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Pitfalls in understanding suicide. Some reflections on philosophy and the act of suicide

In this lecture I'm going to tell you some personal, philosophical and more generally *human* things about the act of suicide. Before I start, I have to admit that I am not an expert in suicide itself or in suicidology. I am not a counsellor or a nurse, and I have never attempted suicide myself.

I will start with a small anecdote. Once upon a time, in 2007 to be precise, I was in a quite gloomy state of mind in which nothing made sense or had meaning any more. All spiritual and mental life seemed to have been sucked away, and I was stuck in a kind of soggy swamp where time seemed to stand still. It was nothing but suffering, with no reason or cause for that suffering. Yet at no time did I seriously consider ending it. I knew that the good life did exist somewhere, that it was possible, that this miserable time would pass, and that the lust for life would return. But although I never had serious plans to commit suicide, at that time I did have a fascination with ways of committing suicide, and I searched the internet for all kinds of information about how you can commit suicide; who had done it, why and how.

My personal case is neither exceptional nor particularly noteworthy, but I use this anecdote for a different consideration. The fact is that when I later spoke to a friend about this, he said to me that in itself, looking for information about suicide on the Internet shows that you are more likely to commit suicide. And so although I may never have seriously thought about it myself, my *objective risk* of suicide was increased.

Epidemiological, statistical research indeed shows that there are several factors that increase the risk of suicide. Some of these factors are: whether suicide occured in your immediate family; living in a large city; pursuing a profession as an artist or poet; migrating to another culture; lacking a stable, trustworthy relationship with others, and so on.

No doubt the epidemiologists and statisticians among us know a lot more about such probabilities and correlations, and this is also certainly valuable information for general psychosocial support in the prevention of suicide. For example, if it turns out that there is a certain combination of factors that heavily increases the risk of suicide, more attention could be paid to these people at the group level. However, such generalised findings do not bring us any closer to the people concerned. For everyday nursing practice, general explanations in terms of causal relationships are insufficient. Instead of explanations, something else is needed, namely understanding. In psychology and philosophy, understanding and explaining are two very different things, which are nevertheless often mixed up.

If you *understand* a suicidal person, then you understand how this particular individual experiences and thinks. You can put yourself in their shoes, sympathise with them, and try to stare with them into the abyss of death. But if you want to *explain* a suicide scientifically, you leave out the black box of the person's inner self, and subordinate it to the average external and observable behaviour of a member of a group. You then reason about a group of cases as if they were rats in a maze, some of which do not find the exit (or do find the exit?).

Take the example of the suicide of the well-known Dutch writer Joost Zwagerman. If we explain his suicide scientifically, we can note that his father had attempted suicide. Zwagerman had also been living apart from his wife and children for several years. Moreover, he was a writer. In addition, he had been almost obsessively preoccupied with suicide for a long time prior to his suicide. When we add up these risk factors, we can scientifically establish how much greater the chance was that Zwagerman committed suicide than an average Dutchman for whom these risk factors do not apply.

But what use are all these chances and risk factors when you talk to someone for whom this applies? And evenmore, what use is it to the persons themselves, what use was this knowledge to Joost Zwagerman or to me at the time when we were pondering on suicide? When we know all about probability patterns of suicide, do we also know *why* Zwagerman did it?

Talking in terms of risks and chances conceals the fact that with suicide we are not dealing with gradual chances, with risk increases and risk decreases, but with absolute decisions: people decide for themselves whether they will commit suicide or not. A chance suggests that there is an objective possibility, that there is a chance somewhere on a scale between 0 and 100%. But it is not about an objective chance on a sliding scale, but about a subjective decision, about something you do or not do.

Talking about suicide in terms of chances and probabilities suggests exactitude and scientificity, but in fact they are unreal abstractions. The chance of getting lung cancer is higher if you smoke, and this is a real objective chance. A certain percentage of smokers will get lung cancer, whether they intend to or not. Lung cancer is more common among smokers, it is something that just happens to you. This cannot be said of, for example, the relationship between whether you have a parent who committed suicide and whether you will commit suicide yourself. Talking about it in a similar way with concepts like risks and probabilities makes it seem as if suicide happens to you, in an analogous way to how lung cancer happens to someone who smokes. It is as if someone who commits suicide or wants to commit suicide no longer has a will of his or her own, no freedom of choice, but is an unwilling subject to objective increases in probability of which he or she must then hope that the increase does not lead to the act.

This also applies when we refer to a mental disorder such as depression as a risk factor. Depressed people, when you examine it on a group level, do also appear to commit suicide more often, just as with many other mental disorders, but it makes little sense to start talking to people who are depressed about the increased risk that they run of suicide because of their depression. For here too, there is a great cloud of conflicting, complex inner considerations, thoughts and feelings that precede suicide. From that cloud suddenly a decision emerges: suicide or no suicide. It makes no sense to reduce that person's subjective complexity to a quasi-objective term like depression. And to add one more metaphor to this argument: when a depression is like a clouding of the sky, a suicide is like an unexpected strike of lightning: *facilitated* by the clouding, but not *caused* by it.

In addition, citing terms such as depression in cases of suicide makes even less sense than citing smoking in cases of lung cancer. Because in the definition of depression, the supposed consequence is already included as a possible symptom. Having suicidal thoughts is in itself an indication of depression.

Thus, you sometimes hear this strange, twisted reasoning that in cases of suicides that we do not understand, the suicidal persons must have been depressed, otherwise they would not have

commited suicide. The presence of a prior depression that is indicated because of the suicide then suddenly becomes an explanation or causing factor of that same suicide. Because depression is often considered just as an illness like any other, we become deceived by our own thoughts and language. As if the person did not really want to commit suicide, but was forced to do so by the illness. As if suicide were the logical outcome of an history, written by doctors in terms of illness; and as if it were not the most free act possible, namely the self-determination over life and death. In the absence of religion and autonomous thinking, we prefer to listen to the doctor's soothing words, and we get disconnected from complex questions without answers surrounding life and death.

In the scientific and medical language, the absurdity and paradox of the act of suicide, and the horror and fascination for the suicidal person, disappear. The problem of suicide disappears from the realm of freedom and ends up in the realm of disease patterns and symptoms, in the realm of the unfree and the impersonal.

In everyday nursing practice, where contact between people is central, suicide risk assessments are no more than the preconditions, the frameworks within which the encounter between the person who wants to live and the person who does not, takes place. Just as in good psychiatry, an objective diagnosis should only be the first start of a conversation, and not the conclusion, scientific suicidology can only be that: a preparatory phase of care, but not yet care itself.

The scientific views imply a sober, observant attitude towards suicide, in which the freedom aspect of suicide is hidden from view, and in which the theme of suicide is wrapped up in a language that talks about observable behaviour and phenomena. In this way, a distanced, detached position is taken, in which the actual people involved, the suicides are not granted any capacity to act. In other situations this is called the medical gaze, observational distance, or analytical coldness. Questions about the meaning and sense of life and death do not play a role in this analytical medical kind of reasoning, and therefore it is possibly a candidate for replacement by automatic calculating machines, like AI systems, in contrast with the real care workers, the nurses, that can principally never be replaced by any kind of robot.

Besides the clinical or rather statistical-behavioural view, another way of thinking and talking about suicide plays an important role in our time. This is the individualistic, liberal ideology in which autonomy and respect for individual choices are central. From such thinking, one stresses the freedom of choice, and one will not so easily hinder the other’s freedom, nor morally condemn the other. In this liberalism, one tries not to set limits or impose coercion on the other person. Despite all the good intentions, this attitude also implies a certain detachment, impartiality, but also a distance from the existential questions of life and death, which are precisely at the heart of suicide.

Both the scientific attitude and the individualistic, liberal conception of autonomy are the fundamental values of our time. Both have strong arguments and are defensible and respectable positions. Both are also partly a reaction to earlier practices around suicide, which are now often seen as immoral. After all, for centuries suicide has been severely condemned, both by the church and by the state. It was punishable by corporal punishment, imprisonment and even the death penalty. With the scientific objective view and the legal concept of self-determination, it was hoped that this morality could be overcome, but it led to an often cold and detached attitude in official discourse.

Nevertheless, despite the general detached scientific outlook and the liberal laissez-faire attitude, suicide is still considered an avoidable act. No longer by means of a legal condemnation by the state or a religious judgement by religion, but still simply in an everyday way, because no matter how much autonomy and freedom we grant to others, we find it intensely sad when our nearest and dearest depart from life. Not because of the law, nor because of religion, but simply out of direct sympathy, compassion, solidarity, and a sense of being in the world together. We live together, and the suicide of one person is also the burden of another. It hurts to see those close to you suffer, or to see them want to stop living, because those others are fundamentally us. And it is ultimately from this everyday common life of those left behind that the WHY question is asked. And not the scientific why, which gets an answer in terms of probabilities and objective connections. It is a why to which no answer will be adequate, and which has more the characteristics of an exclamation or an accusation, without it being clear against whom this exclamation or accusation is made.

From the dismay and the Why question follows a personal search, or investigation of what had happened. And this searching of the why afterwards, is at the same time a searching of the why for next times, and an investigation of how prevention can work. How can we ensure that this is prevented? How to further investigate the why of suicide, beyond science, beyond generalising psychology?

What we can do in such an understanding research is to try to put ourselves in the shoes of the suicidal person, to explore the suicidal world from the inside. Of course, it helps when we have tangible messages from our loved one's inner world: what he or she had already told us, or what we find in diaries or letters afterwards. Or simply, what comes up in conversations with the suicidal person. Then we try to understand what it is like to be him or her, or to have been him or her. In understanding this, we not only understand an individual other person, but we also understand the more general moods and attitudes towards the world that everyone has. It is an understanding from qualitative recognition, and not from quantitative determination. With understanding you learn something of concepts that fall outside the measurable range of scientific psychology or diagnostic psychiatry, such as despair, loneliness, disgust, failure, melancholy, meaninglessness, etc., and you understand the backgrounds, circumstances, and the factors that play a role in the context of suicide.

We then read the many suicide accounts, fictional, or non-fictional. We then come to understand them to some extent because we then also touch our own loneliness and despair. We are still doing research, it might as well be called scientific, but it is of a different kind. It is dedicated rather than detached. It is about qualities rather than quantities. It is about stories and interpretations, rather than facts and behaviour. This research may be called narrative, or interpretive or even phenomenological. This research requires the ability to think analytically as well as to think and perceive spherically, visually and interpretively.

But also the listening, sympathetic understanding attitude towards suicide comes up against a limit. This too does not lead to a total unravelling. It may help us to understand the worlds and thoughts leading up to suicide, but ultimately the act of suicide itself remains incomprehensible. Jeroen Brouwers, the Dutch writer who died this year, says the following in his monumental study of suicide among writers:

"The incomprehensibility lies not so much in the complexity of the suicidal world, but more in the act of the suicidant, which, although originating in a world, is directed at a non-world, at something

that is not about life, something that has no content, is unknowable, and about which nothing meaningful can be said."

In other words, you can understand the whole background of the suicide act, but that still leaves the question, why suicide? The world can be awful, worthless, frightening or depressing, and it may seem understandable that someone would want to get away from it. But it is not an escape, because an escape implies leaving a space and going somewhere else. It is more of a space destruction than an escape. And apart from destroying space, it is also destroying time. Suicide is not an act in the world, as other acts are. Instead, it is the act that ends the world. Suicide does not take place in the world, but on the boundary of the world, and therefore on the boundary of the comprehensible and empathic.

This brings us to the limits of the narrative and the interpretive and to the abstract emptiness of the inexpressible, and the incomprehensible. There we also come to the paradox of suicidal freedom. I said it before: suicide is by definition an act that is performed in freedom. After all, if it were not a free act it would not be suicide but murder, natural death or an accident.

The freedom of suicide is stranger and darker than that of the modern concept of freedom that is related to autonomy and responsibility. It is not a freedom that the human subject possesses, that they can use and shape to their will, but it is a freedom by way of which that same human subject including its freedom is *abolished*. Nor is it about the freedom to be able to take balanced decisions. Instead, it is a paradoxical freedom, that chooses between incomparable impossible possibilities. For there is no balance of pros and cons of suicide, there is only a decision from nowhere.

The term balance suicide that is sometimes used in suicidology is therefore misplaced. If we were to use the metaphor of the balance or the scales, the result would be a scale with, on the one side, life with its supposed qualities and temptations of pleasure, meaning and happiness. But at the other end, there would only be a hammer. That hammer does not outweigh the temptations, but smashes the whole scale so that there is nothing left to weigh, and no balance.

Suicide is the paradoxically voluntary step into the zone where free will no longer exists. It is an act of life in which one chooses not to live. In suicide, the arm, the hand, and your body make movements with the aim of making movement impossible. With suicide, you choose to never be able to choose again.

Because of all these bewildering paradoxes, talking and thinking about suicide is like a minefield. Those who strive for measurable solutions, results and conclusions end up in false solutions, false certainties, or failed attempts at understanding the incomprehensible. Yet we must continue to talk and think about it. Because where there is silence, isolation and loneliness lie in wait. As long as the why-question has no definitive answer, there is hope, and the decision is postponed.

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