The relationship between economic values and socio-cultural values for helping us understand how to prevent suicide"

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I'd first like to thank the Karolinska Institute, the Swedish Parliament and the World Health Organisation for the opportunity to be here today. When I first saw the program for this conference, I thought it looked rather curious to see an Australian among the speakers and perhaps you find it curious too. By way of explanation, I therefore also need to thank the European Network of Users and Survivors of Psychiatry (ENUSP), who suggested me as a speaker for this conference and negotiated with the organisers to help make it happen. The reasons for ENUSP's advocacy on my behalf will, I hope, become apparent during my talk.

It's almost exactly ten years ago that I went to my local library and got out all the books it had on suicide. There were only a few, but this was thebeginning of a journey that has now brought me here to the Swedish Parliament.

After reading these books, I started looking for more information on suicide on the internet and had my first introduction to suicidology. As I read the academic literature on suicide I found myself beginning to feel uncomfortable and soon realised that it was because I could not find my own experience of suicidality anywhere in this literature.

Before long, this discomfort led to a PhD at Victoria University in Melbourne, in which I argue that suicide is best understood as a crisis of the self. As the 'sui' in suicide, the self is both the victim and the perpetrator of any suicidal act, which should make it a central concept for the study of suicide. But concepts of the self, I learned, are only rarely discussed in suicidology.

So I'd like to begin by discussing our sense of self and presenting a conceptual map of it as the context for out topic today. The model I use is called the Integral Model and comes from the American philosopher Ken Wilber. It is not only a map of the self but also a map of the various ways of knowing the self. It begins with the distinction between knowing the self from the inside, or what is usually called subjective knowledge, and knowing it from the

outside, through its external appearances, or what is usually called objective knowledge. Said another way, it is the distinction between the intentional knowledge of the felt or lived experience and the knowledge that can be obtained through the observation of externally visible behaviours (Fig 1).

The first important point being made here is that subjective and objective knowledge are two different but equally valid ways of knowing any humanly experienced phenomenon – they are complementary rather than in competition or mutually exclusive. For some scientists this is a controversial, even heretical claim to make, but I agree with Wilber that subjective and objective knowledge are both valid because they are both real and they are both significant. They are also both useful. Indeed Wilber constantly emphasises that both are also *necessary* – that one form of knowledge without the other is inevitably an incomplete form of knowledge. We therefore need to study all the different ways of knowing our topic of interest, which for us today is the topic of suicide. And for this we need concepts and methods that are appropriate for researching these different knowledge domains. For instance, to explore subjective ways of knowing we need phenomenology, narrative and other first-person research methods and I must mention that in my research the still rather new but exciting discipline of Consciousness Studies was especially valuable. For the objective ways of knowing we have the familiar, traditional sciences of biology for the science of our bodies and neuroscience and psychology for the study of the brain and mind (Fig 1).

At this point, Wilber adds another dimension to his Integral map of the self. As social creatures, part of our sense of self is as members of a society, or a collective of other similar selves (Fig 1).

This gives us the four quadrants of the Integral Model, where the Lower-Left quadrant is the domain of intersubjective knowledge or the *cultural* knowledge of collective meaning-making through mutually shared experiences. And the Lower-Right quadrant is the observable exteriors of our social worlds, or what Wilber calls inter-objective knowledge. As with the two upper quadrants, the two lower quadrants represent two distinct knowledge domains, which require their own concepts and methods to study them. The Lower-Left quadrant, as the domain of culture, is best studied with concepts and methods such as we find in anthropology, ethnography and hermeneutics. The Lower-Right quadrant of social systems, is the knowledge domain of disciplines such as sociology, epidemiology, ecology and economics.

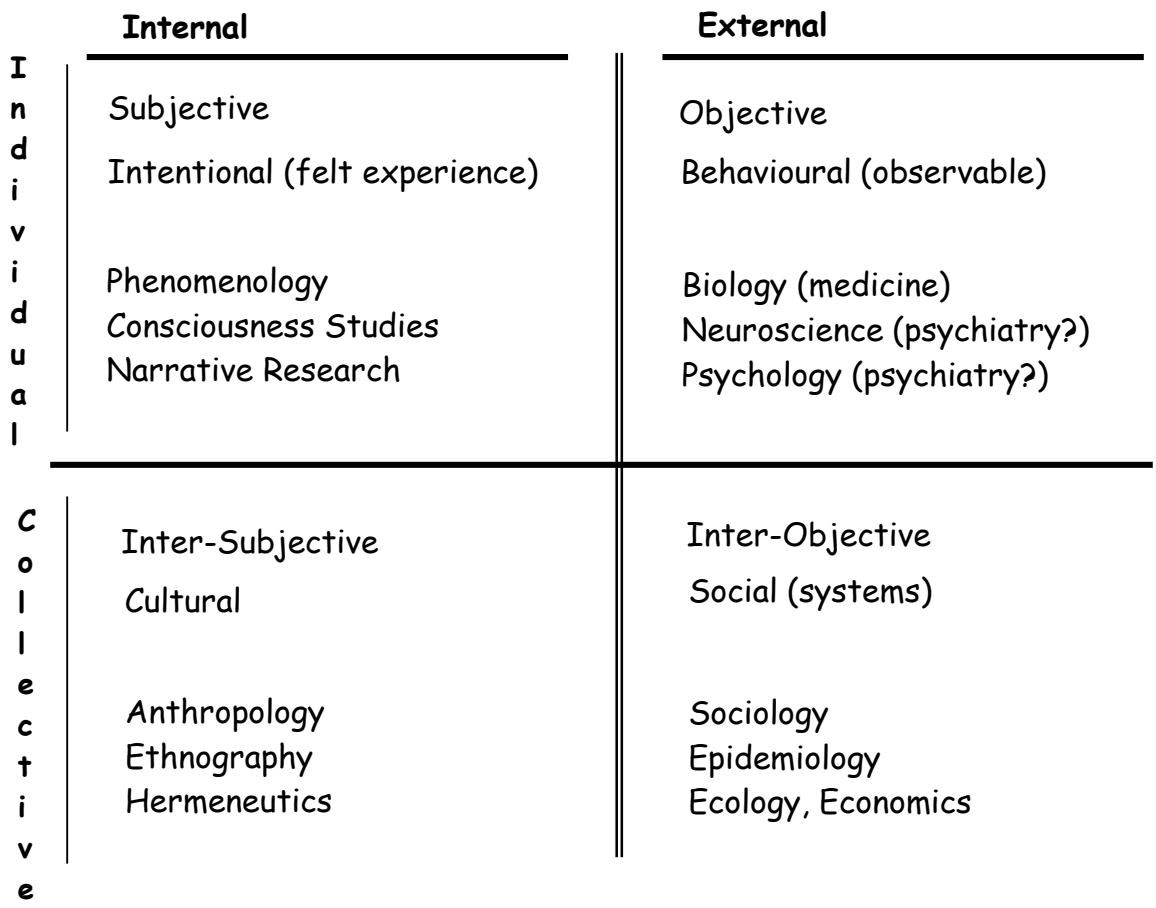

Fig 1 – the four quadrants of the Integral Model

Before looking specifically at economic and cultural values as they relate to suicide, I must quickly complete the map of the Integral Model.

I first want to change the labels on our map. The words subjective and objective have both become heavily loaded words in the modern scientific paradigm. To put it bluntly, objective knowledge is seen as good whereas subjective knowledge is seen as bad. I prefer to talk about first-person and third-person knowledge in the hope that this more neutral language will help us recognise that, as Wilber says, both forms of knowledge are necessary as equal partners (see Fig 3).

And then following this idea a little further, we can re-label the upper and lower quadrants to show that first-person and third-person knowledge both have singular and plural forms (see Fig 3).

I must also be faithful to Ken Wilber and very briefly add another layer to complete the picture here of his Integral Model. I was drawn to this model because spirituality was the key

to my recovery from suicidality so that exploring spiritual ways of knowing the self was a major theme of my PhD research. Wilber's Integral Model is the best approach I know for including spirituality within a coherent and rigorous conceptual model. So the extra layer of the model is what Wilber calls the levels of consciousness, which is recognisable as the familiar body-mind-spirit dimensions of life (Fig 2).

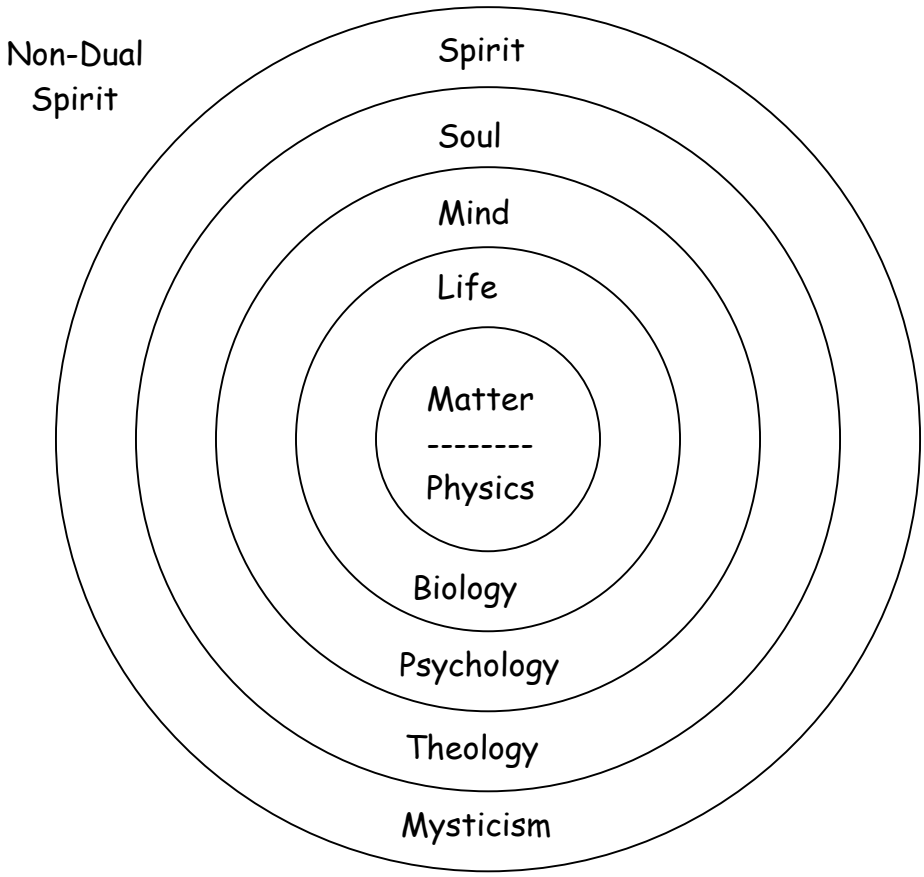

Fig 2 – the levels of consciousness

There's not time today to dwell on this part of the model but part of Wilber's genius is that he saw that these levels were found in all four quadrants, giving us the complete Integral Model, shown here in abbreviated form.

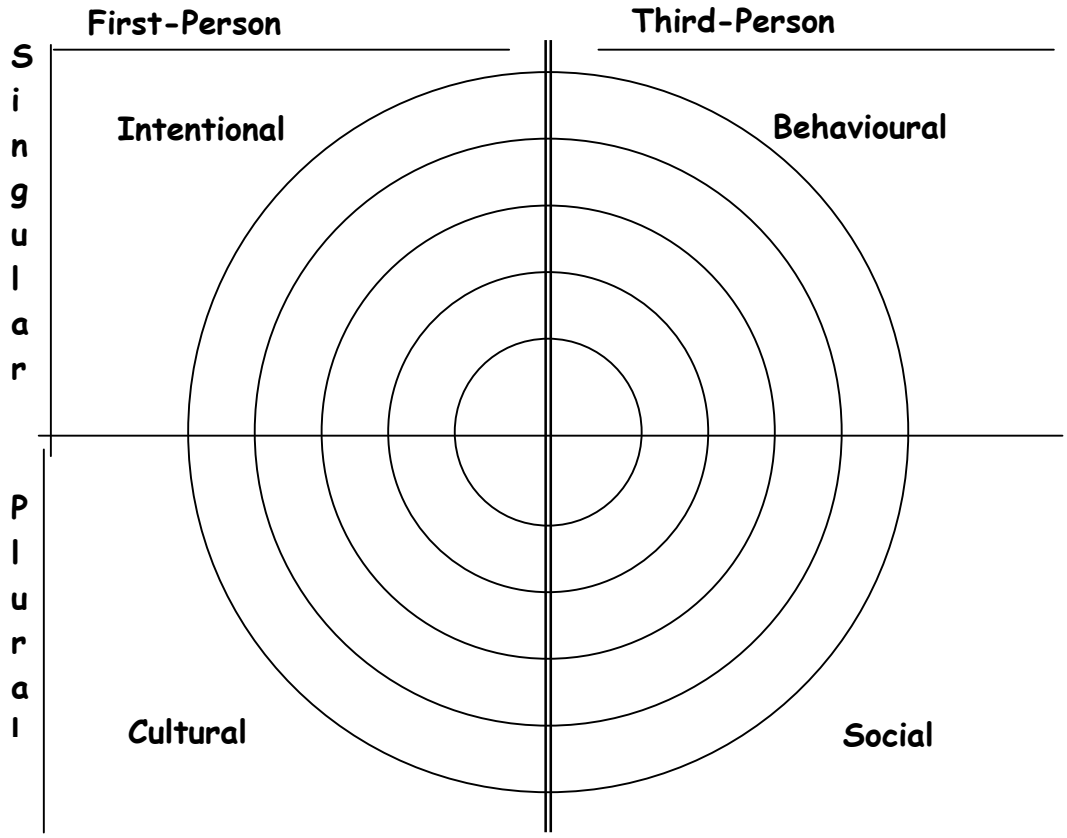

Fig 3 – All Quadrants, All Levels (AQAL)

The Integral Model is sometimes called the AQAL model, standing for All-Quadrants and All Levels. It is also my working definition for the much used but often poorly understood term 'holistic' – so that when I agree with everybody that suicide prevention requires an holistic approach, this is what that word means to me. This model also provides a useful tool for identifying the multi-disciplinary challenge of suicide prevention.

We can use this framework to identify the strengths and weaknesses in our current efforts to understand and prevent suicide. Ideally, it would be good to workshop this with you to hear and map out all the perspectives that we have at this conference. But in the time remaining, I'll use this model to make the following observations on the current state of suicidology and suicide prevention.

The first thing that jumps out at me from this model is the almost complete absence of any phenomenology of suicidality. Although there are many thousands of people like me who have survived a suicidal crisis, we only very rarely hear from them and suicidology shows

remarkably little interest in this important first-person knowledge and expertise – with a couple of notable exceptions.

There are many reasons for this, none of them good. Some people say that suicide, almost by definition, is irrational or crazy so how could we have anything useful to contribute to the scientific understanding of suicide. Others say that the only genuine suicide attempt is a successful one, so that survivors like me can tell us little about "real" suicidality. And there is the peculiar but nevertheless quite popular view that hearing people talk of their suicidal feelings is somehow contagious. These are just some of the many prejudices based on fear and ignorance that feed the toxic taboo of silence around suicide, which is one of the major obstacles to suicide prevention. Breaking this taboo will require hearing very much more of the first-person voice of suicidal feelings.

In mental health more broadly, the importance of the first-person voice is slowly being recognised and included in mental health policies and programs. But on the topic of suicide, we are still mostly silent and invisible – indeed I would say that we are, by and large, a forbidden voice. So I'd like to again acknowledge and commend the conference organisers, and my colleagues at ENUSP, for challenging this taboo and inviting me to speak today. It does not please me at all, however, that I am one of very few suicide survivors, not just in Australia but in the world, who has the opportunity to speak at conferences such as this.

The individual, first-person voice of surviving suicidal feelings is the voice of the Upper-Left quadrant. It is a critical missing piece of the jigsaw in suicide research. If we want to understand suicide, we need to understand what suicidal feelings mean to those who live them. Suicide is not an illness or disease. It is a very deliberate act that is taken by someone after a very deliberate decision. Suicide prevention requires that we understand very much better than we currently do what it is that leads a person to take that decision. For this, the voice of the Upper-Left quadrant needs to be heard.

But I believe that it is the Lower-Left quadrant that holds the key to suicide prevention (Fig 4).

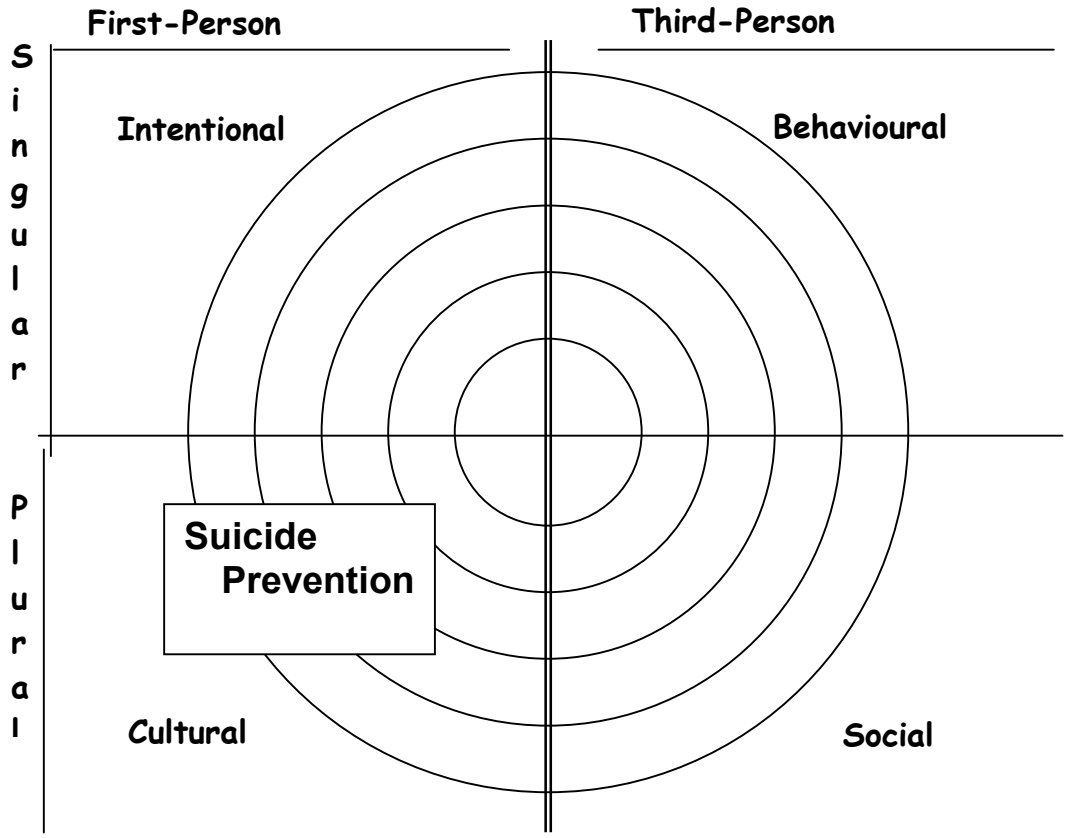

Fig 4 – Lower-Left quadrant, the key to suicide prevention

The two left-hand quadrants are the knowledge domains of personal and collective *values*. The Lower-Left quadrant includes those spaces where we meet and connect with each other. It is the space of mutual recognition and understanding where we collectively find and cultivate the values that give meaning to our lives. It is those spaces where we discover and develop our sense of self, within and through the communities of our families, friends, colleagues and peers.

The intersubjective, cultural knowledge of the Lower-Left quadrant is almost as neglected by suicidology as the Upper-Left quadrant. I am firmly of the belief that the key to suicide prevention is what we might call "mentally healthy" communities – though I prefer the phrase psychosocial wellbeing rather than mental health. Although therapeutic interventions to help those who are already actively suicidal are obviously important, I am not at all confident that this will achieve significant reductions in the suicide toll. Real suicide prevention requires doing all that we can to prevent or minimise suicidal feelings from arising

in the first place. And for this we need healthy communities, in the fullest sense of the word – not just physical health, not just mental health, but psychosocial wellbeing. And this is a challenge located primarily in the Lower-Left quadrant.

If we now turn our attention to the two right-hand quadrants, we see that this is where we spend most of our time, effort and money on suicide research and suicide prevention. The dominant influences in contemporary suicidology are the Upper-Right domain of medical science and psychiatric services and the Lower-Right domain of epidemiological studies and social policies and services. This is clearly the case whether you look at the suicide research literature, the programs of suicide prevention conferences, or the suicide prevention policies and programs that get funded.

I was disturbed to read in one of the Forewords of the Consensus Paper for this and the Budapest conference that "Suicide is primarily an outcome of untreated depressive illness". I was particularly alarmed to read this in a document called a Consensus Paper. As a visitor to Europe and a guest at this conference, it is uncomfortable for me to have to say this here, but I am aware of many people in Europe who do not share this view. I know this from the extensive literature out of Europe from academics, scholars, practitioners and others who disagree with this assertion. I also know it from many fellow users, ex-users and survivors of psychiatry. It is hard to understand how this rather narrow and much contested medical perspective of suicide can be asserted as a consensus here in Europe. Who was included in this consensus? Who was excluded? Is it a scientific consensus or a political one?

One other Upper-Right, medical perspective that we find in suicide prevention must also be mentioned. I think it is time that the antidepressant experiment of the last 20-30 years is declared a failure, at least for suicide prevention. Despite massive increases in the consumption of antidepressants during this time, as the Consensus Paper says, "no decisive success in prevention of suicides can be seen". Either these drugs are not reaching the right people, or they are just not working – and I know that I am just one of many people for whom they did not help at all. A third possibility, I suppose, is that the current suicide rates would be even higher if it wasn't for antidepressants, which would be alarming news but thankfully there is no evidence to suggest this.

Finally we get to the Lower-Right quadrant, which is the quadrant of, amongst other things, economics – the theme of this conference. This is the quadrant of the social determinants of

suicidality that are investigated through the ubiquitous epidemiological studies we find in suicidology, which are important to help identify particular at-risk groups and any social factors that can help protect against suicide. The Lower-Right is also the quadrant that looks at the social infrastructure that might be put in place to help prevent suicide. This includes not only the physical infrastructure for the delivery of services, such as hospitals, community health centres and so on, but also public policies and laws, workforce issues, and the role of the media in suicide prevention.

The relationship between the economic crisis and suicide prevention is for me about the relationship between the economic values of a society and its cultural values. With the help of the Integral Model we can see that it is our personal values that give meaning and purpose to life, which are so important for understanding suicide. This is the Upper-Left quadrant that is so neglected by suicidology. And we can also see through this model the critical role of community in shaping our values through the culturally shared meaning-making of the Lower-Left quadrant, which is also largely overlooked by suicidology.

I see two challenges for suicide prevention in the current economic crisis. The first is minimising the impact it may have on a person's sense of self, on the values that give meaning and purpose to their lives. To give an example of this from Australia, which appears to have avoided the worst of the economic crisis, the main concern at the moment is rising unemployment. Of particular concern is that most of this rise in unemployment is occurring among young people, especially those just leaving school. There is a real danger of this economic crisis leaving us with a significant number of disenchanted, disempowered and possibly very angry young people who feel that society offers them little potential for their future. If this occurs, then we can expect more crime, more drug abuse, more violence and more suicides.

The second challenge of the economic crisis for suicide prevention is also an opportunity. Along with the fiscal stimulus packages, welfare support payments and other economic measures to prevent economic collapse, we now have an opportunity to ask how can we use the economic levers of social policy to promote confidence and a sense of purpose among those at greatest risk during these difficult times?

This is a great challenge because a community's values cannot be created by legislation, nor by government policies and programs. The values that give meaning to life can only be

created by people themselves, not by any government or bureaucracy, which must be a source of much frustration to many well-intentioned politicians, bureaucrats and service providers. But we are not entirely powerless in this endeavour. Although we cannot legislate, invent or impose cultural values on a community, there is much that can be done to facilitate communities finding their own personal and cultural values.

I have argued that it is the Lower-Left quadrant that is the key to suicide prevention. So how can the social and economic policies of the Lower-Right quadrant promote the sense of community that is needed to help prevent or minimise suicide? This is a challenge that requires our attention, including the need for research in this area. But allow me to make just a few suggestions in the time I have left.

The critical cultural space that is urgently needed for suicide prevention is the need for safe spaces where suicidal people can tell their stories. We know that any major public health initiative begins with people coming forward and telling their stories. This is especially true when there is substantial stigma associated with the particular public health issue, such as HIV/AIDS, drug and alcohol addictions, mental health in general, and even medical conditions such as cancer. Good public health policy requires breaking through any taboos that frustrate our understanding of the issue and obstructs good policy development.

I need to emphasise that these spaces must be *safe* spaces. People will not come forward to tell their stories if they fear they will be stigmatised and discriminated against. As a crisis of the self, suicidality is already heavily laden with feelings of inadequacy and shame, which are only made worse by current community attitudes towards it. A further requirement of the safe spaces that are needed is that they cannot be places where we run the risk of being locked up and perhaps drugged against our wishes simply because we disclose our suicidal feelings. Our mental health laws need to be examined to really find out whether they help or hinder suicide prevention.

These safe spaces are not just needed to inform our understanding of suicide. They are also places where the healing of suicidal feelings can begin. Once again this is well known in many public health issues, including now – at last – in many mental health programs where the healing power of peer support is being recognised and put into practice. But as yet, such places are almost non-existent in suicide prevention programs, which is another measure of the power of the taboo at work.

So the challenge for suicide prevention that comes with the economic crisis can also perhaps be an opportunity. An opportunity to use this crisis to focus some attention on the underlying malaise in our societies where far too often people are choosing death rather than life. It is an opportunity to recognise that there is more to our sense of self and our sense of wellbeing than just biological health or material economic values, especially in the more affluent parts of the world such as my home country. There is an opportunity here, in the midst of economic crisis, to decide to commit resources to promoting wellbeing through building communities guided by a truly holistic understanding of what it is to be human.

I'd like to conclude by returning to the Upper-Left quadrant. In this short tour around the quadrants we have seen a little of how they all interact with each other. But it all begins in the Upper-Left quadrant with the suicidal feelings of an individual person. The wide-ranging community conversation of the Lower-Left quadrant that we urgently need begins with the first-person voice of those who have lived suicidal feelings. Suicide prevention needs to promote and engage with this whole-of-community conversation. Suicide prevention does not begin without first hearing from those who know suicidality from the inside.

I therefore urge the organisers of the conference in Budapest in December to make sure that this voice is heard at that conference. Suicide prevention is currently bogged down in the excessive medicalisation of suicidality. Please open up the conversation to include the voices, ideas, knowledge and expertise from all the quadrants and all the stakeholders in this important issue. And please, let's not prematurely pretend there is a consensus until all the necessary voices have a seat at the table.

Finally, I'd like to take a moment to remember Professor Edwin S Shneidman who sadly passed away earlier this year at the age of 90. Professor Shneidman was a pioneer of suicidology, indeed one of its founding fathers, and I want to acknowledge his great contribution to the field. I also want to acknowledge the wonderful personal encouragement he gave to me as an apprentice suicidologist. Like myself, he rejects any causal relationship between depression and suicide and coined the word 'psychache' as his core concept for explaining suicide. Psychache, he says, is psychological *pain* – not illness! – that is caused by thwarted or frustrated psychological needs. There are others now, such as the Aeschi Group, who carry his bright torch and keep alive not only his important concept of psychache but also his great respect for the actual suicidal person.

I thank you again for the opportunity to speak here today. And I leave you with the words that Ed Shneidman used to sign off one of his letters to me.

May your psychache be minimal – thank you.