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Scientism as a Social Response to the Problem of Suicide

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Abstract As one component of a broader social and normative response to the problem of suicide, scientism served to minimize sociopolitical and religious conflict around the issue. As such, it embodied, and continues to embody, a number of interests and values, as well as serving important social functions. It is thus comparable with other normative frameworks and can be appraised, from an ethical perspective, in light of these values, interests, and functions. This work examines the key values, interests, and functions of scientism in suicidology and argues that although scientism has had some social benefit, it primarily serves to maintain political and professional interests and has damaging implications for suicide research and prevention.

It seems highly probable that the most striking cultural relics of the twentieth century would be the hundreds of papers and books written as part of a sustained attempt to study suicide scientifically (Atkinson 1975, 144).

The transformation of suicide from an act of moral and philosophical significance to an object of scientific study figures largely in the historiography of suicide. The popular or received view of this transformation suggests that earlier cultural attitudes towards suicide were founded on an unsatisfactory concept of suicide and its causes (Battin 1995). Traditional beliefs in the moral, religious, and spiritual significance of suicide came under doubt in an age where principles of human knowledge were discussed in light of ideas about reason, the nature of human perception, natural laws, and claims to certainty. This shift in fundamental concerns from questions of

morality to questions of causality was not, as Douglas (1967) suggests, necessarily a result of disagreement about the empirical facts of suicide, for there was no simple distinction in empirical terms between post-Renaissance works on suicide and those of the late seventeenth and eighteenth centuries. Then, as previously, the use of historical case studies was the basic method underlying almost all serious works on suicide.

But whereas earlier works by humanists such as de Montaigne (1958) and Donne (1977) had used case studies to investigate moral and theological questions relating to suicide, later works began to make use of them to arrive at certain scientific conclusions regarding the facts of suicide and the explanation of these facts (Douglas 1967). The hereditary basis of suicide, the connection between suicide and melancholy, the prevalence of suicide in cities, and the role of hope as a powerful protective factor against suicide were all identified as important determinants of suicide with little empirical support apart from historical case material and cases reported in the press. This did not make them any less significant—a point attested to by the frequency with which these ideas appeared in scholarly works on suicide over the next two centuries (Douglas 1967).

To be clear, suicide continued to be thought of as a moral problem, the moral aspects of suicide continued to be studied, and its management—whether aimed at reforming individuals or society—was similarly moral. Indeed, as Giddens (1965) has argued, suicide was arguably one of the most thoroughly discussed and analysed social problems of the nineteenth century, and philosophical works that outlined the nature of the harms caused by suicide to family, friends, and society, such as those by Aristotle (2000) and Thomas Aquinas (1990), provided the theoretical and ethical bases upon which suicide prevention could be justified. Yet factual interest in the determinants of suicide gradually replaced philosophical and theological debate, as the study of suicide became increasingly marked by the use of formal methodologies and efforts to legitimize science as the primary mode for studying suicide (Laird 2011). Rather than view this shift as a fully formed social phenomenon, scientific understandings of suicide can be seen to coexist, however uneasily, with more traditional meanings and moral understandings of suicide that consider suicide as a symbol of heroism, sinfulness, cowardice, dishonour, or liberty (Battin 1995).

The view that these facts were the primary concern of scholarly interest and that they must determine the methods of discovery by which suicide was to be investigated, however, marked a clear transformation in thinking from that of previous eras and cultures and was based on a number of philosophical assumptions about knowledge, reality, truth, and the nature of human experience, as well as normative judgements about suicide that made such scientific reasoning possible. The use of formal methodologies for the study of suicide was therefore fostered by larger historical currents in intellectual thought and, in particular, the emergence of sociology and psychological medicine, which sought to be recognized as valid, legitimate, and scientific. Increasing specialization, deference to scholars working within the field of study, and competition and collaboration between disciplines were thus prominent features of late nineteenth and early twentieth century approaches to the study of suicide (Laird 2011).

It is frequently argued that scientifically grounded knowledge of suicide is required to advance knowledge and to manage and prevent suicidal behaviour. Yet disagreements over methodology and the value of “non-scientific” theories (de Wilde 2002; Hjelmeland and Knizek 2011), the disjunction between scientific and subjective accounts of suicidal behaviour (Cutcliffe and Ball 2009; Webb 2006), and limited advances in suicide prevention over the past five decades are, for a growing number of scholars, symptoms of a broader crisis of the scientific paradigm of suicide research. But while attempts to subvert the claims of precedence made by scientific suicidology and to broaden the research programme have been a feature of recent critical works (see, for example, Fitzpatrick, Hooker, and Kerridge 2014; Marsh 2010; White 2012), the question of why suicide researchers and prevention organizations have withdrawn from ethical discussion of suicide is a point less frequently raised.

That suicide is irreducibly moral is in many ways self-evident. The issue of suicide involves normative judgements about the permissibility of suicide, the value of human life and suffering, and the justification of prevention (Donnelly 1990; Battin 1995). These judgements typically invoke moral concepts such as rights, duties, harms, autonomy, rationality, justice, and so forth. But the moral realm can also be understood from an axiological perspective to include the values that underpin our vision of “good” human life. The association between suicide and morally significant experiences that threaten or impede these conceptions of human well-being and

flourishing such as illness, suffering, grief, loss, shame, and misfortune suggest that suicide is shot through with moral evaluations (Fitzpatrick 2014). The tendency to withdraw from ethical discussion of suicide is therefore perplexing and poses a set of important questions in terms of the social and political response to suicide in contemporary Western society.

In what follows, I argue that scientism embodied, and continues to embody, a social and normative response to the problem of suicide rather than a well-reasoned response to a complex moral and ethical concern. As such, it is comparable with other normative frameworks such as religion, politics, and the law—providing ways of conceptualizing and evaluating human action, life, suffering, and death, and, in doing so, representing a range of interests and values and serving one or more social functions (Sadler et al. 2009). The ethical, then, is conceived here as “a realm of value that includes morality and other values” (Gaita 2011, 47). In this view, politics, religion, and the law are not considered different or incommensurable kinds of value than morality; and, in some cases, moral values may be overridden by other values.

Although contemporary suicidology is a multidisciplinary domain and cannot be plausibly understood as scientific in the epistemic sense of the word (that is, as expressing the philosophical view that only science reveals the truth), our assumptions about the meaning of suicide and the concepts we employ have been strongly influenced by historical and theoretical presuppositions and values that privilege scientism. These continue to be reproduced and sustained by social practices and the stories that define our communities. By examining the key values, interests, and functions of scientism in suicidology, this work aims to illuminate the broader social, political, and moral factors that help sustain the view of suicide as a scientific problem and the implications of this for our understanding of suicide, suicide prevention, and suicidal persons.

Science as New Grounds for Intellectual, Social, and Moral Discourse

There is a tendency to view the history of human enquiry into suicide as an archetypal, linear narrative in which certain earlier and confining modes of philosophical, religious, and ethical thought have been unseated by reason and the scientific method (Fitzpatrick 2014). This historical perspective resembles what Charles Taylor has described as “an ‘acultural’ theory” of

modernity (1995) or “subtraction story” (2007). Subtraction stories of modernity conceive of the transition from premodern to modern society in terms of a general human capacity (for example, for reason and scientific thinking) that given the proper conditions will emerge because these are what human beings “normally” value. Western modernity is thus understood in terms of progression via the advancement of reason and scientific thinking that casts off certain beliefs and allegiances. What this position overlooks, however, is how Western modernity is underpinned by its own positive vision of the good that is only one option amongst many available others, rather than the only viable option left once the myths of philosophy and religion have been eroded.

For example, as Houston has noted, in a large majority of accounts of the changing understandings of suicide, secularization and medicalization are seen as interdependent with “clinical discourses supplanting religious ones and doctors replacing clergymen as the interpreters of self-destructive behaviour” (2009, 92). But rather than seeing the “scientific” study of suicide as a homogeneous movement developed in conjunction with a secular outlook and with agential intentions, writing on suicide in the eighteenth and nineteenth centuries was decidedly pluralistic, with scholars engaging with different, often competing, ontologies, epistemologies, and intentions. The medical view of suicide was only one strain of intellectual thought, with sociologists emphasizing the social processes that contributed to suicide. Despite contemporary claims that sociological and medical approaches to suicide were antithetical, early works suggest that this was not the case. Medical and social approaches were often combined, and the work of physicians writing in the field was as likely to refute a purely medical understanding of suicide as it was to accept it. For example, works by Brierre de Boismont (1865) and Hamilton (1875) considered the material and moral conditions of urban life—alienation, poverty, unemployment, housing, and the disruption or breakdown of traditional social relations and values—as important contributing factors. It was understood that people killed themselves due to a variety of reasons, and medical professionals proved highly discriminating in their understanding of the causes of suicide and, in particular, the troubling nature of the relationship between mental illness and suicide (Houston 2009).

Historians of early modern Europe have therefore questioned the view that the medicalization of suicide was comprehensive and widespread, a result of the powerful influence afforded the medical profession, and that it marked a clear shift from the moral to the scientific—from the prescriptive to the descriptive (Houston 2009; MacDonald 1989). Rather, they see a wider cultural and political context for medicalization in which the medical profession played only a minor role. A more prominent role is accorded the social and cultural environment in which scientism, Enlightenment humanism, and romanticism brought profound changes in understandings of self and society (Macdonald 1989). The emergence in Western Europe of an unprecedented common space in which the public, linked through the print media and small group or local exchanges, began to discuss matters of common interest also had considerable normative force in changing public opinion and practices (Taylor 2007). Emerging from this public debate was a view of suicide as a relatively commonplace, albeit tragic, human event—the result of various circumstances: illness, poverty, physical suffering, love, grief, shame, poverty, honour, and humiliation (MacDonald 1989; Minois 2001)—while the response of organizations such as the Royal Humane Society demonstrated a pastoral concern for suicidal persons in recognizing that these people can and should be helped (Colt 2006).

This process of “ground-up” medicalization shows how larger social values and beliefs contributed to more tolerant and sympathetic attitudes towards suicide in early modern Europe. Religious and moral denunciations did not abate entirely, yet attitudes and responses to suicide changed perceptibly, with both families and civil authorities working in concert to discourage collective punishment by personalizing moral responsibility for suicide—a task made easier by the advance of individualism (Minois 2001). How much of this was simple expedience or based on a true recognition of mental illness as the cause of suicide is unclear, for the medical view of suicide at this time did not necessarily preclude the understanding that social, political, and economic factors were the primary sources of psychological disturbance, alienation, and suicidal despair (Tierney 2010). It does suggest, however, that the medicalization of suicide was shaped, in the first instance, more by the political, social, and cultural environment than by the ideas and intentions of the all-powerful medical profession. At the same time, it indicated growing acceptance of mental illness as a cause of suicide and an expectation that doctors would be involved in the physical care of suicidal persons (Houston 2009).

These social changes coincided with similar developments in philosophical and scientific thought. This project was primarily epistemological as modern, rational modes of knowing came to replace medieval ones based on religion and tradition. Yet it was also anti-metaphysical insofar as its epistemological presuppositions were based on naturalist and materialist ontologies that denied the need for explanations other than those provided by the natural sciences and that sought to explain phenomena in physical terms. Of central importance to this intellectual project, therefore, was how to give suicide—a situated action—empirically verifiable form explicable by natural laws in accordance with these views. As Paperno (1997) argues, in order for science to dislodge religion, it had to replace a Christian ontology with a materialist view of human nature. In the case of medicine, the physiological body would serve as the object of investigation, while sociologists, due in no small part to Durkheim (1951) and his construction of the model of the social body as a means for developing a systematic sociological analysis of suicide, would turn their attention to uncovering the social processes that produced suicide through the study of aggregate data. Despite important theoretical and political differences between the two disciplines with regard to the causes and management of suicide, both shared a number of important similarities, including a normative view of suicide as a form of (individual or social) dysfunction, a progressivist approach to addressing social problems through science, and the view that empirical scientific methods were able to strip away all of the “myths” of philosophy, theology, and social beliefs to reveal a stable, objective, and universal truth about suicide.

Methodological Scientism and the Crisis of Suicidology

Suicide continued to be dealt with explicitly in art, literature, drama, and philosophy throughout the nineteenth and twentieth centuries, yet the publication of medical and sociological studies increased exponentially from 1830 on as increasingly sophisticated theoretical and empirical models were applied to the study of suicide (Weaver 2009). However, something more than just the application of new methodologies occurred as the focus of intellectual inquiry shifted towards greater factual interest. Previous methods and objects of study that had until this point figured prominently in intellectual discourse on suicide were supplanted by the methods of the natural sciences and those aspects of suicide most suited to discovery by these methods.

The view that the methods of the natural sciences could be extended to the study of human action and society marks a form of academic-internal scientism (as opposed to academic-external scientism or scientism within the broader society) and what Stenmark (1997) has termed *methodological scientism*. For Stenmark, a claim of methodological scientism requires not only the use of natural science methods within a discipline or field of research but the use of these methods “in such a way that they exclude (or marginalize) previously used methods” (1997, 18).

A series of recent bibliometric studies of English-language suicidology journals provide compelling evidence for a claim of methodological scientism in suicidology. A study by Hjelmeland and Knizek (2010) entitled “Why We Need Qualitative Research in Suicidology,” for example, reports that qualitative studies accounted for only three per cent of all published studies in the three leading suicidology journals for the period(s) 2005–2007. A further study by Goldblatt and others (2012) evaluated and classified the abstracts of all studies published in the three leading suicidology journals for the five years between 2006 and 2010. Findings indicated a high proportion of epidemiological studies in all three journals (32.7–40.1 per cent), particularly in relation to cultural studies (1.9–6.9 per cent) and studies relating to ethics (0–0.7 per cent). In discussing these findings, the authors considered the predominance of empirical epidemiological studies to be the result of an editorial preference for more robust, straightforward “empirical” research—findings that undermine the claim for methodological pluralism in suicide research made by these journals and the organizations they represent.

Critical assessments of the field of suicidology by leading researchers lend further weight to this claim and the potentially damaging impacts of methodological scientism on suicide research. In a provocatively titled commentary on the suicidology research literature, “The End of Suicidology,” David Lester (2000) spoke of the impending demise of suicidology if researchers continued to replicate the findings of previous studies rather than introducing new research focuses and producing and testing new theories. Echoing similar sentiments to those expressed by Merton Kahne (1966) some thirty years previously, Lester chastised researchers for using the same tired and familiar research methods to repeatedly draw the same stereotypical conclusions. Andrej Marušič (2008) extended this criticism, claiming that the current impasse lay in

increasing specialization and, in particular, the subdivision of suicidology into different research disciplines and focuses. Thus, the complexity and multidimensionality of suicide is simply not integrated or adequately explained. Rogers suggests that this is because these studies (and contemporary suicidology in general) are grounded in atheoretical empirical frameworks and that without a theory in which to ground these findings, the results of these studies contribute little more than “a seemingly random collection of facts” (2001, 17).

For critics such as these, the problem of contemporary suicidology lies in the absence of theoretically driven, scientifically rigorous, and practically relevant research rather than in the limits of the current research orthodoxy. Of course, data collected using scientific methods are useful, and a number of integrative theories have been developed to account for the synergistic effects between risk factors—achieving explanatory rather than predictive power. Yet rarely do researchers reflect on the usefulness of this research output in relation to the historical and philosophical assumptions that gave rise to this narrow concept of science in the first place (Klein and Lyytinen 1985). Instead, researchers aspire to attain more reliable and valid measurements, construct validity, and operational definitions, thereby retreating further into science. This (over)emphasis on empirical scientific methods, while not scientific in the epistemic sense of the term, arguably creates the conditions for scientism in suicidology to flourish through the generation and sustaining of evidence hierarchies that determine not only the criteria by which research is judged but also the objects of study and research methods most suited to meeting these criteria.

In contrast, Hjelmeland and Knizek (2010, 2011) claim that suicidology’s continued focus on more tangible risk factors such as mental illness has led to the loss or truncation of equally important sociocultural dimensions of suicide. The inability of qualitative research methods to measure up to stringent scientific criteria has meant that the cultural study of suicide has taken a backseat to more robust scientific programmes of epidemiology, biomedicine, and cognitive science. Hjelmeland and Knizek’s argument for greater use of qualitative methods in suicidology is therefore intended as both a corrective to the “current mantra of ‘evidence-based’ practice” (2011, 9) that favours epidemiological and biomedical research and intervention studies (e.g., randomized controlled studies), while at the same time presenting as a way forward in which

both mixed-methods and exploratory qualitative research can help shed further light on the relations between different risk factors and bridge the gap between research and practice. For Hjelmeland and Knizek, the danger of methodological scientism in suicidology lies in its narrowing of the object of study to those aspects that can be researched using scientific methods only.

There are, of course, other kinds of expertise and ways of knowing beside those generated by scientific methods. Cultural historians, for example, have shown how a culture's attitudes towards suicide reflect its larger social values and beliefs (Hill 2004; Minois 2001), while cultural and literary scholars have examined how both fictional and nonfictional texts serve as a staging point for the construction and transformation of the meanings of suicide (Higonnet 1985, 2000; Paperno 1997). Mental health professionals, including nurses, social workers, and clinicians who work closely with suicidal persons, have also developed a body of knowledge that, in some cases, is intuitive, unconventional, and practical rather than theoretical. The work of Cutcliffe and Barker (2002), for example, focuses on fundamental interpersonal processes for the care of suicidal persons such as acceptance, tolerance, engagement, understanding, and the importance of inspiring hope. And community outreach workers and educators, together with the many non-professional staff who make up telephone crisis counselling services, also understand suicide as a complex social and moral concern that requires multiple, creative responses (Nelson and Armson 2004; White 2012). The diminished value accorded the non-scientific realm may therefore be understood as a consequence of a more residual tension within contemporary suicidology that involves both its epistemic as well as its political and moral dimensions—or, put differently, between the twin aims of acquiring knowledge as well as practically applying that knowledge.

Contemporary suicidology is fundamentally an instrumental activity, with the findings generated by scientific investigation directed towards ways of preventing suicide (Maris, Berman, and Silverman 2000; Pompili 2010). It is impossible, therefore, to completely distinguish the epistemology of suicide from its political and moral interests (Mishara and Weisstub 2005). The most disastrous implication of methodological scientism in suicidology, therefore, is its elimination of the study of value-judgements that underlie suicidological practice and that are the

basis for seemingly just and virtuous actions (Loughlin, Lewith, and Falkenberg 2013). One of the primary interests of this work, therefore, is to understand the values, interests, and social functions that sustain and encourage belief in scientific methods in suicidology despite the significant problems that beset research and prevention. Drawing on the work of Sadler and others (2009), this final section will provide a deeper consideration of the ethical implications of scientism in suicidology through a discussion of the key values, interests, and the social functions it serves.

Values, Interests, and the Social Function of Scientism in Suicidology

As well as changes within the broader political and cultural environment, the gradual moral reevaluation of suicide that took place over the eighteenth and nineteenth centuries was aided by the development of new techniques for administering and managing civil society made possible by the new human sciences of political economy, psychological medicine, and sociology (Tierney 2010). In particular, the science of statistics as both an indicator of the general health and well-being of society as well as a form of government rationality for regulating the behaviour of individuals marked an important development in the modern response to suicide, as it enabled the presentation of important facts regarding the characteristics of suicide from which preventative measures could then be argued. Police files and case studies provided the basis for identifying a number of predisposing, occasional, and general causes of suicide.

Tierney's (2010) study of early proto-sociological treatises shows the different responses these generated amongst administrators from regulatory policies aimed at regulating the behaviour of individuals by means of education and the promotion of more virtuous, healthy activities through to the alleviation of poverty and broader social reform. Of particular note in these works is the reversing of the traditional moral focus of responsibility from those who take their own lives to the sources of despair and injustice that caused these actions. These works were not silent on the everyday miseries, indignities, and misfortunes that befell individual lives and the need for sensitivity and compassion in dealing with suicidal persons, marking a convergence between the traditional Christian pastorate, liberalism, and the spirit of scientific enquiry.

For those who worked closely with suicidal persons such as asylum superintendents, medical opinion coalesced around a protean view of the interaction between environmental factors and physical and mental health, with treatment combining organic, psychological, and social interventions (Kushner 1989). Despite the less benevolent aspects of moral treatment that have been the subject of ongoing critical debate (Digby 1985; Foucault 1965; Scull 1989), medical practitioners shared with other social reformers a moral commitment to the care of the whole person. What was distinctive about this reform movement from the perspective of current psychiatric practice, therefore, was the development of a new sensibility towards the treatment of suicide and, in particular, an unswerving faith in the redemptive power of the institution and its promise of cure (Scull 1989). Professional disputes over scientific evidence within psychiatry coupled with the increase in patient populations and budgetary constraints over the course of the twentieth century would eventually result in the balance of these values shifting towards management and control (Kushner 1989)—a situation that would continue in light of subsequent policies of deinstitutionalization and pharmacological advances brought about by neuroscience.

Organized suicide prevention efforts such as those provided by London's Royal Humane Society also played an important role in changing prevailing public sentiment about suicide prevention by recognizing the ambivalence of many suicidal persons upon whom they were called upon to rescue and whose subsequent recovery was proof that suicidal persons could be helped (Colt 2006). By the twentieth century, national suicide prevention organizations such as the National Save-A-Life League (U.S.A.), the Samaritans (U.K.), as well as international organizations such as the Salvation Army were in operation in many countries and served as the main focus of suicide prevention activity. These organizations provided emotional support, comfort, and, in some cases, practical and financial assistance to distressed people in the belief that human sympathy, love, and understanding were more important than professional help. Organizations such as these were not intended to obviate professional help if and when required (Colt 2006). However, their success and subsequent expansion serve as a telling admission of the limitations and fears that kept many people from seeking professional help, as well as bringing to light how values of care, control, and cure were, to differing extents, manifested within early suicide prevention efforts.

The formalization of suicidology in the late 1960s as a specialized field of research with its own academic publications, professional organizations, and fellowships was important in demarcating the study of suicide as an independent and important field of scholarship as well as marking it as an area of growing concern for health professionals. Up until this time, suicide prevention had been primarily the activity of lay volunteers, and one of the main functions of suicidology was to develop suicide prevention strategies and to disseminate information to health professionals (Colt 2006; Kushner 1989). This overriding clinical focus meant that the emphasis of suicidology, since its inception, has been on identifying the commonalities of suicide in order to develop clinical measures to prevent suicide and to assist suicidal persons. Concurrent with this trend towards increasing specialization in suicide research, therefore, has been the move to make suicide less specialized and a special case of a much broader phenomenon—mental illness (Fearnley 2009; Weaver 2009). Indication of the specialized and arguably limited scope of suicidology is evidenced by the predominance of Western and, in particular, North American research derived almost exclusively from the fields of psychiatry and clinical psychology (Cardinal 2008). The influence of these narrow and specialized domain assumptions on problem creation and framing in suicidology, as well as on the process and methods by which these problems are approached, means that research findings are enormously homogeneous, giving them considerable epistemic and normative force.

Nowhere is this more evident than in policy and practice imperatives that have focused almost exclusively on the identification, management, and treatment of mental illness and where technologies of care such as surveillance, therapy, and pharmacology play an increasingly important role. While moral responsibility for suicide has been mitigated, to some extents, by reframing suicide as a primarily medical and technical issue—an explanation that has proven both ethically and functionally useful insofar as it enables persons to render potentially uncertain and unsettling experiences intelligible, facilitates treatment, and safeguards people from condemnatory moral judgements of their actions by claiming objectivity (and by implication victimhood)—it does so by erasing the moral, political, and existential contexts in which these actions occur and, by extension, the political rationale that permits this erasure (Mills 2014). Despite vast evidence for the social determinants of suicide and social programmes that have proven to reduce its incidence, political and economic forces (in many cases those same forces

that lead to suicidal distress in the first place) are able to circumvent any moral responsibility for suicide by recasting it as a primarily individual and technological problem—one best met by efficient, market-based technological solutions (Mills 2014; Sadler et al. 2009) and the fostering of health-promoting behaviours (Petersen and Lupton 1996).

The issue of care and working with people at risk of harm reflect this normative stance, adopting in most cases a “defensive,” “observation led,” and short-term position (Cutcliffe and Stevenson 2007; Cutcliffe et al. 2006). This approach to care implies that as long as proximal risk factors are dealt with, then the risk of suicide will be averted. Hence, the emphasis is on identifying and treating suicidal persons, usually with antidepressant medication and psychological therapies, and observing and monitoring persons (Rawlins cited in Cutcliffe and Stevenson 2007)—approaches that have been shown to be effective in the management of depression but with no consistent evidence to show their efficacy in reducing suicide (Caine 2013; Gunnell and Frankel cited in Cutcliffe and Stevenson 2007). The narrowing of research to those factors, symptoms, or conditions most amenable to change through education or medical intervention, however, may redefine or miss the underlying social causes of suicide, thereby treating the symptoms rather than the causes of the problem. The emphasis on identifying “at-risk” persons and populations in order to provide specialist health services not only overlooks the significance of these contributory factors as important contributors of suicidal distress, it also assumes that the services and treatments currently being provided are inherently beneficent rather than posing as potential threats to well-being and citizenship (Pilgrim and Rogers 2005).

The growing role of the psychiatric survivor movement in recent years has resulted in the broadening of the concept of recovery to include awareness of the importance of such things as social support and interaction, access to material resources, and social and political recognition (Bracken and Thomas, 2005; Davidson, 2012). A similar trend can be observed in suicide prevention with “suicide attempt survivors” becoming increasingly assertive of their right to contribute to research and the development of more effective interventions for suicidal or recently suicidal persons (American Association of Suicidology 2014; Webb 2006). As Davidson (2012) argues, this has helped shift the focus away from individualist to collectivist models in policy and practice, yet at the same time it has resulted in researchers seeking to bring this

concept into the scientific arena in order to develop the evidence base for personal recovery (for example, see the National Action Alliance for Suicide Prevention 2014). This appropriation of the concept of personal recovery is evidence of the ways in which science works to depoliticize resistance accounts while at the same time using them to enhance and solidify institutional interests (Costa et al. 2012). But as Davidson writes, “the concept of personal recovery is not itself an ‘evidence-based practice’ and need not be made into one in order for its influence to continue to spread” (2012, 365). Rather, it is social and political action, *not* scientific research, that is of greatest importance here.

These criticisms remind us that the abstractions of science and the technical responses they generate cannot alone solve the problem of suicide. This is because, as the scientific response itself shows, suicide is not strictly an empirical problem, but a complex social, moral, and political concern that is deeply embedded in historically evolving meanings and contexts. The degree by which common sense understandings of suicide have converged with scientific knowledge throws further light on the claims of discovery made by social and medical scientists (Atkinson 1975). In challenging these, and the enormous body of scientific work on suicide that has emerged over the past century, Atkinson demonstrates how we, as human beings, are already implicated in conditions of existence in which an intimate understanding of pain, suffering, anxiety, despair, distress, and hopelessness are manifest without recourse to scientific explanations. The scientific study of suicide was not, in the first instance, characterized by a detached, narrowly objectifying relationship with suicide but by an experiential or practical knowledge of the broader sociopolitical and moral contexts in which suicide was embedded and from which scientism was derivative. By objectifying this knowledge, abstraction, fragmentation, and ultimately alienation have occurred (Macquarrie 1986). The more we know about suicide as an artefact of science, the less we think about its moral dimension as it relates to fundamental human questions of suffering, meaning, identity, and response.

Conclusion

One of the most powerful functions of representations of suicide, whether in science or religion, is their creation of moral order and coherence. Although these are fundamentally different ways of seeing the world, both science and religion provide ways of orienting ourselves and of

opening the world up to us by means of an overarching meaningful ritual structure (Macquarrie 1986; Mellor and Shilling 1993). While empirical scientific methods have provided a strong empirical basis for making judgements about causation, the exclusion of other modes of understanding and the emergence of scientism have discouraged critical questions about those dimensions not amenable to study using scientific methods, thereby concealing important social, moral, and political concerns. Despite efforts to diminish the stigma associated with suicide through the use of scientific methods, damaging moral views persist in the attribution of meaning, causation, and moral responsibility for suicide and its prevention as a result of specific value-judgements and interests. The epistemological claims of science should not be overstated. Scientism in suicidology has potentially destructive implications not only for the development of a critically reflective and meaningful science of suicide but also for a fuller, richer understanding of suicide and suicide prevention. A pluralist methodology that has room for scientific, philosophical, as well as more creative modes of enquiry such as those found in art and literature may be more responsive to the complexity of suicide and its many dimensions and manifestations. Efforts to further our understanding of suicide and to reduce or prevent suicide and suicide-related stigma are unlikely to succeed, therefore, unless researchers, policymakers, and suicide prevention organizations deal directly with these sensitive methodological and ethical issues.

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