

Distinguishing Between Suicidality and Mental Illness

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IN modern Western society, suicide is considered a derivative of mental illness. Though suicide has occurred throughout human history, its widespread attribution to mental illness has developed only in the last 200 years due to the medicalization of deviance [Conrad and Schneider, 1980]. Most current research on suicidality is produced by the medical and legal sectors and focuses on methods of prevention, assuming the irrationality of suicidal ideation. Current sociological inquiries tend to neglect meaningful contextual analysis and frame suicidality as an individual mental problem which must be addressed through prevention methods targeting high-risk individuals [Wray et al., 2011]. The dominance of cultural values that promote medical understandings of previously non-medical phenomena has led academics and the general population to accept mental illness as the cause of suicide without completing sufficient critical analysis [Pridmore, 2011]. The connection between suicidality and mental illness makes sense from a broad perspective and applies to many cases but does not address several key issues that arise upon contextual exploration of the topic. This paper observes the complexities of mental illness and suicidality through contemporary and historical standpoints to determine the degree to which they are connected. It finds that the widespread understanding in modern Western society that suicidality is inherent and automatic evidence of mental illness is misled due to its basis in oversimplified conceptions of mental

illness and suicidality. Specifically, it demonstrates that suicidality is caused by a diverse variety of factors and can occur in the absence of mental illness.

The perspective that suicidality is inherently derived from mental illness implies that the presence of mental illness can be objectively determined. Although the clinical identification of individual mental illnesses can be supported by evidence, the broader concept of “mental illness” is a subjective descriptor which cannot be defined by any one characteristic. Rather, mental illness is a hypothetical construct which describes a diverse range of deviant psychological modes or characteristics [Morey, 1991]. In contrast to many other medical conditions, the category of “mental illness” has no essential distinguishing characteristic and thus cannot be explicitly defined ([Zechmeister, 2018]). Suicidality is not inherently evidential of mental illness because the hypothetical construct of mental illness is not itself a disease with which suicidality can be comorbid.

That said, it is generally understood that “mental illness” refers to maladaptive mental patterns which significantly disrupt one’s ability to function physically, emotionally, or both. Those who are mentally ill struggle with “normal” life processes that are considered manageable to the mentally healthy person [Sanati, 2009]. Psychiatrist Paul McHugh divides the diverse manifestations of mental illness into four categories. Most of these categories describe the exacerbation of a mental pattern that is considered normal

when exhibited to a lesser extent or in abnormal or distressing life conditions [McNally, 2012]. The categories detail abnormal responses to general life, in which a person fails to respond in a healthy way to regular lived experiences. Determining whether a person is mentally ill is difficult because their mental state must be weighed against their experiences to determine whether it is a “normal” reaction to their situation. If this weighing is not performed, and a person’s mental state is judged outside of the context of their situation, the concept of mental illness ceases to have meaning. Thus, mental health and mental illness must be distinguished through contextualized judgments of abnormality.

Suicidality indicates an unwillingness to continue living for any number of reasons. If the reason is that one cannot function in regular life conditions without struggling psychologically, mental illness is present. However, if one has simply endured or is enduring something that is widely considered unbearable even for a mentally healthy person, then their suicidality is not pathological, and they may be considered mentally healthy [Dorff, 1998]. The element that ultimately distinguishes between these concepts is normality. Importantly, what constitutes “normal” behaviour is a significant point of contention in psychology and can be determined only theoretically in a process of social consensus. What is considered normal and abnormal varies immensely throughout history and across cultures, and thus, no action or state can be objectively said to stem from mental illness or health [Leenaars, 2002]. Thus, an understanding of suicidality among modern conceptions of mental health and illness must be constructed from a place of strong intercultural and historical awareness. This must be done with the understanding that mental health and illness are fluid, and suicidality has the potential to be seen as frequently, but never certainly, abnormal.

The idea that suicidality is irrevocably linked to mental illness rests on the assumption that, morally,

death should always be avoided [Ashraf, 2007]. This perspective is informed by a wealth of cultural and historical discourse surrounding the value and meaning of life. Critical consideration of this basic life and death paradigm is necessary to understand the various perspectives on suicidality. Although Western society conceptualizes suicidality in terms of methods of prevention and the experience of the individual, many current and past cultures focus on its moral repugnancy instead of examining its practical effects [Sanati, 2009]. Today’s discourse fits well with the modern movement for mental health but lacks the critical lens of past eras and other cultures.

Although there have been diverse perceptions of suicide throughout history, one common thread is the idea that it is a boldly intentional act. Until suicidality was introduced into the medical sphere in the 1800s, society held various perspectives on its morality but generally agreed that responsibility for the act rested on the individual, whose mental stability was not in question [Marsh, 2013]. Suicide was widely labeled a criminal act since the time of Ancient Greece when philosophers argued that taking one’s life was a conscious choice that disrespected state resources and had negative social effects [Ashraf, 2007]. The decriminalization of suicide in Western society removed the historically accepted agency of those who experience suicidality and positioned them as powerless victims of an irrational outcome of mental illness. Regardless of whether suicide is framed as a criminal act or a victimizing experience, it is and has been considered unnatural and abominable in Western society [Ashraf, 2007]. Since suicidal persons are not presently criminalized, they must be victimized, regardless of context, to substantiate the Western cognitive bias that suicide is wrong. To escape this limiting bias and examine the connection between suicidality and mental illness more critically, one must explore the perspectives of non-Western knowledge systems.

In various non-Western historical and contem-

porary cultures, suicide is seen, in certain circumstances, as a rational and even morally upright act. Suicidality can be considered, outside of the limiting criminal/victim framework used in the Western world, as an experience more strongly rooted in the social and environmental context than in one's individual immorality or pathology. For example, during most of Japan's history, suicide has been seen as a justifiable escape from the pressures of living [Leenaars, 2002]. Mainstream Japanese society saw suicide as a pitiable but sensible way to escape economic stress, political disgrace, or other troubling life situations as recently as the twentieth century. It was even considered honourable to the point of necessity in certain contexts, such as when it was used a method to escape military capture, or as an apology made by school principals under whose watch large numbers of students had been harmed [Hayakawa, 1957]. Thus, suicidality was seen as a tool used to react to life situations and experiences, and not as a measure of morality or mental stability.

There are several other examples of suicide being understood outside of the context of mental illness. The Chinese traditions of Confucianism and Taoism value human life as the highest gift, and as such, "[see] no right to suicide" [Hayakawa, 1957]. Similarly, the Christian religion often poses suicide as taking away the God-given gift of life, sinful because it removes God's power over life and death. Some spiritual traditions of the Indigenous peoples of Turtle Island posit suicide as the abhorrent result of a person being out of balance and not appreciating nature's gift of life. However, unlike the Chinese and Christian traditions, the Indigenous traditions in question have historically held certain exceptions to the spiritual aversion to suicide. For example, they have historically considered it acceptable for a warrior to give their life in battle to win, or for elders to walk out into snowstorms to preserve food for younger generations when it was scarce [Leenaars, 2002]. In India, suicide has been widely condemned, being permitted

only when a person has sinned beyond redemption [Hayakawa, 1957]. Thus, even in cultures which have a general moral, social, legal, or spiritual opposition to suicide, it is often the case that some suicides are permitted. Historically, cultures and societies have not opposed suicide absolutely. Most importantly, they have not evaluated those experiencing suicidality based on mental abnormality or instability, but rather on their morality or immorality as autonomous people.

Today, Western culture surrounding life, death, and suicide is shifting. While suicidality is still overwhelmingly linked to mental illness in Western ideologies, new ideas regarding human normality and autonomy are surfacing. A notable instance of this is the current discourse around euthanasia [Dorff, 1998]. Western society's increasing acceptance of euthanasia indicates that at least some proportion of the suicidal population is seen as mentally stable, because amidst the current wave of mental health action, society strives to prevent dangerous acts of mental instability.

There are also other cases in which suicidality is arguably not the result of psychological abnormality, but rather a normal response to unbearable life conditions. In direct contrast to the idea that suicide is abnormal, one contemporary line of thought argues that opting to stay alive while suffering agonizing or hopeless conditions or circumstances can be considered abnormal [Dorff, 1998]. For example, a prisoner undergoing continuous torture with no hope of ever escaping may be considered rational in their suicidality because they are clearly assessing their living conditions and believe death to be more bearable. Similarly, a person suffering mental anguish due to treatment-resistant mental illness may be rational in their suicidality (i.e., not suicidal as the result of mentally ill thought patterns) if they have conducted a similar assessment. A more controversial example is that of suicidality provoked by economic distress, in which case the person's belief in the hopelessness of

their situation may be rational under the economic system within which they exist. Judgements that find this response to be abnormal must be contextualized, as the observer may not be able to understand the level of distress caused by this situation. Incidences of complete loss of family or terminal illness might also lead to suicidality in rational, “normal” people [Pridmore, 2011]. Thus, observing the context of suicidality majorly weakens the legitimacy of the overarching statement that suicidality is inevitably linked to mental illness.

The contemporary idea that suicidality is inherently tied to mental illness is based in a flawed system of medical “knowledge” that emphasizes the ostensible abnormality of suicide based on its moral wrongness [Marsh, 2013]. This initial characterization conflated abnormality with immorality and led to suicidality being understood as a mental illness rather than a rational state of mind with culturally determined moral value. At the time of the initial pathologization of suicidality during the early 1800s, the institutionalization of the “mad” was emerging [Scull, 1991]. The concept of “the insane” was shifting from being understood as an obscure, scattered demographic, to being seen as a measurable, dangerous population [Scull, 1991]. Institutions were built to hold the insane, but were often a guise to detain criminals, the poor, and other social outcasts [Scull, 1991]. As society grew critical of this practice and more interested in the causes of insanity, the medical field intervened and created the concept which we now call “mental illness” [Marsh, 2013]. The perceived moral wrongness of suicidality made it a prime candidate for medicalization, which would allow medical professionals to exercise control over the suicidal population. As Ian Marsh explains in their work on the historiography of suicide, “the arguments for... madness were somewhat sketchy... the force of such statements relied less on supporting empirical evidence, more on an emerging and productive configuration of power-knowledge,” [Marsh, 2013]. By po-

sitioning suicidality as an internal, individual pathology and ignoring the social context, medical professionals reframed a mindset which had historically been seen as rational in some Western histories and in other cultures.

This new knowledge system surrounding suicidality has undergone considerable change since its formation but remains largely intact today. Marsh discusses the current “regime of truth,” in which the seemingly fundamental pathologization of suicide dominates modern thought surrounding suicidality, and the only substantive discussions revolve around treatment, not nature or cause (2013). Suicide is individualized and decontextualized based on the claim that denying the contribution of mental illness to suicidality is dangerous and ignorant [Marsh, 2013]. This type of discourse equates the consideration of non-pathological factors with the complete rejection of the contribution of pathology, effectively blocking critical analysis of the current Western understanding of suicidality. These strategies reinforce the apparent strength of this understanding without providing actual evidence for its legitimacy.

In their work “Medicalisation of Suicide,” Saxby Pridmore argues that there are major scientific flaws in conceptualizing suicidality as a medical problem [Pridmore, 2011]. Pridmore finds that psychological autopsies – a main source of scientific evidence for the causal nature between mental illness and suicide – are highly subjective methods of research whose retrospective nature renders them unreliable and of questionable validity (2011). They also point to the sometimes-fallacious medicalization of distress as a factor in the problematic research; when contextually reasonable levels of distress are perceived as disordered, suicide is inevitably pathologized, because distress is almost always a precursor to suicidality [Pridmore, 2011]. This process of applying medical diagnoses to “inescapable aspects of... being human” allows suicidality to be viewed as abnormal even when it is based in rational human judgement of unen-

durable conditions [Pridmore, 2011].

Factors other than mental illness are also prevalent in causing suicide, according to several studies performed in Asia which found social determinants to be the leading cause of suicidality [Pridmore, 2011]. In modern non-Western cultures, suicide is frequently seen as the result of people observing reality rationally and making a decision [Pridmore, 2011]. Sociologists have argued that suicidal actions contain social meaning, and that suicidality is measurably exacerbated in those embodying certain intersectionalities [Wray et al., 2011]. Suicidality is also conceptualized as a rational individual's purposefully communicative act, which is utilized to critique society, rather than an unstable individual's desperate escape [Hayakawa, 1957]. Thus, not only is the current framework of mental illness and suicidality inherently flawed, but there are also many other substantial causes of suicidality that do not call the sanity of the individual into question.

This paper has argued that the dominant contention of modern Western thought that suicidality and mental illness are inherently linked is flawed and

that suicidality cannot necessarily prove the existence of something as fluid as mental illness. No human state, including suicidality, can necessarily prove the existence of something as fluid as mental illness. Cultural and historical analyses demonstrate that there are cases in which suicide is a rational act, and that the suicide-mental-illness framework is flawed. Conceptualizing suicidality only within the rigid framework of mental illness inhibits meaningful analysis of how suicidality develops and the implementation of important methods of suicide prevention. As stated by Pridmore, "the great disadvantage of all-suicide-is-caused-by-mental-disorder thinking is that important social, cultural, economic, and political factors, about which much might be done, are neglected in favour of the medical solution," (2011). Thus, suicidality is logically unable to be conceptualized as necessarily indicative of mental illness, and framing it as such poses a threat to the development of prevention and treatment. This calls for broad reassessment of social and medical understandings of suicidality and mental illness in the context of lived experiences.

AUTHOR BIOGRAPHY

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