The Politics of Suicide   David Webb, January 2013

I've often wondered what draws people to the study of suicide. For the great pioneer of Suicidology, Professor Edwin S. Shneidman, it was the vast archive of suicide notes that he stumbled across during an errand at the Los Angeles coroner's office. Many others, it seems, are motivated by the loss of a loved one to suicide or perhaps, for those in the caring professions, the loss of a client. For me, my interest is as a survivor, which is surprisingly rare given that there are so many of us.

Identifying as a suicide survivor immediately brings us face to face with the politics of suicide and, in particular, the politics of Suicidology. When I first started looking at the suicide literature, I did a Google search on "suicide survivor", hoping to connect with fellow survivors. Google replied with dozens, maybe hundreds, of hits but instead of fellow survivors, I found that this language had been claimed by those bereaved by suicide. I was rather taken aback by this. I didn't know what to call myself. I fed a few other terms into Google but without success. It seemed like we were invisible to Google and I felt that even the language we might use to identify ourselves had been stolen. For years I have struggled to find acceptable language with which to identify myself within Suicidology and the public discourse on suicide. Calling myself a "suicidality survivor" felt clumsy and I wasn't comfortable with "suicide attempter" or "suicide attempt survivor" because these discriminate against suicidal people who have not (yet) made (or disclosed) a (serious) attempt.

After almost a decade of inadequate labels for my place in the study of suicide, I finally decided to reclaim the language that I wanted at the beginning. I am a suicide survivor. I am a survivor of the powerful and frightening urge to die. Part of the reason I want this language is that this is what most people understand it to mean. When I have had to explain to friends that Suicidology uses suicide survivor to refer to the bereaved, they have always been surprised. Like me a decade ago, their common sense meaning of the term is the one that I now reclaim. But I also reclaim this language as a political statement against the prejudices in Suicidology that "invisibilises" the suicidal person. After all these years, and long after completing my PhD on Suicidology in 2006, I have learned that academic and intellectual arguments by themselves will not bring about the radical change that I believe we need in the public discourse on suicide and suicide prevention. To advance this public discourse we must recognise and address the politics of suicide.

In this chapter, three distinct but intersecting political issues are identified that are contaminating the current discourse on suicide. The first of these, the politics of first-person knowledge, continues the survivor perspective of this introduction to argue that Suicidology needs to hear the first-person voice of survivors. The politics of the medicalisation of suicide then identifies not only one of the primary sources of the prejudice against the survivor voice, but also other medical dogmas that ensure the current discourse remains narrow, shallow and unhelpful. And third, the politics of suicide and human

rights is the elephant in the room where society's fear, ignorance and prejudice create the institutionalised discrimination that dehumanises and makes second class citizens of suicidal people.

The politics of first-person knowledge

Qualitative research now stands alongside quantitative research as a legitimate form of rigorous, disciplined research, notwithstanding some tired, old die-hards who continue to insist that the only real research is the "hard science" of objective, measurable certainties. There is no need here to argue the legitimacy of qualitative research. Much of the qualitative research I see could also be called *first-person research* in that it is concerned with the lived experience and the inner meaning-making of whatever our topic of interest might be. For instance, education researchers are now routinely researching into how we learn from the student perspective. This also is generally accepted as legitimate research these days, so that for at least several decades there has been much valuable and useful research of this kind in what we might broadly call the "human sciences". Not all qualitative research is first-person research though, so we still find some resistance to first-person research in academia, even among some qualitative researchers.

My PhD research was always going to be first-person, though I had no idea what form (method/ology) it might take. Initially, I wanted to interview other survivors to look for any spiritual themes in their stories. I soon learned that this would lead to major problems with the Ethics Committee - which is another serious political issue, but one for academia to deal with rather than this chapter. This left me with only one first-person story for me to work with - my own. This introduced other problems, however, most notably the problem of a sample size of one, especially when that one was myself. It was suggested that I look into the emerging field at the time of autoethnography, which was a very worthwhile exercise and I could have easily located my finished thesis within this discipline. But my curiosity led me to the field of Consciousness Studies where I was introduced to the more established discipline of phenomenology, which is where I positioned my work in the end.

The turning point of my PhD arose from a casual remark, almost an aside, by my supervisor, Professor Ron Adams. I was writing my story while also researching the literature of Suicidology when Ron observed that my story was not really the data of my study but more like an analytical tool. Discussing this further, we figured that my story was like a lens or prism through which we were examining Suicidology. This made the data for my research the collected knowledge - the collective wisdom, if you like - of the discipline of Suicidology. My N=1 problem disappeared. More importantly, looking through the prism of my story also revealed some pretty huge gaps in Suicidology. And as Ron was fond of saying, find a gap in an academic discipline and a PhD is there to be found.

From this moment everything fell into place. The two main gaps in Suicidology exposed by my story were the almost complete absence of the first-person voice of survivors and the even more complete absence of any spirituality. I was not too surprised by the absence of spirituality, indeed this was what

originally motivated me to pursue this project. But I was taken aback to find the actual suicidal person so absent. I then had to investigate why this is so, and found two classes of prejudices: scientific prejudices against first-person knowledge in general; and, even more disturbing, prejudices against the first-person knowledge of suicide survivors in particular.

A major Suicidology text, both then and now, is the "Comprehensive Textbook of Suicidology" (Maris et al, 2000), which defines Suicidology as "the *science* of self-destructive behaviors", and 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, all italics theirs)[1]. This is the bias of the old "hard science" die-hards, but one that I regularly encountered, such as one eminent psychiatrist at a conference in Milan who insisted that mental health research must observe "the rules of science". The source of this bias against first-person knowledge is the excessive influence of medical thinking that has come to dominate mental health and Suicidology over the last few decades.

Of even greater concern are the prejudices against the first-person voice of suicide survivors in particular. Some pedantic experts insist that suicide, by definition, requires a dead body so that, for them, calling myself a suicide survivor would be oxymoronic. It is also commonly argued that suicide attempt survivors have little, if anything, to tell us about those who succeed in killing themselves, reflecting the popular taxonomy in Suicidology of contemplators, attempters or completers as three distinct and quite separate categories. The sub-text here, which is occasionally uttered, is 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 data which consistently shows that the strongest among all the weak predictors of suicide is a previous attempt.

Another prejudice that silences the first-person voice can be seen in the ongoing debate within Suicidology on whether there is ever such a thing as a rational suicide. The underlying assumption here is that suicide is, almost by definition, irrational. You've got to be crazy to kill yourself, right? Once again, this is offensive to people like me, and I doubt such attitudes would get so much air-time if there were more survivors participating in these debates. This debate also implicitly privileges rationality above all other ways of knowing, which is not only a hotly contested point of view these days but also distinctly unhelpful for understanding and preventing suicide.

There are so many ways that the survivor voice is silenced. Typically it is done by diminishing the validity and legitimacy of our experience. For instance, there is an informal prohibition of talking about succeeding or failing at suicide, which extends to the formal media guidelines on reporting on suicide. I agree that we don't want to glamourise or sensationalise suicide, but when I came to in hospital and realised what had happened, I felt like I had failed. And there ain't no sense of failure quite like failing at suicide. I claim the right, indeed the need, to speak about this experience in my own language. The

prohibition against talking of failing invalidates and denies my experience as I felt it. I have given just a few of many possible examples of how we are spoken of as less than whole, less than human. It is little wonder that survivors speak up so rarely. I have learned that there is often a kind of hatred towards suicidal people that, in my naivety, I underestimated when I first started speaking publicly about my suicidal history.

The politics of first-person knowledge in Suicidology has to be fought on many fronts. Intellectually, Suicidology has to be dragged into the 21st century to recognise and accept the legitimacy, validity and importance of first-person knowledge. Personally, I think we should just stop talking about subjectivity and objectivity because they have become so loaded with bias - i.e. objective is good knowledge, subjective is bad - that they are virtually useless. Rather, we should talk of first-person and third-person ways of knowing, recognising them as two different perspectives, two different epistemological windows, into any particular humanly experienced phenomena. Each perspective tells us something of value, something that cannot be seen or told by the other. One is not better than the other. Rather, they complement and complete each other. But one without the other is an incomplete and partial form of knowledge. One form of knowledge by itself, such as we find in Suicidology, is not so much incorrect as it is incomplete. It is not objective versus subjective but first-person as well as third-person.

Another front where the politics of first-person knowledge in suicide must be fought is the social challenge to stamp out the hateful prejudices against suicidal people. These prejudices are quite widespread and deeply entrenched in the community, so it will take time. Suicidology should take a leadership role in this challenge, but first it must get rid of these prejudices from among its own ranks. Although I see a difficult road ahead, the solution here is quite simple, I believe. Suicidology, open your doors to suicide survivors. The only remedy for ignorant prejudice against a population, such as racism, sexism, homophobia etc, has always been face to face encounters with those discriminated against. If you allow us into your conversations we will let you know when you say such silly, and sometimes offensive, things as the examples given above. We need to be part of these conversations in sufficient numbers to support each other and so that it doesn't require great bravery to speak up. You will find that not all genuine attempts succeed, that we can talk of our failures without sensationalising suicide, and that we can talk rationally about our experiences, but also maybe that there are other valid ways of thinking than just rationality. You will learn that we are human, just like you.

I don't see how the public discourse on suicide can move forward unless and until we confront the politics of first-person knowledge. And that this cannot occur unless and until those with the first-person knowledge of suicidal feelings, suicide survivors, assume their rightful place at the very heart of this conversation. The intellectual and academic argument for this is quite straightforward and clear. It is the political argument that must be confronted if we are to get past this first and most urgent obstacle to a more meaningful and useful public discourse around suicide and suicide prevention.

The politics of the medicalisation of suicide

Suicidology can be viewed as having three "parent disciplines" - sociology, psychology and psychiatry. The sociology of Emile Durkheim is still discussed in Suicidology, with his taxonomy of egoistic, altruistic, anomic and fatalistic suicides (Durkheim 1952/1897). But his most enduring legacy are the ubiquitous epidemiological studies that make up about two-thirds of the refereed research papers on suicide in recent years. Psychiatry's early pioneers on suicide include Karl Menninger (1938), Erwin Stengel (1964) and James Hillman (1964), though these were all psychiatrists of the psychoanalytic or psychodynamic school that was largely abandoned by mainstream psychiatry in 1980 with the introduction of the DSM-III (DSM 1980). The DSM-III and subsequent revisions of the DSM have been an attempt by psychiatry to establish itself more strongly as a medical science, with a diagnostic system of distinct categories of disorders that are assumed to be due to underlying medical/biological illnesses. Working from these assumptions, biological psychiatry, or *biopsychiatry*, has become the dominant influence in psychiatry, and also in Suicidology and mental health more generally.

Within psychology, one of the pioneers of modern Suicidology was Professor Edwin S. Shneidman, who was the founder and inaugural president of the American Association of Suicidology (AAS) - indeed I believe he first coined the word 'Suicidology'. Another term he coined was 'psychache' (pronounced psyche-ache), which he saw as the defining feature of all the many suicides he studied. He defined psychache as psychological pain - not illness - that was due to thwarted or frustrated psychological needs. As a psychologist, Shneidman would then apply his particular taxonomy of psychological needs when working with his suicidal clients. Shneidman sadly died in 2009, age 91, lamenting what was happening to the discipline of Suicidology that he had helped found. In particular he lamented that Suicidology was being excessively medicalised by the juggernaut of modern biopsychiatry and the DSM, which he described as "too much specious accuracy built on a false epistemology" (Shneidman 2001 p 5).

I share Professor Shneidman's lament about this trend in Suicidology. The medicalisation of suicide is now so complete that it is not only the prevailing perspective within modern Suicidology but also the popular view of the general population that sees the medical illness of Depression as the primary cause of suicide. This widespread acceptance of Depression, or occasionally some other mental "illness", as the cause of suicide has not come about because any new scientific evidence. The most that can be said about the scientific status of Depression as a biological, medical illness is that it is an hypothesis whose validity has not yet been established. And even if you accept Depression as a genuine medical illness, which is hotly contested, all that can be said is that there appears to be some correlation between depression and suicide, but it is serious error to confuse correlation with causation. Depression (even if you believe in it) is not a terminal illness. Suicide occurs when a person takes a *decision* - a deliberate, psychological, cognitive decision - to kill themselves. A suicide attempt may have medical consequences, including but not only death, but it is rarely, if ever, caused

by a medical illness. An unbearable medical illness may be a factor in coming to the decision to suicide, but even then it is the decision to die, 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 few recent decades. And the popular view that Depression causes suicide is due to a really quite massive public relations campaign, such as the *beyondblue* National Initiative on Depression in Australia, which is just one of many "defeat depression" campaigns around the world in the recent times[2]. The fallacy, the myth-making, of this public relations was summed up by Professor Shneidman as:

> *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.* (Shneidman 2002, p 200)

Another medical public relations exercise has been the touting of "evidence based mediicine", which has colonised just about every aspect of life so that we now talk about evidence based strategies, policies, programs and practices. It seems a sensible, common sense idea that the decisions we take and the activities we perform are based on the best evidence available. But the criteria for what constitutes valid evidence within the medical field are not necessarily the criteria that should be applied to other fields. For instance, the "gold standard" of medical evidence is the fully randomised, double-blind control trial (often abbreviated to RCT), which is appropriate for, say, testing new drugs, But RCTs are not only often impossible but also totally meaningless for researching many other questions. They are particularly useless for enquiring into the invisible, unmeasurable, dark depths of subjective experience. RCTs can be an excellent research method when working with observable, measurable, third-person (objective) data, but are simply irrelevant when working with first-person (subjective), experiential data. Despite this, and many other occasions when the medical criteria for the validity of evidence is inappropriate, it is the medical "hierarchy of quality of evidence" that is assumed and applied.

The supremacy of medicine's hierarchy of evidence is a reflection of medicine's power and influence reaching well beyond its own boundaries. Many qualitative researchers, not to mention first-person researchers, resist and object to this supremacy, but it is often a struggle - a political struggle. The fight against the medicalisation of everyday life, sometimes called "disease mongering", has emerged in recent years as a major social and political, as well as academic, campaign. The medicalisation of mental health is recognised as a major component of this political struggle and some early signs of progress can be seen. The same cannot be said, however, for the medicalisation of suicide, which

remains largely invisible as an issue. The politics of the medicalisation of suicide has not yet been recognised, which is one of the major obstacles to a more meaningful and useful discourse on suicide.

One further political issue must be mentioned about the medicalisation of mental health and suicide - the pseudoscience of modern psychiatry. The medical colonisation discussed above is about imposing medicine's scientific methods on non-medical issues. This argument does not question or challenge the appropriateness of medicine's research methods for medical issues. On the contrary, it assumes and accepts the judgement of the medical profession that these methods represent the best way to conduct and advance medical science. But even the best methods can be poorly applied, leading to poor science.

Modern psychiatry is not based on any good science. To say this another way, psychiatry fails to observe medicine's own criteria for what constitutes valid evidence. The clustering of symptoms that is the foundation of the DSM may be a reasonable way to formulate a hypothesis that such clusters represent the expression of some underlying disorder or disease entity. But further evidence is required to establish the validity, or otherwise, of any such hypothesis. This has not occurred for any DSM disorder. Rather, psychiatry takes a leap of faith - yes, faith - and declares these disorders to be real by little more than proclamation. This is not good practice of the scientific method that medicine insists we must observe if we are to have evidence based research, and evidence based policies, programs and practices. Psychiatry's diagnostic system is pseudoscience. It is Inevitable then that similar problems arise with the treatments psychiatry offers for disorders based on this diagnostic system, but a critique of this is beyond the scope of this chapter and others have made this critique far better than I could[3].

The pseudoscience of psychiatry (both diagnosis and treatment) is a distinct and separate political issue to the more general one of the medical colonisation of everyday life. Part of the politics here is that the other branches of medicine are well aware that psychiatry is a pseudoscience according to their own standards of what constitutes valid medical science. Despite this, the medical profession as a whole chooses to remain silent about psychiatry's myth-making. I regard this as a serious breach of the social contract we have with the medical profession, which should protect us against the obvious poor science of psychiatry and its consequences. I hold the entire medical profession, not just psychiatry, responsible for the great harm that is being done by psychiatry's flawed science.

The consequences of the medicalisation of suicide, and the politics that sustains it, are serious and often harmful. Perhaps the greatest tragedy is that once we accept that suicide is caused by some notional "mental illness", we fail to look more deeply into what is really happening for that individual that is leading them to consider suicide. Furthermore, by inappropriately blaming a faulty brain, the medicalisation of suicide locates the pathology within the individual, rather than in their environment. With this comes the stigma of a psychiatric diagnosis, which can lead to lifelong discrimination and disadvantage. And a psychiatric diagnosis is usually accompanied by psychiatric treatments, typically

drugs, which are increasingly being shown to have considerable risks, especially when taken for long periods as is often the case. And then, if you do not agree to these interventions, there is the risk that you will be detained and forced to take these treatments whether you consent or not. These are the topic of our next section, politics of human rights and suicide.

Meanwhile, the real issues behind your suicidal distress never quite get attended to. Which is a shame, a tragic shame.

The politics of suicide and human rights

Do our mental health laws help or hinder suicide prevention?

This has always seemed an obvious and important question to me. But there is so little research into this question that we really have no idea what the answer might be. This is really extraordinary, given that protecting people from self-harm, including suicide, is one of the primary justifications for most mental health laws. In an era that demands everything must be "evidence based", there is virtually no evidence that these laws either help or hinder suicide prevention[4][5]. Indeed, if these laws were judged by medical criteria of evidence, which is not unreasonable given their purpose, then they would not be permitted with so little evidence to support them.

It is commonly assumed that at times it is necessary to physically detain or restrain a person who we fear may be about to kill themselves, which is an understandable response to an understandable fear. But mental health laws are very much more than simply detaining someone on the brink of suicide. Mental health laws include criteria that must be satisfied in order to apply the human rights restrictions that these laws authorise. Typically, there must be a risk of danger to self or others that is deemed to be due to a mental illness that is in need of urgent (and effective) treatment. These laws then authorise the detention of these people and imposing medical treatment upon them, whether they consent to it or not.

We must first separate the conflation in these laws of risk to others and risk to self. Threatening other people is against the law and we have sophisticated criminal justice systems for such occasions. Further discussion of the risk of harm to others is beyond the scope of this chapter, other than to ask why extra laws, based on a person's mental health status, are deemed necessary for these situations?

Suicide and self-harm, however, are no longer illegal in most countries. From a legal perspective, this makes them very different to behaviour that threatens other people. The problem that arises with self-harm is how does society judge when it is reasonable to intervene and what kinds of interventions are acceptable, which we'll look at later. For instance, lots of people do lots of dangerous, risky things, like riding motorcycles or hang-gliding. No, of course we don't intervene to protect people from these follies. What about unprotected sex? Or excessive drug or alcohol use (including tobacco)? What

makes the risk of self-harm sufficiently dangerous to justify the state intervening and depriving a person of some quite fundamental human rights? It is very murky and arbitrary territory when society tries to make such judgements. So much so that most of the time people are allowed to, entitled to, take substantial risks. Which is as it should be.

Unless you are deemed to have a mental illness, that is. Then, everything changes. All the old rules no longer apply. And mental health laws are created. Society needs some sort of justification, some rationale, if it is to intervene in ways that deprive people of their basic rights - i.e. in ways that would otherwise be illegal. And society calls upon the medical profession to provide that rationale. If the risky behaviour can be attributed to a medical condition then society can intervene thinking that it is compassionate to do so. Although I sometimes struggle to believe it, given the many abuses that occur, in the end I do actually believe that most people believe these laws are necessary out of a genuine concern for people they see as distressed and at risk of danger.

The problem that arises here, along with the politics, is that the medical justifications do not stand up to scrutiny. As discussed above, suicide (and suicidal behaviour) is rarely, if ever, caused by a medical condition. At the heart of mental health laws is a fiction. It is a convenient fiction for those who want to contain and control people society finds disturbing, but it is a mischievous fiction when it does this by artificially labelling these people as "mentally ill". And it becomes a dangerous fiction when it then also becomes the justification for imposing medical treatments on these people without their consent.

The second great conflation found in mental health laws is that little distinction is made between detention and treatment. A proper human rights analysis would make a very clear distinction between the right to liberty and the right to refuse unwanted medical treatment. Both are serious, fundamental rights. But they are different. The best description I've heard of this difference is that detention controls *where* you are, but forced psychiatric treatment controls *who* you are. I heard this from Mary O'Hagan, a psychiatric survivor and former Commissioner at New Zealand's Mental Health Commission. And Mary, like many psychiatric survivors, regards forced psychiatric treatment as the more severe intrusion on her human rights or, in her words, "I'd rather be tied to a tree than be forced to take neuroleptic drugs".

With mental health laws based on the fiction of "mental illness", detention and forced treatment usually come as a package. Indeed some of these laws include the criteria that the mental illness must be "treatable" for the law to apply, and that the person is in urgent need of this treatment in order to prevent harm to self or others. Invariably these treatments are drugs, though it does also include ECT, electroconvulsive therapy or shock treatment, as it is often called. As noted above, the safety and efficacy of these treatments is hotly debated and beyond the scope of this chapter, other than to mention that the use of these treatments without consent adds another dimension to these

controversies. And that many survivors share Mary O'Hagan's experience of forced treatment as very much more severe than being locked up against your will.

Returning to the original question - Do our mental health laws help or hinder suicide prevention? - it can now be seen that it is reasonable, indeed necessary, to ask this question. In the absence of any formal research, what arguments or evidence can we look to for an answer to this question?

First, we must consider the human rights principles that say human rights are important because harm and suffering are the inevitable consequence of violating these rights. Furthermore, well established human rights principles say that any exceptions - or limitations, to use the legal jargon - of these rights should only be permissible when there are compelling reasons to justify it. In Australia the phrase used is that any limitations must be demonstrably "reasonable, necessary, justified and proportionate". I do not know of any jurisdiction that has presented such compelling reasons for its mental health laws. On the contrary, what we see is little more than status quo assumptions - father-knows-best assumptions - that force is necessary to save lives, but without any solid evidence to support them.

Then there is the evidence of a mountain of personal testimonials that many people experience psychiatric force as an assault. Some call it torture and demonstrate that it meets the criteria for all the recognised definitions of torture. Others liken it to rape. What is certain is that, in legal terms, psychiatric force would be an illegal assault but for the protection of mental health laws. This mountain of first-person evidence, however, is easily dismissed by the prejudices against first-person knowledge, especially when it is the knowledge of people labelled as mentally ill. The politics of first-person knowledge intersects here with the politics of human rights.

Following the first-person evidence, there is the common sense argument that assaulting someone who is already distressed, perhaps to the point of contemplating suicide, is not a helpful response. On the contrary, it can often be very harmful. I have not yet found anyone who can explain to me how assaulting a suicidal person is meant to help them. On the other hand, such an assault can push someone over the edge. For many suicidal people, the psychiatric ward is often the last straw, the last hope, that we might grasp for at the end of a long and difficult road. But instead of finding help and hope, we are assaulted. It is hardly surprising that for many this truly is the last straw. Psychiatric force is sometimes the final nudge to a suicide attempt, indeed it can trigger suicidal feelings in a person with no history of suicidality. Or, as I've heard it said, "I'd never been suicidal until I got to the psych ward".

Against this, we hear first-person testimonials of people who believe that psychiatric force saved their lives. This view puts principles aside to make a pragmatic argument that psychiatric force saves more lives than it kills, which I say contains a "gruesome equation"that requires the calculation of how many deaths due to psychiatric assault is acceptable? I fortunately do not have to nominate an acceptable

ratio because I believe that psychiatric force is never justified and that there are always alternatives to force. Advocates of force, however, are obliged to say what is an acceptable number of deaths for each life saved.

Along with deaths that are directly attributable to mental health laws due to the violence they permit, there are other serious consequences of these laws. First of all, and its remarkable that this never gets stated, these laws are the primary source of the so-called stigma of mental illness, which is more correctly called the discrimination against people labelled as "mentally ill". These laws make second class citizens of us when they deny us the right to liberty and the rights over our own bodies. All the other sources of stigma/discrimination pale in comparison so that all the "stigma busting" campaigns are a pathetic joke if they do not address this primary source.

But perhaps the most tragic consequence of these laws is that they cause many people to actively avoid the very mental health services that are supposed to be there to help them. The standard message for suicidal people is to seek professional help, but many people, especially those with previous experience of mental health services, think that the risks associated with professional help are too great. It is altogether possible that our mental health laws contribute to, rather than reduce, the suicide toll. But we don't know for sure because we have failed to ask, "Do our mental health laws help or hinder suicide prevention?"

Glimmers of hope

For most of my 10+ years as an observer and student of Suicidology, the only significant glimmer of hope – or dissenting voice, if you like – within mainstream Suicidology has been the Aeschi Group[6]. In particular, this group of eminent Suicidologists has kept alive the legacy of Ed Shneidman with their emphasis on understanding the suicidal experience from the first-person perspective of the actual suicidal person. Without Aeschi, the future of Suicidology looked very grim to me. But in just the last year or so, there are some early signs that a shift is occurring. It is too early to declare it a tipping point, but there are glimmers of hope that substantial change for the better is perhaps not too far away, though my optimism falters when I'm reminded of the medical juggernaut that still very much dominates contemporary thinking about suicide.

First, the Aeschi Group continues to develop by holding its first conference in the US ("Aeschi-West") in 2013. And I believe that the Collaborative Assessment and Management of Suicidality (CAMS) approach developed by David Jobes, one of the Aeschi founders, is beginning to get mainstream recognition (see the Aeschi website for more on CAMS). We are now also beginning to see more academics articulating a dissenting view to the mainstream, predominantly medical model of Suicidology. This parallels, but is distinct from, the growing academic discourse that is critical of the medicalisation of mental health in general. Some of these dissenting academics can be found in other chapters of this book. Ian Marsh's book *Suicide: Foucault, history and truth* is worth a special mention

as a rare voice speaking of the politics of power that sustains the status quo discourse of contemporary Suicidology. And there is now also Suicidology Online[7], a refreshing, new forum for critical thinking about suicide and Suicidology.

Another exciting development that I regard as at the cutting-edge of contemporary thinking about suicide is happening with and within indigenous communities. This is occurring in Australia and New Zealand, and I also hear of similar projects in Canada and the US. What excites me about these projects is that they are, first and foremost, deeply grounded in a grassroots understanding of local community and culture, plus they invariably also include some recognition of a spiritual dimension to the suicidal crisis. The rest of us would do well to follow and learn from the leadership of these pioneering projects.

We are also beginning to hear just a little more of the first-person survivor voice. A big step forward was taken in late 2011 when Cara Anna, a suicide survivor herself and an experienced journalist, created a blog called 'Talking About Suicide'[8]. Here she interviews fellow survivors, allowing them to tell their own story in their own words, and a year later she had over 35 interviews, many of them quite lengthy. Cara also attended the 2012 conference of the American Association of Suicidology (AAS) as part of a group of survivors, which led to an invitation for her to be the editor of a survivor blog hosted by the AAS and on their website[9]. It remains to be seen whether the AAS can resist interfering with this blog so that it can truly be a forum that is run by and for survivors. But for the moment, the AAS is to be applauded, along with Cara Anna, for taking this initiative. With the global influence of the AAS, this breakthrough may well be duplicated by other Suicidology and suicide prevention organisations around the world. If this occurs, then I firmly believe it will be a catalyst for some major re-thinking about suicide, which would include some of the issues raised in this chapter.

I've said little about (therapeutic) interventions for helping suicidal people, mainly because it's not my area of expertise. But along with Jobes' CAMS approach to therapy, and the exciting indigenous led initiatives, there are a couple of others worth mentioning as glimmers of hope and signposts for the future. First, there is a growing interest (and expertise) in what can be called narrative therapies, which is occasionally being applied to working with suicidal people – indeed narratives, story-telling, are essential elements of both the CAMS and indigenous approaches. In some areas, Narrative Therapy is a well developed discipline and we even see it emerging in narrative medicine and narrative psychiatry. If Suicidology is to fully engage with the first-person voice of survivors then narrative methods, for both research and therapy, will inevitably have a critical role. Another example where narrative is a key element of a suicide prevention program, this time called simply story-telling or 'sharing', is the fellowship of Suicide Anonymous (SA) in the US. Like the 12-step program of Alcoholics Anonymous that SA is based on, the heart and soul of SA is the sharing of stories amongst a group of peers. Of interest, is that the AAS website now has a link to SA's website, which I don't think I would have seen even a couple of years ago.

I also want to mention the Maytree Respite Centre in the UK, even though I only know them by their website (though some UK friends speak highly of them). But on face value, at least, they represent a clear signpost of what is urgently needed in suicide prevention. The most critical need during times of crisis is a safe space where you can just be yourself – and a safe space where you can tell your story (see above). Maytree explicitly offers this safe space, specifically for people who are feeling suicidal. They do not seek to impose any particular therapy on their residents, nor judge them in any way. Rather, they simply offer refuge and sanctuary and respite. The great pity is that they are only able to offer their safe space for relatively short periods of time. But even so, they provide a service that is desperately needed, especially given that our psychiatric wards are, in stark contrast, such unsafe spaces for suicidal people.

I should also briefly mention my own work, where I argue for reconceptualising the suicidal urge as a crisis of the self, rather than due to some notional "mental illness". Sometimes, as in my own case, this crisis of the self is a spiritual crisis, so Suicidology needs to open its doors and consider spirituality as both a possible cause as well as a potential remedy for a suicidal crisis. I then call for a broad community conversation on suicide, with survivors at the centre, to confront the prejudice and discrimination against suicide and suicidal people. I further argue that the key to suicide prevention is "mentally health" communities – I'd prefer to not use this language, but I find it handy as people grasp the idea easily and quickly. And that one clear sign of a mentally healthy community is one that is capable of a sensible, honest and open conversation about suicide. Few people argue with me when I say that the community I live in is not a particularly "mentally healthy" – indeed, societies can be suicidal too and there's plenty of signs (symptoms) of this in the world I live in. I also argue that this healthy, open and honest community conversation on suicide is a healing conversation that would help prevent many suicides.

I have been somewhat surprised, though, to learn that the most radical argument I make, apparently, is to encourage my suicidal soul-mates to value their suicidal feelings as meaningful, significant and important, indeed as very special and even sacred. Some people find this shocking and dangerous, which amazes me. But more importantly, where it really matters, I get terrific feedback from my suicidal soul-mates that they find these words reassuring, comforting and even liberating. At first I was rather surprised by this, but have since seen how radically true this can be when you have lived with, and even internalised, the prejudices and hatred towards suicide and suicidal people that have been discussed above.

Finally, I have found a further glimmer of hope through my work in the disability community. With their overtly political campaign slogan of Nothing About Us Without Us, a strong first-person statement if ever there was one, people with disabilities have fought for the demedicalisation of disability and a shift to a social model of disability. Politically and intellectually, this campaign has now largely been won with the adoption of the UN Convention on the Rights of Persons with Disabiltities (CRPD), though the struggle continues as it shifts to seeing the Convention comprehensively implemented.

Although we are relative latecomers to the disability movement, the Convention unequivocally includes people who experience psychosocial disability – a much preferred term than "mental illness". This has prompted a lively discourse on how, with the help of the Convention, we might implement a social model of madness. This discourse has not yet reached contemporary Suicidology, but it is inevitable that it will someday.

The glimmers of hope mentioned here would all sit neatly under a social model of suicide prevention, with the CRPD as the blueprint for its implementation. I look forward to that day, which only very recently do I now feel able to believe is not only possible but perhaps not too far off. We must not kid ourselves, though. The resistance will be great from those with vested interests in the status quo. The academic and intellectual arguments for radical change are compelling, though they still need to be further developed and articulated as broadly as possible. The biggest obstacle, however, is the politics of suicide, in particular the politics of first-person knowledge, of the medicalisation suicide, and of suicide of human rights.

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Endnotes

[1] I must also mention what the *Comprehensive Textbook of Suicidology* has to say about spirituality, given that spirituality was the primary motivation for my PhD. The only mention of spirituality in the 650+ pages of this "comprehensive" textbook is 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). It appears that spiritual values and needs are relevant to these authors for the writing of a book but, alas, not at all for the scientific study of suicide.

[2] A recent and telling example of the manufacturing of the belief that depression is a medical illness that causes suicide can be found in a document from the EC-led European Pact for Mental Health and Well-Being titled, "Prevention of depression and suicide. Consensus paper", edited by K. Wahlbeck and M. Mäkinen (2008). When it states that "Suicide is primarily an outcome of untreated depressive illness" in what purports to be a consensus paper, the politics of suicide prevention

becomes apparent. There is no such consensus. Many people, including (dissenting) psychiatrists, psychologists, social workers as well as psychiatric survivors, disagree with this assertion. Wahlbeck and Mäkinen could not possibly have been unaware of this. To find such a statement in a consensus paper says more about the politics of exclusion, rather than the science, of Suicidology.

[3] There are now many authoritative critiques of both psychiatry's diagnostic system and its treatments. For me, the two outstanding authors in this area are Richard Bentall and Joanna Moncrieff. I regard Bentall's *Madness Explained* as a classic, although it has been somewhat superseded by subsequent books. And Moncrieff's "drug-centred model" of psychopharmacology in *The Myth of the Chemical Cure* (2009) quite brilliantly exposes the flaws in psychiatry's "disease-centred model". And I would add Robert Whitaker's book, *Anatomy of an Epidemic* (2010), as another important milestone in the critique of modern psychiatry.

[4] One study that specifically investigates the relationship between mental health laws and suicide rates is the paper by Burgess et al (2004) that compared suicide rates among 100 countries with a diverse range of mental health legislation (including sometimes none). The aim 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" but instead they found that "Contrary to the hypothesized relationship, the study found that after introducing mental health initiatives (with the exception of substance abuse policies), countries' suicide rates rose." They conclude that "It is of concern that most mental health initiatives are associated with an increase in suicide rates." And I would add that it is alarming that such a disturbing finding has not been investigated further.

[5] One major study looking into the efficacy of mental health laws that did include suicide as a variable was done by the UK Department of Health (2007), which concluded that "It is not possible to state whether community treatments orders (CTOs) are beneficial or harmful to patients." Another by Kisely et al (2005), though without suicide as a variable, concluded that "Based on current evidence, community treatment orders may not be an effective alternative to standard care. It appears that compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care." They further noted that "It is, nevertheless, difficult to conceive of another group in society that would be subject to measures that curtail the freedom of 85 people to avoid one admission to hospital or of 238 to avoid one arrest."

[6] http://www.aeschiconference.unibe.ch/

[7] http://www.suicidology-online.com/

[8] http://whichtools.wordpress.com/

[9] http://attemptsurvivors.com/