicide prevention is to create communities where people are less likely to get suicidal in the first place.

Another way of saying this is that the key to suicide prevention is "mentally healthy" communities – I don't particularly like this language but most people get the idea of what's meant by it. When I ask myself what a mentally healthy community would actually look like, I struggle because it is such a huge question that we really should be asking more frequently. It also makes me acutely aware that the society I live in is very obviously not a mentally healthy one.

But one thing I'm certain of is that a mentally health community would be capable of having a sensible conversation about suicide. And again, that this is currently not the case for the society I live in.

Talking about suicide

So the most important thing we can do to reduce the suicide toll is to open up a broad, ongoing community conversation about suicide. This is not only to help prevent suicidal feelings from arising in the first place but also to help those who are actively suicidal. This conversation is essential to bring suicide out of the closet as a public health issue and to dismantle the toxic taboo around suicide, the poisonous silence that feeds the fears, ignorance and prejudices about suicide.

This conversation is also necessary to reclaim this issue as a public issue that is not owned by the professional experts who have failed us so badly. We need to reclaim our personal power, both individually and collectively and take ownership and responsibility for suicide prevention. This also is about our sense of self, this time our collective rather than individual sense of self – the 'We' rather than the 'I', the first-person plural as distinct from the first-person singular.

When I then ponder what this conversation might look like, there's a couple of key elements that must be a part of it. First of all, suicidal people themselves must be at the very centre of this conversation. This can be challenging and perhaps too hard for some people who are currently actively suicidal, so great care is required. But there are many thousands of survivors of suicide attempts who are able to speak of their suicidal experiences. This conversation must embrace and engage with this vast untapped wealth of knowledge and expertise on what it means to be suicidal.

I have been calling for this community conversation on suicide for many years. But only recently did I realise that this conversation is not just about breaking the taboo around suicide and exploring more useful ways of preventing suicide. It finally dawned on me that this conversation is its own suicide prevention strategy or intervention – that talking sensibly about suicide can prevent suicide.

Imagine a person, perhaps a young person struggling with their sense of self, who begins to doubt whether they want to continue living. Imagine that this person lived in a community where they knew they could talk about these feelings safely – a mentally healthy community. Imagine a community where there were safe spaces where this person could take some timeout to consider the big questions that were arising for them. Imagine, if you can, a community where suicidal feelings are respected rather than feared and despised, and where the suicidal person is welcomed rather than shunned. I find it difficult to imagine this community. But I can dream.

A radical challenge – to honour and respect your suicidal feelings

I'll finish with what I've been surprised to learn is in fact the most radical alternative, the most radical challenge, that I make about how we think about suicide. At the very beginning of the book from my PhD, *Thinking About Suicide*, I speak directly to my fellow suicidal soul-mates and invite them "to honour and respect your suicidal feelings as real, legitimate and important".

When I wrote this I didn't think it was such a big statement but the feedback I've had from fellow survivors has shown me that this is perhaps the most important thing I say in the whole book. One illustration of this is the response of a friend and fellow survivor in Melbourne who kindly allowed me to use her words on the back cover of the book:

> *I have never before read anything relating to suicide that speaks of suicidal feelings as being worthy of respect. The possibility that I may actually be able to honour these feelings is a totally new concept, one which has proven to be a catalyst for change and personal growth.*

Summing Up – a Rose Garden for Suicide Prevention

Most of the key elements of my rose garden vision for suicide prevention seem rather obvious to me, but they need to be stated because many of them fly in the face of the current thinking and practices of mainstream suicidology.

1. **Prohibit psychiatric violence – stop beating us up**

   Legally sanctioned psychiatric force is the primary source of the stigma against suicide and suicidal people. It also does not work as a suicide prevention strategy. On the contrary, psychiatric violence can make a suicidal crisis more severe and can even trigger suicidal feelings in someone who has previously never been suicidal. Real progress with suicide prevention cannot commence until the current reliance on psychiatric force is abolished.

2. **Demedicalise suicide**

   The second major obstacle to progress with suicide prevention is the inappropriate and excessive medicalisation of suicide. Suicide prevention requires a whole-of-person, whole-of-community, holistic approach which is not well served by the current medical dominance of suicidology and suicide prevention.

3. **(Re-)Thinking about suicide as a crisis of the self**

Hand in hand with the demedicalising of suicide must come a re-thinking of suicide in non-medical terms. The concept of psychache is useful here, but thinking about suicide as a crisis of the self is also proposed.

4. Mentally healthy communities

The purpose of mental health policies and programs needs to shift away from the treatment of mental illness (including so-called prevention and early intervention strategies based on the medical model) to a model based on the promotion of psychosocial wellbeing. The aim here is to create communities where suicidal feelings, and other forms of psychosocial distress, are much less likely to arise in the first place. It will also create communities that are much more able to respond constructively to such crises if and when they do arise.

5. Safe spaces for suicidal people

Perhaps the most critical component of a mentally healthy community is to have safe spaces for people who are feeling suicidal (or other forms of psychosocial distress). These can be simply for some timeout from life's daily demands in order to spend some time with these feelings in a safe and supportive environment. But they can also be spaces where stories of crisis and distress can be told and shared, which in turn can often then be the starting point for genuine healing.

6. Social model of madness

The medical model of suicide – and of all forms of psychosocial distress – is a demonstrable failure that frequently causes great harm, including deaths by suicide, and urgently needs to be replaced. Our disability cousins have long recognised this failure of the medical model and have developed a social model of disability that is now enshrined in the UN Convention on the Rights of Persons with Disabilities (CRPD). This social model, and the CRPD, can form the basis

for the radical redesign and rebuilding of mental health systems that will promote rather than diminish psychosocial wellbeing and "mentally healthy" communities.

7. Survivors as researchers

As a psychiatric survivor who has been fortunate enough to have done a PhD on my particular topic of suicide, I make the (simple) point that a vital key to bringing more of the survivor perspective into research is to have more survivors as researchers. It follows from this that there needs to be affirmative action programs, such as scholarships, to make this happen.

8. Funding – stop wasting money on what we know does not work

We must stop wasting (lots of) money on what we already know does not work. Which reminds us of the political struggle we face before we will see the radical transformation of our mental health systems that is so urgently needed.

Postscript and acknowledgment

I'd like to congratulate the organisers for a successful and important conference and thank them for the opportunity to be part of it. Psychiatric survivors around the world are giving voice to their first-person experience, knowledge and expertise, which is the shining hope for a better future for all our fellow survivors. Nothing About Us Without Us.

References

Michel, K. and Jobes, D. (Eds) (2010). *Building a Therapeutic Alliance with the Suicidal Patient*, American Psychological Association: Washington DC

Pescosolido, B., Martin, J., Long, S., Medina, T., Phelan, J., Link, B. (2010) 'A Disease Like Any Other'? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence", *American Journal of Psychiatry online,* Vol. 167. No. 11, full article available at: http://ajp.psychiatryonline.org/data/Journals/AJP/1818/appi.ajp.2010.09121743.pdf

Shneidman, Edwin S (1996). *The Suicidal Mind*, Oxford University Press: Oxford,

Shneidman, Edwin S (2002). *Comprehending Suicide: Landmarks in 20th century suicidology*, American Psychological Association: Washington DC

Webb, D. (2010) *Thinking About Suicide: Contemplating and comprehending the urge to die*, PCCS Books: Ross-on-Wye