

[This is the full article. It was published in briefer form in VICSERV's New Paradigm February 2002]

Suicide – Mental Illness or Spiritual Crisis?

David Webb - suicide survivor

This paper was first presented at the conference “Exclusion and Embrace – Conversations about Spirituality and Disability” in Melbourne, Australia, 18-21 October 2001. I would like to thank the Melbourne City Mission for organising the conference and giving me the opportunity, motivation and encouragement to prepare and present this paper.

Abstract/Introduction

The mental illness of depression is defined in terms of symptoms only, symptoms which by themselves are little more than everyday life experiences but which collectively and when severe can render a person dysfunctional and disabled. These symptoms can be viewed through different lenses leading to different diagnoses and treatments. A strictly medical lens sees a biological malfunction of the brain and pharmaceutical treatment will be recommended. A psychological lens will see the cognitive and emotional *mind* and typically counselling therapies will be recommended to analyse, comprehend and modify distressing or dysfunctional patterns of behaviour. A psychosocial lens sees the broader social context and considers issues such as poverty, homelessness and community support services. A comprehensive public health policy must embrace all of these dimensions and, to some extent, this is found in both the literature and in public health services.

These symptoms can also be viewed through a spiritual lens which sees the crisis as an opportunity for spiritual growth. Cultures dominated by scientific, materialist values are unable to respond well to spiritual needs. There is a need for reconciliation between the scientific and the spiritual and although there is much in the philosophical and theological literature on this, it rarely finds its way into public health debates or policy.

1. The Diagnosis of “Depression” – is it an illness?

The most authoritative and influential medical reference for the diagnosis of mental illnesses is the “Diagnostic and Statistical Manual of Mental Disorders” of the American Psychiatric Association[1], known as the DSM. Although a creation of psychiatry (and American psychiatry at that) the diagnostic categories and criteria of the DSM are also widely used by non-medical mental health practitioners such as psychologists.

The diagnostic criteria for depression that we typically see (e.g. as used by the ‘beyondblue’ National Initiative on Depression[2]) are essentially the same as or derived from the DSM. These criteria can be summarised as:

- at least one of the following symptoms:
 - depressed mood most of the day, nearly every day
 - diminished interest in previously pleasurable activities
- plus at least three of the following symptoms:

- a decrease or increase in appetite
- sleeping difficulties – either too much or too little
- lethargy or restlessness
- feelings of worthlessness and/or guilt
- difficulties concentrating and/or indecisiveness
- thoughts of death or suicide

The DSM requires that these symptoms must be present for at least two weeks and that they represent a change from “previous functioning” or, more precisely, that “the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning”

Some explicit exceptions or exemptions to these criteria are specified for situations where these symptoms might be appearing because of:

- drugs – either prescribed medications or drug abuse
- some “general medical condition” – the example of hypothyroidism is given
- bereavement

The first thing that can be seen from these criteria is that this illness (called Major Depressive Episode in the Mood Disorders category of the DSM) is defined solely in terms of symptoms. There is no attempt to describe or explain the cause of the disorder, in either medical or psychological terms. We will see later that in fact no biological marker for detecting and diagnosing this illness currently exists.

Next, we see that all of these symptoms are in fact common, everyday experiences that we are all familiar with from time to time in any normal, healthy life. The DSM therefore attempts to elevate them to the status of a “Disorder” by specifying that this symptom profile must be present consistently for at least 2 weeks for a diagnosis of depression. Even then some disclaimers for other possible reasons for this symptom profile are required.

One thing missing from these criteria is sometimes taken up elsewhere such as by the ‘beyondblue’ initiative. This is the black hole of misery and despair that can overwhelm anyone who suffers it. As ‘beyondblue’ says, “depression is much more than just a low mood”. It is a deeply personal and very subjective experience that can be disabling and even life threatening.

But is “depression”, as the DSM, ‘beyondblue’ and the general medical profession would have us believe, a genuine medical illness?

We have seen that no attempt is made in the DSM to describe or explain any cause of this “illness”. We have also seen anyone presenting with these symptoms is explicitly exempted by the DSM from this diagnosis where certain other conditions apply (e.g. bereavement). Are these symptoms anything more than just that – symptoms? Does clustering these symptoms in some statistical (and sometimes arbitrary) manner indicate a genuine, distinct illness? One illustration of this is that exactly these symptoms can arise when a person is suffering from sleep deprivation, something all too common in today’s hectic world. But is sleep deprivation an *illness*? Or would the DSM exempt that as some other “underlying medical condition”?

This is an important question because the appropriate treatment for anyone presenting with these symptoms probably depends on identifying the cause of them. In the case of sleep deprivation the “treatment” is quite simple (though getting more regular sleep may be difficult to achieve). Often the cause is emotional stress or trauma arising from some loss or grief, which perhaps needs to be understood and resolved. Does this make sadness or grief an illness? There are many possible underlying reasons why these symptoms might arise. But is it legitimate to identify this clustering of symptoms as an illness which then becomes the explanation for the cause of the symptoms?

The question is also important because the assumption that depression is an illness then leads to other conclusions that depend on this assumption. One of these is the theory that depression is caused by a chemical imbalance of the brain. We will see later how this widely accepted view is a myth, supposedly supported by some very poor science, that is based on this assumption. Another example is the claim by ‘beyondblue’ and many others that “depression is the leading cause of suicide”. This only makes sense if depression is a genuine illness and not just a set of symptoms. These symptoms may perhaps be one indicator of potential suicidality but to declare them as a *cause* without some further evidence is not scientific and not justified.

Current medical practice and public health policy insists that we must rely on the best, evidence-based data and practice. This paper seeks to challenge the assumption that depression is a distinct, genuine and diagnosable illness. It takes the criteria of the DSM outlined above as the starting point for this discussion and looks at them through four different lenses – the medical, psychological, psychosocial and psychospiritual perspectives. Each of these four different ways of viewing this symptom profile can give us useful insights into what may be happening for the person that is experiencing them. Each perspective can lead to differing explanations for the possible cause or causes for the distress and despair. Each has its own preferred responses (sometimes called treatment) to helping someone who is experiencing this suffering. All have a contribution to make to our understanding. None of them yet have a definitive explanation or “cure”.

But first a couple of disclaimers are required.

First, the four different perspectives presented in this paper are not distinct and separate and certainly not mutually exclusive. We are learning that the most effective therapeutic responses to many of the so-called mental disorders often embrace all four dimensions. The theme of this conference is “exclusion and embrace” and we find both these aspects in mental health. The various points of view that this paper discusses often speak very different languages. We need to welcome and embrace these differences and find ways that we can speak meaningfully to each. We also find exclusion where so much of the disability of what is commonly called mental illness comes from ignorance and prejudice that breeds fear and stigma. We must embrace each other to have the conversations necessary to remove this ignorance behind the fear and stigma. But we must also resist the deliberate exclusion that comes from institutionalised prejudice as found in the DSM and insist that all voices be heard in this important public discussion.

Secondly, the “depression” that is discussed here is specifically the depression that the DSM alludes to. This is sometimes called “existential depression” (or even exogenous

depression). It therefore, like the DSM, does not include “depressions” due to some other medical conditions or induced by drugs. In particular, it does not include the condition known as bipolar disorder (formerly known as manic depression). The author has never had a diagnosis of bipolar, has very little detailed knowledge of it and others have written eloquently of their first-hand experience of it[3]. The only comment to be made here is that there is significant evidence that bipolar is distinct and different to the depression discussed here, including, it seems, that bipolar does seem to have a substantial underlying biological cause. This paper would therefore regard, possibly incorrectly, that bipolar and perhaps also the “depression” commonly associated with the diagnosis of schizophrenia are due to some other medical condition and therefore outside the scope of this paper. Similarly, the “twin sisters” of depression, the anxiety and panic disorders, although perhaps having some parallels to the discussion here, are also outside the scope of this paper.

2. The Medical Model

The distinguishing feature of the medical model of depression is that it is seen to be an illness of the brain. The assumption here is that the brain is the organ of the mind.

This biophysical view of the brain and mind inevitably leads to the conclusion that any mental dysfunction is due to brain malfunction. This is a particularly sweeping assumption to make given how little we know about the function of the brain. Despite much scientific progress in unravelling the mysteries of the structure and chemistry of the brain we must admit that what we do know about the brain is still much less than what we do not know. There is still no solid scientific explanation for such fundamental brain functions as memory, far less the subtle complexities of moods. Wild claims are made by the likes of Francis Crick[4] that we are on the threshold of a biochemical explanation of consciousness itself even though there is still no agreement yet as to what consciousness *is*. And even if this biochemistry is described, what does this tell us about the actual experiencing of thoughts and feelings? Crick’s biochemical holy grail has been described as trying to appreciate a painting by Rembrandt by analysing the chemistry of the pigments in the paint.

But returning specifically to depression, this biophysical view leads to what has become a widespread myth that depression is due to a chemical imbalance in the brain, sometimes referred to as the “broken brain” theory. Although several hundred different neurotransmitters have been identified, much attention has been given to just a few of them, in particular serotonin. Depression is then said to be due to a biological deficiency, perhaps genetic, of insufficient serotonin in the brain. The currently most popular family of anti-depressants are the selective serotonin re-uptake inhibitors (SSRIs) which aim to increase the serotonin levels in the brain by inhibiting the natural process of them being reabsorbed. These SSRIs are said to restore the alleged chemical imbalance that is the cause of low moods.

There are so many flaws in this argument that this paper can only mention a few. First, there is actually no evidence at all that “depression” is *caused* by reduced serotonin levels. There *is* evidence that serotonin levels are reduced during periods of low mood but there is no evidence that this is anything other than another symptom, albeit this time a biological one. It is also sometimes argued that feelings of low mood can be induced by deliberately depleting serotonin levels but this only tells us that artificially

altering serotonin levels affects our mood, a hardly surprising result. Some psychiatrists even argue that the only chemical imbalances that occur in the brain are those induced by psycho-active drugs such as these SSRIs[5].

Evidence of the weakness of the chemical imbalance theory is that there is no biological marker to test for this imbalance – no blood test, no brain scan, none at all. Proponents of this theory argue that this is only because the tests for serotonin are so difficult, delicate and expensive to perform, requiring either fluid from the brain itself or, somewhat less hazardously, spinal fluid. But even with these difficult to get fluid samples, medicine is not currently able to tell us what the correct healthy level of serotonin might be for any particular individual at any particular time. Serotonin levels can vary significantly between people and also within the one individual depending on time of day, how much sleep they have had, what they have eaten, and so on, probably even what they are thinking of or feeling at the time the sample is taken. Finally, it is not so much the levels or actual amounts of this chemical that is so important but rather its (fluctuating) concentrations relative to many other chemicals in the brain. Brain chemistry is complex and very subtle and, we must admit, still not well understood.

But even if this theory were true, which many doubt and is unproven in any scientific sense, what can we say about current medical practice based on this theory? Do these SSRI medications actually work? There is no doubt that many people do get some relief from their “depression” with these drugs and they probably do have an important role to play as an intervention at critical times. But exaggerated claims are made of their efficacy. Firstly, not all people respond to these drugs in the same way – that is, their effect is not predictable. When this occurs it will often be recommended that a different brand, a different SSRI chemical, be tried. This variation between individuals is not understood – again, there is no way of testing whether any particular drug will work for you. Next, there is a known and quite high placebo effect in the use of anti-depressant medications. And most importantly, how effective is effective? Many people report the effects of these drugs to be that they take the edge off their depression but the underlying sadness, sorrow or unhappiness is still present and still evident. This is sometimes reported as not so much an elevated mood but as an absence of mood. Another common effect reported is that you don’t seem to care about things quite as much or in the way that you used to. The real effects of these drugs are seen by some as subduing the symptoms rather than remedying them or curing them.

This is not to say that these drugs don’t have a role to play. Many who take them are grateful for their symptoms to be subdued and this can be a precious relief that can give some time and space to restore some calm and perhaps some physical health. By taking the edge off the symptoms it can also create an opportunity for some other therapies, such as counselling, to be explored which might hopefully resolve the underlying reasons for the despair. This reasonable and sensible approach to the use of these drugs can make them a useful part of the toolkit to move towards a full and genuine recovery. But to claim that these drugs repair a broken brain is to misrepresent them and can cause great harm.

An extreme consequence of this medical model is the conventional wisdom among doctors that a person may have to take these drugs for the rest of their life, especially if they have more than one “relapse” into their depression. At best, these drugs can be a

temporary band-aid – and one that must be medically managed very carefully – not a cure.

There are many other issues related to these drugs that are not pursued here. These include the difficult problems of side-effects, interactions with other medications and the risks of addiction and withdrawal effects. There is considerable concern in the community about the over-use of these drugs and the inadequate supervision of their use. And rightly so for they are potent chemicals that should only be used with the greatest of care.

In a public health system where the first contact for health care is usually the General Practitioner, medicine has a vital role to play in responding to depression. But the medical model has the fundamental flaw where the brain is seen as the organ of the mind which then leads too easily and too quickly to a biophysical, pharmaceutical form of treatment.

3. The Psychological Model

The distinguishing feature of the psychological model for depression is that the *mind* is both the source of the condition and also the primary vehicle for its treatment. This view of the mind is distinct from the medical view which sees the mind and the brain as virtually synonymous.

From a psychological perspective, the mind is not so much neurons and biochemistry but properties such as memory, thoughts and feelings, cognition and learning. This view more closely relates to the personal experience we all have in relation to “having a mind”. We talk of having memories, thoughts and feelings. We can recall situations that give us joy and sadness. We can learn new ways of doing things, including new ways of thinking. It is through this notion of the mind that we explore human concepts such as values and beliefs. It is the mind, we feel, that is in distress when we are depressed. The important quality here is that the subjective experience of the individual sufferer is recognised and given significance.

There are many different forms of psychological approaches, including some that are practiced by the medical profession. So the first point to be made is that psychological approaches are not mutually exclusive to the medical treatments discussed above. Indeed most psychiatrists would include psychological perspectives in the diagnosis and treatment of their patients. Psychologists and other non-medical psychotherapists, however, do not have the authority to prescribe medications so there is something of a schism between the medical profession although fortunately this is lessening as collaboration is becoming more common.

Psychological treatments are often referred to as the “talking cure”. Frequently this talking occurs in a one-to-one relationship with the therapist although group therapies are not uncommon. The nature of the talking that occurs can vary widely depending on the varying schools. There are far too many varieties to survey here so just a few are used to illustrate some of the main features of the psychological approach.

First, mention must be made of the psychoanalysis that traces its origin to Freud, Jung and Adler. This tradition is of particular interest as it has always had strong connections

with the medical profession and psychiatry. Psychoanalysis seeks to explore the depths of the psyche in an almost philosophical quest to understand the nature of being human. In recent times, mainstream psychiatry seems to be distancing itself from this tradition (e.g. almost all reference to psychoanalytic ideas have been removed from the most recent editions of the DSM). Curiously, at the same time, psychoanalysis seems to be developing a new popularity in some quarters, seemingly due to its use of imagery and archetypes and its willingness to address spiritual questions such as the soul and the spirit. Psychiatry prefers to steer clear of spirituality as it strives to maintain the appearance of being scientific, so this perhaps explains why psychoanalysis is losing favour. It also explains why it might be gaining favour in those growing sections of the community where there is a clear yearning for spiritual issues to be addressed.

Although psychoanalysis' imaginative explorations of the psyche can be fascinating and indeed can give useful insights into the human condition, it does not have a happy track record of success. Psychoanalysis is characterised by a long-term, often very long, relationship between the therapist and the patient/client. This relationship is central to the psychotherapeutic processes of psychoanalysis and can often itself become a major complication in the life of the patient/client. Another weakness of psychoanalysis is that although it dares to delve deeply into the psyche and finds a soul, its notions of soul are often unsatisfactory. A distinguished psychoanalyst and author, James Hillman, identifies the question "What does the soul want?" as central but only comes up with the rather unsatisfactory answer that what the soul wants is to want[6]. Poetic but not really very useful.

The "talking cure" that we hear most about these days, particularly with regard to depression, is Cognitive Behaviour Therapy (CBT). CBT aims to help us learn to recognise our negative or dysfunctional thinking as early as possible. It then seeks to identify strategies for responding differently to these thought patterns in less destructive, and hopefully constructive, ways. CBT is seen as more of a short-term therapy compared with the lengthy psychoanalytic approach with a focus on specific responses to specific circumstances. It seems to be a very effective approach to a wide range of difficulties including depression. It is "classical" psychology in that it uses our rational minds to analyse and comprehend and to negotiate and learn. It does not seek to explore the inner depths of the psyche. It can, like the medications, help make the situation more manageable (less dysfunctional) which will facilitate opportunities for more in-depth enquiry should that be appropriate.

CBT has the endorsement of the medical profession and 'beyondblue', for instance, recommends it as an alternative to or in conjunction with medication. Indeed we hear from 'beyondblue' and others that medication and psychotherapies such as CBT are "equally effective" in the treatment of depression. Again it must be asked what is the definition of "recovery" that is being used here? Is it just the subduing of the symptoms as with the drug therapies? CBT is more likely to bring about meaningful changes in a person's life that will help reduce and possibly even eliminate the depression. But the danger here is that sometimes simply coping can be confused with a real recovery.

This equivalent efficacy of medication and CBT also leads to a curious question sometimes referred to as the "equivalence paradox". This paradox asks how can two such dissimilar treatments produce the same result? In other words, how can talking fix a chemical imbalance in the brain? This paradox reveals another flaw in the medical,

brain-oriented model of depression and so again cautions us against it and the drug therapies that flow from it.

In fact we are being misled about these therapies. While it is true that both drugs and CBT do provide assistance to some – either by themselves or in combination – neither of them are reliably effective for all depressions. Depression, particularly severe suicidal depression, is just not that simple. So when it is said that they are “equally effective” it must also be said that they are also equally ineffective, particularly in severe cases.

A final example of the psychological approach that must be mentioned is the growing understanding and response to what is now commonly called Post-Traumatic Stress Disorder. The origins of PTSD goes back to the “shell shock” of soldiers returning from war, but is now recognised as an appropriate model for victims of torture or violent crimes, including rape and domestic violence. More recently the definition of PTSD has been expanded to include not only the immediate victims of trauma but also those who may have witnessed a traumatic event. In particular, PTSD is proving a useful model for responding to those who suffer as a consequence of childhood abuse. We are only beginning to learn the true extent and consequences of childhood abuse in our societies, in particular sexual abuse. Memories of these childhood traumas are often suppressed and may only manifest as some dysfunction much later in life, many of the symptoms being essentially the same as the symptoms of depression. In Australia we are fortunate to have the Advocates for Survivors of Childhood Abuse (ASCA) taking a lead in exposing this problem and taking constructive steps in response to it, but much remains to be done. We are learning that effective treatment for PTSD is usually multi-faceted with drug therapy, CBT style counselling as well as deep therapeutic enquiry into the nature of the self all being used at various stages as appropriate. The interested reader is referred to “Trauma and Recovery” by Judith Herman[7] for a thoughtful and comprehensive discussion of this.

An advantage of psychology over the medical model is that it attempts to address the complex but vital notion of our sense of self. Psychology talks a great deal about “self-esteem” and has numerous methods and techniques for promoting it. This sense of self and the need to care and nurture it is seen as essential for our emotional wellbeing and so psychology is right to give it prominence. Unfortunately there is no clear description or definition of what this sense of self actually is.

It is very difficult to discuss notions of self without stumbling in to other difficult questions such as soul and spirit and the meaning and purpose of life. These are historically spiritual questions and modern, mainstream psychology would like to see itself as scientific and rational. It therefore finds it difficult to deal with these questions so it either avoids them altogether or regards them as aspects of our mental beliefs and values. As mentioned, psychoanalysis tries to grapple with the soul and is finding itself isolated from the scientific, rational mainstream. Other psychotherapies may try to acknowledge spiritual concerns but usually still sees them as aspects of the mind.

So we return to the essential characteristic of psychology which is the exploration of the mind. This is both its strength in that it responds more fully, more holistically, to the human experience of depression but also its great weakness for the assumption that the mind is at the core of the human experience denies the spiritual dimension. Another

weakness is that depression and other mental “illnesses” are usually seen as a malfunction of the mind similar to the “broken brain” of the medical model. Rarely are these “mental” experiences ever seen as natural, normal and even healthy responses to life, distressing and disturbing though they may be.

4. The Psychosocial Model

There are two key features to the psychosocial model. First, it emphasises the existing talents and strengths of the person rather than pathologising them. Second, it looks to environmental circumstances as critical for wellbeing and, where there is some dysfunction, for recovery.

This approach is more accepting of the person *as they are*. It does not assume that behaviour that is outside the recognised norms of society necessarily means that some illness, disorder or pathology is present. Where there is suffering, the environment will be examined as possible sources of the suffering and, if found, attempts will be made to change the environment.

This is very relevant and appropriate in what is commonly referred to as “mental illness”. We should not automatically judge *different* behaviour as a mental *illness*. Furthermore, it is well known that one of the major difficulties for people labelled with mental illness is the societal stigma that goes with it. This stigma and the negative responses and disadvantages that come with it in our society may indeed be the primary or even sole source of any discomfort or distress that such a person might feel.

From these two key principles of the psychosocial model some very different responses to “treatment” arise. Indeed the word “rehabilitation” is usually preferred to “treatment” with this perspective. It is a more social perspective which encourages a participatory approach to rehabilitation. It is less oriented towards professional experts (i.e. therapists) who “cure” and more oriented towards supporting the fullest development of whatever capacities an individual might have. It also works towards social change that will reduce the discrimination and prejudice against those who are seen as “different” and often find themselves as unemployable and marginalised.

This model is particularly relevant for what is often regarded as the more severe mental “illnesses” such as schizophrenia. It is beyond the scope of this paper (or the knowledge of its author) to discuss this in detail here. The reader is referred to another speaker at this conference, John Watkins, for a knowledgeable, intelligent and sensitive understanding of what is called psychosis and schizophrenia (see also his books [8]). In Melbourne and Victoria another valuable source for more information on the psychosocial model is Psychiatric Disability Services of Victoria (VICSERV)[9].

This psychosocial perspective also has significance, however, for depression. There is a tendency to classify mental illnesses these days as either low prevalence and high impact (e.g. schizophrenia and bipolar) or high prevalence and low impact (e.g. depression and anxiety). The motivation for these classifications seems to be primarily for economic reasons by those who are trying to identify the costs to the community of various illnesses to develop public health policy. The clearest example of how this classification fails to accurately reflect the real health issues is with “depression”. If

“depression” truly is the major cause of suicide as ‘beyondblue’ would have us believe then it can hardly be classified as low impact.

This influence of economic forces is at the core of the ‘beyondblue’ initiative. Rather than a genuine enquiry into why so many in our society are so unhappy, ‘beyondblue’ adopts the attitude that depression is understood and that good treatments are available. Their job then becomes one of campaigning to reduce the stigma and discrimination around the illness and to encourage people to present themselves to their doctors for these treatments. This “father knows best” attitude actually worsens the discrimination against sufferers of depression as it reinforces the them-and-us stigma that society already has about “madness”. The reason why ‘beyondblue’ adopts this stance seems to be twofold. First, it is dominated by the medical profession and therefore the medical model. Secondly, their motivation seems to be more to do with economics than with health. They have detailed statistics of the cost of depression to the economy through days lost, sickness benefits and so on and, like the DSM and psychiatry, see employment as one of the key indicators of recovery. As mentioned above, this medical response is often to just subdue the symptoms sufficiently for people to be able to get back to work. But is this really recovery?

Another psychosocial aspect of depression and also related to these economic forces is that often the depression is at least exacerbated by depressing social circumstances. These can be many and varied and are mostly familiar to all of us. The hectic pressures of modern life, especially in the cities, places great demands on our psychological wellbeing. Indeed sleep deprivation is being recognised as a major health factor for many, the symptoms of which can be exactly the same as the symptoms of depression. Insecurities at work and at home, dehumanising work, disenchantment with our political and social leaders, a pervasive culture of fear – there are many social influences that can contribute to someone developing these symptoms of depression.

It can be argued that often the sickness and dysfunction is not with the individual but with society. Many are calling for a more compassionate society that respects and empowers people as member of our communities rather than regarding them as the inputs (workers) and outputs (consumers) of a society that has become the servant to economic imperatives. Many are dropping out. Sometimes by retreating to the wilderness, sometimes by escaping into drugs – how many of the drug deaths are actually suicide? And many more are becoming very depressed.

We cannot truly hope to address what some are calling the epidemic of depression without also taking a hard look at the social environment in which this is occurring. The psychosocial model has much to offer in this regard, not just for the “high impact” cases that have learnt to live on the fringe of society but on a broader scale that reaches across the whole community.

5. The Biopsychosocial Model

It is appropriate at this point to note that there is a trend towards a more interdisciplinary approach in some areas based on these three models. This biopsychosocial perspective recognises that all three dimensions are equally important for a truly meaningful recovery.

This approach has perhaps been most recognised and is becoming more evident in addiction therapy. The physical complications of drug addiction (including alcohol) must be attended to and includes the physical withdrawal processes often called detoxification, attending to the all too common physical injury due to the drug abuse and restoring the often depleted health and vitality of the person. It is also well known that usually the greatest obstacles to a full recovery – i.e. staying off the drugs after the initial detox – are the psychological aspects of addiction. This may include typical mental health issues such as depression and anxiety and all the symptoms and causes associated with these – trauma, fears, guilt and shame and feelings of worthlessness etc. These will often respond to psychological therapies such as CBT. Equally, the person's social circumstances need to be considered and, where appropriate, some changes made if possible. One of the major triggers for relapse with drug addiction is that after the initial detox the person returns to their old social environment and finds the same worries and temptations that led them to use in the first place. Similarly, their history of drug abuse may mean that their ability to find work or some other meaningful, constructive activities can be limited. Poverty, homelessness and discrimination are just some of the social factors that might be present that could compromise a full recovery.

Neglecting any one of these dimensions for both the cause and the recovery can lead to the same result – relapse. This trend is to be encouraged and the challenging interdisciplinary nature of it has to be recognised so that doctors, counsellors and social workers and others can work together more effectively. Institutional changes are also required to facilitate this more comprehensive strategy. And beyond the service provider community, an ongoing process of increasing social awareness is needed to overcome the prejudices and discrimination that it so prevalent in the wider community and leads to the disabling stigma and marginalisation of people who are suffering, for whatever reason.

An essential ingredient at all levels in these processes is for the voices of consumers to be genuinely heard. There is no greater expertise than the experience of those who have “been there”. The collective wisdom of those who have suffered and struggled is invaluable and yet perhaps the most common complaint from this “consumer” community is that they are not listened to. Genuine consumer representation in both the provision of services and in formulating public health policy must be elevated from the inadequate level found today. This means that some of the organisations and committees involved in these processes must be consumer led and consumer controlled. Others must have genuine consumer representation which means that they must become properly paid consultants to these processes alongside the professionals from the various service provider groups and public authorities. Anything less is tokenism which not only breeds resentment but also diminishes the capacity of these processes to address the issues effectively.

6. The Psychospiritual Model

The psychospiritual model differs from the previous models by recognising a dimension to the life experience that the others either deny altogether or struggle to deal with effectively within the conceptual framework of their model. The psychospiritual model accepts that we have spiritual needs in the same way that we have physical needs and psychological needs. These spiritual needs can be essential to our sense of wellbeing and, similarly, if neglected can lead to despair, dysfunction and illness.

Discussing spirituality is fraught with danger as there are so many points of view as to just what is spirituality, with many definitional problems in the language that we use. The definition for spirituality offered by this conference is more than adequate our purposes:

that which is other than mundane and gives meaning and purpose to being

First, though, we return to the central issue of this paper – suicide. It is the author’s personal experience, as well as an assertion here, that central to the suicidal dilemma there is often the question “What does it mean to me that I exist?”. If suicide is being considered then this question, in some form or other, is likely to arise. And if a satisfactory answer to this question cannot be found then suicide becomes an increasingly logical and attractive option.

The first observation to make from this is that both the question and any possible answers to it are virtually entirely subjective. They are about an individual’s sense of self *to themselves*. It is not about what it means to their family or friends or their value to their community, although these may be considerations in this enquiry. In this sense it is a very private and indeed selfish contemplation. Furthermore any answer to this question is largely irrelevant to anyone other than the person who is asking it. That is, the *only* person who requires an answer to it in order to avoid suicide is the person themselves. Again, selfish and intensely subjective. This subjectiveness means that there is no instrument that can be used to measure the extent or intensity of the despair and doubt that gives rise to this question. Similarly, it is impossible to measure in any objective way the adequacy (or inadequacy) of the possible answers to this question. It is utterly intangible in any physical, material, observable or measurable sense.

This subjectivity of suicidality therefore relates to the first part of our definition of spirituality – *that which is other than mundane*. The word “mundane” here does not refer to one of its common usages, that of dull or ordinary. But nor does the phrase “other than mundane” necessarily mean the transcendental or ecstatic. The mundane being referred to here is the physical, material realm of our human experience. This is the realm that science thrives in, the realm of observable, measurable *objects*. Science has been supreme in analysing and comprehending the physical world as evidenced by the technological achievements of recent centuries. Indeed, science has been so successful that it has achieved a dominant position in our thinking of what the universe is and how it operates. A notable example of this is how science has played a key role in the collapse of many religions, particularly in western societies. Science challenged and undermined many of the dogmas of the churches. And quite rightly so, for many of these churches had lost contact with their spiritual origins and become political institutions, more concerned with winning converts and exercising political power. When they tried to assert their authority to deny the truths that science was revealing, it was the beginning of the end of their influence – again, rightly so.

With the conquest of science over religion, the intellectual landscape became essentially atheistic. There was no room in science for any discussion of God, spirit or soul. The universe became a purely physical universe that could be studied and understood by rational and reductionist scientific methods. Religious faith became a lifestyle choice, not much more than which football team you might barrack for (or indeed not at all).

We declared ourselves to be a secular society and while religious faith and practices were allowed and indeed protected by the state, many chose to discard all religious belief and Australia today is a largely atheistic/agnostic society. Science and rationalism had truly won. Unfortunately the baby got thrown out with the bath water and spirituality was also discarded with this rejection of the churches.

This dominance by science and discarding of spiritual awareness has diminished our understanding and appreciation of our universe and of our selves. The great pioneers of science such as Newton and Descartes did not regard the universe to be *solely* materialistic and mechanistic. While they saw the power and potential of science they also recognised that science was indeed limited to the observable and measurable *objective* aspects of this universe. Through its struggles with the churches to assert intellectual control, anything that could not be described, understood and explained by science became magical and therefore not real. Given that science could only analyse and comprehend an objective, physical reality, the subjective meaning of even our own feelings have been progressively devalued and dismissed as unreal and illegitimate.

The eminent Australian scientist Charles Birch, in his exquisite little book “Feelings”[10], calls for a restoration of the legitimacy and status of the subjective experience that science is unable to describe or explain. These experiences, such as love and compassion, can only be detected by our subjective experience of them. They are as real and substantial to us as any rock that we might stub out toes on and yet they have no material or substance. Birch, an emeritus professor in biology, scoffs at suggestions that consciousness can be explained solely in biochemical terms. There is something else going on and it is real and, we will see, meaningful and important. And first and foremost it is subjective, something which is *other than mundane*.

If we now look at the next phrase in our definition of spirituality – *and gives meaning and purpose to being* – we can see how these subjective experiences have a substantial reality. Birch says that these subjective feelings are in fact the most important “things” in our lives. We are inspired and motivated by our feelings and thoughts. Our sense of self is intimately connected to these intangible, subjective feelings and thoughts. We typically regard some of these, such as love and compassion, as the highest of human virtues. Indeed, many will claim that this is what distinguishes us from the rest of the animal kingdom. These intangible feelings and thoughts are important to us.

Finally we need to look again at our definition of spirituality and ask what it is within us that finds meaning and purpose through these “other than mundane” subjective experiences. And the answer, found in our definition, is that it is our sense of *being*. This brings us back to the suicidal dilemma. Who or what is the *me* that experiences this sense of *me-ness*? What is this *being-ness* that I call me? This is the age-old spiritual question of “Who am I?”. Is it possible to find a satisfactory answer to this perplexing question? This is not some academic, philosophical, intellectual exercise. If you are contemplating suicide it is the most important and pragmatic question that needs to be faced. Camus in “The Myth of Sisyphus”[11] claims that suicide is the only important philosophical question, just as many spiritual sages for millenia have told us that the essential spiritual question is “Who am I?”.

First, looking at this question intellectually and philosophically, we are quite likely to find ourselves stuck in the way that psychoanalysis and most psychologies do. As

mentioned above, the notions of self found in these schools of thought are often inadequate and unsatisfactory. There is certainly no clear agreement on what this sense of self actually is. Self can be described as the experience of consciousness but that then begs the question of what is consciousness? We certainly do not currently have any satisfactory scientific description or explanation of what consciousness is. And to describe self in terms of what the self experiences, whether it is thoughts and feelings or behaviour and relationships, still does not adequately describe or explain the self itself. We all recognise (or appear to recognise) that there is some core to our being that we identify with as our selves. We recognise the value and importance of this innermost sense of self when we talk of the need to nurture our self-esteem and so on. We also recognise that we can often experience distress or despair, especially perhaps suicidal despair, when there is a conflict between our sense of self from within and our experience of our lives in the outer world. This tension between the experience of the *in-here* with the *out-there* can become a great conflict.

Psychology has much to say about relating to the *out-there* but less on the *in-here* experience. Some schools of psychology will attempt to look at this question in terms of relationship. That is, they attempt to explore the relationship of the self with the self. This may be revealing and even useful but ultimately becomes a paradoxical conundrum which again cannot be resolved mentally or intellectually.

It was pointed out earlier that the fatal flaw of most psychologies is that they view the mind as the essence of our sense of being, of our sense of self. Although psychology, like Birch, recognises the meaningfulness and therefore the importance of our subjective thoughts and feelings, it fails to look beyond the mind as the source of our sense of being. This fatal flaw overlooks that there is something within each of us that experiences this sense of “having a mind”. We sometimes call this consciousness but then we fall into the trap of assuming that consciousness is just another aspect or manifestation of mind. Such intellectual arguments can quickly become convoluted and paradoxical. And unanswerable because the mind is actually incapable of describing itself. This may seem a somewhat controversial assertion but we must at least accept that currently we have been unable to get our minds to describe what the mind and/or consciousness is. Whether science will one day unravel this mystery remains to be seen but there are many who claim that this scientific holy grail is actually unachievable.

Pursuing this intellectual and philosophical line of enquiry takes us rationally to a dead-end. We must therefore, for the time being at least, conclude that we have no answer to this question and that it may indeed be unanswerable. At this stage, if we have religious faith then we may call upon our belief in God or some other belief system to accept this mystery into our lives. Or perhaps the atheistic existentialist will conclude that life truly is utterly meaningless but somehow plod along with it all the same as some sort of biological imperative.

Underlying this conundrum is a belief – and it is nothing more than a belief – that the mind is the essence of our being. This is actually a recent development in the history of humankind, arising very much from the conquest of science over religion. It is best summed up by the famous quote from one of the pioneers of scientism, Rene Descartes, “I think therefore I am”. But if we alter this great statement just a little and assert instead that “I am therefore I think” this invites us to examine this *am-ness* within

which the experience of thought arises. This is an invitation to spiritual rather than intellectual enquiry.

The spiritual enquiry into the nature of the self does not begin with the assumption that the mind is the essence and source of our sense of self. On the contrary, spirituality argues that there is an undefinable – indescribable and inexplicable – *spirit* within which arises all that we experience. We can confuse ourselves and play word games asking whether consciousness itself is just another word for this spirit or whether it is just another manifestation of it. It actually doesn't matter. We can also have confusion and indeed conflict (with ourselves and others) pondering whether this spirit comes from some god or other similar notion of some external higher power. Although this can be interesting and entertaining, and perhaps important for some, it is not actually relevant to the discussion here. The suicidal dilemma requires only that a meaningful sense of self must be found for the person who is contemplating their own self-death. As a great Indian sage[12] used to reply when asked questions about God, "first find out who you are, then see if you still have any questions about God".

If we allow ourselves to accept the possibility that our experience of "having a mind" is just another manifestation of spirit (or consciousness) rather than the essence of who we are, then this is an invitation to explore this spirit. When we do this we find that the mind is actually the major obstacle to experiencing, understanding and connecting with this innermost spirit or sense of being. Our wondrous, busy, versatile minds like nothing more than to take control and make intellectual argument about who we are and what we are experiencing. So how do we get past this obstacle? The simple answer is meditation. But we must be very careful in the use of this word. As so often in spiritual discourse, there are many different definitions and interpretations of what is meditation. We will not attempt to explore all these subtleties now so the definition of meditation offered here is simply "that which we experience when the mind is quiet".

This notion of meditation has been spoken of in many ways. It is the space between the thoughts. It is the self that remains present when the mental self is absent (i.e. is truly quiet). It is pure consciousness, uncontaminated by thoughts. It is the self without ego. It is a bottomless, timeless silence. Great works of art and literature have been created in adoration of this deeper sense of self. But any such creative expression of it can only be an approximation of it. For any image of the self can only ever be that, an image. This is true also for any mental image or construct we may make of this deepest, most innermost and most private sense of what we are.

This inner silence can also manifest in other ways. Sufferers of what is called "depression" will often speak of either a black hole within them or a feeling of great emptiness. This can be truly frightening and disabling. At its extreme it can be lethal.

Hillman was criticised earlier for his inadequate view of self when he correctly recognised that the critical psychoanalytic question was what does the self want, but could only answer that what the self wants is to want. This yearning of the self is commonly recognised, particularly among those diagnosed with depression. But we need to go beyond Hillman and dare to ask what does the self yearn for? It may seem glib in the fashion of Hillman to claim here that what the self yearns for is itself. But this is nothing more than what Jesus exhorts us to do when he says "know thyself".

This yearning can be excruciating. It is made more excruciating if we believe that the self is to be found in the mind. This false belief that “I am my mind” (Descarte’s “I think therefore I am”) is the source of a sense of self that is separate and independent of others and whatever created us. This egoic, mental sense of self believes that the mind is in control and we find many psychotherapies that seek to develop our *self-control*. This false belief, this mental construct, that seeks to control that which cannot be contained or controlled is fearful and fierce. Many who struggle with despair talk of the pain of the past (memories) and/or the fear of the future (fantasies). These are both mental constructs again that can demonise the present. But their strength and power over us is only as strong as our belief that that the mind is actually in control.

Those who have confronted near-death experiences, whether it be suicide or cancer or some other life threatening encounter, will often report that a key moment occurred when they surrendered to what they faced. This is not the same as giving up. It is more an heroic act of acceptance than fatally giving in. It may be expressed in terms of surrender to one’s self or perhaps to one’s God. What is also reported is that this moment of surrender only comes after a long struggle, often to the point of utter exhaustion. This heroic act of surrender is often frightening and the very last thing we are willing or feel capable of doing.

For the suicidal, this surrender is to dive into this black hole, into this bottomless emptiness. Which is terrifying. We must be very clear here. This is **not** a surrendering to the urge to kill yourself, which is just a “simple” acting out of the desire to be free of the pain. No, it is a surrender to this yearning of the self. This self that wishes to be known, fully and without any contamination or corruption by fears or memories or any other thoughts or feelings. It is the self that is always present, waiting in silence beneath the chaotic busy-ness of the chattering mind. It is a self without any notion of time and space. It is a self untarnished by any past experience or future possibility. It is unknowable by the mind and therefore it terrifies the mind. It is a self that our modern world denies and abuses.

Diving into this yearning can be too scary. Some of us would rather kill ourselves than go there. But those who, by some grace or good fortune, have had to encounter this deepest, inner self consistently report that the rewards are great. For within this self comes the liberation from our greatest fears. This renewed, fuller, more whole sense of self that is revealed is characterised by peace and freedom. Any fears of death, so often at the core of our despair, are lifted. Demons from the past no longer find any nourishment in this tranquility. And the future can remain mysterious and acceptable, indeed full of excitement and possibilities. There is a self esteem that is not propped up with mental, psychological buttresses but stands alone, empty and fragile but invincible.

In some spiritual circles this is described as enlightenment or nirvana or, perhaps more accurately, self-realisation. These are just more mental words that can block the path to the self. So often these spiritual traditions demand that great discipline or devotion is required in order to attain these lofty goals which are dangled before us with little hope that we might ever achieve them. But this liberated sense of self is not something that is attained or earned. It is nothing more than the truth of who we already are that is revealed when the false beliefs of the ego, of the mind, are let go of. It is true that all the many practices of meditation and postures and worship and diet etc etc can all help.

But none of them are *necessary*. All that is necessary is a willingness to surrender to who we truly already are.

This sounds far too simple, and it is, for this surrender, as we have seen, can be a fearful thing. But much of this fear comes from our false beliefs, the denial of our spirituality and a social environment that rather than encouraging spiritual enquiry, positively dismisses and discourages it. This must change if we are to hope that we might reverse the growing incidence of suicide in our communities.

7. A Way Forward – Reconciliation of Science and Spirit

The theme of this conference is “Exclusion and Embrace” which points to a way forward in our efforts to deal with depression, suicide and disability. To achieve this we must work towards a reconciliation between the scientific and the spiritual for science without passion is barren and spirit without reason is dogma.

We must embrace the differences and come to a more wholistic, ecological and interdisciplinary understanding of these differences. We are seeing how the medical, psychological and psychosocial mental health services are now recognising the need to work together, despite sometimes very different perspectives. But if we look at the public health policy documents on mental health and suicide prevention, there is a stark absence of and discussion of our spiritual needs. This must change. It will be difficult as each point of view has its own concepts and language, so effort is required to learn how to speak to each other and welcome everyone into the debate. In understanding and embracing our differences, we must also humbly accept our ignorance and admit that we do not currently have very good answers to many of the problems we face. We must open our hearts and our minds to all who have something to offer, especially those closest to the experience of despair, those who have suffered or are still suffering, the so-called consumers.

We must also resist the disabling discrimination of exclusion. No one point of view can be allowed to dominate. We must insist on an equal seat at the table for all and resist those who seek to limit the diversity of views. We must also resist the exclusion that comes from prejudices such as is found in the DSM. We must resist diagnostic labels that in any way mark us as “abnormal” simply because we are different or suffering. We must also resist the exclusion of the bad science and bad treatment that is based on such elitist, them-and-us prejudices and challenge the illegitimate authority that seeks to impose these bad medicines on us. This will inevitably be a political as well as an intellectual struggle for there are substantial vested interests of wealth, power and status at stake. We must therefore also re-assert our rights as citizens and not as “consumers” and make our own legitimate claim for a more comprehensive and just response to the disability and suffering that discriminates, marginalises and abuses us.

References

- [1] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV)*, Washinton, 1994
- [2] ‘beyondblue’: the national depression initiative – www.beyondblue.org.au

- [3] Jamison, Kay Redfield, *Night Falls Fast*, Alfred A. Knopf, New York, 1999
- [4] Crick, Francis *The Astonishing Hypothesis: The scientific search for the soul*, Scribner's, New York, 1994
- [5] Breggin, Peter, *Toxic Psychiatry*, Harper Collins, London 1993
- [6] Hillman, James, *Healing Fiction* Spring Publications (Continuum Publishing Group), Dallas, 1994
- [7] Herman, Judith, *Trauma and Recovery*, Basic Books 1997
- [8] Watkins, John, *Hearing Voices: A Common Human Experience*, Hill of Content, Melbourne, 1998
- [9] Psychiatric Disability Services of Victoria (VICSERV) Inc – www.vicserv.org.au
- [10] Birch, Charles, *Feelings*, University of New South Wales Press, Sydney 1995
- [11] Camus, Albert, *The Myth of Sisyphus*, 1942
- [12] Osborne, Arthur (Ed.), *The Teachings of Sri Ramana Maharshi in his own Words, 6th Edition*, Ramanasramam, Tiruvannamalai, 1993
(see also www.ramana-maharshi.org)