The Urge to Die

David Webb

The word 'suicide' seems to trigger an almost reflex response in many people, an emotional gut reaction that may include feelings of horror, bewilderment, fear, shame, guilt or anger. Many people seem stunned that anyone would choose to die. I find this odd because the urge to die is very familiar to me. It surprises me that so many people, including most suicide prevention experts, seem to find choosing to die so utterly mysterious.

I'm surprised even further when I look at the suicide numbers. The World Health Organisation estimates that globally about a million people will die by suicide this year. To help put these big, global numbers into perspective, the WHO have estimated that suicide accounts for about half of all violent deaths—i.e. equal to the combined total for homicide (31%) and war-related deaths (19%). Despite these numbers, if you counted the column inches or broadcast hours in the mainstream media, you would think that suicide is rare in comparison to homicide or war-related death.

Closer to home, about 2,000 people suicide in Australia each year, which is considerably more than the road toll. On top of this, it is estimated that for each completed suicide, another 20-30 other people will make a serious suicide attempt. Then for each of these suicide attempts, about another 10 people are estimated to give serious consideration to suicide. This all adds up to about half a million people or more each year.

I've not been one of these statistics for more than a decade now. A conservative calculation that would include old-timers like me is that there must be at least half a million suicide attempt survivors alive in Australia today. And a staggering 2-5 million people, maybe more, who have thought deeply about suicide for themselves—or 10-20% of the population. Why, then, does suicide remain such a mystery?

One reason is that the academic study of suicide, known as suicidology, gives remarkably little attention to the lived experience of suicide attempt survivors. There are several reasons for this, none of them good.

First, some suicidologists believe that suicide attempt survivors can tell us little about those who succeed in killing themselves. Sometimes this is said rather more bluntly as the only genuine suicide attempt is a successful one. This view is contradicted by the data, which show that most completed suicides are preceded by an unsuccessful suicide attempt. It is also a view that people like me find offensive

Another reason why suicidology ignores the lived experience of suicide attempt survivors is its prejudice against subjective knowledge as unscientific. The importance of first-person knowledge is now generally recognised throughout the human sciences and although the 'consumer voice' is beginning to be heard in mental health more generally these days, it still remains largely absent from suicidology.

A further reason why suicidology denies the validity of the first-person voice is rarely stated explicitly but is often implied. For instance, there is a long-running debate within suicidology on whether suicide is ever rational, a debate I've always found rather pointless and irrelevant—indeed quite silly. This debate also reveals that most suicidologists still regard suicide as crazy and therefore, almost by definition, crazy people cannot contribute anything useful to the study of suicide.

There's an even more alarming reason, however, why the millions of suicide survivors remain largely invisible and 'in the closet', not only within suicidology but also more generally in the wider community. The usual word for this is 'stigma', though it should be called by its correct name, which is discrimination. Stigma means a stain and suggests some flaw in the suicidal person, whereas recognising it as discrimination requires us to look at the prejudices of those who stigmatise the suicidal person.

When I first started speaking publicly about my suicidal history, nearly ten years ago, I underestimated the animosity in the community towards suicidal people. I was aware of the many myths around suicide, which were often an attempt to deny or hide from the reality of suicidality. I saw that many of these myths—such as that suicidal behaviour is attention-seeking behaviour or 'just' a cry for help—represented a kind of fearful grasping for any explanation other than the reality of suicidality. We are so fearful of suicide—fearful that the person may do something dangerous but also fearful of potential consequences for ourselves—that we make every effort to convince ourselves that suicidality is anything other than what it actually is.

But I was not prepared for the anger I saw towards the suicidal person. I think I first noticed this at suicide conferences where those who have lost a loved one to suicide usually have quite a strong presence. Along with their grief and sorrow, there was also quite often some anger and resentment towards the person who had died. This may be mixed with feelings of guilt and shame, usually unwarranted but nevertheless still there, for having somehow failed to help their suicidal loved one. And sometimes you'd hear angry and bitter remarks that come from a deep sense of betrayal such as, "How could they do this to me?"

I do not wish to criticise those bereaved by suicide, even when they sometimes say things that are hurtful and unfair about suicidal people. Their unique and agonising grief is an important voice in the public debate on suicide, including their very real feelings of anger, shame, guilt and betrayal. My criticism is that there is another first-person voice that is essential to this debate but which is largely absent, the voice of those who know suicidal feelings 'from the inside', the actual suicidal person.

Have you ever found yourself in a conversation where people are talking rudely about a particular group of people—e.g. gay people, immigrants, drug users—and you are one of these people but no one else in the conversation knows this? I have felt like this at suicide conferences where people often speak as though there are no suicidal people actually in the room. This is most noticeable when offensive remarks are made—such as "the only genuine suicide attempt is a successful one"—and no one seems at all bothered about this. This would not occur, or would be promptly corrected, if suicide attempt survivors had as strong a voice at suicide conferences as those bereaved by suicide.

It is the gatekeepers of the public debate on suicide who are most responsible for the exclusion of and discrimination against the suicidal person—this conversation 'about us without us'. I mentioned some of their prejudices against the first-person voice of suicidality earlier—it's anecdotal, subjective, unscientific, not genuinely suicidal and, most of all, we're crazy. But more than just this, I have also painfully come to realise over the years that these gatekeepers, not just here in Australia but around the world, share the animosity towards the suicidal person that we find elsewhere. Indeed, I have seen that the suicidal person is often despised by those who claim leadership roles in suicide prevention.

This has been very difficult for me. I have had regrets that I have gone public with my story and would now hesitate before encouraging others to do so. I've had times when I've wanted to drop out and withdraw from the work I've been doing for the last ten years. I was prepared and willing to face the resistance I knew would come from those with a vested interest in the status quo of the suicide prevention industry. But the nastiness of this resistance caught me by surprise.

I have been sustained, however, by moments of hope and by the support of numerous people who have encouraged and inspired me to go on. In recent years I have worked in the disability sector where you'll meet people who understand discrimination very well and who have fought against this discrimination for many years. At the heart of the disability movement is a shift away from the traditional medical model of disability, based on an individual's impairments, towards a social model based on social inclusion and human rights.

A similar shift is urgently needed in mental health in general and in particular in society's attitudes towards suicide.

Discrimination—society's prejudiced attitudes towards suicide—is the single most urgent issue for suicide prevention. It is this discrimination, fuelled by fear and ignorance and prejudice, that lies behind the toxic taboo that surrounds suicide and poisons the public debate about it. The only way that discrimination has ever been dismantled has been to hear from those who are discriminated against. The disability community has known this for a long time and has conducted their campaign under the slogan: 'Nothing About Us Without Us'. We will not begin to make progress with suicide prevention unless and until society's current discrimination against suicidal people is challenged and dismantled.

The first step in this direction has to be reversing the growing trend of the last few decades of medicalising suicide. Despite quite massive public relations in recent years telling us otherwise, suicide is not primarily a medical issue. A suicide attempt may have medical consequences, including death, but it rarely—if ever—has a medical cause. It therefore rarely—if ever—has a medical solution. The suicide debate worldwide is currently dominated by the medical model, which represents the major obstacle to a better understanding of why some people choose to die. The medical model is also one of the primary sources of the prejudices that feed the discrimination against suicidal people. Suicide prevention will not advance while it remains governed by the medical profession.

This may sound all very grim, and indeed I find it hard not to be pessimistic, but there are some glimmers of change on the horizon. Within mainstream suicidology there is a group of about eight eminent suicidologists who call themselves the Aeschi Group (after the name of the Swiss village where they meet every two years). Their focus is on psychotherapy with suicidal people and they challenge the current status quo of suicidology by positioning the suicidal person as the expert—rather than as some sick misfit—at the centre of the therapeutic encounter. They also emphasise a narrative approach to therapy with the suicidal person's story in their own words as the 'gold standard' for understanding their suicidal crisis. I must say that what they propose all seems rather obvious to me, but in the context of modern suicidology they represent a refreshing and radical alternative. I rate their work as 'essential reading' for anyone interested in psychotherapy with suicidal people, and some resource references can be found at the end of this article.

The Aeschi Group in some ways also represent the continuing legacy of one of the great pioneers of suicidology, the US psychologist Professor Edwin S Shneidman, who sadly died a couple of years ago at the age of 91. One of Professor Shneidman's core concepts was that suicide is caused by *psychache*, which he defined as psychological pain—not illness—due to thwarted or frustrated psychological needs. He then worked with a taxonomy of psychological needs to identify those that a person might need help with in order to alleviate (not cure) their psychache. Like the Aeschi Group, Shneidman also showed great respect for the suicidal person's own understanding of their psychache, saying, "It is the words that suicidal people say—about their psychological pain and their frustrated psychological needs—that make up the essential vocabulary of suicide". He died lamenting the medicalisation of suicide and fearful that his important concept of psychache would die with him. Fortunately, the Aeschi Group and a few others have picked up his bright torch and are carrying it forward.

I was therefore delighted recently, much closer to home, to receive the latest brochure from LiFE (Living is For Everyone) Communications here in Australia entitled 'Suicide: worried about someone?' I was delighted because they mentioned psychache in their discussion on understanding suicide. I should also acknowledge that their revised LiFE Framework documents of 2007 marked a distinct and welcome shift towards a more socio-cultural approach to suicide, though it still contained much of the medical nonsense. Another glimmer of hopeful change here is that Suicide Prevention Australia (SPA) has also recently acknowledged the importance of hearing from suicide attempt survivors in its Position Statement on Supporting Suicide Attempt Survivors—though in other ways SPA remains a bastion of the medical model and the status quo thinking of the suicide prevention industry.

Despite these glimmers of hope, I'm not at all confident that the real changes we need are occurring. The dominant influence is still very much the Patrick McGorry bandwagon and organisations like *beyondblue* telling us that suicide is caused by mental illnesses requiring medical treatment, typically psychiatric drugs. Real progress will not commence until the debate moves beyond this shallow and unhelpful response.

Before finishing, I should say a little about my own work. Although I endorse Shneidman's concept of psychache, I prefer to conceptualise suicidality as a crisis of the self, for several reasons. First, it correlates more closely with the lived experience of suicidal feelings which, as I've indicated, is an essential but largely missing piece in the current suicide debate. It also raises important questions that suicidology currently ignores, such as who or what is this 'self' that is in a suicidal crisis? This then leads to another issue that was central to my own suicidal crisis—the role of spiritual needs and values in our sense of self—which suicidology also ignores.

Quite early during my PhD research, I wrote to Professor Shneidman politely requesting that he expand his definition of psychache to include spiritual needs along with psychological needs. To my amazement, I got a charming letter in reply, and a copy of his latest book, but no, he did not agree to my request though he did give it respectful consideration. I raised this question with him again when I had the great good fortune to meet him during my visit to the US in 2007. Once again he respectfully declined, but he did say that what suicidology needed was a proper phenomenology of suicidality, which my work also calls for, so I figured I'll settle for this from this great man.

Whenever I mention spirituality and suicide, I feel it's necessary to be clear that I do not claim that every suicidal crisis of the self is necessarily a spiritual crisis. Nor do I claim that spirituality is some universal panacea for a suicidal crisis. Even for those who do understand their suicidal crisis as a spiritual crisis, I do not claim that my understanding of spirituality is any better than the many other ways that people understand their spirituality. I find spiritual zealots as annoying as most of us do. But I do say that suicide is best understood as a crisis of the self and that if we truly explore our sense of self, we will probably find ourselves, in one way or another, in some sort of spiritual territory. I also say that spirituality can be a healing path out of a suicidal crisis for some people, which is confirmed not just by my own experience but by that of many others.

Spirituality also reminds as that thinking about suicide as a crisis of the self also demands a truly holistic approach. The medical 'blame it on the brain' approach is woefully inadequate in this regard, which Shneidman's psychache goes a long way towards correcting. Along with the psychological and the spiritual, though, we must also include the social, cultural and historical contexts of any particular suicidal crisis of the self.

The current suicide prevention debate in Australia is moribund. The only hope I see for turning this around is for the community to reclaim ownership of this debate. A broad, ongoing community conversation is required that first of all must challenge and dismantle the discrimination against those of us who struggle with the urge to die. Progress with suicide prevention will not be possible unless and until the community faces up to society's prejudices against suicidal people.

This will be a difficult conversation to get going, and not just because of the resistance it will face from those with a vested interest in the current suicide prevention industry. We must admit that we are all clumsy novices as we tentatively begin this conversation and must be gentle on ourselves as we stumble forward. We must recognise our own fears about suicide, fears for ourselves as well as for others. Two of our greatest fears come together in suicide, our fear of death and our fear of madness. Death and madness are also topics that we as a society do not discuss very skilfully, so the suicide conversation we need will have to bring these two scary issues out of the closet also. This is beginning to occur with the euthanasia debate, but euthanasia is very different from the suicide we're talking about here. We have a long, long way to go, but the conversation must begin.

This conversation must also consider that communities and societies can be suicidal too, not just individuals. There is plenty of evidence of this occurring, not the least the way we are destroying the environment that we all depend on for our survival. Furthermore, we must also look at the dehumanising, soul-destroying aspects of our culture that not only damage our sense of self but also our sense of community. We need to discuss and re-think the important role of suffering that is part of every human story and move away from the current 'diagnose-and-treat' response to psychological pain. We need to talk about our collective psychache, not just the psychache of individuals.

Ed Shneidman famously said that "suicide prevention can be everyone's business". I'll say that suicide prevention *must* be everyone's business—and this begins with a community conversation.

I'll finish with some words inspired by Al Alvarez and his book *The Savage God* that always remind me of the huge and humbling task before us as we embark on this conversation:

> *We must at all times remember,*
> *that the decision to take your own life*
> *is as vast and complex and mysterious as life itself.*

And I'll finally sign off with the words of Ed Shneidman again—this time the beautiful salutation and blessing that he used to sign off one of his letters to me:

May your psychache be minimal... 💠

References

The Aeschi group is http://www.aeschiconference.unibe.ch/
They've recently published their first major book:
Building a Therapeutic Alliance With the Suicidal Patient
Konrad Michel and David A. Jobes (Eds)
American Psychological Association, 2010
http://www.apa.org/pubs/books/4317248.aspx

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

David Webb's PhD at Victoria University (2006) is believed to be the world's first on suicide by someone who has attempted suicide. David has been a board member of the World Network of Users and Survivors of Psychiatry (WNUSP) and is the International Representative for the Australian Federation of Disability Organisations (AFDO). He has represented both WNUSP and AFDO at numerous UN forums on the UN Convention on the Rights of Persons with Disabilities (CRPD). His book, Thinking About Suicide, *based on his doctoral dissertation, was published by PCCS Books, UK in 2010.*