Critical Suicidology

Transforming Suicide Research and Prevention for the 21st Century

Edited by
Jennifer White, Ian Marsh, Michael J. Kral, and Jonathan Morris

UBCPress · Vancouver · Toronto

23 22 21 20 19 18 17 16 15 5 4 3 2 1

Printed in Canada on FSC-certified ancient-forest-free paper
(100% post-consumer recycled) that is processed chlorine- and acid-free.

Library and Archives Canada Cataloguing in Publication

Critical suicidology : transforming suicide research and prevention for the 21st century / edited by Jennifer White, Ian Marsh, Michael J. Kral, and Jonathan Morris.

Includes bibliographical references and index.
Issued in print and electronic formats.
ISBN 978-0-7748-3029-4 (bound).—ISBN 978-0-7748-3031-7 (pdf).—
ISBN 978-0-7748-3032-4 (epub)

1. Suicide. 2. Suicide—Prevention. 3. Suicide—Sociological aspects. 4. Suicidal behavior. I. White, Jennifer, editor

HV6545.C75 2015 362.28 C2015-905396-X
C2015-905397-8

Canada

UBC Press gratefully acknowledges the financial support for our publishing program of the Government of Canada (through the Canada Book Fund), the Canada Council for the Arts, and the British Columbia Arts Council.

UBC Press
The University of British Columbia
2029 West Mall
Vancouver, BC V6T 1Z2

www.ubcpress.ca

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Introduction

Rethinking Suicide

JENNIFER WHITE, IAN MARSH, MICHAEL J. KRAL, AND JONATHAN MORRIS

Throughout the world, suicides account for a significant number of premature deaths each year. According to the World Health Organization (WHO), one million people die by suicide annually, representing a global mortality rate of 16/100,000 (WHO, 2013). Each suicide is estimated to personally affect at least seven individuals (Canadian Association for Suicide Prevention, 2004). Suicide, like many other complex social problems, is often a subproblem of other, larger problems (Brown, Harris, and Russell, 2010). For example, newspaper headlines such as "Greek woes drive up suicide rate" (Smith, 2011) or "Rape, bullying led to N.S. teen's death says mom" (Canadian Broadcasting Corporation, 2013) attest to the fact that suicide cannot be easily understood in singular, static, or acontextual terms. On the contrary, suicide and suicidal behaviours are deeply embedded in particular social, political, ethical, and historical contexts. As such, they are rarely amenable to cause–effect reasoning, quick fixes, or technical solutions. In short, suicide is a complex problem that is always "on the move." Not surprisingly, given its complexity, the evidence about how to prevent suicide and suicidal behaviours is rather sparse (DeLeo, 2002; Gould and Kramer, 2001; Mann et al., 2005; Thompson, 2005). We contend that this provides an opening for fresh thinking and justifies the consideration of alternative approaches.

As one step in this direction, this book offers a theoretically diverse and imaginative challenge to the existing order within suicidology. We begin

from the premise that we need frameworks, strategies, and concepts that are relevant for the complex times in which we are all living. The authors of this edited volume argue, in their own different ways, that the field of suicidology has become too narrowly focused on questions of individual pathology and deficit, as well as too wedded to positivist research methodologies, and thus has come to actively exclude from consideration approaches to understanding and preventing suicide that do not fit well with these orthodoxies. This book thus sets out to critique this contemporary "regime of truth"; it also proposes a number of coherent, practical, and creative alternatives to the status quo. It takes a critical perspective on suicide and suicide prevention in an effort "to understand a social reality through introduction of another, more penetrating frame of reference … beyond accepted explanations and rationalizations … [from] a wider frame of reference than the discipline in question" (Kagan, Burton, Duckett, Lawthom, and Siddiquee, 2011, p. 12). Collectively, this volume represents a reframing of suicide and suicide prevention; it moves away from the usual objective and positivist approaches towards more contextualized, poetic, subjective, historical, ecological, social-justice-oriented, and political perspectives. We hope this book will help contribute to the creation of a field of critical suicidology.

Mainstream Suicidology and Its Limits

Some American observers have suggested that the field of suicide studies or "suicidology" was born in the 1950s and 1960s with the published works of Norman Farberow and Edwin Shneidman (Spencer-Thomas and Jahn, 2012); actually, a much longer history of the medical-scientific study of suicide can be traced (Laird, 2011; Marsh, 2010). For example, early-nineteenth-century medics formulated ideas about the causes and treatment of suicidal behaviours that are strikingly similar to contemporary approaches to understanding suicide in terms of individual pathology. (They also sought to make use of statistics and empirical clinical observations to guide their actions and reasoning.) At different times the study of suicide has produced highly contextualized and nuanced framings of suicide. This includes, for example, various sociological treatises since Emile Durkheim's foundational 1897 text (e.g., Atkinson, 1978; Douglas, 1967; Halbwachs, 1978) as well as the more recent books and papers of Edwin Shneidman (1985, 1993, 1996). In recent years, however, we have seen a return to approaches to research, policy, and practice more redolent of nineteenth-century reductionist, mechanistic medicine.

The identification and management of individual risk has dominated professional and research conversations in the field of suicidology for several decades now. As Douglas (1992, p. 16) trenchantly observed, living in a risk society means we are "ready to treat every death as chargeable to someone's account, every accident as caused by someone's criminal negligence, every sickness a threatened prosecution." In this context, it is not altogether surprising that the evidence-based practice (EBP) movement has gained so much traction among suicidologists and clinical practitioners (Rodgers, Sudak, Silverman, and Litts, 2007). At the heart of EBP is the idea that program and policy decisions should be informed by a rational (i.e., scientific) understanding of "what works." This has the effect of rendering suspect all other ways of knowing (practical wisdom, traditional Indigenous knowledge, learning through experience, collaborative knowing, etc.).

As each of the authors of this book suggests, when a singular form of evidence is privileged as superior or more "truthful" than others, much gets lost, including creativity, plurality, and freedom of thought (Holmes, Murray, Perron, and Rail, 2006). Furthermore, the notion of "evidence" is typically discussed as if it is neutral and unproblematic – as if the techniques and claims of science are beyond questioning. This unreflexive approach to research and practice entrenches a singular view of knowledge production and suicide prevention; besides that, the authority with which the EBP discourse is expressed misleadingly suggests we can be certain about the effectiveness of scientific approaches to preventing suicide. This is far from the case.

That *quantitative* researchers have made important contributions to suicidology is beyond dispute. Yet it is increasingly apparent that a persistent positivist bias has resulted in an intellectual culture that privileges scientific medical approaches over other ways of knowing about suicide, including interpretive, moral, and aesthetic ways (Fitzpatrick, Hooker, and Kerridge, 2014). For example, from 2005 to 2007, less than 3 percent of the research articles published in three international suicidology journals were based on qualitative studies (Hjelmeland and Knizek, 2010). Meanwhile, the editor of one of the most prominent North American journals dedicated to the study of suicide has recently suggested that "an insistence on the rigorously and quantitatively scientific [is] a natural next phase for a maturing field of knowledge … without which genuine progress is distinctly unlikely" (Joiner, 2011, pp. 471–72). We argue that such a narrow and hierarchical approach to knowledge generation belies the instability and plurality of the problem and also excludes and marginalizes potentially important voices in our ongoing conversations about suicide. Ian Marsh and Heidi Hjelmeland take up

this particular critique in more detail in the first two chapters of this volume.

In a related vein, suicide prevention programs and interventions are frequently conceptualized in universal, apolitical, and decontextualized terms, giving them a "one-size-fits-all" quality (Rogers and Soyka, 2004). In sharp contrast, this book takes as its starting point the idea that suicide is characterized by multiplicity, instability, social context, complexity, and historical contingency. As Marsh (2010, p. 7) has recently noted, "suicide as a discursively constituted phenomenon will always resist complete description, if for no other reason than as a cultural product it lacks any unchanging essence that could act as a stabilizing centre by which to secure such a description."

For this reason, we suggest that multiple frameworks, methodologies, epistemologies, and perspectives – including the unique first-person, "insider knowledge" (Epston, 1999) that is available to those whose lives have been directly touched by suicide and suicidal behaviour, as well as the local knowledge of particular communities – are required to adequately (re) theorize suicide and its prevention. Range and Leach (1998) made much the same point when they recommended that greater methodological diversity and a more reflexive and humble posture towards knowledge generation (exemplified by many feminist and qualitative research frameworks) be seriously considered if the field of suicidology was to advance in any meaningful way. There are, of course, many scholars and practitioners who are approaching the study and prevention of suicide from multiple perspectives and diverse disciplinary traditions, but as Fitzpatrick, Hooker, and Kerridge (2014, p. 5) have observed, "this is not necessarily true of suicidology," which as a distinct social practice coheres around specific values and professional commitments that authorize what can be seen, known, and done. By raising new questions, exposing taken-for-granted assumptions, and directly challenging the current orthodoxy governing suicide prevention, including the discourse of EBP, this volume offers a range of fresh possibilities for reimagining alternatives.

Organization of Book

We have already hinted at some of the limitations of static descriptions, categorical thinking, and narrow conceptualizations of knowledge for acquiring a richer understanding of suicide and suicide prevention. But we also recognize that we can never completely abandon our inherited

vocabularies, traditions, and ways of making sense of the world, which in the West typically means that we are always influenced by discourses of individualism, neoliberalism, and humanism and their embedded assumptions about autonomous selves, rationality, scientific progress, and human achievements. Despite our best efforts to rethink suicide, we are limited by the terms and categories we have inherited (Gergen, 1999). This means that while we may get closer to capturing some of the fluid, dynamic, multiple, contradictory, and discursive qualities of suicide, selves, or knowledge, we will continue to bump up against the limits of language and categorical thinking. With all this in mind, an unexpected challenge has been how to organize the sections and chapters of this volume in a way that does justice to our multiplicities as authors and editors. We are all multiply constituted, and our identities are neither static nor final; that is why it has been so difficult to decide how to represent authors, frame contributions, and group chapters into sections – whatever choices we make will be problematic.

Also, readers will be coming to this work with their own multiple and overlapping identities – as suicide prevention practitioners, social activists, academics, suicide attempt survivors, educators, bereaved persons, students, and service users, among others. Since these are not discrete identity categories, we cannot predict which chapters will have the most resonance for different readers. At the same time, even though a key strength and unique contribution of this book is the variety of perspectives, traditions, and experiences being brought together in one volume, all of this diversity may present some challenges to audiences, who will encounter very different orientations, writing styles, world views, intellectual traditions, and points of departure. Rather than attempt to smooth over these differences, we prefer to let them stand as sites of creative tension and as a testament to our multiplicities as authors, editors, and readers.

After much deliberation, we have organized the book into three parts. Part 1, "Critiquing Suicidology: Constructions of Suicide and Practices of Prevention," offers different (but overlapping) critiques of the current dominant "regime of truth" in the study of suicide and the practice of suicide prevention. Each chapter critically engages with some of the dominant ways in which knowledge about suicide is produced and calls for more expanded approaches. In Chapter 1, Ian Marsh outlines a number of key assumptions that underpin contemporary suicidology and calls into question the usefulness to practice of each of these beliefs. He argues that by unsettling these taken-for-granted assumptions, we can create a space where new ideas and practices may emerge, allowing the field of suicidology to move away from

its overreliance on expert notions of individual deficit and pathology and towards more genuinely inclusive, collaborative approaches that can draw on a wider range of knowledge and experiences in relation to suicide prevention. In Chapter 2, Heidi Hjelmeland advances the argument that current efforts to research suicide are dominated by quantitative methods that have focused largely on analyses of individual risk and protective factors and the performance of psychological autopsies, with a reliance on the randomized controlled trial as the "gold standard" for building the knowledge base about suicide. She argues for a greater emphasis on qualitative, socioculturally informed, multidisciplinary forms of research to enhance our understanding about suicide.

In Chapter 3, Lisa Wexler and Joseph Gone focus on suicide prevention in North American Indigenous communities. They illustrate how scientific and medicalized descriptions of suicide – which characterize most mainstream prevention and intervention efforts – risk recolonizing the very people the efforts are designed to help. In a call for a more culturally responsive approach to suicide prevention, Wexler and Gone examine the effects of multidimensional trauma and the role of interpersonal social responses. They underscore the need for approaches that engage with the longer-term project of decolonization. In Chapter 4, Jonathan Morris explores how the assumptions embedded in conventional suicide prevention approaches get played out in a classroom setting. Drawing on his research with students and educators involved in a classroom-based youth suicide prevention program, Morris argues that "suicide" is made intelligible within this setting in a distinctive, productive, but ultimately highly constrained way. He explores the limitations placed on what students and educators can say and do within such programs, arguing that "messier" but potentially more useful conversations are being obscured through such practices. In Chapter 5, Simone Fullagar and Wendy O'Brien describe the results of their qualitative inquiry into womens' experiences of depression, with a focus on those who reported thinking about suicide. They critically explore the role of gendered discourses in the framing and production of suicide as a problem. Their research underscores how qualitative methods, and the posing of different kinds of questions, can make it possible to explore dimensions of the sociocultural context of suicide.

Part 2, "Insider Perspectives," brings together the perspectives of those who have direct personal knowledge of suicide and suicidal behaviour, making this section one of the most original contributions to this edited volume. Becker (1996) argues that knowing the actor's point of view makes for more rigorous and complete research. The voices of those who have "insider

knowledge" have largely been erased in much of the published suicidology literature, which has tended to privilege the voices of researchers, academics, and other experts. This is a problematic rendering since it suggests that "insiders" are always other to the "researchers and other experts." This dualism is productively undermined in Chapter 6 by Marnie Sather and David Newman, who write from the perspective of narrative therapists *and* as "insiders," since both have survived the loss of a loved one to suicide. Their chapter describes their innovative work with those who are grieving a loss due to suicide. They highlight the importance of using carefully crafted questions to elicit culturally salient ways of making meaning that privilege the existing knowledge, skills, and experiences of those who are bereaved.

In Chapter 7, Yvonne Bergmans, Andrea Rowe, Michael Dineen, and Denise Johnson integrate professional knowledge with the knowledge of those who have lived through the experience of being suicidal. They critically examine how professional knowledge narrowly constructs persons in distress and discuss the implications for those who seek professional help. In Chapter 8, building on this theme, Andrea Rowe offers a compelling narrative of her experience living with recurrent suicidality and multiple psychiatric hospitalizations. She critically reflects on the multiple forms of stigma that accompanied these experiences and directly challenges professional assumptions that position suicidal individuals as manipulative attention seekers, underscoring that suicidal behaviours are fuelled by anguish, desperation, loss of control, and hopelessness.

Part 3, "Creating Alternatives: Re-envisioning Suicide and Prevention," explores potential alternatives to evidence-based suicide prevention programs, which are so often imposed on minority groups and other communities. In Chapter 9, which is based on a keynote presentation, Vikki Reynolds shows how a social justice orientation demands that we rethink current biomedical and individualistic understandings of suicide. Her highly original analysis involves using language in creative ways. She illuminates how stigmatized minority groups at higher risk for suicide suffer socially, even while their suicides are blamed on individual risk factors – their "psychopathologies." Meanwhile, research is increasingly showing that evidence-based programs do not work well with minorities (Castro, Barrera, and Martinez 2004; Castro, Barrera, and Steiker, 2010), which brings into question the cherished principle of program fidelity. In Chapter 10, Rob Cover explores the issue of suicide and suicidal behaviour among queer (i.e., nonheterosexual and non–gender normative) youth. Drawing on dominant representations of queer youth suicide in popular culture as well as in mainstream suicidology, he

offers an original and powerful critique informed by poststructural analysis. Arguing that current explanatory frameworks are often dated, oversimplified, and limited, he offers some fresh alternatives. Specifically, he suggests that rather than continuing to focus narrowly on preventing suicide among queer youth, it might be more productive to shift attention to "how sexual subjectivity is produced through narrow discourses that continue to posit a heterosexual norm and a tolerated homosexual other."

Chapter 11, which is quite different in style from previous chapters, provides a philosophical treatment of suicide and is punctuated by a series of personal poems written as responses to suicide. Specifically, Katrina Jaworski and Daniel Scott offer a challenging yet provocative reading of suicide by drawing on the selected works of poets and philosophers such as Jacques Derrida, Judith Butler, Margaret Atwood, and Jan Zwicky. They explore how it is that much of our experience of suicide remains unfathomable even though many decades of empirical research and thought have been devoted to rendering the subject understandable. The authors suggest that poetry offers a medium through which we can explore the unfathomability of suicide, particularly in relation to its temporal aspects. Poems can address questions that are usually absent from academic considerations of the subject; they also demonstrate the potential usefulness and importance of such an approach to suicidology. In Chapter 12, Michael Kral and Lori Idlout show how the community's point of view can be applied towards effective suicide prevention for Indigenous peoples, who have the highest suicide rates in North America. Their chapter injects culture – a long-neglected topic – into suicidology (Colucci and Lester, 2012). Finally, in Chapter 13, Jennifer White highlights how mainstream, school-based suicide prevention programs narrowly construct youth. She offers alternatives that promote practices of collaboration, possibility, accountability, and joint action. Part 3 of the book, then, provides clear examples of what is possible when researchers, practitioners, and policy makers begin with a different point of departure than mainstream suicide prevention efforts.

Towards More Generous, Creative Possibilities

As editors, we have brought several decades of experience as clinicians, researchers, educators, policy analysts, community action workers, and suicide prevention practitioners to the task of compiling this unique volume. Our own individual and collective experiences of disquietude with standard approaches to suicide prevention have united us in our attempts to seek out

alternatives. Given the diverse, unfixed, relational quality of human experiences, and given the disproportionately high rates of suicide and suicidal behaviours among certain groups (e.g., Indigenous populations in North America and elsewhere, sexual minority populations, males, elderly persons), singular or standardized ways of understanding and preventing suicide, based on psychiatric and psychological formulations of individual pathology, can be of only limited usefulness.

New voices in the field of suicidology need to be heard if we are truly to comprehend suicide in this present moment in all its complexity and difficulty. This means making space to hear the contributions of social justice advocates and activists, poets, mental health practitioners, service users, those with lived experience of suicidality and their family members, and Indigenous peoples, as well as anthropologists, child and youth care practitioners, and qualitative researchers, among others. This book brings together these voices, and the result is a unique volume that we believe respectfully challenges the status quo of suicidology and opens up new conversations on the subject of suicide and its prevention. By creating a more expansive platform for these theorists, researchers, practitioners, service users, and advocates to be heard – several of whom have historically occupied positions on the margins – this volume invites a fresh consideration of what suicide prevention work can and could involve; it also makes a compelling case for the development of genuine alternatives to the limited, theoretically unimaginative, and often ineffective approaches that dominate the field at this present time. The book thus fits within the interpretive, critical social sciences (Rabinow and Sullivan, 1987).

With this volume, our hopes have been raised that genuine, practically grounded alternatives are within our grasp. We believe the time is ripe to consider new questions and to explore practices that are transdisciplinary and imaginative (Brown, Harris, and Russell, 2010). We do not seek to provide definitive answers, but neither do we aim to shut down debates that can provide productive avenues for exploring differences and clarifying positions. We are dedicated to pursuing approaches that are grounded in a strong set of ethical and socio-political relations. In other words, we are interested in frameworks, theories, and practices that can make a positive difference in the world in which we all live. We agree with Raewyn Connell (2011, p. 6), who captures our vision for an engaged and democratic social science: "Social science has some capacity to multiply the voices heard in public arenas. And social theory has a capacity to bring imagination into dialogue with current reality. Doing social theory always means recognizing that things could be otherwise; that – to borrow a phrase again – "another

world is possible." The kind of world we want to make possible is one in which suicide prevention research and practice efforts are attuned to processes rather than exclusively content driven. We envisage a world where taking risks with language and thinking is permissible, where relational processes and understandings become the norm, where planning and knowledge-generation efforts are more democratic and less hierarchical, where the definition of evidence is open to qualitative perspectives, and where efforts to prevent suicide are more community-led and less professionally owned. In short, we envisage a future where relational, strengths-based, culturally responsive, and social justice–oriented approaches to understanding, caring about, and transforming the world come to prevail.

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PART 1

Critiquing Suicidology: Constructions of Suicide and Practices of Prevention

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1

Critiquing Contemporary Suicidology

IAN MARSH

> *A picture held us captive. And we could not get outside it, for it lay in our language and language seemed to repeat it to us inexorably.*
>
> – Wittgenstein, *Philosophical Investigations*

How can we best understand what suicide and suicide prevention are now? By this I mean, how can we think about the ways we have come to conceptualize suicide, the assumptions we make about what it is, what should be done, and by whom? I do not think these are idle, abstract, academic questions, for the truths constructed in language about suicide (in defining what it is, and its causes and solutions, for example) produce many material effects in terms of national and international policies, research priorities and funding, and prevention practices. More subtly, a whole field of experience is formed in relation to authoritative knowledge of suicide – for suicidal people, attempt survivors, and their families and friends, as well as professionals involved in prevention and research.

One way of engaging with these questions is to map the discursive, practice, and institutional resources most commonly brought to bear in constructing "suicide" as a particular sort of issue that requires a certain set of

responses in order to manage it. By attempting to map discourses[1] in relation to suicide, we can ask questions such as these:

- How is suicide most commonly talked about?
- What are constructed as the truths of suicide?

Similarly, if we look to map practices, we can ask:

- What is done in relation to suicide? By whom?

And if we look at the institutions most usually involved in conceptualizing and managing suicide as a problem, we can ask:

- Who gets to speak the truth of suicide?
- What happens to people identified as being at risk of suicide?

In attempting to explore the ways in which contemporary truths of suicide have come to be discursively formed, and the related "truth-effects," we are seeking to cast some light on the "kinds of familiar, unchallenged, unconsidered modes of thought [on which] the practices that we accept rest" (Foucault, 1988, p. 155). This form of inquiry has a critical and ethical dimension (Brookfield, 2011), for in looking to identify the assumptions that frame our thinking and determine our actions in relation to suicide, and in asking questions about the effects of so constituting the subject/field based on those assumptions, we can begin a discussion about whether the assumptions identified and examined could usefully be retained, modified, or discarded. Again, these are not idle or abstract academic discussions, or mere questions of semantics, for how we frame the issue of suicide has material effects from the macro (e.g., in the formulation of national policies and the distribution of large-scale research funds) through to the micro (e.g., in the shaping of the conversational interaction between therapist and client). I would argue that such an inquiry is necessary today in suicidology, for what are in essence assumptions are too often unreflectively taken to be undeniable truths, and the effects of the continual production and reproduction of these truths have remained largely unexamined.

Suicidology Now

In a previous study (Marsh, 2010), I suggested that within contemporary suicidology, there are particular assumptions that dominate research and practice:

1. Suicide is pathological ("People who kill themselves are mentally ill").

2. Suicidology is science – ("We will come to the best understanding of suicide through studying it objectively, using the tools of Western medical science.")
3. Suicide is individual – ("Suicidality arises from, and is located within, the 'interiority' of a separate, singular, individual subject.")

These three assumptions could usefully be critiqued in terms of their value and utility. Each is outlined in more detail below. I show how they enter into and guide research and practice by reference to a recently published chapter in *The International Handbook of Suicide Prevention* (Silverman, 2011). I then discuss the limitations unnecessarily placed on our understanding of suicide by the insistence on the truth and necessity of these assumptions, alongside a brief consideration of other possibilities for thought and action that are opened up once one breaks free from such constraints.

Suicide Is Pathological ("People who kill themselves are mentally ill")

This is, I think, the most commonly held (and defended) assumption in suicidology. In many ways it is the dominant assumption that drives research, policy, and practice. Modern suicidology is founded on this claim (Marsh, 2010). It seems to have been implicitly accepted as a truth of the field, albeit sometimes expressed overtly:

> In all the major investigations to date, 90 to 95 percent of people who committed suicide had a diagnosable psychiatric illness. (Jamison, 1999, p. 100)

> Approximately 95 percent of people who die by suicide experienced a mental disorder at the time of death. (Joiner, 2005, p. 191)

> A review of 31 studies involving 15,629 cases of suicide reported that 98% had ICD- or DSM-defined mental disorder. (Kapur and Gask, 2006, p. 260)

> The presence of a psychiatric disorder is among the most consistently reported risk factors for suicidal behavior. Psychological autopsy studies reveal that 90–95 percent of the people who die by suicide had a diagnosable psychiatric disorder at the time of the suicide. (Nock et al., 2008, p. 139)

Such a position (that people who kill themselves are mentally ill) tends not to be offered up as one possible reading among many. (White and

Morris, 2010), but rather as the most important factor, one that should not be overlooked. Kay Redfield Jamison (1999, p. 255), for instance, writes that to ignore "the biological and psychopathological causes and treatments of suicidal behavior is clinically and ethically indefensible."

These claims are often framed as unassailable truths, and they have come to dominate thinking on suicide to such an extent that it is now hard to think otherwise about the issue, or to imagine suicide prevention practices not in some way diagrammed in relation to mental illness and its detection and treatment. Margaret Pabst Battin (2005, p. 173) writes of the "uniform assumption that suicide is the causal product of mental illness, the normatively monolithic assumption seemingly so prevalent in contemporary times," and argues that "the only substantive discussions about suicide in current Western culture have concerned whether access to psychotherapy, or improved suicide-prevention programs, or more effective antidepressant medications should form the principal lines of defense" (p. 164).

Of course it hasn't always been thus. Prior to its modern "medicalization," suicide in Europe had for a long time been thought of and managed predominantly as a sin and a crime (MacDonald and Murphy, 1990; Watt, 2004). With the emergence of a recognizable "psychiatric" profession in England and France from the late eighteenth century, alongside the rise of the asylum as a site of containment and study of the "mentally ill," patient suicide came to be formed as a distinct type of problem (see Esquirol, 1821, for example), and responsibility for the care and management of the suicidal increasingly fell to (or was claimed by) asylum physicians, alienists, "mad doctors," and attendants (Hacking, 1990; Marsh, 2010).

Without doubt this reformulation of suicide as a question of pathology opened up many possibilities for thought and action (as is evidenced by the vast psychiatric, psychological, and psychotherapeutic literature on the subject), but it is perhaps worth noting here the somewhat arbitrary nature of the early-nineteenth-century claiming of suicide for medicine – for there was no discovery of pathological anatomy (Esquirol, 1821; Forbes, 1840), or of diseased instincts or impulses (Prichard, 1840), to support medical claims of expertise. An aetiological link between underlying pathology and signs and symptoms of "suicidality" has been theorized in many different forms since, but empirical support has proved to be elusive.[2] What *has* been established, though, is a self-authenticating style of reasoning that, in Ian Hacking's terms (1992, p. 132), "generates its own standard of objectivity and its own ideology." Such a "regime of truth" (Foucault, 2002, p. 131), formed around a "compulsory ontology of pathology" (Marsh, 2010), has been productive, but perhaps due to the unresolved uncertainties associated

with the main disciplines involved in suicidology (psychiatry and psychology) with regard to the truth-status and utility of the knowledge it generates, it is a field that has remained somewhat defensive, unreflective, and uncritical in relation to the assumptions under which it operates.

Although there remains a lack of convincing empirical findings of a link between underlying (physical or mental) pathology and suicidal acts (Hjelmeland, Dieserud, Dyregrov, Knizek, and Leenaars, 2012), there is still an obvious strategic logic to the idea that mental illness causes suicide and that we should therefore work to identify and treat those unwell but currently un- or under-treated in order to reduce deaths.[3] It is perhaps the limitations of such an approach that need to be acknowledged more openly, and the assumptions that underpin it more thoroughly held up to critical inquiry. At the very least, even if operating from within a predominantly health or medical paradigm in relation to suicide, we should question the often-assumed aetiological link between mental illness and suicide, acknowledge that the identification of those at risk remains highly problematic in the absence of observable clinical signs or objective tests (Law, Wong, and Yip, 2010), and admit that the evidence for the effectiveness of interventions once "suicidality" has been identified is sparse (van Praag, 2005; Johannessen, Dieserud, Claussen, and Zahl, 2011; Nock et al., 2013). Such a critical stance can help us cast light on the utility of allowing the assumption that suicide is best understood (or should only be understood) in terms of individual mental illness to dominate suicide theory, research and prevention practices to the extent that it does.

Suicidology Is Science ("We will come to the best understanding of suicide through studying it objectively, using the tools of Western science")

That suicide should be studied "scientifically" has become another truth within suicidology. The opening sentence of the *International Handbook of Suicide Prevention* (2011) has it that "suicidology *is* the science of suicide and suicide prevention" (O'Connor, Platt, and Gordon, 2011, p. 1; emphasis added). In theory, such a stance is unproblematic – if science is taken to be "the intellectual and practical activity encompassing the systematic study of the structure and behaviour of the physical and natural world through observation and experiment" that leads to "a systematically organized body of knowledge on a particular subject" (Oxford Dictionaries). In practice, however, what constitutes a "scientific" approach within suicidology has come to be defined in a very narrow way. The editor of one of the main suicide journals,

Suicide and Life-Threatening Behavior, recently wrote of the "values, priorities, and procedures" (Joiner, 2011, p. 471) in place at the journal, concluding that it was only by means of "hypothesis testing with fair tests using valid and quantifiable metrics" (Joiner, 2011) that the field of suicidology would advance. Thus, the "accurate translation of complex phenomena into numbers, numbers then amenable to inferential statistical analysis, or, at the very least, descriptive statistical analysis," is taken to be the most desirable approach to studying the subject. In terms of papers that would be considered for publication in the journal, a hierarchy is established whereby

> the fully experimental design is advantaged over the quasi-experimental and the quasi-experimental over the nonexperimental. All other things being equal, the multistudy paper will compete for journal space more successfully than the single study (because of, among other factors, the emphasis on reproducibility), as will the longitudinal more than the cross-sectional, and the quantitative more than the qualitative (Joiner, 2011, p. 471)

This positioning of suicidology as a particular sort of (positivist) scientific venture produces many effects, not the least of which concerns the sorts of research that are deemed legitimate, fundable, and publishable. Hjelmeland and Knizek (2010, p. 74) report that

> in the period 2005–2007, less than 3% of the studies (research articles) published in the three main international suicidological journals had used qualitative methods. In Archives of Suicide Research 1.9% (n = 2), in Crisis 6.6% (n = 4), and in Suicide and Life-Threatening Behavior 2.1% (n = 4) of the studies published had used a qualitative approach, most often in addition to a quantitative one.

Such figures reflect the dominance of quantitative approaches and the search for objective, empirically grounded facts of suicide, and the marginalization of approaches to research that do not promise such certainties. However, whereas the current editor of *Suicide and Life-Threatening Behavior* sees "an insistence on the rigorously and quantitatively scientific ... as a natural next phase for a maturing field of knowledge ... without which genuine progress is distinctly unlikely" (Joiner, 2011, pp. 471–72), for others this retreat into numbers, measuring, and counting is highly problematic. Jennifer White (2012, p. 48) points to the tendency of suicidology to favour "narrowly defined conceptualizations of "scientific rigor"" and argues (in this volume) that such an approach may not give us a deep appreciation or

sufficient understanding of the fluctuating, historically contingent, and relationally constructed nature of youth or suicide. Nor do they make room for multiple, emergent and contextually specific possibilities for doing prevention work." Similarly, Heidi Hjelmeland and Birthe Knizek (2011, p. 604) argue that suicidology needs to move away from "simply explaining suicidal behaviour to understanding it" and needs to embrace "pluralistic methodologies to develop new suicidological knowledge." This favouring of "explaining" over "understanding" is, again, not just a purely academic or research issue, but one that has "real world" effects. David Webb (2010, p. 40), from an attempt-survivor perspective, expresses it thus:

> The academic and professional discipline of suicidology strives hard to be an objective science, but in doing so renders itself virtually blind to what are in fact the most "substantial" and important issues being faced by the suicidal person. To me, as someone who has lived with and recovered from persistent suicidal feelings, when I look at the academic discipline of suicidology, it feels as if the expert "suicidologists" are looking at us through the wrong end of their telescope. Their remote, long-distance (objective, empirical) view of suicide transforms the subjective reality and meaning of the suicidal crisis of the self – that is, the actual suicidal person – into almost invisible pinpricks in the far distance.

The knowledge gained through quantitative studies can be important in the attempt to establish an "evidence base" in suicidology, but it is also limited (Hjelmeland, 2011; Hjelmeland and Knizek, 2011; Hjelmeland, in this volume). Other forms of knowledge and knowledge production are needed, ones perhaps founded on a different set of assumptions from those currently favoured within suicidology about the nature of suicide and how best to understand and respond to its prevalence and persistence.

Suicide Is Individual ("Suicidality arises from, and is located within, the 'interiority' of a separate, singular, individual subject")

The final assumption that I think underlies most suicide research and strongly informs practice is the belief that suicidality (suicidal thoughts, feelings, and behaviours) arises from, and is located within, the "interiority" of a (separate, singular) individual subject. Michael Kral (1998, p. 229) has talked of the "great origin myth" in suicidology – the implicit notion that "the ultimate origin of suicide, whatever the stressful precursors, lies within the person." Kral (1998, pp. 229–30) argues that