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Suicidology as a Social Practice

Scott J. Fitzpatrick, Claire Hooker and Ian Kerridge

Centre for Values, Ethics and the Law in Medicine
The University of Sydney

Abstract Suicide has long been the subject of philosophical, literary, theological, and cultural-historical inquiry. But despite the diversity of disciplinary and methodological approaches that have been brought to bear in the study of suicide, we argue that the formal study of suicide, that is, suicidology, is characterised by intellectual, organisational, and professional values that distinguish it from other ways of thinking and knowing. Further, we suggest that considering suicidology as a 'social practice' offers ways to usefully conceptualise its epistemological, philosophical, and practical norms. This work develops the idea of suicidology as a social practice and considers the implications for research, practice and public discourse.

Keywords Suicide, suicidology, social practice, ethics

Background

Suicidology, often defined as the scientific study of suicide, has had, and continues to have, important consequences for the ways we view and relate to suicide and suicidal persons. It is our contention that moral responses to suicide are one of the most significant of these consequences. Moral constructions of suicide are deliberately avoided (or erased) in the science of suicide, and yet morality persists, little, or imperfectly acknowledged in its practices. Morality also persists in its very epistemology, and thus also in the health policies, discourses and instruments (not to mention the concepts, experiences, and emotions of patients, their families, and the general public) that suicidology underpins. Recent and ongoing criticism of suicidology, particularly with regard to its epistemic conservatism, the disjunction that exists between scientific accounts and experiential accounts of suicidal events, and the difficulty of integrating cultural dimensions of suicide into its research

program (Cutcliffe and Ball 2009; Hjelmeland 2010, 2011; White 2012), challenge us to rethink the moral and epistemic dimensions of suicide research.

But can we make meaningful claims (let alone about moral and epistemic commitments) about a field as diverse and as multidisciplinary as suicidology? There are many who would reply that in the diversity of research into suicide (from performance studies, population statistics, and psychiatry to narrative and neuroscience), few ways of understanding or responding to suicide are excluded. But while suicidology may not be monolithic, it is (to extend the geological metaphor) an identifiable formation. Suicidology has a traceable history that is relatively clearly delineated and complete with major actors and significant events. It has great internal variation in terms of disciplinary approaches, yet it is fairly homogenous in the epistemologies it constructs, even across apparently fundamental disagreements about method and focus. It also has a fairly uncontroversial framework of goals, together with the methodological and conceptual instruments with which to meet them, all wielded by public advocates and exponents. In other words, suicidology is a coherent, singular, and powerful *social practice*.

In this paper we demonstrate how viewing suicidology as a social practice has considerable utility because it exposes moral and epistemological foundations and biases and enables critical analysis of its constructs, discourses, assumptions, and commitments. Drawing on the work of Langford (1989) and Isaacs (1998), we begin our analysis by delineating five interrelated features which reflect the nature of social practices. We then propose an account of suicidology as a social practice whose identity is shaped by a number of values – epistemic, professional, organisational, and external – which reflect these five features of social practices. Following this, we present a substantive picture of the contemporary practice of suicidology as it has come to be historically actualised. Finally, we discuss the implications that follow the construction of suicidology as a social practice in the domain of research, practice, and public discourse, and in particular, for our engagement with the morality of suicide.

Discourse on suicide has a long history. Pre-modern writings on suicide were largely philosophical, historical, and literary, and interested primarily in the way that suicide reflected cultural norms and meanings (Minois 2001; Weaver 2009). Changing social and intellectual values in late eighteenth century Europe manifest in processes of

decriminalisation, secularisation, and medicalisation contributed to the emergence of a distinctly 'modern' conceptualisation and treatment of suicide, vested in scientific methodologies that could establish general 'facts' (Minois 2001; Wright and Weaver 2009). This reconceptualisation of suicide meant that knowledge gained previously and using 'non-scientific' methods – for example, through metaphysical speculation, aesthetic judgements, and cultural and personal reflection – became a principal point of difference. The deliberate eschewing of moral judgement was another.

In this paper we revisit this well-known history through the conceptual lens of suicidology as a developing social practice, in which epistemic and moral commitments were never separated, but were instead inseparable. This perspective allows us to follow the development of suicidology as an intertwined social, conceptual and moral entity, an entity that has remarkable coherence despite the increasing specialisation, competition, and collaboration between disciplines that so profoundly shaped suicide research over the past 150 years (Laird 2011). And it reveals how profoundly important moral commitments are and have been to this social practice. As historians and advocates have identified with respect to other areas of nineteenth century social science (such as sex, violence, and criminality),[1] while science has undoubtedly provided important means by which suicide could be understood, it also has epistemic and moral force and is inscribed with assumptions about human experience, illness, action, and identity. In this regard, the dominance of scientific understanding has determined its scope, meaning, norms, limits, and language – constructing suicide as a social reality and shaping the social response to it. It is, therefore, both a deeply moral and heuristic enterprise.

Social practices and their key features

Social practices, as the name suggests, do not exist independently of persons, but are 'both constructed by, and constituted by persons' (Isaacs 1998, 5). Consequently, they embody many of the characteristics of persons, such as a set of values, beliefs, dispositions, and intentions (Isaacs 1998). In social practices, however, a person's actions are directed toward the achievement of a common goal or purpose which is not attainable by individuals; and one in which the social practice depends upon for its existence and identity (Langford 1989). As Langford explains:

[1] For example, see Foucault (1973), Bashford (2004), and McCalman (1998).

> A social practice depends for its existence and identity on the overall purpose which its members share and are reciprocally aware of sharing; and it is their possession of beliefs and purposes which make it possible for them to engage in such practices.... [A] social practice [is] given unity and identity by the overall purpose which [then] gives direction and point to the behaviour of its practitioners. (1989, 27-28)

The overall purpose of social practices may be theoretical – concerned with the acquisition of knowledge; but it may also be practical – concerned with bringing about change (Langford 1989). In suicidology, knowledge may be sought for its own sake, but also sought with the intention of informing strategies for preventing suicide. As well as providing unity and identity to a practice, it also provides justification for certain ways of 'seeing' and 'doing' which are necessary to the realisation of these aims (Langford 1989). Social practices may, therefore, be understood as a shared set of beliefs and actions derived from the tradition of the practice. As Langford writes:

> A social practice may be said to be carried on in accordance with the way of seeing and doing provided by a tradition, which not only gives it structure at any particular moment, but also maintains its continuity with the past and provides it with direction for the future…. a tradition tells those who are guided by it, not only what to do, but also how to do it. (Langford 1989, 31)

Maintaining continuity, therefore, is only possible insofar as ways of seeing and doing are shared equally by members. This may include certain practices, procedures, and conceptual schemes, but also the existence of a shared social reality. A second feature of social practices – that of tradition, helps to generate cohesiveness, but also, a sense of 'allegiance and solidarity' with other members of the practice which, in turn, 'provides the foundation of role-based moral authority' (Isaacs 1998, 6).

A third feature of social practices – the induction, learning, and socialisation of new members – makes possible this unity, cohesion, identification, and solidarity (Isaacs 1998). New members cannot grasp these shared commitments, values, beliefs, and actions from outside the practice, but must learn from those already working within it (Isaacs 1998). Processes of

learning and socialisation are crucial to the disseminating and continuity of a social practice over time, and equally, to its adaptability. Change is possible – as new skills, procedures, and techniques replace older ones and existing members acquire new ways of seeing and doing – but these must be recognised as 'legitimate within the practice' and 'appropriate to the demands of change' (Isaacs 1998, 7).

The authorisation of certain ways of seeing and doing points to a fourth feature of social practices which is that of an organisational or institutional authority structure. Isaacs (1998, 7-8) expresses this point as follows:

> It is this dimension of a social practice which legitimates, protects, and regulates what counts as authentic interpretations of both the purpose of the practice and its guiding tradition.... [It] presupposes both a shared intellectual or disciplinary content and a professional, institutional, or organisational authority structure. Such a structure would encompass the protection of a tradition [and] the legitimation and dissemination of authentic developments to the practice.

To these four internal features of social practices, we can add a fifth feature – social embeddedness. Social practices are embedded in time, history, and culture. They are also 'part of a larger whole, the community' to which they contribute and, which, in return, has a shared interest in the contribution and efficiency of that practice (Langford 1989, 31-32). It is to be expected, therefore, that these external social contexts may impact intellectually, economically, and politically upon the practice in question, as well as its future development (Isaacs 1998). These five features, purpose, tradition, learning and socialisation, organisational authority, and social embeddedness, reflect the nature of many social practices and provide a useful framework for critically examining the practice of suicidology and its scope, aims, norms, and development.

Suicidology as a social practice

The study of suicide is the focus of numerous disciplines including, but not limited to, medicine, sociology, psychology, philosophy, history, anthropology, nursing, and law. This means both that a great many understandings, approaches, meanings, concepts, theories, and methods exist, and that suicidology is unavoidably a multidisciplinary domain rather than a

cohesive, independent science (Knizek and Hjelmeland 2007). There is some merit in this position in that it recognises that suicide is a complex and multifaceted phenomenon and that a multidisciplinary approach provides the most suitable means for researching these multiple dimensions. It is also true that practitioners who respond to suicide are an equally diverse group that will include very different preferences and approaches. But while research into suicide is diverse and multidisciplinary, this is not necessarily true of suicidology. Suicidology, we argue, can be conceived of as a social practice which is i) directed towards an overall purpose, ii) shaped by particular traditions, iii) dependent upon processes of learning and socialisation to sustain it, iv) in possession of an internal authority structure which governs particular ways of seeing and doing, and v) embedded socially, culturally, historically, and politically.

The aim of suicidology

Suicidology is generally conceived of as the scientific study of suicide and suicide prevention and entails the study of a broad range of self-destructive behaviours, thoughts, and feelings, including completed and attempted suicide, deliberate self-harm, suicidal ideation, and other suicidal gestures (Maris, Berman, and Silverman 2000). Its purpose, therefore, is twofold. Suicidology is concerned with acquiring knowledge of suicide and suicidal behaviour, but also with applying that knowledge. Although the concept of suicidology does not logically necessitate prevention in accordance with the goals of scientific practice, it is the view of suicidology that persons who are suffering, in pain, or mentally ill should be able to access other forms of relief other than death; indeed, that in many cases either the prevention or relief of such suffering will prove possible. Thus, the study and prevention of suicide are interdependent, with knowledge of suicide seen as a necessary prerequisite for prevention (Maris, Berman, and Silverman 2000).

Suicidology, therefore, is not only descriptive, it is evaluative. It is directed toward the prevention and control of suicide – values which are intrinsic and built into the very framework of contemporary suicidology. These values provide suicidology with a common goal, fostering unity and a sense of identity amongst its practitioners. But equally significant, they serve to demarcate the practice of suicidology from other practices by way of these purposes or ends, and in doing so, provide justification for certain ways of seeing and doing deemed most appropriate to achieving these ends.

A ‘solid scientific foundation’ is considered pivotal to achieving suicidology’s aims (de Wilde 2002; Leenaars et al. 1997; Maris, Berman, and Silverman 2000), and yet the view of suicide as a problem which could be investigated and addressed scientifically marked a clear transformation in thinking from that of previous eras and cultures. No longer the province of theologians and moral philosophers, suicide became the focus of the emergent modern sciences of social statistics and psychological medicine (Wright and Weaver 2009) – two traditions that would have a profound impact on the development of suicidology as a social practice.

The foundations of scientific suicidology

It is a truism in the history of suicide that from the eighteenth century on discourse on suicide shifted perceptibly away from philosophical and theological debate over the meaning and morality of suicide toward greater factual interest. This shift towards secularisation, decriminalisation, and the emergence of the new sciences of sociology and psychological medicine in the study of suicide was neither swift nor clear. It is, however, worth offering a brief historical sketch of suicidology to show how it came to be a social practice with specific traits. In particular, the gradual moral revaluation of suicide during the nineteenth and twentieth century is significant for understanding the strength of contemporary suicidological discourse.

While it is true to say that the discourses of psychology, medicine, and sociology gradually came to displace the traditional moral discourses of philosophy, religion, and law – resulting in a more lenient and compassionate response to suicide – it would be wrong to assume that suicide was no longer considered a moral problem, or that morality was completely excised. Indeed, suicide found a distinctly modern expression in eighteenth and nineteenth century Europe. Radical transformations in traditional social relations wrought by modernity created substantial social disruption. Increasing urbanisation, the shift from traditional skilled labor to wage labor, and the loosening of traditional social and cultural ties contributed to a number of social ills including crime, madness, alcoholism, and suicide – each of which were regarded as potent cultural symbols of the threats to the traditional social and moral order posed by modernity (Kushner 1993)

As Weaver (2009, 22) has noted, this may have been because suicide was culturally constructed and because "[w]riter after writer made it into an epic crisis of Western civilisation." Accordingly, writing on suicide took on a decidedly reformist tone in many modern works – whether aimed at reforming individuals or society (Tierney 2010). The persistent interest in suicide as a complex *social* phenomenon and the emergent interest in suicide as a *medical* phenomenon are reflected in the increase in publications on suicide throughout the nineteenth century. Between 1830 and 1950, for example, the publication of medical, sociological, and psychological titles on suicide increased exponentially in comparison to moral and literary studies (Weaver 2009). Emboldened by new scientific ways of knowing and new methodologies, researchers sought to transcend – or, as we might suggest, to shift – moral questions in order to focus on the determining causes of suicide, thus placing what Fichman (cited in Turner 2010, 99) describes as 'an epistemological divide between science and politics, ethics, religion, and other cultural forces'.

Suicide and medicine

From its inception, the formal study of suicide has been closely associated with the emergence of new research fields (Laird 2011). The modern medical study of suicide is situated in what Hacking (1991) has referred to as one of the great periods of expansion of the psychiatric profession. Etienne Esquirol, whose lengthy contribution on suicide in the French medical dictionary published in 1821, and later included in his treatise on insanity, *Mental Maladies* (1845), would become the main progenitor of the medical view of suicide. Like others writers on suicide during this period (for example, Pinel and Winslow), Esquirol's conception of suicide centred on the (increasingly normative) thesis that suicide was a symptom of mental derangement. Esquirol's work associated social causes with physiological causes of disease, and importantly, with organic disturbances in the body's organs or tissues.

Esquirol approached suicide using the innovative ideas and methods of what is broadly termed the 'Paris school' of medicine, famous for the innovation of considering and investigating disease (including mental disease) as resulting from pathological lesions in the body. Broadly speaking, this replaced two thousand years of seeing illness as unique to each sufferer (rather than replicated in different sufferers), a result of imbalances in internal 'humors' (Ackerknecht 1967; Goldstein 1987; Hannaway and La Berge 1998; Huertas 2008);

it implied, among other things, that the sufferer had no moral or emotional control over or influence on disease. Esquirol and his colleagues searched for signs of pathological lesions or disease in the organs of victims of suicide. The cranium, brain, gall bladder, liver, and heart of suicide victims were all subjected to intense pathological scrutiny. Although findings varied, no conclusive evidence could be found for an organic basis for suicide (Burrows 1828; Esquirol 1845; Winslow 1840). Nonetheless, despite scepticism as to the value of anatomical studies and the contribution that it could make to identifying a specific pathology responsible for mental derangement, Esquirol's work promoted the increasingly accepted view that suicide should properly be regarded as a symptom of a disordered mind.

The 'medical' view of suicide was significant in two important respects. First, because it made a general claim that suicide was a medical *not* a moral problem. This simple statement, however, conceals an important truth. Medicine is not morally neutral. The understanding of certain forms of behaviour as problematic and the domain of medicine – as opposed to the family, church, or state – is itself morally significant and may create new problems as sociological and ethnographic works on medicalisation have shown (see Conrad and Schneider 1985; Illich 1990; Kitanaka 2012; Kleinman 1986). To define suicidal persons as 'mentally ill' places the act of suicide under a different moral light and influences the way we understand, respond to, and talk about suicide.

Second, the medical view was also significant for substantiating this position by claiming an accompanying organic pathology for suicide. In this view, the cause of suicide was individual and internal – the effect of a physiological or psychogenic agent or condition – and medical means, therefore, the only suitable mode of treatment. This meant that suicide could be understood as a special case of a much broader phenomenon – mental illness – resulting in the diluting of the object of study (Weaver 2009). Third, and finally, by backing this claim on statistically grounded argumentation rather than conclusive empirical evidence meant that it remained open to challenge from those who believed that suicide was not, in every instance, the outcome of mental pathology, and thus to alternative theoretical views from within psychology and from the newly emerging discipline of sociology (Hacking 1991; Weaver 2009).

Suicide, social statistics, and sociology

The emergence of systematic methods for collating and analysing statistical data also marked a pivotal historical shift in intellectual thought and the methodological investigation of suicide. Statistics helped to actualise the problem of suicide. They conveyed authority and gave suicide, whose only observable sign at this point was the act itself, an empirically verifiable form, and provided scholars with new techniques of argumentation that would have a profound impact on shaping the knowledge structure of suicidology (Hacking 1991; Marsh 2010; Weaver 2009). Statistics were especially useful for classifying and ordering the frequency and motives for suicide documented in police reports and judicial inquests (Weaver 2009). As well as methods, suicides were also categorised by age, gender, marital status, time and location of death, as well the causes of suicide. The terms *motives* and *causes* were often used interchangeably, but the separation of causes into predisposing causes, indirect and direct causes, and general causes was a common feature of statistical studies throughout the period (Hacking 1991; Weaver 2009). For the most part, however, these studies did little more than describe statistical patterns between suicide and other phenomena. Nevertheless, the sheer wealth of statistical data available meant that it was possible to form generalisations (Weaver 2009).

Statistical data also placed considerable pressure on the medical model of suicide, reinforcing the view amongst many – physicians included – that mental illness was only one of many possible contributing factors to suicide, and that the idea of suicide as uniformly identical and always an instance of mental illness was a mistake and concealed a much broader range of motives (Hacking 1991; Weaver 2009). But while the routine collection of data enabled researchers to locate certain patterns in age cohorts, gender, marital status, method, and seasonality, and a number of contributory motives or causes of suicide, this data was not enough to explain these regularities (statistical laws) and to generate a systematic theory of suicide (Taylor 1982). These needed to be coaxed from the data using newly systematised notions of cause[2] or speculations about the meanings of certain patterns. The former resulted in the tendency for scholars to conflate statistical laws with causation, while the latter resulted in the proliferation of preconceived ideological positions about suicide, the individual, and society (Hacking 1991; Weaver 2009).

[2] For example, Quetelet (1842) proposed a social physics that applied the Gaussian theory of errors in astronomy to both physical attributes and the social world in order to make statistical laws consistent with determinism (see also Hacking 1991).

It was Durkheim's remarkable ability to synthesise these innumerable statistical measurements into a systematic theory of suicide which, arguably, has been his greatest legacy. Much has been written about Durkheim's *Suicide* (1951) and its influence on contemporary suicidology. [3] While a detailed description of Durkheim's thesis and its critiques is beyond the scope of this work, it is important to be cognisant of his work's impact on the field of suicide research. The most obvious starting point for discussion is Durkheim's belief in the social causes of suicide. While this may seem self-evident, the popular view at the time was that suicide was an individual act and that the tendency to suicide was fixed in the (psychological or physiological) constitution of the individual. Durkheim set about challenging this view – arguing instead that suicide had an important social meaning.

Durkheim's work and the more general intentions of his 'project' have been the subject of considerable debate. In many ways, this debate reflects ongoing methodological concerns regarding the appropriate methods for studying suicide (qualitative versus quantitative methods), and ongoing theoretical disagreement regarding how suicide should be understood (socio-cultural versus biomedical approaches). A number of critics of *Suicide* consider Durkheim's work to be strongly linked to the positivist tradition, including his designation of social phenomena as 'facts', his application of statistical techniques for testing hypotheses, and most importantly, his construction of general, law-like propositions for explaining suicide (Atkinson 1978). Others, such as Douglas (1967) and Taylor (1982) challenge this interpretation of *Suicide* and suggest instead that Durkheim's argument for an extra-individual force of meaning (that is, a non-observable 'suicidogenic current') was the very antithesis of positivist thought, and signalled a radical fusion of psychological and sociological thought. Criticisms of *Suicide* have therefore tended to focus as much on its methodological rigor as on its psychological assumptions.

The development of systematic methods for the collection and analysis of data on suicide would have a profound effect on shaping the practice of contemporary suicidology in several key respects. First, it provided researchers with a new form of evidence for investigating suicide that was both abundant and easily accessible. This, in turn, resulted in a new line of statistically grounded reasoning that was used to not only describe statistical regularities, but to explain them (Hacking 1991).

[3] See Atkinson (1978); Douglas (1967); Pope (1976); Taylor (1982).

Second, the value accorded quantification meant that these explanations carried considerable normative force. Numbers dictated certain judgements and choices. It required the disaggregation of suicide and people into discrete units or categories by which they could be enumerated. This resulted in new facts about suicide, but at the same time, it also profoundly transformed the ways that suicide, suicidal persons, and the practices of suicide research and prevention were conceived. The gradual displacement of religious discourse on suicide through growing scientific and medical knowledge, together with various liberal arguments against the punishment of suicide, resulted in the complete moral revaluation of suicide. Technological, social, and organisational advances for measuring and analysing life made it possible to respond to the 'problem' of suicide through more positive means – not by prohibiting and punishing it, but by regulating the conduct of individuals and groups via practices of normalization, exclusion, education, discipline, and therapeutics – processes that Foucault describes in terms of governmentality (Tierney 2010),

By the end of the nineteenth century the empirical foundations of suicidology and the objects of its study, as individual psychopathology and/or as the consequence of social forces external to the individual, were now in place. Thus, the tensions and complexities between understanding suicide as moral/existential, as individual pathology, and as exemplification of social structures/ populations have been part of suicidology from the beginning, being simplified away during times when the social practice has narrowed its scope or been more stringently normative in its operation and allowing for change within the practice.

Suicidology and institutional authority

The pronounced influence of these traditions and the ways of seeing and doing they provided, signify, in many important respects, the birth of contemporary scientific suicidology. By the start of the twentieth century a conspicuously 'modern' conception of suicide had come to dominate Western thinking and the foundations for the scientific study of suicide were firmly in place (Wright and Weaver 2009). While suicide research occasioned a degree of interdisciplinarity, several further elements were necessary in order to establish suicidology as a formal, coordinated, and specialised field of study of theoretical and practical importance. The establishing of professional organisations, institutional structures, and journals were key to this process.

The pioneering work of Edwin Shneidman, Robert Litman, and Norman Farberow in founding the Los Angeles Suicide Prevention Centre in 1958 marked a significant step in the establishment of suicidology as a practice that integrated both suicide research and suicide prevention. As well as commencing a program of research that would, over the course of subsequent decades, profoundly influence the field and provide a model to subsequent generations of professional suicidologists, Shneidman and colleagues recognised the need for a service capable of providing support to persons in a suicidal crisis and a clinical treatment service soon followed (Shore 2007).

Changes in mental health policy and care also contributed to the advancement and viability of suicidology. The Mental Health Act of 1963 passed by the United States Congress led to a reassessment of mental health policy and care, culminating in a policy of deinstitutionalisation and the establishment of community-based-care models for the mentally ill. The Los Angeles Suicide Prevention Centre would benefit from these changes, receiving National Institute of Mental Health funding the following year, allowing it to expand its research and prevention activities (Shore 2007). By the close of the twentieth century, national suicide research centres such as the Centre for Suicide Research at Oxford University in the United Kingdom and the Australian Institute for Suicide Research and Prevention (AISRP) at Griffith University had been formally established in most Western countries.

As well as the establishment of national research centres, national and international organisations such as the American Association of Suicidology (AAS), the International Association for Suicide Prevention (IASP), and the International Academy of Suicide Research (IASR), were also established, and with them, a number of academic journals devoted entirely to research on suicide and suicidal behaviour: *Suicide and Life-Threatening Behaviour* (1971), *Crisis* (1980), and *Archives of Suicide Research* (1996).

Research centres, journals, and organisations played a leading role in professionalising, legitimating, and regulating the activities of suicidologists by establishing training programs, offering formal accreditation, producing research agendas, disseminating research through peer reviewed journals and conference proceedings, and through the awarding of competitive grants (Cutcliffe and Ball 2009). These not only helped to legitimate and safeguard the

epistemic and procedural content of suicidology, but to demarcate and privilege the activities of professionals from those of the public, and/or those without formal training.

Homogeneity and orthodoxy of research methodologies in suicidology

Much has been made of the conflict between competing disciplines and sub-disciplines and the limitations of particular methodologies in the study of suicide. Yet despite these tensions, the basic approaches to research are markedly similar regardless of disciplinary background (Fearnley 2009). Sociological studies, for example, rely as much on psychology as they do statistics in formulating theories of suicide which explain it in terms of social integration (Durkheim 1951), social and personal disorganisation (Cavan 1928), or frustration-aggression (Henry and Short 1954), while Douglas's (1967) argument for the study of the 'situationally determined' meanings of suicide is more in keeping with a hermeneutic approach than with the objective, formalised, statistical methodology which has dominated sociological research on suicide. Similarly, psychoanalytic approaches, such as Herbert Hendin's *Black Suicide* (1970), make unreserved use of statistical data despite publically deriding such methods elsewhere (Fearnley 2009). Suicidology would absorb these methodological tensions by observing the axiological distinction between nomothetic and idiographic knowledge and recognising both as legitimate within the practices of suicidology. These would subsequently form the basis of all research.

Such methodologies, however, preclude certain ways of seeing suicide – for example, 'suicide as sin' is no longer part of contemporary suicidological discourse although it continues to figure in lay understandings. Questions of methodological orthodoxy and whether genuine diversity exists within suicidological research are, therefore, valid and important questions given claims for suicidology's multidisciplinarity. While suicidology has not been completely impervious to criticism regarding the limits of a purely medical framing of suicide, disagreement amongst scholars occurs primarily at the level of research method. Much of the current debate, therefore, centres on the distinction between nomothetic (quantitative) and idiographic (qualitative) approaches and the irreducibly different set of values on which they are founded. Consequently, it tends to overplay the opposition between the general and the particular, and between the medical and the socio-cultural dimensions of suicide. Such distinctions, however, are misleading. Qualitative research in suicidology often involves the quantitative analyses of qualitative data, while social and cultural factors are

widely acknowledged as contributory factors in epidemiological research. More importantly, the distinction between research methods in suicidology obscures the fact that the majority of research shares the same paradigmatic and normative space.

Nomothetic knowledge

Broadly speaking, nomothetic knowledge is loosely used as shorthand to refer to research which employs quantitative methods, although this is not always a helpful distinction as qualitative research can also be nomothetic. Nomothetic approaches therefore, are perhaps better understood as those which deal with populations as opposed to individuals. These may involve 'big picture' analyses of the kind which seek to explain suicide in whole nations or populations; or alternatively, they may involve 'little picture' analyses of suicide involving particular sub-groups or variables (Stack 2002). Such research is generally concerned with answering the following questions: i) Within a given population, who are the people that engage in suicidal behaviour? ii) Why do particular people engage in suicidal behaviour? And iii) how effective are interventive and preventive strategies in reducing suicidal behaviour?

This focus on the distribution and determinants of suicide and suicidal behaviour means that epidemiological research plays an important role in suicidology. To date, epidemiological studies have identified a range of correlates for suicide and suicidal behaviour including, but not limited to, age, nationality, gender, methods, (un)employment, mental illness, religious beliefs, alcohol and substance use, bullying, sexuality, meteorological conditions, and genetics. This large body of research provides us with a comprehensive picture of suicide and suicidal behaviour at the beginning of the twenty-first century. Epidemiological research reveals that suicide is more prevalent amongst men with the exception of India and China where there are no considerable differences between gender rates, while suicidal behaviour occurs more frequently among women, young persons, and those with a diagnosed psychiatric disorder (Nock et al. 2008). Despite significant cross-national variability regarding gender and suicide, age and suicide, and rates of suicide, there is an overall consistency with regard to key risk and protective factors. Research has identified a range of psychiatric, psychological, biological, socio-economic, cultural, and interpersonal factors as having a significant bearing on the prevalence of suicide, while protective factors – or those

which might decrease the probability of suicide – include religious affiliation and practice, spirituality, and social and family support and connectedness (Nock et al. 2008).

As a result of these findings, it is widely accepted that suicide is multifactorial and that a simplistic monocausal model is inappropriate (De Leo 2002; Marušič 2008). One of the challenges for suicidology, therefore, has been the development of systematic suicidological theory. For Taylor (1982), Rogers (2001) and others, the complexity and multidimensionality which is a feature of contemporary empirical studies is problematic as the factual data produced by these studies 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).

Despite identifying a number of key risk factors or predictors for suicide including a diagnosis of depression, a history of previous suicide attempts, alcohol or drug dependency, and physical illness, the multifactorial nature of suicide and the problem of proving a direct causal link between certain causal factors and suicide means that the construction of theoretical models is both complicated and ambitious (Goldney 2000; Maris, Berman, and Silverman 2000).

The role of theory in suicidology cannot be overstated because epidemiological data can be collected and presented in multiple ways and may serve multiple interests (Mulhall 2001). And because theory construction is shaped by methodology and the epistemologies in which they are grounded (Maris, Berman, and Silverman 2000), different theoretical perspectives inevitably result in suicide being conceptualised and explained differently. This is generally not regarded as a problem, as different theoretical perspectives can, and do, exist. However, it does mean that questions regarding the 'objectivity' of nomothetic knowledge – a value which is often attributed to it and against which more 'subjective' idiographic approaches are measured – becomes a point of debate.

The value and utility of nomothetic research is also linked to broader ethical and political questions regarding the use and privileging of different research methodologies and methods. Social epidemiology, for example, focuses not just on biomedical factors, but on social,

economic, and political factors (Mulhall 2001). In contrast, most strategies aimed at reducing suicide are framed almost exclusively within a biomedical and individualistic model and focus on risk factors such as depression and alcohol and substance abuse. Social, economic, cultural, and political factors and their relationship to suicide are often ignored or played down in epidemiological research. Idiographic knowledge, which utilises qualitative methods, is considered more appropriate for capturing these dimensions of suicide.

Idiographic knowledge

The idiographic tradition is relatively well-established within the field of suicidology with personal documents such as suicide notes, diaries, biographies, and letters providing an important source of data for researchers. Allport's (1951) work on the value of personal documents to psychological research informs much of the idiographic suicidological literature. He argued that the vivid personal stories of individuals serve as important clinical documents in their own right, and considered the work of Helen Keller and Clifford Beers as two examples of stories which have wrought profound social, political, and institutional change. It was William James's *The Varieties of Religious Experience* (1902), however, that Allport considered to be 'the first great book in psychology to rest its case entirely upon the use and interpretation of personal documents' on the grounds that no other method was as well suited to capturing such existential subject matter (1951, 5).

Allport used such cases to make a more expansive epistemological claim – that knowledge of the <u>particular</u> forms the basis of all knowledge. He writes:

> To believe that generalized knowledge of human nature can outstrip knowledge of particular expressions of human nature is a grave blunder made not infrequently by both psychologists and sociologists.... [I]t has become apparent that nomothetic abstractions have led to oversimplified versions of human motivation.... As seen in case documents, personal causation is a far more intricate matter. (Allport 1951, 56-57)

There is little doubt that first–person accounts shed more light on the nuanced psychological and socio-cultural features of individual cases than nomothetic approaches. But idiographic

knowledge, as Allport recognised, may also provide the basis for more generalised knowledge.

Like nomothetic approaches, the idiographic also deals in uniformities and generalisations – whether through the use of 'mixed methods' research (which combines qualitative and quantitative methods) or through the quantitative analyses of qualitative data (that is, the coding, tabulation, and analysis of words, sentences, and/or themes). Indeed, as with nomothetic approaches, it is argued that for suicide to be studied as unitary phenomena, there must be some commonalities with regard to its individual meanings. As a result, it is arguable that qualitative research has adopted many of the characteristics of nomothetic knowledge by favouring methods which help yield quantifiable, testable, and generalisable findings, rather than those of a more exploratory nature (Hjelmeland and Knizek 2010, 2011).

Despite the growing trend in contemporary suicidology toward the quantitative study of qualitative data, a number of studies have sought to engage with the concrete particularities of idiographic source material. One of the most notable is Edwin Shneidman's *Autopsy of a Suicidal Mind* (2004). Shneidman, a long time advocate of the study of the individual, devotes an entire volume to the study of one person's suicide by utilising a method known in suicidology as the *psychological autopsy* (which utilises official records such as medical histories, autopsy and police reports, as well as personal documents and interviews with those known to the deceased – providing researchers with information regarding the suicidal person not available in most epidemiological studies).

One of the book's greatest virtues is that it sheds light on the nuanced psychological features of a life marked by suicide, thus providing a suitable counter to the more abstract, generalised findings of nomothetic knowledge. But this does not mean that *Autopsy of a Suicidal Mind* provides 'an unequivocal analysis of Arthur's suicide' – as the analysis of his case is contested and leaves much out (Pianalto 2004). Very little, for example, is made of the existential features of Arthur's life. Indeed, as others have noted, rather than seeing Arthur's frequent philosophical discussions with his brother and father as attempts to find a sense of meaning in the pain and suffering which he was experiencing, these are dismissed and considered symptomatic of a much broader condition or illness and, therefore, unimportant in the context of Arthur's suicide (Pianalto 2004).

This criticism reflects a broader concern with the discursive nature of the psychological autopsy which makes it particularly susceptible to claims of interpretive bias. In a review of research based on the psychological autopsy model, Pouliot and De Leo (2006, 492) claim that in the majority of psychological autopsy studies to date, 'suicide is almost exclusively researched under the single paradigmatic umbrella of medicine', meaning that in most cases research focuses on the presence of a given psychiatric condition rather than on (equally important) socio-cultural factors. The idea that biographical data can be sifted for evidence of a discernible psychopathology (or some other hidden 'truth' or 'meaning') in isolation from the contexts in which it has been produced suggests that qualitative research in suicidology may be conducted in ways that are consistent with empiricist and objectivist epistemologies – approaches more commonly associated with quantitative research (Crotty 1998; Taylor 1982). These findings, together with the growing number of quantitative analyses of qualitative material, suggest that the dichotomy between quantitative and qualitative methods in suicidology is misleading, and that both approaches may share the same paradigmatic and normative space – that of medical objectivism.

Implications that follow the construction of suicidology as a social practice

Suicidology, therefore, is unquestionably a social practice – directed toward the scientific study and prevention of suicide. Although shaped by multiple, often competing, epistemologies, the view that suicide was preventable and that science offered the best means for achieving this gave the practice of suicidology identity, unity, and direction. The intellectual traditions of sociology, psychology, and medicine provided the analytic frames, concepts, and methods by which suicide was studied and explained, and, along with the establishment of professional organisations, institutional structures, and journals, helped to demarcate the field of suicidology as a specialised domain of study. Despite a degree of interdisciplinary tension and debate over research methods, suicidology can be delineated by certain key normative epistemological and methodological features.

Suicidology, as is the case in any epistemology, values some knowledge claims over others – describing some data as 'evidence' and other data as less strong and less important. It therefore creates order, establishes process or method, attributes meaning, and determines both causation and outcomes – giving it considerable moral and political force. It is impossible, therefore, to completely distinguish the epistemology of suicide from its moral or

political interests (Mishara and Weisstub 2005). This implicit link between epistemology, methodology, and ethics is reinforced by the fact that many prominent suicidologists also play important social and moral roles – as clinicians, nurses, advocates, mental health workers, and policy-makers. This close connection between world views and moral values means that the social practice of suicidology has significant practical implications for research, practice, and for public discourse.

First, for those committed to the notion of methodological pluralism in the study of suicide there is a concern that the privileging of scientific medical approaches within suicidology results in the loss or truncation of important understandings of suicide. For example, the inability of qualitative research methods to measure up to stringent scientific criteria has meant that humanities and social science research has taken a backseat to the more robust scientific programs of epidemiology, biomedicine, and cognitive science. The point here is that the lens of suicidology and its focus upon and prioritising of more tangible risk factors, symptoms, or conditions may impede the study of less quantifiable, but equally important, social, cultural, and political factors (Hjelmeland 2010; Hjelmeland and Knizek 2011).

Complex human and social phenomena such as suicide are not easily assimilated by conventional methodologies and logics whose capacity to capture the ephemeral, indistinct, complex, messy, confused, disordered, wild, and unpredictable aspects of suicide is limited (White 2012). This, in many ways, goes to the heart of the paradox of contemporary suicidology which, on the one hand acknowledges the limits of its knowledge about suicide and the inadequacy of simple explanations or solutions, but on the other hand remains almost exclusively invested in scientific methodologies as the most effective means of acquiring that knowledge. This is not to discredit the value of conventional methodologies. However, it does demand that suicidology reconsider the distinction between different ways of knowing and ask whether scientific explanations of suicide should have greater authority than other ways of knowing suicide, including moral or aesthetic understandings.

Second, the nexus between methodology, epistemology, and practice is also critical to understanding the moral and ethical implications of suicidological practice and the ways these manifest and normalise certain ways of thinking or acting. Knowledge about suicide is grounded in, and validated by, our representations of it; by the concepts, theories, models, and language that suicidologists use to describe and explain it (see Webb 2009). These, in

turn, influence practice, and the ways that suicide and suicidal persons are responded to. Understanding the primacy accorded to scientific theories of causation in biomedicine and epidemiology helps to explain why it is that even when we understand suicide as multifactorial, it is still – in terms of a social response – seen as requiring an individual and medical response rather than one that requires social or institutional change (see Petersen and Lupton 1996). The way persons understand and explain their actions, the responses their actions generate (particularly with regards to norms of care), and the adoption of various health promoting behaviours that people report following a suicide attempt, are all examples of the way the normative force of suicidology impacts upon practice and upon human lives.

Finally, while public discourse on suicide has always been especially diverse, increasing professionalisation and medicalisation has resulted in a noticeable shift away from more rich, varied, and open public discussion of suicide toward a discourse which is narrow, increasingly framed in biomedical terms, and lacking cultural and epistemic richness or diversity. Suicide, at least within contemporary Western thought, is regarded first and foremost as a public and mental health issue. And while suicide can, and should, be treated in this way, it also continues to pose morally unsettling questions about illness, pain, suffering, and the meaning and value of human life and death. To limit the discussion of suicide to certain kinds of descriptions – some of which may redefine or overlook important aspects of suicide – is both myopic, for it gives insufficient weight to the complexity of suicide or to the degree to which it is embodied and socially felt, and misguided, for it misses opportunities for developing coherent social responses to suicide.

While biomedical approaches to suicide have yielded important benefits, the development of a critically reflective suicidology, as well as a fuller, richer understanding of suicide, requires that we reflect upon the intellectual traditions and practices of suicidology and the epistemological assumptions underpinning them. For critical reflection on these issues may lead to suicidology adopting a less prescriptive view of science and to revitalizing its research practices in order to more fully embrace creative, open-ended methodologies alongside more conventional ones so as to capture the silences and absences of contemporary suicidology. Importantly, the benefits of a more inclusive and diverse set of methodological practices which are attentive to the social and cultural complexity of suicide may also be of practical value. As White (2012) has argued, highly structured, standardised, and pre-determined prevention and intervention measures may not always be the most effective, and there is a

need for practitioners and communities to be responsive to the dynamic, multiple, and emergent meanings that suicide might have for different people.

But the challenges confronting suicidology are not only methodological, but ontological and political as well. They concern questions about the kinds of realities suicidology wishes to acknowledge in its practice and the ways it represents and responds to suicide. As a social practice constructed by, and constituted by persons, suicidology does not stand outside the moral realm. In making claims about the nature of suicide and the best ways of responding to it, suicidology embodies and legitimates a moral response to it (see Frank 1992). These knowledge claims, the criteria by which they are evaluated, and the practices which they support should be an important focus of sociological, philosophical, and political inquiry. Shifting our understanding of suicidology to being a social practice takes debate about the nature of its methodology far beyond traditional arguments concerning the need to accommodate humanities disciplines and qualitative methodologies in what is predominantly a science-based field.

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