

***‘Suicidology as a Social Practice’: A Reply to Tom Widger***

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In recent years, a growing body of critical literature has emerged that challenges the dominant norms and practices of mainstream suicidological research. Concerns over epistemology and methodology, the (political) rationales that determine how suicide is researched and responded to, and the lack of measurable advances in knowledge and prevention, are, for a growing number of scholars, symptoms of a more widely felt paradigm crisis in contemporary suicide research. Tom Widger (2015) crystallises the incommensurability between the globalising paradigm of ‘scientific’ suicidology and the meanings and nuances of self-inflicted death in specific cultural contexts, extending the concerns raised by our article ‘Suicidology as a Social Practice’ (2014). While recent debates have largely focused on issues of methodological pluralism as a way of moving suicidology forward, Widger questions the degree by which any study of suicide can truly subvert the suicidological paradigm when it produces both the subject and object involved. As he says, the very *concept* of suicide is suicidological.

Widger’s central challenge to all those involved in suicidology is to articulate whether ‘post-suicidological’ suicide research is even possible, and, if so, what it might look like. Certainly it seems desirable. Anthropological work, of the kind Widger undertakes, reveals just how much suicidology cannot ‘see’, and just how richly meaningful (if painfully so) self-inflicted death is in different cultural contexts. Such work illustrates the interrelatedness and inseparability of the meanings of suicide from broader cultural-normative views on life and death, their correspondence with a multitude of motivations and causes, and, above all, the problem of suicide’s interpretation and representation.

It is this nexus between the representation of suicide (questions of ontology), how we should think about it (questions of epistemology), and how we should practically respond to it (questions of ethics and politics) that we sought to expose in our original article. So although we are in agreement with Widger that human interpretive practices must become a central subject of suicidological inquiry, we suggest that these cannot be uncoupled from the ethical realm in which a social practice like suicidology operates.

At the core of suicidology is something pressing and urgent: the distress of persons who seek to end their own lives and the devastation and grief of family members, friends, and communities that result from suicide. Harm and suffering, therefore, are the impetus for prevention. Widger is motivated by the same impetus – and he borrows this much from suicidology: the frame that suicide is a problem that needs prevention. But does taking up this ethical position rely on, or at minimum reproduce, the discourses and concepts of suicidology (as Widger wonders)? For, as he points out, it is the very concept of suicide that enables current preventively-oriented explanations and makes the epistemological terms of suicidology *seem* inescapable.

To prevent suicide, we need explanations to guide our actions. There are two categories of these in suicidology that we need to assess seriously if we wish to contemplate how we can shift to a different sort of suicidology, or to a new entity altogether that leaves the

epistemological constructions of ‘suicide’ behind. The first is the explanatory power of the concept of ‘mental illness’ as the cause of suicide. The second is the power of the scientific methodologies that have generated and tested new concepts and provided new insights into the causes of suicide.

### **The Power of the Concept of Mental Illness as the Cause of Suicide**

The defining of human experience in terms of biomedicine is a powerful process because it can generate concepts that are functionally useful in describing salient dimensions of phenomena. These functions have a close fit with the social ‘work’ that concepts – such as diagnoses – do, for example, validation and nomenclature for suffering. As an umbrella term, the category of mental illness is not especially meaningful, explains little, and is a tautology of sorts in that “the (suicidal) act defines the illness and the illness defines the act” (O’Connor 2003, 298). Yet defining suicide as an act of mental illness (whether officially diagnosed or not) has a number of powerful ethical functions.

First, explanations cast in terms of mental illness can help mitigate suffering – much of which arises from blame and social judgement (Sudak, Maxim & Carpenter 2008; Tzeng & Lipson 2004). The concept of ‘mental illness’ is rooted in a perspective that reduces blame by removing an individual’s responsibility for their suicidal act. Second, externalising the problem gives it the structure of explanation. It makes what was occult understandable and rational. Third, it catalogues and relates symptoms, giving persons back control over often very overwhelming circumstances and telling them unequivocally what to do. Thus, it provides treatment. Finally, it validates experience and offers an appropriate reformulation of the self. As a consumer, one has access and exposure to a range of views of what mental illness is and means. So, although diagnosis is a biomedical entity, there is a set of narratives available for persons to draw on that enable incorporation of the nuanced, the referential, and the existential—those aspects that biomedicine overlooks.

The ethical/ontological concept of mental illness is made more persuasive by the observation that many recover from a suicide attempt and then go on to live fulfilling lives. This implies that when they attempted suicide the reasons that led them to the act were not as immovable as they must have seemed, and that the suicidal person was not thinking and perceiving ‘reality’ clearly at the time, and hence, was suffering from an abnormal distorting cognitive pathology. Further epistemological validation is similarly judged to have occurred when pharmacological and psychological treatments for mental illness produce predicted and beneficial effects: this is interpreted as evidence for the validity of both the ontological reality of physiological explanations of mental illness and of the concept of mental illness altogether.

However, there are several problems with the concept of mental illness of concern to both Widger and ourselves. The first is that the concept of mental illness deletes, omits, or renders invisible many of the most important explanations of suicide, at least insofar as those suffering and attempting and surviving suicide are concerned. The second, concerns the ontology of mental illness as it relates to suicide. Neither Widger nor ourselves would consider mental illness the ‘cause’ of suicide. Indeed, as Widger notes, the view of

suicide as an illness to be prevented is refuted by the majority of his Sinhalese participants, evidence that it is a historically and culturally specific concept designed to fit the society that produced it. Of course in saying this we are concerned not with the utility, epistemological status, or harms of the concept of mental illness, but with its connection to suicide. We note, however, that the same question must necessarily be asked there; that is, how useful and how harmful is the concept of mental illness?

We also have a number of ethical concerns regarding the concept of ‘mental illness’. First, by implying that those who are thinking of ending their lives are not thinking or perceiving accurately, moral agency is diminished and with it the deep recognition that a moral violation has taken place in which a person’s values, capabilities, or sense of self are thwarted and suicide a final act of moral clarity, self-determination, and hopelessness—a situation not capturable in terms of ‘mental illness’. Second, the concept is one that maps onto a particular kind of personhood—that of contemporary late capitalist/neoliberal society. The self of this society is individual, bounded, autonomous, and reflexive; one that is called upon to take responsibility to maximize personal wellbeing across the life course. Increasingly, any falterings in happiness or satisfaction are ascribed to a failure in the individual, and yet these individuals face more extensive insecurity and social flux than did the generations that preceded them (Giddens 1991). The concept of ‘mental illness’ fits this sort of self. As a diagnosis it provides validation and ethical and practical relief—not because of the impact of mental illness per se, but because of the parts of life it holds in view as areas of intervention (from controlling the emotions through to the fostering of social connections). Those that recover from suicide attempts don’t do so because the diagnosis of mental illness is ontologically correct—but because they are selves defined by ideas such as responsibility, freedom, initiative, authenticity, recovery, and self-improvement; and because they are living in a society of sufficient resources and social mobility to enact these ideas, at least some of the time.

Of course the ontology and epistemology of mental illness, and mental illness as a cause of suicide, are irresolvably complex. The power of the concept in the face of the transformation of experience as a result of pharmacological and psychological treatments is not something to turn one’s back on, as advocates within the Sinhalese diaspora and other diaspora (and at-home) communities will tell us. Rather than an all-defining reality, such concepts, including the biomedical explanations that underwrite them, are perhaps best regarded as what they are—*heuristics* whose functionality is defined by how *well* they explain things (‘things’ being the data we have including lay informant accounts) and importantly by how well they *don’t*. And that in practice is what happens inside many consulting rooms, where sympathetic and insightful family practitioners and psychiatrists search for metaphors and narratives that can support and enable patients and alleviate some suffering. So should post suicidology include the concept of mental illness? We suspect that the answer is yes—but only if it is used in a very cautious fashion, one highly self-conscious of its limits; rather in the manner in which Americans advocate for the use of guns but never display in practice.

### **Epistemology and Moral and Political Interests**

It may be that our chief problem with suicidology is not the very concept of suicide itself—even though it imports certain culturally specific features that make the

perspective of the Sinhalese different and ‘unseeable’ and produces and constructs its subject and object in the terms of Western epistemology and discourse—but with the weighting of causes in biomedicine around mental illness. This weighting inevitably focuses attention on those risk factors that can be addressed at the individual level through medical intervention or education. It therefore overlooks the social determinants of suicide and those factors that contribute to suicidal distress including, for example, social injustice, inequitable socioeconomic policies, or gender and sexual oppression. By attributing these factors to personal attributes rather than to structural deficiencies and state institutions, the political and economic forces that foster these inequities, and which may lead to poor mental health and suicide, remain unchallenged (Mills 2014). But it is these that offer us the greatest and most ethically appropriate arenas for prevention and intervention. Many of these can’t be ‘seen’ without the quantifying methodologies of epidemiology, and they generate explanations that are as much at odds with Sinhalese explanations of self-inflicted death as they are with those of conservative Western politicians. In both cases the methodology can and should challenge the values and concepts of the societies in which it is applied. It is also amenable, as most scientific concepts are, to some redefining through culturally specific lenses.

In our view then, a ‘post-suicidological’ suicidology is one that recognises this nexus between ontology, epistemology, ethics, and politics. The way problems are prioritised or de-prioritised in suicidology, together with the criteria by which certain data are designated as evidence and other data as less strong or less important are, after all, a question of values (Carter, Rychetnik, Lloyd et al. 2011). As the work of Stuckler and Basu (2013) and Mills (2014) has shown, the mechanisms by which sociopolitical and economic conditions of inequality and alienation come to be reconfigured and rearticulated as individual problems—as medical problems rather than as ethical and sociopolitical problems—exposes the moral and political commitments of institutionalised suicidology. Any attempt to conceive of a ‘post-suicidological’ suicidology, we believe, needs to start here. That is, with the moral and political ideas that are embedded in our social and professional cultures and which underpin contemporary responses to suicide, and with the ethical consequences of these.

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