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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 rela-
tion 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 sui-
cide 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, modi-
fied, or discarded. Again, these are not idle or abstract academic discus-
sions, 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 ther-
apist and client). I would argue that such an inquiry is necessary today in
suicidology, for what are in essence assumptions are too often unreflective-
ly taken to be undeniable truths, and the effects of the continual produc-
tion and reproduction of these truths have remained largely unexamined.

Suicidology Now

In a previous study (Marsh, 2010), I suggested that within contemporary suicid-
ology, 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; Winslow 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, prior-ities, and procedures" (Joiner, 2011, p. 471) in place at the journal, conclud-ing 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 num-bers, numbers then amenable to inferential statistical analysis, or, at the very least, descriptive statistical analysis," is taken to be the most desirable ap-proach 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 re-producibility), 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) pub-lished 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 addi-tion to a quantitative one.

Such figures reflect the dominance of quantitative approaches and the search for objective, empirically grounded facts of suicide, and the margin-alization 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

Whether examining biological, psychological, or social factors related to suicide, the received explanation has been that the idea of suicide ultimately originates within the person. That is, the conscious decision to end one's life is believed to be some product of an aggregate of personal factors for a given individual ... We believe that if we identify enough of the right individual factors, we might one day be able to predict or prevent suicide. This belief in an individual-centered style of explanation in suicidology holds us powerfully within its frame.

Others have noted the strongly "individualized" way we have come to conceptualize suicide in the West. For Katrina Jaworski (2010, p. 51), the very definition of suicide as "the act of deliberately taking one's own life" already establishes it as something individual in nature: "The definition summons an individual as the author of the act, solely responsible for the act. There is an agent behind the act, recognised as being the one who decides on the act. As such, the deliberate choice decided by the agent appears to be determined largely by the activities of a disembodied mind."

When suicide is defined and explained in this way, such deaths come to be understood as private, individual events largely divorced from issues of social justice, practices of exclusion and oppression, politics, stigma, relations of power, and hate (Reynolds, in this volume). Suicidality is taken to originate either from an internal mental/psychic space (as in the literature that constitutes suicide as primarily a result of individual psychological or psychiatric disturbance), or from some form of internal bodily pathology (as in, for example, in (neuro)biological accounts), or from a combination of the two. Such "interiorities" are taken to require expert reading by mental health professionals, who look to find and treat ahistorical and acultural signs and symptoms of illness in the individual (Marsh, 2010). The historical and cultural formation of suicidal subjects cannot be read within such a scheme, and, just as importantly, the historical and cultural resources potentially able to counteract or resist suicide come to be viewed as only marginally salient relative to the identification and treatment of individual mental disorders, abnormalities, or disturbances. Yet as Heidi Hjelmeland (2010, p. 34) makes clear, "suicidal behaviour always occurs and is embedded within a cultural context and no suicidal act is conducted without reference to the prevailing normative standards and attitudes of a cultural community." Later in the chapter I say more about approaches that endeavour to more broadly contextualize the issue of suicide (by drawing on a range of ethical, political, and community-oriented frames of thought), but first I wish to look at an example of how the assumptions discussed above can enter into and guide research and practice.

An Illustration

It's not too hard to see these three assumptions at work in the field of suicidology – in research papers presented at conferences, and in journal articles and textbooks, but also in policy documents (e.g., national suicide prevention strategies) and, most importantly, in practice, where suicide is almost always read as pathological and individual in nature, with medical-scientific language and practices taken to be the best (and, it is often implied, the only) way of conceptualizing and managing the problem.

By way of illustration, I want to look in more detail at one article that, I think, exemplifies the way the assumptions discussed above are embedded in suicidology discourse, and how they are presented as natural and necessary truths.

For the recently published and multiauthored *International Handbook of Suicide Prevention* (O'Connor, Platt, and Gordon, 2011), Morton M. Silverman has provided the opening chapter – "Challenges to Classifying Suicidal Ideations, Communications, and Behaviours." That chapter argues that there is a problem in the lack of uniformity in the "terms, definitions and classifications for the range of thoughts, communications, and behaviours that are related to self-injurious behaviours, with or without the intent to die" (Silverman, in O'Connor, Platt, and Gordon, 2011, p. 9). It reviews these issues from a historical perspective and sets out "current efforts to improve our ability to communicate clearly, consistently, and confidently about suicidal individuals" (p. 9). Finally, "recommendations are made as to the next steps in the process of developing and implementing a standardized nomenclature and classification system for the field of suicidology" (p. 9).

Assumptions about suicide being individual and pathological and about the study of it needing to proceed along scientific/positivist lines are encountered throughout the chapter. For example, Silverman (2011, p. 10) writes that "suicidal behaviour is often undiagnosed, under-treated, or mistreated in clinical settings because it is misunderstood" and that "one of the major difficulties in communicating about suicidal phenomena with our patients and within our discipline (as well as across disciplines) is that we do not speak the same scientific language."

Silverman argues that there is a need for uniformity in language use and in the ways phenomena and behaviours are categorized, and that a lack of standardization is holding back research and prevention efforts. The effects of this drive to uniformity within suicidology strike me as problematic. It seems that what is being worked towards (and Silverman's chapter is not an isolated example of this style of thought) is a narrowing down of the

linguistic and practical resources available to us to make sense of, and to engage with, issues around suicide. This would appear to be driven by a belief that suicide is somehow a singular and stable "thing" or phenomenon and thus readily amenable to singular description. (Silverman [2011, p. 11] writes that the "ongoing debate concerning nomenclature" is perpetuating "the use of multiple terms to refer to the same behaviour.") Alongside this drive towards linguistic uniformity is a desire to seek out "objective" elements of suicide that can be accurately measured, compared, and categorized:

> Consensus is required with regard to the development, implementation, and evaluation of clinical and preventive interventions [Silverman, 2006, p. 21]. All the components of the suicidal process then must be identified, labelled, and classified if we are ever to reach the point where we all can share information and observations to help identify and treat truly suicidal individuals and develop interventions to prevent the onset, maintenance, duration, intensity, frequency, and recurrence of suicidal thoughts and behaviours. Classifying individuals on the basis of the intent of their self-injury is a useful scientific and clinical endeavor.

Silverman (2011, p. 14) argues that for this to happen, it is necessary to move away from "our almost total reliance on self-report for understanding and recording such important components of the suicidal process as suicidal thoughts, intent, motivation, planning, accurately remembering and reporting prior life events, assigning significance to life events, appraisal of current stressors, history of prior self-destructive behaviours, etc."

In the conclusions to his chapter, Silverman (2011, p. 22) sets out what he sees as an ideal destination or goal of this endeavour:

> An ideal goal is to develop, for example, a classification system similar to that used in oncology, where first a tumour is classified by type of cancer, and then by staging (e.g., based on size, location, degree of invasiveness, extent of metastasis, etc.), which not only informs diagnosis, but also treatment, management, monitoring, and prognosis. In a similar fashion, "staging" criteria for suicidal behaviours might be degree of intent, lethality of method used, likelihood of rescue, degree of planning (impulsivity), and presence and status of psychiatric or medical illness. Scales or ranking systems can be developed to measure these elements and provide clinicians and researchers with a richly nuanced approach to classifying the full range of suicidal thoughts, communications, and behaviours.

Uniformity of language use, it is argued, could potentially (and usefully) lead to the development of scales and ranking systems to objectively classify types and stages of suicidal thoughts, communications, and behaviours. Suicidal behaviour could thus be read as a form of individual pathology amenable to the sort of categorization found in "mainstream" medicine, which would then inform "treatment, management, monitoring, and prognosis" (p. 22). Such a goal has obvious appeal, but for me, it also raises certain questions.

Imagine for a moment being told you had a "type 2, stage 4 suicidal state" that came with a "30% chance of survival over 2 years" or some such like. What would you do with that information? What effects would that information have on you? And at a more general level, how amenable are "suicide," "suicidal behaviours," and "the suicidal process" to singular, objective descriptions and categorizations? Is suicidal behaviour analogous to cancer? Is suicide prevention that similar to oncology?

The medical analogy Silverman is drawing on in his chapter is certainly a powerful one. The suggestion is that "suicidal behaviours" could be (with a sufficiently uniform use of language) objectively measured and categorized as if they were tumours, and thus not only "diagnosis" "but also treatment, management, monitoring, and prognosis" (2011, p. 22) of a suicidal individual could proceed along similar lines to those of a cancer patient. For the comparison to work, however, we have to take the "degree of intent, lethality of method used, likelihood of rescue, degree of planning (impulsivity), and presence and status of psychiatric or medical illness" as analogous to the "size, location, degree of invasiveness, extent of metastasis" of a tumour. But most tumours present as visible and measurable "things" that can (with the right equipment) be observed, measured, and categorized in a way that intentions, likelihood of rescue, impulsivity, and the presence or absence of psychiatric illnesses cannot, and I don't think that is simply a problem of uniformity of language use. The elements that constitute the stages of a tumour, being observable and measurable, offer a degree of certainty and predictability of outcome that does not map well against the mutable and contingent elements of the "suicidal process." For example, the changeable social, cultural, and relational elements of a person's life surely have effects on the "suicidal process" far in excess of what they would have on the progress and outcome of a tumour (e.g., reconciliation with spouse, finding a new job). It is the same with the meanings given to events and situations by the clients themselves. It is suggested that because such elements cannot be "objectively" observed and measured, they should be set aside in favour of factors that can be. The danger is that if we exclude such elements from any conceptualizing and categorizing of the "suicidal process," we will lose sight of the importance of these context-

ual, relational, or "subjective" factors, and this can have effects beyond research. It is often those more subjective, contextual, and relational factors, by dint of their transience and contingency or changeableness, that allow for hope to be part of any intervention with a suicidal person, and our language should remain open and flexible enough to allow for those to be part of the conversation. By excluding from our vocabulary terms that fall outside the medical-scientific, we would be reducing the possibilities for thought and action available to the field of prevention. By insisting that suicide be read as an issue primarily (or even exclusively) of individual pathology, as something analogous to oncology, we would be limiting the field to an unnecessarily impoverished and decontextualized set of discursive resources.

Conclusion

This chapter has suggested that three assumptions dominate suicidology now: that suicide is pathological, that suicidology is (or should be) science, and that suicide is individual. These assumptions, to paraphrase Wittgenstein (1953), lie in our language, and the medical-scientific language of individual pathology and deficit is repeated inexorably. As Judith Butler (2004, p. 309) notes, "certain kinds of practices which are designed to handle certain kinds of problems produce, over time, a settled domain of ontology as their consequence, and this ontological domain, in turn, constrains our understanding of what is possible." This is the case with suicidology, where the (somewhat arbitrary) early-nineteenth-century claiming of suicide for medicine, and the introduction of "medical"/psychiatric practices (identification, diagnosis, and treatment of "cases" within a medical setting), theorizing (relationship between various, and contingent, categories of pathology and suicide), and forms of inquiry (epidemiological studies, case studies) have led to a "settled domain of ontology," but one that is highly problematic. Medical-scientific discourse has undoubtedly been productive in terms of generating theories, monographs, conferences, journals, academic careers, and so on, but it also limits and restricts, to a troublesome degree, what can be authoritatively said and done in relation to the issue of suicide. Silverman's proposals (analyzed above), while undoubtedly well-meant and thoughtfully considered, exemplify what suicidology has become and where it is heading (unless checked). As the field becomes further enmeshed in practices of categorizing, measuring, and counting, it risks losing the means to understand and engage with the complex and changing contexts in which suicidal individuals are formed and suicides occur. However, the assumptions, beliefs, and formulations that underlie thought and practice in relation to suicide are such that redescription is always possible

and that we can draw on alternative vocabularies and constructs, setting aside assumptions not taken to be useful and formulating issues in ways not bound by them. In seeking to develop "a nomenclature that is free of bias – philosophical, theoretical, biological, sociological, political, religious, cultural, etc." (2011, p. 13) – Silverman frames the plurality of language resources available for constituting our understanding of suicide as problematic in that they somehow compromise objective scientific description.

By drawing on these diverse and multiple discourses in thoughtful and creative ways, we might begin to construct understandings of, and responses to, suicide that are culturally congruent and meaningful and that are able to deal with the fluidity and contingency of the cultural production of suicide. We might move beyond the idea that the language we employ is somehow representative of reality, ideologically neutral and without constituting effects. We might begin to reflect on the ways our language practices work in productive and ideological ways, sensitive to how language produces effects. As an example of this, in her paper "Wasted Lives: The Social Dynamics of Shame and Youth Suicide," Simone Fullagar (2003, p. 301) points to the ways in which "authoritative" accounts of suicide, based on assumptions of individual pathology, can have unintended negative consequences, both in terms of "privatizing" such acts (i.e., denying the social contexts in which they are created) and in terms of constituting subjects in ways that can exacerbate rather than relieve suffering:

> Discourses of mental health and illness within suicide policy and prevention programmes actually work to invisiblize the effects of culture on the embodied self. The emphasis on diagnosis and treatment of suicidal ideation, depression and self-harm as mental health problems may actually participate in the process of subjectification whereby the subject "sees" their own self as pathological and hence shameful.

Today, many researchers and clinicians are attempting to redirect the field of suicidology away from its reliance on individualized, pathology-based ways of constructing and responding to the issue (e.g. Kral and Idlout, 2009; White and Morris, 2010; White, 2012; authors in this volume). They accept and embrace a multiplicity of descriptions, they strive to be inclusive in their research designs and interventions, they value conversational approaches over expert monologue, and they look to build solutions from the ground up rather than impose them from above. These approaches are noticeably community (rather than service) owned and led; the experts (including "at risk" groups, such as youth, mental health service users, and

prisoners, as well as "front line" practitioners) are taken to be in the community and are looking to build collaborative, relationally focused solutions founded on strengths-based (rather than deficit) models.

How we think and act in relation to suicide is necessarily grounded in the assumptions we make about what it is and how it should be studied, understood, and responded to. By critically engaging with these assumptions, paying close attention to the context in which they have come to be formed, and analyzing the effects of constituting the issue in those ways, we can ask questions about the value and utility of current, dominant ways of constructing the subject (Brookfield, 2011). From here we can begin to imagine and explore possibilities other than those the present seems to impose on us. We have come to think about suicide almost solely in terms of individual mental illness and risk, and as a consequence "an individualised, 'internalised,' pathologised, depoliticized and ultimately tragic form of suicide has come to be produced, with alternative interpretations of acts of self-accomplished death marginalised or foreclosed" (Marsh, 2010, p. 219). But if suicide is a problem, it is as much a social, ethical, and political issue as a mental health one, and we need to be able to draw upon a wide range of discursive resources in order to adequately frame and respond to its possibility or actuality.

Notes

1   Sets of "meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events" (Burr, 1995, p. 48).
2   It is a field, however, that draws much on anticipatory or proleptic discourse – the sense that we are on the cusp of a medical/scientific breakthrough in relation to the aetiology of suicide has been a feature of psychiatric writings on the subject for nearly two centuries.
3   As an example of this style of thought, Isacsson, Rich, and De Leo (2003, p. 457) argue that "depression is a necessary cause of most suicides. Based on this proposition, it has been suggested that effective suicide prevention must focus on improving identification and treatment of depression in the population."

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