Suicide and the Internalization of Culture: Three Questions

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Abstract Despite much writing and discussion on suicide that gives credence to the importance of a multidimensional perspective, the current view of suicide continues to be strongly person-centered. Examining suicide from a cultural vantage point, three questions are suggested for investigation concerning (1) the internalization of the idea of suicide, (2) individual and collective vulnerability to this idea, and (3) the 'great origin myth' in suicidology. Although the act of killing oneself is ultimately that of an individual, it is argued here that it is less a solo venture than a product of the collectivity of ideas. A deeper understanding of suicide will be realized through theory incorporating the dialectic of person and culture.

Key words constructionism • internalization • risk • suicide • theory

At the meeting ground of culture and psyche, investigators in psychological anthropology have been looking more closely at how cultural messages 'get under people's skin' (Strauss, 1992: 1). Inquiry is turning to questions such as: How does culture find its way into the mind? How does culture inform notions about options for action, about what is taken for granted, about who in your world you are? (Cole, 1996; Shore, 1996; Shweder, 1991). In this paper I ask three questions related to the psychological internalization of culture and more specifically, to how the idea of suicide is internalized through culture. Given that suicide, like everything else that is complexly

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human, takes place in a powerful social context, it is worth our while to pursue such questions from new vantage points.

**Lethality Theory**

Writing on the suicidal mind has centered on the notion of escape from an unbearable psychological state. An heuristic approach to the psychology of suicide was provided by Shneidman (1985), who viewed suicide as a function of two necessary and sufficient conditions: perturbation and lethality. Perturbation is exactly that: upset, disturbance, agitation, and pain. In the autobiographical account of his severe depression and near-suicide, William Styron (1990) describes some of his feelings in experience-near terms:

I began to sense the onset of the symptoms at midafternoon or a little later — gloom crowding in on me, a sense of dread and alienation and, above all, stifling anxiety. I suspect that it is basically a matter of indifference whether one suffers the most in the morning or the evening; if these states of excruciating near-paralysis are similar, as they probably are, the question of timing would seem to be academic. (p. 12)

The pain persisted during my museum tour and reached a crescendo in the next few hours when, back at the hotel, I fell onto the bed and lay gazing at the ceiling, nearly immobilized and in a trance of supreme discomfort. (p. 17; all italics added)

Styron even suggested we replace the term 'depression' with one that fits the experience, such as 'brainstorm'. In research done on the mental state preceding suicide and parasuicide, including one year prior to death (e.g. Clark & Fawcett, 1992; Fawcett et al., 1990), notes left moments before death (e.g. Leenaars, 1988), and various forms of attempted suicide (Heckler, 1994), it is clear that high perturbation — including depression comorbid with anxiety, mood lability, and sometimes even panic attacks — may indeed be the type of pain experienced among the suicidal.

Crossing one's threshold of tolerance for perturbation is usually believed to be the most important precursor to suicide (Menninger, 1938; Motto, 1992). Individual differences certainly exist for both physical and psychological pain thresholds, and each person's threshold may change depending on factors related to their state of mind at any given time. Yet most people who accumulate the known risk factors for suicide will never kill themselves. Perturbation should be viewed specifically as motivation rather than having any more direct link with suicide. Perturbation acts as motivation when a threshold of tolerance is crossed. Whatever the person's choice of action, the primary motivation will be to diminish or end the upset, but perturbation alone will never lead to or be the cause of suicide.
Lethality is the direct and fatal link to suicide. The term 'lethality' in the suicide literature has usually been taken to mean the likelihood that the method used would cause death in a particular individual. The term has been used rather loosely in the literature to mean a specific method, a set of behaviors, or a description of a person and this has prevented it from being integrated adequately into suicide theory. A more theoretically coherent definition of lethality views it as a conscious choice, as the idea of death generally – and suicide specifically – selected as the course of action in response to perturbation (Kral, 1994). Fairbairn (1995) has similarly argued that suicide be understood primarily through conation, as the person's intentionality toward death.

Lethality theory is primarily concerned with the idea of suicide, where it comes from, who accepts it, and how forms of this idea are disseminated across and within communities and cultures. Virtually all current suicide theory, from clinical practice to research, is perturbation theory. We have learned much and continue to discover more about understanding and treating perturbation, from subjective experience to neurochemical correlates, but we know next to nothing about lethality: how the idea of suicide becomes internalized and later selected as a course of action by some people. A lethality theory of suicide would focus on the idea of suicide, in the context of how ideas are spread and adopted more generally through society (e.g. Lynch, 1996). For such a perspective, however, a new look at suicide is required.

**Penetrating, Embedded Ideas**

A recent issue of *Time* featured the following story of an entertainment celebrity's suicide:

At 25, actor Salman Shah was one of the brightest stars of Bangladeshi cinema. His adoring fans were stunned when he was found dead Sept. 6 in his Dhaka apartment. His wife told police he had hanged himself after the couple argued over allegations that he was having an affair with a co-star. Thousands of mourners poured into Sylhet, his hometown, for his funeral. Some devotees found their anguish too painful to bear. Within five days, four grief-stricken teenagers had committed suicide, and another was hospitalized after also attempting to end her life. When Salman's final film, *Truth Never Dies*, opened in Bangladesh movie houses last Friday, many parents kept their adolescent children at home, fearing the movie's denouement would prove fatally depressing. In his last role Salman plays an angry young man fighting social injustice who is sentenced to death by hanging. ('Fallen Star,' 1996)

Life imitating art imitating life? Whatever Shah's personal experience of perturbation, he chose to hang himself to death. This is but one example
of a suicidal model being internalized by a particular individual, in this case the model including both the act of suicide and its method: death by hanging. But what does it mean to speak of something being 'internalized'? Webster's dictionary (1983) defines 'internalize' as 'to incorporate (as values or patterns of culture) within the self as conscious or subconscious guiding principles through learning or socialization' (p. 632). This concept of internalization is at the center of the fields of psychological and cognitive anthropology (D'Andrade, 1995; Hutchins, 1996; Stigler, Shweder, & Herdt, 1990) and is vitally important not only for our understanding of ourselves as cultural beings, but for our understanding of suicide.

Internalization might be viewed through the simple and familiar example of tying one's shoe laces (Westin, 1996). It is something we do so automatically that we are at odds to try to explain to someone exactly what we do without actually going through the operation. How we came to learn this was anything but automatic, but now we have guiding principles for tying a shoe that we are barely aware of. We do not consciously attend to these principles, and although we once did, we are not likely to do so again unless we are teaching a young child the skill. Most of what we do, what we say and how we say it, what we think and how we think it, is internalized in a similar way, to the point that it becomes quite automatic, commonsensical, and otherwise 'obvious.'

We are largely unaware of our own schemas of knowledge about the everyday world and ourselves. Schacter (1996) has described the nature of implicit memory, which includes semantic memory, 'the intricate network of concepts, associations, and facts that constitutes our general knowledge of the world' (p. 169). There is evidence that such semantic networks of conceptual knowledge influence us without our awareness. Schacter argues that in addition to contributing to our everyday actions, implicit memory provides the basis of gender, racial, and other stereotypes we have about groups of people. Implicit memory encodes the 'subjective norms' (our personal links to who and what is important and influential) that make up the core of who we are: our attitudes, values, beliefs, and behaviors.

The manner in which we die is no exception. As many thanatologists have observed, we die as we have lived. One example comes from historian Joyce Salisbury's (1994) work on the cultural history of martyrdom. Salisbury notes how the details of Saint Perpetua's death in a public forum followed an identifiable cultural idiom. When the wild animal set upon her by her captors was not interested in killing her, a novice soldier was called in to finish her off. He was unsure how to strike her, so she bared her neck as had done other martyrs before her and guided his sword to it with her own hand. Smith (1997) adds that Perpetua was undoubtedly influenced by social events of her time: her spiritual father's own flight into martyrdom in the name of Christianity; popular Hellenistic romantic novels
about heroines seeking death in the name of virtue; Christian pulp literature written for women about women (and apparently by women) finding 'true happiness only in death' (p. 103); and numerous heroic accounts of Christian women martyrs. Smith writes that martyrs generally represent a group phenomenon, taking strength from their sense of collective identity and representing . . . serious rifts within society' and that 'martyrdom can be extraordinarily contagious' (p. 18).

Ideas are not only cognitive schemas or representations of one's world and ways to act in it, but often contain strong affective components. Hatfield, Cacioppo, and Rapson (1994) have found that emotional contagion is a normal regulatory feature of any social group, operating through subtle but powerful processes that include mimicry and synchrony. As one purveyor of social ideas, the media influences us through norms, roles, positions of authenticity, assimilation of social expectations, group membership, information, and by providing models and guides for action. Through cognitive and affective arousal, some people will become more attentive to — and identify with — its particular products (DeFleur & Ball-Rokeach, 1989).

Suicide is no exception to this contagion of emotionally charged ideas. In a 15-year review of the literature on sociological risk factors in suicide, Stack (1996a) found strong evidence for a media contagion effect on suicide (see Maris, 1997; Phillips, 1974; Phillips, Carstensen & Paight, 1989). The primary effect, however, was through the publication of not just any suicide but of entertainment celebrity suicides, with a lower but significant effect of political celebrity suicides, followed by publicity of 'psychiatrically disturbed' suicides. The effects of these media-influenced suicides were especially noted among younger and older people. In these cases, it appears that a previously held idea about one's own possible suicide can be triggered and reinforced by the media. So the parents' concern for their children in response to the young actor's suicide in Bangladesh is not without empirical support.

There are other lines of evidence for suicide as a type of social logic, including clusters throughout history and examples of how the method by which people kill themselves is highly 'local' (Kral, 1994). Whether one chooses a gun, poisoning, a rope, jumping off a building, or getting oneself shot by police, the logic and method of suicide are socially embedded. Stack (1996b) has also found a strong relationship between the acceptability of suicide and suicide rates across 35 nations. Ideas have significant consequences. Alfred North Whitehead (1933) once wrote that an idea 'has a creative power, making possible its own approach to realization' (p. 53). We are only beginning to look seriously at the power of cultural ideas like suicide. This leads to my first query: How deeply embedded is suicide in the cultural system of ideas?
Ideas move like swells in the ocean through society, breaking on receptive shores. In a seminal paper on suicide and social influence in which he coined the term 'the Werther effect' – after Goethe’s 18th century novel which was banned following an outbreak of young men killing themselves in the manner of the story’s hero – Phillips (1974) wondered who might be most susceptible to the idea of suicide as a solution to their woes. He suggested Durkheim’s notion of ‘anomie’ as one trait of vulnerable people: normlessness and finding no meaning in social life. Today we have lists of risk factors that characterize those in the West who have killed themselves: sociodemographic factors such as being male, divorced, gay, Aboriginal, young adult or elderly, etc. and factors related to emotional perturbation such as depression. These risk factors do not directly address the subjective experience and idea of suicide and its relationship to the self. The experience and expression of identity are increasingly viewed as historically and culturally situated (e.g. Allen, 1997; Harre & Gillet, 1994) and this can be linked to the type and prevalence of ideas of suicide.

Considering some forms of psychopathology as a product of culture, Good (1992) suggests that we study the effects of culture on the course and outcome of lived illness experience. Good argues that research must begin to address ‘the development and popularization of prototypical narratives’ (p. 191) surrounding distress, with a view of symptoms as symbolized experiences within their ‘cultural domain, a domain of intersubjective meanings, a network that entails a complex of symbolized meanings’ (p. 197). Such efforts can be applied to the study of suicide. Taking the cultural shaping of illness experience as a given, Kleinman (1988a, 1988b) proposes that clinicians and researchers examine the cultural narratives or explanatory models of both patients and healers. There is a need to study the idioms of distress and explanatory models not only of ‘suicidal’ people, but those of their most salient cultural milieu. Culturally internalized experiences and expressions of distress, perhaps as western ‘cultural syndromes,’ are similarly being ascribed to such presentations as eating disorders (Ritenbaugh, Shisslak, Teufel, & Leanard-Green, 1996), multiple personality disorder (Hacking, 1995), chronic fatigue syndrome (Shorter, 1992), recovered traumatic memory (Showalter, 1997), and the western form of depression (Jadhav, 1996).

To address individual and collective vulnerability, some have suggested that we focus on historicized experience. Kleinman (1988a) views vulnerability as a product of cultural norms and bodily processes, suggesting that people develop ‘archetypes of distress’ (p. 60). I have proposed that the idea of suicide and how to do it are internalized for some people as an archetype, accessed during periods of heightened distress (Kral, 1994).
notion that culture has motivational force internalized as action schemas is receiving increased attention (D’Andrade & Strauss, 1992).

Is there a ‘type’ of mind more likely to internalize the idea of suicide? As already mentioned, in western culture the most pervasive psychological theme in the literature on suicide has been escape. From Freud onward, escape from intolerable perturbation has been found to be a common psychological thread across suicidal minds. Might people who are used to escaping from negative self-awareness be more likely to choose suicide as another form of escape?

One particular style of escapist coping defense, ‘repressive coping’ or ‘self-deception’, may lead some to accept suicide as a course of action when all else fails, under high perturbation (Kral & Johnson, 1996). Studies show that some people habitually deny experiencing states of upset such as anxiety yet their bodies (autonomic nervous system) indicate that they are in fact easily stressed and made anxious, especially when they think others may be judging them negatively. These people are more prone to depression, prefer solitary activity, are less willing to disclose personal information, are more likely to deny problems, have an overly positive self-presentation in spite of objective problems, are more likely to avoid negative memories and remember fewer childhood memories in general, are more likely to use escape defenses such as distraction, distancing, and intellectualization, and are more prone to certain medical problems such as high blood pressure and lowered immunocompetence (Schwartz & Kline, 1995; Weinberger, 1990).

Similar patterns of repressive coping and self-deception have been found among those who have killed themselves. Could differences in the prevalence of this coping style help explain social differences in the prevalence of suicide? In North America, males are at much higher risk for suicide than females: Are men in western culture more likely to manifest this style of escapist coping? Suicide as escape may fit the personal logic of escapist, self-protective coping styles. For some people, suicide may thus become the ultimate act of psychological self-protection rather than self-destruction

Yet individuals are always located in a social web. Can one then speak of vulnerable communities? Durkheim (1897/1951), of course, discussed four types of suicide linked with various forms of societal structure. Of these, he argued that anomic suicide was the type most prevalent in western society. Anomic has been interpreted as both ‘normlessness’ and ‘insufficient regulation’ in society (Gibbs, 1994), such that a person’s ‘goals cannot be meaningfully integrated with the expectations which have been institutionalized in values and norms’ (Parsons, 1960: 144). People and even entire communities can experience anomie when there is ‘rapid and uncontrolled change in the conditions, institutions, or values constitutive of the social system in the largest sense . . . [in the] absence of meaningful
symbolic systems and norms which [control] anxiety and [provide] a connective tissue in society' (La Capra, 1972: 159–160). Durkheim and other sociologists argued that the fact that suicide rates are considerably high or low in particular communities or cultures indicates the need to examine the social fabric underlying suicide.

Many have pointed to suicide trends among aboriginal people in North America and elsewhere as an example highlighting this anomic context of suicide. Suicide rates among young Amerindians, although highly variable across communities, have been elevated over the last few decades. Studies of this tragic trend have noted that suicide in these communities has been one symptom of community powerlessness, identity diffusion, and rapid modernization (Berlin, 1985; Kirmayer, 1994; May & Van Winkle, 1994). LaCapra's (1972) notion of anomic as caused by 'runaway change' at the social level is born out when examining suicide in many aboriginal communities, especially as experienced more recently in the eastern Arctic following missionary work, residential schools, forced relocation of families and communities, and other acts of internal colonialism (Kirmayer, Fletcher, & Boothroyd, 1997).

A number of writers have also discussed individual and collective sadness and suicide emerging from high, unattainable expectations. In his existential and Jungian reading of Durkheim, Meštrović (1992) develops further the concept of anomic as a consequence of human desires that are never satisfied. Failed hyperoptimism thus becomes a cultural risk factor. Meštrović argues that anomic societies are those with neat divisions between in-groups and out-groups where the out-group begins to take on the values and norms of the in-group yet is unable to integrate or achieve them. Baumeister (1991) has similarly argued that the contrast between high expectations and poor outcomes leads many to suicide. Baumeister cites evidence in support of suicidal behavior being related to transitions involving the worsening of one's loftier situations and expectations; losses involving love, prosperity, status, or health occurring in democratic societies with high standards of living; suicides being more frequent after holidays, weekends, and even birthdays; college students whose higher-than-average grades have recently dropped being at higher risk than other college students or their peers not attending college. These examples all involve a theme of falling from an experienced or hoped-for grace, that practitioners working with suicidal people know all too well.

It appears that communities can also lose grounding in their traditional culture or conscience collective, to employ Durkheim's phrase, and begin to internalize expectations that lead to disappointment, disillusionment, and loss of meaning. As Schopenhauer once wrote, 'the more intense the will is, the more glaring is the conflict of its manifestation, and thus the greater is the suffering' (cited in Meštrović, 1992: 116). Further systematic
investigation is needed on suicide as a collective behavior. A second query then: Who is more prone to internalize the idea of suicide, and under what personal and cultural conditions?

**Suicidology’s Great Origin Myth**

The final question in this paper returns to the notion of internalization of culture by examining a common belief or myth, sometimes explicit but mostly implicit in clinical work and suicidology research, having to do with where suicide ‘comes from’ in the first place. Despite much agreement in the literature that suicide is multidimensional, there exists no coherent theory tying together these dimensions, or a sense of which factors are most important. In fact, the popular theoretical views of suicide in this century have been largely unidimensional (e.g. biological, social) and focused on identifiable risk factors (e.g. low serotonin, high anomie). Furthermore, we have held strongly to the notion that the ultimate origin of suicide, whatever the stressful precursors, lies within the person. Belief in this person-centered origin of suicide is strongly held, though implicit. In this last section, I argue that it is time to move beyond this paradigm if we are to deepen our understanding of self-inflicted death.

Kuhn (1962, 1977) considered the critical examination of major paradigms or belief systems an ‘essential tension’ in the progress of any discipline. Such investigation might well be guided by the distinction made by Toulmin (1961) between prediction and explanation, when he wrote that ‘there proves, in the end, to be no substitute for a direct and detailed inquiry into the nature of explanation itself’ (p. 23). What is needed is an inquiry into the legacy of explanation in suicidology, particularly into our understanding of the locus of the origin of the idea of suicide appearing in the mind of the individual prior to engaging in this act.

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. Biological studies, for example, finding correlates of suicide are described as ‘promising . . . a reconceptualization of suicidal behavior’ (Winchel, Stanley, & Stanley, 1990: 97). A neurobiology of suicide, while a critical component to be sure, endeavors to find the trigger for the idea of suicide in the brain. The psychological and social approaches typically also claim they have found the final common pathway of all those risk factors to be within the person. Psychological theories invariably focus on escape from perturbed and now intolerable consciousness. Sociological and anthropological approaches, while emphasizing external and social sources of stress and influence, still assume a pancultural psychic unity
within individuals that ultimately 'responds' in a universal way. There is reason to question whether all psychological constructs are so structured (e.g. Bruner, 1990; Shore, 1996). Yet 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. Thus the final query in this essay: *Is it time to ask different questions in suicidology?*

**Conclusion**

The questions in need of exploration raised in this paper address internalization and vulnerability through a new paradigm that has yet to be applied to suicidology. The notion of implicit schemas or archetypes of experience, motivation, and action may be a fruitful direction for further understanding the confluence of person and culture in suicide. The time is ripe to take seriously Corin's (1996) call for the use of a kind of 'anthropological imagination' in suicidology. We must now begin to examine the cultural narratives of suicide and their impact on individuals and groups. The cultural approach is complementary to, but conceptually different from, the current paradigm in suicidology. This new approach is likely to foster the development of a conceptual language with important consequences for research, practice, and prevention.

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**References**


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