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Re-conceptualising suicidality

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Editors’ intro

After his own “four years of madness” in the late 1990s, David Webb looked into the literature on suicide and was alarmed to find that the first-person voice of attempt survivors was almost completely absent. Even more lacking from the literature was any mention of spirituality, which was the key to David’s recovery and survival. This enquiry became a PhD at Victoria University, completed in 2005, which is thought to be the world’s first PhD on suicide by a survivor. In 2010 David published a book *Thinking About Suicide* based on his PhD research into suicidality. For more than a decade, he argued, advocated and campaigned for the inclusion of attempt survivors in the public discourse on suicide – in academia, in public discussions on suicide and, importantly, in disability human rights forums. This included time on the board of the World Network of Users and Survivors of Psychiatry (WNUSP) and working for the Australian Federation of Disability Organisations (AFDO). David has represented both these organisations at numerous United Nations disability forums. He had to retire from active work in 2012 when he was diagnosed with a rare auto-immune disorder.

We are pleased to present the slightly edited closing chapter of David’s PhD thesis in this collection. Originally entitled “Epilogue: Who are we?” this part of the thesis was not included in his book “Thinking about Suicide”. In strong connection with that book this text also stands on its own and offers important ideas about how we could re-think suicidality and turn prevention into a collective, community endeavour. David’s text is also offered as a reminder of efforts to make sense of our collective experiences that existed long before the term Mad Studies was coined.

Suicidality as a crisis of the self

Thinking about suicide – that is, contemplating suicide for yourself – is an intimately personal, private and often secret feeling that many people struggle with. The story of my book tells something of this struggle for one individual. It tells of the pain of struggling to live in your own skin. It tells of the anguish of feeling an utter misfit in the world you find yourself living in. It tells of the agonising crisis of the self, where life as you experience it has lost all meaning and purpose. It tells of the dark, inner loneliness and isolation, the hopelessness and helplessness, of
nowhere to go with these feelings. The story there also tells of attempts to overcome or perhaps deny these feelings, sometimes through a noble search to find meaning in life, at other times through the less noble escape into self-medication. It also tells of seeking help but only finding more hopelessness and helplessness. And at the end of this story, unlike many other similar stories, there is a happy ending, when peace was finally found where it was least expected but where it had been all along – in the silent, spiritual heart of my being.

The motivation to tell this story of one individual’s thinking about suicide is to offer it as my contribution to our collective thinking about suicide – that is, our efforts to comprehend suicide so that we might help prevent it. Some people may think that we can learn little from one individual story, especially, according to one school of thought, when that story does not end in a ‘completed’ suicide. I obviously disagree with this view, although I do not attempt to make any generalisations from a single story, particularly when that story is my own. On the contrary, I regard suicide and suicidality as mysterious as life itself. But this does not mean that we cannot understand it much better than we currently do. Along with my personal story in the narratives of my book, which I regard as the most valuable contribution that I have to offer, I have also reflected on the various aspects of this story in the commentaries. The aim here is to encourage, stimulate and provoke critical thinking and discussion about these issues. But the emphasis throughout the book is on understanding the individual experience of suicidality. In this epilogue I feel obliged to consider and make some comment on how the stories in this book might help us find a way forward in our suicide prevention strategies and campaigns.

My experience, and my subsequent research and ‘making sense’ of it, has shown me that the greatest flaw in our current thinking about suicide is that we don’t understand it at all well. In particular, current thinking about suicide prevention does not appreciate or give enough attention to what suicidal feelings mean to those who experience them. Enormous effort and expense are being expended on identifying risk and protective factors, medical explanations and treatments, and ways to encourage the suicidal to come forward and seek help. But remarkably little effort has been made to comprehend the actual lived experience of suicidality – the silent, invisible meaning of it to those who live it. On the contrary, there has been a distinct lack of attention to the subjective meaning of contemplating suicide, so much so that it seems like a determined effort to look the other way.

In the prologue of my PhD thesis I spoke to my suicidal soul-mates and urged them first and foremost to respect and honour their suicidal thoughts and feelings as real, legitimate and important. I now make the same call to the experts of suicidology, but also to all concerned about suicidality in our communities. Any attempt to reduce the incidence of suicide and other self-harming behaviour must include – and should be based on – an understanding of suicidal feelings and what they mean to those who live them. This cannot and does not happen while we continue to pathologise these feelings as symptoms of some (dubious) mental illness. It is these feelings that are central to understanding suicidality because it is our feelings, not some notional illness, that cause us to deliberately choose death. Current ‘expert’ thinking about suicide largely disregards subjective feelings as irrelevant to understanding suicidality. This arises partly from medical prejudices against subjective knowledge, but also from prejudices found in the wider community that see suicidal feelings as mad, bad or somehow ‘broken’ feelings for a person to have.

These prejudices tell us more about our fears around suicide than they do about the lived experience of feeling suicidal. Behind these prejudices we find two of our most potent fears, which come together in our fear of suicide – the fear of death and the fear of madness. As a society we still tend to have more fear of death than respect for it as a part of life. Our fear and
denial of madness as also a part of life are perhaps even stronger. In some ways this is understandable, for death and madness can be painful or ugly to experience or witness, so that we want to look away and not see them. But they also go to the very heart of the mystery of what it is to be human. To deny death, or madness, is to deny life. We can, and indeed must, acknowledge our fears as part of respecting and engaging fully with life. But not to allow these fears, which become prejudices when we deny them, to poison our efforts to understand suicidal feelings. If we hope to make progress in suicide prevention, we must all recognise these fears but not allow them to become prejudices that deny the real, legitimate and important feelings of those contemplating suicide for themselves.

The denial by suicidal people themselves of the legitimacy of suicidal feelings only complicates and undermines their struggle to stay alive. So I urge my suicidal soul-mates to respect and honour these sacred feelings. Equally, the denial of the legitimacy of suicidal feelings by those we seek help from, and by the general community, complicates and undermines our efforts at suicide prevention. So I call upon the experts of suicidology, and the wider community of everyone concerned about suicide, to also respect and honour suicidal feelings as part of the sacred mystery of life. Without this the toxic taboo that surrounds suicide, fed by ignorance and shame, fear and prejudice, will continue to dominate and thwart our efforts at suicide prevention. The first and most important message that I hope might be taken from my work is the need to change our thinking about suicide from one of fear and denial of suicidal feelings to one of respect and honour for them. This applies equally to the expert thinking about suicide prevention as it does to the personal thinking about suicide of my suicidal soul-mates.

In the Interlude section of my book that asked, ‘Who Am I?’, I argued for our thinking about suicide to shift from a medical, mental illness way of thinking to a more whole-of-person approach that sees it as a crisis of the self. I argued that reconceiving suicidality as a crisis of the self raises important and useful questions, in particular around the lived experience of suicidality and the personal, subjective meaning of suicidal feelings to those who live them. This would by itself go a long way towards promoting a healthier, more respectful attitude to suicidal feelings – and to those who have them. Thinking about suicidality as a crisis of the self also prompts useful questions about the social self, or the relationship between self and community. This important aspect of our sense of self for many people has not been emphasised in the stories in my book because my particular journey into and out of suicidality was very much a private, personal and spiritual journey. This is not the case for everyone though (another reason why I do not try to make generalisations from my own story). When we look at the current, expert collective thinking about suicide we find that the social aspects of our sense of self are almost as neglected as our personal, subjective feelings. Once again it can be seen that this exclusion of the social self is due to the excessive influence of medical ways of thinking.

Some experts in suicidology would argue that this is unfair of me. They would say that suicidology, reflecting its roots in sociology, is much more aware of the social dimension of suicidality than is found in the broader mental health field. While I would agree with this, I would interpret this as a sad reflection on our approach to mental health rather than something for suicidology to be too boastful about. I have said throughout my book that suicidology, under the dominant influence of psychiatry and the medical ‘treatment’ of suicidality, still sees suicidality very much in terms of a medical pathology that is located within the individual. There is some competition between psychiatry and psychology whether this pathology is located in the mind or the brain, but little serious discussion about the possible social origins of suicidality. With these underlying medical assumptions, most of the social analysis that suicidology does pursue is primarily the ubiquitous epidemiological study that searches for risk and/or protective factors for preventing or alleviating this pathology. The sociology of suicidology is largely the
It gives almost as little attention to the social self and our sense of social wellbeing as it does to our individual sense of subjective wellbeing.

In the broader mental health field, there is also some competition between the medical model of mental illness and what is sometimes called a ‘social model’ of mental health. The psychosocial approach of this model gives more consideration to a person’s social environment and emphasises recovery and rehabilitation rather than the ‘diagnose and treat’ approach of the medical model. Although there is quite a bit of talk of integrating these various models into a biopsychosocial approach, the reality is that the ‘bio’ of the medical model continues to dominate, consuming the vast bulk of limited resources available for mental health. I strongly support the move towards a genuine biopsychosocial approach, but even this does not really address the ‘social self’ that I am referring to.

The critical weakness of many of the more social approaches to suicidology (and mental health) is the same weakness that we find in the models that focus on the individual. As they strive for the same scientific credibility that psychiatry and psychology claim for themselves, they use essentially similar, and equally flawed, criteria for their notion of ‘evidence based’ practice and research, with similar consequences. The invisible, subjective, lived experience of the social self fails to register on their objective, scientific radars that see only visible, third-person ‘data’. And just like the subjective, individual self that the medical model fails to see so that it ignores, dismisses or denies it, social models that work only with third-person perspectives will be similarly blind to the vital intersubjective lived experience of the self as a social being.

**Suicidality as intersubjective experience**

The term ‘intersubjective’ is not a familiar one for many people (it’s only appeared for me as a result of my research), so it is worth being clear and careful with our language here. As with the excursion into postmodern thinking in the Interlude, I am particularly indebted to the American philosopher Ken Wilber (2000) for his clarity on this topic and, in general, follow his terminology. We are all familiar with the notion of the personal, subjective, invisible world of our own inner lived experience, which has been the emphasis in my research. Sometimes this is called the first-person perspective of felt experience, as opposed to the third-person perspective of observable behaviour. As social creatures, we also have mutually shared subjective – that is, intersubjective – experiences. Our intersubjective world is every bit as important as our subjective world, and is similarly neglected by objective science, including much of the social sciences.

Let’s make this clear with an example or two. I used the example of love as a significant and meaningful subjective experience that a strictly third-person science simply fails to detect at all. Love is an equally good example of a mutually shared intersubjective experience. Along with the individual subjective feeling of love, which can occur with or without the loved one present, there are also those precious moments when we feel a sense of mutually shared union, or communion, with a loved one – the intersubjective experience of love. Anyone who has experienced this knows that love exists, is real and that it is often shared. And just like the individual, personal feeling of love, these shared moments are of enormous meaning and significance to those who experience them. And in exactly the same way that the subjective experience of love is invisible to medical science, so too is the intersubjective experience of it.

Love is perhaps a particularly powerful example, but there are many more everyday, intersubjective experiences. The individual, subjective experience is sometimes described as that ‘Ah-hah’ moment when we recognise something to be true – when we live the truth of that moment. Intersubjective experience is then sometimes called a collective ‘Ah-hah’ moment.
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when we experience and live a mutually shared recognition of the truth of that moment. A common example of such collective ‘Ah-hah’ moments is humour or comedy when laughter spontaneously rises up within us as we collectively recognise and delight in the wit and humour of a good joke or a funny moment. There are also those times when we bear witness to someone’s pain and suffering and recognise it as our own, whether through some similar experience we’ve had or because of a natural empathy for the other. This can occur between two people or in groups of thousands – indeed ‘mob hysteria’ is another example of shared, intersubjective experience, this time of fear.

Intersubjectivity refers to collective, first-person experiences, in the same way that subjectivity refers to individual, first-person ones. Ken Wilber (2000) highlights this by describing the language of subjectivity as ‘I’ language while the language of intersubjectivity is ‘We’ language, or the first-person plural – in contrast to the ‘It’ language of third-person, objective knowledge. The significance of the first-person domains of knowledge (both the singular ‘I’ and the plural ‘We’) is that they are the domains of value and meaning. Wilber calls the singular, subjective ‘I’ knowledge aesthetic knowledge, which is characterised by values of sincerity, integrity and truthfulness. Collective, intersubjective ‘We’ knowledge, is cultural knowledge characterised by a sense of morality based on shared values. Objective, third-person knowledge, on the other hand, is almost by definition value neutral. A clear example of this is that the science of the brain is totally value-neutral – knowledge about the brain’s neurotransmitters, for instance, tells us nothing about the value and meaning of what we experience.

Yet what is most significant and important in any human experience is the value and meaning of that experience to those who live it as it is lived. And value and meaning can only ever be found in the first-person knowledge of subjective and intersubjective lived experience. Put another way, value and meaning can never be found in objective, third-person knowledge. Despite this, the traditional sciences of third-person, objective knowledge have become privileged above first-person, subjective and intersubjective knowledge. Moreover, the ideology of the traditional ‘hard’ sciences is exclusively third-person so that first-person knowledge is deliberately and systematically excluded by its criteria for what constitutes valid evidence that can only be met by third-person forms of knowledge. Nowhere is this more evident than in mental health where we see the medical colonisation of what it is to be human by the narrow and shallow evidence criteria of biological psychiatry.

Returning to suicide, suicidality and mental health in general, we can see that collective, intersubjective, first-person knowledge is every bit as neglected as individual, subjective, first-person knowledge. An immediate consequence of this is the widespread individual and collective failure to recognise and appreciate suicidal feelings as real, legitimate and important. But there are other, equally significant consequences. The first of these is that excluding vital first-person knowledge and expertise inevitably leads to an impoverished understanding of suicide and suicidality (and mental health in general). We see the most extreme expression of this in modern psychiatry with its almost total denial of first-person knowledge and experience in the pseudo-science of the DSM (American Psychiatric Association, 1994) and the meaningless, value-neutral science of biological psychiatry.

Despite frequent claims by all branches of mental health that ‘consumer participation’ is now a priority, the reality remains that the unique expertise of those who know about suicidality ‘from the inside’ is still largely excluded. Engaging meaningfully with the first-person expertise of mental health consumers is impossible under the constraints of exclusively third-person science. Even with the best of intentions, the current collective thinking about mental health is intellectually crippled by its ideological commitment to an obsolete notion of what is good science.
There are other reasons why the first-person data, knowledge and expertise, and in particular the collective, intersubjective kind, are necessary for suicide prevention (and mental health promotion). The stories of my book have focussed mainly on the individual, subjective experience of suicidality. I have only touched on some other stories where the collective meaning-making of shared, intersubjective experiences have been part of this larger story, such as family and friends, my time with Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), and the spiritual community of the ashram. I could have acknowledged these more than I have, but my own sense remains that my own spiritual journey was very personal, very individual and also very lonely. This is not at all a complaint, and may be a reflection of my personality as perhaps a bit of a ‘loner’. Besides, today I feel very fortunate and one of the lucky ones, not only because I have survived but also because I am very happy to be where (and who) I am today, which includes being grateful for all of my history, including my suicidality. Despite this, despite my own ‘solo’ journey of recovery, I am quite certain that the real hope for preventing suicide lies in a collective, intersubjective response to it.

When discussing suicide prevention it is necessary to distinguish between preventing suicidality and preventing ‘completed’ suicides. I repeat again that the emphasis of suicide prevention needs to shift to preventing suicidality, not just ‘completed’ suicides. But before looking at the importance of the collective, intersubjective response to preventing suicide, I want to return to another major theme of this book.

**Making safe-spaces to share our stories**

Story-telling is essentially an intersubjective experience where we tell our stories and hear the stories of others. We humans have been described as ‘meaning-making’ creatures and story-telling is such a central feature of this that we could call ourselves story-telling creatures. It is through our stories that we not only come to know others but also come to know ourselves. And the stories that contribute most to this meaning-making are those that resonate for us where something in someone else’s story ‘connects’ with something in our own lives in a significant way. Sometimes this might be a private, personal ‘Ah-hah’ moment when we recognise a truth that we hadn’t seen previously – and we learn and grow with this new, first-person knowledge. At other times, story-telling triggers a collective, shared ‘Ah-hah’ moment and we feel intimately connected with some others. Again, we learn and grow from this. We are all familiar with these occasions and we all recognise them as significant – and they are all first-person, subjective or intersubjective, occasions.

Story-telling is the primary means we humans use to find and create meaning in our lives and also to connect with others. Touch is also very important – both touching and being touched – as is doing things, the various tasks and activities where we learn through the doing, both by ourselves and with others. But it is mainly through story-telling that we make sense of our lives, of others, and of the world we live in. In this sense we might think of the theories of science as stories we humans tell ourselves to help make sense of our world. We also tell our stories through art, dance and theatre – there are many ways that we tell our stories. And always, what gives any story its significance is the value we find in it and the meaning we are able to create from it. This is equally true for the theories or stories of science as it is for the stories of Shakespeare. And always, these significant, value-laden, meaning-making occasions are subjective or intersubjective experiences, sometimes both. First-person knowledge is the knowledge of lived experience and the source of all our meaning-making and all that we value.

We need to resurrect story-telling as vital for both suicidality prevention and suicide prevention. We need to do this to restore subjective and intersubjective values to our suicide...
prevention efforts. First of all we need to hear the stories of those who know suicidality from the inside in order to understand it much better than we currently do. This individual, subjective knowledge is vital but will only become available if we are able to enter into meaningful, intersubjective engagement with those who have the first-person expertise. We need to create spaces where, first of all, these stories can be told, but then we also need to be able to be in these spaces so that they can be heard.

This is perhaps the most critical and urgent need in mental health today. For people struggling with mental health difficulties, whether suicidality or any other expression of mental, emotional, social or spiritual distress, what we most need is a safe space to tell our stories. Telling your story is the beginning of any healing or therapeutic encounter. Indeed, by itself, or perhaps together with hearing the stories of others, the telling of your story may be all the healing or ‘therapy’ that you need. But this can only occur if we feel safe. The calamity of mental health today is that in our current mental health system we have the exact opposite of a safe space where we can tell our stories.

Returning to suicide prevention, a safe space to tell your story is necessary if we are to overcome the biggest obstacle to helping the suicidal. How often do we hear that the first and most urgent task of suicide prevention is to encourage people to seek help – to come forward and tell their story? But psychiatric wards and the psychiatrist’s office are not safe spaces to tell stories of suicidal feelings. Nor, in many cases, is your doctor’s office. It is also probably difficult, if not impossible, to share your story with family or friends. For a whole host of reasons, not the least of which is the fear and taboo that surrounds suicide making almost anywhere in the community difficult, often impossible, and sometimes dangerous to tell your story. Once upon a time we might have ‘confessed’ our story to the priest, but this is also out of bounds for many people today. No, there are very few safe spaces to tell a story about feeling suicidal. This reflects very poorly on the so-called experts in mental health, but it also reflects poorly on all of us. As a society, we have lost the capacity to create spaces – intersubjective spaces – where these distressing stories can safely be told.

But these safe, intersubjective spaces are needed for more than just helping us to first come forward with our stories. The opportunity to tell your story, and to have it heard respectfully, can by itself be very healing. The intersubjective experience of sharing stories – telling yours and hearing those of others – can make a vital, life-saving, contribution to your own making sense of your struggles, which in turn can lead to a pathway out of and beyond them. By sharing our stories, we learn that we are not quite as alone and unique in our despair as we usually feel when we are suicidal. We also learn from those who have been there before us and can find comfort and solidarity among those who, like us, might still be struggling. We might also learn to our surprise that our story becomes part of the precious gift of healing to others who struggle alongside us. Sharing your story, in a safe space, alongside your peers, can at least make a vital contribution to your recovery, and may even be all that you need to move beyond your current story of pain.

In my story, the outstanding example of just such a safe space for story-telling is Alcoholics Anonymous (and related ‘fellowships’ like Narcotics Anonymous). However, the foundation of AA is not the 12-Step program that many people first think of when AA is mentioned. The foundation of AA is the regular meetings where you are invited to ‘share’ your story among a group of your peers, fellow alcoholics, and to hear their stories. And what makes AA a safe space for this sharing is first that you are among your peers so that your own struggles will be respected as real, legitimate and important, without negative judgement. And second, there is the cardinal rule of AA that enshrines anonymity as both permitted and protected, one of the key ingredients of the safe space created by AA for sharing what are often shameful and difficult stories.
In mental health and other health and disability fields, groups similar to AA are typically called ‘peer support’ groups. They are greatly valued by participants or ‘consumers’ and some groups do it very well. But they all have a lot to learn, I believe, from the ‘experts’ in peer support, the drunks of AA. And as a society we also have a lot to learn from these drunks about how to support each other when we experience times of difficulty in our lives. And governments and health departments have a great deal to learn about the healing power of such communities that are so much more effective, and also cost-effective, than the current expensive medicalising of human difficulties and distress.

This brings us to how these safe, intersubjective, story-telling spaces are vital for the even bigger task of preventing suicidality – that is, of preventing suicidality from arising in the first place. I am sceptical whether we can achieve significant reductions in the suicide toll if we just focus on trying to prevent the already suicidal from killing themselves. It seems to me that surviving suicidality is often a matter of grim determination by the individual, combined with a fair bit of pot luck, as in my own story. First there is the problem already mentioned that we tend to go underground and can be very hard to reach. Then there is the luck or otherwise, it seems, of whether you survive your initial attempts to kill yourself. Next is how problematic it can be, should you reach out for help, to find someone who you can safely talk to and who can maybe help. Although we still need to do all we can to help the actively suicidal, it all seems a very perilous journey. The real hope for suicide prevention is preventing suicidality.

Who are we?

For me, the key to preventing suicidality is to promote and create healthy communities. This is a slow process and a long-term goal but one that will be more effective (including cost-effective) in the long run. Suicidality is just one of many symptoms in our society of not only high levels of distress in the community but of our collective failure as a society to prevent and respond to this distress. We need to include with suicidality things like our widespread drug abuse and drug addiction (especially with alcohol and prescribed drugs), the high levels of crime and homelessness, and I would include other public health issues such as obesity, asthma and diabetes. And most of all, and often not unrelated to these other issues, we need to re-think what we mean by mental health. We need to ask what would a mentally healthy community look like and how might we proceed towards creating that?

I think a few critical issues leap to our attention when we ask these questions. First, despite our material abundance, we are not a particularly healthy society. We are overweight, the incidence of asthma and diabetes seem to be rising, and we are seriously drug-addicted (of all kinds – alcohol, coffee and especially prescription drugs). We are also not a very happy or contented society with widespread anger, sadness, social stress and emotional distress, and massive consumption of anti-depressant medications. Despite these widespread difficult personal and social issues, and despite our material abundance, economic and material values still dominate our thinking and the political agenda. We are not very generous or compassionate to our neighbours, whether they are within or outside our national borders. We are in fact not very compassionate to ourselves. Everyone seems to be working harder just to stay where they are, with stress and distress a constant feature of most people’s lives. Many people are dropping out of the rat-race, either by deliberately choosing less affluent but more peaceful lifestyles, or by escaping into drugs, madness and suicide. As one wit observed, the real problem with the rat-race is that even when you win you’re still a rat.

Instead of responding to this as a medical epidemic of ‘depression’ and getting people back to work with the help of their ‘happy pills’, we need to re-focus on creating and promoting
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wellbeing. We have the material wealth these days to make wellbeing and quality of life a national priority, if we choose. If we choose this rather than the current self-destructive madness, then we would find that what we need is not that dissimilar to what the suicidal, the mad, the addicted, and other ‘drop-outs’ so desperately need. We need to connect or re-connect with what is most important to us. We need to discover or rediscover what really gives life value and meaning. We need to listen to our pain and suffering, and to the pain and suffering of others. We need to care – truly and deeply care – for ourselves and for each other. For this we need to tell our stories, and to hear the stories of others.

We need safe spaces where we can tell our stories. In families, in the schools, in local neighbourhood community centres, in the workplace, in sporting clubs, in churches, mosques and temples. We need to discover how to trust each other again. We need to create time simply to be with each other, as well as time for quiet, private solitude where we can reflect on and tell ourselves our own most intimate stories. We need to ask the same question that I discovered was behind my suicidality: ‘What does it mean to me that I exist?’.

You might find it odd that I’ve not mentioned spirituality in this epilogue, given that it is so central to the story of my book. But I believe that the challenge we face as a society that wishes to reduce the suicide toll is exactly the same challenge I faced when I was struggling with my suicidal feelings. At the core of suicidality is a crisis of the self and the key to my recovery was a deep, personal enquiry into who or what I was and am. For me, this led me into spiritual territory and, frankly, I don’t see how it could ever be otherwise. But I might be wrong. For others, self-enquiry might take them into reconnecting with family and community, or to a new relationship with their working life. Others might turn to the creative arts to give expression to a renewed, reinvigorated and re-enchanted sense of self. All of these possibilities, and others such as joining a church, are for me full of spiritual value and spiritual wisdom. If we attend to what is really most important and re-connect with what our souls are really crying out for, then it seems to me that suicidal feelings and many other forms of madness are much less likely to arise.

And as social creatures, to do this we need to touch and feel and hear each other. We need to share and communicate who we are and what we need to live life fully. And to do this … we need safe spaces where we can tell our stories.

Having painted this somewhat optimistic and thoroughly idyllic dream of the future, it is necessary to remind ourselves that suffering and madness are probably always going to be part of our lives and our communities. The challenge then is still much the same. We need to respect and honour suffering and madness as a rich and vital, if difficult, part of life’s mystery. Suffering and madness have so much to teach us about what it is to be human. We need to hear these stories so that we can learn from them. Again, to do this … we need safe spaces where we can tell our stories.

The final, perhaps obvious, observation that needs to be made as we look at the broader issues around suicide prevention is that societies and communities can also be suicidal. Once more we find that the emphasis on suicide as a pathology of the individual distracts us from our collective suicidality, which may indeed be a major contributing factor in individual suicidality. Even if we take a simplistic symptomatic approach to suicidality, as psychiatry does, then we can see many symptoms in our societies that could be called suicidal symptoms. Some have been mentioned above – crime, drugs, the madness ‘epidemic’. We can add to these the environmental crisis where we are destroying the biosphere on which we depend. This is surely collective suicidality. We demonise and lash out against the ‘other’, failing to recognise that in doing so we are harming ourselves, and the current globalisation of economics as almost the sole measure of our wellbeing diminishes us and will perhaps destroy us. And spirituality, which
lies at the heart of the mystery of our being, has been reduced to a fashion statement as another optional lifestyle choice.

If we are serious about reducing the suicide toll then we must also get serious about our collective sense of self. In the same way that my personal suicidality forced me to confront the fundamental spiritual question of ‘Who am I?’, our collective suicidality obliges us to ask an equally spiritual question – ‘Who are we?’.

Note


References

