Describing and Redescribing Suicide: From Pathology to Questions of Social Justice?

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Abstract
Exploring historical perspectives on suicide can help us to critically engage with contemporary thought and practices. By examining how suicide has come to be problematised as a particular type of issue requiring a certain kind of response, and by identifying and questioning the assumptions which underpin these formulations of the 'problem', we can ask important questions as to the necessity and utility of current ways of framing and responding to suicide. We can perhaps come to see more clearly that contemporary framings of the issue have a history, that these are the result of human practices, and that they emerge out of a network of contingencies and are thus open to change. This matters, I think, because there are relationships between the ways in which suicide is constructed, what gets done in relation to the issue, and the effects in terms of peoples' experiences of suicidality and suicide (including people who are suicidal, people bereaved by suicide, as well as clinicians and practitioners).

If we trace a history of suicide from 1880 to the present day in terms of thought and practices, we can see that it has been dominated by 'a compulsory ontology of pathology'. That is, we have come to think about suicide largely in terms of individual mental illness, and practices of risk assessment and management, diagnosis, treatment, confinement, and observation within medical / psychiatric spaces such as psychiatric hospitals and mental health units (formerly asylums) have come to be naturalised as necessary and effective responses, with prevention as the guiding principle.

Deaths from suicide have, consequently, come to be understood as private, individual events largely divorced from social, cultural and political contexts (that is, issues of social justice, practices of exclusion and oppression, politics, stigma, and relations of power). However, work explicitly linking suicide to issues of injustice, inequality, exclusion, and oppression has more recently emerged out of the Critical Suicide Studies Network – constituting what could be called a political or social justice approach to suicide. In this paper I explore what possibilities for thought and action are opened up through the discursive construction of suicide as a question of social justice rather than individual pathology, and consider what this might mean for people who are suicidal, those bereaved by suicide and for those, including mental health nurses, whose work is intimately tied up with notions and practices of suicide prevention.

Introduction

When talking or writing about suicide, my thinking is usually informed by a number of experiences, perspectives and roles. When much younger, I was employed in a community mental health team as an Occupational Therapist and worked with very many suicidal people in the 10 years I was there. That work made me curious as to how suicide had come to be thought of as primarily a mental health issue, as many of the service users I worked with were adamant their desire to die was a rational and understandable response to their life circumstances and experiences of life. This led me to try to find out more about suicide through undertaking a research degree; in particular I was interested in why considerations around a person's mental health, rather than say ethical, philosophical, social or political concerns, seemed to dominate our understanding and practices. As part of this study, I endeavoured to trace a history of medical and psychiatric thought in relation to suicide and looked to understand the 'truth-effects' of constructing suicide as a consequence of individual pathology (Marsh, 2010). One outcome of publishing this work once it was completed was that I ended up in contact with many people who were also questioning the assumptions and practices of mainstream prevention and out of this we founded the critical suicide studies network, an international group of scholars, practitioners, people with lived experience, and activists who continue to work for more socially just responses to the issue. I have also been involved in suicide research more widely, using discourse analysis and online ethnography to better understand suicide, particularly those that occur in public places (Marsh, Marzano, Mosse & Mackenzie, 2020; Marsh, Winter & Marzano, 2021). I have also been part of a public health suicide prevention group in the south-east of England for a long time, I have a role as a suicide-safer project lead for local universities and I have volunteered for the Samaritans for many years.

I should say that none of this, of course, gives me any unique insights or special knowledge – suicide is complex and maybe, at its heart, essentially unknowable – but each role has, at least, afforded me an opportunity to reflect with others on the ways that current approaches to the issue might be problematic – for people who are suicidal, for those with responsibility for prevention, as well as those bereaved by suicide.

The different work I have been involved in has also led to a belief that history can help us to engage critically with contemporary thought and practices. That is, by examining how suicide has come to be problematised as a particular type of issue requiring a certain kind of response, and by identifying and questioning the assumptions which underpin these formulations of the 'problem', we can ask important questions as to the necessity and utility of current ways of representing and responding to suicide. We can perhaps come to see more clearly that contemporary framings of the issue have a history, that these are the result of human practices, and that they emerge out of a network of contingencies and are thus open to change. This matters, I think, because there are relationships between

the ways in which suicide is constructed, what gets done in relation to the issue, and the effects in terms of peoples' experiences of suicidality and suicide (including people who are suicidal, people bereaved by suicide, as well as clinicians and practitioners).

In this paper I will briefly outline a history of thought and practice in relation to suicide since the late 19th century, and reflect on how an understanding of that history might form the ground for a 'critical history' of the present. I will then look at critiques of current ways of understanding and responding to suicide put forward by the Critical Suicide Studies Network, and how these might open up spaces for thinking about suicide in alternative ways. As an example of this, I will outline what a political or social justice approach to suicide might look like, and discuss how this approach could offer possibilities for new ways of approaching the issue. I will also outline critiques of suicide prevention practices that focus on 'suicidism' – the notion that suicidal people experience marginalisation and oppression due to their desire to die.

'A Compulsory Ontology of Pathology'

If we trace a history of suicide from 1880 to the present day in terms of thought and practices, it has, arguably, been dominated by 'a compulsory ontology of pathology' (Marsh, 2010). That is, we have come to think about suicide largely in terms of individual mental illness, and practices of risk assessment and management, diagnosis, treatment, confinement, observation and restraint within medical / psychiatric spaces such as such as psychiatric hospitals and mental health units (and formerly asylums) have come to be naturalised as necessary and effective responses, with prevention as the guiding principle.

The emergence and development of this medical / psychiatric style of thought in the 19th century can be read in terms of the formation of a particular 'regime of truth' in relation to suicide, one centring on an understanding of suicide as arising as a consequence of individual pathology. Although other views (philosophical, moral and religious) continued to be aired (Houston, 2009), and the process of medicalisation piecemeal and complex (Laragy, 2013), it is this 'thought style', and related practices (confinement, constant watching, restraint), that come to dominate over the next century and more, up to the present. This particular 'regime of truth' has undoubtedly opened up possibilities for understanding and managing self-destructive thoughts, desires and acts, but, equally, it is also troublesome in terms of its assumptions and effects. An individualized, 'internalized', pathologized, de-politicized and ultimately tragic form of suicide has come to be produced, with, I believe, alternative (and potentially more useful) interpretations of acts of self-accomplished death marginalized or foreclosed (Marsh, 2010).

These discursive practices position suicidal individuals as, almost invariably, mentally unwell, and thus not fully responsible for their actions; instead, clinicians are taken to be the responsible, accountable and possibly culpable agents in relation to

the suicide of a patient. This under-emphasising of the agency of people with a desire to die, and the concomitant overstating of the agency and reach of mental health staff, serves neither well nor fairly; in my experience, this often creates tensions, anxieties and an aversion to (or a detached acceptance of) risk for staff, and a sense of powerlessness and lack of validation of their desires and actions for those who are suicidal. Whilst not ignoring or discounting the often supportive and lifesaving work that does occur within such a structure, relationships can also emerge which are oppositional and distrustful.

In terms of suicide prevention, public health plans often focus on the identification and treatment of mental health difficulties within 'at risk' populations, despite the lack of effective screening or identification tools (Mulder, 2011; Chan et al., 2016). Broader public health messaging encourages 'help-seeking' for those in crisis (most often framed as a mental health crisis), despite the often many different and complex relationships suicidal people can have with 'helping' services.

Critical History

Whilst there is undoubtedly coherence and logic to what we could call a mental health approach to suicide (and it provides a compelling narrative to many), its dominance and the assumptions embedded within it are somewhat problematic. So how might history be of use in opening up the topic so that alternative, potentially more useful, understandings can arise? Criticising dominant forms of thought can be difficult; strong normative forces can be at work, and the vocabulary and concepts we can draw upon are often more constraining than liberating, so written through are they with accepted meanings. The 'truths' of suicide (as an act of pathology) are often forcibly set out and defended, and are embedded in 'authoritative' texts such as national suicide prevention strategies (Department of Health, 2021), WHO guidance (2021), research published in the main suicide academic journals, in guidelines for media reporting (Samaritans, 2020), and in campaigns such as those from the Zero Suicide Alliance.

It is perhaps here that history can be utilized to call into question the presumed naturalness, inevitability and usefulness of such views, and I think the approach taken by Michel Foucault can be of help. Foucault's work (for example, 1965; 1977, 1981) concerned itself with mapping the complex relationships between the production, dissemination and circulation of authoritative knowledge, particular relations of power-to-knowledge and knowledge-to-power, and certain 'truth effects' in terms of the constitution of objects and subjects of knowledge. His writings were also forms of critique – they sought to call into question the 'taken-for-granted', and to cast light on and challenge the necessity of the 'kinds of familiar, unchallenged, unconsidered modes of thought the practices that we accept rest' (Foucault, 1988, p155).

For Foucault, historical analysis needed to follow certain principles in order to function as a form of critique. His studies were guided by a consistent anti-essentialism, particularly in relation to questions of human nature - a scepticism towards all 'anthropological universals' (Foucault, 2000, p461), indeed to all 'universals', was a necessity if history was to have a critical function. When related to suicide, such a history would have to be resistant to grounding its analysis in terms of either an invariant object (that is, the assumption of 'essential' or universal features of suicide) or subject (the idea that certain attributes or characteristics are to be found in all suicides and suicidal individuals) of study. In place of the idea of suicide as an unchanging object of study, a critical history would look to establish such an object as an historical and 'cultural' formation or product. Similarly, the idea of the "constituting" subject would have to be rejected in favour of one taken to be "constituted", or formed in relation to certain historically and culturally specific forces. Finally, practices and power relations would be taken to be central to the production of particular 'regimes of truth', and need to be drawn upon to account for the formation of subjects and objects at particular times and places.

These principles, I believe, allow for an analysis of how suicide has come to be constructed in the way that it has, and can also act as a critique of contemporary thought, practices and institutions. A 'history of the present' in relation to suicide would highlight the contingencies involved in its formation as primarily a concern of medicine / psychiatry; and it would look to map particular 'truth effects' in terms of the objects and subjects produced in relation to authoritative medical scientific knowledge of suicide – that is, how does the production and circulation of such authoritative knowledge over time shape the experiences of clinicians, suicidal people, attempt survivors and those bereaved by suicide.

There is not the space here to set out detailed descriptions of each of these areas, but the following are summaries of the sorts of arguments that might emerge from such a 'critical history';

Contingency
It is possible to argue, for example, that there was nothing necessary or inevitable about the early nineteenth century redescription of suicide as pathological and medical. No empirical evidence presented itself that couldn't be ignored. Physicians initially theorized on the existence of diseased organs (in the viscera) that were said to account for a propensity to suicide. In the absence of validating anatomical evidence in autopsy, speculation focused instead on the brain as the 'seat' of suicide, but no consistent findings of abnormality could be found. Talk of diseased and perverted impulses and instincts came to the fore around mid-century, but again, as unobservable phenomena, evidence remained elusive as to their exact location and nature. Shifting categories of illness (suicidal monomania, melancholia, moral insanity) also appear throughout the century, set out in differing relations to suicide, but, as with theories of pathological anatomy and abnormal impulses, the certainty

with which they were expressed, I would argue, stood in contrast to their rather limited explanatory powers and practical usefulness. Even with more recent history, the somewhat fluid nature of psychiatric categorisation and the very broad definitions with which it sometimes works, makes it difficult to take at face value the oft-quoted figure of 90% of those who commit suicide having a diagnosable mental illness (Jamison & Hawton, 2005).

Truth effects

By positing a constituted rather than constituting subject it is possible to map the effects of the production and circulation of authoritative knowledge on the formation of subjects – in Foucault's (2000) term the connected processes of objectivication and subjectivation (p326-327).

Medicine (later psychiatric and other 'psy' disciplines) discursively constructed suicide as arising due to some form of pathology located within the (physical or mental) interiority of the individual patient. This truth of suicide found numerous outlets of expression in the nineteenth century and onward (in medical books and articles, newspaper stories, magazines, coroners' inquests, asylum reports and case notes, in conversations between staff and consultations with patients, etc.), and through such means came to influence how people thought and acted with regards to suicide. Ian Hacking (1986, 1995) further proposed that there was a "looping effect" whereby the changes undergone by people in response to being classified come to affect the systems of classifications themselves. Hacking argued that people come, albeit imperfectly, to resemble descriptions of themselves and their categorisation. Over time the classificatory system (for instance psychiatric nosology) alters to accommodate the differences between existing descriptions and presenting 'signs and symptoms', and a form of dialogue is thus set in motion – a process of construction and co-construction between classification and those classified, creating 'truths' of suicide that are prone to shifts and recalibrations as new theories or ideas emerge, but always diagrammed around notions of pathology and irrationality and formed through (as well as maintaining) unequal relations of power between researchers and clinicians and those with a desire to die.

It is the contingency and fluidity of authoritative knowledge in relation to suicide, as well as its constituting effects, that are often overlooked I believe. Experiences of suicidality, as well as the form and meanings of suicidal acts themselves, are always produced from available, historically situated, cultural sources. If, however, we assume, as do many contemporary theories of suicide, that both suicide and the experience of suicidality are underpinned by unchanging, universal elements we are likely to overlook many of the cultural and historical factors involved in their formation. Understanding the contingency of the suicidal subject, though, (and the constituting elements of such a subject), allows for a different way of approaching the issue. Our investigations would focus less on trying to locate assumed invariable elements of suicide and instead look to understand the changing cultural forces

involved in the formation of suicidal subjects over time. Such a stance would open up very different ways of understanding suicide and the experience of being suicidal. For instance, authoritative contemporary descriptions of suicide could be understood not as universally applicable, objective descriptions of reality but rather as distinctive styles of thought that produce particular effects. We would be able to understand the ways in which vocabularies, concepts, metaphors, images and stories are used to form certain ways of framing suicide, and that these descriptions partially (but often quite forcefully) shape the experiences of people within their sphere of influence – suicidal individuals, survivors, mental health professionals, indeed each of us.

Critical Suicide Studies

Understanding these processes, and the wider cultural, social and political forces that constitute and shape suicide and the experiences of suicidal people, has been at the forefront of the efforts of many scholars, activists, and clinicians to reimagine suicide and suicide prevention this last decade.

As a response to the assumptions and practices of mainstream or traditional suicidology a Critical Suicidology, or now Critical Suicide Studies (CSS), emerged during the 2010s. A main impetus for the movement was frustration at the limited, and limiting, approaches to theory (mostly ‘psy’ based theories which focus on individual psychology and behaviour in isolation), research approaches (a hierarchy of evidence prioritising quantitative and positivist approaches over qualitative and lived experiences ones), and practices (an almost exclusive focus on prevention, most often through the detection and treatment of mental illness), which dominated the field (Chandler, Cover, & Fitzpatrick, 2022).

The field of critical suicide studies looks not just to critique the limitations of dominant quantitative, positivist and pathologising approaches, but to move beyond that to construct alternative readings and descriptions of suicide, and to develop congruent ethical research and clinical practices. A broader disciplinary base (looking to the humanities and social sciences not just the ‘psy’ disciplines) and collaboration with people with lived experiences and from marginalised communities are taken to be both an ethical and practical necessity within critical suicide studies (Chandler, Cover, & Fitzpatrick, 2022).

However, the aim has not been merely to develop alternative descriptions of suicide within current, accepted parameters (most usually those involving a focus on individual mental health, risk factors, causation and prevention), but to explore what understandings of, and responses to, suicide can be constructed within an expanded framework which doesn’t take current notions and practices of prevention to necessarily be the best approach to understanding, supporting and working with people with a desire to die.

In terms of research, qualitative approaches are taken to be of central importance to understanding suicide within critical suicide studies (Chandler, 2020; Hjelmeland and Knizek, 2010). Such approaches allow for more consideration of the wider contexts, structures and relations of power out of which suicide and responses to it emerge and become entrenched. Attention to 'language, discourse, power relations, and social histories' can show how knowledge, practices, 'and ideas about life, death and suicide are not settled but are always being (re)produced and co-constituted in multiple and fluid ways within specific, social historical, cultural and political contexts' (White, 2017, p. 473). Consequently, many scholars within CSS draw on European poststructuralist approaches and use methods such as critical discourse analysis to analyse how suicide is constructed in policy documents, the media, popular discourse, and academic texts (Chandler, Cover, & Fitzpatrick, 2022).

These ways of critically engaging with how 'suicide' is constructed can unsettle assumptions that we are dealing with a singular phenomenon with one meaning, and again highlight the social constitution and contingency of core beliefs and accepted practices.

Similarly, being open to a plurality of perspectives on suicide, including importantly being attentive to first-person accounts from people with lived experience, can open up the field to new understandings and ways of responding to suicide.

As Chandler, Cover and Fitzpatrick (2022) argue, the 'qualitative turn and the ethical commitment to the centrality of lived experience obliges an ethical framework focussed on moving the field beyond medically reductionist, technological, ahistorical accounts of suicide towards complex, locally situated, historically and politically informed moral engagement (Turner, 2009)' (p5).

A Political or Social Justice Approach to Suicide

Such a focus on the historical and cultural formation of suicidal subjectivities also creates possibilities for exploring what could be considered the 'politics of suicide'. Mark Button (2016) frames these as involving both the interrogation of "the cultural scripts that sustain a punitive model of human agency" as well as "addressing the material-institutional conditions that prevent a dignified form of reciprocal social care from forming" (p6). The first points to an approach which doesn't take for granted notions such as 'intention', 'agency', 'autonomy', or even 'mental' or 'psychological', but which instead interrogates the effects of such constructions on our sense of self and its perceived livability, particularly in relation to those in society who are marginalised or deemed 'other'. The second opens up consideration of what a social justice approach to suicide would look like – a move away from psychocentric understandings (the reducing of human problems to flaws in individual bodies/minds) (Rimke 2010; Rimke and Brock 2012) of suicide to approaches which centre more on questions of exclusion and oppression, politics, stigma, relations of power, and hate (Reynolds 2016).

Analyses of the relationship between particular social concerns such as unemployment, rising levels of inequality, poverty, social integration or exclusion, and deaths by suicide have been a fairly consistent feature of modern bio-political engagements with the issue. Yet, there is still a limit in how far scholars, public officials, clinicians, and concerned citizens are willing to go in thinking about the constitutive interactions between individuals and the entrenched and long-term social-structural conditions and processes in relation to which individuals live. A social justice approach to suicide and suicide prevention – inspired by scholars such as Iris Marion Young (2006, 2011) – emphasizes that we need to develop a greater understanding for the ways in which structural social processes create enduring background conditions – with their own cultural, economic, and policy histories – that generate and consolidate more suicide risk factors (and undermine protective factors) for some people more than others. To adopt a social justice approach to patterns and specific concentrations of suicide ideation, attempts, and deaths within different countries and communities neither presumes nor requires that we identify a particular set of actors or institutions that are liable for this differential positioning in relation to suicide. But a social justice approach to suicide does require that we examine the relationship among multiple and simultaneous risk factors like poverty, ethnicity, sexuality, rurality, and limited access to health care as more than the operation of fate or mere bad luck. Generalized and differential individual positioning in relation to suicide arises out of the interaction of multiple subjective, interpersonal, and external factors operating over time that are rarely reducible to individual choices or the easily specifiable actions of liable persons or institutions. The analytic and normative framework of social justice is appropriate and necessary in the case of suicide because it highlights the role that social-structural processes can play in the formation of vulnerability to suicide without presuming that this framework could ever serve as the full or complete account of all deaths by suicide.

Such an approach moves beyond traditional sociological or social determinants of health perspectives. For while a relationship between suicide and various forms of social disadvantage and marginalization has been long recognized by researchers, a social justice approach posits that behind these issues and inequalities are also socio-political drivers or forces – including colonialism, racism, heteronormativity, patriarchy, and downward economic mobility – that also influence patterns and rates of suicide around the world. These “social facts” of suicide tell a political story – a story (or a series of stories) that is frequently punctuated by marginalization, persistent public policy neglect, cultivated indifference, and bad faith.

Given that the “social facts” of suicide have been long established, we can legitimately ask why it is that a more explicitly political and socio-structural narrative around suicide has not previously emerged, or, put another way, why it is that knowledge of the relationship between various dimensions of inequality and suicide has not led to a more organized or systematic political response within global suicide

prevention efforts. One answer, as stated above, is that for nearly two centuries the dominant way of framing the issue has been as an individual mental health problem, and this has strongly shaped the ways in which suicide is conceptualized and responded to in practice.

For Heidi Rimke (2000; 2010a; 2010b; 2016), the ways in which human problems come to be framed as innate pathologies of the individual mind and/or body can be conceptualized as "psychocentrism," and the social production of psychocentric knowledge in relation to suicide has meant that not only are the complex social and political contexts of such deaths obscured, but also responses to the issue have tended towards the individual level with collective and political responses marginalized or absent. Suicide has thus remained outside of politics, although I would also argue that to frame suicide primarily as an issue of individual mental health is itself a political act. Thus, part of a social justice response to suicide requires that we understand, as Chloe Taylor argues, "the political nature of our current ontology of suicide as pathology" (2015, 20), and for this a critical history of suicide is necessary.

Implications for prevention policy and practices

The exact nature of the relationship between currently existing dominant "psy" approaches and emerging social justice formulations – the extent to which they could be said to be complementary or necessarily in opposition – is a yet-to-be settled question. For most, the aim of a social justice approach to suicide is not to refute dominant bio-medical and psychological approaches to suicide that focus on the role of individual psychopathology in suicidal behaviour. Rather, a social justice approach – conceived and anchored in normative commitments to equal moral freedom and human dignity – seeks to contextualize and supplement this dominant understanding with more explicitly political, structural, and socio-cultural accounts of the factors involved in rising rates of suicide, especially as these rates are concentrated within vulnerable populations and the intersections among them (native peoples, the elderly, veterans and military personnel, individuals in poverty, rural residents, LGBTQ youth, and others). Whereas the dominant framework in the analysis and prevention of suicide sees *individual* psychopathology at work, a social justice approach *also* sees historically and structurally embedded *social* pathologies that call for both deeper contextual analysis and more organized social and political responses. A social justice approach also seeks to understand the complex interactions between various social pathologies (inequality, intergenerational poverty, racism, sexism, heteronormativity, marginalization, stigma, and social isolation) and individual or group experiences with suicidality. As such, a social justice approach to suicide requires that scholars, policy makers, and practitioners investigate the underlying and often overlooked connections that link the rising rates and disproportionate concentrations of suicide within specific populations to the wider social, political, and economic conditions bearing on individuals' lives.

As Iris Marion Young has argued:

> To judge that a suffering or disadvantage is unjust . . . implies that we acknowledge the circumstance as grounded at least partly in institutions and the social processes they generate. When we acknowledge such social causes of suffering or disadvantage, we thereby at least implicitly recognize an obligation to try to improve those social processes (2011, p33).

As Jennifer White (2021) states, such recognition and call to action also needs to be accompanied by a shared understanding of our interdependence and relational accountability, and the taking of a stance that 'does not shy away from acknowledging and addressing our potential *complicity with harm*.' Once we accept that suicide emerges from contexts of social injustice of which we are all a part, suicide prevention can be re-imagined from a social justice perspective as a collective responsibility and social movement to mediate the harmful effects of 'the cruelties, forms of dispossession, and injustices of the present, while at the same time never 'forgetting' the historical harms that have contributed to the experience of suffering and suicidal despair.' Suicide prevention from a social justice perspective thus becomes more of a collective, relational, and political endeavour than is currently the case, redrawing the boundaries of the field in ways many within existing mainstream suicidology might find challenging.

'Suicidism'

A further challenge to dominant ways of thinking and responding to suicide, and another potentially fruitful area of (critical) historical work, is the idea, most recently articulated by Sartje Tack (2019) and Alexandre Baril (2017, 2018, 2020), that the notion of suicide prevention itself is problematic.

As previously noted, constructing accounts of suicide and suicidality that run counter to the prevailing prevention narrative and accepted socio-cultural norms around such experiences, desires and forms of death is challenging. As Tack (2019) argues, prevention is constructed as the 'pre-discursive truth of suicide outside the realm of what can be questioned' (p50), and thus it can be difficult to find an acceptable language with which to articulate alternative (such as 'pro-choice') perspectives. Indeed, such is the dominance of the prevention imperative that it can even be hard to grasp what possibilities for thought and action exist outside of its reach. These difficulties are faced by researchers but also surely more acutely by those experiencing such a desire to die, who are routinely taken to be irrational and 'other'. For Baril (2020), the silencing and marginalisation of the views and experiences of suicidal people, and the lack of access to the theoretical tools needed to understand and explain the oppression they experience, represents forms of violence and injustice, which he names as 'suicidism'. Drawing on Fricker's (2007) notions of testimonial and hermeneutical injustice, Baril (2020) argues that the 'judgment of suicidal people as irrational, incompetent, illegitimate or alienated' (no page) destroys the credibility of suicidal subjects and invalidates their voices.

Prevention approaches that rest on notions of irrationality and pathology as explanations for suicide, it is argued, often seem to fail to meet the needs of many people in crisis and distress, or those who live with chronic suicidality (Webb, 2010; Delano, 2013). For Baril (2020), a solution of sorts, and a kind of bridge between prevention and acceptance or validation of a desire to die, is 'suicide-affirmative' healthcare. Here, a non-coercive approach is advocated, one that;

> 'would offer care and support through an informed-consent model, taking for granted that the expert in the decision to transition, in this case from life to death, is the person making the decision. It goes without saying that before implementing this approach, it would be important to engage in extensive critical reflection regarding the conditions, regulations, safeguards, and type of accompaniment, as well as the simultaneous sociopolitical changes necessary, to reduce suicidal ideations. These concrete aspects of a harm-reduction approach would have to be determined primarily *by and for* suicidal people and their allies, mobilizing their expertise on suicidality' (no page).

There is much to admire in Baril's (2020) formulation, such as the foregrounding of the wishes, needs and expertise of suicidal people in any decision-making process and the acknowledgement of the necessity of first creating 'safer spaces' within which deliberations and 'critical reflection' can occur, ones that, 'must be as free as possible from forms of judgment, stigmatization, paternalism and oppression and must foster a welcoming environment so that suicidal people can freely express their lived experiences, thoughts and demands without fear of reprisals and negative consequences' (no page).

For Baril (2020), alongside the opening up of new thought and practices around suicide would have to be an acceptance that, for a small number, suicides would occur. Such deaths, however, Baril (2020) argues, would be less traumatic for all involved, with people determined to die able 'to carefully plan their death several weeks or months in advance, to say goodbye to their loved ones and to leave this world using less lonely and violent means than those usually employed in completed suicides' (no page).

From a social justice perspective, however, the possibility would remain that any such approach would not fully escape the forms of power that constitutes and produces suicides according to a pernicious social logic (Button, 2016; Marsh, 2019). The interactions between social structures, hierarchies, and moral economies of human worth, the psychic and emotional life of people caught up in such regimes, and deaths by suicide are unlikely to cease to function (Mills, 2017; Marsh, 2019), and the formation of 'suicidal subjectivities' over time within unjust systems would continue but be masked by approved processes of consent. The concern would be that any such model would not, in reality, represent a genuine form of liberation[i].

Conclusions

As Judith Butler (2004) notes, ‘certain kinds of practices which are designed to handle certain kinds of problems produce, over time, a settled domain of ontology as their consequence, and this ontological domain, in turn, constrains our understanding of what is possible’ (p309). This is the case, I believe, with suicidology, where the nineteenth-century medicalisation of suicide, and the introduction of medical / psychiatric practices (identification, diagnosis, and treatment of ‘cases’ within a medical setting), theorizing (relationship between various, and contingent, categories of pathology and suicide), and forms of inquiry (epidemiological studies, case studies) have led to a ‘settled’, but I think problematic, ‘domain of ontology’. Medical-scientific discourse has undoubtedly been productive in terms of generating theories, monographs, conferences, journals, and so on, but it also limits and restricts, to a troublesome degree, what can be authoritatively said and done in relation to the issue of suicide. Deaths from suicide have come to be understood as private, individual events largely divorced from social, cultural and political contexts (that is, issues of social justice, practices of exclusion and oppression, politics, stigma, and relations of power).

Tracing the histories of current dominant thought and practices can help us to understand that our current understandings of suicide and approaches to prevention are based on culturally and historically situated assumptions and notions, for instance of agency and personhood, as well as what constitutes illness and rationality. Understanding the contingency of contemporary constructions of suicide allows us to shift our focus in attempts to make sense of such acts, as well as allowing us to question the assumptions which currently underlie our ways of responding to people experiencing a desire to die. By drawing on diverse and multiple discourses in thoughtful and creative ways, we might begin to construct alternative understandings of, and responses to, suicide that bring to the forefront social, political and ethical questions largely absent when suicide is constructed solely as a consequence of individual pathology.

Work explicitly linking suicide to issues of injustice, inequality, exclusion, and oppression has more recently emerged out of the Critical Suicide Studies Network – constituting what could be called a political or social justice approach to suicide. Such a process of redescription is also happening in relation to discourses of prevention, and the ways in which people with a desire to die can be silenced and denied agency and choice. These approaches, I believe, might allow for engagement with long-standing practical and ethical questions relating to suicide in new and useful ways.

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i Though one can argue in a similar way to Foucault (1981) that the act of suicide itself represents an escape from all forms of power.