The Many Languages of Suicide

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Abstract
I used to sometimes feel invisible when I was deep in my own suicidal despair. Now, although enjoying a robust "recovery", I find that my current research into suicide often renders me invisible again. More precisely, the various languages of suicide - in the academic literature, in public health policy documents and in conferences like this one - speak of my experience as some sort of exhibit in a glass jar to be pointed at. The language of science, objective and rational, struggles to capture the dark mystery of suicide and our understanding of it suffers accordingly. The language of direct, first-hand experience - intimately personal and subjective, sometimes irrational and paradoxical, often poetic and spiritual, and possibly frightening to some - must be included in our discourse to empower others to speak up and to dismantle the ignorance and stigma around suicide. This paper (and my current research) looks at the language of spirituality to deepen our understanding of the suicidal crisis.

Suicidality.

Contemplating suicide is like no other feeling. This life force within you that has taken you from birth to this present critical moment is losing its potency. Despite the joys and wonders of this extraordinary gift of life, you are thinking that it's not worth it. For whatever reason, life has become too difficult, too painful … and extinguishing this life force becomes a real possibility.

Suicidality is so hard to talk about when you are feeling it. Nobody wants to believe that this could be happening. You don't even want to believe it yourself and you try so very hard to convince yourself that it's OK, that it's not really that bad. But it is. You might think you are mad or going mad, which can be both a horror and relief. At times you don't recognise this person that you have been all your life. You might wonder whether you have already died and this body, mind and personality are some sort of peculiar post-life memory. But the pain brings you back to reality and you realise that you are still very much alive. And it's unbearable.

If you are brave enough to seek help your psychache[1] will likely be denied. Once you get past the "pull yourself together" school of therapy you will find, depending on your access to services but particularly on your luck, all sorts of interpretations of your problems. Busy doctors and psychiatrists will diagnose the so-called illness of depression and give you a pill to fix your broken brain. Perhaps you will find some counselling to learn new ways of dealing with your negative thinking or relationship problems. Or maybe your problem is your drug abuse and you enter the drug rehab merry-go-round. An important moment for me was when a dear supportive friend was talking with about "my problem" and I had to stop her and tell her that what she was calling my problem was in fact my life.

Suicidology.

I think my journey into suicidology really began when I was looking at a website not long after my recovery. It was an authoritative site with many scholarly papers. Wading through these I saw that a central theme here was the apparently important categories of suicide

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[1] Defined by Edwin S. Shneidman as psychological *pain* arising from frustrated or thwarted psychological needs – a much more accurate and useful term than "depression".

contemplators, attempters and completers. I found this odd because the boundaries between these categories were not as significant in my experience as was being suggested here. I found myself getting annoyed and eventually realised it was because whoever these papers were talking about it was certainly not me.

Since then I have felt this many times as I study the literature of suicidology. The dissection of suicidality into biological, psychiatric, psychological and sociological components left me feeling like some specimen in a glass jar. Nobody was talking about what suicidality *felt* like. The person actually experiencing this despair has become lost and invisible – so many trees but not a forest in sight.

I felt invisible again when I entered "suicide survivor" into my Internet search engine and found many websites for those bereaved by suicide – wonderful for those facing this acute form of grief. But almost nothing for those of us who have survived a suicide attempt. What do I call myself? How can I reach out to my fellow survivors without a name for us? I still don't know? And I still can't find many of my soul mates despite the many thousands of us that we know are "out there". We are hidden behind labels of depression and other mental "illnesses" where discussion of suicide is generally avoided. Language is important and I need a word or phrase to identify this role in my life.

The Self.

Fairly early on in what became a four year struggle with myself, I said to a friend that I couldn't see any way out without some unimaginable change in my consciousness. To illustrate my point I said this change would have to be comparable to the change that occurs during puberty. This alternative consciousness was invisible to me, just as adolescence is unknowable to the young child.

Suicide, the self killing the self, is a *crisis of the self*. Despite this, there is little discussion of the self in suicidology. Instead we find many implied selves from the various disciplines that come together under the umbrella of suicidology.

The physical, objective sciences of biology and medicine, focussing on the physical body, have little to say about the subjective experience of selfhood. This is appropriate, for when a genuine biological condition is the cause of suffering then good medicine is necessary. Subjective psychological issues arise in medicine, interestingly in pain management particularly, and also in some of the more holistic, body-mind schools of medicine. But a neurological explanation of consciousness is still a long way off so even if we accept the questionable assumption that the brain is the organ of the mind we must admit that what we know about the brain is much less than what we don't yet know.

Psychiatry has an unhealthy emphasis on "abnormal" behaviour, which it now carefully calls "disorders", but without attempting to define normal. The misleading "illness" of depression, so pervasive in suicidology, pathologises our most human qualities so that we suppress symptoms without addressing the causes. Combined with biological psychiatry, the dominant trend over recent decades, we become little more than biochemical robots to be managed by drugs. Psychoanalysis dares to ponder the self with imagery and metaphors that can help us know ourselves but is losing influence with the current push towards biological psychiatry so favoured by the pharmaceutical companies. Psychiatry has lost its soul, or perhaps more accurately it has sold it.

Psychology talks of the self in more human terms with its emphasis on the mind rather than the brain. Using concepts of thoughts and emotions, intentions and desires, personality and relationship, its language connects more strongly with the human dimension of suicidality. Although psychology has much to say about the self and is a lively research topic, there is

currently no general agreement on what constitutes the self. Instead there is a bewildering array of concepts relating to the self, such as self-esteem and self-awareness, but no satisfactory definition of selfhood itself. What they all have in common though is the assumption that the mind is the essence of our being. This is Descartes' famous dictum of "I think therefore I am". For my kind of suicidality, I now see this as the fatal flaw in psychology.

I must briefly mention sociology because it seems mandatory in suicidology to mention Durkheim. Jokes aside, the cultural and social contexts of suicidology require more attention be given to the sickness of society rather than the current emphasis on it as a sickness of the individual. For real suicide prevention – that is, to minimise suicidality arising rather than just treating it after it has already arisen – we need to stop blaming the victim so much and address issues such as social isolation, poverty, homelessness, domestic violence and the institutionalised abuse of our children. At the individual level though, the concepts of self in sociology and social psychology emphasise our relationships with others. These are relevant and useful but the conceptual weakness here is that the self is defined in terms of some "other" self – a tautology where the self itself remains undefined.

Some of the most interesting current research into the self and subjectivity is found in the work of post-modern thinkers in cultural studies and philosophy. These are not frivolous academic speculations but important contributions to how we come to know ourselves. Although rarely discussed in suicidology, these ideas are relevant and useful for our understanding of the self that is at the core of suicidality.

Meantime, within the suicidal individual, this poorly understood, subjective experience of the self is active in all its complexity and subtlety. These many dimensions of selfhood are fused into a single identity which is in crisis. They cannot be looked at in isolation without losing the wholeness of the suicidal experience. Paraphrasing Alvarez in *The Savage God*, "we must at all times remember that the decision to take one's life is as vast and complex and mysterious as life itself".

Spiritual self-enquiry.

With hindsight I can now say that at the core of my suicidal dilemma was the question "What does it mean to me that I exist?". This question points to what is recognised as one of the key indicators of suicidality – hopelessness. For me, hopelessness arises from an absence of meaningfulness. If I feel that my life is entirely without any meaning and purpose, and no hope of it ever being otherwise (i.e. helplessness), then suicide becomes a progressively more and more logical and attractive option. Why put up with this pain when there is absolutely no point?

This question also points to suicide as a crisis of the self. This sense of meaninglessness and hopelessness is very personal, intimate and subjective. It is about my pain as I experience it. It is about my deepest, innermost relationship with me, with my self. You can never know another person's pain and no scientific instrument can measure the severity of my pain against yours. It is not physical, objective or even rational. If we reduce and dissect it into its component parts we find the whole does not add up to the sum of its parts. Our best scientific endeavours have been unable to adequately describe, explain or comprehend this subjective experience of selfhood. Consciousness, our sense of self, remains a scientific mystery and may remain so forever, for the scientific method is a method for the physical world of objective reality. A purely scientific response to suicidality will never be adequate.

Spiritual self-enquiry saved my life. After four years of agonising struggle and exhausted with desperation and failed therapies, I attended to the essential spiritual question of "Who am I?". Almost immediately and almost effortlessly, I let go of my suicidality like a snake

shedding a no longer useful skin. It took a while to physically recover from the wretched medications but the real "recovery" of freedom from my suicidal psychache arrived and continues to this day.

The spirituality that I speak of here is not of any faith-based religious kind. Nor is it based on any external God or Higher Power, though I am now more sympathetic than I once was to these paths to spirituality. Briefly, the spiritual teachings that were available to me came largely from yoga and the invitation to look for the answer to this "Who am I?" question not with the mind but in the silence of a quiet mind. To experience the self with a truly quiet mind, if only for a fraction of a second, is to discover that we are not who we think we are. Any thought, any mental experience of the self, can only ever be an approximation of the self, not the self itself. The inevitable and radical implication of this is that the mind cannot be the essence of our being. This can be disturbing for the typical Western, educated mind in a culture dominated by the belief that consciousness is an attribute of the mind.

This spiritual self-enquiry, leading to the recognition that "I am therefore I think" rather than Descartes' reverse logic, has set me free. This self that exists before the first thought arises (invariably the "I" thought), and which some may call the soul, is characterised by peace and freedom. I am not only free of my suicidality but also free to embrace life in ways that had previously been impossible. An added bonus was that this "awakening" helped me make sense of my suffering, important for a mind like mine. I now understood why all those therapies felt like a dance on the surface, never reaching to the core of my despair. As Edwin S. Shneidman says, contemplating or deciding to suicide is truly a storm in the mind. But much as I admire Professor Shneidman, I will argue with him that the self that the suicidal mind seeks to destroy is not of the mind. I am first a human *being*, not a human doing or a human thinking.

I am not proposing spiritual self-enquiry as some new, improved therapy for suicidality. Nor do I seek to convert anyone to any particular spiritual belief system or to follow any particular guru. I still bristle when evangelical zealots try to convert me to their God and find this trade in the souls of others frightening. My argument here and my plea to this conference is for the self and self-enquiry to have a seat at the table of suicidology. I further ask that spiritual wisdom, spiritual ways of knowing and spiritual practices, so rich and full of the meaningfulness, also have a seat alongside our other knowledge, therapies and practices. We cannot allow science to continue to banish our spirit from this difficult discussion.

The "original voice" of suicidology.

My greatest concern is how rarely we hear the "original voice" of suicidology, the first-hand accounts of suicidality.

There are many reasons – none of them good – why this suicidal voice is so silent, so invisible. Shame and stigma make it difficult, particularly when you are feeling suicidal. We are expected to be silent and when we do speak up we are often not heard, our voice is denied. This is of particular concern when it comes from those we seek help from or from the institutionalised censorship of simplistic diagnostic labels. Another obstacle is the ambivalence of suicidality. We don't want to believe it ourselves, even when we find ourselves thinking about it all the time for days, weeks, months, maybe years. The pervasive fear of death in our culture, sharpened by suicide where death is deliberately chosen, feeds this silence and deprives us of the language we need to talk about it sensibly. Shame, stigma, denial, self-doubt and fear combine to create a very real and powerful taboo against talking of our suicidality.

We need to hear these voices. Most importantly it is needed to empower those who are contemplating suicide to speak up and hopefully reach out for help. Part of the poison of

suicidality is the loneliness. When you hear others who truly know suicidality, whether they've recovered or are still struggling, then you are no longer quite so alone in the world. Stories of survival and recovery can sometimes spark a light at the end of the tunnel of hopelessness, another of suicidality's poisons. I was told to hang in there, that the pain would pass which, although true, was not believable at the time. Hearing this from a survivor can help. We need to hear the voice of others to help us find our own voice. Healing and recovery begins with telling your story.

Suicidology and conferences like this one also need to hear the "original voice". The subjective experience of suicidality is the original raw "material" of what we are trying to understand here today. It is also the criteria by which we must judge our response to suicide. This "original voice" is required both to inform and to validate our theories and practices. Suicide notes, like psychological autopsies, are not sufficient for they fail to capture fully the lived experience of the suicidal dilemma.

But to tell our stories we need a safe place where we can speak up and truly be heard. Counselling with a professional therapist should be one of these safe spaces but too often this is sadly not the case and sometimes tragically makes things worse. It's a risky business sharing your suicidality with some people. But formal therapy sessions alone are not enough. One hour a week in therapy still left me with many lonely hours and I also found it difficult to switch on my agony every Thursday at 3.00 p.m. as seem to be required. Forums like peer support groups and Internet chat rooms can be a precious support at the times we need them most. But where are they? We have them for depression and many other mental "illnesses". We have them for drug and alcohol addiction. And suicide survivors, those bereaved by suicide, have extensive support networks. Sometimes someone will speak up in these groups about their suicidality but it needs to be done cautiously for the taboo is often at work here too.

Conferences like this can help and I'm very grateful for the opportunity to speak here. But we cannot leave it to chance. We need to actively work towards creating safe spaces where the suicidal voice can be heard with respect and full acceptance of the person. This space needs to allow all of that person to be present without fear of negative judgments, which can confront our own fears. It's tough and it's frightening because we know that we cannot save all. But we may be able to help some so we must do it.

Conclusion

My work now as a research student at Victoria University, is to develop further the arguments presented here. First and foremost, we need to hear more "original voice" stories of suicidality. Not only will this empower those who are suffering to speak up and reach out for help but it can also guide us towards a better understanding of the self that suicide destroys. This deeper enquiry into the self must include our spiritual needs as well as our psychological, biological and social needs. Suicidology challenges us to listen to many voices and learn ways of communicating across the many discipline boundaries. But suicide prevention cannot be left solely to the experts. As Edwin S. Shneidman, Emeritus Professor of Thanatology (UCLA) and Founder of American Association of Suicidology, says:

It is the words that suicidal people say – about their psychological pain and their frustrated psychological needs – that make up the essential vocabulary of suicide. Suicide prevention can be everyone's business.[2]

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[2] From the preface of "The Suicidal Mind" by Edwin S. Shneidman (Oxford University Press, 1996),