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CONTAINING ‘SUICIDE’: SCIENTIFIC, PUBLIC, AND POLITICAL ASPECTS OF A MORAL PROBLEM

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To all—past, present, and future— who know what it's like

to weigh one's death against their life

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List of Acronyms

AAS	American Association of Suicidology
ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
AFSP	American Foundation for Suicide Prevention, Previously "American Suicide Association" (ASA)
APHA	American Public Health Association
CDC	Centers for Disease Control
CSSP	Center for Studies of Suicide Prevention
ESDA	Ethics of Suicide Digital Archive (https://ethicsofsuicide.lib.utah.edu/)
HHS	Department of Health and Human Services
IASP	International Association for Suicide Prevention
ICD	International Classification of Diseases
JAMA	Journal of the American Medical Association
NCBH	National Council for Behavioral Health
NCYSP	National Committee on Youth Suicide Prevention (founders: Charlotte Ross and NY Lt. Governor Alfred DelBello)
NIH	National institute of Health
NIMH	National Institute of Mental Health
NYT	New York Times
SAVE	Suicide Awareness Voices of Education
SLTB	Suicide and Life-Threatening Behavior (journal)
SPAN	Suicide Prevention Advocacy Network
SRU	Suicide Research Unit, at the NIMH
YSNC	Youth Suicide National Center
WHO	World Health organization

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Abstract

In my dissertation, I seek to understand contemporary 'suicide' as a scientific and a political object. In this endeavor, I focus on the features of suicide that make it morally and socially problematic, and the way the discourse on and knowledge production about suicide work to 'contain' moral concerns and emotions that arise around it. I conduct my investigation in three parts, paying attention to different structures that participate in the social construction of 'suicide'— specifically the conceptual, organizational/political, and scientific.

In my first chapter, I argue that the realizations of the human capacity to play a part in one's own death (a type of death I dub 'ipsal death') have emerged as matters of concern throughout human history. I identify significant commonalities and differences across different instances of discourse about these ipsal deaths, focusing on the boundaries that distinguish 'bad' ipsal deaths from acceptable ones and on discussions of who or what is responsible for such deaths. In this, I identify contemporary discourse on 'suicide,' and scientific discourse more specifically, as an instance of these broader efforts to come to terms with ipsal deaths. I also note two factors that distinguish the contemporary discourse on 'suicide', as compared to similar kinds of discourse across other contexts. Specifically, contemporary 'suicide' exists in an environment shaped by 1) institutional and organizational structures, as well as 2) scientific knowledge production and scientific disciplines, to which I turn in the following chapters.

My second chapter, drawing on archival data, newspaper publications and interviews, traces the history of the development of suicide as a 'national problem' in the 20th century US and examines the way different organizations, stakeholders, data artefacts and emotions played a role in constituting suicide as a public problem. Through this I identify four features that significantly shape the position 'suicide' occupies as a public problem: 1) the understanding of suicide rates as excessive, 2) difficulties in emphasizing the social causes of suicide, especially with respect to the final two features: 3) the State's power to shape the definition of, and the response to, the problem, and, finally, 4) emotions of those affected by suicide.

In the third chapter, through a publication analysis of scientific work published on suicide, I follow the scientific production of knowledge about suicide across the period between 1960s and 2020. I show that although the field has overall been dominated by the medical sciences, and especially psychiatry, over time it has been diversifying in three ways: 1) following broader patterns of proliferation of interdisciplinary journals, 2) steadily increasing presence of some other disciplines, such as clinical psychology, and 3) with respect to thematic clusters that have been arising in the literature.

My overarching goal in is integrating these three distinct views of 'suicide' is to provide a multi-dimensional perspective on how different kinds of social structures grapple with and work to contain what is ultimately a complex moral problem.

Introduction

In April 2018, the 51st Annual Conference of the American Association of Suicidology (AAS) took place in Washington DC, bringing together over 1,200 attendees. The theme of the conference was "Integrating Science, Experience and Political Will" and, fittingly, the three-day event was immediately followed by the "First Annual National Rally to Prevent Suicide," which gathered over 500 participants in front of the Capitol (APA, 2018). At the conference itself, 'suicide' and 'suicide prevention' emerge as contested. A few talks—centered in the conference program and featuring well-known figures—are explicitly oriented towards critiquing a certain 'status quo' of suicide research and prevention. Craig Bryan, PsyD, the 2016 recipient of AAS's Shneidman award (McIntosh, 2020), delivers a plenary titled *On Conventional Wisdom, Cliché, and Saving Lives*, in which he tackles a question that he says has been bothering him for past several years:

> 'Why aren't we better, at suicide prevention?' And I pose this question, I decide to focus on this because I found that in the suicide prevention community, and arguably within the mental health system more broadly, and society, we often speak about suicide and suicide prevention with a great deal of conviction. We talk about risk factors, and warning signs, things that people should be doing to save lives, but despite our confidence, despite, you know the certainty that we often purvey when we're talking about suicide and suicide prevention, the data here from United States aren't actually all that good. And contrary to what we might expect, suicide rate over the past decade have been going up, even though we have increased awareness, we've increased efforts, we've increased different strategies. (transcribed from a live recording: Dr. Sally Speaks Facebook page, 2018)

Joe Franklin, PhD, an Assistant Professor of Psychology, presents similar concerns during his 'Thought Leader Session' titled *All Our Data are Pointing Toward a Radically Different paradigm for Suicide Research*, and so does David Klonsky, PhD, in his TED-style talk—given to a room

so crowded it was difficult to physically enter—titled *Suicide Prevention Is Stalled: Have We Been Doing It Wrong?* Finally, a debate between philosopher Peggy Battin, and psychologist Thomas Joiner—likely the best-known name at the conference—examines the boundaries of suicide itself, with the topic '*Physician Aid-in-Dying' is Not the Same as 'Suicide.'*

The rally stands in stark contrast to the conference—as the hotel basement ballrooms are replaced with a lawn basking in the late-afternoon sunlight and PowerPoint slides make way for banners, doubts regarding definitions, theoretical frames, and prevention approaches disappear in the face of directed confidence and enthusiasm. An hour of brief speeches given by representatives of various institutions wraps up with a chant lead by the AAS president-elect at the time, David Covington, and Dan Reidenberg, director of the National Council for Suicide Prevention and the executive director of the Suicide Awareness Voices of Education:

> DC: Dan, what do we want?
>
> DR: We want a $150 million to the National Institute of Mental Health to support suicide prevention research as outlined in the National Research agenda.
>
> DC: When do we want it?
>
> Audience: NOW. We want it now.
>
> DC: What else do we want, Dan?
>
> DR: We want the FDA to expedite the review and the approval process for new medications to treat those living with mental health conditions.
>
> DC: When do we want it?
>
> Audience: We want it now!

DC: What do we want, Dan?

DR: We want Congress to enact the Excellence in Mental Health and Addiction Treatment expansion[1] beyond its current eight state limit. So that certified community behavioral health clinics can improve access to and quality community healthcare.

DC: We want them to hear us up here. When do we want it?

Audience: We want it now!

DC: What else do we want, Dan?

DR: We want Congress to enact the National Suicide Prevention Improvement Act[2] to ensure the people in crisis can have access to comprehensive crisis services, phone hotline, text and chat services and that the quality and capacity of those crisis services meets the needs of all Americans.

DC: When do we need that?

Audience: We need it now!

DC: What do we want?

DR: We want Congress to invest in suicide prevention, to address the needs of adult suicide prevention, expansion of the Zero Suicide[3] pilot grants to behavioral health care settings, and development of CDC pilot programs and grants to implement and evaluate comprehensive community-based suicide prevention as well as improved tracking for special populations.

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[1] S. 1905 — To increase the number of States that may conduct Medicaid demonstration programs to improve access to community mental health services (in reference to the "Certified Community Behavioral Health Clinic" (CCBHC) model).
[2] H.R.2345 - National Suicide Hotline Improvement Act of 2018, includes designating a three-digit dialing code for the National Suicide Hotline.
[3] Zero Suicide initiative aims to prevent all suicide deaths within healthcare systems.

DC: When do we want it?

Audience: We need it now!

DC: What do we want?

DR: We want an end to suicide!

CD: When do we want it?

Audience: We want it now!

DC: Thank you.

Audience: [cheers, claps…]

(transcribed from a recording: AAS Facebook page, 2018)

While something special seems to be happening in these spaces, the most notable thing about them is that they are far from unique. The literature on suicide is rife with disagreements over methodologies, prevention approaches and definitions, and different community attempts to 'end suicide' appear again and again in different forms. Even as a rally in front of the Capitol, the 'First Annual National Rally to Prevent Suicide' is not really the *first*—over 20 years before, in May 1996, the "First Annual National Awareness Day for Suicide: A National Problem" held an event in the same exact spot (AAS, 1996). At the same time, it is clear that each instance of discourse on suicide—as much as it might be replicating a previous one—accomplishes *something* and in that has a particular function in the communities that it occurs in.

In fact, as I sought to understand the contemporary discourse on suicide[4] in a broader cultural and historical context, I noticed similar concerns and questions emerging, sometimes in very unexpected places. Contemporary arguments that frame suicide as exacerbated by capitalism or as ultimately a matter of social justice (Button & Marsh, 2019, Case & Deaton, 2020) seem to echo writings from the end of the 19th century which blame increasing rates of suicide on the fact that "a small number of the rich men have been able to lay upon the masses of the poor a yoke little better than slavery itself" (Ducey, 1894, p. 27) or that highlight the need to "protest against society, or those individuals who are absolutely responsible for the miserable conditions which drive men to desperation and ultimately to suicide" (Mowbray, 1894, p. 43). The death of Socrates grasps the attentions of philosophers in the modern times (Frey, 1978) as much as it did during his time (Plato, 1920/1892 in ESDA, Plato (c. 424-c. 348 B.C.), 2015), while the reflections on difficulties of living and the temptation of death seemed worthy of writing down even thousands of years ago (A Dispute Over Suicide, 1950 in ESDA, Egyptian Didactic Tale (c. 1937-1759 B.C.), 2015; Qu, 1985 in ESDA, Qu Yuan (c. 340-278 B.C.), 2015; or English Standard Version Bible, Job 3:20-26).

This broad history of discussions of self-inflicted deaths, make 'suicide' stand out as a seemingly unresolved—or maybe unresolvable—issue, one that emerges repeatedly and that each society might need to grapple with in their own way. Humans—whenever and wherever they might live,

[4] I use 'suicide' as well as other related terms such as 'taking one's own life' and 'killing oneself' without much attention to nuance in the introductory chapter. However, terminology itself is important to my work, and I discuss it in detail in Chapter 1, Section 3.1.

have always had the ability to take their own life and when they did, their act and their death would present significant challenges for the individuals in their community and the social order as a whole. Deaths that are intended and/or enacted by the deceased individual frequently emerge as a complex and high-stakes moral puzzle—drawing on questions of duty, agency and even the meaning of life itself. As such, these deaths have been capturing interests and imaginations of people throughout history and across the world. They have featured prominently in literature and have been extensively discussed by theologians, lawmakers, philosophers and, most recently, scientists, as they sought to determine *which* deaths we should be especially concerned with, *who* or *what* is responsible for those deaths, *what* the appropriate responses or consequences are when they occur and *who* has the authority to answer these questions.

Therefore, while 'suicide' has a very particular meaning today, it is not entirely possible to speak about the 'emergence of suicide as a problem' the way one might discuss, for example, trauma (Fassin & Rechtman, 2009), obesity (Saguy, 2012), attention deficit disorder (Lakoff A. , 2000) or child abuse (Hacking, 1991). Self-inflicted deaths seem to have always been a possible, if not an active problem, and this 'ubiquity' means 1) that in to understand contemporary suicide prevention and science of suicide, it is necessary to consider them as *instances of* a general class of societal attempts to grapple with the realities of certain kinds of problematic deaths, and 2) that analyzing this general class can give us insights into both *why* self-inflicted deaths might inherently be a moral problem and *what* strategies societies have at their disposal for grappling with such concerns.

Human lives are characterized by a series of challenges and difficulties. As we move through life, we face many existential decisions, high degrees of uncertainty and different kinds of pain and suffering. In navigating these, we rely on the knowledge and technologies made available to us by societies we live in. Stories and songs, religion, philosophy, laws and customs, science, and simply language itself—all of these cultural products and structures produce knowledge and meaning about the world around us, shaping our actions, beliefs and affect. Much of this process is implicit, but frequently we also draw on different cultural domains explicitly, especially when the everyday is disrupted by unusual or unwanted occurrences. In these instances, different kinds of discourse can be used to organize and 'contain' the disruption within existing structures of knowledge and values, making it a possible object of social and individual action oriented towards minimizing it.

It is these practices of 'containment,' and especially how they might interact with the scientific knowledge production, that I wish to examine through the problem of 'suicide.' I approach my investigation from two directions. First, I consider discourse on suicide-like phenomena across historical and cultural contexts to identify the sets of concerns that deaths like suicide raise, and which any discussion of those deaths must answer in order to successfully 'contain' suicide. In doing this, I also analyze contemporary understandings of suicide as an instance of this broader set of practices of containment. Second, I take a closer look at some of the specifics of contemporary 'suicide' that have not yet been addressed in existing literature: 'suicide' in the context of the political realm and social movements, and 'suicide' as a scientific object in an increasingly complex (inter)disciplinary context. Through this, I build on our existing understanding of the social construction of suicide, and examine the role of different institutional

structures in the shaping of contemporary attempts to grapple with complex moral problems such as suicide.

My work is informed by various data sources. I embarked on my investigation by conducting participant observation at different suicide conferences in the US, including the American Association of Suicidology (2018, 2019 and 2020), International Academy of Suicide Research (2017), and regional-prevention based Kevin's Song Conference (2017) and Suicide Prevention Coalition of Colorado's "Bridging the Divide: Suicide Awareness and prevention Summit" (2018). During this period, I was also subscribed to the AAS-affiliated suicidology listserv (and have also conducted some analyses of its archives), keeping track of ongoing developments in the field, I followed the AAS social media, and conducted interviews with 16 individuals, including current and past presidents of AAS. While these experiences feature in my dissertation in limited ways, they have motivated the project as a whole. In pursuing the answers to questions that were raised through my ethnographic experience, I have also conducted archival research (digitally and in the AAS offices), an analysis of various historical sources, and computational analysis of different sets of data, including NYT publications, suicide research funding, and publications on suicide. I provide an overview of my data and methods at the beginning of each chapter, and provide a more detailed description in Appendix A: Methods.

I structure the dissertation as follows. First, in the *Literature Review*, I provide an overview of existing work on 'suicide', identify some of the gaps in this literature and lay out the general theoretical framework for my dissertation. *In Chapter 1: Social construction of 'suicide' as a moral object,* I draw on a corpus of writings on self-inflicted deaths to examine what I argue are

two essential aspects of 'containment work': symbolic containment through boundary-drawing, and the containment of norm-destabilization through determinations of causality and ascription of responsibility, while contextualizing contemporary discussions regarding the definitions and causes of suicide within this broader set of discourses. Then, I present two more focused studies examining two separate aspects of contemporary 'suicide.' *Chapter 2: The development of 'suicide' as a public problem in the 20th century US* charts the institutional and political developments around suicide up to the Senate's recognition of suicide as a 'national problem' in 1997. I argue that although various organizational developments provided the necessary structure through which suicide got established as a public problem, the affective dimensions of suicide that mobilized communities and reconceptualization of suicide as issue that has broad-reaching impacts on others, and the nation as a whole, was what ultimately led to success of suicide as a problem. Additionally, I argue that the 'public problem' frame enables the State to contain concerns over suicide, while also moderating critiques of society as a causal factor in suicide. *Chapter 3: The (Multi/Inter)disciplinarity of the Production of Knowledge on Suicide*, endeavors to map out the scientific knowledge production about suicide over the past 50 years, showing evidence of significant 'individualization' of suicide in the scientific literature and highlights the ways professional authority can serve as a way of containing suicide as a particular kind of a problem. Finally, I close with a *Conclusion* that reviews the argument I build throughout my dissertation and then considers its broader implications.

Literature Review

The overarching question I ask in my dissertation is "How do societies in general, and contemporary US in particular, grapple with the phenomena of self-inflicted deaths?" As such, my work is in conversation with the existing work which examines 'suicide' as a socially situated phenomenon, including research on different practices of and attitudes towards suicide, as well as processes of knowledge production about suicide, spanning a variety of social science and humanistic disciplines. In this chapter, I first lay out the broad theoretical framework for the dissertation as a whole, noting that I provide more focused framing at the beginning of each chapter. I focus specifically on social constructionism, sociology of science and the interaction between science and phenomena deemed 'problematic.' Then, I review three different sets of existing work on suicide, highlighting some of the gaps in the literature and specifying the directions in which my own research expands and innovates on this previous work.

1. General Framework

In focusing on the discourse and structures through which 'suicide' is shaped as a phenomenon, I approach my subject matter through a lens of social constructionism. As I will discuss in more detail in the following sections, I share this approach with other scholars. The idea that the reality and the knowledge produced about it are socially contingent has shaped much of social science scholarship over the past decades, for example in sociology of knowledge (e.g. Berger & Luckmann, 1966), critical theory (e.g. Foucault, 1990/1976; 1995/1975;), science and technology studies (Kuhn, 2012/1962; Latour & Woolgar, 2013/1979), medical sociology and anthropology (Brown, 1995; Kirmayer, 1986) and many more. While the idea behind social constructionism is

not controversial in itself, there are tensions arising with regards to what kinds of phenomena are social constructed, and the extent to which they are constructed. A continuum emerges here between *realism* on one hand—the idea that there is an objective reality that can be discovered and accurately described through knowledge production — and *nominalism* on the other, which posits that what we take to be 'reality' is shaped by, or in the strictest sense, produced by, knowledge production as a social process. (e.g. Hacking, 1999, pp. 63-99). This tension is especially evident within the realm of phenomena that have to do with people, when any boundaries between the 'natural' and the 'social' are further blurred. Something like 'mental illness' for example is a highly contested object with some emphasizing it as a physiological pathology analogous to physical illness (e.g. see discussion in Harrington, 2019), while others analyzing it as a purely social category of 'residual deviance' (e.g. Scheff, 1966).

Hacking emphasized the special character of some of these phenomena in our social reality through the notion of 'human kinds,' which he elaborates as follows:

> When I speak of human kinds, I mean (i) kinds that are relevant to some of us, (ii) kinds that primarily sort people, their actions, and behaviour, and (iii) kinds that are studied in the human and social sciences, i.e. kinds about which we hope to have knowledge. I add (iv) that kinds of people are paramount; I want to include kinds of human behaviour, action, tendency, etc. only when they are projected to form the idea of a kind of person. (Hacking, 1995, p. 354)

Human kinds, he emphasizes, have "intrinsic moral values" (Hacking, 1995, p. 367), and "are formulated in the hope of immediate or future interventions in the lives of individual human beings" (Hacking, 1995, p. 352). Furthermore, these kinds affect the social world itself, and the individuals they are applied to, giving rise to what he calls "looping effects of human kinds" (Hacking, 1995). Hacking identifies five important aspects of the process of "making up people" which gives rise

to human kinds—including classification of people, actual individuals in these classes, institutions that "firm up" these classifications, knowledge produced about them, and the experts in charge of this knowledge (Hacking, 2007, pp. 288-89). Here, Hacking emphasizes the relationships between conceptual frameworks and institutional/professional structures, which is the line of inquiry I pursue in my work as well. Furthermore, much of his focus is specifically on the role of 'human sciences' in the construction of human kinds. The relationship between 'human kinds' and 'moral values' here is significant—science and morality in this case emerge as intrinsically linked.

In fact, while social constructionism as a lens can be applied to phenomena at different times and places—in fact, it is what characterizes the relativist approach in anthropology—its main focus is often on the contemporary context and the scientific and the professional realms, which is also an aspect of contemporary 'suicide' that I examine in more detail. It has been well established by scholars in the social science and beyond that knowledge is socially situated, and that scientific knowledge—a product of 'science' as a social institution (Merton, 1938; 1973)— is no exception. Jasanoff (2004) captures the interaction between (scientific) knowledge and society as a whole through the concept of co-production which she describes as

> "the proposition that the ways in which we know and represent the world (both nature and society) are inseparable from the ways we choose to live in it. Knowledge and its material embodiments are at once products of the social work and constitutive of forms of social life; society cannot function without knowledge any more than knowledge can exist without appropriate social supports. Scientific knowledge, in particular, is not a transcendent mirror of reality. It both embeds and is embedded in social practices, identities, norms, conventions, discourses, instruments and institutions—in short, in all the building blocks of what we term *social*. (emphasis in the original; Jasanoff, 2004, pp. 2-3)

Notably, there are limits to the kind of knowledge that science can produce, and the questions it can answer. On one hand, there are explicitly stated questions of right and wrong, of how to live and act, that fall outside of its purview (see e.g. Durkheim, 1995/1912, pp. 431-33). On the other hand, there are those questions, ones that frequently emerge in discourse on public issues, that Weinberg (1972) calls "trans-scientific." These are the questions that are "epistemologically speaking, questions of fact and can be stated in the language of science [but that are] unanswerable by science; they transcend science," and include questions in much of social sciences, the answers to which are limited by the complexity and unpredictability of human beings (Weinberg, 1972).

With these limitation of science in mind, there is a general understanding that "scientific understandings are frequently either intrinsically uncertain or diverse enough to be used to justify a range of competing political agendas" and "that in all but the most trivial of cases science cannot compel specific political outcomes" (Pielke, 2004). However, despite this, science is often "politicized" (Pielke, 2004) and the political is "scientized" (see e.g. Aronson, 1984, Harding, 1992), especially within the context of recognized social problems. Scientific work is often central to establishing the definitions and relevant causal chains (as well as 'primary causes' best suited for interventions) of particular problems. Woolgar and Pawluch (1985), for example, examining scientific literature on social problems, introduce the notion of 'ontological gerrymandering' to capture one of the central functions of this discourse. They find that "both theoretical statements and empirical studies manipulate a boundary, making certain phenomena problematic while leaving others unproblematic," even as the *apparent* goal is to "portray statements about conditions and behavior as objective." This kind of a process is embedded within Hacking's (1995 2007) aforementioned idea of the 'human kinds.'

However, ‘science’ is not a homogenous endeavor, and ‘scientific knowledge’ is not a monolith that interacts with the world in consistent ways. Rather, it is a dynamic collection of perspectives and approaches which are often conceptualized as ‘disciplines’ or ‘specialties.’ Examined with respect to concerns internal to science, disciplines are recognized as institutionalized communities built around shared cognitive structures (Whitley, 1974). Kuhn (2012/1962), writing from a nominalist perspective and building on his notion of paradigms as structures that “define the legitimate problems and methods of a research field” (p.10), sees particular disciplines as groups of practitioners governed by a paradigm (p.179) or a set of paradigms (p. 181). As such, “disciplines serve an important analytic purpose: namely, they break down into epistemologically manageable parts what is in reality an immensely complex world” (Carolan, 2008). Furthermore, they also structure social communities of scientists institutionally—organizing teaching, research and job markets through university departments and disciplinary conferences (Abbott, 2001, pp. 127-129, Hjørland & Hartel, 2003). At the same time, discussed with the attention to interactions between scientific knowledge production and society, disciplines are viewed more critically. Drawing on Foucault and Bourdieu, for example, Lenoir (1993) defines disciplines as “dynamic structures for assembling, channeling, and replicating the social and technical practices essential to the functioning of the political economy and the system of power relations that actualize it” (p.72). Disciplinary divisions, and disciplinary “ownership” of certain issues, therefore, become important factors in how issues are framed, understood, and addressed, that is, how they are ‘constructed.’

Finally, throughout my work I have started to develop a functionalist perspective, as I grew interested in the question of what a category like suicide, and the processes that bring it into being,

accomplish within a community. Durkheim, for example, posits 'society' as an entity with its own needs, with respect to cohesion between its members and stability of these relationships, and argues that to properly understand an aspect of society we must understand its function, that is the "social need it satisfies" (e.g. Durkheim, 2014/1893, p. 45). Social scientists in general understand culture, including socially constructed categories, as means through which humans make sense of our world and our individual selves, regulate behavior and interpersonal relationships, experience and manage emotions etc. (see e.g. Durkheim, 1995/1912; Geertz, 1973; Lakoff G. , 1990; Brown D. E., 1991). It is within this broad perspective that I have started to theorize 'containment' as a function of symbolic practices of defining and explaining suicide. More specifically, if there is something about deaths like suicide that presents a consistent issue for society as a whole, bringing up not only strong emotions but also complex questions about the value of life and meanings of death, this would make the idea of suicide, and suicide deaths themselves highly disruptive. In such a context, existing categorizations of deaths as good and bad, explanations regarding their causality and established social responses would function so as to contain these disruptions. While I am still developing this particular concept, the notion of 'containment' has become an overarching idea that binds the pieces of my work together.

To summarize, my overall interest is in the way a phenomenon like suicide is produced through discourse and social structures, including scientific knowledge production, and the kind of functions this 'construction of suicide' might have. In my analytical chapters, I expand on this in a few directions. In Chapter 1, I will think about social constructionism in the context of cultural universals, while paying more attention to understandings of causality and social ascription of responsibility, as I investigate whether there are any patterns to how suicide-like phenomena are

constructed. In Chapter 2, I focus on suicide as a 'social problem' from a perspective that does not aim to understand some 'objective realities' of a problem, but rather the processes through which something becomes an object of public and political concern, and in this I am guided by the sociology of social problem (Kitsuse & Spector, 1973). Finally, in Chapter 3, grounded in the understandings of the importance of disciplines in the shaping of knowledge, I focus on examining the landscape of scientific knowledge production with respect to the participation of different disciplines. These specific foci of my work have been motivated by particular gaps in the existing literature on 'suicide,' which I turn to in the following section.

2. PREVIOUS WORK ON 'SUICIDE'

Historical and cross-cultural perspectives on suicide are not new, and they feature prominently throughout the history of discussions of suicide. Philosophical and religious texts frequently made use of some well-known deaths, like that of Socrates[5] (e.g. Seneca, 1920 as excerpted in ESDA, Seneca (4 B.C. – 65 A.D.), 2015; Epictetus, 1944 as excerpted in ESDA, Epictetus (c. 55-c. 135), 2015; Moore, 1790, pp. 152-54), Cato[6] (e.g. Plutarch, 1919 as excerpted in ESDA, Plutarch (c. 46-c. 120), 2015; Sym, 1637, pp. 220,242; Flemming, 1773, p. 5), or Lucretia[7] (Augustine, 1871, pp. 28-30; Piggott, 1824, p. 153) in order to discuss morality of suicide, or different kinds of or attitudes towards self-killing at other times. Certain events, like the series of young women killing

[5] Greek Philosopher Socrates (c. 470-399 BC) was sentenced to death, but he drank the poison himself.
[6] Roman Senator Cato the Younger (95BC - 46BC) took his own life after Julius Ceasar—the two were vicious political opponents—won his civil war
[7] Roman noblewoman Lucretia (died c. 510 BC) who was raped and then took her own life after reporting the events to her husband and father.

themselves in Miletus in Sparta also makes a frequent appearance (e.g. Moore, 1790, p. 242; Miller S. , 1805, p. 69). References to suicide in distant places, most frequently India are also common, and can be found at least as early as the 11th century (e.g. Al-Ghazali, 1997 as excerpted in ESDA, Abu Hamid Muhammad Al-Ghazali (1056-1111), 2015; Battuta, 1929, pp. 190-193 as excerpted in ESDA, Ibn Battuta (1304-1368/69), 2015; Sym, 1637, pp. 192-93). Additionally, from its inception, the genre of the 'scientific suicide monograph', later developing into edited volumes, frequently includes discussions of suicide at other times and in other places (e.g. Winslow, 1840; O'Dea, 1882; Westcott, 1885; Durkheim, 1951/1897; Cavan, 1928). Much of this earlier work relies on sources of debatable quality, especially with respect to understandings of suicide in other cultures. However, significant work has been done in the past few decades, by historians and anthropologists, that—instead of using 'other suicides' as a rhetorical tool—focuses on other times and places in and of themselves. This work highlights how 'voluntary deaths' and 'acts of taking one's own life' have had different places in human lives and communities depending on the broader social and cultural context. This is not to say that history is always reviewed for its own sake—Marzio Barbagli (2015), for example, in his *Farewell to the world: A history of suicide*, ultimately builds a sociological theory of suicide, while Jennifer Hecht (2013), in her *Stay: A History of Suicide and the Philosophies Against It*, focuses specifically on tracing arguments against suicide, at least in part in order to construct a "a nonreligious argument against suicide." (p.5)

Having established my general theoretical framework, I move to examining previous literature that I am in conversation with, specifically the contemporary work. My goal here is twofold. First, I wish to present some of the ground that has already been covered so that I can build on it in my

own work. For example, much has been written about the broad transition of 'suicide' in the Western world from a set of disparate contextually understood phenomena, to 'self-murder' as a sin in Medieval times under the purview of the Church and concurrent conceptualizations of it as a crime, to medicalization of suicide as an outcome of insanity (see Section 2.3 for more detail). This overarching change is important in the understanding contemporary suicide, and it is important to acknowledge, but it is also not the exact focus of my work. Second, in reviewing this previous work, I also make note of some of its goals and scope, so as to specify the ways in which my project is distinct.

I structure my review into three broad section, roughly with respect to the primary focus of the authors, though there is clearly overlap across the three. First, I examine work that focuses on suicide across (generally Western) history, though I do note that this is quite a heterogenous set with respect to the ultimate goals of the work and even its place on the realist-nominalist spectrum. Then, I review some ethnographic records, emphasize some of the diversity in how suicide is 'social constructed' while also highlighting a lack of comparative work in this realm. Finally, I focus on a few scholars, including aforementioned Ian Hacking, who have grappled explicitly with the knowledge production about 'suicide,' specifically the way it has been taken up in the scientific and the professional realms.

2.1.Historical studies of 'suicide'

Most 'histories of suicide' have been written by classicists and historians, and they focus overwhelmingly on Europe. They cover three broad eras that are often explicitly contrasted with one another—the Antiquity of Ancient Greece and Rome (e.g. van Hooff, 1990; Hill, 2004) the

Christian Middle Ages (e.g. Murray, 1998 and 2000, Butler, 2006; McNamara, 2014), and the early Modern period in Western Europe (e.g. MacDonald & Murphy, 1990; Watt, 2004) which saw the transition from the medieval to contemporary conceptualization of 'suicide.' Taken together, they tell roughly the followings story:

Looking back to the ancient world, we find evidence of attitudes towards the acts of taking one's life that are quite distinct from the contemporary Western notions of suicide. Overall, two significant differences emerge. First, the acts in question are framed and expressed concretely in ways that emphasize context. Second, in most contexts that are discussed, these acts of self-killing are frequently praised as an honorable way to die. For example, in the few instances of self-inflicted death that appear in the Bible, these deaths are acts of vengeance, or acts of last resort in the face of an army's defeat. Across the Jewish antiquity intentional deaths were not condemned, though the mass-suicide of over 900 individuals, following a three-year siege of Masada did lead the Jewish leaders in 70 AD to speak against such fanatical martyrdom (Rosen, 1975, pp. 4-5). Voluntary deaths were similarly not denounced in the Ancient Greece and Rome, even though they featured much more prominently in literature, philosophical work, and as historically notable occurrences. Additionally, during this time, we see the acts of taking one's own life being increasingly framed in less agentic terms. Starting around 5th and 4th centuries BCE, the Greeks come to frequently posit these acts as forms of 'dying' rather than 'killing', speaking often of "dying by one's own hand," "grasping death" or, in case of what today we might term a lover's suicide, "perishing together." The Latin term, *mors voluntaria*, lit. voluntary death, continues this trend (Daube, 1972). Within this frame, choosing to die is often seen as a good and honorable death, if done under appropriate circumstances and exemplifying valued characteristics—for

example showing honor in a shameful situation, accepting one's inability to lead a happy life within a Stoic framework, or following an order to die with dignity instead of facing an execution (Tuominen, 2014; Grahn, 2014; Hill, 2004). In contrast, suicide of soldiers, slaves and criminals was generally disapproved of (Rosen, 1975, p. 11). These kinds of representations of intentional death as contextual and often admired are not unique—in fact we see fairly similar attitudes across Non-Western societies until, and sometimes even beyond, contact with the Western world.

The profound shift in the Western perspective towards an overall antagonism vis-a-vis the acts of self-killing is generally traced to the late Classical period and the early Middle Ages. Many factors seem to have contributed to this change: economic considerations, for example, likely led to prohibition of intentional death among servants, while contact with the pagan religions that were permissive of the practice likely influenced Christianity to advocate for the opposite (Rosen, 1975, p. 12). However, many scholars see the role of the religious leaders and philosophers as pivotal—in opposition to the acts of voluntary martyrdom, they came to condemn intentional death as an act of killing a person and, therefore, a sin. This position began to form following the self-sacrifice of Jesus Christ that, on one hand, glorified such death through the foundation of a new religion but, on the other hand, encouraged many of the religion's followers to follow suit. By the fourth century AD, the Christian fathers increasingly came to regard many of these deaths as false martyrdom, and increasingly struggled with ambivalence regarding self-inflicted deaths in other contexts. Then, in fifth century AD, St. Augustine clearly articulated a position against intentional death in his City of God, arguing that

> No man may inflict death upon himself at will merely to escape from temporal difficulties, (…) on account of another's sins, (…) on account of past sins, (…)

> out of desire to attain a better life which he hopes for after death. (St. Augustine, quoted in Minois, 1999, p. 27).

This condemnation is officially adopted by the Church through a series of councils in the sixth century, though it is not until the 13th century that we see evidence of clear sanctions of self-killing, when the Church refused to conduct a Christian burial into consecrated ground for those who killed themselves. Around that time, in addition to constituting a sin, the act of taking one's own life came to be seen as a crime as well, and civil law prescribed appropriate repercussions. This development of strong negative attitudes in late-medieval Europe was not simply a result of changes within the Church, but rather a nexus of understandings regarding the feelings of 'despair,' (Murray, 2000, pp. 374-395) legal considerations of 'intent' vs. 'action' as navigated through the distinction between canon and civil law (Murray, 2000, p. 415), concerns about 'pollution' as evidenced by preoccupation specifically with the methods used in acts of suicide (Murray, 2000, pp. 448-9), and ideas about the kinds of people who would break vs. uphold existing prohibitions against suicide (Murray, 2000, p. 452). As a result of these changes, across Europe, the body of the deceased came to be punished as a criminal might be, while the surviving family often had their property confiscated. However, while these sanctions might have had an impact on choices of nobility and their pursuit of a 'good death', the commoners continued to take their own lives (Minois, 1999, pp. 34-8).

Within this legal and religious system, the distinction between acting rationally and acting in insanity took clear shape, and ultimately played a crucial role in changing orientations towards self-killing. Though philosophers of the Ancient world have already acknowledged that insanity can drive a person to kill themselves, there was little practical reason to explicitly establish insanity as a cause of the act until the late Middle Ages. As most clearly exemplified in the English law, it

is during that time that two kinds of self-murder verdicts emerged: one was designated *felo de se*—Latin for 'felon of himself'—an illegal act that would result in a punishment of the deceased and their family, while the other was one designated as *non compos mentis*—'of unsound mind'—and was not followed with any sanctions. For centuries, the *non compos mentis* verdict was rare and self-murder was frequently punished across Europe. However, the 17th and 18th century brought yet another change: over the course of two hundred years, *felo de se* verdict became less common and ultimately quite unusual. For example, in 1660s in England, it constituted more than 90% of verdicts, and dropped to less than 10% by the 1710s (MacDonald & Murphy, 1990, p. 122), most likely due to the increasing secularization of societies, development of medicine, and the emerging concerns with human life and experience (see e.g. Minois, 1999; Watt, 2004).

This reorientation toward self-murder as a result of insanity is accompanied by two other moves that truly give birth to what will become the contemporary 'suicide.' First is the introduction of the word itself. The first abstraction of the act of 'murdering oneself' into the nominalized 'self-murder' or 'self-slaughter' is seen in Old English in the 16th century, a trend soon spreading to other European languages. Then, in the 17th century, as those who kill themselves are becoming absolved from the verdict of *felo de se*, the word 'suicide' makes an appearance (Daube, 1972). Etymologically tied to 'homicide,' and frequently employed in the compound 'commit suicide,' the new word still captured the prevailing sentiments toward self-murder but it also, as an abstract noun, came to further reify these acts as objectively same in their essence.

The clear categorization tied in with the second significant move that occurred in that period—the emerging practice of counting and classifying deaths. In the 18th century, the socio-political

contexts, as well as broader changes in power-regimes, led countries to see a great value in accurate numerical population data and to ultimately see this data as indexing quality of life and the moral values of a nation, resulting in the development of the field of moral statistics while suicide—an epitome of a social pathology—came to be understood as a countable phenomenon with objective external reality (for a detailed discussion of the relationship between suicide, moral statistics and national concerns, see Section 2.3 below). As a result, it became necessary to correctly classify a death as a suicide with respect to some knowledge about what a suicide is—not only for the sake of an individual and their soul, but for the sake of the new national project. This process shaped the meaning of counting deaths, as well as the meaning of suicide itself. (see e.g. Hacking, 1990, pp. 64-80)

While the existing literature tells a more-or-less coherent and continuous story, it is important to recognize that the authors approach their object of inquiry in different ways and with different goals. Some authors are strongly attuned to the social contingency of suicide, and the difficulties in making comparisons across different contexts, while others confidently make such comparisons. Hill (2004), for example, emphasizes the importance of social roles within the Roman society as central to understanding Roman 'suicide':

> The definition of "suicide" most relevant to the analysis of Roman discourse, then, is not 'any case of death resulting directly or indirectly from a positive or negative act of the victim himself,' because this focuses excessively upon the agency of death. The relevant definition is rather, "any death possessing implications for the social standing of the deceased." (Hill, 2004, p. 11)

He continues the discussion by focusing on the conception of the 'self' noting that

> [t]he *divergence* between modern Cartesian perspectives on the self and the concept of self that might profitably be used to render Roman discourse on

> suicide intelligible, however, *is so extreme* that the *difficulty of formulating a phrase capable of linking the two is severe*. (emphasis mine, Hill, 2004, p. 15)

In Hill's view, then, what might have been a category of self-inflicted deaths in Ancient Rome might be incommensurable with contemporary 'suicide.' In contrast, doing a close reading of 960 instances of 'self-killing' in Antiquity, van Hooff (1990), engages with the descriptions of these deaths at the time and shows how they were understood in a variety of ways, many quite familiar to the modern reader. The emphasis Hill (2004) places on 'social standing of the deceases' as central to Roman conceptions of suicide emerges in van Hooff's (1990) work as a focus on 'shame':

> Where modern observers would rather assume despair or grief as the predominant motive the ancient reporter was inclined to put shame in the forefront. The predominance of shame as a motive is the most important difference from the modern paradigm of suicide, which concentrates on internal motives like depression and feelings of guilt. (van Hooff, 1990, p. 120)

Ultimately, much of the work that does trace 'suicide,' including both methods by which individuals took their own lives, frequencies of those deaths and local attitudes towards these deaths, generally presuppose a stable sort of death that could then be followed across time. Some of this tension, as I will argue in the next chapter, has to do with the analytical categories used, and I propose to address some of these tensions by following not 'suicide' but rather the 'social construction of 'suicide'' across contexts.

Additionally, it is important to note that much of the historical engagement with 'suicide' ends with the 19th century. While some scholars write about developments past the turn of the century with respect to professional and scientific realms (see Section 2.3), the story of relevant political and social changes in the 20th century has yet to be told, which is what I take up in Chapter 2.

2.2. 'Suicide' in the ethnographic record

Notably, the story of 'suicide' that I have outlined above is not shared across the world. Even though, with increasing globalization, 'suicide' increasingly looks more similar across the world, it is generally recognized that culture plays a significant role not just in attitudes towards self-inflicted deaths, but in circumstances and forms of these deaths. For example, in some places, there are histories of so-labeled 'ritual suicides,' such as seppuku in Japan or suttee/sati in India that were not only approved of, but even socially demanded (Barbagli, 2015, pp. 191-219; Abrutyn, 2017). Ethnographic descriptions of small-scale societies further expand our understanding of forms 'taking one's own life' might take. For example, writing about the Pueblo peoples, Benedict (1934, pp. 117-18 as excerpted in ESDA, Pueblo, 2015) notes that "[t]he situation that to us parallels our practice of suicide occurs only in folktales" and is mostly interpreted by the Pueblo as an act of vengeance. However, the culture offers a seemingly institutionalized form of what Benedict calls a 'suicide pledge':

> In many of the tribes a man who saw nothing ahead that looked more attractive to him could take a year's suicide pledge. He assumed a peculiar badge, a buckskin stole some eight feet long. At the end where it dragged behind upon the ground it had a long slit, and the pledger as he took his pledged place in the forefront of their guerilla warfare was staked to his position through the slit in his insignia. He could not retreat. He could advance, for the staking did not, of course, hamper his movement. But if his companions fell back, he must stay in his foremost position. If he died, he at least died in the midst of the engagements in which he delighted. If he survived the year, he had won by his courting of death all the kinds of recognition that the Plains held dear. (Benedict, 1934, pp. 117-18 as excerpted in ESDA, Pueblo, 2015)

Lowie (1913, as excerpted in ESDA, Crow, 2015) describes a similar custom among the Crow:

> The [Crow] custom of seeking death as a Crazy Dog individually seems to be relatively old. When a man for some reason became tired of life, he announced himself a Crazy Dog. This implied that he must thenceforth "talk crosswise",

> that is, express the opposite of his real intentions and do the opposite of what he was bidden. His most essential duty, however, was to rush into danger and deliberately seek death. This obligation, curiously enough, was limited to one season. If at the end of this period he had by chance escaped death, the Crazy Dog was absolved from his pledge, unless he voluntarily renewed it for another season. (Lowie, 1913, as excerpted in ESDA, Crow, 2015)

The "taking of one's own life" also seems to exist in a somewhat obscured, though more intentional, fashion among the Hopi (Nequatewa, 1936, p. endnote 32, as excerpted in ESDA, Hopi, 2015)

> If a Hopi has enemies, or there is someone who is causing him great misery, he becomes so unhappy that he wishes to destroy himself. But he cannot do away with himself without "losing face" as the Chinese say, or in other words, losing his reputation as a brave man. Therefore, he looks about for someone, or some other tribe, who may be bribed to make a sham attack upon him or upon his village during which he will be killed. It is arranged with the enemy that he will be the first to rush out against them and as soon as he is killed the enemy will promptly retreat. Of course, a few innocent people may suffer in the melee, but this seems to be regarded only as a regrettable necessity.
>
> A man desiring to make arrangements for his suicide will meet secretly with the "enemy," taking him gifts and between them all the details of the affair will be arranged. It is agreed upon at this time that the victim shall wear all his valuables, such as strings of turquoise, etc., so that the hired assassins may thus receive the remainder of their pay from the body of the "victim." And so it is that the Hopi suicide makes a glorious end!

Furthermore, across cultures, we see local categories of 'suicide' encompassing sets of events or behaviors that are quite unlike the contemporary 'suicide', exposing differences in the conceptual structures surrounding self-inflicted deaths. For example, among the Maori, the word *'whakamomori'* which means "being desperate, or doing a desperate deed," although it is mostly used to denote 'suicide,' can also refer to a person leaving their home and family, a very different kind of tearing a person away from the social fabric (Johansen, 1954, as excerpted in ESDA, New Zealand, 2015) The category of 'suicide' among the Mojave,' as described by Devereux, also

seems to expand beyond contemporary 'suicide' and includes, for example, "certain stillbirths (…) which are believed to be caused either by the spontaneous unwillingness of a future shaman to be born, or else by the fact that the bewitched nonshamanistic fetus was taught by a witch 'the fatal trick' of killing both itself and its mother at birth," "[t]he death of a suckling who, because its mother is pregnant once more, has to be weaned suddenly and therefore allegedly makes itself sick from spite," "[t]he willing victims of witches" or the "straying of senior warriors into enemy territory" (Devereux, 1961, as excerpted in ESDA, Mojave, 2015)

Writing about the 'suicide of resolve' in Japan, Kitanaka (2008) notes that Japanese culture recognizes "different degrees of intentionality in those who commit the act—from a reckless desire for escape from an unbearable reality to a fully premeditated act," which foment different reactions to the said death. Japanese language, in fact, provides a very rich 'vocabulary' for suicide, including the aforementioned suicide of resolve (覚悟の自殺, *kakugo no jisatsu*), double/lovers' suicide (心中, *shinjuu* or 情死, *joushi*), suicide due to bullying/harrassement (いじめ自殺, *ijime jisatsu*), suicide due to overwork (過労死自殺, *karoushi jisatsu*) etc. Acts frequently discussed as 'a type of suicide' in western literature, such as the ritual *seppuku* (切腹, lit. cut-belly) or *junshi* ('following one's master into the grave', 殉死 lit. martyrdom-death), are also linguistically distinct from the idea of 'self-killing' (*jisatsu*).

The above review is certainly not comprehensive, but serves to illustrate a diversity of 'suicides' in the world. Across time and place, individuals contribute to their deaths in different ways, for different reasons, and communities, structure these acts and deaths into different sets of categories and establish diverse sets of attitudes towards them. Despite this diversity, however, there has not

yet been an attempt to conduct a comparison across these contexts, in the vein of some of the historically comparative work that I have discussed in the previous section. The only cross-cultural study that I am aware of, utilizes the eHRAF World Culture corpus to test different evolutionary theories regarding what causes suicide, and is not interested in what 'suicide' might mean across the different contexts (Syme, Garfield, & Hagen, 2016). While this is not something I take up in this dissertation, as my main focus is in primary sources as opposed to ethnographic writing, it is an important gap and direction for future research.

2.3. 'Suicide' in the scientific and the professional realm

Alongside the examinations of 'suicide' in different cultural and historical contexts more broadly, there is a small set of works that is focused specifically on how 'suicide' interacts with the institutions of science and medicine. I have already referenced some of this literature in section 2.1 when I discussed history of 'suicide' in the West, which often ends with the medicalization of suicide. As my dissertation is closest to this literature in its underlying goals and focus, I wish to focus on a few specific scholars here, and highlight the ways in which I wish to expand on their work. I open with more general work that focuses on social construction of suicide, then I discuss some reflections on the engagement of scientific disciplines with the topic of suicide, and end the section with a review of work on suicide classification.

Taking my general framework into account, it is prudent to open with work by Ian Hacking, a philosopher of science, who has taken up 'suicide' as an example across his writing (1982; 1990 1995; 2002; 2007; 2008) in order to illustrate significant changes that occurred in the 18th and 19th century Europe. Building on Foucault's notion of biopower and its two poles the "anatamo-politics

of the human body" and the "biopolitics of the population," (Hacking, 1982), Hacking examines two processes that shaped contemporary suicide. In this, he recognizes both a universality and a social contingency of suicide:

> Suicide has of course attracted attention in all times and has invited such distinguished essayists as Cicero and Hume. But the distinctively European and American pattern of suicide is a historical artifact. Even the unmaking of people has been made up. (Hacking, 2002, p. 113)

This 'artificing' of suicide occurs with respect to the medicalization of suicide—in the realm of the 'anatamo-politics'—and the counting of suicide as a tool of the 'biopolitics of population.' In terms of the medicalization, that is the understanding of 'suicide' as a medical problem and the changes that brought it under the purview of the medical profession, Hacking characterizes the medical logic of the early 19th century as follows "a) madness is medical. (b) Suicide is madness. So (c) suicide is medical. But (d) all disease is organic. So (e) madness is associated with organic defects. So (f) suicide is associated with organic defects" (Hacking, 1990, p. 69). In terms of enumeration, Hacking makes note of 'statistics enthusiasm' that blossomed in the period of 1820-1840, as an "overt political response by the state" to developing revolutionary sentiments. He described the overall efforts as follows:

> Find out more about your citizens, cried the conservative enthusiast, and you will ameliorate their conditions, diminish their restlessness, and strengthen their character. Statistics, in that period, was called moral science: its aim was information about and control of the moral tenor of the population. The motives were genuinely philanthropic, but that, as we have come to realize, means that they aimed at the preservation of the established state. (Hacking, 1982, p. 281)

Notably, counting of suicide as subjected to some 'general laws' and an indicator of community pathology, was of significant interest to the moral statisticians at the time (Hacking, 1990), and Hacking even credits 'suicide' with giving rise to numerical sociology (Hacking, 1994).

Hacking's focus, however, is not so much on understanding 'suicide' as much as it is on the 18th and predominantly 19th century developments that gave rise to a whole new orientation towards matters of society and individuals lives. He therefore pays little attention to social construction of suicide across other contexts, or organizational and political developments after 19th century, both of which I take up in my work.

In contrast to Hacking's interest in broader developments, Ian Marsh, also writing from a Foucauldian perspective, focuses on suicide explicitly in his *Suicide: Foucault, History and Truth* (2010). The central thesis of the book is that current understandings of suicide do not represent a 'truth' that has been *discovered* and reported on, but are in fact a 'truth' that has been *produced* through historically contingent sets of scientific and medical practices. Marsh describes the current 'regime of truth' as that of a "compulsory ontology of pathology in relation to suicide'' (p. 28) which "makes (…) difficult the development of other ways of constituting suicide and the formation of alternative objects, concepts and subjectivities in relation to self-accomplished death." (p.66). This 'truth' is produced through established concepts, authoritative text, practices such as the 'psychological autopsy' —the goal of which is to understand the mental state of the deceased— media accounts etc. The effects of this 'truth,' Marsh argues, are just as broad: it shapes "suicidal individuals" into "passive victims of illness processes that may push them into self-destructive behavior", while positioning clinicians as "responsible and accountable for the actions of their patients" (p.57); it emphasizes the mental-health approach to suicide as the best course of action while constituting mentally ill as a "potential risk" to themselves; it negates the value of knowledge produced by "non-specialists;" and it forecloses or marginalizes "alternative readings of suicide,"

e.g. viewing it not as an action of a "victim of mental illness" but a "'free-choosing' autonomous individual" erasing questions about the politics of autonomy (p. 72) or conceptualizing suicide not as "statements concerning the internal, mental state of isolated individuals" but as a "outcomes of a play of culturally situated, relationally unequal forces" (p.74) which would bring suicide into the domain of 'social justice.' All of these processes, Marsh argues, might negatively impact suicide prevention efforts, or increase the suffering surrounding suicide. Marsh' primary goal, then, is not the understanding of how and why 'suicide' is socially constructed in particular ways, but is, rather, a critique of the contemporary construction of 'suicide.'

Marsh bolsters his characterization of the present 'regime of truth' by employing a Foucauldian approach to the past. Focusing specifically on the period between the 17th and the 21st century, he traces the shift from 'sin to insanity' as well as development of scientific and clinical engagements with suicide. In this, his work is similar to Hacking's though a bit more expansive—Marsh offers some commentary on 'suicide' in Roman times, to offer a contrast with the contemporary regime, and continues some of his discussion into the 20th century, focusing specifically on the dominance of the "monolithic" discourse on suicide in the 'psy-sciences' (psychiatry and psychology, see Rose, 1988).

This focus on professional authority and disciplines with respect to suicide is evident in other works, and is one of the central lenses through which constructions of suicide post 19th century are discussed. Howard Kushner, (1991), for example, traces interactions between different scientific perspectives on suicide over time, and critiques the lack of synthesis between them:

> Sociologists have claimed that suicide is a social disease, psychoanalysts have assumed it results from intrapsychic conflict; while neuropsychiatrists have

> insisted that suicide is an organic disorder. Although protestations have appeared regularly from members of each profession asserting that they have considered the insights of the other, the demands of professional orthodoxy have made it difficult for a true synthesis to emerge from the ranks of any of the three specialties. Yet, without such synthesis, we will have moved no closer to the answers we seek than Durkheim, Freud, and Kraeplin had almost a century ago. (Kushner, 1991, p. 90)

Similarly, reflecting on the contemporary state of affairs, Maung (2020) argues that, beyond professional orthodoxy, what keeps the disciplines apart and restricts integration are epistemological incommensurabilities, specifically regarding approaches to causality and the conceptualization of mental disorders as evident in the differences between "psychological autopsy studies, epidemiological studies, biological studies, and qualitative studies." In contrast, however, Fitzpatrick, Hooker and Kerridge (2015) assert that despite apparent "conflict between competing disciplines and sub-disciplines and the limitations of particular methodologies in the study of suicide (…) the basic approaches to research are markedly similar regardless of disciplinary background."

The degree to which disciplines shape knowledge on suicide is further complicated by heterogeneity of disciplines being examined. Within discussions of medicalization of suicide and mental illness, most attention is dedicated specifically to the field of psychiatry, or sometimes to the field of 'psy-sciences' (Rose, 1988; Marsh, 2010). However, even though the psy-approaches are often discussed as a monolith, it is important to note that distinct frameworks have existed—and have been battling over professional authority—within the 'mental health' professions for nearly a century, if not longer. Kirmayer (1986) and Pols (2001) highlight three distinct approaches to mental health overall, and within the field of psychiatry itself: 1) biological or somatic, 2) psychological, with a focus on an individual approach to overall mental well-being, and 3) social,

advocating social reconstruction as the most important approach to mental health. Along these same lines, there are also tensions within individual psy-professions (Benjamin L. T., 2005) as well as between researchers and practitioners (Miller R. B., 2001). The tensions above appear as kinds of "fractal distinctions" (Abbott, 2001, p. 10), that is the re-production of particular dichotomies across different levels of analysis. I make a note of these to emphasize the need for caution when making statements about disciplinary assumptions and commitments. Any discourse on disciplines makes certain kinds of generalizations and can, in itself, be viewed as oriented towards some goal or another—whether it is to claim that most approaches to a topic are similar, or that they are incommensurable.

While disciplines clearly shape contemporary 'suicide,' the broad conceptual discussions offered by the scholars above are not oriented towards capturing the scientific study of suicide as a whole, nor are positioned to trace any developments into the current time: Maung (2020) and Fitzpatrick et al's (2015) work is synchronic, while Marsh (2010) and Kushner (1991) end their discussion in the 1980s. Through my publication analysis in Chapter 3, I aim to provide an analysis complementary to this previous work, trading the detailed reading and context for a dynamic big-picture view.

Finally, in line with Hacking's emphasis on contemporary 'suicide' as constituted through the counting suicides and the production of suicide rates, various scholars have long been interested in these processes and how they might be affected by the social context they occur in. Much of this work grapples with the question of whether some 'actual' number of suicides is underreported due to different biases in the classification processes (see Pescosolido & Mendelsohn, 1986 for a

general discussion), with concerns ranging from some broader considerations of underreporting due to stigma, to more specific questions regarding misclassification of particular kinds of deaths, such as single-car accidents (e.g Connolly, Cullen, & McTigue, 1995) and drug self-intoxication (Rockett, et al., 2014) or misclassifications of deaths in groups of individuals due to their gender (Canetto, 1993) or ethnic or racial group (Rockett, et al., 2010). In this literature, social factors and overall uncertainty that affect death classification are highlighted, but generally without problematizing ambiguities of suicide definition and with the goal of 'correcting' misclassification. In contrast, some sociologists discuss 'suicide' as an interactionally constructed category, highlighting not just the 'social construction' of suicide rates, but of the phenomenon itself.

For example, Douglas (1967, pp. 163-231), critiquing existing sociological work on suicide, cautions researchers in their use of official suicide statistics as he recognizes the statistics themselves as a product not just of individual observers' determinations—which are inherently uncertain—but also of local understanding of what kinds of deaths are suicides—an understanding that might be at odds with the researcher's definition. He notes:

> [It] is a fundamental part of the argument of this work that there does not exist such a thing as a "real suicide rate.: Suicides are not something of a set nature waiting to be correctly or incorrectly categorized by officials. The very nature of the "thing" is itself problematic so that "suicides" cannot correctly be said to exist (i.e. to be "things") until a categorization has been made. moreover, since there exist great disagreements between interested parties in the categorizations of real-world cases, "suicides" can generally be said to exit and not exist at the same time, though this might seem a rather incongruous way of putting it. (Douglas, 1967, p. 196, footnote)

Timmermans (2007) captures this sentiment of the ambiguity of 'suicide' in his ethnographic study of a medical examiner's office, in which he discusses the complexity of factors that come into play when examiners determine causes of death, including suicide. Timmermans shows how the medical examiners negotiate the stigma of suicide and two seemly opposing pressures: the public health officials who suspect underreporting, and relatives who accuse them of over reporting (p.81). In case of equivocal deaths, they navigate this space by closely engaging with all of information available to them, as well as their knowledge and intuition, inductively building a case for or against a suicide determination. Still, when a case is unclear, the examiners might prefer to err on the side of non-suicide—as one examiner puts it "You owe that to the family and the decedent." (p.96). Timmerman's analysis is also theoretically powerful—beyond positing a 'social construction of suicide' he notes three very distinct notions of suicide that coexist and sometimes clash: the biographical suicide (as conceptualized by the survivors), the suicide as a statistical rate (as it emerges for the epidemiologists and public health officials) and medicolegal suicide (as assembled by the medical examiners) (p.107.). "The coexistence of three notions of suicide means," he argues, "that suicide as an entity independent of claims makers does not exist. Whatever phenomenon we classify as "suicide" reflects the criteria and work practices of the classifier." (p.109) It is important that this is not just a theoretical stance, but an empirical finding, illustrating the value of doing this kind of qualitative work both for our understanding of suicide and for our understanding of the processes of knowledge production.

While I am not engaging with the micro-sociological practices of suicide classification, I see my work as directly contributing to claims made by Douglas and Timmermans. Specifically, as I discuss current definitions of suicide in Chapter 1, I will highlight the inconsistencies in attempts

to define ‘suicide’ and argue that the definitions are unstable because they include moral judgments. In engaging with this material, I keep in mind the embeddedness of the process of classification itself in the broader context.

3. SUMMARY

As I try to understand contemporary ‘suicide’ I broadly follow the social constructivism lens. That is, I ask about the ways particular categories and understandings of ‘suicide’ emerge and how they interact with the social context they emerge in. This approach builds on and takes much inspiration from previous work on the topic, which has examined ‘suicide’ across different historical and cultural contexts, with respect to social changes and developments in medicine and science. Ultimately, I will be expanding on this previous work in three directions: 1) in terms of the breadth of data, as I will focus on a great diversity of texts of suicide as well as a very large corpus of scientific publications on suicide, which will enable me to examine different kinds of trends, 2) temporally, as I will focus on some of the more contemporary developments that have not been previously examined, and 3) theoretically, as I will expand my analysis into the questions of ascribing responsibility, suicide in the political realm, and the role of affect in shaping ‘suicide.

Chapter 1: Social construction of 'suicide' as a moral object

1. INTRODUCTION

There is little ambiguity about what 'suicide' is in contemporary discourse. An online search for 'suicide' predominantly returns simple factual information about the phenomenon, e.g. "Suicide is the third leading cause of death in 15-19-year-olds" (WHO, n.d.b) or "Suicide is a major public health concern" (NIMH, 2021). The websites of some suicide-specific organizations, such as the AFSP (the American Foundation for Suicide Prevention), AAS (American Association of Suicidology) or IASP (International Association for Suicide Prevention), offer no definitions whatsoever, while others, like the CDC, offer only a brief description, "Suicide is death caused by injuring oneself with the intent to die," (CDC, 2021) mimicking the equally pithy opening line of the Wikipedia entry: "Suicide is the act of intentionally causing one's own death"(Wikipedia, n.d.). The media similarly present 'suicide' as a very clear referent, letting us know that so-and-so's death was ruled a suicide, and asking, for example, "Will the Pandemic Result in More Suicides?" (Tingley, 2021) or "Can an Algorithm Prevent Suicide?" (Carey, 2020). And while there exist significant concerns about accurate *classification* of suicides (see e.g. Rockett, et al., 2010; Rockett, et al., 2014), these often presuppose a stable meaning of 'suicide'—the uncertainty is generally framed as a result of imperfect information.

Notably, 'suicide' today is also contrasted with other kinds of 'self-inflicted deaths,' often times based on the understanding of the primary causes as categorically different. For example, 'suicide terrorism' is very rarely discussed as 'a kind of suicide' but is generally seen as a 'kind of terrorism,'

and scholars have argued that evidence suggests suicide terrorists are not, in fact, "suicidal" (Townsend, 2007). "Physician assisted suicide" has also been reframed as 'Physician-Assisted Dying' (or 'Physician Aid-in-Dying')—the American Association of Suicidology has published a statement in 2017 explaining why "'Suicide' is not the same as 'Physician Aid in Dying'" (AAS, 2017) and these deaths are recorded on death certificates not as 'suicides' but as natural deaths, with the underlying disease marked as the cause of death (see e.g. DC Department of Health, 2017). The boundaries drawn here are intertwined both with how these deaths are evaluated as good (PAD) or bad (suicide and suicide bombing), and with the ideas regarding what should be done about the 'bad' set (suicide prevention vs. anti-terrorism efforts).

At the same time, also with respect to understandings of causality and common etiology, 'suicide' is discursively integrated into concerns with some broader phenomena, e.g. in investigations of 'suicidal and (non-suicidal) self-injury' (e.g. Nock, 2014); alongside alcoholism and drug-abuse, in the new notion of 'deaths of despair' (Case & Deaton, 2020); or, maybe most notably, in conceptualizations of 'suicide' as a symptom of mental illness, or as a kind of a mental illness in itself, in the form of the 'suicide behavior disorder' (see e.g. Fehling & Selby, 2020). Each of these different lenses not only emphasizes a different approach to prevention, but can, at least implicitly, lay blame for suicide deaths onto different entities, from state policies and capitalism, to inadequate access to mental health care and unavailability of medication.

It is clear then, that 'suicide' is socially constructed—both the boundaries around the deaths that we have come to call 'suicide,' and the way we understand these deaths are contingent on the broader socio-political context:

> Suicide has of course attracted attention in all times and has invited such distinguished essayists as Cicero and Hume. But the distinctively European and American pattern of suicide is a historical artifact. Even the unmaking of people has been made up. (Hacking, 2002, p. 113)

Yes, contemporary 'suicide' is 'made up' but Hacking's first point is equally important: suicide has been a matter of some concern across human history. And, in fact, in each particular context, there is a unique 'suicide' that emerges, as good deaths are distinguished from bad deaths, and the 'bad' deaths necessitate some kind of a social response. As historian Miriam Griffin asserts, "there has probably never been a social code that has sanctioned [suicide] absolutely *without conditions*" (Griffin, 1986, p. 2, emphasis in the original).

Therefore, to understand contemporary 'suicide,' it is important to examine not just the way in which it is unique —something scholars have documented extensively—but also to understand it as just one of the many instances of other constructions of 'suicide-like' phenomena. This is the task that I take up in this chapter. I posit that discourse that categorizes and explains instances of self-inflicted deaths is part of the process that 'contains' moral concerns about these deaths, and structures the social and emotional responses to them. In considering the definitional processes, I pay specific attentions to the kinds of deaths that are singled out as 'bad', versus those that are considered permissible or even honorable, as I ask whether there are any patters in where and how these boundaries are drawn. I argue that that any commonalities might point to similarities in the function of cultures while also providing a structure through which we can better understand some of the tensions in today's discussions of suicide. My focus on explanations and blame is motivated by two things: first, the understandings of what causes a suicide are an aspect of the meaning 'suicide' has in a particular context. Second, as I will further discuss in the literature review, understandings of causality are a crucial aspect of the process of blame and assigning responsibility,

which shapes social responses to suicide. As I have discussed in the previous chapter, existent literature has contrasted different understandings of causality across different contexts, from the emphasis on specific life circumstances, to the influence of the Devil to mental illness, but has not systematically examined differences and similarities in how responsibility is ascribed with respect to these understandings. I, therefore, build on this previous work by mapping out a set of possible loci of blame, and identify a modern innovation—blaming 'society'—which has not been previously theorized within the literature on suicide.

The chapter is organized as follows. First, I engage in more detail with some of the literature I have reviewed in the previous chapter, highlighting tensions which have prompted my analytical approach. Then, I lay out this approach, which introduces a new analytical category of 'ipsal deaths,' as well as my data and methods. My analysis proceeds in three parts. In the first section I characterize the contemporary discussions of 'suicide' with respect to disagreements regarding definitions and causality. I focus mostly on the scientific discourse, not only because it is so tightly connected to overall understandings of 'suicide' but to show how scientific discourse often actively engages with moral concerns about suicide. This first section offers relevant context for the reader, expanding on my introduction, and motivates my inclusion of scientific discourse alongside other realms of knowledge production. In the second section, I then focus specifically on boundary drawing across the space of ipsal deaths, emphasizing three common concerns that emerge frequently—a duty to live, considerations of individual agency and intent, and contexts that can suspend the duty to live. Finally, in the third section, I offer a discussion of three broad understandings of causality with respect to different loci of blame and responsibility that they give rise to. I close with a discussion that summarizes my main findings and contemplates their

implications for our understanding of contemporary 'suicide' and the scientific study of the phenomenon.

2. Literature Review

In reviewing relevant previous work, I build on the foundations that I have laid out in the dissertation's *Literature Review*, and especially my discussion of existing work on historical and ethnographic discussions of 'suicide.' I have already shown that much of this work acknowledges that the understandings of 'suicide,' as well as the shape suicide deaths take is contingent on local contexts. However, I have also noted that the literature either emphasizes differences in 'suicide' across contexts, or focuses on the ways different factors shape suicide in a particular context. That is to say, there has not been a systematic effort to map the patterns of, or organize the diversity in, different constructions of 'suicide,' which is what I endeavor to do in this chapter. In doing this I take up two questions that are not explicitly addressed in the literature on suicide, but which I consider to be crucial in understanding it as a phenomenon. First is the question of universality of some phenomena that are disruptive to human lives and societies—including deaths overall and self-inflicted deaths specifically—and the role culture and categories play in 'containing' these disruptions. Thinking more broadly about practices of categorization is what motivated my focus on boundary-drawing as one of the objects of my analysis. Second is the question of blame and responsibility in the context of social responses to bad events. While the current literature on suicide often discusses changing attitudes towards suicide, with respect to tolerance, approval or disapproval, as well as changing idea about what causes suicide, the focus on blame enables me to combine both of these features and tie them to social action, also laying ground for the next chapter,

in which I pay close attention in how political and causal responsibility for suicide are discussed in the 20th century US.

2.1. Universals, culture, and boundary making

Although there are significant debates surrounding both the nature and extent of 'human universals,' as well as the value of studying them, various commonalities across human cultures have been recognized. These include, for example, sets of linguistic features and patterns of classifications, facial expressions and emotions, kinship structures, conceptions of personhood (such as intentionality and responsibility), notions of social roles and duties, distinctions between in-group and out-group, existence of child-rearing and division of labor, presence of systems of governance and rules and laws (especially with regards to violence, rape and murder), as well as practices oriented towards healing and preventing misfortune or death (Brown, 1991). Scholars have also proposed a "Universal Moral Grammar," noting significant cross-cultural similarities in the structures of moral judgment, including shared notions of concepts such as "obligatory, permissible, and forbidden," distinctions based on "causation, intention and voluntary behavior," as well as analogous structures in "all systems of criminal law" (Mikhail, 2007). There are various explanations as to why these universals might exist, and it is likely that there are sets of universals with distinct etiologies—some being closely tied to our biology, others being a response to shared needs or environmental challenges, while some possibly being a result of our migratory histories. (see Brown D. E., 1991: Chapter 4 for a more detailed discussion).

Notably, the significant common denominator across human societies is that we have, and significantly rely on, some sort of a culture. As Geertz (1973) puts it—quite colorfully—we are

'incomplete or unfinished animals who complete or finish ourselves through culture.' He argues that:

> "our central nervous system (…) is incapable of directing our behavior or organizing our experience without the guidance provided by systems of significant symbols. (…) Such symbols are thus not mere expressions, instrumentalities, or correlates of our biological, psychological, and social existence; they are prerequisites of it." (Geertz, 1973, p. 49)

Ultimately, then, we would expect culture, including social norms, systems of value and meaning etc., to facilitate individuals and communities in facing a variety of predictable as well as unpredictable challenges they might face in the world, by guiding us in making sense of various events and shaping our behavior accordingly (also see Malinowski, 2015/1944 and Durkheim, 1995/1912)

For example, pertinent to the focus of my work, sociologists and anthropologists highlight death as a universal and complex problem for human experience and societies (e.g. Blauner, 1966; Palgi & Abramovitch, 1984; Kearl, 1989; Kellehear, 2007). On one hand, death is very disruptive of the life of family/loved ones or even the community as a whole, and the awareness of death and mortality can significantly shape individual action. On the other hand, death is inevitable, and cultures, without exception, develop means of containing its practical, emotional, and other effects, through ritual, institutions, beliefs etc. Some of this work is done through implicit or explicit categorization of deaths into 'good' and 'bad'. While we see differences across cultures in what it means to 'die well,' and even the extent to which 'death' is perceived as a negative event, the idea that some deaths are 'better' or 'more acceptable' than others is common across cultures (Seale & van der Geest, 2004). Furthermore, scholars have noted that, despite various differences in these perceptions,

> [s]ome ideals about dying well seem nearly universal: a death occurring after a long and successful life, at home, without violence or pain, with the dying person being at peace with his environment and having at least some control over events. Conversely, ideas of bad death also have a remarkable overlap in very divergent cultures and societies. (Seale & van der Geest, 2004)

Drawing on work by Berta (Berta, 2001), Kellehear (2007, p. 87) characterizes this 'good death' as "a death [that] follows recognisable and sanctioned patterns and characteristics. Not to follow these patterns, for example in the case of suicide, is a breach that is religiously and socially punishable." In contrast to good deaths, which "[affirm good lives and social relationships," bad deaths

> represent an affront or breakdown of these relationships. Bad deaths do not permit a settling of debts and obligations; they do not allow one the controlling role in setting one's social and economic affairs in order. Bad deaths promote disorder." (Kellehear, 2007, p. 94)

Beyond the context in which the death occurs, understandings of what caused a death are also tightly entwined with categorizations of death as 'good' or 'bad' and the structuring of social responses to it. This is well evident, for example, in the way categorizations of death have been institutionalized in modern times through practices that classify each death by its cause and 'mode': natural, accident, suicide and homicide. The category of "natural" contrasts with others, 'unnatural' deaths that require further investigation and are incorporated into other institutions. This is not to say that all 'natural' deaths today are viewed as good (in fact, many are not), but to highlight that deaths exist in the moral realm not just with respect to the process of dying, but also as potential consequences of human actions—a concern a take up in the following section.

Importantly, 'capability for self-murder' is also recognized as a human universal (Antweiler, 2016, p. 94). This however, does not mean that self-inflicted deaths will be of concern in each and every

society. It is understood that some universals, even if occurring in all societies, might be occurring very rarely and that low incidence rates might mean that a certain trait or trait complex might not appear for generations, especially in small-scale societies (Antweiler, 2016, p. 194). At rates measured per 100,000 a year, suicide could be completely absent from any living memory in some contexts. While, like with other universals, there are disagreements as to the etiology of this capacity to knowingly participate in bringing about our own death (Catanzaro, 1984; Syme, Garfield, & Hagen, 2016; Soper, 2018), there is no evidence that would indicate that this capacity might not be universal. As such, we would expect many cultures to, in some way, include self-inflicted deaths into their schemas of dying, or of human action overall. While these deaths do not necessarily contain some 'essence' that would make them stand out as a special category of death that stands in contrast to some other kinds of deaths, it is notable that they often do emerge as such, as is evident from my review in the previous chapter.

Overall, categorization is a process that has received significant attention from various social scientists and other scholars, especially with regards to the shaping and organizing of human experience. Lakoff (1990) for example, writes:

> "Categorization is not a matter to be taken lightly. There is nothing more basic than categorization to our thought, perception, action, and speech. Every time we see something as a *kind* of thing, for example, a tree, we are categorizing. Whenever we reason about *kinds* of things—chairs, nations, illnesses, emotions, any kind of thing at all—we are employing categories. Whenever we intentionally perform any kind of action, say something as mundane as writing with a pencil, hammering with a hammer, or ironing clothes, we are using categories. (Lakoff G. , 1990, pp. 5-6)

Many categories are, Lakoff asserts, at least to an extent contingent on the physical world. However, social and cultural realities are not understood and described through categories, but are

rather *produced* through them (Lakoff G. , 1990, pp. 207-8), which is ultimately the idea central to social constructivism.

Examining the commonalities across processes of categorization, scholars have placed significant emphasis on distinctions and boundaries between categories. As linguist Ferdinand de Saussure, noted, "concepts[8] are purely differential and defined not by their positive content but negatively by their relations with other terms of the system. Their most precise characteristic is in being what the others are not" (Saussure, 1915/1966, p. 117). This particular understanding of how categories work in general—that is, that the meaning is established relationally through distinction—formed some of the foundation of both structuralist and post-structuralist theory, and the focus on boundaries and boundary-work emerges frequently across the social sciences. It is this general tradition that I follow in my focus on boundary-drawing practices around 'suicide.'

2.2.Causality and blame

In order to understand the meanings categories like 'suicide' take in different context, it is necessarily to more closely look at the ideas regarding what causes suicide— and what these understandings of causality mean for how instances of 'suicide' should be taken up in social action. Specifically, if seen as a bad death, or an overall bad event, instances of self-inflicted deaths are likely to trigger attempts to explain the said deaths, and ultimately assign blame and guide action that would constitute a social repair.

[8] 'concepts' and 'categories' are very closely related ideas, 'concepts' are generally defined as mental representations of categories (Van Mechelen & Michalski, 1993)

In their review of the construct, Malle, Gugliermo and Monroe (2014) define blame as a particular kind of a moral judgement that is activated solely by negative events and evaluates agents as morally responsible for the said event. They distinguish between the (individual) 'cognitive' and 'social' blame, while acknowledging that 'cognitive blame is critically constrained by and inherits properties from social blame.' Further they point out that 'blaming and praising people for their behaviors is a key mechanism to implement (…) patterns of social-cultural regulation" which enables the "fulfillment of social-biological needs" (Malle, Guglielmo, & Monroe, 2014). Blame is therefore an important piece of regulation of individual's behavior in a community, and is activated when an event is detected as a violation of a recognized norm system. This process is, in part, institutionalized through criminal law, which stabilizes social norms by ascribing responsibility and distributing appropriate punishment (Simmler, 2020; see also Durkheim, 2014/1893)

Blame as a process is tightly entwined with the understandings of *causality*, and the way a negative event is made sense of. Douglas (1992, pp. 5-6), for example, writing about social responses to misfortune (such as a woman dying) describes a closed set of ways in which this death could be understood and makes note of associated obligatory responses to misfortunes, as documented by anthropologists across the world. There are three main choices, she argues, that is three "types of blaming" (Douglas, 1992, p. 6), tied to a particular kind of an explanation: 1) the death is seen as a result of the deceased' moral transgression and has to be followed by appropriate rituals, 2) death is seen as caused by "internal adversaries" (Douglas, 1992, p. 5), who bested the deceased in the shared project of looking after one's own interests; they are not blamed but the death might give

rise to acts of retribution, 3) death is seen as caused by an outside enemy, which is then to be sought out and punished. The three kinds of understanding are not equally common within each society, rather one kind of explanation tends to be the dominant one, and communities are organized around it. While this schema captures responses to what is understood as a 'misfortune', and need not be replicated in cases of 'suicide,' it does exemplify 1) that particular explanations generate specific kinds of responses and 2) that patterns of explaining and responding can be identified across cultural contexts.

Additionally, Douglas's observation about 'a dominant explanation' is also worth noting, as studies of causal cognition and blame emphasize the idea of a 'primary' or an 'actual cause.' Scholars distinguish, for example, between *scientific* causation, which is oriented at producing prediction about a system and allows for complex interaction between multiple causes, and *folk attributive* causation, which is oriented towards questions of praise and blame, influenced by normative factors, and distinguishes between (primary) 'causes' and 'background conditions.' (Hitchcock, 2007). In the later schema, the ideas regarding the 'primary cause' appear to be tied to moral judgements regarding human actions (e.g. Alicke, 2000), and show evidence of cross-cultural variation. Scholars have, for example, noted that cultures tend to emphasize either internal or external explanations of an individual's behavior, ascribing more weight to either individual agency and disposition (common in 'individualistic' cultures) or contextual factors (common in 'collectivistic' cultures') (e.g. Norenzayan & Nisbett, 2000). As a result, the magnitude of blame and punishment can vary across different dimensions, agency and intentionality being more relevant, for example, in the West, and harm to the collective having a greater weight in the East (Feinberg, Fang, Liu, & Peng, 2019).

However, the idea of specific primary or 'actual' causes, scholars have argued, is also important within the scientific context, as it is necessary to mobilize scientific understanding into effective interventions (Hitchcock & Knobe, 2009). Debates regarding these 'actual causes' is where we see the politics of causation at work in contemporary contexts. These conflicts are often conceptualized through notions of 'person blame' and 'system blame' as ideologically different orientations towards social problems (Duke, 1978; Polisar, 1989), or 'proximal' and 'distal' causes as different 'levels' which are often (mis)interpreted as mapping onto differences in causal strength (Krieger, 2008).

Taking above into consideration, it is clear that tracing discourse regarding the causes of, as well as blame and responsibility for self-inflicted deaths, and cataloguing different 'types of blaming' with respect to 'suicides,' will enable us to understand broader patterns in how 'suicide' can be made sense of or responded to, as well as characterize the contemporary 'suicide' with respect to these frames of possibility. Therefore, throughout my analysis, I pay attention to any explanations of suicide deaths, attributions of responsibility and discussions of relevant consequences (such as punishment).

3. METHODS: ANALYTICAL APPROACH AND DATA

My project for this chapter, as I have laid it out, seeks to examine discourse about 'suicide-like' phenomena across contexts, an analysis that presents conceptual and practical challenges. Therefore, before I discuss my data and the specifics of my analysis, I first introduce a new term,

which I will rely on in making some of my claims, and then move to discuss some concerns regrading cross-cultural research using secondary sources.

3.1.Introducing 'ipsal deaths'

In the previous chapter, I have identified a tension between tracing 'suicide' across contexts and the understanding of 'suicide' as contingent on a specific context. I have also argued that boundaries drawn around these categories of 'suicide' themselves become an important object of inquiry. This interest in lines drawn between and around certain kinds of death, however, opens up a bit of a tricky question—what kind of conceptual space are these boundaries being drawn in, and how can we conceptualize and refer to this space? For example, consider the common practice in suicide literature, of using terms such as 'suicide' and 'self-inflicted' or 'voluntary death' interchangeably:

> "From remotest antiquity to today, some men and women **have chosen death**. Society has never been indifferent to that choice. On rare occasions acclaimed as an act of heroism, **suicide** has more often been subject to social reprobation because it was considered an insult to God, who have us life, and to society, which provides for the well-being of its members. (Minois, 1999, p. 3, emphasis mine)

> Thus the **practice of voluntary death** was known in the middle Ages, but it occurred in very different ways in different social categories. The peasant or the craftsman **hanged himself** to escape poverty and suffering; the knight or the cleric **arranged to get himself killed** to escape humiliation and to deprive "the infidel" of a victory. In the first instance **we have direct suicide of what the sociologists call the "egotistic" type**, in the second, **indirect and "altruistic" suicide**. The goal was the same, the means and motivations differed. (Minois, 1999, p. 12, emphasis mine)

Here, Minois overlaps descriptive terms such as 'choosing death' and 'voluntary death,' with the notion of 'suicide' which has clear and significant contemporary meanings, but seems to be used as an overarching analytical category, e.g. distinguishing "egoistic" and "altruistic" suicide. In this context of different modes of reference, what does it mean to say that "Physician assisted death *is not* suicide" even though we would understand it to be a 'voluntary' death? Or, in contrast, what does it mean to consider Indian 'sati/suttee' as a type of *suicide* when it has been strongly contested whether the widow's participation in the practice is actually voluntary, with some describing sati as a "social murder" instead (see e.g. ESDA, Hindu Widow (c. 1889), 2015).

The central issue here is that 'suicide' is frequently used as an *emic* category, that is category that exists within a particular cultural context, while — at the same time— an attempt is being made to use it as an *etic* category, that is a category defined by an objective outside observer,[9] even though the definition is rarely provided and the two separate meanings are generally not clearly distinguished. Scholars do recognize this issue and try to get around it—Marsh (2010) for example, discusses "self-accomplished deaths in ancient Greece and Rome," (p.79) noting that "Roman 'suicide' is not like [suicide in modern discourse]" (p.80). At no point is it made clear, however, what these distinct phenomena—suicide and 'suicide'—have in common or how they inform one another. If they are both different kinds of something, what are they different kinds of? Should we talk about 'Suicide' with the capital S, and through more notational gymnastic, discuss suicide$_{\text{Roman}}$

[9] *Emic* and *etic* come from 'phonemic' and 'phonetic' in linguistics, indicating a difference between culturally salient differences between sounds and purely acoustic differences. '*Emic'* refers to a within-culture view, while '*etic*' refers to a view from the outside not anchored in any particular context.

and $\text{suicide}_{\text{Contemporary}}$ as different kinds of 'Suicide'? It is also unclear, then, whether it is appropriate to discuss changing attitudes towards 'Suicide' over time at all, if there is a significant change in kinds of suicide that occur in different contexts. This referential ambiguity, therefore, can 'accidentally' unify possibly distinct concepts without offering an analytical rationale and obscure differences—as well as possible similarities—in local *emic c*ategories.

In order to address these definitional issues, I wish to introduce a new concept that will enable me to better conduct my analysis. In doing this, the first hurdle I have to cross is defining the kind of space, the kind of set I am working with. Even in contemporary definitions, 'suicide,' is often conceptualized as two different things: on one hand, it is a *kind of death*—e.g. "Suicide is defined as death resulting from intentional self-injurious behavior, associated with any intent to die as a result of the behavior" in the *Oxford handbook of Suicide and Self-Injury* (Posner, Brodsky, Yershova, Buchanan, & Mann, 2014, p. 11), on the other, it is also a *kind of act/behavior*— e.g. "the act of killing oneself (…) deliberately initiated and performed by the person concerned in the full knowledge or expectation of its fatal outcome" (World Health Organization, 1998, p. 75). Terms often used interchangeably with suicide, or in attempt to refer descriptively to a set of phenomena that we now think of as 'suicide', show the same kind of dualism (also see Daube, 1972 for history of the language used to discuss 'suicide'). We have, for example "killing oneself" or "taking one's own life" (acts), as well as "voluntary death" and "dying by one's own hand" (deaths). Clearly, the two are tied together, as 1) the deaths are at least implicitly defined by the acts that cause them, and 2) the fatal outcome is the central aspect of the definition of the act—resulting, for example, in the distinction between 'suicide' and 'suicide attempt.' I have decided to put the behavior aside, as I argue that the concern with the act is a result of the outcome. Taking

‘death’ and categorizations of deaths as my starting point, I focus specifically on boundary-making with respect to the kinds of death, though I acknowledge that any boundary-making across this space is also conducted using the language of ‘acts’ (e.g. self-murder).

The second hurdle is defining this space that I am interested in. On one hand, I acknowledge that ‘physical death’ might be the best starting point as it is—for the most part—not culturally contingent. Any boundary drawing that separates certain kinds of deaths from others will be informed to an extent by the local cultural context. On the other hand, ‘physical deaths’ is too broad of a category, and to focus on boundary making across this whole space is a task beyond the scope of my work. Instead, I argue that—based on the extensive record of stories and discussions of ‘things like suicide’ across historical and cultural contexts—there is something unique about those deaths in which the deceased can be perceived to have played some sort of a role in bringing about their death.

This description does not make for an objective definition, as the ‘perception’ of one’s role is, in itself, culturally contingent. Consider, for example, the discussion of the ‘suicide’ category among the Mojave who, according to Devereux (1961 as excerpted in ESDA, Mojave, 2015), perceived a fetus as being able to intend its own death. As such, the definition would not pick out the same kinds of deaths across context, but this is not necessarily an issue for my analysis. Ultimately, I simply need a way to refer to the complete set of deaths that, within a particular context, might stand out because they are seen as somehow being brought about by the deceased, so then I can focus on how (and if) this set of deaths is further categorized and managed.

In order to refer to the deaths picked out by this definition, I propose a neologism— "ipsal death"—"ipsal" from a latin pseudo-root 'ips-' *(ipse*/*ipsa*/*ipsum;* him/her/it-self) and the suffix -al ('related to'). *Ipsal deaths* are therefore those kinds of deaths in which the person who died is perceived to have played some sort of a role, whether through intention, action or inaction, in their death. This would unite notions of 'self-inflicted' (physically), 'self-initiated' (socially) and 'self-intended' (psychologically).

In my work, therefore, I ask which ipsal death emerge as problematic? Why are they seen as 'bad,' are they seen as 'bad' in a particular way, and are there any common dimensions along which societies draw boundaries around these 'bad' ipsal deaths, and how are these particular 'bad ipsal deaths' then understood and managed. In this context, I see suicide as ultimately referring to a set of 'bad' ipsal deaths and view efforts to determine whether a certain kind of death is or is not a suicide not as simple acts of refining definitions, but as attempts to trace and establish ultimately *moral* boundaries, akin to what Woolgar and Pawluch (1985) call "ontological gerrymandering." It would be, for example, self-evident that physician assisted deaths, suicide bombings, and overdose deaths are ipsal deaths—which of these, if any, constitute 'suicide'—as a category of ipsal deaths that are especially problematic as per a common line of moral reasoning—is a question that is posed and addressed through practices of definition and classification. These discussions of what does and what does not belong into a salient category of 'bad ipsal deaths,' and why deaths might be categorized as such, are the main object of my inquiry.

3.2.Cross-cultural research and analytical approach

As Ember and Ember (2009) emphasize, "uniqueness and similarity are always present" across human cultures, what matters is what one chooses to focus on (p. 3-4). They posit that "comparison is possible because patterns (kinds of phenomena that occur repeatedly) can be identified" (p. 6) and argue that these similarities can be recognized if we think of them as 'variables', that is qualities or quantities that vary along specified dimensions, noting that "[t]here is no right or wrong conceptualization of variables; the researcher may choose to focus on any aspect of variation (p.5). That said, it is clear that in this kind of a comparative study, it is necessary to abstract the accounts and fragments of texts from the cultural discourses in which they were produced and in which they were embedded. This abstraction does not just 'flatten' the richness of meanings, but can introduce errors, especially when working with translated materials (see also the next section).

I recognize these limitations and concerns, and therefore do not seek to make any absolute statements about the ubiquity of certain boundary-drawing patterns or exhaustiveness of the types of blaming that I identify. My overall interest is also not in comparing and contrasting cultures as a whole, and I do not wish to extrapolate cultural characteristics from specific aspects of discourse that I identify. Ultimately, I pursue an understanding of the common shapes of 'discourse on suicide' to 1) contextualize contemporary/scientific discourse on suicide within a broader set of similar activities and 2) try to understand what characteristics of 'ipsal deaths' seem to make it problematic across contexts. In this I make no claims of comprehensiveness or representativeness. This caveat has to be made especially with respect to my focus on written texts which—while containing ideas deemed worthy of being written down—also create a significantly biased record.

In that regard, my work might be best understood as a cross-cultural "ethnography of argument" (Woolgar & Pawluch, 1985).

3.3.Data and analysis

To conduct my analysis, I have built a corpus of texts that discuss 'ipsal deaths.' In this process, I have relied significantly on *The Ethics of Suicide Digital Archive* (Pabst Battin (Ed.), 2015), edited by philosopher Margaret (Peggy) Pabst Battin. The archive is

> intended as a comprehensive sourcebook, a collection of primary texts covering as fully as possible the immense range of thinking about the ethics of suicide in both the Western and non-Western traditions, as well as in both literate and oral cultures—in short, the full range of human discussion and dispute that leads up to current times. (Pabst Battin, 2015)

The archive consists individual texts and excerpts from longer works, that discuss suicide at different degrees of depth and explicitness, and often includes scholarly discussion of the context in which the work was produced and reflections on ideas and themes expressed in it. I have followed many of these excerpts to their full versions, so I could read beyond the included sections, and have also come across additional texts that do not appear in the archive. Additionally, as I was familiarizing myself with suicide in contemporary science and law, I have read through many sources and have collected a set of texts that are either representative of today's theories and discussions, or unique in relevant ways (e.g. specific legal cases.) For more details on the corpus and the analysis, see *Appendix A: Methods, Section 3. Historical Texts*.

In my analysis, I focus mostly on texts in which ipsal deaths are discussed very explicitly, as opposed to the more implicit ways they might emerge in texts such as plays, such as to minimize the factors that might confound my interpretation. I also pay more attention to primary sources, as

opposed to, for example, anthropological reports which also introduce additional concern with respect to mediation of the particular context in which the text were created. Throughout my discussion, I illustrate my analysis with what I find to be representative but also clearest examples.

While conducting historical and cross-cultural research today is much easier than in the past, due to wide availability of digital records and translations, it also presents is own set of issues, three of which are significant in the context of my project.

First, I rely heavily in my analysis on the sources drawn from *The Ethics of Suicide Digital Archive*. While this archive has made this project possible, I also recognize it as a product of its time. Like the 'Histories of suicide' which I have discussed in my *Literature Review*, the archive collects materials on certain ipsal deaths, while not others. To mitigate the effects of this selection process, I also independently looked for sources, though citations and mentions not just in literatures on 'suicide' but also those on death and dying, death classification, homicide, accidents etc.

Second, any historical project is biased towards certain times and places due to varying availabilities of the written records. In relying mostly on work that has been not only translated but also digitized, I further constrict my data-pool. However, as my goal is not a comprehensive overview, but rather the highlighting of similarities within a certain corpus, this limitation presents less of a concern. Taking into account the heavily Euro-centric discussions of suicide, I have put additional effort into reviewing original sources from other places, and to cast my net wide—e.g. looking beyond the Indian *sati/suttee* and Japanese *seppuku* which feature prominently in the literature. While not an ideal source, early anthropological record also offers insight into ipsal

deaths in small-scale societies. Unsure of the context in which these writings were produced, I discuss them sparingly and only as records in which individuals were trying to make sense of their systems to the anthropologist in question.

Third, beyond the sources in Early Modern and Modern English, I rely significantly on other's translations. While I have sometimes checked specific passages or expressions in the original to gain more context—often through intensive use of online dictionaries and secondary sources—there is a significant amount of mediation occurring, through which meanings can easily be lost or obfuscated. However, as my analysis will hopefully show, a focus on the activities of boundary drawing themselves makes the specific meaning less of an issue.

4. Scientific discourse on Suicide

I start my analysis by considering 'suicide' through the lens of scientific discourse, focusing on the contemporary context, but also drawing on the beginnings of scientific engagement with suicide in the 19th century. As has been argued in detail by Hacking (e.g. 1990) and Marsh (2010), 'suicide' as it exists in the current (Western) society emerges through scientific knowledge production about suicide, which is why my focus here is on discourse within science. My goal in this is trifold. First, I show how and why the current context motivates my historical inquiry. Second, I wish to emphasize the way scientific knowledge production can have a moral function akin to that of discourse in philosophical, religious and legal realms, which further justifies my inclusion of some scientific sources alongside other texts in my later discussion. Third, I wish to lay some conceptual ground for my engagement with the scientific realm, which I take up in the next chapter with respect to the role of science in the development of suicide as public problem,

and which is the focus on my third chapter. That way, I can better integrate the three chapters together as I bring them together in my Conclusion.

In the current section, my goal is to establish the science of suicide as actively participating in the discourse that contains and engages with suicide as a matter of moral and political concern. I then show how these concerns might appear both in the processes of boundary-drawing around 'suicide' as an object of inquiry, and discussions regarding the causes of, and responsibility for, suicide.

4.1. Framing suicide as a problem: The moral and political aspects of science

As I have noted in my *Literature Review*, science has long been recognized as a social process, albeit one (frequently) regulated heavily so as to align it as closely as possible with ideals of objectivity and rationality. While there are significant discussions today as to what 'good science' can or should look like within the social sciences, including significant critiques of positivism and objectivity in general, even at its most 'objective' social science struggles to achieve the kind of distance that natural sciences might be able to do. This is not only due to the kind of methodology available to each collection of disciplines, but with the characteristics of their objects of inquiry. Hacking, for example, argues that the 'kinds' frequently studied by the social sciences—what he calls 'human kinds'— are inherently moral, and as such characterize the endeavor of studying them as a moral one (Hacking, 1995).

Some of the early scientific work on suicide sought to distance itself from previous discussions of morality, emphasizing the scientific nature of the inquiry. Most famously, the main purpose of

Durkheim's work on suicide is not to explain suicide as much as it is to chart a direction for sociology as a field, with suicide simply being a great case study to do so:

> **Suicide has been chosen as its subject, among the various subjects that we have had occasion to study** in our teaching career, because few are more accurately to be defined and because it seemed to us particularly timely; its limits have even required study in a preliminary work. On the other hand, by such concentration, **real laws are discoverable which demonstrate the possibility of sociology better than any dialectical argument**. (Durkheim, 1951/1897, p. xxxv)

Durkheim also stays quite 'agnostic' towards suicide throughout his work, and in the final section on 'Practical consequences' he asks:

> Should the present state of suicide among civilized peoples be considered as normal or abnormal? According to the solution one adopts, he will consider reforms necessary and possible with a view to restraining it, or, on the contrary, will agree, not without censure, to accept it as it is. (Durkheim, 1951/1897, p. 328)

Durkheim concludes that suicide is "probably [an element of] any social constitution" (p. 330), but also notes the abnormal nature of the strength of the suicidogenic currents in his own time, as evidenced by rapid increases in suicide, which is additionally problematic to the social structure due to the rapidity of the change (p.336). For Durkheim, then, 'suicide' is a theoretical puzzle and a problem only in particular circumstances.

In many ways, however, Durkheim is an exception to the rule. Most work scientific work on suicide is written in response to a perceived problem, and with a goal of addressing it, a framing more or less explicit. Morselli's work, preceding Durkheim's, includes the following in the first paragraph of the preface to the English edition:

> So fortunate a reception is not due so much to the slight merits the work may possess, as to the nature of the subject of which it treats; because **every day cases of suicide occur and increase under our eyes**, and everyone is warmly interested in this **tragic psychological characteristic of our age.** (Morselli, 1903/1881, p. v, emphasis mine)

Similarly, In the preface to his volume *Suicide and Insanity: A Psychological and Sociological Study*, Strahan (1893) writes: "I consider the present an opportune moment for teaching the lesson contained in the following pages. **The remarkable prevalence of suicide** in England this summer brought **the painful question of self-destruction** prominently before the public" (1893, p. v, emphasis mine). Westcott (1885) notes that the question of suicide is "one well worthy of the earnest consideration of the community ; indeed, it may be legitimately regarded as one of our Social Problems," and argues that the steady increase of suicide in Europe (as opposed to the steady decrease of crime) "awakens our **sympathy** on behalf of the unhappy victims, [and] should [also] stimulate our exertions towards promoting the **diminution of this moral plague spot**." (Westcott, 1885, pp. v-vi, emphasis mine).

This trend of writing with respect to the problem of suicide continues—if not flourishes—today. Consider the introductory paragraphs of the three most recent well-known theory papers on suicide, all authored by clinical psychologists (emphasis in bold is mine; references within excerpts removed for readability):

> Approximately **one million individuals worldwide died** by suicide in 2000, and estimates suggest that **10 to 20 times more individuals attempted** suicide. Only two interventions have been shown to prevent deaths by suicide and only one form of psychotherapy has been shown to prevent suicide attempts in more than one clinical trial. Why is the state of knowledge for **such a devastating**

> **psychological phenomenon** relatively lacking? (Van Orden, et al., 2010, emphasis mine)
>
> Suicide is a **leading cause of death** worldwide, **killing more than 800,000 people** each year. A much larger number of people make suicide attempts, with some researchers estimating that **approximately 25 attempts occur for every suicide death**. An **even greater number of people consider suicide**; a worldwide study found that for every person who attempts suicide, there are two to three who have seriously considered suicide without attempting it. Given this **immense public health problem**, suicide has been the focus of many research and prevention efforts, particularly in the past few decades. However, despite these efforts, there is no evidence of **sustained reductions in suicide rates**. The development of **more effective prevention and intervention** strategies will very likely require a deeper understanding of the fundamental processes that cause suicide ideation, attempts, and deaths. (Klonsky & May, 2015, emphasis mine)
>
> Suicide is a **major public health concern** with **at least 800 000 people dying by suicide** each year across the globe an**d at least 20 times that number attempting suicide**. The pathways to suicide are complex, with suicide being the end product of an interplay of biological, clinical, psychological, social, cultural risk and protective factors. Although knowledge of risk factors for suicide has grown markedly in recent decades, our ability to predict suicide is no better now than it was 50 years ago. There are many reasons why the field of suicide research has not enhanced its predictive ability; key candidates include the low base rate of suicidal behaviour, as well as the fact that risk factors are often assessed in isolation and in a static rather than in a dynamic fashion. In addition, until relatively, recently, there was a paucity of comprehensive theoretical frameworks that have attempted to understand the emergence of suicidal ideation and the transition from thinking about suicide to attempting suicide/dying by suicide. (O'Connor & Kirtley, 2018, emphasis mine)

In contrast, ipsal death phenomena in the non-human world are generally considered more of a puzzle to be solved and a problem for *theory* rather than anything else. Compare the above to, for example, the introductory paragraph of a paper titled “On the paradigm of altruistic suicide in the unicellular world” published in the journal *Evolution* (Nedelcu, Driscoll, Durand, Herron, & Rashidi, 2011):

The Problem of Self-Induced Death: An Evolutionary Conundrum

> "Natural selection will never produce in a being any structure more injurious than beneficial to that being, for natural selection acts solely by and for the good of each. No organ will be formed . . . for the purpose of causing pain or for doing an injury to its possessor."
>
> (Darwin)

> Typically, evolutionary theory has been concerned with explaining life. Within this framework, selection is expected to promote the evolution of various molecular, physiological, and behavioral mechanisms (i.e., adaptations) that increase the individual's ability to avoid death. In this view, death is seen as the failure to survive and should not be selected for. **Hence, conditions that promote an individual's own death—and the evolution of active mechanisms of self-destruction—are more difficult to envision**. However, because of the hierarchical organization of biological systems, selection can act at different levels, and death can occur at multiple levels. (Nedelcu et al., 2011, emphasis mine)

Some of the difference between these frames is purely disciplinary. However, discussions of contemporary suicide in evolutionary terms are not only rare, but they are also recipients of a kind of pushback that would be very unexpected, if not impossible, in the non-human sciences. Consider, the opening of the article titled "The Evolutionary Puzzle of Suicide" published in the *International Journal of Environmental Research and Public Health*, authored by a team of psychiatrists (Aubin, Berlin, & Kornreich, 2013), which at the moment of writing has 24 citations listed on Google Scholar (references removed for readability, emphasis in bold is mine.)

> "Natural selection will never produce in a being any structure more injurious than beneficial to that being, for natural selection acts solely by and for the good of each. No organ will be formed for the purpose of causing pain or for doing an injury to its possessor."
>
> Charles Darwin

1. Introduction

> Evolutionary theory is typically concerned with explaining life. Within this framework, selection is expected to promote the evolution of various biological mechanisms that increase the individual's ability to avoid death. The evolution of mechanisms of self-destruction is more difficult to envision.
>
> **The estimated global burden of suicide is one million deaths per year**, with a great inter-country variability. [Brief review of previous knowledge and proximal/distal risk factors, including a discussion of Joiner's Interpersonal theory of suicide, as well as evolutionary psychology] (…) The purpose of this narrative review is to present several non-mutually exclusive hypotheses that propose adaptive mechanisms that lead to suicidal behavior.

Note that the first paragraph cites the Nedelcu et al. (2011) article discussed above, and the paper overall is still framed as an 'evolutionary puzzle.' At the same time, however, immediately following the 'puzzle frame,' the paper emphasizes the 'global burden of suicide,' the latter, at the very least, establishing the perceived importance of the topic.

Now, consider Joiner et al.'s (Joiner, Hom, Hagan, & Silva, 2016) reflection to this particular strain of theories of suicide, a part of their paper "Suicide as a Derangement of the Self-Sacrificial Aspect of Eusociality" published in the *Psychological Review*, and currently with 115 citations as per Google Scholar:

> There are compatibilities between that account and ours, especially as regards perceived burdensomeness, but there are at least three important differences. First, our perspective emphasizes **distorted perceptions** of burdensomeness, whereas the "altruistic suicide hypothesis" points to actual burden on kin. **Second, our framework sees suicide as a derangement of an adaptation,**

> **whereas the "altruistic suicide hypothesis" views it as an adaptation under certain conditions**. (…)
>
> Relevant to suicide as a **derangement**, there is wide agreement among suicide researchers that, at a minimum, **90% of all suicides involve mental disorders** (e.g., Harris & Barraclough, 1997). The debate is regarding which figure from 90% to 100% is correct; our position is that it is 100%, for the following reasons. First, suicide involves the **unsanctioned and frequently brutal killing of an innocent**; the state of mind that one's own death has inviting properties; the potential deaths of others via suicide contagion (Hecht, 2013), not to mention the occasional actual deaths of bystanders (e.g., those landed upon by suicidal people jumping from a height in an urban setting, those killed by chemical exposure; Joiner, 2014); the **deprivation of choice and life** to one's future self (Hecht, 2013); **the deprivation of choice and future care and comfort to loved ones**; and the **willingness to devastate dozens of people into a shocked state of bereavement** (Cerel, 2015), **not infrequently without warning and certainly without their consent**. Any one of these is suggestive of psychopathology; their conjunction is a clear exemplar of psychopathological functioning. (Joiner, Hom, Hagan, & Silva, 2016, emphasis mine)

Note here that the question of whether 'suicide' could be viewed as an adaptation in particular condition is not addressed from an evolutionary point of view, but rather a moral one, as evidenced by the kind of language used: "unsanctioned and brutal killing of an innocent," "deprivation of choice and life," "willingness to devastate dozens of people." It is not possible, or at the very least it would be highly unusual, to make this kind of an argument with respect to phenomena in unicellular organisms.

Ultimately, then, while it is certainly possible to consider suicide as a morally-neutral phenomenon, an element of "any social constitution" (Durkheim, 1951/1897, p. 330) that can be explained sociologically, or an evolutionary puzzle that can be explored through biology or biological anthropology, this kind of perspective appears very rarely within the scientific discourse. Most

often, ‘suicide’ is explicitly taken up as a problem, not simply a behavior that should be understood, but a harmful act that can be prevented. This frame affects how ‘suicide’ is defined and how the causes behind it are explored and discussed, the questions that I explore next.

4.2. Definitions of suicide and their functions

Within the scientific community, there have been significant discussions about what ‘suicide’ really is, how best to define it, and the stakes of correct definitions. From the inception of scientific examination of suicide, researchers have not only produced their definitions, but have heavily emphasized the importance of defining their object of inquiry. For example, writing in 1897, Durkheim opens his volume on suicide writing:

> Since the word “suicide” recurs constantly in the course of conversation, it might be thought that its sense is universally known and that definition is superfluous. Actually, the words of everyday language, like the concepts they express, are always susceptible of more than one meaning, and the scholar employing them in their accepted use without further definition would risk serious misunderstanding. (Durkheim, 1951/1897, p. 1)

Durkheim here emphasizes the distinction between common uses of ‘suicide’ and ‘suicide’ as an analytical category that needs to be accurately defined before one can embark on a scientific investigation. Nearly 100 years later, in 1985, Shneidman similarly writes:

> To put it another way, the definitions of suicide that we see in textbooks, use in clinical reports, read in newspapers, and hear in everyday talk are just not good enough to permit us to understand the events we wish to change. The basic need, in relation to suicide, is for a radical reconceptualization of the phenomena of suicide. What is required is a new definition of suicide followed by a broadening of many clinical and social activities based on that new understanding. (Shneidman, 1985, p. 4)

Then, 20 years later, in 2006, De Leo et al. (2006) again emphasize the insufficiency of the 'everyday' sense of suicide, while also highlighting still existent definitional issues:

> Each person intuitively knows what he or she means when the topic of suicide arises in everyday conversation. However, the definition of suicide is inherently more complex than the simple words "killing oneself." Although it is doubtful that we will ever be able to construct universally unambiguous criteria to comprehensively characterize suicidal behaviors (and, overall, firmly establish the intention behind them), for scientific clarity it would be highly desirable that the set of definitions and the associated terminology be explicit and generalizable.

Throughout this period, from Durkheim to De Leo et al., various definitions are developed, in an attempt to neatly define the phenomenon in question. As an illustration, Table 1. shows a small selection of the dozens of existing definitions. What is notably here is that 1) there is not an established definition of suicide, rather the phenomenon is continuously re-defined and 2) while there is clear similarity across these definitions, they do not align perfectly and, as shown in Figure 1-1, they differ in the kinds of deaths they ultimately would or would not designate as 'suicide.'

Durkheim (1951/1897, p. xl)	[T]he term suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result.
Operational Criteria for Determining Suicide (Rosenberg, et al., 1988)	[Suicide is] death arising from an act inflicted upon oneself with the intent to kill oneself. (A/N: discussion also specifies 'injury' as a cause of death)
WHO (1998, p. 75)	The act of killing oneself (…) deliberately initiated and performed by the person concerned in the full knowledge or expectation of its fatal outcome
De Leo et al. (2006)	Suicide is an act with fatal outcome, which the deceased, knowing or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes.
Oxford Handbook (Posner, Brodsky, Yershova, Buchanan, & Mann, 2014, pp. 9,11)	Suicide is defined as death resulting from intentional self-injurious behavior, associated with any intent to die as a result of the behavior. (…) An act of suicide must be self-instigated or self-initiated but not necessarily self-inflicted.

Table 1-1. Definitions of suicide in selected publications

There does exist a certain contemporary 'prototypical suicide death,' a meaning that comes to mind to most people when they hear the word suicide—a person who in a state of deep despair or psychological pain chooses to end their life.[10] This 'prototypical suicide' would, non-surprisingly be classified as a suicide by each of the definitions in Table 1. However, scholars frequently wrestle with a series of boundary cases in attempts to refine their definitions and limit the scope of relevant discussions and theories to only certain kinds of deaths. Below, I list some of some such cases that frequently emerge in the literature, with a brief note on the main source of ambiguity.

- *(PAD) Physician assisted dying* - death is imminent, the person is just taking control of how they die, desire to die unclear.
- *Socrates drinking poison as directed by the authorities* - behavior under another's threat, self-inflicted, but not self-initiated.
- *Not seeking medical care that could save one's life* - death is not a result of an act, rather a failure to act.
- *'Suicide-by-cop'* — the injury is not self-inflicted, even if intended and self-initiated.
- *A soldier's sacrifice, e.g. jumping on a grenade so as to protect his comrades* — there is no intent to die, even if the act is self-initiated, inflicted, and known to be possibly lethal.
- *A person starving themselves to death in protest* — the goal is, maybe, 'to bring about wanted changes', but not to die.

[10] It is notable that the death has to be described with respect to an explanation or a cause as opposed to anything else. This is something that I explore later in the chapter

None of these deaths would be the prototype of contemporary definition of suicide, and most are not really what scholars, activists, or policy-makers are interested in at all ('suicide-by-cop' being a possible exception). Further, the definitions as outlined in Table 1 would handle each of these cases differently, as visualized in Figure 1. Notably, the one case that they might all designate a suicide—Physician Assisted Dying, has been recognized as different from suicide both by the death with dignity acts (e.g. DC Department of Health, 2017) and AAS (2017).

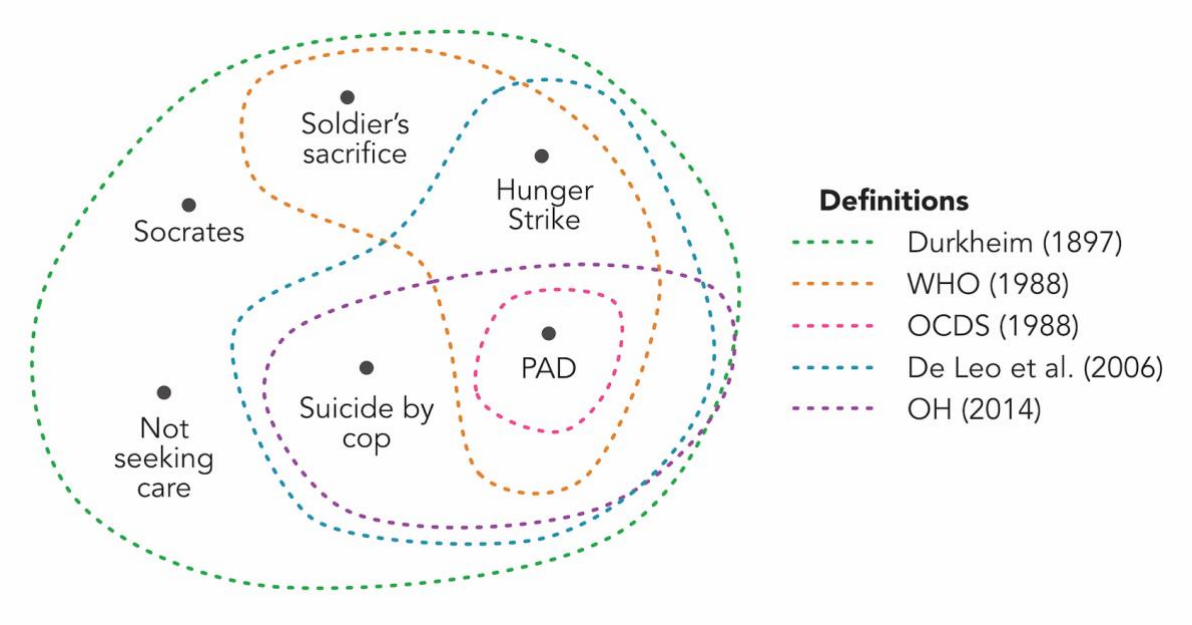


Figure 1-1. Some differences in the kinds of deaths classified as 'suicide' by different definitions.

Importantly, these definitions are very closely entwined with theory, as they can circumscribe a set of deaths that is to be described and explained. For example, De Leo et al. (2006), writing about the importance of and difficulties regarding the definitions of suicidal behavior, citing Maris,

Berman and Silverman's (2000) discussion of the theoretical components of suicidology, establish the following:

> The theoretical perspective explains the basis of the behavior. However, definitions are a description of the concept rather than an explanation, and should not be guided by theory. (p.8)

Note, however, that in this sequence of research moves, the 'concept' that is described by a definition is left unexamined, that is it is presupposed that there is some set of deaths that is then taken up by science and refined into a clear object of inquiry. At the same time, not all scholars see definitions necessarily *preceding* theory, rather they see theory as possibly *informing* the categorization of deaths. Joiner (2005), for example, in laying out his Interpersonal theory of Suicide, argues that his model "may also contribute to the resolution of long-standing dilemmas in the field of suicide research, treatment, and prevention, and explain some puzzling suicide-related facts" such as the question of "what constitutes a proper definition of suicide itself." (Joiner, 2005, pp. 138-129) Ultimately, Joiner here creates a definition of out a hypothesized joined etiology, implying that suicides are exactly those self-inflicted deaths that occur due to a person's thwarted belongingness and perceived burdensomeness.

In either case, whether definitions are built as descriptions of some existing albeit vague concept, or out of an etiology, the stakes here are significant—definitions impact not only formal classifications and therefore statistics themselves, but also prevention efforts and even public ideas of what suicide is, or is not. The boundary-drawing in this case, by separating the deaths of concern to suicidology from those outsides of its purview, under the frame of 'suicide' as a problem, also seem to have a moral function. Defining a certain kind of death as a, or not a, 'suicide' oftentimes encodes ideas about the perceived 'pathology' of the act. And even if this does not explicitly

designate the act itself as 'right' or 'wrong,' it can set up a moral obligation for intervention and prevention. The question of if, and especially *how* to intervene emerge as important within discussions of what causes suicide as well.

4.3.The production of data on causes of suicide

As I have noted above, the literature on causality generally distinguishes 'folk' from 'scientific' understandings of causality, with the later seen as not concerned with moral evaluations and biases, and instead interested in examining causal systems in full (Hitchcock, 2007). Scientific studies of suicide, do in fact, emphasize 'suicide' as a complex phenomenon brought about by a variety of biological, psychological and sociological factors and even though researchers generally focus on very specific causal chains, they generally do at least mention this full picture.

However, as Hitchcock (2007) also notes, even in the context of "scientific conception of causation," "our interests and values may influence which systems we choose to investigate." This influence on systems that we choose to investigate can have significant impacts on the data that is collected and causal connections that are perceivable. Furthermore, science also operates under diverse sets of social constraints, including claims of professional authority and political needs in terms of effective prevention. With the respect to the later, understandings of what kind of factors are *modifiable*, can also direct research efforts. For example, APA's *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors* notes that "[f]inancial difficulties or unemployment can (…) be difficult to modify, at least in the short term" and instructs practitioners to focus on those risk and protective factors that can be modified (Jacobs, et al., 2003). While these guide practice, it is important to note that this is also the context that produces

significant knowledge about and theories of suicide, and that these are likely shaped by the practical needs of clinical work. Maybe not surprisingly, then, the three most recent theories of suicide, all put forth by clinical psychologists, emphasize what they call an 'ideation-to-action' framework (see e.g. Klonsky & May, 2015). In this, they shift focus from understanding what might lead a person to contemplate taking their own life to the specifics of how these thoughts might lead to action, ultimately narrowing the field of what are considered to be most relevant causes and best candidates for intervention.

Clinical practice aside, much of our knowledge about suicide deaths, as opposed to suicidal ideation and behaviors, and especially with respect to so called 'risk factors' as important parts of the causal structure of suicide, is based in large-scale and even population-level data on suicide deaths. Furthermore, it is this kind of data that played a significant role in shaping contemporary 'suicide' (Hacking, 1982; 1990) and it is what, as I will argue in the next chapter, enabled the discourse about suicide as a 'public problem' in the 20th c US. It is therefore worth examining the way data-collection practices and scientific knowledge production interact.

We see the earliest evidence of record-keeping on suicide deaths within the legal system, in Medieval England. The information was collected about all 'suspicious deaths,' which were examined by the coroner and evaluated by the coroner's jury, and recorded in a series of documents, including Coroner inquests (sent to the courts for final judgement) and Eyre court rolls (McNamara, 2014). The information, resembling to an extent the death certificates of today, included

(i) the name of the deceased;
(ii) how s/he died;
(iii) the place of death;

(iv) the name of the first finder of the body;
(v) the verdict – felonia de se or misfortune/misadventure (infortunium);
(vi) whether the deceased had any chattels, and, if so, how much they were worth and who was in possession of them or answerable for them;
(vii) whether the neighbouring vills, neighbours and first finder came to the inquest or the eyr

(From Seabourne & Seabourne, 2001)

McNamara (2014) notes that while these documents provide very little in terms of motives or narratives of suicides, they frequently do offer a particular frame for contextualizing a death, commonly infirmity or criminal activity. Even in deaths judged to be *felonia de se,* as opposed to *infortinatum*, mentions of physical infirmity, 'fever,' 'frenzy,' or 'distress' are commonly recorded as parts of the relevant causal sequence (McNamara, 2014). Also common are mentions of 'fear,' especially in the context of arrested or escaping criminal (McNamara & Ruys, 2014). As evident in writings by Henry de Bracton (Bracton, 1879 as excerpted in ESDA, Henry de Bracton (c. 1210-1268), 2015), discussed in of the sections bellow, the established causality of a self-killing played an important role in determining the appropriate social consequences for the act, so records of these frames are expected.

Apart from this early example, however, we do not see significant efforts at keeping detailed records about ipsal deaths and their possible causes until the 19th century and what Ian Hacking calls "the avalanche of numbers" (Hacking, 1982; 1990: p.80), and here we see suicide becoming tangled up both in the criminal and medical record keeping. In terms of the legal records, the most vivid example might be the work of André-Michel Guerry, a French lawyer and statistician, who constructed a data-collection schedule for the constables in which they were to record:

> on the spot where the suicide was found: the sex, age and state of health; profession or social class; residence, birth place, marital status, number of

> children; finance: rich, comfortable, poor or miserable; education: literate, can read and write, illiterate; state of mind; morality (judicially condemned? adulterer? gambler? prostitute? concubine? drunkard?); religion. Then there should be a record of the place, the medical circumstances, the date and hour, and the weather. How was it done? Why was it done? Was a letter left? Previous attempts? A parental history of madness or of suicide? What objects were found at the scene, or in the victim's pockets? (Hacking, 1990, p. 79)

While the formal process did not come to include all of these details, Guerry's efforts were fruitful and spread far beyond France. By the time Morselli (1903/1881) wrote his volume on suicide in the second half of the 19th century, he is able to compile detailed tables on both means and what he called 'motives' (see Table below for a list) of suicide deaths in countries across Europe.

Throughout the 19th century, we also see a development of the classification of diseases and causes of death, which ultimately ends up guiding the data collection on death certificates. The question of what 'causes' death is a complex one. Benjamin (1976), focusing on the discussion of physician assisted death/euthanasia but speaking to death more generally, argues that we need to distinguish two types of causality— social ($cause_s$) and pathological ($cause_p$). To illustrate the difference, Benjamin uses the example of a person dying after being poisoned by another. To ask how and why the deceased ingested the poison ($cause_s$) is distinct from the question of how and why the ingested poison killed the deceased ($cause_p$). This distinction is sometimes made through the terminology of 'cause' (referring to the pathological) vs 'manner' (the social) of death, but in many cases the question is far more complex, and dates at least as far back as 1839-40 and what Hamlin (1995) calls the 'Chadwick-Farr' Controversy. In short, in developing a nosology that will become the International Classification of Diseases (ICD) across the following decades, statistician and epidemiologist William Farr designated some deaths as being due to 'starvation' (including want of warmth, food, etc.) Chadwick, however, requested the cause be further specified—likely

because the idea of Englishmen dying of hunger went against his social policy efforts—and attributed to specific physiological causes, like diseases exacerbated by starvation. This question of what causes should be specified is deeply political, and imbued with moral values of what the world should be like—but also produces 'facts' crucial to scientific research.

Ultimately, while "acute transmissible diseases, presumably with single specific causes, became paradigmatic," (Hamlin, 1995) this framework of specifying a single physiological 'immediate' cause of death became hegemonic in death certificates, relying on the developing ICD. Within this context, suicide was counted under a more general heading of 'violent deaths,' that are increasingly elaborated through developments of ICD. The category now termed 'external' causes, is split into 'accidents', 'intentional self-harm and assault (as well as other special-use categories such as 'legal intervention' and 'Misadventures to patients during surgical and medical care'; WHO, n.d.a[11]). Importantly, the main aspect of ipsal deaths that is elaborated within the system is the observable $cause_p$ of suicide, of what is more commonly referred to as 'means.' This practice continues until today and, concerns about misclassification aside, death certificate data is generally taken as the most authoritative data on suicide. Causes of death are classified by suicide means (e.g. hanging, poisons of different kinds, different kinds of firearms etc.), and the only context that can be included is one that can be coded using ICD codes as 'contributing causes' (e.g. mentions of alcoholism or mental illness.)

[11] ICD-11 is now in use, with slightly different language

Notably, by end of the 19th century, the death certificates come to be the only comprehensive and systematic records on suicide deaths, and the data on other context and 'presumed causes' that Morselli (1903/1881) could draw on disappears. This development aligns with the progression of medicalization of suicide—as concerns about suicide left the criminal system, there was no institution to collect and organize this data. *Why* individuals might take their own lives seems not to have been of social relevance any more, and as a result, scientific research on this question was heavily impeded. This only started changing recently, for example in the US with the development of the NVDRS (National Violent Deaths Record System) in 2002. The focus of the NVDRS is not on suicides specifically, but the broader category of 'violent deaths' which, in case of the NVDRS, includes "homicides, suicides, unintentional firearm deaths, deaths of undetermined intent, deaths due to legal intervention (excluding executions) and deaths due to terrorism (excluding acts of war)" (Blair, Fowler, Jack, & Crosby, 2016). The current NVDRS list of possible 'Suicide Circumstances' (National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2021) in many ways, resembles the classifications as presented by Morselli, with the main difference being in the focus on a singular presumed cause vs. a multiplicity of circumstances. (Table)

Morselli (1903/1881, p. 278)	**NVDRS (National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2021)**
Mental disorders	Current mental health problem
	Current depressed mood
	Current treatment for mental illness
	Ever treated for mental health problem
Physical disease	Physical health problem
Weariness of life, discontent	Crisis in preceding or upcoming 2 weeks
Passions (violent passions, crossed love, jealousy, avarice, anger	

Table 1-2. Comparison of the motives of suicide in Morselli's work and the NVDRS data

Morselli (1903/1881, p. 278)	**NVDRS (National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2021)**
Vices (libertinism, drunkenness, and alcoholism)	Other substance abuse problem
	Previous perpetrator of violence in the past month
	Alcohol dependence
	Victim had other addiction (e.g., gambling, sexual)
Afflictions, domestic troubles (besides domestic troubles it includes all anguish of the affections, opposition, and dissensions in family or office, the loss or absence of beloved people, indignation at unjust reproofs, bad conduct of relations, delusive hopes, &c)	Family relationship problem
	Intimate partner problem
	Argument or conflict
	Physical fight between 2 people
	Other relationship problem (besides family)
	Previous victim of violence in the past month
	School problem
	Suicide of friend or family member in past 5 years
	Other death of friend or family member
	Anniversary of traumatic event
	Exposure to disaster
	Caretaker abuse/neglect led to death
	Job problem
Financial disorders	Financial problem
Misery (misery and the fear of it, the lack of food and work)	Eviction or loss of home
Remorse, shame, fear of condemnation	Recent criminal legal problem
	Other legal problems
	Other information
	Person left a suicide note
	Disclosed intent to commit suicide
	History of suicidal thoughts or plans
	History of suicide attempts
	Victim had history of abuse/neglect as a child

Table 1-2, continued

While there are certainly other contexts in which science-external concerns and conditions shape the science of suicide (e.g. available research funding), my goal in this section is not to discuss these at length. Rather, my goal was to show, using one significant example, how even scientific understandings of causality are shaped by some broader trends.

4.4. Section summary

In this section, I have argued that the science of suicide does not exist as separate from other discourse on suicide. Rather it is oftentimes called upon to address 'suicide' as a problem and the knowledge it produces about suicide not only shape, but are shaped by existing concepts of what 'suicide' is and understandings of what the most important factors in 'suicide' deaths are. I argue that science today is simply one of the tools that we utilize to contain 'suicide' and that much of scientific discourse is continuous with discussions of ipsal deaths in different realms. I therefore move to characterize this overall discourse more broadly, also including examples from scientific works when relevant.

5. BOUNDARY DRAWING AND THE BAD IPSAL DEATHS

Across the texts that I review, there is little evidence of *disinterest*, no matter the domain. While it is expected that religious, philosophical and legal texts are trying to establish the questions of right and wrong, scientific texts overwhelmingly approach ipsal deaths through the lens of some kind of pathology. There are three main themes that emerge in the discourses on ipsal deaths that I have analyzed, and I discuss each in the section below. First is the establishment of life as inherently good, or even of a 'duty to live,' against which ipsal deaths are framed as problematic. Second, boundaries are frequently drawn with respect to the extent of the deceased's intentionality, highlighting the purposeful action against 'life' as a violation of particular concern. Finally, many discussions differentiate contexts in which intentional ipsal deaths are appropriate and those in which they are not, indicating that the 'duty to live' is not absolute and it can be suspended especially if the death is legible as a meaningful social action.

5.1. The duty to live: Why ipsal deaths are 'bad'

Many texts explicitly frame the ipsal deaths they are concerned with as 'bad,' 'wrong,' or 'pathological,' generally with reference to an established set of values, rules or sources of authority. In Table , I offer some of the examples of this kind of discourse, making note of the different entities that ipsal deaths are conceptualized as being in opposition to. What all of these discussions have in common is that they task an individual—implicitly or explicitly— with preserving their life. Ipsal deaths are a concern because, if one is to preserve their life, any role a person might have in bringing about their death is open to scrutiny. A certain imperative to live is expressed with respect to a variety of frames: God, parents, society as a whole, virtue, oneself, or simply biology.

Source	**Quote**	**Violation against**
Confucius (2013a, in ESDA, Confucius (551-479 B.C.), 2015)	Our body, limbs, hair, and skin are received from our parents, and so we do not dare to injure or harm them. This is the beginning of filial piety.	Parents
Aristotle (1925 in ESDA, Aristotle (384-322 B.C.), 2015)	Again, when a man in violation of the law harms another (otherwise than in retaliation) voluntarily, he acts unjustly, and a voluntary agent is one who knows both the person he is affecting by his action and the instrument he is using; and he who through anger voluntarily stabs himself does this **contrary to the right rule of life**, and this the law does not allow; therefore **he is acting unjustly. But towards whom? Surely towards the state, not towards himself**. For he suffers voluntarily, but no one is voluntarily treated unjustly. This is also the reason why the state punishes; a certain loss of civil rights attaches to the man who destroys himself, on the ground that **he is treating the state unjustly**.	Rule of Life, the State
Chrysippus (Arnim, 1903 in ESDA, Chrysippus (c. 280-c. 206 B.C.), 2015)	But the Stoic philosophers too understood philosophy to be the practice of death, and for this reason they wrote of five ways of reasonable departure from life. **Life is like a great party in which the soul seems to feast,** and all the ways of reasonable departure from life correspond to the ways in which a party is broken up.	One's own soul
The Questions of King Milinda (Milindapañha, 1890 in ESDA, The Questions of King Milinda (c. 100 B.C.), 2015)	It was in order that so good a man as that, one whose good qualities are so many, so various, so immeasurable, **in order that so great a treasure mine of good things, so full of benefit to all beings, might not be done away with**, that the Blessed One, O king, out of his mercy towards all beings, laid down that injunction, when he said: "A brother is not, O Bhikkhus, to commit suicide."	Benefit of others

Table 1-3. Examples of texts that discuss ipsal deaths with respect to a duty to live

Source	Quote	Violation against
Augustine, (1871, p. 26)	Why, then, should a man who has done no ill do ill to himself, and by **killing himself kill the innocent** to escape another's guilty act, **and perpetrate upon himself a sin of his own**, that the sin of another may not be perpetrated on him?	Self
Sym (1637: pp. 53-54)	And this sin, of all others, is most **against the Law of Nature**, for that **self-preservation** arms a man to turn upon others unlawfully invading him to kill him. And also, it is *against that self-love*, which is the rule of our love to others and therefore what we may not lawfully, in this case, do to others, we can less lawfully do it to ourselves against this **general law of love;** in breaking whereof, specially towards ourselves, we violate the whole law, the general sum whereof is love.	Nature/self preservation, self-love and love of others.
Rowley (1804, pp. 112-13	1. In a religious view, it is **contrary to the divine precepts of Christianity**, and therefore criminal. 2. In political view, it robs mankind of those services, whether corporeal or mental, that **society at large has a right to expert and demand** of each individual forming a part of the whole. Suicide is a crime, then, where the duties of every individual are politically considered. 3. In a moral view, it is an heinous crime, as far as it relates to the **duties a man owes to his relations or friends through life**: it is a dissolution of all those ties by which men are bound either by interest or affections. No human being can exist without the assistance of some of his own species ; nor does any person live whose corporeal or mental services, either for labor or advice, may not become useful.	Divine precepts, society at large, friends/family
Hecht (2013, p. 4)	Unlike so many other dangers to public health and safety, suicide can seem like a crime without a real victim. But the person who commits suicide is, in fact, a real victim. Additionally, the friends, family, and **community of those who die suffer mightily, even fatally, and are likewise victims**. The whole of humanity suffers when someone opts out. The suicide is also a real victim because **he or she had a future self that may not have wanted this.**	Self, community, humanity.
Oxford Handbook of Suicide and Self-Injury (Nock, 2014, p. 1)	Self-injurious behaviors are among the most alarming and perplexing of all human behaviors. Most of what we do as humans is aimed at keeping ourselves **alive and passing on our genes**. We eat, sleep, work, cooperate with others, procreate, and sacrifice for our offspring all in the service of **survival**. So why, then, in some instances do some people act in complete **opposition to this innate and ever-present drive for self-preservation?**	Genes, self-preservation.

Table 1-3, continued

While this discourse does not, in itself, draw clear boundaries, it does establish ipsal deaths as maters of concerns, and sets up the stakes against which boundaries might be established. If an individual is perceived to have played a role in their death, their actions are seen as being in conflict with the established understanding of what is 'good' and/or 'natural'. This seems to open such

deaths to scrutiny. We see this concern clearly articulated in contemporary times, in understandings of 'suicide' as pathological as well as, in more general discourse, as 'selfish' (transgression against loved ones) or as a 'permanent solution to a temporary problem' (transgression against self).

5.2.Extent of one's role in death

While playing a role in one's own death is seen as some sort of a violation across contexts, there is significant boundary drawing that occurs with respect to the extent of this role. I examine this role in terms of temporality, instrumentality, and intentionality and discuss each in turn below. Some of the boundary drawing work that is implicit, in that the boundaries are drawn by not even including certain kinds of deaths in the discourse which marks them as conceptually separate. This is especially the case in considerations of temporality and instrumentality. Other times, the boundary-drawing is explicit, especially when it comes to discussions of intentionality, which I discuss in most detail.

In terms of temporality, it is important to note that discussions overwhelmingly and sometimes explicitly focus on temporally bounded and acute events. A notable exception is John Sym (1637) who posits the category of 'indirect self-murder' (see Table) and discusses actions that can over time lead to death. While different cultural prescriptions certainly exist at various times and places around how to preserve health etc., it is significant that ipsal deaths without a clear temporally proximal cause generally do not become matters of concern. It is as if the imperative to live does not, or cannot extend that far. Another recent exception is, possibly, the emergent category of "deaths of despair" (Case & Deaton, 2020) which attempts to groups together deaths from suicide,

alcohol use, and drug use according to a perceived common cause, which disregards temporality and also intentionality.

With respect to instrumentality, boundaries can be drawn with respect to the nature of this proximate cause, specifically based on whether the person has physically acted upon their body or not. That is, 'seeking death'—as in purposefully putting oneself in situations that endanger life—might be distinguished from 'killing oneself,' as for example in Sym's indirect and direct murder. While apparently intentional exposure to risky situations does seem to make up a culturally legible kind of behavior in some contexts (e.g. the "Crazy Dog" pledge which I discussed in the *Literature Review*, Lowie, 1913 in ESDA, Crow, 2015), this kind of ipsal death is very rarely discussed as a matter of concern.

That said, references to instrumentality do seem to interact with understandings of intentionality in important ways, as individual's acting upon one's own body seems to serve as evidence of intent and conceptually distinguishes different kinds of death. For example, late 18th century authors put significant effort into arguing for similarities between suicide and dueling (e.g. Moore, 1790; Hey, 1812; also see discussion in Minois, 1999, p. 10), but the boundary between the two stays firm. Today in the US, 'suicide-by-cop' is an emergent and highly contested category partially due to the politically-charged instrumentality involved and complexities of establishing intentionality. Finally, questions of instrumentality as tied to intentionality also emerge today with respect to 'euthanasia' and 'physician assisted dying,' in which, again, the individual's action is taken as evidence of their intention.

In terms of intentionality specifically, the individual's intent or goal repeatedly emerges as the piece of central concern throughout my corpus. First, there is the general ability to form intent, often tied to questions of (in)sanity and occasionally age (and for a brief period at the turn of the 20th c, emerging in the discussions of 'whether animals can commit suicide'), as exemplified by excerpts in Table 1-. In the West, there sometimes seems to be a tension in the relationship between suicide and insanity: on one hand, presence of insanity means that a death was not a suicide death (inability to form intent), but on the other hand, suicide itself is sometimes argued to be *evidence of* insanity. There is significant blurring here that occurs mainly within the category of 'insanity' (e.g. with respect to emergent category of mental illness, which does not necessarily imply impaired ability to formulate intent), and partially with respect to practical ramifications of the legal categories of '*felo de se'* ('felon of oneself') and '*non compos mentis*' ('not in one's right mind') that I have discussed in the *Literature Review*. I make note of this tension, considering the important role of 'mental health' in discourse on 'suicide,' though a more detailed discussion is outside of the scope of the current work.

Source	Quote
Caesarius (1929/1220-1235, p. 241)	If the cause be **only melancholy and despair**, not madness or wandering of the mind, there can be little doubt that they are damned. **In the case of those who are mad or weak minded, in whom the power of reason is lost, they are assuredly saved**, however they die, if they were in a state of grace before the madness took them.
Henry de Bracton (1879 in ESDA, Henry de Bracton (c. 1210-1268), 2015)	But what shall we say of a **madman bereft of reason? And of the deranged, the delirious and the mentally retarded? Or if one labouring under a high fever drowns himself or kills himself?** Quaere whether such a one commits felony de se. It is submitted that he does not, nor do such persons forfeit their inheritance or their chattels, since they are without sense and reason and can no more commit an injuria or a felony than a brute animal, since they are not far removed from brutes, as is evident in the case of a minor, for if he should kill another while under age he would not suffer judgment. (…) **That a madman is not liable** is true, unless he acts under pretense of madness while enjoying lucid intervals

Table 1-4. Examples of texts discussing the individual's ability to form an intent

Source	Quote
Webster dictionary 1828/1913 (Webster's Dictionary 1828, n.d.; Webster's 1913, n.d.)	Self-murder; the act of designedly destroying one's own life. To constitute *suicide* the person must be of **years of discretion and of sound mind.** The act of taking one's own life voluntary and intentionally; self-murder; specifically *(Law)*, the felonious killing of one's self; the deliberate and intentional **destruction of one's own life by a person of years of discretion and of sound mind**.
Ingersoll (1984, p. 18)	Those **who take their lives in painful, barbarous ways**-who mangle their throats with broken glass, dash themeselves from towers and roofs, take poison that torture like the rack-such persons **must be insane**. But those who take the fact into account, who weigh the arguments for and against, and who decide that death is best-the only good-and then **resort to reasonable means**, may be, so far as I can see, in **full possession of their minds.**
Operational Criteria for Determination of Suicide (Rosenberg, et al., 1988)	"'Intent' requires that the decedent knew or had in mind that a specific act would probably result in death. **Alcohol, drugs, mental illness, or youth may all contribute to an individual's inability to have the mental capacity to form intention.** (…) Similarly, mental illness does not make it impossible to form intent: it is important to look for specific evidence that the deceased understood and intended the likely consequences of this act near the time he or she decided to proceed with the act." (p.1449)

Table 1-4, continued

The framing across these examples above differs: some of the earlier works seem focused on establishing blame or culpability—the person 'not being in their right mind' relieves them of responsibility for their action. In contrast, the later works do not feature that kind of language and even, in case of Ingersoll (Ingersoll, 1894), who is building an argument towards a right to die, seem to position the ipsal deaths in case of insanity as the more problematic ones. Irrespective of the framing, however, the definitions of ipsal death of concern are frequently made with respect to one's ability to form intent.

That said, not all intents are considered equal—discourse on ipsal deaths frequently grapples with the exact content of the deceased intentions. First of all, did they desire to die, or was the desire something else? Vitoria (1997/1573 in ESDA, Francisco de Vitoria (1483/92-1546), 2015), for example, notes that suicides are only those deaths in which the person "orders himself to die and the order entails the statement, 'I wish to die." Similarly, the presence of the purpose to kill oneself is one of the things that distinguishes Sym's (1637) "direct" and "indirect" "bodily self-murder,"

and in O'Dea (1882) the 'intention to destroy life' is necessary for a death to be considered suicide. Second, if the deceased did desire to die, the sources of this intent, that is the motivations for the death are also discussed as relevant to the evaluation of the act.

Source	Quote	Emphasis
Aristotle (1925 in ESDA, Aristotle (384-322 B.C.), 2015)	As has been said then, Courage is the observance of the mean in relation to things that inspire confidence or fear, in the circumstances stated; and it is confident and endures because it is noble to do so or base not to do so. But **to seek death in order to escape from poverty, or the pangs of love, or from pain or sorrow,** is not the act of a courageous man, but rather of a coward; for it is weakness to fly from troubles, and the **suicide does not endure death because it is noble to do so, but to escape evil.**	Specific motivation
Tattvarha Sutra, 2-5th c AD (Tattvartha Sutra 7:22 , 1992 in ESDA, The Jain Tradition (599-527 B.C. to 5th century A.D.), 2015)	It is argued that [Sallekhanā] is suicide, since there is voluntary severance of life etc. No, it is not suicide, as there is no passion. **Injury consists in the destruction of life actuated by passion**. Without attachment etc. there is no passion in this undertaking. A person, who kills himself by means of poison, weapons, etc., **swayed by attachment, aversion or infatuation, commits suicide**. **But he who practises holy death is free from desire, anger and delusion.**	Specific motivation
Vitoria (1997/1573 in ESDA, Francisco de Vitoria (1483/92-1546), 2015)	I concede only that they do not kill themselves with the intention to kill themselves. None of the deaths in these arguments, whether lawful or not, is suicide in the sense that I accept, that is, the suicide **orders himself to die and the order entails the statement, "I wish to die."**	Intent to die
Sym (1637, p. 85)	**Direct** bodily self-murder is the killing of a man's body or natural life by himself, or his own means, **advisedly, wittingly, and willingly, intending and effecting his own death. Indirect** self-murder of the body is when a man advisedly, wittingly, and willingly intends, and does that which he knows may be of itself, the means of the destruction of his natural life, although **he does not purposely intend to kill himself** thereby. Or it is the killing of a man's own body, by unlawful, either moral or natural means of his own using, without intending of his death thereby.	Intent to die

Table 1-5. Examples of texts discussing the nature of one's intent

Source	Quote	Emphasis
Huang, 17 c (Huang, 1984 in ESDA, Huang Liuhong (1633-c. 1710), 2015)	Among women who commit suicide, some kill themselves **because of ill treatment** at the hands of their parents-in-law, while others do so **because of their husband's cruelties.** These **unfortunate women deserve our sympathy**. However, there are cases in which a woman, having a quarrel with her mother-in-law, having an occasional argument with her husband, or having exchanges of heated words with a sister-in-law or even a stranger, kills herself in a **paroxysm of distress. This kind of self-destruction does not constitute a case for condolence.** As to men who commit suicide, some suicides are **due to dire poverty or suffering from extreme cold and hunger**; others are the **victims of private or official debts** without means to repay. These people are entitled to our compassionate consideration. But there are those who **sacrifice their lives because of insignificant grudges and choose to die in the homes of their enemies**, their **main purpose being to vent their spleen** and let their relatives seize the enemies' property on trumped-up charges. Such acts of depravity cannot be condoned.	Specific motivation
O'Dea (1882, p. v)	By the term suicide is meant the intentional destruction of one's own life. (…) It **excludes deaths from acts or lines of conduct which, howsoever much opposed to self-preservation, are not intended to destroy life.** Although in judging examples belonging to this class it is customary to declare them suicidal, yet such declaration is rather a moral estimate of conduct tending to death than a technical deliverance as to the character of the death itself.	Intent to die

Table 1-5, continued

Notably, the motivation of the deceased is not evaluated the same way across contexts. In 4th c BC Greece, for example, Aristotle (1925 as excerpted in ESDA, Aristotle (384-322 B.C.), 2015) condemns ipsal deaths motivated by escape from poverty, pain and sorrow as acts of cowardice, not courage, which would otherwise designate the acts as noble. In contrast, in 17th c China, Huang considers ipsal deaths in those similar conditions—poverty and extreme suffering—to be worthy of sympathy, in contrast to the deaths of those who act due to "insignificant' matters who are not victims of difficult circumstances and should be condemned for their acts (Huang, 1984 in ESDA, Huang Liuhong (1633-c. 1710), 2015). However, that attention is paid to internal states of the deceased, and the circumstances of the death, across various contexts is significant. That wishing to die is more appropriate in some context than in other again highlights the limits of responsibility to live, or, rather, socially condoned or even honored suspensions to this duty.

5.3.When can the duty to live be suspended?

Across the texts, an important question that regularly emerges has to do with if, and when, one's duty to live can or should be suspended, and it's often expressed in reference to either to some competing duties or to the value of life itself. Other duties or virtues can be seen as competing against—and possibly superseding— one's duty to preserve life (e.g. to help another, not to harm another, to fulfill some sacred duty etc.). When discussions occur within a singular cultural context, these deaths will often not emerge as a focus of concern at all and are often conceptualized and categorized separately from other ipsal deaths in positively-valued categories (e.g. 'self-sacrifice'). Tensions arise in cross-cultural discussions: Indian *suttee,* for example, while commonly discussed as 'suicide' in the West, has historically been discussed not in relation to some other ipsal deaths but either 1) conflicts in scripture regarding the duties of the widow, or 2) differences between the practice of suttee and effective murder of the widow (e.g. Roy, 1906/1818 excerpted in ESDA, Rammohun Roy (1774–1833), 2015)

Source	**Quote**	**Competing duty**
Confucious (2013b in ESDA, Confucius (551-479 B.C.), 2015)	The Master said, "Among those who have [good] purpose and those who are ren, none will seek life at the expense of harming ren, and there are those who will cause death for their person in order to accomplish what is [or accords with] ren.	Ren (goodness, highest virtue)
Dharmashastra (in ESDA, Dharmashastra (c. 600 B.C.—c. 200 A.D.), 2015)	For him who committing suicide becomes an Abhisasta [outcast], his blood-relations (sapinda) shall not perform the funeral rites. He is called a suicide who destroys himself by means of wood, water, clods of earth, stones, weapons, poison, or a rope. (Vasishtha Sutra XX, XXIII) Now the duties of a woman (are as follows). After the death of her husband, to preserve her chastity, or to ascend the pile after him. (Vishnu Smriti XXV)	Duty to husband/ chastity
Al-Ghazali (1997 in ESDA, Abu Hamid Muhammad al-Ghazali (1056-1111), 2015)	**The most perfect of delights** is that which is the lot of the Martyrs who are slain in the way of God. For when they advance into battle they cut themselves off from any concern with the attachments of the world in their yearning to meet God, **happy to be killed for the sake of obtaining His pleasure.**	obtaining God's pleasure

Table 1-6. Examples of discourse on those duties that compete with the duty to live

Source	Quote	Competing duty
Tosafot (in ESDA, Tosafot (12-14th centuries), 2015)	R. Tam said: In those cases in which they are afraid that idolaters may force them to sin by tortures that they will not be able to withstand, then it is a mitzva to destroy themselves as in the case of the young people taken captive to be used as prostitutes who threw themselves into the sea.	Avoidance of sin
Luria (in ESDA, Solomon ben Jehiel Luria (1510-1573), 2015)	To save the lives of others it is permissible to kill oneself… Nevertheless, one can set the house afire so that he and his children will be burned to death in a time of decrees [i.e., persecutions], and this is not considered suicide, but like letting oneself be killed, and this is permissible.	Helping others, devotion
Rattray (1927, in ESDA, Ashanti #6, 2015	Suicide, except under certain peculiar circumstances, was formerly regarded in Ashanti as *a capital sin*. (…) Not all forms of what we would term 'suicide' were regarded as sins; in fact, under certain circumstances, **the action of taking one's own life was considered as honourable and acclaimed as praiseworthy**; e.g. to kill oneself in war by taking poison, or sitting on a keg of gunpowder to which a light was applied, **rather than fall into the hands of the enemy or return home to tell of a defeat**; to take one's own life in order to **accompany a beloved masters or mistress** to the land of the spirits; and finally, those especially interesting cases, where a man commits suicide **to wipe out what he considers his dishonour** and because he cannot stand the ridicule of his companions	Preserving honor, duties to master/mistress,

Table1-6, continued

The suspension of duty to live also frequently emerges in the context of the perceived decreasing value of one's life, specifically in old age. This kind of boundary-drawing is tightly bound with ideas about the value of human life and is generally articulated with respect to 1) ideas of a 'good death' as an extension, not an interruption, of a good life and 2) social duties to the dying. Two main concerns seem to arise in navigating the morality of ipsal deaths in the context of decreasing value of one's life. One is tied to an individual's right to die with respect to the general imperative to live (can the duty ever be suspended or not?) and the other is tied to others' responsibility, or lack thereof, towards the dying (e.g. is allowing or facilitating their death a form of murder? Who is responsible for helping to keep them alive?). The latter is especially interesting as it not only brings up those questions of 'instrumentality,' but also further highlights the fact that the discourse of ipsal deaths, and the ipsal deaths themselves, do not exist in a vacuum but rather interact with other frameworks and categories. As I will discuss in the following section, in terms of

responsibility and blame for bad ipsal deaths, boundaries between categories like 'murder' and 'suicide' can be quite blurry.

Source	Quote
Plato (1920/1892 in ESDA, Plato (c. 424-c. 348 B.C.), 2015	**if a man was not able to live in the ordinary way he had no business to cure him**; for such a cure would have been of no use either to himself, or to the State. (…) This is the sort of medicine, and this is the sort of law, which you sanction in your State. They will minister to better natures, giving health both of soul and of body; **but those who are diseased in their bodies they will leave to die, and the corrupt and incurable souls they will put an end to themselves. That is clearly the best thing both for the patients and for the State.**
Tattvartha Sutra, 2-5th c AD (in ESDA, The Jain Tradition (599-527 B.C. to 5th century A.D.), 2015)	Sallekhanā is **making the physical body and the internal passions emaciated by abandoning their sources gradually at the approach of death**. (…) It is argued that it is suicide, since there is voluntary severance of life etc. No, it is not suicide, as there is no passion. Injury consists in the destruction of life actuated by passion. Without attachment etc. there is no passion in this undertaking. A person, who kills himself by means of poison, weapons, etc., swayed by attachment, aversion or infatuation, commits suicide. **But he who practises holy death is free from desire, anger and delusion. Hence it is not suicide.**
More (1999/1516, in ESDA, Thomas More (1478-1535) , 2015	But **if the disease be not only incurable, but also full of continual pain and anguish,** then the priests and the magistrates exhort the man (seeing he is not able to do any duty of life, and by overliving his own death is noisome and irksome to other and grievous to himself), that he will determine with himself no longer to cherish that pestilent and painful disease. And, seeing his life is to him but a torment, that he will not be unwilling to die, but rather take a good hope to him, and either dispatch himself out of that painful life, as out of a prison or a rack of torment, or else suffer himself willingly to be rid out of it by other. And in so doing they tell him he shall do wisely, **seeing by his death he shall lose no commodity, but end his pain. And because in that act he shall follow the counsel of the priests, that is to say, of the interpreters of God's will and pleasure, they show him that he shall do like a godly and a virtuous man.** (Note: this is from More's *Utopia*, in which he conceptualizes and ideal society. The work, nonetheless, expressed his values.)
Hume (1932, in ESDA, David Hume (1711-1776), 2015)	I am not obliged to do a small good to society, at the expense of a great harm to myself. **Why then should I prolong a miserable existence**, because of some frivolous advantage, which the public may, perhaps, receive from me? If **upon account of age and infirmities**, I may lawfully resign any office, and employ my time altogether in fencing against these calamities, and alleviating, as much as possible, the miseries of my future life: **why may I not cut short these miseries at once by an action**, which is no more prejudicial to society
AAS (2017)	PAD is not a matter of life or death; it is a matter of a foreseeable death occurring a little sooner but in an easier way, in accord with the patient's wishes and values, vs. death later in a potentially more painful and protracted manner. (…)

Table 1-7. Examples of discourse on ipsal deaths in the context of illness and end-of-life

What emerges from these discussions is that in addition to death itself being a problem, living too long—or maybe better to say, prolonged dying—also presents an existential problem for societies at different times. The ethnographic record especially, features various reports of people in old age

being “left behind” (e.g. Hilger, 1952 in ESDA, Arapaho #14, 2015; Wallace & Adamson Hoebel, 1952 in ESDA, Comanche #13, 2015) or arranging their own deaths (e.g. Wilkes, 1845 in ESDA, Fiji #2, 2015; Weyer, 1969/1932 in ESDA, Eskimo of Diomede Island, 2015). It is likely that various material factors play a role here—e.g. in terms of demands of life and resource availability, general causes of mortality and life expectancy, as well as technologies and institutions that prolong life and organize care of the elderly— but cultural ideas about death in general also seem to play a significant role.

5.4. Section summary

In examining the boundary drawing practices with respect to ipsal deaths, I focused on aspects of ipsal deaths that are presented as matters of concerns across different contexts and I have shown that there are some important commonalities that emerge across different discourses on ipsal deaths. I argue that these patterns can not only offer a generic framework for how categories might be constructed around ipsal deaths in any given context, but might also speak to the kind of challenge ipsal deaths present to human societies overall. For example, that ipsal deaths are often seen as bad, specifically with respect to values and beliefs that necessitate people to live, indicates that cultures are oriented towards sustaining life. Similarly, concerns about intent highlight the importance of individual agency in the context of moral judgements, and the discussions of specific motives for and circumstances of ipsal deaths point to tension between the value of an individual’s life to them, and the value of the life to the community or some other socially endorsed ideal, which likely have to be continuously negotiated.

In terms of discursive practices of explicit boundary-making, questions such as 'Is X suicide?' generally seem to stand for "Is X the bad kind of an ipsal death?" The purpose of these distinctions overall appears to have something to do with seeking some change: Don't X, stop X, we need to do something about X. Majority of texts I review were composed to someone and for something: to admonish, to alarm, to clearly establish rules, to help, to encourage to endure, to make live. With this kind of reading, we can understand the attempts to define 'suicide' within science as similarly participating in the collective effort of determining which deaths we should be worried about and prevent, and which ones are some other kind of a problem, or no a problem at all.

Of course, these conceptualization of particular kinds of ipsal deaths as bad or problematic in some way are entwined with understandings of who or what is to blame for them. I have already gestured to this by highlighting the relationship between individual intention and culpability in some texts, but now I turn to the question of blame specifically.

6. CAUSALITY, RESPONSIBILITY AND BLAME

In the previous section, I have shown that boundary drawing within the space of ipsal deaths is frequently conducted with respect to the notions of intentionality (was there an intention? what was the intention?) as well as understandings of motivations behind human action. Through this process, certain ipsal deaths emerge as 'bad deaths' which are seen as going against (super)natural laws, as well as harmful to communities. Predictably, actions that bring about such bad ipsal deaths are bound up—more or less formally—with different kinds of prohibitions, sanctions or more general ideas about prevention. These ideas of appropriate responses to ipsal suicide deaths are themselves tied to understandings of what was the *(main) cause* of a particular ipsal death, or

particular kinds of death. The ideas about what causes ipsal deaths therefore play a significant role in both determining whether some kind of social response is necessary in case of a particular death, and what this response should be. While causes of good ipsal deaths are wholly unproblematic by definition, the question of the cause is a somewhat contested ground in cases of bad ipsal deaths as they are tightly bound to the processes of assigning blame and bringing about punishment, as necessitated by their moral evaluation.

In this section, I look more closely at these ideas about causality in the cases of 'bad' ipsal deaths, and examine how and where any responsibility or blame for these bad deaths is attributed. I show that across history, causality was commonly attributed either to the deceased individual (e.g. their character, ignorance, or some sense of 'mental illness') or an identifiable external actor (supernatural, like the Devil, or another person or organization), all of whom fit easily within established schemas of assigning blame and, if relevant, punishment. However, in the 19th century Western culture, we see a new locus of responsibility emerging—'the society,' with which discussions of suicide enter the realm of the political. More specifically, it is during this time that certain conditions of life—which were previously noted but not considered under anyone's purview—come to be seen not only as mutable, but as something that the State can and should take charge of. This development aligns with significant sociopolitical changes, including an increased focus on management of individual bodies and populations (c. Foucault's biopower as discussed in Hacking, 1982), as well as appearance of humanitarianism and socialism or communism, which emphasized, in their politics, the duties of society to individuals. While previous work on history of suicide emphasized the 'medicalization of suicide,' I argue that this emergence of a society as a conceivable causal factor presents a more interesting discontinuity. In

case of medicalization, the locus of causality, and the potential object of intervention continues to be an individual. However, when 'society' becomes a possible cause, new ways of holding entities accountable, and of conceiving intervention have to be created. I continue this discussion in Chapter 2, as I show how this process takes place across the late 19th and the 20th century in the US.

In discussing the types of blame that I have noted in my corpus, I follow a slightly different approach than in the previous section, in that I focus on building a conceptual structure rather than cataloguing a series of examples. With respect to my interest in how responses to ipsal deaths as bad events might be incorporated into established practices of assigning responsibility, I identify three broad types of blame, and illustrate each with a few examples that I discuss in more depth. First, there are the human actors (or actors that can be understood as 'social' in some way) that are easily assimilated into established legal/religious/moral structures. Second, I deal with a set of (imagined) non-corporeal entities, focusing on the Devil and depression, that themselves cannot be held responsible, but show that there might still exist responsibilities with regards to moderating their influence. Finally, I take up the discussion of life's circumstances and what I consider to be the major shift in social thought regarding responsibility—a shift from individual's responsibility to society toward the possibility of envisioning the society's responsibility to individuals and the lack of existing structures that can be relied upon to enforce these responsibilities

6.1.Looking for the killer: Self vs Other

Throughout my corpus, many writings that discuss the immorality of certain (or all) ipsal deaths stress the moral responsibility of the individual and the punishment the deceased will have to endure as a result of their transgression, generally in the afterlife. At the same time the idea of

others driving or inciting a person to take their own life emerges frequently, at different times and at different places, especially within writings on law/social rules, which are called upon to hold those others accountable.

6.1.1. Blaming the deceased

The understanding of the deceased as morally culpable for their death is very visible in all discussions that condemn some form of 'self-killing' that frame the act as that of a willing actor committing something akin to murder of another. The two—killings of self and killings of another— are often juxtaposed, which is also evident in the language itself—as Daube (1972) notes, languages frequently use a combination of 'self' and 'kill' to express the idea of suicide. For example, the Dharmashastra Sutras, produced and compiled in the long period of 600 BC - 200 AD, group those who take their own life together with those who take lives of others, and declare the consequences of the former as follows:

> For **he who takes his own or another's life becomes an Abhsiasta** [outcaste]. (*Apastamba Sutra I.9.25, I.10.28.17* in ESDA, Dharmashastra (c. 600 B.C.—c. 200 A.D.), 2015))

> For him who committing suicide becomes An Abhisasta, **his blood-relations (sapinda) shall not perform the funeral rites.** He is called a suicide who destroys himself by means of wood, water, clods of earth, stones, weapons, poison, or a rope.
>
> (…)
> **He who attempts suicide, but remains alive, shall perform a Krikkhra penance during twelve days**. (Afterwards) he shall fast for three (days and) nights, being dressed constantly in a garment smeared (with clarified butter), and suppressing his breath, he shall thrice recite the Aghamarshana. (*Vasishtha Sutra, XX, XXIII,* in ESDA, Dharmashastra (c. 600 B.C.—c. 200 A.D.), 2015)

Plato similarly aligns certain ipsal deaths with acts of killing another. In his *Laws,* in the section discussing homicide, he writes:

> **And what shall he suffer who slays him who of all men, as they say, is his own best friend?** I mean the suicide, who deprives himself by violence of his appointed share of life, not because the law of the state requires him, nor yet under the compulsion of some painful and inevitable misfortune which has come upon him, nor because he has had to suffer from irremediable and intolerable shame, **but who from sloth or want of manliness imposes upon himself an unjust penalty.** For him, what ceremonies there are to be of purification and burial God knows, and about these the next of kin should enquire of the interpreters and of the laws thereto relating, and do according to their injunctions. **They who meet their death in this way shall be buried alone, and none shall be laid by their side; they shall be buried ingloriously in the borders of the twelve portions the land, in such places as are uncultivated and nameless, and no column or inscription shall mark the place of their interment**. (Plato, 1920/1892 in ESDA, Plato (c. 424-c. 348 B.C.), 2015)

As I have discussed in the previous section, across philosophical and religious traditions, win Plato's writing we see formulations of an 'imperative to live' in which case causing one's own death is clearly morally reprehensible. At the same time, establishing consequences for this kind of behavior, that is punishing the moral transgression, presents a difficulty for each of these traditions as the person does not fall easily within the reach of usual social sanctions. The puzzle is generally resolved by one or more of the following three strategies.

First, the deceased's body can stand in for the full person. Sometimes the 'body' itself is punished (see Minois, 1999, pp. 31-36), sometimes it is denied a proper burial (see examples above, also Minois, 1999, pp. 36-40), and this is in overlap with the following two strategies, and sometimes it might actually participate in a ritualized trial as an accused (e.g. by Ashanti law, as described by

Rattray, 1927 in ESDA, Ashanti #6, 2015). Second, the consequences for the deceased in the afterlife might be clearly laid out, if a sense of afterlife exists. Isha Upanishad tells us that the 'slayers of the Self', upon death, go to Devilish worlds covered in blind darkness (*Isha Upanishad* in ESDA, The Vedas, Upanishads, and Puranas (c. 1500-c. 500 B.C.), 2015). Similarly, among the Inuit of Cumberland sound those who take their own life are said to "go to a place in which it is always dark, called '*Kumetoon'* and where they go about with their tongues lolling" (Boas, 1907 excerpted in ESDA, Eskimo of Cumberland Sound, 2015). According to the Hadith, "The Prophet said, 'He who commits suicide by throttling shall keep on throttling himself in the Hell Fire (forever) and he who commits suicide by stabbing himself shall keep on stabbing himself in the Hell-Fire." (in ESDA, Hadith: The Sayings of Muhammad (7th-9th centuries), 2015), and Dante, in his 14th c Divine comedy, the souls of those whose minds 'believing [they] could flee disdain through death, made [them] unjust against [their] on just self" (Alighieri, 2014/1472, Canto 13) are transformed into trees with knotted and gnarled branches and black leaves, and are then painfully munched on by the Harpies. The souls look for their bodies but cannot wear them, rather the bodies come to hang on the trees. (Alighieri, 2014/1472, Canto 13)

Finally, the surviving family of the deceased can be made to suffer consequences, in lieu of the deceased themselves. Bracton's (1879 excerpted in ESDA, Henry de Bracton (c. 1210-1268), 2015) 13th century discussion of English laws and customs, for example, highlights certain cases of 'slaying oneself' as intimately tied with felony. In these cases, the deceased goods and inheritance are confiscated. Otherwise, only his 'movable goods' are confiscated indicated that even when the death is not considered a felony, some social consequences emerge, though this might also be the Crown's attempt to gather money (Davis, 1997). It might also be possible to

consider some turn of the 20th century discussions on suicide and insurance in the US as establishing certain familial consequences in case of suicide deaths (Elliott, 1885; Lawyer, 1901).

All three of these strategies, ultimately, frame the bad ipsal death as a transgression and situate the moral responsibility for it in the deceased individual. In this, they resemble the first type of blame as described by Douglas (1992), which focuses the blame on the deceased, and seem to be tied to established procedures that move from blame to specific consequences and punishment, indicating an institutionalization of the process. Other times, however, the deceased is seen as a victim, and responsibility is ascribed to others.

6.1.2. Blaming Others

The question of *others* responsibility for an ipsal death frequently emerges in the boundary-drawing that I discussed in the previous section, with respect to the extent of a person's role in their death and the motivations behind their intent. The process of designating a death a certain way often includes the process through which it first has to be determined whether someone else is to blame.

For example, writing down Yoruba customs and laws, A.K. Ajisafe (1924, excerpted in ESDA, Yoruba, 2015) notes the following:

> When a man **finds life burdensome, disgraceful, and perilous to him**, and consequently commits suicide he is given great credit and honour. But when **out of shame for a mean act** he commits suicide, his corpse is considered abominable and cast into the bush unburied.

(a) **Should a man or woman be provoked to commit suicide, the provoker is held responsible for the same**. The penalty is a very heavy fine to be paid to the family of the victim or forfeiture of the provoker's life. The corpse of the suicide is not buried, but is removed to the house of the provoker till the judgment shall have been satisfied; then the corpse is taken over by the family, who bury it according to the rites and ceremonies for the burial of suicides. (Ajisafe, 1924, excerpted in ESDA, Yoruba, 2015; emphasis mine)

Anthropological writings recording the customs among the Tlingit in Alaska record a similar idea of looking for the person responsible for an ipsal death:

"If a man commits suicide, a cause is always sought, and **he who is regarded responsible for the cause is blamed and his tribe made to pay damages**…" (Jones, 1914, excerpted in ESDA, Tlingit #46, 2015 ; emphasis mine)

"An injured person who has no possibility of revenge, or someone who is pursued and sees no way out, takes his life with the thought that he is thereby injuring his enemies, for the **person who drives another to suicide will still be held responsible by the dead man's friends and relatives, just as though he had killed him outright**. (…) When in 1875 a Stikine chief, Fernandeste by name, committed suicide while he was being taken to Portland for a hearing because he became depressed on account of his circumstances, according to the report, his relatives demanded compensation of General Howard, claiming that the other Indians called them cowards because they had not taken revenge for his death. To pacify the Stikine, Howard gave them 100 blankets and delivered the body of Fernandeste. (Krause, 1956, excerpted in ESDA, Tlingit #44, 2015; emphasis mine)

And in his "*Complete Book Concerning Happiness and Benevolence,"* a manual for local magistrates in 17th c China, Huang Liu-Hong writes the following:

When a suicide case is reported, the magistrate should go to the place where it happened and examine the corpse immediately. When real grievances of the deceased can be ascertained, the person who has caused his death should be

> punished with heavy blows and levied a fine to pay for the burial expenses and to pacify the spirit of the deceased. On the other hand, if the suicide is committed without provocation or valid reason, the magistrate should order the relatives to have the corpse buried and no innocent people should be implicated in the case. Thus the evil trend of false accusation can be suppressed and the people will know how important it is to value their own lives. (Huang, 1984, excerpted in ESDA, Huang Liuhong (1633-c. 1710), 2015)

Across these three diverse examples, we see that the central concern are not the actions of the deceased, but the possibility that others acted in a morally reprehensible way and therefore brought about the ipsal death. Ascertaining the motives behind the death, therefore, enables the prosecution of others, if appropriate. In many ways these cases of ipsal deaths do not fit well within contemporary notions of suicide and appear more like cases of homicide.

In contemporary times, especially in the West, discussions of others' responsibility for an individual's suicide are quite rare and might even be deemed inappropriate. Consider, for example, Thomas Joiner's discussion of responsibility and blame in his seminal volume, 'Why People Die by Suicide' (2005):

> My model emphasizes perceived burdensomeness and a perceived sense of low belongingness. It is painful for survivors to understand that their loved ones, lost to suicide, perceived these things about themselves; but **it is helpful, I think, to understand that these were perceptions, not realities that should be blamed on survivors.**

It might be pertinent, however, to note that even Joiner's theory does note 'child abuse' as a risk factor for suicide. It is not clear whether one should infer any blame of child abusers from here, though the agents of the abuse are generally absent from theories of suicide, as if it can be suffered without being perpetrated.

At the same time, the idea that external others can contribute to an individual's suicide, and that they should be held responsible for it continues to exist and has to be negotiated within legal systems, if not within theories of suicide. Notably, contemporary law generally distinguishes physical means of suicide from suicidal intent, in that it is mostly concerned with the legality of facilitating another's ipsal death by providing material means, generally in the context of 'assisted dying.' In contrast, holding others responsible for contributing to the motivation behind the act is quite rare, and has emerged in legal cases and literature only in recent times. Additionally, it incorporates complex discussions regarding causality. I illustrate with two best known examples within the current literature.

In the US, a case that stands out is the 2014 death of Conrad Roy (18), who took his own life after receiving a series of texts from his girlfriend, Michelle Carter (17), urging him to do so. In an unprecedented decision, a Massachusetts court charged Carter with involuntary manslaughter:

> According to the State, Michelle's actions were **both objectively and subjectively reckless**. Michelle was objectively wanton or reckless because "a normal ordinary woman in [her] position would appreciate the danger in advocating that carbon monoxide poisoning is a painless and effective way of committing suicide to a suicidal teen." Alternatively, the prosecution argued that her conduct was also subjectively wanton or reckless because, under Michelle's own admission, she knew that Conrad was susceptible to suicidal thoughts, and she had advance knowledge of his plan to commit suicide. **The State alleged that Michelle caused Conrad's death by enabling him to produce carbon monoxide and by telling him to "get back in [the car]" when he had second thoughts.**
>
> Alternatively, **omission or failure to act when the defendant had a duty to act** can also constitute wanton or reckless conduct for purposes of manslaughter prosecution." A defendant has a duty to act if (1) he or she has a special relationship to the victim or (2) he or she created a life-threatening condition." The State relied on the latter theory, **arguing that Carter created a life-**

> **threatening condition for a suicidal Conrad by directing Conrad to obtain a generator and pressuring him to commit suicide**. Because she created the life-threatening condition, Michelle had a duty to take reasonable steps to alleviate the risk of him carrying out the plan. Michelle could have alleviated the possible harm to Conrad by either preventing his suicide or alerting his family of his plans, but she failed to do so. (Zavala, 2016)

The central focus of 'blame' here is the explicit inciting towards suicide and maybe to a lesser extent, failure to prevent death (see next section), but the argument also strongly tied to the question of material contribution—note the focus on 'enabling him to produce carbon monoxide,' which does to an extent build a bridge to the cases of 'assisted suicide' mentioned earlier.

In contrast, some recent discussions in the UK present a more complicated case, as they orient themselves not around inciting/failing to prevent the act itself, but rather around the causation of the desire to die itself—a concern akin to those I discusses earlier in this section. In such a way, they are much more tightly bound to both the scientific and folk ideas about what 'causes suicide.' Consider, for example, the 2005 death of Gurjit Dhaliwal in London, who hanged herself after suffering domestic violence over a period of years. Gurjit's husband, although cleared of all charges, was initially prosecuted for "psychological manslaughter" in an otherwise unprecedented case. Lodge (2020) discusses the case in the *Journal of Criminal Law:*

> The decisive issue in Dhaliwal's case was whether grievous bodily harm required a finding that the victim had been caused to suffer a recognised psychiatric illness or whether the infliction of serious psychological illness or injury would suffice to ground the manslaughter charge. Perhaps borne out of a fear of creating uncertainty, casting the culpability net too widely, and unjustifiably criminalizing the causing of 'normal' human emotions (such as grief, fear, anger), the Court of Appeal upheld the trial judge's determination that nothing short of recognised psychiatric harm or injury would constitute 'bodily harm' in this context. The Court accepted the innate evidential difficulties encountered in cases where there is no opportunity, by reason of their

> untimely death, for experts to examine victims to determine whether there is sufficient evidence of a recognised psychiatric illness. (Lodge, 2020)

The question of 'responsibility' here ultimately relies of broader understandings of 'psychiatric' and 'psychological illness'—their relationships to the body and to suicide itself. Unlike in earlier cases described above, in which another's conduct could easily be seen as 'causing' an ipsal death, the question here is rather whether 'psychiatric illness' was caused—with an implication that the death would be less avoidable (or the deceased less responsible) if that were the case.

The differences that emerge across contexts in the extent to which another person can or should be blamed for an ipsal death are significant and interesting. In some of the—notably non-Western examples—that I have discussed first, it appears that looking for the person who caused the death is the *first* step in making sense of an ipsal death. The deceased might appear morally at fault only if this salient outside influence cannot be established. This process aligns with Douglas's (1992) third type of blame, in which an 'outsider enemy' is blamed, sought out and punished. This kind of response, however, appears rarely in Western discourse and, as evidenced by some contemporary cases, the apparent boundary between 'suicide' and 'homicide' or 'manslaughter' seems difficult to cross. This difference might be a result of overall different ideas about individual agency and interpersonal relationships and further investigation into the topic could be quite productive.

6.1.3. A note on non-human actors

As I have examined additional literature to better understand my corpus, I did notice some cases in which the actor that can be found responsible and punished for an ipsal death is not a human

being, but can still be conceptualized as a possible object of law. For example, in Ancient Greece, we see evidence of inanimate objects or body parts as possibly holding responsibility for a death, in cases of both accidents and ipsal deaths. Naiden (2015) reports a paraphrase of Demosthenes (a 4th c BC Greek statesman):

> We exile pieces of wood and stones and iron implements, voiceless and senseless things that descend on somebody and cause his death, and if anyone does away with himself, we bury the hand that did it.

Naiden interprets these kinds of actions both as a response to the 'apparent guilt' of the object, as well as the idea of the object as a source of 'pollution' or '*miasma'* that, like the presence of a murderer, needs to be managed. "The non-human agent served as a substitute for a murderer" (Naiden, 2015).

As a more contemporary example of holding non-human agents responsible for ipsal deaths, there is the case of *karōshi and karōshi-jisatsu* (overwork deaths, and overwork suicide) in Japan. Through a social movement in the 1970s and 1980s, *karōshi* was recognized as a kind of death (generally due to heart attacks, stroke or suicide) caused by long working hours and stress. This ultimately led to a series of court rulings that affirmed the employers' responsibility for their employees' well-being, and a 2014 *Karoshi Prevention Countermeasures Promotion Law* (see e.g. Morioka, 2008; Asgari, Pickar, & Garay, 2016; North & Morioka, 2016). This process relied greatly on the possibility of suing and holding *companies* responsible within the present legal system, and ability to localize causality in a particular entity. As such, this stands in contrast do discussion of 'social causes' of suicide that I will present below.

What the variety of blamed entities that I have described above have in common is that they easily exist within established structures for assigning blame and meting out punishment, for example through legal systems of religious doctrine. The parties held responsible are easily identifiable, their responsibility is tied directly to actions that are understood to be the main cause of the ipsal death, and the transgressive act is punished through existing social codes. The understanding of the cause and the blamable agent, however, do not always necessarily align, and this is the set of interpretations that I turn to next.

6.2.Seized by an extra-social other: the Devil and the Black Dog

Another repeating theme in the corpus is the influence of what I call an 'extra-social' force, especially within the Western tradition. Throughout history, this is often a super-natural Other, but I will argue that modern conceptions of mental illness present a congruent idea. What these have in common is that the perceived cause is outside of the social realm and cannot itself be held responsible, though its influences are understood as something that can and should be managed. What is negotiated, then, is the responsibility for tempering these influences. I examine this particular set of cases through two more detailed case studies, focusing on accidie and the Devil in medieval Europe and a popular framing of 'depression' today in order to build a case for the similarity across the two, being that the understanding of ipsal deaths as a sin is often contrasted with the understanding of them as tied to insanity (Watt, 2004; Marsh, 2010). Clearly, there are significant conceptual and overall metaphysical differences across these two kinds of discourse, but I do wish to point out what I believe to be significant similarities in the framing and the way 'extra-social' causes are negotiated with respect to responsibility and blame.

Consider, for example, writings of Caesarius of Heisterbach, a 13th c prior in a German monastery. In *Dialogus miraculorum* (Caesarius of Heisterbach, 1929/1220-1235), Caesarius compiles numerous didactic stories in a form of a dialogue between a Monk and a Novice. He tells multiple stories of ipsal deaths, tying each to despair, melancholia and ultimately one of the seven principal sins, *accidie*. Here is one of these stories (emphasis mine):

> This brother was well known to me; from his youth to old age he had lived both respected and liked by all his brethren, so that none in all the Order seemed stricter than he in the observance of the Rule, or more endowed with virtues; seldom would he speak, and seldom use the accustomed relaxations of the Rule. **Yet by some incomprehensible judgment of God, he grew so melancholy and cast down, that he became completely obsessed with fear of his sins, and altogether despairing of eternal life**. It was not that he was troubled with any lack of faith, but rather that he lost all hope of salvation; by no authority of scripture could he be lifted up, by no examples be restored to the hope of pardon; though it is believed that he had never been a great sinner. When his brethren asked him what it was that he feared, and why he despaired, he would reply: " I cannot say my prayers as I used, and so I am afraid of hell." **Because he was afflicted with this vice of melancholy, accidie laid hold of him, and from the two despair was born in his heart**. Placed in the infirmary, one morning, having determined upon death, he went to his superior and said: " **I cannot fight against God any longer. The other took little heed of his words, but he went away to the fish-pond near the monastery, threw himself in and was drowned.** (Caesarius of Heisterbach, 1929/1220-1235, pp. 239-40)

While the story above, the initial cause is 'some incomprehensible judgement of God,' melancholy and accidie are more frequently attributed to Devil's temptation. Discussing these vices more generally, Caesarius tells a story of a young woman who decided to dedicate herself to God. "[T]he devil in hatred of so much virtue shook her with various temptations, and, inflaming the innocent heart of the virgin with the poison of melancholy, brought her in full health to sickness." (Caesarius of Heisterbach, 1929/1220-1235, p. 235). Similarly, letting the Novice know 'how

dangerous it is to be attacked by accidie", the Monk tells him of a time when "[t]he devil had, as was shown by the event, filled a certain monk so full of accidie, that whenever the time came to get up for matins, he was immediately covered with sweat from a kind of cowardice and fear of the service." (Caesarius of Heisterbach, 1929/1220-1235, p. 224)

Ultimately, Caesarius's message is that humans can fall into series of temptations, including the kinds that can lead to taking one's own life, and that they have the responsibility to resist them. "Stand fast in the faith," the reader is told, "be strong and He shall comfort thine heart and put thou thy trust in the Lord." (Caesarius of Heisterbach, 1929/1220-1235, p. 236) A cure for this state, Caesarius writes, might also include "human words or examples," which will help one resist the temptation and perceive the acts of the Devil, but sometimes the only sufficient cure is "Divine power" (for example in a form of a fortuitous accident) (Caesarius of Heisterbach, 1929/1220-1235, p. 254)

Compare the above narrative with the metaphor of the 'Black Dog' based on a 2007 book and endorsed by WHO in a YouTube video, titled "I had a black dog, his name was depression" (WHO, 2012), which currently has over 10.5 million views. Notably, this metaphor extends beyond the video, and is evident in memes, the #IHaveABlackDog hashtag, and has given the name to the Australian "Black Dog Institute."

> I had a black dog. His name was depression
> Whenever the black dog made an appearance,
> I felt empty and life seemed to slow down.
> He could surprise me with a visit for no reason or occasion.
> (…)
> Black dog could make me think and say negative things.
> He could make me irritable and difficult to be around.

> He would take my love and bury my intimacy.
> (…)
> The black dog had finally succeeded in hijacking my life.
> When you lose all joy in life you can begin to question what the point of it is.
> Thankfully this was the time that **I sought professional help.**
> This was my first step towards recovery and a major turning point in my life
> (…)
> I also learnt that there was no silver bullet or magic pill.
> Medication can help some and others might need a different approach altogether.
> (…)
> The more tired and stressed you are the louder he barks,
> so **it's important to learn** how to quiet your mind.
> It's been clinically proven that regular exercise
> can be as effective for treating mild to moderate depression as antidepressants.
> So **go for a walk or a run** and leave the mutt behind.
> **Keep a mood journal;** getting your thoughts on paper can be cathartic and often insightful
> Also **keep track of the things** that you have to be grateful for.
> (…)
> The most important thing to remember is that no matter how bad it gets…
> if you take the right steps, talk to the right people, black dog days can and will pass.

Yet again, a personalized extra-social other appears, out of nowhere, and affects the person's mood and behavior, possibly driving them to 'begin to question what the point of it is' (a clear reference to suicidal ideation within today's context). There is also advice (or imperative for action) offered to an individual stricken by this black dog in order to resist it—'learn how to quiet your mind,' 'go for a walk or a run,' 'keep a mood journal,' 'talk to the right people.' While the initial cause cannot be controlled one can—and maybe *should*—resist its negative influence. In fact, much of today's discussions of suicide does rely on an individual's responsibility for asking help and for the management of their own 'mental illness.' E.g. Consider Joiner's (2005) following comment:

> Make no mistake, the standard of care is important—at ties even life-saving—and therapists are expected to meet it rigorously, including involuntary

> hospitalization of the patient if needed. But beyond that, **responsibility for life choices resides with patients**. (Joiner, 2005, p. 19)

At the same time, these extra-social causes are also acknowledged as not completely under control of the impacted person, creating opportunities for others to be responsible for preventing an ipsal death as well. In Caesarius's time, for example, after a nun "troubled by the vice of melancholy, and so much harassed by the spirit of blasphemy, doubt and distrust, that she fell into despair" apparently tried to drown herself, she was taken back to the monastery "and watched over (…) with greater care than before." (Caesarius of Heisterbach, 1929/1220-1235, p. 238) By the end of the 19th century, friends and family are tasked with calling the doctor if they perceive certain changes in a person's mood or behavior (e.g. American Journal of Insanity, 1844b; O'Dea, 1882, p. 300, also see Chapter 2 for a discussion) In contemporary times, the responsibility of others to prevent suicide is a heavily contested ethical and legal issue, pitting the practitioner's responsibility to protect a suicidal individual from some supposed extra-social forces against the individuals' own rights and agency.

The understanding of ipsal deaths as caused by an extra-social other interacts with the process of assigning responsibility and blame less clearly than in the set of circumstances I reviewed in the previous section. In Cesarius's work, there is still a connection between the moral failure of the person (in resisting accidie) that has consequences for the deceased in the afterlife. However, the deceased is not simply framed as a 'self-murdered' but also, to an extent, a victim of a dangerous attack *by* accidie. And while in contemporary times individuals are viewed as *responsible* for their mental health, they do not emerge as explicitly blameworthy for their failure to fulfill their responsibility. Furthermore, while it is established that others can help an individual in resisting the extra-social other, their inaction might also not activate the blame process—at the least, the

possibility of holding someone responsible for failing to prevent something might be a modern innovation, anchored in more general ideas of (professional) negligence.

Overall, there seems to be a set of understandings of ipsal deaths that does not actually strongly activate the system of blame, as there are no clearly identifiable acts of transgressions. This apparent 'lack of blame' is reminiscent of Douglas's second type of blame though the alignment is not perfect—the deceased here is not viewed as bested by 'internal adversaries' as much as by 'external circumstance.' Ipsal deaths, here, are understood as results of specific internal states that are, in turn, understood to be caused by entities that are outside of the sphere of social influence, exuding some influence that can only be managed. However, by the end of the 19th century, the primary cause of these internal states comes to be conceptualized as a new entity—society—that can be more explicitly controlled, giving rise to what I argue is a new and unique understanding of ipsal deaths, one that continues to produce tensions today.

6.3.The difficult life: Responsibility of the individual to society vs. society to the individual

> Birth, O king, is full of pain, and so is old age, and disease, and death. Sorrow is painful, and so is lamentation, and pain, and grief, and despair. Association with the unpleasant is painful, and separation from the pleasant. The death of a mother is painful, or of a father, or a brother, or a sister, or a son, or a wife, or of any relative. Painful is the ruin of one's family, and the suffering of disease, and the loss of wealth, and decline in goodness, and the loss of insight. Painful is the fear produced by despots, or by robbers, or by enemies, or by famine, or by fire, or by flood, or by the tidal wave, or by earthquake, or by crocodiles or alligators. Painful is the fear of possible blame attaching to oneself, or to others, the fear of punishment, the fear of misfortune. Painful is the fear arising from shyness in the presence of assemblies of one's fellows, painful is anxiety as to one's means of livelihood, painful the foreboding of death. Painful are (the punishments inflicted on criminals), such as being flogged with whips, or with sticks, or with split rods, having one's hands cut off, or one's feet, or one's hands

> and feet, or one's ears, or one's nose, or one's ears and nose. Painful are (the tortures inflicted on traitors) (…) [very vivid descriptions of torture] Such and such, O king, are the manifold and various pains which a being caught in the whirlpool of births and rebirths has to endure. Just, O king, as the water rained down upon the Himâlaya mountain flows, in its course along the Ganges, through and over rocks and pebbles and gravel, whirlpools and eddies and rapids, and the stumps and branches of trees which obstruct and oppose its passage,– just so has each being caught in the succession of births and rebirths to endure such and such manifold and various pains. Full of pain, then, is the continual succession of rebirths, a joy is it when that succession ends.
>
> The Questions of King Milinda (Milindapañha, 1890 in ESDA, The Questions of King Milinda (c. 100 B.C.), 2015)

Across history and cultures, ipsal deaths are very frequently tied to life circumstances and specifically to suffering and life's difficulties. Conflict, pain, poverty, grief—these are frequently seen as precipitating ipsal deaths. As I have discussed in the previous section on boundary-drawing, ipsal deaths are sometimes seen as appropriate responses to these circumstances and the blame mechanism is not activated, as is frequently the case with ipsal deaths in old age/fatal illness, acts of sacrifice etc. Other times, however, the deaths are seen as still seen as bad and the question then becomes—who is responsible?

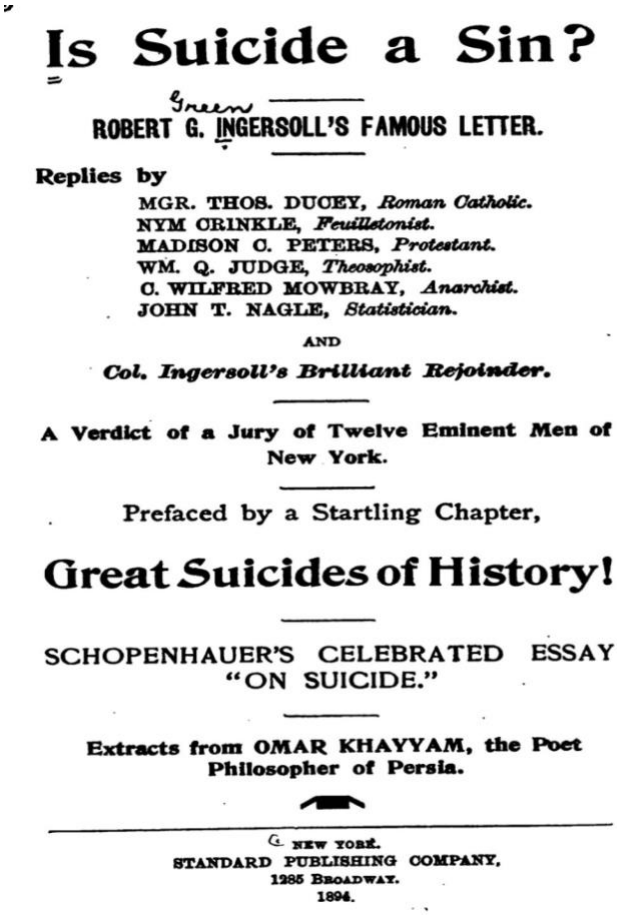
For the majority of history, as has been evident in previous examples, some sort of moral responsibility is placed on the individual—for despite the difficult circumstances, they are perceived as having to *endure* them and fulfil the duty to live. Consider some of the examples as laid out in Table 1-8.

Source	Quote
Aristotle (1925 in ESDA, Aristotle (384-322 B.C.), 2015	As we have said, then, courage is a mean with respect to things that inspire confidence or fear, in the circumstances that have been stated; and it **chooses or endures things because it is noble to do so, or because it is base not to do so**. But to die to **escape from poverty or love or anything painful** is not the mark of a brave man, but rather of a coward; for i**t is softness to fly from what is troublesome, and such a man endures death not because it is noble but to fly from evil…**
al-Tawhidi (as quoted in Rosenthal, 1946, excerpted in ESDA, Abu Hayyan al-Tawhidi (c. 923-1023), 2015)	Recently we saw what happened to a learned Šayḫ. This Šayḫ had come to live in very reduced circumstances. Therefore, people began to avoid him more and more, and his acquaintances no longer wanted to have anything to do with him. This went on for a while until one day he entered his home, tied a rope to the roof of his room, and hanged himself, thus ending his life.(…) Even if compliance with the demands of the intellect, or information derived from both intellect and revelation would have required him to commit such a deed, **he should not have handed himself over to destruction.**
Fleming (1773 in ESDA, Caleb Fleming (1698-1779), 2015)	As to others of mankind who **have fallen under very heavy afflictions,** immediately and apparently from the hand of heaven, and are conscious that they have not brought on those their disstresses by their own follies and vices, these, seeing the visitation to be no other than a fatherly chastisement, are never so presumptuous or daring. In truth, all men who live as probationers, or who act in character, learn to say with Job whenever evils fall heavily upon them," Shall we receive good at the hand of God, and shall we not receive evil ? —The Lord gave, and the Lord hath taken away, blessed be the "name of the Lord."
Madame de Stael (1813, pp. 2, 18)	Suicide originates in misery—a subject worthy of the deepest investigation, since it is one that bears closely on all the moral constitution of man. (…) It is, however, wrong to stigmatize suicide as an act of turpitude, a harsh sentence, which excites repugnance· in every liberal mind. On the other hand, **we should not identify the nobler bravery which resists evil with that negative courage which fears everything but death.**
Hecht (2013, p.xi)	"**Don't kill yourself. Suffer here with us instead.** We need you with us, we have not forgotten you, you are our hero. Stay."

Table 1-8. Discussions of the responsibility to endure life's difficulties

The apparent reasoning here is very similar as that in the examples of 'resisting' extra-social forces—notably, as exemplified by Flemming (1773, excerpted in ESDA, Caleb Fleming (1698-1779), 2015), life's difficult circumstances themselves can also be understood as being caused by these extra-social forces, in which case the two 'cases' are actually equivalent. Ultimately, across the corpus that I have examined, acknowledgements of life's difficulty are generally accompanied with assertions regarding the individual's responsibility to *endure* these, often with respect to their duty to live, which I have laid out in Section 5.1

In contrast to the above, a new idea appears in the 19th c discussions of suicide, in the context of concerns about problems caused by "the civilization" and the numbers that indicated increasing rates of suicide deaths across Europe and North America. Through production of numerical data, which I have discussed in Section 4.3, 'suicide rates' become an object of concern, and with broader sociopolitical changes, 'society' emerges as an imaginable actor, one that can cause and possibly be held responsible for suicide deaths. I discuss some of this process more broadly at the beginning of the following chapter, so here I focus on a single volume, featuring a few essays that are representative of this new discourse.



Is Suicide a Sin?

ROBERT G. INGERSOLL'S FAMOUS LETTER.

Replies by

MGR. THOS. DUCEY, *Roman Catholic.*
NYM CRINKLE, *Feuilletonist.*
MADISON C. PETERS, *Protestant.*
WM. Q. JUDGE, *Theosophist.*
C. WILFRED MOWBRAY, *Anarchist.*
JOHN T. NAGLE, *Statistician.*

AND

Col. Ingersoll's Brilliant Rejoinder.

A Verdict of a Jury of Twelve Eminent Men of New York.

Prefaced by a Startling Chapter,

Great Suicides of History!

SCHOPENHAUER'S CELEBRATED ESSAY "ON SUICIDE."

Extracts from OMAR KHAYYAM, the Poet Philosopher of Persia.

NEW YORK.
STANDARD PUBLISHING COMPANY,
1285 BROADWAY.
1894.

Figure 1-2. Title page of the book "Is Suicide a Sin?" published in 1894

In 1894, in midst of discussions regarding the moral status of suicide, an eye-catching volume "Is Suicide a Sin?" (Ingersoll R. , 1894a) was published in the US, seemingly for a popular audience. The title page, (Figure 1-2), promises a 'verdict of a jury of twelve eminent men of New York" on the question of 'Is Suicide a Sin?,' including a "startling" chapter on "Great Suicides of History!" and Schopenhauer's "celebrated essay" on the topic. Robert Ingersoll was an American lawyer, nicknamed "The Great Agnostic" due to his pro-agnosticism work (Jacoby, 2013). His "Famous letter" that is at the center of this volume, was originally published in the newspaper *New York World* on August 7th 1894, and its authorship was disputed until a September 1st Article in the *New York Times* (NYT, 1894b) that proclaim "Ingersoll says he wrote it: Acknowledges the letter on 'Is Suicide a Sin.'" What really stands out in the letter, and across several responses to it, is the tension between different perspectives on one's responsibility in light of life's difficulties.

To start, Ingersoll himself writes the following, in what was consequently interpreted as possibly arguing "in favor of suicide as a way for a person to get rid of his troubles" (NYT, 1894b):

> Why should a man surrounded by flames, in the midst of a burning building, from which there is no escape, hesitate to put a bullet through his brain or a dagger in his heart? Would it give "God" pleasure to see him burn? When did the man lose the right of self-defense? (Ingersoll R. , 1894, p. 15)

As a brief note, the 'burning building metaphor' is *very* common in discussion of suicide today. Let us continue:

> The law we have in this State making it a crime to attempt suicide is cruel and absurd and calculated to increase the number of successful suicides. **When a man has suffered so much, when he has been so persecuted and pursued by disaster that he seeks the rest and sleep of death, why should the State add to the sufferings of that man?** A man seeking death, knowing that he will be

> punished if he fails, will take extra pains and precautions to make death certain. (Ingersoll R. , 1894, p. 19, emphasis mine)

For now, then, Ingersoll is mainly arguing against considering suicide a sin or a crime, and in that he is pushing against established norms against suicide and prosecution of suicide attempts, considering them ineffective. However, he is not overall supportive of suicide as an act, but assigns moral culpability elsewhere:

> We should remember that nothing happens but the natural. Back of every suicide and every attempt to commit suicide is the natural and efficient cause. Nothing happens by chance. In this world the facts touch each other. There is no space between—no room for chance. Given a certain heart and brain, certain conditions, and suicide is the necessary result. If we wish to prevent suicide we must change conditions. We must by education, by invention, by art, by civilization, add to the value of the average life. We must cultivate the brain and heart—do away with false pride and false modesty. We must become generous enough to help our fellows without degrading them. We must make industry—useful work of all kinds—honorable. We must mingle a little affection with our charity—a little fellowship. We should allow those who have sinned to really reform. We should not think only of what the wicked have done, but we should think of what we have wanted to do. People do not hate the sick. Why should they despise the mentally weak—the diseased in brain? Our actions are the fruit, the result, of circumstances-of conditions—and we do as we must. This great truth should fill the heart with pity for the failure of our race. (Ingersoll R. , 1894, pp. 20-21)

In the context of the discourse that I have reviewed across this chapter, there are two new arguments here. First, in contrast to the frequently noted duty to live and a certain 'wrongness' of ipsal deaths, Ingersoll emphasizes it as a *natural* response to given circumstances. Second, building on this premise, he side-steps individual causes or responsibility altogether, morally

evaluates the circumstances themselves, and highlights our collective responsibility towards changing those, and, as a result, emphasizes the responsibility of society towards individuals.

Some responses offer further texture to these tensions between the responsibility of an individual to endure difficulties vs. the responsibility of society to change them. For example, Father Ducey, in an essay titled "Injustice Makes Suicide" wholeheartedly agrees with some of the issues as put forth by Ingersoll[12]:

> The growth of industry and the surprising discoveries of science; the changed relations of masters and workmen; the enormous fortunes of individuals and the poverty of the masses and the general moral deterioration, cause great fear to every honest and thoughtful man. The momentous seriousness of the present state of things fills every mind with painful apprehension. * * * All agree and there can be no question whatever that some remedy must be found for the misery and wretchedness which press so heavily at this moment on the large majority of the very poor. * *, * The concentration of so many branches of trade in the hands of a few individuals, so that a small number of the rich men have been able to lay upon the masses of the poor a yoke little better than slavery itself. (Ducey, 1894, p. 27)

However, Ducey ultimately sees Ingersoll, and his arguments for Atheism, as robbing people of hope and strength, and in a predictable move, emphasizes the individual responsibility to endure, especially with respect to others around them:

> If death means oblivion Col. Ingersoll is right. Col. Ingersoll'a policy would make men cowards. A man might abandon wife, children and the obligations of justice to his fellow-man simply because he felt the pangs of disappointment and

[12] Ducey also criticizes Ingersoll for being one of these rich men himself, and "[giving] his interesting lectures for a large financial retainer" (Ducey, 1894, p. 26)

> suffering, and, freeing himself from his portion of the burden, leave an additional burden to others. (Ducey, 1894, p. 28)

Contrast this with the words of Charles Wilfred Mowbray, "Anarchist" and his essay titled "Better Live and Protest!"

> While agreeing in the main with his [Col. Ingersoll's] ideas on suicide, I should hesitate to counsel mankind to take the step which he advises without making some protest against society, or those individuals who are absolutely responsible for the miserable conditions which drive men to desperation and ultimately to suicide. I have carefully followed this discussion and it seems to me none of the writers has dared to face the matter as—to my mind—it should be faced. (…)
> It is all very well to talk philosophically about the grave being better than the cell. It may be to the man who has no hope of ever being released. But to the man who makes war upon society and receives a light punishment I should not counsel suicide.
>
> I should say: "Live, and learn the cause of your misery. Once having learned the cause, strike at the root of the evil, try to alter the conditions, and if you find yourself opposed and are determined to commit suicide, do it; aye, and do it successfully. But don't do it like a coward, without making your protest against those who are responsible for your misery and for the misery of all this ever-increasing army of miserable and suicides. (Mowbray, 1894, p. 45)

Here we explicitly see another novelty, in that suicide is explicitly pulled into the realm of the political. The strength Mowbray offers also lies in individual responsibility, however it is not a responsibility to endure but to rise against. Mowbray provides further guidance about this at the end of his essay, sketching out Anarchist politics and closes with the following:

> This is the hope we hold out to struggling mankind, and while we sympathize with them in their struggles and agree that they and they alone have a right to decide for themselves upon the matter of death by suicide, yet we urge that it is better to strike some blow at that society which forces them to despair than to quietly die like a coward without a protest.

> Educate, in order to understand the real cause of the misery of the world.
>
> Organize, in order to overthrow this system which is productive of luxury for one class and misery and suicide for the toiling masses.
>
> Agitate, in order to bring about a system of society such as Anarchist Communism would mean.
>
> Then and then only will we have got rid of the cause and effect of suicide. (Mowbray, 1894, p. 49)

In this one volume then, we see two new emerging notions of responsibility, with respect to ipsal deaths, neither of which can neatly fit within the established social systems for assigning blame. First, there is the responsibility of the collective towards and individual, which requires a system to find itself accountable—how that happens I will show in the next chapter. Second, in establishing the 'system' as a cause of suicide, the new political (though not moral) responsibility of the individual to oppose the system is made possible and this is a call seemingly taken up, at least in part within the "Lived Experience" movement, something which I hope to address in future work.

6.4. Section summary

In this section, I identify different kinds of understandings of what causes ipsal deaths and the different ways these understandings might be taken up in ascribing responsibility for these deaths. If ipsal deaths are understood as ultimately caused by actions of an identifiable social actor, the said actor can be blamed and punished. If the cause is seen as lying outside of the control of the social realm, blame is not clearly evident in the discourse, which seems to center rather on responsibility to resist, and maybe responsibility to help others resist, these causes. Finally,

understandings of ipsal deaths as caused controllable social circumstances emerge at the intersection of the first two—the cause is an identifiable entity, but not one that can be controlled through legal or religious means. Instead, the ascribed blame here is political.

There are some interesting differences that do emerge across my nascent typology, which would benefit from further exploration. For example, I have noticed that the discourse regarding others' responsibility for ipsal deaths is more common across non-western sources, while the western-sources, instead, were quite marked with the discussions of 'extra-social causes' and life's circumstances which need to be endured. This is likely due to broader cultural differences in how 'misfortunes' and difficulties of life are understood (c. Douglas M. , 1992) as well as maybe different understandings of individual agency (e.g. Norenzayan & Nisbett, 2000), though a more detailed and contextualized study would be needed to further examine this. Additionally, the emergent conceptualization of 'society' as an entity that can be held responsible for suicide, would also benefit from more detailed historical context, which is something I hope to do in future work.

Finally, thinking back to conceptualization of causality in contemporary times more broadly, as well as within science specifically, my analysis would indicate that understandings of causality have significant implications for social action with respect to suicide. Among its other functions, the focus on 'enduring life's circumstances' or, as per the APA guidelines, 'the modifiable factors' which are generally located inside the individual, can serve to avoid the blame process, in that it does not offer identifiable entities that can be blamed. Like the Devil, 'mental illness' comes out of nowhere and can be treated, but there is no one to be held responsible. In contrast, a focus on

social factors would unavoidably make claims that can trigger blame, directed either at individuals, institutions or the State, which are inherently political and morally charged.

7. Discussion

In this chapter, my goal was to engage with the variety of different discourses on what I have called 'ipsal deaths' in order to better understand contemporary 'suicide,' and the ways in which it might be similar or different to related phenomena that were socially constructed in different context.

My analysis of different ways in which particular ipsal deaths are designated as problematic, in contrast to those that are condoned or honored—what I discuss ad 'boundary drawing— have identified three common axes along which these boundaries are drawn. That is to say, while the specific kinds of deaths are categorized as good or bad *differently* across context, the categories contrast in similar ways. These axes correspond to big deep existential questions which are likely triggered by instances of ipsal deaths, and might even be actively worked through as communities grapple with these events. Despite the difficulties of life, cultures overall seem to—at least implicitly—task the individual with a duty to live, and one might speculate that this is the case of culture taking up some of the function of a supposed biological self-preservation instinct. However, this duty is rarely absolute, and individual cultures navigate their own exceptions and allowances with respect to their understanding of an individual's control over their actions (intentionality), as well as broader attitudes towards the value of life and value of death itself. We see much of scientific discourse regarding the definitions of suicide doing the same kind of work, as it tries to circumscribe exactly the set of ipsal deaths that are considered morally problematic. Ian Marsh, for example discussed a 'compulsory ontology of pathology" of suicide in modern times (Marsh,

2010, p. 4), but this might simply be a tautology, if 'suicide' is by definition, the kind of ipsal death that is considered pathological.

In examining the discourse on blame and responsibility with respect to understood causes of ipsal deaths, I have catalogued three main ways in which ipsal deaths can be responded to socially—through blame of identifiable social actors with respect to religious or legal structures, though attempts to manage extra-social forces, and in terms of political claims. While my list is not necessarily exhaustive, it does showcase important diversity and contrasts which have not been the focus of previous study, and which might have important implications for suicide today. First, the difference in extent to which another social actor can be understood as responsible for an ipsal death is significant across contexts, and it highlights the relative lack of discourse regarding others' responsibility for suicide in contemporary times. Clearly this is a deeply political question, especially when we consider the significance of the bereaved survivors in contemporary suicide-related work. However, despite it being a delicate subject, it is likely something that social institutions will have to tackle, and will likely draw on scientific research in doing so. Identifying ways in which contemporary literature and discussions on suicide grapple with questions of violence, abuse etc. will likely be a fruitful direction for research. Second, I have identified the emergence of the idea of 'holding society responsible' for ipsal deaths as a modern invention, and as a perspective that has shaped contemporary 'suicide.' While previous work on suicide focuses mostly on the changes brought about by its medicalization, this more political piece has not been examined in depth previously, and it is what I move on to in my next chapter.

Chapter 2: The development of 'suicide' as a public problem in the 20th century US

> Americans, it has been observed, appear to be alarm-minded and action-oriented. When confronted with a deplorable condition of man or of society, we want to "do something about it," through voluntary pressure groups or by passing a law. Our first inclination, in practice, appears to be expose in muckraking fashion the alarming condition, enumerate the victims, name the "villain." But such an attack begs the question of what can be done; consequently, our second inclination is to appoint a commission to study the problem. In some instances, if the condition is of a tangible character and manageable size and the remedy is within our grasp, the study leads to effective action. More complicated social problems, however, are apt to elicit solutions requiring depth and breadth of understanding and rather drastic changes in prevailing attitudes and systems; they often cut across social, moral, political, and economic biases which are not easily modified. In such instances the expert survey and the publicity attending it may become a substitute for remedial action. (Joint Commission on Mental Illness, 1961, p. xxix)

1. INTRODUCTION

Studying suicide, or studying 'suicide,' in the late 2010s is a unique experience. Nearly without exception, when I tell someone my work has to do with suicide without explaining the exact nature of my research, they lean into the conversation. They might volunteer a story of someone they know, start asking me questions or share some of their own thoughts and concerns on the subject. At the very least, my mention of 'research on suicide' is generally met with nods of approval—it

is a difficult and important problem, people tell me, and it is good that I am spending my time on such an issue. I am inclined to agree, as the opening sentence of many articles on the topic I read imprints me with a singular thought: "Suicide is a serious public health problem." Being that suicide is a serious public health problem, it also comes to be difficult to really put the work aside—tv shows I watch and media articles I read not only feature complex stories involving suicide deaths, but offer resources to take advantage of and numbers to call; people I follow on social media share will occasionally share their own experience of suicide ideation, attempt or loss; an email from the University invites me to partake in a 30-minute "mental health simulation" which "helps students learn to students learn to recognize warning signs of psychological distress and encourage friends to seek help."

Beyond permeating the everyday and the public, suicide also brings people together with a level of intensity that was jarring to me at first. Through my fieldwork at different suicide conferences, I have come to refer to them as "Suicide Expo," so as to capture the mix of energy and swag that permeates the space. The conference pop-up bookstore, right next to the coffee, offers a selection of volumes for any audience: scientists, crisis workers, loss survivors, adults and children—as AAS's tagline reminds us, "Suicide is Everyone's Business." The central area is packed with tables covered in colorful brochures and booklets, bowls of candy, stickers and pens, bookmarks and bracelets, magnets and coasters, stress balls and badges. I have taken the pledge to "Stamp Out Stigma," filed out a *Sources of Strength's* 'What helps me with anger, depression or anxiety' postcard, and grabbed a small journal for their #thankfulnesschallenge. I am now also a proud owner of a "Crisis Response Network" USB adapter, Kognito glasses cloth, Veterans Crisis Line dog-tag keychain, a Neuroflow phone credit card holder, a MIRECC gun lock, a nameless rubber

duck and a ‘Six Feet Over’ crisis-kit that includes, among other things, a sudoku puzzle, yet another stress ball, essential oils and some tea (I did purchase this last one, at least in part because Six Feet Over proclaims to “make suicide prevention cool”). I have also entered the lottery for a LivingWorks backpack—which they seem to have held in light of their rebranding—but was not the lucky winner. Moving past the exhibitors’ tables, against the far wall, there is a large white lattice surrounded by colorful ribbons and Sharpies. A plaque next to it reads

> RIBBONS OF REMEMBERANCE
>
> These ribbons symbolize the growing and ever-changing grief journey. They show us that each of our stories I unique, yet we are all connected. Those that have brought us here, have also brought us together.
>
> Please take a length of ribbon and write your loved one’s name, a message to them, or anything you feel like writing. Tie the ribbon to the lattice, connecting us all together by our shared grief and our hopeful future.”

On the other side of the hall, more ribbons: “Self-Service Conference Ribbons,” help members identify themselves as a member, a student, a crisis worker, a loss survivor (five different ribbons, based on the relationship with person lost) or an ASLE (Attempt Survivor/Lived Experience).

Whether suicide prevention is everyone’s business, or it is simply an increasingly well-developed business, it is now a project spread across numerous institutions, organizations, companies and community groups. The National Action Alliance for Suicide Prevention, the “nation’s public-private partnership for suicide prevention,” “works with more than 250 national partners to advance the National Strategy for Suicide Prevention” (The Action Alliance, n.d.a “About Us”). Their executive committee is made up of representatives from, among others, SAMHSA, Health Resources and Services Administration, Department of Veteran Affairs, NIMH, the Surgeon

General, CDC, National institute of Justice, US Department of the Interior, US Department of Health and Human Services, and, in the private sector, Columbia University, Smith Frozen Foods, The Trevor Project, Community Anti-Drug Coalitions of America, the National Football League, Kaiser Permanente, American Express, Union Pacific Corporation, Facebook, ASFP, the International Association of Chiefs of Police, the Entertainment Industries Council and the MTV Entertainment group (The Action Alliance, n.d.b, "Executive Committee"). Today, a person in crisis can call the National Suicide Prevention Lifeline ("We can all help prevent suicide," National Suicide Prevention Lifeline, n.d.) soon to get its designated three-digit number, 988, or use their webchat. They can also reach the Crisis Text Line ("Your feelings are valid. Need support? Text HOME to 741741 for free, 24/7 crisis counseling. We're here for you," Crisis Text Line, n.d.) via text or Facebook messenger. Veterans can also contact the Veterans Crisis Line, transgender individuals can call the Trans Lifeline, and for LQBTQ youth there's the Trevor Project Lifeline, TrevorText, TrevorChat and TrevorSpace. Suicide loss survivors and other allies regularly come together, fundraising through AFSP organized "Out of the Darkness" walks across the US, and many are moved to start their own foundations. Schools, workplaces and communities can shop from a selection of programs and so-called gatekeeper trainings—from QPR ("Question. Persuade. Refer. Three steps anyone can learn to help prevent suicide," QPR Institute, n.d.) and LivingWorks ("Empowering people save lives from suicide," LivingWorks, n.d.) to Kognito's online simulations ("Suicide Prevention Training for All," Kognito, 2019) and Sources of Strength ("one of the first suicide prevention programs that uses Peer Leaders to enhance protective factors associated with reducing suicide at the school population level," Sources of Strenght, n.d.). And suicide attempt survivors are increasingly comfortable sharing their experiences—a photo and story project "Live Through This" by artist and activist Dese'Rae L. Stage (Stage, n.d.), herself

an attempt survivor, features over 150 portraits of survivors and their stories. Stage, together with Jess Stohlmann-Rainey, an advocate and crisis services trainer, also hosts a weekly podcast, 'Suicide 'n' Stuff.' (Stage & Stohlmann-Rainey, n.d.)

This whole landscape, while not surprising at all today, is quite new, and it was made possible by a series of developments across the 20th century that not only built the necessary institutional infrastructure, but also established suicide as a public problem which needs to be talked about and addressed. This process included a construction of a problem—specifically, the idea that suicide rates are 'too high'—establishment of a professional and community interest groups that brought attention to this problem, and political action that sought to address and therefore contain the said problem. It is this series of developments that constructed today's 'suicide.'

In the previous chapter, I have shown that ipsal deaths have been discussed and grappled with throughout human history. Particular kinds of ipsal deaths were frequently emphasized as 'bad'—they were results of acts disapproved of by philosophy, religious dogma, law, or even, in contemporary times, science. The ideas of these bad ipsal deaths are discursively entwined with the understandings of their causes, and are often framed in a way that, at least implicitly, ascribes the responsibility for the death to some kind of a social agent. These concerns about causality and responsibility also significantly shape not just the contemporary professional approaches to suicide but also contribute to tensions within scientific knowledge production about suicide, which is called upon to delineate and help address an essentially moral problem. I have also argued that the availability of the 'public fact' (Gusfield, 1981, p. 51) of suicide rates, and the resulting concerns about increasing suicide rates as well as questions regarding the role of "society" and "civilization"

in causing suicide—all of which emerged in the second half of the 19th century—created a kind of a 'vacuum' within the existing systems of establishing accountability and assigning blame.

In this chapter, by examining the development of 'suicide' as a public problem in the 20th century US, I build on this foundation that I have established in three ways. First, I provide a more in-depth study of discourse on ipsal death in-context. The written texts that my previous chapters were based on were not simply records of individuals' private thoughts, frozen in time to be scrutinized hundreds or thousands of years in the future by scholars—they were produced and reproduced with a particular purpose, for an audience. Through the case study of 20th c United States I wish to provide a much thicker narrative that can emphasize the nature of discourse as a social act. Second, I take up the question of the 'responsibly vacuum' as I argue that the emergence of suicide as a public problem provided a framework through which the role of 'society' in causing and/or preventing suicide could be negotiated. Third, I take note of social and political functions of science: scientific knowledge production not only supplies the raw materials used in building claims about a problem, but is also expected to guide the response to the problem. At stake here is not only the state of the problem, but also the status of individual disciplines (especially with respect to funding, which relies heavily on successful claims making) as well as the authority of science in general (which rests, in part, in the ability of science to guide policy).

My focus on the US is driven, in part by my ethnographic experience and in part by the availability of and ease of access to a variety of materials (See "Methods" below). I start my investigation in the second half of the 19th century in order to capture the transition that occurred at the turn of the century, specifically the increased concern with suicide rates as an indicator of some social

pathology. I follow the organizational and legal developments up until 1997 (incidentally, exactly 100 years after the publication of Durkheim's *Suicide*), when then the US Senate and the house of representatives both "recognize[d] suicide as a national problem, and declare[d] suicide prevention to be a national priority." (A resolution recognizing suicide as a national problem, and for other purposes., 1997, Recognizing suicide as a national problem, and for other purposes, 1997). I analyze this moment as one in which the State formally recognized suicide as a problem, and took political responsibility for it. I choose to end there as the events in 1997 and those soon following—Surgeon General's 1999 "Call to Action to Prevent Suicide" (Office of the Surgeon General, 1999) and the "National Strategy for Suicide prevention: Goals and Objectives for Action" (Center for Mental Health Services; Office of the Surgeon General, 2001)—emerge as an inflection point. The work of establishing suicide as a relevant issue in the public sphere morphs in the new millennium, as suicide rates start increasing (Figure 2-1), suicide research proliferates (Figure 2-2, Figure 2-3), alongside an increase in the numbers of suicide-related bills introduced into Congress (Figure 2-4) and an increase in suicide-related funding (Figure 2-5). The past 20 years have also brought new concerns (e.g. suicide in veterans and the military), increasing levels of complexity in terms of perspectives and stakeholders, and a variety of critiques regarding the way suicide is conceptualized in research and addressed in practice (as is evident in my *Literature Review*). While I hope to take these developments up in my future work, I contain myself currently to the processes that have come to formally establish suicide as a matter of national concern.

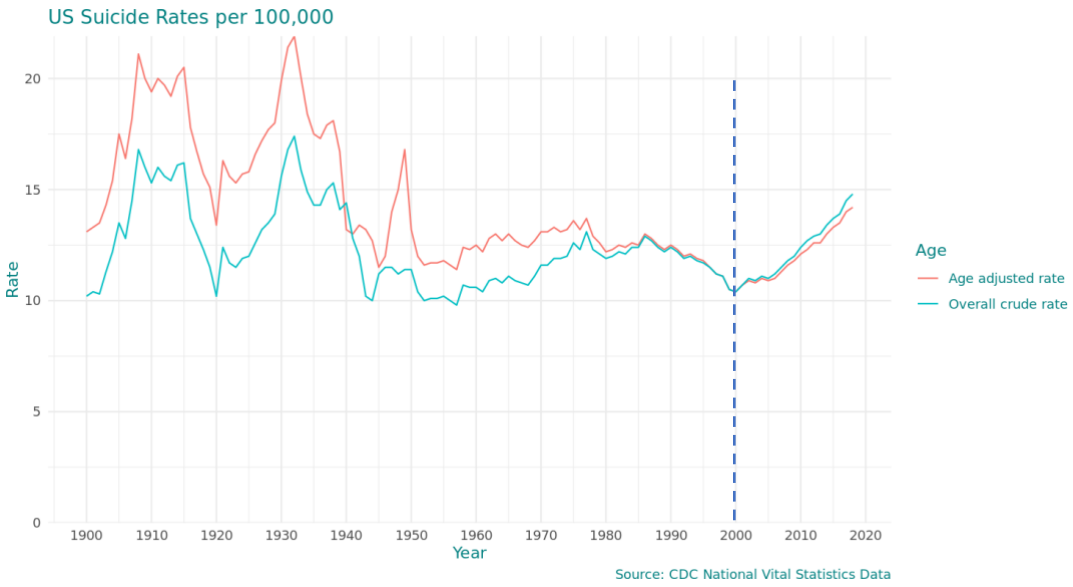


Figure 2-1. Official CDC data on crude and age-adjusted (to 2000 population) suicide rates in the US in the 20th century. Note that all states are included only as of 1933

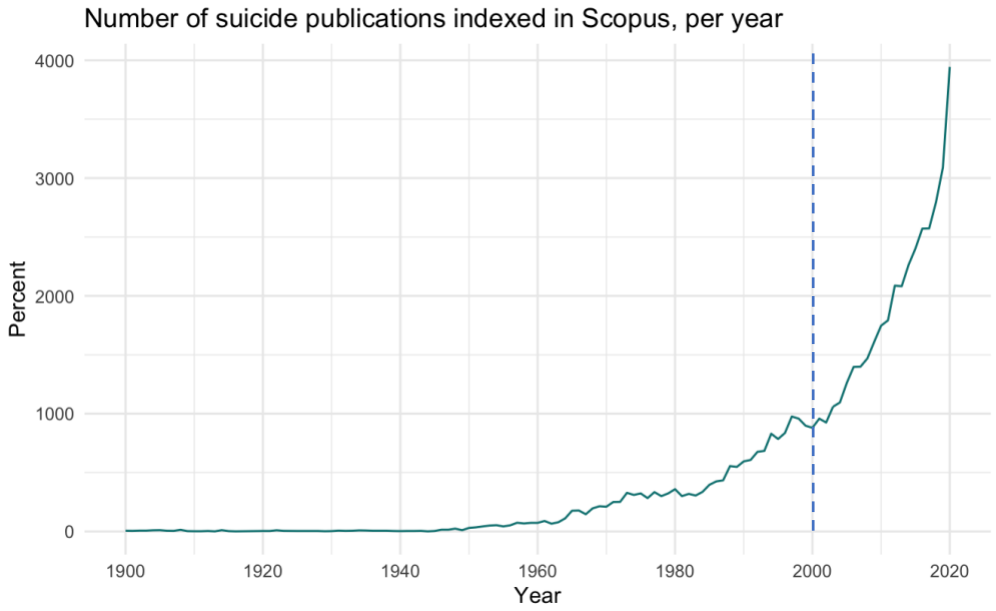


Figure 2-2. Total Number of publications on suicide in Scopus (note this includes all publications, not just US ones)

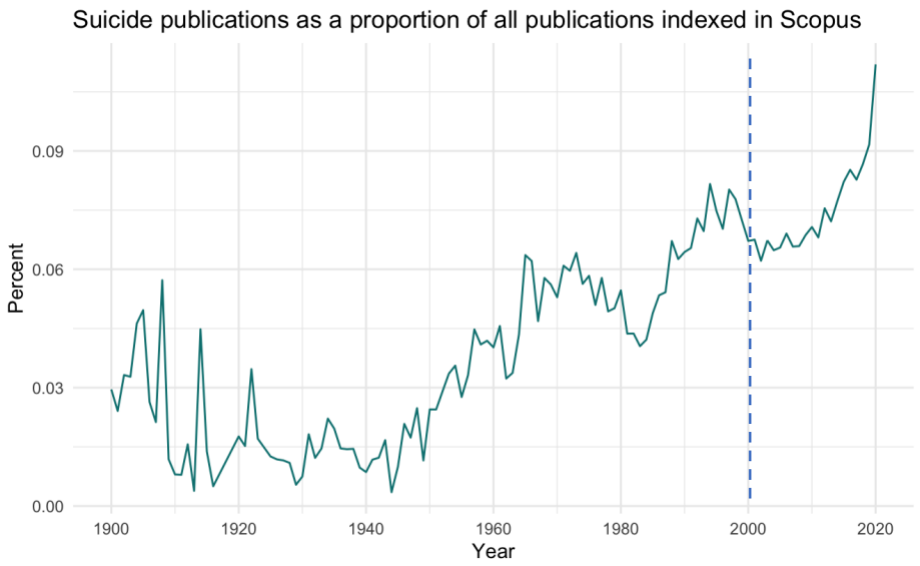


Figure 2-3. Percent of all publications in Scopus that are on suicide (note this includes all publications, not just US ones)

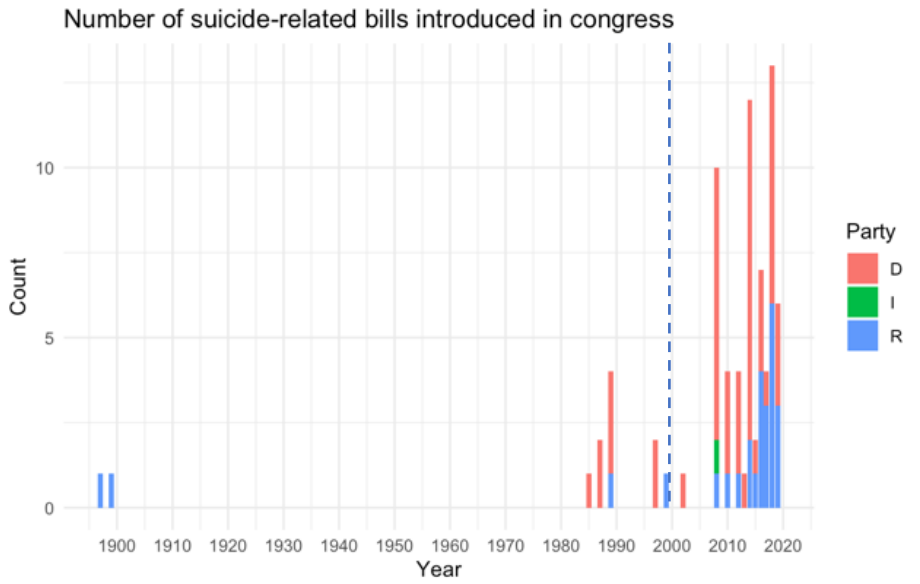


Figure 2-4. Number of suicide-related bills introduced in Congress (includes bills related to 'assisted suicide').

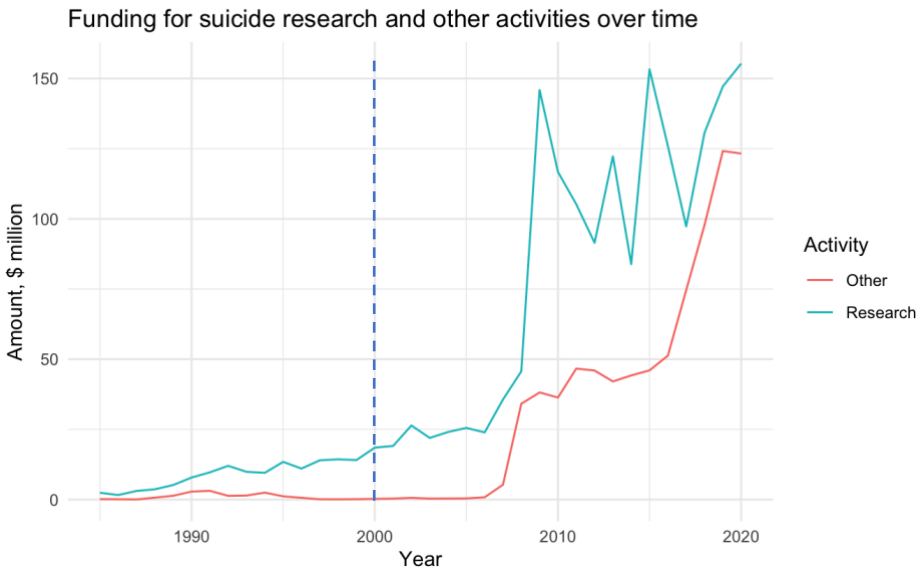


Figure 2-5. Funding from the US government AFSP for suicide research over time, in millions of USD and adjusted for inflation. Time-scale restricted by data availability.

I examine the discourse on suicide in 20th c US as a social act through the lens of sociology of 'social problems,' which defines social problems as "*the activities of groups making assertions of grievances and claims with respect to some putative conditions*." (Spector & Kitsuse, 1973). Not all discourse around suicide in the period that I examine is oriented towards making 'assertions of grievances'—in fact, some of it is explicitly aimed at 'de-problematizing' suicide, e.g. arguing for one's right to die (e.g. Ingersoll, 1894), framing suicide prevention as unethical (e.g. Szasz, 1971) or grappling with euthanasia and physician assisted suicide/dying that emerge as important questions in the 1980s and 1990s. While these concerns interact with the 'problem of suicide' in important ways, they lie outside of the scope of the current work. What I wish to focus on specifically is the emergence of 'suicide' as a problem and the explicit discourse about it as a problem. In this, I argue that the process of making and responding to claims about suicide establishes it as a problem, but also *contains* it in a way that is legible and socially sanctioned.

After laying out my theoretical framing and briefly reviewing my data sources, I lay the chapter out in five sections. In the first section, I provide some general background as I argue that concerns about preventing ipsal deaths are not entirely a product of modernity, and that 'public problem' is the form these concerns take in a context with particular socio-political structures. The next four sections, which are the core of the chapter, I lay out chronologically, emphasizing what I find to be the most significant developments in each era. First, in Section 2, I describe the variety of ideas and concerns around suicide that existed around the turn of the 20th century, as well as some early initiatives that sought to contain it. I highlight a discontinuity between the professional and the public discourse: in that the later took little interest in the former's questions regarding successful treatment (framed as a professional problem), but did take up concerns about rising rates of suicide and possibilities of 'contagion' (framed as a problem in society). In Section 3, I focus on the period starting after WWII and continuing through the 1970s, and review the first wave of the institutionalization of the suicide problem, as contingent on broader organizational and political developments with respect to concerns about 'mental health,' and with only a marginal place within the public discourse. Section 4 covers the 1980s, when 'youth suicide' specifically emerges as a highly visible public problem and mobilizes a robust—though short-term—response in the form of proposed bills, organizations and committees, which displaced concerns with suicide more generally. Despite these apparent 'successes', the problem still failed to securing a more permanent purchase in the 'arena of public problems' (Hilgartner & Bosk, 1988) and, I argue, it highlighted tensions between complex understandings of causality and political demands for easily mobilizable and research-supported interventions. Finally, in section 5, I examine the grass-root activist efforts of a new group of stakeholders—'survivors of suicide'—who re-ignited the 1980s momentum and not only shifted the public conversation to 'suicide' in general, but reframed the

problem in a way that ultimately established the problem of suicide on the national stage and started an era of a significant and sustained concern over the problem.

2. Sociology of Social problems

In this chapter, my focus is on 'suicide' as a social problem. That is, I posit that 'being a social problem' is a specific position a phenomenon can take on within society, which in turns shapes actions and attitudes around it. In thinking about the way 'ipsal deaths' are understood and contained in today's society, it is clear that the social problem position suicide is in in a central piece of the story. It is therefore essential we understand what it means for something to be a social problem, what social problems are and how they develop.

In their seminal article, sociologists John I. Kitsuse and Malcom Spector (1973), argue that, irrespective of any 'objective conditions,' the process through which a social problem emerges is, in itself, a distinctive phenomenon worthy of sociological inquiry (emphasis in the original):

> Thus, we define social problems as *the activities of groups making assertions of grievances and claims with respect to some putative conditions*. The *emergence* of a social problem, then, is contingent on the organization of group activities with reference to defining some putative condition as a problem, and asserting the need for eradicating, ameliorating, or otherwise changing that condition. The central problem for a theory of social problems, so defined, is to *account for the emergence and maintenance of claim-making and responding activities*. (Kitsuse & Spector, 1973)

Kitsuse and Spector, then, move away from any particular 'objective' conditions, and they stay agnostic with respect to the nature of the claims being made, that is they are not interested in their supposed truth or moral value. Rather, they are interested specifically in the discourse and the social processes that establish something as a social problem within a particular context. To

understand' 'suicide' across 20th century, then, it is necessary to understand what claims are being made about suicide as a problem, by whom and to whom.

Building on Kituse and Spector's analytical approach, Joseph Gusfield (1981) introduces the term 'public problem,' which he defines as a social problem "with a public status, as something about which 'someone ought to do something.'" (p.5). In this, he does not draw a theoretical distinction between a 'social problem' (as conceptualized by Kitsuse and Spector) and a 'public problem,' rather he seems to be using the term to avoid confusion regarding other possible understandings of 'social problem.' I predominantly follow him in this move when discussing the claims-making activities regarding suicide in the 20th century US, keeping in mind that 'suicide' had been discussed as a problem *of* and problem *in* society beforehand, but without the kind of entanglement with the public discourse and institutions that is characteristic of 'public problems' (see discussion of dynamics of social problems further below). This specific, narrow focus on the public and the political allows me to build on previous literature, which overwhelmingly follows transformations of 'suicide' through its medicalization and up to the turn of the 20th century. While this history of suicide is essential for how suicide exists in the 20th century, it stops short of investigating the way 'the problem of suicide' was established as a matter of concerns within the political sphere.

As social processes, public problems are embedded within the structures of categorization, causality and allocation of responsibility that I have discussed in previous chapters. The 'putative condition' central to the claims making process, of course, has to be named and understood, in contrast to some other conditions, as problematic (a moral judgement). Such a definitional process is inherently political, as "in the arenas of public opinion and debate all groups do not have equal

power, influence, and authority to define the reality of the problem" (Gusfield, 1981, p. 10). This "ownership" of a problem is not necessarily a given, and individuals, organizations, offices or institutions can and do fight over this authority (Gusfield, 1981, pp. 10-11).

Furthermore, the definition of a public problem is not simply about identifying a set of conditions as problematic, but includes claims regarding responsibility for the said problem. Gusfield (1981) distinguishes between two kinds of responsibility, causal and political:

> The first—causal responsibility—is the matter of belief or cognition, and assertion about the sequence that factually accounts for the existence of the problem. The second—political responsibility—is a matter of policy. It asserts that somebody or some office is obligated to do something about the problem, to eradicate or alleviate the harmful situation (Gusfield, 1981, pp. 13-14)

These two kinds of responsibility—cause and political obligation—together with the notion of ownership, make up what Gusfield identifies as three central aspects of structure of public problems and they can overlap and interact in different ways. Causal and political responsibility might be related (e.g. in terms of environmental concerns, those causing the problem have the obligation to address it) but they do not have to be. Owners of the problem, for example, might fail to 'fix the responsibility on" the actors perceived as causally responsible (Gusfield, 1981, pp. 14-15). Available knowledge about the problem in general, and science in particular, play a significant role in considerations of definitions and causality (Gusfield, 1981, pp. 15-16), which is something I turn to in more detail at the end of this section.

In terms of the dynamics of social problems as social processes, there seem to be some commonalities to their 'natural history' as well as factors that impact their success, which can provide guidance as we aim to understand the process through which suicide could become a kind

of a thing that is 'a national problem,' and, ultimately, 'everyone's business.' Spector and Kitsuse (1973) sketch-out a case-study driven model of claim-making that constitutes a social problem:

> Stage 1: The attempts by some group(s) to assert the existence of some condition, define it as offensive, harmful, and otherwise undesirable, to publicize the assertions and stimulate controversy and to create a public or political issue over the matter.
>
> Stage 2: The recognition by some official organization, agency, or institution of the group(s) legitimate standing. This may lead to an official investigation of the matter, proposals for reform, and the establishment of an agency to respond to those claims and demands.
>
> Stage 3: The re-emergence of claims and demands by the group(s), expressing dissatisfaction with the established procedures for dealing with the imputed conditions, the bureaucratic handling of complaints, and the failure to generate a condition of trust and confidence in the procedures as sympathetic to the complaints, etc.
>
> Stage 4: The rejection by complainant group(s) of the response or lack of response of the agency or institution to their claims and demands, and the development of activities to create alternative, parallel, or counter-institutions as responses to the established procedures.

The process of a social problem, of course, is more complicated that this rise-and-fall schema would have it seem. As Hilgartner and Bosk (1988) emphasize through their 'public arenas model,' social problems exist simultaneously at different stages of development, relationally with respect to other social problems, while "embedded within a complex institutionalized system of problem formulation and dissemination" in which they compete for public attention. A variety of factors external to the claims regarding the problem—including the novelty of the problem, the political context, the capacity to generate strong emotions, and opportunities for collaboration across problems—contribute to making the problem more or less successful. Due to the limited 'carrying

capacity' of the public arena and the competition for this resource, attention to different problems is unequally distributed. At any one time, and dynamically shifting over time, a few problems come to be very successful and becoming "the dominant topic of public discourse," others manage the grab some public attention, and the majority "remain outside of or on the extreme margins of public discourse" (Hilgartner & Bosk, 1988). This suggest that, while studying suicide knowledge production as well as claims-making about suicide, it is important to pay attention to the kinds of suicide, or the kinds of suicide problems that animate public or scientific concern. Specifically, when we do see increasing interest in suicide in the public or the political realm, we should try an identify aspects of discourse that might be driving this interest, for example due to their novelty or emotional charge. I will argue, for example, that dissemination of suicide rate data at the turn of the century and centering of youth suicide and youth suicide clusters in the 1980s were exactly the kinds of moves that framed the problem as something new, and that were very effective at producing a strong emotional response.

Additionally, as I have emphasized in previous chapter, a significant factor in the development of problems are the knowledge producing activities surrounding the problem, specifically scientific practices. Not only is scientific work often central to establishing the definitions and relevant causal chains (as well as 'primary causes' best suited for interventions) of particular problems (e.g. Woolgar & Pawluch, 1985; Hacking, 1995), but claims regarding problems can play an important role in establishing the professional authority and acquiring funding (Aronson, 1984, pp. 14-19). While my focus in this chapter is primarily on the public discourse, I acknowledge the role of science in this discourse and emphasize the main frameworks that shape the 20th century developments in Section 2, and then highlight some professional authority concerns in Section 3.

Guided by the notion of 'social problems' as outlined above, I trace the different groups who are making claims, groups that assert the ownership over the problem, the ways the problem is framed, and the attempts to assign political as well as the causal responsibility for the problem. (Gusfield, 1981). In this, I wish to emphasize the non-linear development of public problems (e.g. see Hilgartner & Bosk, 1988) and the relevance of various factors to the ultimate 'success' of claims making. The main question that I address is as follows: Assuming that the recognition of suicide as a national problem by the State is a means of containing concerns about suicide, how did that particular response come about, why then, and what specific concerns is it 'containing'? In answering this question, I posit the 'social problem position' not as a continuation of that process through which suicide has been reconceptualized from sin to crime to insanity, but rather as a development along a different axis altogether. In the previous chapter, I have argued that the different understandings of suicide as an act play an important role in containing it as a moral problem. However, as I will show, what is central to claims making around suicide as a problem is not the act itself, but the sense that there is too much of it. While the 'volume' of suicide was not easy to perceive throughout human history, it becomes such by the 19th century and it becomes conceivable not as an individual act but a collective phenomenon. It is this 'collective' suicide, and the concerns that it gives rise to, that are contained through public and political claims-making, and which I explore in this chapter.

3. METHODS

In the current chapter, I draw on a diverse set of sources. In discussing earlier concerns with suicide prevention (Section 1) I offer a few examples from my historical corpus, specifically the texts that

I have coded as *prevention*. To examine 'suicide' in the political sphere, I have used ProQuest Congressional (ProQuest, n.d.), searching for bills and other documents on suicide. I have selected the most relevant of these for close reading, and I engage with them extensively in the analysis. Additionally, I have built a small database of all bills introduced in Congress to visualize interest in suicide over time. As a way to characterize discussions in the public sphere over time, I rely on The New York Times archive (NYT, n.d.a, "New York Times Article Archive"), as its database is complete, easily searchable and retrievable via API (NYT, n.d.b, "The New York Times Developer Network"; the retrieved data does not include full articles, but does contain headlines and leads). While this archive is not representative of public opinions, or even newspaper publishing, it can serve to illustrate some trends over time and it is a corpus commonly used by social scientists for such purposes (see e.g. Zinn & McDonald, 2016; Silva, 2017; Felson, Adamczyk, & Thomas, 2019). In my analysis, I present some general trends (based on keyword mentions and publication volume) and I also engage with individual examples to illustrate discourse at different times. As examples, I often choose the articles listed as 'most relevant' in a particular period within the NYT archive search results. The organizational information I have gathered primarily through organizational publications and various reports, as cited, and have sometimes relied on secondary sources. Some of the information I have gathered through websites as archived by the Internet Archive Wayback Machine (Internet Archive, n.d.), through interviews with relevant figures and documents they have shared with me, or requests to state departments for organizational data. I gathered data on funding for suicide research and prevention through a few databases, covering any governmental agencies (e.g. NIMH, SAMHSA, VA, NIH) as well as the American Foundation for Suicide prevention (the largest private funder of suicide research). For more details, see Appendix A: Methods.

4. SETTING THE STAGE: EARLIER CONCERNS WITH SUICIDE PREVENTION

The current literatures on suicide 'as a problem,' and on social problems in general, discuss these as modern phenomena. Marsh (2010), for example, argues that the idea of suicide as a problem and as something that should be prevented emerges with the 18th century, with the largescale socio-political transition in what Foucault calls 'regimes of power.' Specifically, while the pre-18th century sovereign rulers were mainly concerned with transgressions against the law—and therefore their rule—and they exercised "the right to *take* life or *let* live" (Foucault, 1990/1976, p. 137, emphasis in the original), with the 18th century and the emergence of the modern state, concern is no longer on individual actors but managements of populations as a whole, and the state comes to exercise the "power to *foster* life or *disallow it* to the point of death." (Foucault, 1990/1976, p. 138, emphasis in the original). Across this broad shift, Marsh (2010) concludes, the nature of the problem that is suicide also transforms (emphasis mine):

> Whereas in relation to **sovereign power suicide could be considered a problem of transgression that demanded the enactment of appropriate punishment** (confiscation of goods, desecration of the corpse, excommunication, burial in unconsecrated ground), within a bio-political economy of power suicide represents something of a challenge to those techniques and strategies that aim to foster health and vitality (in short, life itself) in the face of disease and decay (and ultimately death). **Such deaths are not read as inevitable, and the problem of suicide now is that it is an unnecessary death—it is, and should be avoidable and preventable.** (Marsh, 2010, pp. 98-99)

What Marsh (2010) is arguing here is that the idea of suicide as something that can and should be prevented is unique to the modern times. Similarly, Spector and Kitsuse (1973), in laying out a natural-history model of a 'social problem,' emphasize the role of modern structures—agencies, institutions and other official organizations that interact with the claims-making process. And

while my focus is exactly on ipsal deaths as entangled within these modern structures and in the period deeply shaped by the biopolitical, to understand how this context is both similar and different to the time preceding it is important to examine ideas about prevention of ipsal deaths more broadly. In this section, I provide a selection of discussions that focus on preventing some ipsal deaths, in order to both emphasize the kind of situations that seem to give rise to discussions of 'preventing' suicide and to add this layer to the historical discussion of suicide. As I have noted in my *Literature Review,* many histories of suicide, in focusing on attitudes, often emphasize the question of punishment and other consequences (as evidence of negative attitudes), and are not as concerned with discourse on prevention. This is despite the fact that the two, as we will see, seem to be tied, in that punishment was in certain context conceptualized as an important deterrent.

Concerns with preventing bad ipsal deaths, though maybe not analogous with the contemporary notion of 'suicide prevention,' have existed throughout history. For example, in the Greek town of Miletus in what was likely early 3rd century B.C., there was a series of self-killings by young women. "The malady seemed to be of divine origin and beyond human help, until, on the advice of a man of sense, an ordinance was proposed that the women who hanged themselves should be carried naked through the market-place to their burial. And when this ordinance was passed it not only checked, but stopped completely, the young women from killing themselves" (Plutarch, Plutarch's Moralia, 1949, p. 509 as excerpted in ESDA, 2015). On a somewhat larger scale, some scholars argue that Christian condemnation of suicide emerged, at least in part[13], to address the

[13] A variety of factors likely influenced this shift. Economic considerations and shortage of manpower in the declining Roman Empire came to extend the prohibition of suicide to servants

perceived problem of 'false martyrdom.' As the prosecution of Christianity ended, the context in which one could "die for their faith" disappeared, and so did the only context in which an act of taking one's own life could be justifiable within the Christian doctrine. The Christian leaders then started to increasingly denounce 'false' martyrdom, and a series of writings and councils led to an explicit condemnation of act of self-killing by the 5th century (Minois, 1999, p. 27). While the argument is theological, the discourse is clearly didactic. In the City of God (written in the early 5th c AD), for example, Augustine takes up a series of "reason[s] for suicide" that might be thought of as "sound" (Augustine, 1871, p. 38) and argues against them, coming to a singular clear message— there are no just causes of suicide (Augustine, 1871, p. 39) and no one should take their own life, even if following an example of a saint, because "in certain peculiar cases the examples of the saints are not to be followed." (Augustine, 1871, p. 37) He elaborates as follows:

> But this we affirm, this we maintain, this we every way pronounce to be right, that no man ought to inflict on himself voluntary death, for this is to escape the ills of time by plunging into those of eternity; that no man ought to do so on account of another man's sins, for this were to escape a guilt which could not pollute him, by incurring great guilt of his own; that no man ought to do so on account of his own past sins, for he has all the more need of this life that these sins may be healed by repentance; that no man should put an end to this life to obtain that better life we look for after death, for those who die by their own hand have no better life after death. (Augustine, 1871, p. 38)

The proscription here is to live, to heal and repent any sins if necessary, and not be burdened by sins of others inflicted onto oneself. Some of the language used— "this is to escape the ills of time

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and criminals though confiscation of the deceased's possessions (Minois, 1999, p. 29), while contact with pagan religions that were permissive of suicide urged Christianity to advocate against it (Rosen, 1975, p. 12).

by plunging into those of eternity"—is quite reminiscent of some of today's pithy remarks regarding suicide as a "permanent solution to a temporary a problem." In fact, the many different works that I discussed in Chapter 1, which highlight the duty of a person to live through hardships, can be viewed as not just condemning the act of suicide, but rather as a strategy to, as Marsh puts it, "foster health and vitality (…) in the face of disease and decay" Marsh, 2010, pp. 98-99).

The concern with preventing ipsal deaths becomes explicit in the early 17th century England. As the number of inquisitions of 'self-killing' seemed to increase, this is interpreted as an increase in the numbers of self-killings (though this was likely an artifact of increasing prosecution, not increasing number of deaths (see MacDonald M. , 1989). In the first book published in English on the topic, "Lifes Preservative against Self-Killing", Calvinist minister John Sym, characterizes the time as one in which "so many doe wretchedly, and unnaturally kill themselves" (Sym, 1637, p.a). Addressing Lord Robert Rich, Earl of Warwick, he writes:

> "The *discourse* is of a mixed and various nature; and the theme of *self-killing* is the *subject* both of *Divinity,* and of *humanity*; of *Religion*; and of *Law*: the full handling whereof may be serviceable to the *Kings Majesty,* for preservation of the *lives* of his *people,* against the blow and mortal wounds of a *self-killing* hand: and may be useful for the public good of the *Church* and of the *Commonwealth*; both for the safety of the *souls* and *bodies* of their members; and also, in point of *Honour*; that the *government* of so gracious a *King,* and the glory of so famous a Nation may not be ignominiously stained, by *self-murdering* practices. (Sym,1637, p.A2, spelling modernized for readability)

We therefore see a clearly identified problem — the many who kill themselves— as a problem for the individual lives (bodies and souls), the public good, and the honor of Nation as a whole. The responsibility for addressing this problem is placed both on religion and the law, as well as the 'Christian Readers' interpolated in the Preface. After presenting a lengthy argument as to why

people might take their own life and why that is in all cases wrong, Sym lays out three courses of action for prevention of self-murder: 1. things we can do for ourselves, such as fostering in ourselves a strong morality and faith, 2. things we can do for one another, such as confiding in, supporting and praying for one another, as well as helping individuals discover and remove "motives and causes" of their temptation to self-murder, and 3. things we can do "without the tempted" in order to save them, such as praying for them, closely observing them, restraining them and taking away the means by which they might end their life. (Sym, 1637, pp.311-326) Even within the framework of self-killing as a sin, we see these acts conceptualized as some sort of a problem that can and should be addressed. Furthermore, we also see evidence of the kind of 'claims making' characteristic of social problems—though the reach of Sym's work and the scale of concern around suicide at the time are unclear.

Additionally, concerns regarding 'discouraging' or 'preventing' certain ipsal deaths are not a uniquely Western phenomenon, there's evidence of them from across the world. For example, reports on some of the American Indian peoples in the 17th century (specifically the Huron nation, Iroquois and the Senecas) take note of an established fear among parents that their children might take their own life, for example by hanging or eating a poisonous root, Audachienrra. These deaths were ascribed to severe parental treatment, and as a preventative measure the parents would extensively indulge their children (Wallace A. F., 1972 in ESDA, Huron, 2015). In 17 c China, Huang Liuhong (Huang, 1984, as excerpted in ESDA, Huang Liuhong (1633-c. 1710), 2015) wrote of his time as district magistrate of T'an-ch'eng and Tungkuang, where "Suicides by hanging were daily occurrences and self-destruction by cutting one's own throat or drowning in the river were common events." Huang "became alarmed at the situation," both due to the deaths themselves,

which he saw as an affront to one's parents and the cycle of reincarnation, as well as the possibility that suicides might be wrongfully avenged (he clearly distinguishes between cases of self-destruction that deserve our sympathy as they are caused by something or someone else, who should then be held accountable, and the acts of suicide for which the person themselves is seen at fault and which should not be condoned). As the man in power, Huang took it upon himself to do something about this, noting the importance of determining the causes of suicide and issuing a proclamation about punishments for suicide or for falsely accusing someone for causing suicide (Huang, 1984, as excerpted in ESDA, Huang Liuhong (1633-c. 1710), 2015).

Despite their very different contexts, the examples above have much in common: in each case an individual or a community takes note of a particular set of ipsal deaths— "young women hanging themselves," "voluntary death," "self-killing," "children taking their lives"— argues that these kinds of deaths ought not to happen, postulates causes of this identified problem, and proposes some sort of action (e.g. exposing the naked bodies of the deceased; appeals to the believers; fostering faith, creating support and intervention; indulging children; punishing suicides). Notably, in many of these cases this claim-making is framed not with regards to the broad questions of morality of ipsal deaths—as seems to mostly be the cause in Augustine's writings—but with respect to a more specific putative condition, that appears both novel and particularly emotionally charged. In the 17th century writings on the Huron, Seneca and the Iroquois, there is concern with children, and similarly in 3 BC Miletus it is a group of young women who hang themselves in what appears to be a short time period. In both 17th century England and China, in writings by Sym and Huang, there is the sense that at their time "'so many doe wretchedly, and unnaturally kill themselves," (Sym, 1637, p.a) or that some suicides "were daily occurrences" or "common events"

(Huang, 1984, as excerpted in ESDA, Huang Liuhong (1633-c. 1710), 2015)—sentiments likely enabled by developing bureaucracies through which these events were made visible as an aggregate.

I emphasize these various concerns regarding the prevention of ipsal deaths for three reasons. First, I highlight a continuity in the way ipsal deaths might be responded to and emphasize that the efforts to prevent ipsal deaths are not exclusively products of the modern biopolitical regime. Across different contexts, alongside concerns of some ipsal deaths being 'wrong' or 'bad' in one way or another, there is also the sense that they are not necessary, are avoidable, and should be prevented, for the good of the individual and the community. While previous work emphasizes the changing attitudes towards ipsal deaths and reconceptualization of the problem of suicide, it is worth noting that overall, understandings of some ipsal deaths as a negative event are tied to the impetus to 'do something about' these deaths *before* they occur. Second, with this history of claims making about problematic ipsal deaths in mind, I wish to expand on Spector and Kitsuse's (1973) model, which Starts with a Stage 1 in which there's an attempt "by some group(s) to assert the existence of some condition, define it as offensive, harmful, and otherwise undesirable" implying that the condition was not recognized as such before. At least in case of 'suicide,' however, these attempts exist against a background of previous concerns with ipsal deaths. If Stage 1 of a social problem denotes a particular kind of a formal organization around a political agenda (as possible within the modern sociopolitical structures), then it might be useful to theorize a 'Stage 0' that consists of prior discourse that informs and mobilizes Stage 1. Finally, while my examples above are not necessarily representative of the history of attempts to prevent some ipsal deaths, I do want to make note of how some of the problem is framed in many of these examples, specifically with

respect to the novelty of some phenomenon or the perceived excess of it. As I will show in this chapter, we see these frames again and again in the 20th century, and I do not want to make it seem like they are specific to this particular context.

However, even though the 20th century is not when we see concerns about preventing some ipsal deaths emerge, nor is it the first time we see claims that position certain ipsal deaths as some kind of a problem, it presents a historically unique development in terms of both scale and the kind of engagement within the public and the political sphere characteristic of a modern 'public problem.' Claims come to be made not just by individuals, but by large groups organized explicitly around the claims-making process, and these claims are not simply publicized—they are taken up through institutions and legislation building a kind of context that is not only qualitatively different from any that had come before it, but that has also explicitly and profoundly shaped the way ipsal deaths are understood, studied, experienced, and managed today.

5. American Suicide through the 1930s: A menagerie of ideas and the rise of concerns over 'Excess Suicides'

In this section, I cover a considerable timespan, from about 1850 to 1930, as this period marks the emergence of institutions, professions, and ideas that come to play foundational roles in later developments of suicide as a public problem. Most notably, it is in this period that we see fields such a psychiatry and public health emerging around—and establishing professional authority over—their respective domains. In 1844, the Association of Medical Superintendents of American Institutions for the Insane (AMSAII) was formed, by its 13 members. The same year, American Journal of Insanity, edited by the Officers of the New York State Lunatic Asylum, Utica is

established in in order to "popularize the study of insanity—to acquaint the general reader with the nature and varieties of the disease, methods of prevention and cure. We [the editors] also hope to make it useful and interesting to members of the medical and legal profession, and to all those engaged in the study of the phenomena of the mind." (American Journal of Insanity, 1844a). In 1892, the AMSAII takes over the journal and in 1893 it becomes The American Medico-Psychological Association (Barton, 1987, p. 89). By 1921, the organization numbers over 1000 members and is renamed "American Psychiatric Association," with the accompanying "American Journal of Psychiatry," (American Journal of Psychiatry, 1921), now addressed to the fellow professionals, no longer a "general reader." This period also gave rise to the institutional structures that enable the production of society-level data on suicide. In 1842, the first US system for collecting vital statistics was established in Massachusetts. By 1933, "all states were registering live births and deaths with acceptable event coverage and providing the required data to the [U.S. Bureau of the Census] for the production of national birth and death statistics" (National Research Council (US) Committee on National Statistics, 2009).

During this time, concerns around suicide are somewhat sporadic and dispersed, and they vary across different spheres of interest. I examine these through three sections. First, I review in more detail the way suicide emerges in the discourse within the professional sphere, including physicians, asylum attendants and statisticians, and show that 'suicide' is not a concern in and of itself, as much as it is considered a symptom of broader pathologies. I delineate two separate issues that exist in this context: one that has to do with appropriate treatment of the suicidal, and the other that has to do with increasing suicide rates and the implicit sense of an 'excess' of suicide deaths. Second, I consider public sentiments as recorded through the New York Times articles, and

contrast these with the professional discourse—while the latter is dominated with references to insanity or abnormality and discussions of treatment, the former is much more concerned with the social and interpersonal factors that cause suicide and takes up the problem of increasing suicide rates. This sets up the overall frame of the suicide problem, in that the concern is not with the fact that suicides occur, but with the notion that the overall incidence of suicide is larger than some (always unspoken) number. Finally, I take a closer look at some of the first instances of initiatives in which suicide was identified and responded to as a problem, as prototypes of efforts to come.

5.1.Professional Concerns

The knowledge constructed within the professional (including scientific) domains provides both the raw material and the authority upon which claims about problems are built (e.g. see Gusfield, 1981, pp. 28-29). Furthermore, as the knowledge is communicated from within a professional community to outsiders, it is a sort of a claim in itself, through which a professional community can establish its authority over a problem and make claims about the necessity of the work it is doing (Aronson, 1984). A closer look at the professional discourse on suicide is, therefore, central to understanding the context in which the public problem of suicide emerges.

Within the period in question, suicide becomes established as a matter of concern mainly within two professional contexts—medical and legal. The legal concern is very limited in scope, and most often has to do with discussions of suicide with respect to life insurance (e.g. Tesse, 1870; Lawyer, 1901; Lawton, 1904; Parker, 1910). As such it is not directly interested in or making claims about suicide as a problem that should be addressed, rather it is simply a tricky legal issue to be

discussed.[14] I therefore focus mostly on the broadly medical—and what, over time, gets institutionalized into a psychiatric—context. At the end of the section, I also briefly reflect on relative absence of attempts from other professions to claim ownership of suicide as a problem.

By mid 19th century, suicide has been thoroughly medicalized in the US—it is understood to be under the purview of the medical professionals at the time and is no longer a matter of courts, but rather medical journals and asylums where, as argued by the asylum superintendents, the individuals with propensity to suicide could be contained and cured—an argument which also worked to sustain public and governmental support of asylums (Kushner, 1991, pp. 35-41). For example, an article in the first issue of the American Journal of Insanity, titled "Cases of Insanity—Illustrating the Importance of Early Treatment in Preventing Suicide," (American Journal of Insanity, 1844b) argues that one should be concerned when someone's character or behavior changes following some negative life's circumstances. And if a person becomes "reserved and melancholy; loses his affection for his family and his business; prefers to be alone; is undecided in his purposes, and restless and sleepless at night;" then, the article argues, "there is indication that immediate action in his behalf may be necessary to his safety." (American Journal of Insanity, 1844b) More specifically,

> [T]he only security that such persons have, is the constant care of a judicious friend, or what is still better for their recovery, a residence in a well-directed

[14] Insurance companies themselves do seem to play a role in production of knowledge about suicide, specifically with respect to data collection and analysis, but it is unclear whether this is an overall professional interest, or an artifact of a few individual's interest in the topic and data availability. Most notable of these is Louis Dublin (discussed on p.160), who published significantly on the topic and who was a statistician at the Metropolitan Life Insurance Company. This is something that I hope to look into further in the future.

> Lunatic Asylum—for usually such persons need medical treatment. (American Journal of Insanity, 1844b)

Writing more than three decades later, James O'Dea, a Canadian physician and a Member of the "Medico-Legal Society of New York", offers a series of approaches to suicide prevention across three chapters. Some of these suggestions are very broad, including changes in laws regarding suicide, specific approaches in the religious and moral education of children, while others are oriented specifically at "Prevention by Medical Advice and Treatment." (O'Dea, 1882) This last chapter includes advice aligned with the popular therapeutic practice of the time, so called 'moral treatment,' which emphasized "character and spiritual development," via manual labour, religious worship and distraction from morbid thoughts, ideally in an institutional context where a person could be removed from any negative influences of their usual environment (Luchins, 1989). O'Dea suggests, among others, keeping the mind occupied, spending time outdoors and getting enough exercise, restricting the use of stimulants or practicing "the faculty of analyzing states of feeling so as to separate facts from impressions" (O'Dea, 1882, p. 299). Additionally, he also emphasizes the necessity of professional care in assuring the "safety" of persons: echoing the 1844 American Journal of Insanity article, he suggest calling the physician as soon as certain behavior changes are noted, such as isolating oneself, getting no pleasure form work, or eating and sleeping little (O'Dea, 1882, p. 300), and notes that a suicide "should awaken most serious apprehensions for the future of the person immediately concerned, and cause his family or friends to take prompt steps to secure his safety in an asylum" (O'Dea, 1882, p. 303).

Through the period, suicide was overall seen as a result of social, psychological and biological factors (e.g. see O'Dea, 1882, p. 2). In this context, the extent of the relationship between suicide and insanity was somewhat contested—suicide might be framed by some as a "fatal consequence"

of the disease (American Journal of Insanity, 1844b), while others might argue that suicide is not necessarily a problem of insanity, and that a minority of suicide might be 'sane' (e.g. O'Dea, p.257-271). Ultimately, however, alienists of the time were far more interested in treatment, rather than etiology, and saw themselves as able to prevent suicide through modification of environment via the 'moral treatment,' as well as the occasional use of newly developed stimulants and sedatives (Kushner, 1991, pp. 35-41). Irrespective of what was thought to cause suicide, the medical profession established authority over preventing individual deaths.

By the turn of the century, however, this landscape was shifting. First, a widening rift between the early neurology and psychiatry started developing. Advances in medicine, and specifically bacteriology, provided a push for a more serious consideration of (organic) etiology of mental illness, while the governmental demands on the increasingly populated asylums pressured psychiatrist of the time to look for different approaches to care. As a result, certain disorders (e.g. schizophrenia) were recognized as organic and best addressed within the structures of an asylum, while others (e.g. melancholia) were seen as affective and best suited for individual psychotherapy. The appropriate treatment of the suicidal, then, came to depend on the perceived root causes of the suicidal tendency—in most cases not the organic insanity, but rather a psychological disturbance (Kushner, 1991, pp. 51-61). While the asylum superintendents of the 19th century took significant note of "circumstances in a man's social, domestic, or other affairs" as potential precursors to a suicidal state (American Journal of Insanity, 1844b), by the turn of the century considerations of social causes of suicide, and with them the 'moral treatment', were abandoned by the medical profession as outdated, and were left to be taken up by the rare social scientist instead (Kushner, 1991, pp. 51-61), while 'suicide' continued to exist within the purview of psychiatry.

At the same time, however, in addition to the question of how best to address suicide—a profession-internal problem—by the end of the 19th century a different issue starts emerging, one that grasped public attention and that forced the medical professionals to continue grappling with 'the social.' The issue is one of the perceived increases in suicide rates, in the US and across the Western world, which had by then become easily perceivable through the expanding practices of record-keeping. This increase becomes an important concern of physicians and psychiatrists as they try to understand what might be causing it and what to do about it. An article in JAMA, for example, reporting on an anti-suicide commission in Cleveland (see Section 5.3), discusses the issue as follows:

> Suicide is increasing and is becoming more than ever a matter for concern to the well-wishers of the race. Many suicides can undoubtedly be accounted for by mental aberration, either actual insanity or temporary morbid impulse. With the increase of insanity suicide would also naturally increase. It seems doubtful, however, that we can properly attribute the very notable increase of self-destruction to these causes alone. The too prevalent pessimistic tendencies of the present time are probably still more responsible. (…) while the actual pathologic causal factors above mentioned mainly interest us as medical men, we can not altogether overlook the social disease that we believe is the main cause of the growing evil of to-day. (JAMA, 1905)

The increase in suicide rate, therefore, challenges the idea that suicide is simply a product of insanity, and recognizes some external factors that need to be addressed. The exact factors identified, however, differ and are often entwined with broader debates regarding 'concerns for

the race' and eugenics.[15] JAMA article discusses a general 'social disease' of 'prevalent pessimistic tendencies,' especially in the case of the 'despondent and suffering' (JAMA, 1905). Forbes Winslow, a British Physician who had previously situated suicide in the "derangement of the brain and the abdominal viscera" (1840), speaking at the Medico-Legal Congress in New York in talk titled "Suicide as a mental epidemic," ultimately attributes the "alarming increase of suicide" to the fact that "[a]ll human actions are under the influence and power of example more than precept." The causal chain that he identifies is, therefore, in "[t]he great publicity given by the press in publishing revolting details of crime and trials, thus reacting perniciously in the minds of weak-minded persons" and the "[i]nsufficient power of legislature in suppressing such publicity" (Winslow, 1895). Charles Pilgrim (the president of the NY State Commission in Lunacy), speaking at the annual meeting of the American Medico-Psychological Association in 1906 also notes that the number of suicides cannot be explained by the increase in insanity, but locates the source of the problem in the state of society itself:

> It is a truism that the greater the opportunities for failure and disappointment, the greater will be the tendency to self-destruction. The advances and progress of the last few years, while making life more attractive for the few, have made it more difficult for the many. Our wants have increased faster than our ability to supply them. Wages have not increased as rapidly as has the cost of life's necessities. (…) Education also has made the masses dissatisfied with their

[15] There are broader concerns around this time in the hereditary nature of 'insanity' as 'degeneracy'. Though these, in some ways, resemble contemporary discussions of 'predispositions' they are heavily moralized and politicized and entwined with discourse about population control and eugenics. In this context, suicide is not necessarily problematic e.g. Robert Rentoul, a physician in Liverpool writing in the American Journal of Sociology, in arguing for sterilization in certain cases of 'degeneracy' discusses 'encouraging of suicide' as an alternative, though he dismisses the idea as inefficient because it would not 'attack the causes of degeneracy' (Rentoul, 1906). This is a topic that deserves a more delicate treatment than I can provide in the current work, and it also seems to be more pertinent to the European, rather than the US context (note that both Winslow and Rentoul are writing from Britain). It is for these reasons that I do not explicitly engage with it in my work.

> conditions of life, and the extension of pseudo-scientific doctrines has weakened religious sentiment. (Pilgrim, 1907)

These kinds of concerns with the state of society, and the effects of 'civilization' appear common at the time. Statistics at the time revealed suicide to be more common in cities than in the countryside (in contrasts to today's apparent trends) and were as such taken up as evidence of suicide as a consequence of modern development.

While Pilgrim does not offer a possible solution, Tom Williams offers one eight years later at the same meeting (emphasis mine):

> The safe-guarding of those in custody on account of mental unsoundness is a problem for their guardians, which will not be considered here. **The problem we have to study is one of preventative medicine, and concerns thousands of suicides due to distress of mind, the result of pscyho-sociological conditions**, before which, to judge by their great increase, society shows a helplessness which, in view of present psychopathological knowledge, is reprehensible. (Williams T. A., 1915)

As a solution, based in the "present psychopathological knowledge", Williams lays out a cognitive therapy for suicide, which he attributed to mental distortions. Suicide, he says, "is like turning the wheel towards the precipice in order to avoid obstacles in the road which appear insurmountable." The best remedy, Williams argues, is psychotherapy that, akin to conditioning in the case of Pavlov's dog, can help modify individual's perception of their reality and idea associated with it. This is a clear move of claiming professional authority over suicide and "distress of the mind" even if these originate in social condition—the main 'problem' is not really the social conditions, but rather individual's ability to adapt to the changes, which were sometimes also framed as a temporary disturbance rather than a more permanent new state (MacDonald A. , 1902, p. 7). While these conversations regarding prevention are not centered on suicide *per se*, but rather they

incorporate suicide—as a result of mental disturbance—within discussions on the extent of psychiatric professional domain (see Pols, 2001),[16] they offer an important frame within which suicide overall can be understood and managed. Furthermore, they allow us to see how the psy-professions could have held onto their authority over suicide even in the light of explicit discussion of non-medical factors in suicide.

What is interesting in this context of concerns regarding increasing suicide rates is a relative lack of uptake from more 'society-oriented' fields such as sociology (American Journal of Sociology was established in 1895, the Association est. 1905) or public health (American Public Health Association established 1802, the journal established in 1911). This is not entirely surprising, given that 'suicide' had existed almost exclusively in a clinical context across the second half of the 19th century, but it is worth noting nevertheless.

American sociologists do not really show much interest in—let alone claim any ownership over—the increase of suicide rates, or suicide in general, at least for a while. Durkheim's work, for example, is not received with much enthusiasm, not only with respect to his general theoretical approach, but with regards to the explanation of suicide. In a review of Durkheim's work in the American Journal of Sociology, and a reply to Durkheim's response to the said review, Gustavo Tosti (Tosti, 1898a; Tosti, 1898b) minimizes the importance of the phenomenon of suicide to

[16] Additionally, there seem to be some concerns about suicide among physicians, but focus on this is outside of the scope of this work.

sociological inquiry, and ultimately sees the question of suicide as answered by invoking Tarde and the 'law of imitation' (emphasis mine):

> We must, henceforth, keep straight to the path through which the **greatest conquest of modern thought has been made in the line of sociological research**—I mean the **discovery of that law of imitation** which, in spite of Durkheim's grammatical or philological criticism, remains the **cornerstone of any possible interpretation** of social life. (Tosti, 1898b)

This focus on imitation aligns with the discourse around this time that was also evident in the medical profession as well as, as we will see below, the public. In fact, there seems to be a broader uptake of Tarde specifically, as compared to Durkheim. The Hearings on the 1902 Bill "To Establish a laboratory for The Study of the Criminal, Pauper, and Defective Classes" (1902, see section on initiatives below) references Tarde, but not Durkheim in the discussion of criminality.

It is not until 1928, with Ruth Cavan's book 'Suicide,' that we see any significant engagement with suicide within American sociology, However, even then, she does not write in response to 'suicide' as a problem, but rather "because of an interest in human nature in the midst of perplexities and because of a curiosity as to why people, even when perplexed, commit suicide" (Cavan, 1928, p. vii) As a result, the book only offers three opportunities for the control of suicide at the very end: 1) maintaining social organization in "fairly small, isolated, undisturbed units" (p. 331) which Cavan dismisses as "not compatible either with the present trend of social life or with present ideals of progress " (p. 332), 2) "cultivating attitudes unfavorable to suicide" (p. 332) and 3) "methods of education and training which would develop in the first instance resourceful, reflective characters" (p. 332). While offering these as suggestions emerging from her discussion, Cavan does not assign any entity or any professions with these tasks of 'attitude cultivation' or 'education.' Ultimately, the work as a whole does not become at all influential (and has by now

become quite forgotten), and Cavan remains one of the few sociologists interested in the topic at the time—of the 14 articles and book reviews that seem to focus on suicide published in AJS before 1945, Cavan authored 6, and her work is the subject of the 7th.

Within public health, a focused interest in suicide emerges even later, and is mostly driven by a single person, Louis Dublin, a statistician, the president of the American Public Health Association (APHA) in 1932 (APHA, n.d.), and the eponym of the AAS's "Louis I. Dublin Lifetime Achievements Award." Apart from a single article in 1922 on suicide among physicians (Hubbard, 1922), Dublin's reports on Vital statistics, including suicide, are the only publications that discuss suicide in the American Journal of Public Health prior to early 1930s. Then, in 1933, Dublin and his research assistant Bessie Bunzel publish the volume *To Be or Not to Be: A Study of Suicide* (Dublin & Bunzel, 1933), which provides an in-depth review of suicide statistics, historical information, as well as sociological and psychological theories of suicide. In many ways, the book provides little new information, and offers a surprisingly limited and eclectic set of suggestions for suicide prevention in its last chapter. Dublin and Bunzel mainly highlight the role of support, "ordinary kindliness and sympathy" and "wise guidance at a moment of crisis" as provided by some voluntary societies like Save-A-Life league. They also argue that financial aid can be a mode of temporary relief is sometimes absolutely necessary and note the value in religious teachings which, although sometimes harmful, can provide solace for many people in trouble (Dublin & Bunzel, 1933). More notable here is the framing that, unlike Cavan's work, explicitly positions suicide as a problem, in a format that is very common today. Dublin and Benzel open Chapter 1 as follows (emphasis mine):

> NO ONE will ever know how many people ask themselves "To be or not to be?" All that we can say definitely is that **about 22,000** of them will answer the

> question by committing suicide this year in the United States. This is no small matter; nor does the total, large as it is, indicate the **true importance of the social problem involved**. For every case listed there are countless unsuccessful attempts, many of which never get into the public record. (Dublin & Bunzel, 1933, p. 3)

Furthermore, the book assigns the responsibility to address the problem to a wide variety of professionals, in that it argues that suicide "concerns equally the physician and the lawyer, the teacher and the social worker, the statesman and the moralist, the priest and the philosopher (Dublin & Bunzel, 1933, p. vii) but does not make clear claims regarding suicide as a *public health* problem.

Ultimately then, throughout the period and beyond, 'suicide' is strongly anchored within the purview of the medical professions, and can be mobilized by them to further justify their activities (e.g. asylums as places that can ensure the 'safety' of people). Even as concerns about increasing suicide rates emerge, and are discursively tied to social conditions, the emergent discipline of psychiatry can offer its own solution—preventative psychotherapy—and keep its ownership over the problem. Most other claims regarding what could be done with respect to suicide are not conceptualized within a clear profession or discipline, and are not oriented to explicit others, at best they are speaking to a broad sense of 'social responsibility.' The only exception might be concerns about possible effects of publication on suicide, addressed both at the media and the government, which we do see taken up in the public sphere. It is unclear when these concerns about publicity originated, or how wide-spread they were in the community as a whole but they do occur in other writings as well (e.g. Hume, 1910; Fenton, 1910)

5.2.The Public Sphere

In examining the discourse in the public sphere, I focus on newspapers, both as a medium through which information deemed of relevance was disseminated, and as a kind of a public forum where discourse happened, e.g. through letters to the editor. The published articles do not necessarily capture all sentiments or even general sentiments about suicide, as they are mediated by the editors' decisions as to what should be published. Additionally, the writing and the format are also guided by professional conventions—a 1911 Handbook on "The Writing of News" (Ross C. G., 1911), for example, suggests that "routine suicide stories receive bare mention at the most" and, "if a suicide story is to be covered in detail," instructs the journalists not to "stop with the obvious—find out the 'why' of it all." Ross C. G., 191, p. 133). However, the publications do allow us to observe the kinds of concerns that succeeded in presenting themselves to a broader audience, and they allow us to systematically track these across time, while keeping the venue (news) constant. As such, they are especially suited for the kind of historical analysis that I conduct.

In the period prior to 1930s and 1940s, publishing overall and publishing about suicide specifically, differed significantly from what we see today. Specifically, short reports of various events, crimes etc. were very common, and seemed to position suicide as nothing more than a curiosity. These accounts generally identified the deceased (by name and some social role), the method used, and alleged motives or other relevant factors behind the suicide death or attempt. Consider, for example, the following typical examples:

> "Suicide and Attempt at Suicide. Augusta, Thursday, May 6. DAVID DAVIDSON, an Israelite, blew out his brains with a musket to-day, and S.C.LANE, from Philadelphia, a traveler, attempted to cut his throat but was prevented. Both had been drinking very hard." (NYT, 1858)

> "SUICIDES. COLUMBUS, Ohio, July 12.— A young man, named Gill, residing near Middleport, Licking Country, last night committed suicide by taking arsenic. His wife had recently applied for a divorce, and this, no doubt, was the cause of the suicide. Charles Bollinger, an aged inmate of the County Infirmary, cut his throat to-day, and will hardly recover. BOSTON, July 12, A young lady, aged about twenty-two years, named Currier, a daughter of Police Officer Currier, of this city, committed suicide this evening by shooting herself through the heart. Jealousy is supposed to have been the cause." (NYT, 1973)

> "The Bravado of Suicide. SACRAMENTO, Cal., June 11. —Henry F. Dillman, an ex-Chief of Police of this city, committed suicide last evening by shooting himself through the head. He stood in a barroom, took a drink, said good-bye, and fired. No cause for the act is known." (NYT, 1895b)

Most articles identify the victim, the means, and the putative cause, with simple headlines such as "Suicide by Drowning" (NYT, 1886; NYT, 1888a; NYT, 1888c; NYT, 1889b; etc.), "Suicide by Fire" (NYT, 1877a; NYT, 1896a; NYT, 1896b; etc.), "Causeless Suicide" (NYT, 1889a), "Suicide of a Bookkeeper" (NYT, 1897a), "Suicide by poison" (NYT, 1852; NYT, 1864; NYT, 1872a; etc.), "Suicide at Trenton" (NYT, 1872b; NYT, 1877b; NYT, 1897b), "An Unexplained Suicide" (NYT, 1883; NYT, 1885; NYT, 1888b; etc.) or "A Politician's Suicide" (NYT, 1895a), and this trend continues through this period. For example, in the 1930s, many headlines are very similar: "Centenarian a Suicide" (NYT, 1933), "Suicide by Freezing" (NYT, 1935a), "Manufacturer a Suicide" (NYT, 1935b), "Attempts Suicide in a Park" (NYT, 1938). It is notable that the cause is generally taken as clear and easily identifiable—drinking, divorce, jealously—and there is no evidence of condemnation. These short reports are quite common and numerous, and are the reason behind a fairly significant presence of suicide in the newspapers compared to the period after 1950, as seen in Figure 2-6.

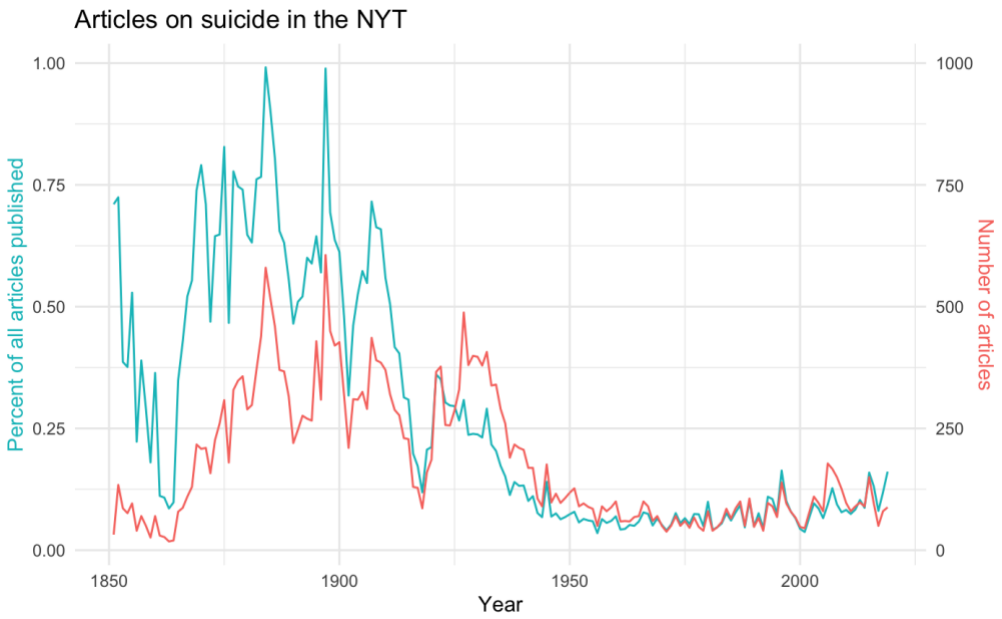


Figure 2-6. Articles on suicide in the NYT: Percent of all articles (left axis) and total number (right axis)

In addition to the short reports as outlined above which make up the majority of the articles on suicide, starting in around 1880s the NYT also starts featuring articles and letters to the editor that discuss the phenomenon, or problem, of suicide more generally. Notably, not all of these are critical and, in fact, some seek to explicitly de-problematize suicide. A set of articles, for example, use the newspapers as a public platform to discuss ethics and legality of suicide, noting that, "The whole law about suicide is radically wrong. Every man has the power to take his own life" (NYT, 1887) and that "New-York is alone, not only among the United States, but among civilized communities, in treating an attempt to commit suicide as a crime" (NYT, 1894a). This is also the period in which Ingersoll's essay in the *New York World* (another newspaper) prompts the edited volume 'Is Suicide a Sin?' (Ingersoll R. , 1894, See Chapter 1 for discussion). These debates, revolving around a person's right to take their own life, are interesting in that they show evidence of yet-incomplete medicalization of suicide—we learn that in the 1890s suicide was still a crime

in the State of New York—as well as a lack of uptake of the professional's emphasis on treatment. At the same time, the claims they make are of a different kind than the ones that are the focus of this chapter, and even though these conversations occur throughout the 20th century and are worth tracing, they are outside of the current scope of my work.

Debates on the ethics of suicide aside, the rest of the publications that discuss suicide do seem aimed at raising awareness or even concern about suicide deaths. While these are not numerous, a closer examination of these writings reveals three themes of note: 1) reporting on suicide statistics, specifically with respect to growing suicide rates, 2) concerns with 'contagion' due to media reporting, either in case of suicides overall or the use of particular methods, 3) reflection on suicide with respect to some negative conditions in society, especially destitution. We have seen all three of these themes in professional discourse on suicide, though it is notable that the public discourse mirrors, or takes up, the discussion regarding the social environment, but not the emphasis on 'medical treatment.'

In terms of the interest in suicide rates and what they might indicate the material clearly draws on international concerns. An 1881 publication, for example, re-prints an article from *London Truth*, which cites statistics on the increase in the number of suicides in different countries and some trends in rate differences by sex, marriage status and means used (NYT, 1881). By the beginning of the 20th century, possibly with the increasing availability of data in the US, these discussions turn to the local context. A 1905 editorial titled "Suicide" (NYT, 1905a) notes that

> even in this country, where the conditions of life are a good deal easier than in many, suicide is a factor in the equation of human mortality which must be reckoned with, and is not so abnormal a happening that it does not admit of

> statistical classification in actuarial calculations. Moreover, it is progressive. In fifty of the principal American cities the suicide rate for the eleven years 1893 to 1903, inclusive, was 16.30 per 100,000 of inhabitants; in 1903 it was 18.93.

The article concludes by citing statistics from some other countries and cities and positions the US relative to them: "That the average of suicides in the United States in only about 3.5[17] per 100,000 is cause for congratulations, notwithstanding the fact that in Russia, Ireland, and Spain it is still lower." (NYT, 1905a) Suicide, here, is noted as a matter of interest, but not yet a problem that has to be addressed – the relatively low rates, especially as compared to many other countries, seem not to provide impetus for concern. A 1909 article is also ambivalent as it reports on previously published tables of suicide mortality in 65 US cities. The author reflects specifically on a recent financial panic that had impacted the rich more than the poor and concludes, that increases in suicide rates are not necessarily bad:

> Suicide on this or on any account is always deplorable, yet in so far as it indicated an awakened anxiety in minds where responsibility slumbered, it is a good sign rather than a bad one. For each death self-invoked from that cause there must have been works of reform and salvation in the lives of many. (NYT, 1909)

A couple of years later, however, we see clearer formulations of the problem of suicide: e.g. "HIGH SUICIDE RATES; A Reader Attributes them to high Atmospheric Pressure (Elkin, 1912), "GROWING SUICIDE RATE. The Rev. H.M. Warren Praised for His Rescue Work" (Clark, 1913), "SUICIDES UP 26 PER CENT—Insurance Company finds Rate Index of Economic

[17] The source for this figure seems to be the work by Prof Frederick L Hoffman, though it is unclear how the estimate had been calculated. I make note of this as the rate of 3.5/100,000 is significantly lower that the CDC figure of 11.3 (crude, CDC, n.d.b) though that rate is based on data from a limited number of states. The way numbers are mobilized and discussed, however, is more important that tracing 'accurate' numbers.

Conditions" (NYT, 1921a), "SUICIDE IN MASSACHUSETTS; Rate Nearly Tripled in 70 Years—Unemployment partly to Blame" (NYT, 1921b). While these articles are generally accompanied by proposed explanations for the phenomenon (such as atmospheric pressure, or unemployment), or some expert findings, the problem is sometimes explicitly positioned as something we do not know enough about. One article fairly bluntly opens with the following: "Despite advances in modern medicine and psychology, the causes of suicide are believed to be no better understood today than two centuries ago" (NYT, 1922). While the rest of the article summarizes knowledge about suicide (ranging from regional comparisons to demographics, methods and causes, all laid out with high certainty about figures), there is an implicit call here for better understanding, especially in the context of "an alarming increase the number of suicides among children and young people" and the fact that "the total number of suicides for the entire country is on the increase" (NYT, 1922). Whether directly drawing on scientific discourse, critiquing the actual state of knowledge on suicide, or even acting as platforms for professionals' claims-making, these articles emphasize the close connection between the professional and the public realm.

In addition to these general concerns about suicide rates, more specific issues are also raised, a common one having to do with 'contagion' and the role of the newspapers with respect to the increasing suicide rates, again paralleling similar concerns in the professional sphere. An 1897 letter to the editor, for example, complains about the newspaper's reporting on suicide. The author urges for the reporters not to discuss methods used in the article so as not to spread information about the best methods by which one can take their own life. His main concern is with a deadly poison—carbolic acid—which has frequently been featured in the NYT articles and seems to be

increasingly common in the city (Jones S. , 1897). Two years later, it seems that the carbolic acid has spread to Washington DC—a Dec 24 1899 headline reads "War on Carbolic Acid. Washington Authorities Try to Prevent Suicide by the Drug" (NYT, 1899). Worries about suicide contagion are also brought up in a letter to the editor from 1907, though these have to do with the overall number of articles itself. The author states:

> 'Spreading the Suicide Germ" K.D.S. complains about the increase in writings on suicide. "Suicide is a contagion, and as the tainted milk or water is related to the typhoid epidemic so is the large number of suicide items published related to, and in a great measure responsible for, the increased number of suicides" (K. D. S., 1907)

In these letters, we can see claims being made regarding suicide, assigning the newspapers some responsibility—both political and causal—for the problem. This is the same sentiment that was evident in Forbes Winslow's address (1895), though it is unclear whether this concern over media emerged separately in the professional and the public sphere, or if one informed the other. Either way, by 1911, we see it taken up by the journalists—the 1911 handbook on writing for newspapers I have previously mentioned, also notes the following, in discussion of ethical reporting and paper's choices as to how to report a suicide death:

> The theory is widely accepted that the publication of a suicide story, especially one that goes into detail, may implant the suggestion of suicide in persons of morbid mind, or may lead those who have been thinking of suicide to act. It is largely for this reason that many newspapers give little space to news of this character unless it concerns someone of prominence or contains some unique human-interest feature. (Ross C. G., 1911, p. 132)

In addition to contagion, the other locus of blame that occurs in the NYT records draws both on concerns about the economy and employment (as is evident in some of the writings regarding suicide rates, as discussed above), as well as general humanitarian attitudes. For example, the

superintendent of the Relief New York Association for Improving the Condition of the Poor, Mrs. H. Ingram, writes to the editor in 1909, responding to a recent suicide "of a man of honorable family and record, on the ground of destitution." Distressed, she goes on to write:

> "It is desirable that wide publicity be given to the fact that there is no occasion in New York for lack of the physical necessities of life such as food, clothing, shelter, medical care. The people of New York are too generous and their philanthropic agencies are too well equipped to permit preventable physical suffering, provided it is brought to their attention. Is it asking too much that those in acute distress make known their need and permit an opportunity for its relief before responding to a tragic means of ending it—a means which may only intensify the suffering of those left behind? (Ingram, 1909)

This framing of suicide as a tragic result of "preventable physical suffering" contrast significantly with discussions regarding insanity in the medical realm, while also highlighting a responsibility of those "in acute distress" to seek help and prevent "the suffering of those left behind."

Once the US enters the Great Depression, we also see a few references to 'Depression suicides', that is "suicides due to financial losses" (NYT, 1932b). Another article (NYT, 1932a) highlights the results of a statistical study by Dr. Frederick L. Hoffman, which found that "the suicide rate in the United States during 1931 reached the highest figure recorded since 1915 and very nearly approached the highest ever known" and "credits the economic depression with being the contributing factor to the large increase in self-destruction." Consequently, Dr. Hoffman "Urges Move to Combat Trend by Aiding 'Those in Desperate Need'" (NYT, 1932a). While there are a few other examples of scholarly interest in the relationship between the economic cycles and suicide at the time (e.g. Hurlburt, 1932) this interest is not extensive either in scholarly research or the *New York Times*.

To more systematically examine trends across the NYT data, especially with respect to some of the themes that we might expect to emerge, I also draw on the data collected through the NYT Archive API, which returns a list of articles given a specific search (e.g. 'suicide'). The data on the articles includes the article title and lead paragraph, in which I look for keywords corresponding to particular themes (see Appendix A for more information). Because of the inconsistent way 'contagion' is discussed, it is difficult to track, so I focus on only four themes: 1) 'Econ' — mentions of poverty, debt, destitution, which we might except in the context of the Great Depression and with respect to concerns about the state of society, 2) 'Insane'—mentions of insanity, madness, melancholy, and being depressed, as these would seem likely to occur in the context of professional interest, 3) 'Military'—including mentions of solders and veterans, which could be important in light of WWI, and, lastly 4) Rates, which looks for 'suicide rates' specifically (Figure 2-7). Note that the y-axis differs across the four themes, and is the lowest for 'Rates' which is not unexpected, given that only a small portion of the dataset consists of discussion of suicide, and the majority of entries are brief reports on suicide deaths. Comparing the economic factors with the mentions of insanity, the former seems to be a bit more common (rarely less than 2% of articles), while latter actually seem to become less common after 1920s and overall appear in less than 5% of articles in any given year. There is also a clear spike in mentions of soldiers and veterans around WWI, which occurs due to an increase number of reports of soldier deaths, though I cannot find any evidence of suicide being discussed as a problem among soldiers or veterans. Finally, we see occasional appearance of discussion on suicide rates starting around 1910, again after mid 1920s, and foreshadowing an increase after 1940.

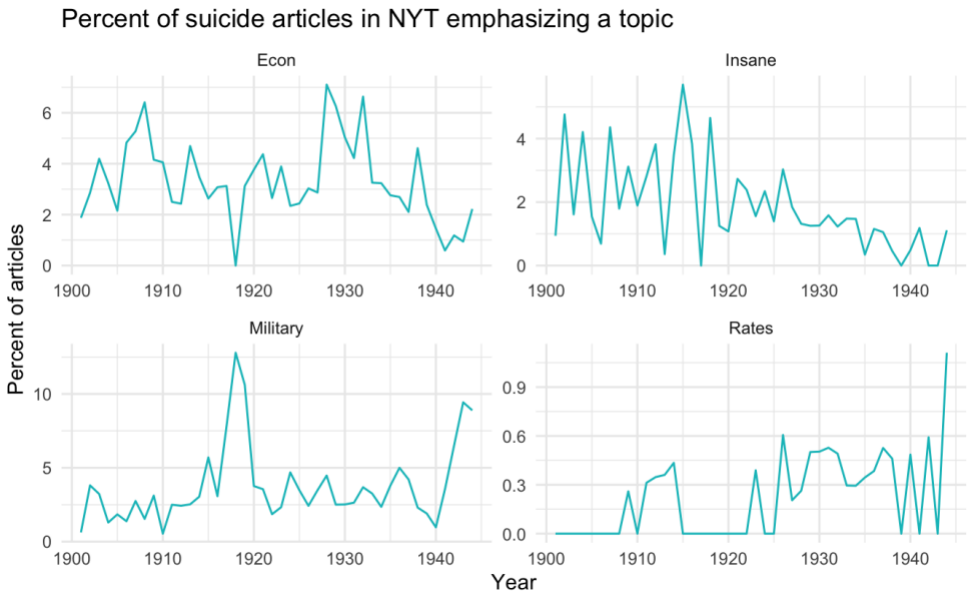


Figure 2-7. Emphasis on particular topics in the NYT, 1900-1945

Overall, throughout the NYT record, suicide deaths seem to constitute events of interests—as evidenced by extensive reporting on particular suicides. Around the turn of the century, we also see different concerns emerging, including increasing suicide rates, worries about suicide contagion, especially as facilitated by newspapers, suicide means access, human suffering and possible humanitarian efforts, as well as considerations of those 'left behind' by suicide deaths. In general, there is little focus on insanity (see Figure 2-7), which does contrast with the professional discourse. This might not be surprising, as the kind of 'suicide' perceived by the two groups is distinct—the medical profession encounters the potential suicide in a clinical context, while the public is primarily represented with stories of suicide deaths of often every-day people facing different life challenges, or the public fact of 'suicide rates' which even within the medical realm open conversations about social factors and conditions. Given some of these concerns evident in the public realm, it is not surprising that the early suicide-related initiatives were aimed not just as

care and treatment for the insane, but also addressed the extra-medical realm of 'contagion' and 'friendly support.'

5.3.Initiatives

Beyond just the discussions regarding suicide, and occasional calls for something to be done, there also are a few responses to the perceived problem of suicide in this period—which can be seen as a set of pioneering initiatives, or early prototypes of responses to the suicide problem—across three broad categories: legislation, community prevention efforts, and profession-driven research endeavors. All of these show suicide as gaining enough attention in order to enter the political sphere or receive funding, even if just briefly.

In terms of legislation, era sees the first attempts at introducing legislation aimed at suicide prevention, as well as bills seeking to establish support for the study of social problems more generally. In 1896 (A bill to prevent the multiplication of suicides, 1896) and then again in 1897 (A bill to prevent the multiplication of suicides, 1897), George Washington Ray, a New York republican, introduced a Bill to prevent the multiplication of suicides, which aimed to control suicide related reporting so that "no newspaper or so-called Police Gazette shall be transmitted through the mails of the United States which contains any picture of a suicide or any details relating thereto beyond the simple statement of death by suicide, giving name, date, and place." While nothing came out of those bills, they do echo the public's concern with 'suicide contagion.' Then, in the period between 1902 and 1910, there is an attempt to more generally address problems in society—the bill "To establish a laboratory for the study of the criminal, pauper, and defective classes" introduced into the house multiple times (starting with 57 H.R. 10160 in 1902; and ending

with 61 H.R. 17172 in 1910) is accompanied by a report on "Statistics of Crime, Suicide, Insanity and Other Form of Abnormality and Criminological Studies" (MacDonald A. , 1902). The report, echoing some of the professional arguments, sees the main causes of increases in crime and abnormality to be in the rapid development of society and the "haste of civilization" which puts "an abnormal strain upon the nervous system as compared to the muscular system" (MacDonald A. , 1902, p. 7). However, it also posits that these effects might be temporary and would last only until we adapted to the new environment. (MacDonald A. , 1902, p. 7). Still concerned about the current state of society, the bill and the accompanying report propose a laboratory be formed in the Department of Justice for the study of these issues, the work of which "shall include not only laboratory investigations but also the collection of sociological and pathological data, especially such as may be found in institutions for the criminal, pauper and defective classes, and generally in hospitals and schools." Suicide appears in the bill hearing (Hearing on the Bill (H.R. 14798) to Establish a Laboratory for the Study of the Criminal, Papuer, and Defective Classes, 1902) a few times, but only in passing. While the said laboratory does not seem to have been founded, it is notable that the report includes with it significant support for the proposal across a wide variety of stakeholders (from anthropologists and physicians, to lawyers and various religious bodies). The legislative attempts to establish the said laboratory also show that the State was navigating political responsibility over social problems already at the turn of the century, and that it was relying on scientific knowledge production in efforts to do so. The failure to establish the laboratory also highlight the importance of federal support for large-scale social research endeavors.

A few years later, we also see the first bills addressing concerns regarding mental health. Introduced in 1914, the bill "To provide divisions of mental hygiene and rural sanitation in the

United States Public Health Service" (63 H.R. 16637, 1914) proposes a division of public health whose duties would be "to study and investigate mental disorders, and their causes, care and prevention." The accompanying hearing (Mental Hygiene and Rural Sanitation, 1914) frames the need for such a division as follows:

> It is conservatively estimated that there are now in the United States 250,000 insane persons and 300,000 mental defectives. The influence of these abnormal states on the production of pauperism and criminality and on race development requires systematic investigation to determine their causes and methods of prevention.
>
> The social, economic, and public health problems involved affect not only each State but the Nation as a whole. Some studies are now being made, but they should be extended, and there is need of correlating all existing data in order that they may be made available to protect the mental health of the public at large and to ameliorate conditions among those already suffering from mental disorders. (Mental Hygiene and Rural Sanitation, 1914, p. 3)

In continuity with the 1902-1910 bills, the 1914 bill emphasizes social concerns—"pauperism," "criminality" and "race development"—as central to the problem of mental health. Interestingly, despite concurrent discussions of increasing suicide rates both in the public sphere and among professionals, neither the hearings nor the bill mention suicide at all, as an explicit source of concern or a rhetorical device. While the bill was not passed, it does show emergent attention to the problem of mental health, one which will be taken up more successfully after the end of WWII.

Within the realm of community efforts, we see first suicide prevention organizations emerging at the beginning of the 20th century. In 1905, as reported by both the New York Times and the Journal of the American Medical Association, the mayor of Cleveland established an anti-suicide commission, "that is, a body of experts who shall devise ways and means of preventing the

despondent and destitute from self-destruction" (JAMA, 1905). Later that same year, seemingly at the recommendation of the commission, the city established "a clinic for the cure of drunkenness" (NYT, 1905b). According to Rev. Harris R. Cooley, interviewed by the NYT, "One-half of all the appeals for aid that have come to the Anti-Suicide Commission are pathetic pleas for a drunk cure. (…) Not a single day passes in which I do not receive letters begging me to show some poor drunkard how to become a sober man." (NYT, 1905b)

Only a year later, in 1906, a first significant and longstanding suicide-prevention effort was started by Rev. Henry Marsh Warren of New York, in what was to become the Save-A-Life League in 1916. The League, a volunteer-based organization, offered counseling for suicidal individuals, support for those in crisis in the form of legal services, free hospital beds or lodging. Their work also included support for bereaved families, as well as outreach to those who have attempted suicide—whether in person for those local to the area, or via letters. With time, the league developed branches in a few other American cities, as well as London and Paris (Miller & Gould, 2013). There is little information on those other efforts, but the original Save-A-Life League in New York seems to have survived at least through the early 80's (see Hendin, 1995, p. 294).

Finally, at the end of this period, the first professional organization with a focus on suicide is formed, and it was successful in garnering both governmental support and funding. In 1936, "The Committee for the Study of Suicides, Inc." is formed by seven psychiatrists as a chartered corporation (NYT, 1936), funded by philanthropist and business Marshall Field III, and receiving support of the Secretary of New York State, "to make researches and to disseminate knowledge and information as to the causes and motives and ways and means for the prevention of suicides"

(NYT, 1936). The organizing members reportedly embarked on this endeavor because they felt that "self destruction is a preventable disease and this has led to the organization of the group" (New York State Journal of Medicine, 1936). The full committee consisted of eight psychiatrists and two social workers, as well as two consultant members, Dr. Henry E. Sigerist, professor of the history of medicine at Johns Hopkins University, and Dr. Edward Sapir, professor of anthropology at Yale University. (Psychoanalytic Quarterly, 1935). The initial five-year goals were to conduct:

> (1) Intramural studies of individuals inclined to suicide in selected hospitals of mental diseases
>
> (2) Extramural studies of ambulatory cases with suicidal trends or with obsessional wishes for their own death
>
> (3) social studies of suicide
>
> (4) ethnological studies, that is, comprehensive investigation of suicide among primitive races
>
> (5) historical studies. (Nature, 1936)

The ethnological studies were to "include an expedition headed by a psychiatrically schooled anthropologist, a psychiatrist and a psychoanalyst" (Psychoanalytic Quarterly, 1935) but ultimately did not come to fruition, "largely to the difficulty of obtaining adequately trained personnel. A psychiatrist with a sufficient anthropological background might have been found: but no anthropologist with a sound psychoanalytic orientation was available" (Psychoanalytic Quarterly, 1940). The Committee seemed to proceed with the work successfully for a few years, and had set plans to publish a report on the studies conducted in a few large volumes. However, the entry of the US into WWII stopped the project and disbanded the committee. The reports were never published.

5.4.Section summary

There are two ‘suicides’ that emerge in both professional and public discourse around the turn of the century. On one hand, there is suicide in the singular: the individual suicide deaths and potentially suicidal individuals, taken up in different ways across the two contexts. In the professional realm of asylum attendants, alienists and later psychiatrists, these individual cases are often framed as a sort of abnormality that can and should be treated. Though the exact etiology of the issue is contested, clear claims are made regarding the authority of medical and psy-professions over this treatment. Appropriate disciplinary knowledge becomes a matter of concern in research as well, as evidenced by the inability of the Committee for the Study of Suicides to find an “anthropologist with a sound psychoanalytic orientation” (Psychoanalytic Quarterly, 1940) to conduct some of their research work. In contrast, in the public realm, stories of these individual suicide are much more frequently framed as responses to life’s circumstances and occasionally open questions regarding one’s right to take one’s own life, and the legality and ethics of suicide more generally.

On the other hand, there is suicide in the aggregate: data regarding suicide rates and perceived incidence of suicide deaths in a society or a community. Discourse regarding high and/or increasing suicide rates creates a sense of ‘excess suicide’ that cannot be easily contained within the existing professional or public frameworks. These ‘excess suicides’ are what emerges as the main suicide problem, with different actors emphasizing the condition as bad, making claims regarding its causes and proposing solutions. Two main concerns emerge, as evident both in discourse and the initiatives that seem to develop out of it. First, there is the focus on the influence of media reporting and a certain ‘contagiousness of suicide’ which results in some media

guidelines as well as attempts at legislating the reporting itself. Second, there are broader concerns with the state of society that do not offer a clear solution and we see the first few decades of the 20th century grappling with this question. Some emphasize the role of kindness and support in moments of crisis, such as Mrs. Ingram writing in the New York Times (Ingram, 1909), Henry Marsh Warren starting the Save-a-Life league, or Dublin and Bunzel (1933) in their discussion of potential suicide prevention strategies. Others point to strategies that would better equip individuals to avoid a crisis, for example through particular educational approaches (e.g. O'Dea, 1882 and Cavan, 1928), through psychotherapy (Williams T. A., 1915), or addressing some underlying factors such as drunkenness (the Cleveland Commission).

Ultimately, in the period prior to 1930s, we clearly see a 'social problem' of suicide emerging: claims about the problem of suicide, and specifically the problem of excess suicides, are being made in both the professional and the public/political realm; there are attempts to ascribe responsibility and demand changes, whether in the behavior of individuals, in the newspaper publishing practices or in the amount of attention paid to and research conducted on problems in society, including suicide; and there is some initial, mostly local initiative aimed at doing something about the problem. These concerns, however, are not pervasive, or organized, and are not successful in procuring explicit engagement from the State. There is no evidence that 'suicide' existing as a truly public problem. After WWII, with the establishment of an institutional infrastructure that could better support a sustained interest in suicide—especially within the professional and governmental realms—the context in which the 'problem of suicide' could develop changes drastically.

6. Institutions, Organizations, and Suicide as a Public Health Problem, 1940s to 1970s

Sociology of social problems emphasizes the role of groups and institutions in the processes of claims-making that constitute a 'social problem,' and presents a model that presupposed a very particular socio-political context, one in which claims are met with "official organizations" and "official investigations," "establishments of agencies," "proposals for reform," "bureaucratic handling of complaints" etc. (Spector & Kitsuse, 1973). And while these pieces were certainly in existence in the pre-WWII era, in is not until the anti-war period that we see these existing in the form that would ultimately make the institutionalization of concern with suicide possible, allowing for the kind of synchronization and sustainability of efforts and goals that was lacking in the previous period.

The first step that laid the necessary ground was an increased concern with mental health overall, which lead to the establishment of the National Institute of Mental Health in the late 1940s. The 1950's brought a more focus to the discussion of best ways to approach care and prevention, both in terms of mental illness and suicide, the 1960's established the 'staples' of suicide prevention today, and the 70s cooled off some of that initial enthusiasm. In this section, I trace some of these developments focusing specifically on the formation of governmental and professional organizations that have come to contain the problem of suicide. First, I discuss the organization of the National Institute for Mental Health and the changing sentiments regarding mental health and social problems on the governmental level. Second, I trace the institutionalization of the concerns with suicide into the field of 'suicidology,' highlighting the extent of organizational ties between the emerging and the NIMH. Third, I make note of some changes in the field and practice of public

health. Finally, I briefly review some developments in sociology and psychiatry, which are not central to the story that is the focus of the section but are worth noting so as to provide some broader context for the era in terms of knowledge production. Notably, during this period, there does not seem to be an extensive engagement with suicide among the public and the developments are mostly professional. Furthermore, in this context, 'suicide' is not consistently conceptualized as a distinct problem—even among suicidologists— and is consistently integrated into broader matters of concern.

6.1. Mental health legislation and the NIMH

Compared to some of the failed legislative efforts at the beginning of the century, the mental health-related acts of the mid 20th century faired a lot better. The 1945 "National Neuropsychiatric Institute Act" (H. R. 2550, 1945 ; S. 1160, 1945) is reworked into an amendment to the "Public Health Service Act", as the "National Mental Health Act" (1946). Unlike the early 20th c counter-parts, the mid-century conversations forefront the 'mental health problem' as a problem in and of itself, emphasizing not just the hospitalizations due to mental illness but the estimated "6 percent of the population, or approximately 8,000,000 people—more than the entire population of the New York City, [who] suffer from some form of mental illness," and the fact that "the number of mental cases is increasing out of proportion to the population increase" (S. Rep. No. 79-1353, 1946, p. 2). Furthermore, the discussion elaborates on the "social and economic consequences of mental illness" noting that "our country has reason to expect during the postwar period a sharp rise in delinquency, suicide, alcoholism, and other phases of social disorder, all of which are frequently signs of psychiatric disorders" and remarking on "[t]he economic losses resulting from reduced earning power of individuals suffering from psychiatric disorders"(S. Rep. No. 79-1353, 1946, p. 3). While

concern regarding social disorder is still evident, the social issues—including suicide—are now framed as "signs of psychiatric disorders," as opposed to being positioned as the primary motivators of interest in mental health.

With the passing of the "National Mental Health Act" (1946) the government recognizes "mental health' as a unique object of concern, establishes the "improvement of mental health" as a goal worthy of pursuing in and of itself, and claims the political responsibility for matters of mental health. The bill also includes significant material investment, indicating a successful uptake of 'mental health' as a public problem. The act allocates $7.5 million (around $100 million in 2020, adjusted for inflation) for the erection and equipment of facilities that will be the "National Institute of Mental Health," which was formally established in 1949 (this is approximately a thousand times greater than the budget allocated by the 1902 bill). Additionally, the bill establishes a $30 million ($400 million, adjusted for inflation) yearly budget for the Surgeon general to assist establishing adequate public health services.

This federal-level concern with mental-health is confirmed with the "Mental Health Study Act of 1955" (1955) "providing for an objective, thorough, and nationwide analysis and revaluation of the human and economic problems of mental illness, and for other purposes." Among others, the bill highlights (1) the size of the problem (750,000 "mentally ill and retarded patients hospitalized on any given day", with 47% of hospital beds occupied by patients with mental illness), **(**2) burdens on the society—economic costs as well as impact on families of those suffering, (3) potential problems of the current system, as well as (4) the connection between mental illness and

other problems such as delinquency, drug addiction, broken homes, etc., including suicide. The act sees to address these

> complex and the interrelated problems posed by mental illness by encouraging the undertaking of nongovernmental, multidisciplinary research into and reevaluation of all aspects of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill, including research aimed at the prevention of mental illness. (Mental Health Study Act of 1955, 1955)

For this research, the act allocates $1.25 million ($12.5 million in 2020 currency), which ultimately funds the Joint Commission on Mental Health and Illness that brought together 45 individuals from 36 agencies and, over the next three years, produced an extensive report (Joint Commission on Mental Illness, 1961). The report, among other things, recommended (1) a reorganization of the mental health care system away from mental hospital and towards community based care and psychiatric units in general hospitals, (2) increased focus on long term basic-science research on mental health, as opposed to short-term applied projects, (3) developments of services for acute crises and (4) emphasis on public education about mental illness, as opposed to pursuing goals of education as a tool for promoting better mental health. (Joint Commission on Mental Illness, 1961, pp vii - xx). The reorganization and deinstitutionalization of mental health care were further encouraged through the 1963 Community Mental Health Act (see e.g. Wallace D. , 2001), while the emphasis on basic research shaped much of the NIMH's agenda in the following decades.

Of note here is the nearly complete absence of suicide, both in the Act (Mental Health Study Act of 1955, 1955) and even in the report (Joint Commission on Mental Illness, 1961), in which the words itself appears only three times, as a part of long lists of potential problems associated with mental illness—mental illness has at this point successfully emerged as a 'public problem,' but

there do not seem to be any attempts to emphasize suicide as a separate, or especially significant matter of concern, something that does not occur until 1966 with the formation of the Center for Studies of Suicide Prevention (CSSP) under NIMH, as I will discuss below. Although not directly a part of suicide claim-making, however, the mental health acts will come to shape it, as NIMH and the emphasis on community-level care provided an essential handhold for the budding field of suicidology.

6.2.Professional institutionalization—Suicidology

While these major developments in mental health were happening on a national scale, a new initiative was emerging in the professional realm, one that will posit 'suicide and suicide prevention' as an object worthy of focused investigation in a context separate from established fields. This process will ultimately rely on claims about suicide as a unique entity and a problem in-and-of-itself in order to establish a new field of inquiry and wrestle for professional authority over and ownership of the problem of suicide (see Aronson, 1984 for a discussion of the role of social problems in claims of professional authority).

As the story goes, in 1949, a young clinical psychologist named Edwin Shneidman was asked to write condolence letters to the bereaved wives of two suicide victims and was pointed to an innocuous vault in the LA county coroner's office. The vault contained hundreds of suicide notes and Shneidman, highly intrigued, sat down to analyze them. The notes, existing in such a large number, were significant because they had a clear and unmistakable connection to the slippery object of inquiry that is suicide. Scholars have struggled for decades as they embarked to study a phenomenon that becomes inaccessible after it occurs—except indirectly, through others'

recollections, or statistical analyses of correlations (Shneidman, The suicidal mind, 1998, p. 4). Not surprisingly, Shneidman's suicide-note endeavor ended up launching his career. Together with Norman Farberow and Robert Litman, Shneidman conducted three years of research—funded by the NIMH—at the end of which they established the LA Suicide Prevention Center in 1958 (still existing today as Didi Hirsch Mental Health Services). Notably, while Shneidman played a significant role in these endeavors, these events coincided, and were likely vitalized by some global developments. For example, the International Association for Suicide prevention (IASP) was founded in 1960, by an Austrian psychiatrist Erwin Ringel and Norman Farberrow —one of Shneidmans close collaborators. Then, in 1966, the UN formed a unit to study suicide prevention, in response to WHO statistics that saw suicide ranking among the top 10 causes of death in industrialized countries (NYT 'U.N. Unit to study Prevention Service to reduce Suicide' Nov 25th 1966, p.25). It comes to no surprise that the US followed suit.

Unlike the previous efforts, which were oriented either to prevention (e.g. Save-a-Life league) or research (The Committee for the Study of Suicide, Inc.) the LA Suicide Prevention Center aimed to bring together research and practice, as it pioneered a volunteer-staffed 24-hour crisis center that also welcomed scholars on research fellowships. Following the success of the center, Shneidman further extended his reach, in two directions. First, he left the LA center in order to head the Center for Studies of Suicide Prevention (CSSP) at the NIMH, established in 1966, and then in 1968, with its first conference in Chicago, he established the American Association of Suicidology (AAS).

The CSSP was one of the special centers established at the NIMH during its re-organization in the mid 60s with the goal of coordinating efforts that focused on specific problems, such as alcohol and drug abuse, "crime and delinquency," "metropolitan mental health problems," or mental health of children and youth (Labor - Health, Education, and Welfare Appropriations for Fiscal year 1968, 1967). The CSSP, keeping close ties with the LA Suicide Prevention Center, was planned to:

> coordinate an attack on the problem [of suicide], encompassing support throughout the country of research, training, service, and demonstration activities, as well as direct research programs within the Institute itself. In the interests of a nationwide prevention program, investigators are developing diagnostic and predictive tests to identify those who are high suicide risks--for example, through measurable changes in certain adrenal hormone levels which may serve as a biochemical indicator of suicidal intent in depressed persons. Of special importance is the need to recognize the ways in which potential suicides signal their distress, the warnings they inevitably communicate as they desperately seek support. (Labor - Health, Education, and Welfare Appropriations for Fiscal year 1968, 1967, p. 1423)

The center also published the Bulletin of Suicidology, the first suicide-specific publication in the US, and was working on establishing post-doctoral programs in training in Suicidology. These endeavors are explicitly oriented towards establishing a new profession, aimed at addressing what is framed as a "grave national problem" as evident in the foreword of the first issue of the Bulletin (by Stanley Yolles, Director of NIMH at the time; emphasis mine)

> Initiation of the BULLETIN signals the **inauguration of a new profession**, suicidology, the study of suicidal phenomena and their prevention. We conceive of suicidology as a uniquely interdisciplinary profession, involving individuals with a wide variety of backgrounds in science, medicine, health, and allied fields.
>
> The Bulleting of Suicidology is designed to serve as a useful publication **for all individuals in this country who are concerned with, or interested in, the problem of human self-destruction.** (…) We earnestly hope that there will be a widespread expression of opinion concerning this publication not only from individuals in the growing number of suicide prevention centers throughout the

> country, but also from those working in different settings who are **concerned and interested in the grave national problem of suicide and its prevention**. (Yolles, 1967)

The CSSP, although often lauded as a milestone in US suicide prevention, and certainly more successful than the Marshal Field's privately funded and coordinated 1936 Committee, was nonetheless short lived. Shneidman's leaving and the lack of funding (at least in part due to lack of support during the Nixon administration) seem to have played a significant role in the center's demise. The second major factor were likely the studies that failed to show the effectiveness of crisis centers in reducing suicide rates (Hendin, 1995, p. 206-208), despite their rapidly increasing number—from about 20 in 1966 to over 180 in 1972 (McGee, 1974, p.9)—which is often seen as one of the great successes of these early suicide-prevention initiatives. This is not to say that the centers were not accomplishing anything, rather that the services they provided seemed to address acute crisis states rather than suicide specifically. This moment is interesting, as it highlights how the claims regarding a social problem shape the kind of demands within which work to research and respond to the problem needs to occur in order to receive continued governmental support. The specific definition of a problem—e.g. with respect to the *rates* of suicide—is tied to measurable outcomes specific to the said problem—a decrease in the said rates visible in the short term. Ultimately, CSSP disbands soon after Shneidman's departure (ADAMHA, 1989d, p. 25) transforming into the new section of "(Crisis Intervention, Suicide and) Mental Health Emergencies," (see Resnik & Hathorne, 1973a, title page) which soon either disappears or possibly integrated into the "Disaster Assistance and Emergency Mental Health Section."

In contrast to CSSP, Shneidman's other project, the American Association of Suicidology, survives through today. The goal of Suicidology, as a field of study of suicide and suicide prevention, as well as the organization itself, was to bring together experts from diverse fields to enable a holistic understanding of suicide and comprehensive strategies for prevention. The annual conference, a suicide-oriented journal (Suicide and Life-Threatening Behavior, first published in 1971), and a quarterly bulletin (AAS Newslink, first published in 1974) provided a hub for advances in suicide research and developments in suicide prevention, for researchers, practitioners, and others interested in suicide. As such, AAS enabled a national community to form, interact, and coordinate with a focus on suicide, even though the community did not develop to be as diverse as was initially intended. At the same time, it is important to note that even within suicidology itself, this focus on suicide was tenuous. Its journal was originally named "Life-Threatening Behavior," and it became "Suicide" in 1975 (Shneidman, 1975), due to the publisher's belief "that this new moniker will increase the appeal and dissemination of the journal, especially among sociologists, physicians, clergymen, policemen, public health workers, and coroners." The following year (vol 6 issue 1) the journal received the current name, "Suicide and Life-Threatening Behavior." Additionally, by 1981, there are serious conversations about renaming the organization into 'American Association of Suicidology and Crisis Services,' though the change is never made, despite member support (Selkin, 1981).

During the 70s, enabled first by the CSSP and with continued support of AAS, we see developments clearly oriented towards nation-level strategies for addressing suicide. Notably, in 1970, a "Task force of some fifty leaders and students in the field of suicide-prevention, self-destructive behaviors, and dying and bereavement assembled for three days in Phoenix, Arizona,"

(Resnik & Hathorne, 1973a, p. v) funded by an NIMH grant and with CSSP leadership. The task force consulted on a curriculum for suicide studies, and provided a set of recommendations which were published in 1973 as *Suicide Prevention in the 70s* (Resnik & Hathorne, 1973a). The report notes significant accomplishments of the 1960s efforts, including:

> 1) research publications during the past 20 years outnumbered all such previous studies on suicide; 2) four suicide prevention centers in 1959 have grown in one decade in this country to hundreds of suicide prevention and crisis intervention centers; 3) the National Institute of Mental Health established the Center for Studies of Suicide Prevention in 1966; and 4) both an international and a national association of professionals and laymen concerned with the problem of suicide were organized. (Resnik & Hathorne, 1973b, p. 2)

Reviewing the challenges faced by the suicide prevention field, it also makes a series of recommendations, most notably:

1. Development and refinement of suicide-related nomenclature, as well as standardization of and research on suicide death classification

2. Expanding the focus from suicide to life-threatening behaviors more broadly

3. More rigorous research design and sophisticated statistical analysis in research, as well as more research by scholars outside of the "usual mental health disciplines."

4. Provision of treatment targeting high risk individuals, instead of focus on those who would call a crisis center, with hopes for improvement in identifying and reaching "seriously suicidal patients."

5. Establishing standards for crisis centers

6. Educational efforts that would disseminate the "core knowledge" about suicide that already exists, both to future suicide researchers and suicide

> professionals but also potential gatekeepers (Resnik & Hathorne, 1973b, pp. 3-5)

Some of these recommendations are realized throughout the 70s, though more ideological moves end up being more successful than the material ones. For example, in terms of outreach, AAS initiated the national Suicide Prevention week in 1974, sending out "packages of relevant materials," including a TV tape, posters, and template news releases, to suicide prevention centers across the country (sponsored by Merck, Sharp and Dohme Pharmaceutical Company) (Allen, 1974). In contrast, the established interdisciplinary training program at John's Hopkins, started in 1967 by the CSSP grant shut down after only a few years due to a lack of funding after the expiration of the grant (Shore, 2009, p. 35). This state of affairs can be read as indicative of suicide still developing as a public problem at the time— the outreach does the work not only of addressing the perceived problem, but of raising awareness and making further demands of attention to suicide, e.g. by instituting a 'Suicide Prevention week.' At the same time difficulty to sustain funding for a single program indicates a failure to establish suicide as a political priority.

6.3.Public health efforts and suicide

In addition to the activities of AAS and CSSP, the current period, and especially the 60s and 70s, also saw greater attention to suicide within the realm of public health, including the crystallization of 'suicide' as a 'public health problem.' Within the Center for Disease Control (founded in 1946), we see an increasingly consistent amount of attention paid to suicide in their Monthly Public Health Reports. The Feb 1956 issue, for example, features Shneidman and Farberow's "Clues to Suicide," in which they discuss the necessity of empirical study of suicide for the sake of 'anticipating danger' and "[saving] many potentially suicidal persons" (Shneidman & Farberow,

1956). This piece is followed by an article on attempted suicide (Tuckman & Youngman, 1963), and an article on the relationship between suicide rates to social conditions (McMahon, Johnson, & Pugh, 1963). Starting in 1967, with "Suicide in the US, 1950-1964" (National Center for Health Statistics, 1967), the Public Health Service of the US. Department of Health, Education and Welfare also starts producing regular publications that focus on suicide.

Furthermore, there are also explicit calls for the discipline, as well as the Public Health Administration, to pay more attention to suicide. Oliven (1954) in his "Suicide Prevention as a Public Problem" opens the article with a textbox that says:

> There is a challenge here to public health administration to concern itself with the prevention of the 10th to 12th leading cause of death. Can we afford to continue to do nothing about it?

Then, in "Suicide and Public health—An attempt at Reconceptualization?" Crocetti (1959) emphasizes the necessity of the involvement of public health, not just in terms of prevention, but in terms of research, noting the complete lack of "a clearly demonstrable basis for the formulation of a program based in a health department for the prevention of suicide or the reduction of its occurrence." Through his paper, Crocetti emphasizes the importance of rigorous research as central to addressing suicide, and works to establish some professional authority of Public health over these issues.

Crocetti's call does not seem to be taken up within the discipline itself until 1976, when American Public Health Association adopts a position statement on suicide. Notably, the statement was drafted by AAS and presented by Nancy Allen M.P.H, an AAS member and the president of the organization from 1975-76. The purpose of the statement is described as follows:

> The purpose of this position paper is to emphasize the need for public health workers to direct their attention to the national suicide problem (as a part of the larger problem of crisis intervention) and urge APHA to take specific recommended actions in preventing deaths from suicide. (AAS, 1976, p. 13)

With this, some responsibility to address the problem of suicide is given to the APHA and public health workers in general, though the problem is also nested in a broader concern with 'crisis intervention.' The statement then continues:

> The primary objective is to effect a reduction in the present rate of suicidal deaths and to do so in such a way as to be able to demonstrate that lives have been saved. The pursuit of this objective involves developing new treatment modalities, stimulating research, focusing on high risk groups, providing training in suicide prevention, and changing certain current attitudes through appropriate community education. (AAS, 1976, p. 13)

The "Recommended Action" noted at the end of the statement consists of the Executive board appointing "a multisectoral committee to explore the possibilities of obtaining support for a multidisciplinary task force on suicide prevention" (AAS, 1976, p. 14), and in its vagueness makes the position paper appear far more symbolic than action oriented.

Still, by the end of the period, 'suicide' does successfully enter public health policy. When the Surgeon General publishes the first set of national objectives *Healthy People* (U.S. Public Health Service, Office of the Surgeon General and United States, Office of the Assistant Secretary for Health, 1979) and *Promoting Health/Preventing Disease: Objectives for the Nation* (U.S. Public Health Service, 1980), suicide is recognized as a significant problem, especially amongst the youth, and one of the national goals is set as:

> "By 1990, the rate of suicide among people 15 to 24 should be below 11 per 100,000. (In 1978, the suicide rate for this age group was 12.4 per 100,000)." (U.S. Public Health Service, 1980, p. 85)

Interestingly, in contrast to the recommendations of other bodies (including CSSP, AAS and APHA) which focused on disseminating knowledge of suicide, as well as identification of suicidal individuals and provision of appropriate treatment, the 1980 *Objectives* focus on the role of stress in leading to violent behavior (including suicide). Some of the recommendations it makes are as follows:

> — individually focused efforts (exercise, relaxation techniques, adequate sleep, general "self-care", improved psychological coping mechanisms);
>
> — social group focused efforts (mutual aid, self-help support groups);
>
> —societally or institutionally focused efforts to change unsatisfactory environmental conditions such as overcrowded housing, pollution, stressful working' conditions; to modify social norms or values such as relation to smoking and drinking; and to inform the public regarding the role of stress. (U.S. Public Health Service, 1980, p. 84)

This focus on general social conditions, reminiscent of some of discussions from the beginning of the century will carry over into the 1980s but will soon get sidelined. In the 1990 report, suicide is discussed not as a consequence of stress, but as "the most serious of the potential outcomes of [mental] disorders." (U.S. Public Health Services, 1991, p. 60). The diversity of guidelines at this time, however, shows that even as suicide is being defined as a 'public health problem,' and different organizations claim some political responsibility for it, the causal responsibility has not yet been fixed. Instead, it can shift according to other problems, such as 'crisis' or 'violent behavior,' that suicide is grouped with.

6.4. Other developments: Sociology and Psychiatry

As a final note, I wish to acknowledge that there are other changes and transitions that occur during this period that have to do with suicide, but that are not integral to the claims making process that I am following.

For example, in the period, we do see an interest in suicide within American sociology: Henry and Short's (1954) book, *Suicide and Homicide: Some economic, sociological and psychological aspects of aggression,* makes a substantial theoretical contribution, there is a revived interest in Durkheim's work and testing his theory with US data (e.g. Selvin, 1958; Johnson, 1965; Pope, 1976), and by the end of the period Phillips (Phillips, 1974) takes up the question of media influence on suicide and famously theorizes a "Werther-effect," which has significant impacts both within sociology and within discussions of media reporting on suicide.

At the same time, there is a significant shift that occurs in psychiatry over this same period, as the psychoanalytic psychiatric framework loses influence and becomes replaced with a more somatic conceptualization of mental illness (see e.g. Metzl, 2003; Harrington, 2019). This is evident in the rapid development of the psychopharmacological industry as well as the major revision of the Diagnostic and Statistical Manual of Mental Disorders with the DSM-III published in 1980. Suicide gets caught up in these changes—compared to DSM-II (American Pscyhiatric Association, 1968) in which there is a single substantive mention of 'suicide' in one of the examples of what is named "Adjustment reaction of adult life*" (American Pscyhiatric Association, 1968, p. 49), in the 1980 revision there are numerous mentions of suicide, now framed as a potential 'complication' of different disorders (e.g. American Pscyhiatric Association, 1980, pp. 76, 131, 150, 185). This

shift in approaches to mental illness in general and, as a result, to suicide in particular, has had extensive impact on the treatment of suicidal individuals. Its role in the discourse on the problem of suicide, however, is less clear, especially in the period up until the end of the millennium, and tackling it is outside of the scope of the current work. However, I do wish to acknowledge that somatization of suicide within psychiatry has significantly shaped research and funding practices and has become an important point in claims-making regarding suicide in the past 20 years.

6.5. Section summary

The period between 1945 and the late 1970s is overall characterized by significant institutional developments and professional concern in suicide. Major governmental institutions, such as the NIMH, and CDC, and the USPHS are established or re-organized into their contemporary forms, and come to provide a general structure through which matters of mental and public health can be addressed. As focused professional interest in suicide emerges as a practice of 'suicidology' it is relies on these established structures—in terms of institutional support, funding, and even messaging to relevant audiences.

However, even in this context, specialized interest in suicide is also somewhat unstable and continuously seems to be slipping into some broader matter of concern: the NIMH Center for Studies of Suicide prevention (CSSP) becomes a section of "(Crisis Intervention, Suicide and) Mental Health Emergencies," (Resnik & Hathorne, 1973a, title page), the APHA Position statement explicitly clarifies that "the national suicide problem" is of concern to public health "as a part of the larger problem of crisis intervention" (AAS, 1976); the 1980's *Objectives for the Nation* are interested in 'violent behavior' and its ties to stress (U.S. Public Health Service, 1980,

p. 84). This slippage occurs even within suicidology: the Phoenix conference suggests "broadening of the focus to include not simply suicide studies but all types of life-threatening behavior" (Resnik & Hathorne, 1973b, p. 2) and the AAS and its journal go through period of negotiating their names as well. Ultimately then, within a professional sphere, suicide is acknowledged, at the least as an aspect of some more general 'public health problem' by the end of 1970s. And while the exclusive focus on suicide is struggling to find purchase in discourse, the formation of a community—if not a an actual 'field of study— of 'suicidology,' is a significant development. AAS ultimately becomes the first formal membership organization in the US to form around the perceived problem of suicide.

Additionally, while I highlight the above developments as very 'top-down' and driven by professionals, this is not to say that the general public has not played any role during this period. For example, the proliferation of crisis service centers—often staffed by volunteers—in the 1970s speaks to communities' interest in helping people in crisis, and possibly concerns over issues such as suicide. Or, when the director of NIMH, arguing for more resources at the 1967 appropriations hearing (Labor-Health, Education, and Welfare Appropriations for Fiscal Year 1967, 1966, p. 2117) asserts that "the Institute is now being asked to extend its research spectrum into a number of new fields alcoholism drug addiction and suicide, to name but a few," this raises questions about who is doing the asking, and whether there are groups making demands of the government to address these new issues. However, within the records I have accessed in my research, there has not been clear evidence of non-professional claims and concerns. It is likely that 'suicide' simply did not demand any significant attention in the public arena during this time, something that will change drastically in the 1980s.

7. The Problem of Youth Suicide, National Initiatives and Early Legislation: 1980s

While we see 'suicide' successfully mobilizing professionals and securing funding in the previous period, as a problem it is not overly successful or stable, especially when it comes to consistent attention on a national scale and unique sources of funding. In many ways, despite organizational developments that have occurred, there is little evidence of 'suicide' grasping and holding public attention through the end of the 1970s. This situation changes fairly rapidly in the 1980s as a more specific problem—that of youth suicide in particular—enters the public arena. While there are other changes that occur during this time, such as discussions regarding euthanasia and physician assisted suicide, these are very much overshadowed by the "adolescent suicide problem," which is why I focus this section around that particular set of claims. To understand what is happening in the 80s, however, it is necessary to first briefly go back in time and follow a few relevant threads.

Starting in late 1950s, although overall suicide rates in the nation were relative stable, a significant demographic shift occured, in that suicide rates among middle-aged and older adults decreased, while suicide rates among adolescents and youth started increasing (Figure 2-8). Further, due to the epidemiological transition that occurred during the first half of the 20th century (Santosa, Wall, Fottrell, Högberg, & Byass, 2014), death rates have dropped for a series of causes of death, such as pneumonia and tuberculosis, and suicide climbed in the frequently published rankings of causes of death. By 1964, it was in the top 12 causes of death for all age groups, and it was ranked fourth for the 15-24 and 25-44 age groups (National Center for Health Statistics, 1967). By 1980 it was not only the 10th cause of death overall but the third leading cause of death for youth (age 15-24) (CDC, 1985). Around this time, we also see a new 'measure' emerging, that of 'years of potential

life lost' which further emphasizes the severity of the problem in youth, as opposed to the elderly (CDC, 1978, CDC, 1980).

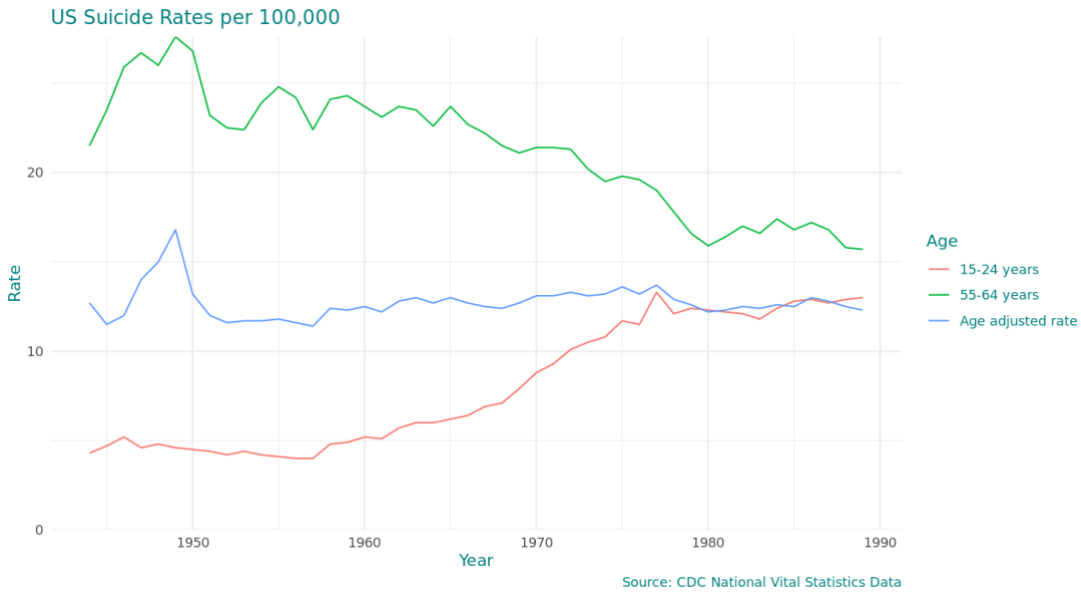


Figure 2-8. Change in suicide rates over time, comparing youth (15-24) with middle-aged adults (55-64)

Professionals have been noting an increase in youth suicide rates since the 1960s, and the proportion of publications on suicide on that specific topic had been steadily increasing since then (see Figure 2-9). However, it was not until the early 1980s that the problem really grasped the public attention (see Figure 2-10). This is, at least in part, due to both 1) increased communications by various professionals and official bodies regarding the rising suicide rates among youth and 2) the emergence of a new kind of a suicide problem—suicide clusters—which not only intensified concern among the experts, but also deeply affected communities and mobilized political attention to youth suicide. In the following sections, I review some of the early claims regarding the problem, and I examine the factors that have made youth suicide successful in the public arena—e.g. on top of concerns about youth, the affective dimension of concerns regarding clusters, as well as matters

of class and race. Then, I focus on the organizational and legislative responses, showing how these processes in themselves might have served to contain concerns over the problem, and also highlighting the way focus on youth suicide served to temporarily displace more general concern with suicide overall.

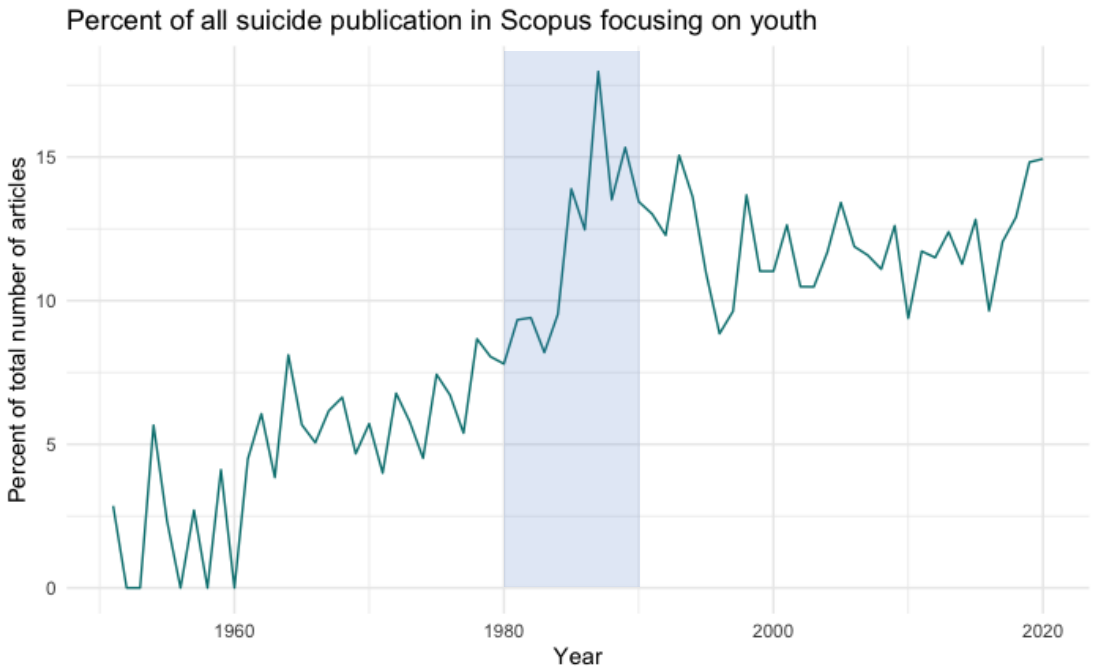


Figure 2-9. Prevalence of articles in the Scopus suicide publications dataset that reference youth, school or adolescents in their title.

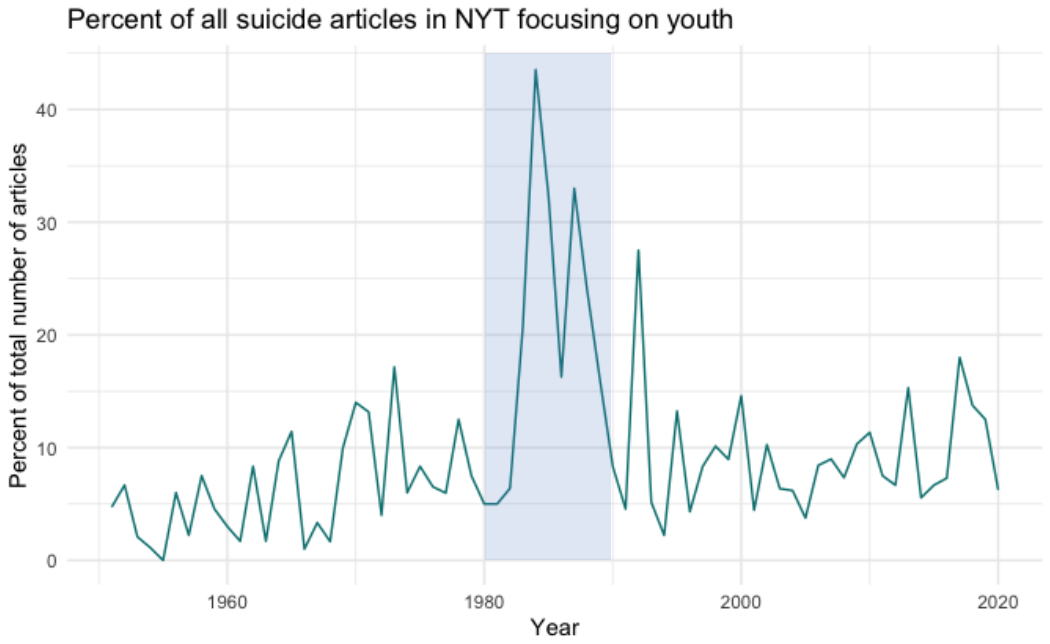


Figure 2-10. Prevalence of articles in the NYT suicide articles dataset that reference youth, teenagers, school students, or adolescents in their title.

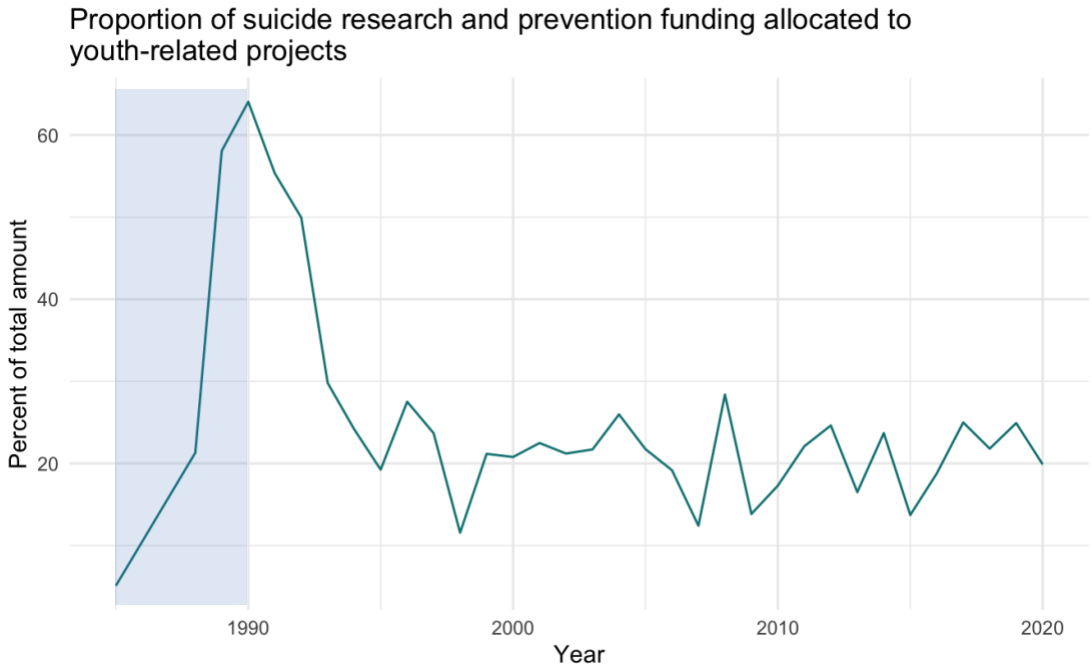


Figure 2-11. Proportion of suicide research and prevention funding allocated to projects on the topic of 'youth' (timeframe limited by data availability)

7.1.The problem of youth suicide and suicide clusters

Concerns about suicide in younger populations are evident throughout the 20th century. The Library of Congress Classification schedule H, for example, assigns a special code for child suicide (HV. 6546) already in 1910 (HV 6546, Library of Congress, 1910, p. 451). In 1922, a NYT article on "Recent suicide statistics" points out "an alarming increase in the number of suicides among children and young people" (NYT, 1922). And in the 1960s, as suicide is being framed as one of the 'major and pressing mental health problems' (Labor - Health, Education, and Welfare Appropriations for Fiscal year 1968, 1967, p. 1439) that were compelling NIMH to direct resources to new areas, we see an emphasis on suicide as not only "the 10th leading cause of death in our country" but are told that "in the 15 to 19 age group, suicide ranks third, exceeded only by deaths from accident and cancer; among college students, it ranks second" (Labor - Health, Education, and Welfare Appropriations for Fiscal year 1968, 1967, p. 1439). Dr. Yolles, the NIMH Director speaking at the hearing for Health, Education, and Welfare Appropriations, further elaborates on the statistic regarding college student deaths:

> Dr. Yolles. They are a rather healthy group and one of the principal causes that leads to suicide is the stress and anxiety in the college situation. We have repeatedly observed the phenomenon which looks like a small epidemic of suicide in a particular college. Usually you have one suicide followed by a number of the others.
>
> Senator Hill. That is usually the case, isn't it, one invites others?
>
> Dr. Yolles. That's true, and in a sense, it is communicable.
>
> Senator Hill. It is not contagious, but communicable.
>
> Dr. Yolles. That is right.

(Labor - Health, Education, and Welfare Appropriations for Fiscal year 1968, 1967, pp. 1439-40)

Therefore, by the 1960s, we see clear evidence of concern with suicide among youth in general, as well as "small epidemics" and "communicability" of suicide in particular, mobilized to highlight the scale and the urgency of the suicide problem.

In the 1970s, we see youth suicide becoming a matter of increased concern, in the US and around the world. A WHO conference in 1974, for example, "assert[s] that suicide among youth had reached epidemic proportions" (Ross C. , 1980), and communities are also noticing and starting to respond to increased incidence of youth suicide deaths. Reporting on the work of the Suicide Prevention and Crisis Center of San Mateo, Charlotte Ross (1980) writes that 12 teenage suicides were recorded in a recent year, compared to three the year prior, in a community of 585,000 residents. As a response, the crisis center piloted a one-year program that drew on schools and school personnel as a suicide prevention resource. In 1979, a NYT article, "Teen-Age Suicide Reported on Rise" (Rubin, 1979) highlights statistics indicating "that youthful suicides tripled within the last 20 years, nearly doubled in the last decade, and are now the third leading cause of death among young people behind accidents and homicides." The same year, the *Healthy People* goals (U.S. Public Health Services, 1991) also emphasize youth as a population among which suicide is particularly concerning.

Through the first half of the 1980s, youth suicide takes center stage across both professional and public spaces. In the Spring 1981 issue of the AAS Newslink, Jim Fortenberry of the Central Crisis Center in Florida writes: "As professional suicidologists, we have to be concerned about the

alarming increase in the frequency of suicide among the youth of the nation" (Fortenberry, 1981). The 1983 Winter issue reports on a Workshop given by two AAS members which stressed the 'Youth Suicide Crisis" (AAS, 1983). By the Summer 1984 issue, there are multiple mentions of youth suicide, including an ad for a "Preventing Teenage Suicide" workbook on page 3 (AAS, 1984a). On page 8, there is an announcement regarding "Preventing Suicide In The Schools" (AAS, 1984c), which advertises a section devoted to the topic in the next issue, and asks members to submit any information they have regarding school prevention programs to the Central Office, with the hopes of providing "a forum for sharing information." A note in the adjacent column also informs the readers of a public affair report on "The Youthful Suicide Epidemic," written by an AAS member, and informs them of how to receive a free copy (AAS, 1984b). Writing in 1985, Ronald Maris opens the article titled "The adolescent suicide problem" in AAS's journal *Suicide and Life-Threatening Behavior* (SLTB) with the following sentence: "Adolescent suicide is probably *the* issue in suicidology right now, as far as the general public is concerned" (Maris, 1985, emphasis in the original).

In terms of the general public, by the early 1980s we see newspapers reporting explicitly on both the problem and the developing initiatives to address it, though this interest intensified in the mid 80s (Figure 2-10). For example, In 1979, an article titled "Teen-Age Suicide Reported on Rise" discusses suicide in Westchester with respect to other teen problems, such as drugs and alcohol, and notes that that supplementary counselors have been placed into the local high schools, with additional funding from the State for training staff in alcohol and drug prevention (Rubin, 1979). "Young Suicides —Tragic and on the Increase" reports both on the statistics and the AAS conference, accompanied by some of the professionals' opinions (Williams J. , 1982), while

“Suicides by Young Worry Townsfolk” tells a story of a town of Bethel, CT, interviewing local leaders regarding the suicide deaths in the community and reporting on a task force that organized an education forum, and also distributed “Call For Help” cards to local youth (Brooks, 1982). In “Speaking personally; Teen-age suicide: How does one Cope?” the author talks of losing a student to suicide, and facts about suicide he has learned since (Downs, 1984), while the author of “New Jersey Opinion; Some 'Experts' Only Obscure Problems of Teen Suicide” asserts that suicide is a problem of drugs and alcohol, and argues against what he describes as “ill-conceived ‘trendy’ suicide prevention programs that play into the ‘suggestibility factor’” and might ultimately “cause more problems rather than provide solutions.” (Newton, 1985)

Concerns about suicide also make it onto the TV. In 1981, an article reports on a new documentary as follows:

> ARMED with decidedly troubling statistics, "Teenage Suicide: Don't Try It!" will be shown on WNEW-TV, Channel 5, tonight at 8:30. (…)
>
> According to Jeff Myrow's script, 57 teen-agers will attempt to commit suicide in the next hour. In the average day, 18 will succeed. In the last five years, the suicide rate among teenagers has climbed 250 percent. The phenomenon, once almost monopolized by youths from minority groups, has crept into the homes of the white, presumably "respectable" middle class and, according to this documentary, has reached epidemic proportions.” (O'Connor J. J., 1981)

The purpose of the documentary seems dual—to increase awareness of the problem and—as it would seem from the title—to act as a preventative measure. The framing on the problem as ‘[creeping] into the homes of the white, ‘presumably “respectable” middle class” also emphasizes the role factors like class and race might play in shaping or even propelling claims making. I reflect on this further as I review the cluster discourse in the paragraphs below. Later, we also see the

topic explored through feature films, “Silence of the heart” (1984)—for which Charlotte Ross (of San Mateo County) served as a “technical advisor” (O'Connor J. J., 1981)—and “Surviving: A Family Crisis” (1985), both of which focus on the painful aftermath of teenage suicide deaths.

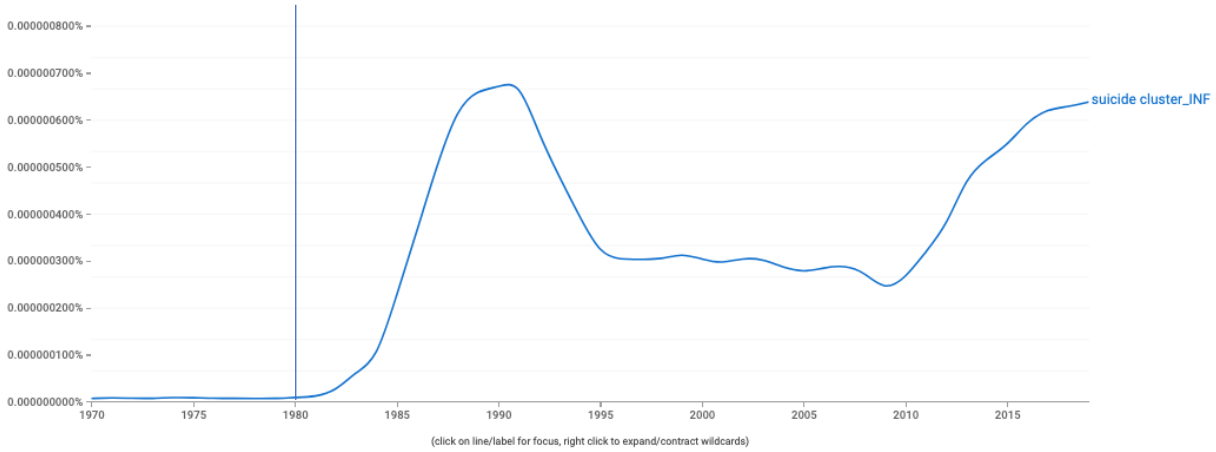


Figure 2-12. Mentions of suicide clusters in the Google Corpus (via Google NGram Viewer, Jean-Baptiste, et al., 2011) Note: ‘INF suffix means the search includes different inflections of the terms, that is ‘suicide cluster’ and ‘suicide clusters’. Values >0 prior to 1980 seem to be a result of texts that discuss research on suicide using so-called ‘cluster analysis’

In the context above, suicide clusters fuel professional and community concerns. Worries about ‘clusters’ are not unprecedented: for example, the suicides of young women in 3 c BC Miletus that I discuss at the beginning of the chapter would today be considered a cluster. Furthermore, as I have already made evident, anxieties surrounding ‘contagiousness’ of suicide, especially with respect to media reporting on suicide, have been a part of discourse on suicide since at least the beginning of the 20th century. In fact, 1970s had revived an interest in this phenomenon with a series of publication on the topic (Motto, 1970; Blumenthal & Bergner, 1973; Phillips, 1974; Barraclough, Shepherd, & Jennings, 1977). However, as a named matter of concern, clusters appear in discourse for the first time in the 1980s (see Figure 2-12). The earliest focused discussions of the phenomena that I could find, “A cluster of adolescent suicide attempts: Is suicide

contagious?" is published in 1983, in the Journal of Adolescent Health Care by two physicians (Robbins & Conroy, 1983). By 1984, at the Senate Hearing on Media Violence, the American Academy of Child Psychiatry and the American Psychiatric Association issue information "about the warning signs of suicide in adolescents, and the contagious nature of teenage suicides, causing them to occur in clusters," amongst which is the following:

> There have been increasing reports of adolescent suicides occurring within the context of "cluster outbreaks." When one suicide occurs in a community, several suicides among young people attending the same high-school or group of schools may result. Research shows that when this occurs, the young people have not always known each other, but may know of the deaths through media coverage.
>
> A number of communities have witnessed this devastating phenomenon. The problem has led the Federal Government to establish a center for the study of cluster suicides at the Centers for Disease Control in Atlanta, Georgia. In addition, the National Institute of Mental health has established a suicide research unit which is sponsoring research on behavioral and biological risk factors for suicide in young people. (Media Violence, 1984, p. 121)

The professionals are not the only one paying attention, and the experiences of these devastated communities are also making it into national news: Plano, TX: "Number of Teen-Age Suicides Alarms parents in Texas City" (NYT, 1983); Westchester area: "Another Teen-Ager is Believed a Suicide in Westchester Area" (Treaster, 1984), "The Haunting Specter of Teen-Age Suicide" (Brody, 1984); Dallas-Fort Worth area: "AROUND THE NATION; Teen-Age Suicides Stir Texas Prevention Drive" (UPI, 1984), Clear Lake, Houston: "FOLLOW-UP ON THE NEWS; Suicide outbreak" (Haitch, 1985). A book *Suicide Clusters* by social worker Loren Coleman traces the period from 1979 to 1987 and makes note of 33 suicide clusters (Coleman, 1987, pp. 114-120). Many of these clusters, especially the ones that grasped the national attention, occurred in affluent

and predominantly white areas. For example, Fairfax Country, where twenty teens (according to Coleman, 1987; other accounts number 11, e.g. UPI, 1984) took their life during the 1980-81 school year, has one of the highest median household incomes in the country and was around 93% white at the time (Felzenberg, 1980), while three highly prominent clusters of 1983/1984, in Westchester Country NY (84% white, 1980 Census) , Plano TX (>90% white, The Plano Community—Demographics, n.d.) and Clear Lake, Houston, TX (accurate demographic data unavailable), all occurred in counties that were in the top 5% by median household income.

In the end, then, the concern with youth suicide in the early 1980s seems fueled by a few factors, beyond just the increase in suicide rates among a population that is generally considered as in need of protection and otherwise at low risk of dying, particularly after the epidemiological transition. Although a small number of adolescent suicide deaths actually occurred as a part of a cluster, the concerns about imitation and contagion have accompanied the problem of suicide since the turn of the century, and the new phenomenon further ignited these. Furthermore, communities experienced the 'clusters' unmediated by statistics, and seemed further mobilized by the proximity of the events. While suicide clusters were not of central concern, they did come to serve as identifiable representations of what was emerging as a significant youth suicide problem, and they were frequently leveraged for emphasis in claims-making about suicide. Third, we see also class and race intersecting with the problem on suicide. Whether the rates or suicide clusters incidence were, in fact, greater in white and more affluent areas or not, the reporting and the discourse came to frame it that way.

The discourse on youth suicide and suicide cluster came to represent a powerful set of claims, and within a span of just a few years in the 80s, the whole country was in a flurry of mobilizing: legislation was being proposed on state and federal level, new organizations and centers were formed, conferences and taskforces organized and reports published (see Table for an overview of these activities). Central to this development was the 'rebranding' of suicide problems as a 'youth suicide problem' that, unlike its former incarnation, seemed to get more traction.

Year	Organizations	National Bills/Laws	National Hearings	State legislation
1983	NIMH establishes a Suicide Research Unit (SRU) AAS Establishes a Legislative Committee		October: "Teenagers in Crisis" (House)	California
1984	National Committee on Youth Suicide Prevention founded (NCYSP)	June: "Commission for the Study of Suicide Act", Lantos	October: "Teenage Suicide" (Senate) November: "Suicide and Suicide Prevention" (House briefing)	Florida
1985	Youth Suicide National Center founded (YSNC) HHS Secretary forms Youth Suicide Task Force. June: National Conference on Youth Suicide	Feb: "A Bill to make grants available for teenage suicide prevention programs," Ackerman Feb: "Youth Suicide Prevention Month" Denton April: "Youth Suicide Prevention Act," Lantos	April: "Tragedy of Youth Suicide" (Senate) September and October: "Hearings on Youth Suicide Prevention Acts" (House)	New Jersey, Wisconsin
1986	NIMH disbands SRU and forms a Suicide Research Consortium CDC publishes "Youth Suicide in the United States, 1970-1980"	April, July: "The Youth Suicide Prevention Act," Lantos and Ackerman June, "To Create a national Center on youth Suicide," Denton Oct: Public Law—"Anti-Drug Abuse Act"		Maryland, Rhode Island

Table 2-1. Overview of the legislative and organizational events in the 1980s

Year	Organizations	National Bills/Laws	National Hearings	State legislation
1987	American Suicide Association Founded (later AFSP)	Jan: "Youth Suicide Prevention Act," Lantos and Ackerman	May: House "Hearing on the Youth Suicide Prevention Act"	Connecticut, New York, North Carolina, Virginia
1988		April: Public Law— "Elementary and Secondary School Improvement Amendments"		
1989	Secretary's Youth Suicide Task Force publishes its four volume report			.

Table 2-1, continued

In the following sections, I follow the major developments as outlined above. First, I take a look at the emergence and activities of various organizations, both as responses to concerns about (mostly youth) suicide, and as claims-making bodies in themselves. Then, I focus on the legislation, and show how focus on youth suicide displaced the broader concerns with suicide in general, though even in the case of youth suicide, it is mainly the claims for symbolic recognition that were successful.

7.2.Organizations

The organizational developments in the 1980s were sudden in their fairly rapid response to different pressures, significant in terms of their presence and activity, but ultimately quite fleeting. First, having abandoned the CSSP and distanced itself from community prevention and crisis centers a decade earlier, NIMH re-established an organizational interest in suicide in response to citizens' groups pressures, This kind of a development follows, nearly to the letter, the Stage 3. of the Spector and Kitsuse's model (1973):

> As local citizens' groups began to mobilize around the issue of youth suicide in the early 1980s, they found natural allies in whatever community-based programs remained. They also found much to criticize in the NIMH approach — both its lack of interest in the community service program and its allegedly one-dimensional and professionally "elitist" definition of the problem. Partly in response to such pressures, a small Suicide Research Unit directed by Dr. Susan Blumenthal was set up in 1983 within the Center for Studies of Affective Disorders in the Division of Extramural Research Programs. (ADAMHA, 1989d, p. 24)

Susan Blumenthal, MD, M.P.A, acted as a representative of the NIMH throughout the hearings and discussions on youth suicide in the mid-80s, but in the end, the unit disappeared as quickly as it appeared, replaced in a restructuring with a more decentralized 'Suicide Research Consortium' (established by 1987, see ADAMHA, 1987), that is active through today. Notably, however, during its tenure, the SRU did seem to channel more funding to suicide research programs. (see Table 2.2.)

Also in 1983, AAS was responding to increasing public concerns about suicide as well, by forming a Legislative Committee chaired by Charlotte Ross. Charlotte Ross, who became interested in suicide in college after her mentor and psychology professor took his own life (Lieblich, 1997), went on to become a founding director of one of the oldest suicide prevention and crisis centers in the US (Suicide Prevention & Crisis Center of San Mateo County, est. 1966), was one of the early leaders in bringing suicide prevention into schools, and has already worked on some of state legislation. The AAS committee quickly started working with Tom Lantos, a San Mateo County area representative, on his bill for the establishment of the commission for the study of suicide which he introduced in Congress in 1984 (see next section).

Total NIMH Support for Extramural Research, Suicide-Related Research and Adolescent Suicide Research* ($000)

	Total	Suicide and Suicide-Related (%)		Adolescent Suicide (% of Total)	
1979	130,910	1,053	(0.8%)	0	
1980	143,515	1,010	(0.7%)	0	
1981	140,259	884	(0.6%)	0	
1982	143,787	2,354	(1.6%)	0	
1983	158,300	2,791	(1.8%)	74	(0.1%)
1984	173,109	3,285	(1.9%)	311	(0.2%)
1985	192,985	3,770	(2.0%)	306	(0.2%)
1986	190,261	1,893	(1.0%)	458	(0.2%)

* Adolescent suicide research is defined as those NIMH-funded projects in which narrative descriptions specify a focus on adolescents. Age parameters, in this table, have not been explicitly defined.

Table 1.

Table 2-2. NIMH support for suicide research 1979-1986, From (ADAMHA, 1989d, p. 31). SRU was most active 1983-1985 based on available information

That same year, Westchester suffered a teen suicide cluster, and Alfred DelBello, a Westchester native and then Lieutenant Governor of New York State, met with twenty-five survivors of suicide and became increasingly concerned about the problem of youth suicide and the lack of an organized effort to address it (Cordell Hollar, 1987, p. 78). As a result, DelBello started his own efforts to gain federal support for a Commission on Youth Suicide Prevention. When the AAS board found out about these efforts, it felt that "Lt. Governor DelBello's activities had the potential for either fragmenting [their] legislative efforts or strengthening them by joining forces—and resources" (Ross C. , 1984). In July 1984, the two parties met and jointly formed the "National Committee for Youth Suicide Prevention," (incorporated on October 24th 1984 in New York, State incorporation documents), initially co-chaired by Ross and DelBello (DelBello, 1984).

By next year, however, Ross is recruited into a different endeavor. She goes to D.C. at the invitation of the First Lady Nancy Reagan, to work with the Department of Health and Human Services (HHS) and develop nation-level youth suicide prevention initiatives (Ross C. , About Me, 2000). Additionally, she is appointed the Executive Director of the Youth Suicide National Center (YSNC, incorporated on April 15th 1985 in California), with Norman Farberow as the secretary (State incorporation documents). Ross's YSNC organized the 1985 National Conference on Youth Suicide and also helped establish a task force, formed by the HHS Secretary Margarett Heckler (NYT, 1986). The task force published an in-depth four-volume report of its findings in 1989, though its circulation and impact are unclear. In an interview with me, one of the major suicidologists at the time, who was heavily involved in the above efforts, said that the report "was immediately quashed by a congressman, because one of the papers was on gay suicide. And the conservative congressman said 'This shouldn't be put under the auspices of the feds.' So there are only 200 copies of that four volume set that was published."

The Task Force report was not the only product of the 1980s that barely left a trace—both the YSNC and the NCYSP practically disappear by the 1990s. While Charlotte Ross, in 1985, took pride in the fact that

> We are a new institution with years of experience, a passionate desire to reach out and help, and a perseverance in dealing with complicated problems. We intend to be your Friends For Life (YSNC, 1985, p. 317)

the organization did not seem to survive her retirement in 1989 (however, it seems to have gotten reborn under the AAS umbrella in 2009 as the National Center for the Prevention of Youth Suicide). DelBello's NCYSP collapsed around the same time as Ross's YSNC, at least in part due to internal strife, as per my interview with one of its board members, Ed Brennan. Already at the beginning

of 1986 (a little more than a year after the founding of NCYSP), Brennan was so dissatisfied by the lack of accomplishments of the organization, and overall disappointed by both NCYSP and YSNC as being nothing more than "public relations glitz efforts," that he left it to start his own organization. He also took a few other NCYSP board members with him. While initially thought up as "American Association to Prevent Youth Suicide" the organization was officially formed in 1987 as "American Suicide Association" and will later become the American Foundation for Suicide prevention (AFSP), thriving today as the largest non-profit suicide-prevention organization (bringing in over $40 mil in revenue in 2018, see Table B-1).

NCYSP	YSNC	ASA/AFSP	Focus
Increase public awareness of youth suicide. Publicize the warning signals of suicidal behaviors.	Developing and distributing educational materials. Coordinating a national awareness campaign.	Educating the public; in particular, alerting family members, teachers and employers to the warning signs of suicide.	Public awareness/ education
Establish a national information and referral system. Disseminate current information on suicide.	Serving as an information clearing house.	Serving as an informational and educational center with regard to suicide; in particular, assisting in the training of professionals in the treatment of suicidal individuals.	Information center/ distribution
Encourage and support youth suicide prevention programs. Create a foundation to support programs to address youth suicide	Providing educational programs and related services. Reviewing current youth suicide prevention programs and developing models which can be responsive to the needs of diverse groups in communities across the country.	Helping to develop, and providing financial support to programs that identify and treat the suicidal individual	Supporting / providing prevention programs
Support research on suicide. Sponsor and support interdisciplinary professional conferences.	Encouraging accelerated research focused on the causes and prevention of youth suicide.	Initiating, inviting proposals for, and funding the most promising research projects in order to advance our understanding of suicide.	Supporting / funding research
	Establishing a national toll-free "hotline" to respond to depressed and suicidal youth and their families.		Hotline
Seek to create a federal commission on youth suicide prevention. Facilitate coordination among and assistance to organizations with similar goals.			Political action
	Supporting and encouraging self-help groups and services for survivors.		Survivors
[A/N: Overall focus on youth]	[A/N: Overall focus on youth]	(The American Suicide Association will focus its initial activities and resources on the compelling problem of youth suicide)	Focus on Youth

Table 2-3. Goals of the three suicide prevention organizations formed in the 1980s. Sources: 1., 2.(Cordell Hollar, 1987, pp. 78-81), 3. Document provided by Ed Brennan

The emergence of similar and similarly named organizations in quick succession, with significant overlap in goals and—to an extent—leadership, is significant. One on hand, it might highlight the sheer importance, size and complexity of the perceived problem that necessitated a certain diversification of efforts—AFSP, for example, in contrast to the two organizations, primarily focused on fundraising for research (even though that, in itself, became a matter of contention, and ultimately played a role in driving Brennan out of the organization, to be taken over by Herbert Hendin). On the other hand, certain aspects of the organizational development might also indicate some influence of political interests or tensions. It is especially unclear what prompted the formation of Ross's YSNC in addition to DelBello's NCYSP. From a claims-making point of view, the organizations appear as *responses to*, not just *participants in*, claims making. In the cases of both NCYSP and YSNC, the organizations were formed, to an extent 'from above,' and while all three organizations worked to increase the public attention to suicide and exert pressure on the federal government, NCYSP and YSNC especially were also political moves in response to the problem.

7.3.National Legislation

Alongside the above-mentioned organizational developments, the 80s were also brimming with legislative activity, both in response to some of the organizational claims-making, and also relying on these organizations for the authority provided by their leaders. Following the timeline of the congressional events allows us to see how the claims about suicide are strategically shaped while the level and the kind of political responsibility is negotiated.

The timeline starts off with the "Teenagers in Crisis" hearing before Select Committee on Children, Youth, and Families; House of Representatives on October 27th 1983. While the hearings discusses a series of issues facing youth, including substance abuse and runaway episodes, suicide is also highlighted and is the exclusive focus of one of the hearing days:

> Many of you have been reading in your local newspapers about the tragedy of teenage suicide. We hope this morning to better understand why young people, full of promise and on the brink of life, choose death. (Teenagers in Crisis: Issues and Programs, 1984, p. 1)

While a matter of concern, youth suicide here is not framed as a separate problem, as much as it is a symptom of overall troubles that might have a common cause that is to be identified and addressed (emphasis mine):

> But while we hope to gain a better sense of what teenagers need when they **are in the midst of the crisis of suicide, substance abuse or a runaway episode**, we will also learn from an expert with deep understanding of adolescence the disturbing fact that great numbers of teenagers in our Nation are growing up with little guidance from adults. (Teenagers in Crisis: Issues and Programs, 1984, p. 1)

As a whole, the hearing weaves together a series of concerns—single-parent households and lack of child-care programs, insufficient extracurricular activities, drug and alcohol use, deterioration of familial and interpersonal relationships etc. The experts called upon to testify are from the area of child/adolescent health and crisis services—no suicidologists make an appearance. Interestingly, there are no mentions of clusters, outbreaks or 'contagion' in any form even though there is a clear conversation regarding locally-high rates. One of the speakers is a mother from Plano, TX who lost a son and another is the director of the Dallas Suicide and Crisis Center who shares the following data: "The Dallas suburb of Plano, where Mrs. DiFiglia is from, had six suicides in one high school within a 6-month period" (Teenagers in Crisis: Issues and Programs, 1984, p. 53).

Instead, the director speaks of 'heightened vulnerability' to suicide in communities such as Plano, in part due to "the failing of the family as an institution," as indicated by the high divorce rates, and stress due to both relocation into Plano (fast population growth) and the "tremendous emphasis on success in an upwardly mobile society and in communities such as Plano" (Teenagers in Crisis: Issues and Programs, 1984, pp. 53-54), the last comment echoing concerns laid out by the Plano mother (Teenagers in Crisis: Issues and Programs, 1984, p. 50). The youth suicide problem here is not yet isolated as an issue of specific concern, but is rather seen as a part of the broader problem of "Teenagers in Crisis" which, in turn is understood as being a result of negative social changes, including dissolutions of inter-personal relationships and communities, increased drug and alcohol use, and environments that are considered not to be supportive of youth development, whether due to insufficient access to activities and care, or high demands placed on the youth.

The following year, there is an increased focus on suicide specifically. In June, Tom Lantos, a Californian Congressman representing the district that includes much of San Mateo county, introduces the "Commission for the Study of Suicide Act of 1984" (98 H.R. 5931, 1984), "[t]o establish a commission to conduct a study of the problems of suicide in the United States for the purpose of providing guidance in developing national policy based on research and effective models of community response." The bill is referred to the committee on Energy and Commerce but it does not move past the committee.

Then, in October, there is a hearing on Teenage Suicide (1984) in front of the US Senate's subcommittee on Juvenile Justice, (emphasis mine):

> Our hearing this morning involves the issue of teenage suicides, where there has been a very dramatic increase over the past 25 years, and **particularly**

> **disconcerting have been the clusters of suicides** which have occurred in communities such as Fairfax County, VA, in 1980 and 1981, and in Plano, TX, earlier this year[18]. The witnesses today will focus on the factors that may lead to teenage suicide, and also on what might be done to prevent that tragedy, and what the Federal Government is currently doing on the subject in a variety of ways, and what action the Federal Government might undertake to expand its activities in this important regard. (Teenage Suicide, 1984, p. 1, emphasis mine)

Compared to the 1983 hearing, the 1984 hearing is focused exclusively on suicide and also incorporates concerns about clusters into the narrative. (Note, this is around the same time that the hearing on Media Violence also makes references to suicide clusters). The hearing also features Alan Berman, the president of AAS at the time, speaking "on behalf of the American Psychological Association" as well (Teenage Suicide, 1984, p. III), as well as parents who lost a son, from Fairfax country, and a teen from D.C. area who shares her own experience with suicide attempts.

Finally, in November of 1984, there is a briefing by the subcommittee on Human Services of the Select Committee on Aging; House of Representatives on "Suicide and Suicide Prevention," requested by aforementioned Tom Lantos:

> The purpose of today's hearing of the subcommittee is to bring attention to **the growing problem of suicide in our Nation**. This tragic and unnecessary loss of lives has reached **unprecedented proportions**. Yet, efforts to reduce the suicide rate or to develop effective prevention programs have been largely neglected.

[18] Based on the events discussed in the hearing and the recorded cases in Suicide Clusters (Coleman, 1987), it would seem that the clusters in Plano 'earlier this year' extends from 1983 and includes deaths discussed at the 1983 Teens in Crisis hearing.

> I requested this hearing to review what we know about suicide and to receive recommendations for Federal action. It is ironic that the role of the Federal Government in providing national guidance for research and prevention has diminished, while the problem has increased. (Suicide and Suicide Prevention, 1985, p. 1, emphasis mine)

Lantos's framing is especially interesting, for his definition of suicide as a "growing problem" and assertion that "[this] tragic and unnecessary loss of lives has reached unprecedented proportions" is not fully supported by data at the time. Furthermore, while Lantos notes the "deeply disturbing phenomenon" of "waves of suicides [that] have occurred in certain communities as the result of one adolescent's death" he argues that "[c]oncern with adolescent suicide should not be allowed to obscure the fact that by far the greatest proportion of suicides are among the elderly" (Suicide and Suicide Prevention, 1985, p. 2). As we will see, over the following years, Lantos comes to change his approach. That said, the list of witnesses does include parents of two 'youth suicide victims,' as well as a student, described as a friend of a suicide victim and a volunteer in a crisis center, and as such the hearings at least implicitly center the issue of youth suicide. Of note is also an increased participation of some of the organizationally-central figures at this hearing: Charlotte Ross, Robert Litman (of the LA Suicide Prevention Center) as well as Susan Blumenthal, head of the NIMH Suicide Research Unit.

In 1985, we see new voices enter a conversation, as well as some changes in strategy. First, two new claimants enter the arena in February. Gary Ackerman, a New York State Representative (relationship with DelBello's efforts unclear), introduces a "A Bill to make grants available for teenage suicide prevention programs" (99 H.R. 1099, 1985). Then, Senator Jeremiah Denton of Alabama introduces a resolution to designate the month of June 1985 as the "Youth Suicide Prevention Month." The resolution notes that "over five thousand young Americans took their

lives last year, many more attempted suicide, and countless families were affected," recognizes suicide as a "phenomenon which must be addressed by concerned society" and a "national problem which can only be solved through the combined efforts of individuals, families, communities, organizations, and government to educate society" (A joint resolution to authorize and request the President to designate the month of June 1985 as "Youth Suicide Prevention Month", 1985; AAS, 1996). The resolution passes into public law three months later (Youth Suicide Prevention Month, 1985).

Second, in April, Lantos introduces a revised version of his 1984 bill, now under the name "Youth Suicide Prevention Act of 1985" (99 H.R. 1894, Youth Suicide Prevention Act of 1985, 1985). As seen in **Error! Reference source not found.**., the bill modifies the language specifically to r eframe suicide from a "significant national health problem affecting *all age groups*" to "a significant national health problem affecting *young people.*" Further, sections are added to place emphasis on primary prevention programs as well as to highlight the relationship to drugs and alcohol, both ascribing blame to particular social factors and discursively tying the problem of youth suicide to other problems that were also of concern at the time.

Commission for the Study of Suicide Act of 1984	Youth Suicide Prevention Act of 1985
To establish a commission to conduct a study of the problems of suicide in the United States for the purpose of providing guidance in developing national policy **based on research and effective models of community response.**	To establish a commission to conduct a study of the problems of youth suicide in the United Sates for the purpose of providing guidance in developing national policy, **and to establish a grant program for States, political subdivisions of States, and private nonprofit agencies for programs to prevent suicide among children and youth.**

Table 2-4. Comparing Lantos's 1984 and 1985 bills. The differences between the two bills are marked in bold.

Commission for the Study of Suicide Act of 1984	Youth Suicide Prevention Act of 1985
SEC. 2. (a) The Congress finds that— (1) suicide is a significant national health problem affecting **all age groups,** as demonstrated by the following facts: (A) suicide is currently the **tenth** leading cause of death in the United States, the third leading cause of death among adolescents, and the second leading cause of death among college and university students; (B) the rate of suicide in this country during the last 25 years among individuals 15 to 24 years of age has increased approximately 300 per-cent; and **(C) suicides in the elderly comprise approximately 40 percent of all suicides committed in this country;** (2) research and national statistics on the physical, psychological, and social conditions associated with suicide have not been coordinated or integrated to provide an adequate data base for solving this national health problem; and (3) additional research and demonstration treatment models, emphasizing multidisciplinary approaches, are needed to provide the most successful and cost effective solutions to this problem.	SEC. 2. FINDINGS. The Congress finds that— (1) suicide is a significant national health problem affecting **young people**, as demonstrated by the following facts: (A) suicide is currently the **eighth** leading cause of death in the United States, the third leading cause of death among adolescents, and the second leading cause of death among college and university students; and (B) the rate of suicide in this country during the last twenty-five years among individuals fifteen to twenty-four years of age has increased threefold; (2) research and national statistics on the physical, psychological, and social conditions associated with suicide have not been coordinated or integrated to provide an adequate data base for dealing with this serious national health problem; (3) additional research and demonstration treatment models, emphasizing multidisciplinary approaches, are needed to provide the most successful and cost effective solutions to this problem; (4) primary prevention of youth suicide must begin before self-destructive behavior reaches advanced stages, which often requires medical treatment and re- sources of governments on the Federal, State, and local levels; (5) primary prevention programs that are aimed at providing community education activities to the general public are the most effective means of reaching children and youth before self-destructive behavior reaches advanced stages and thus are the best means of reducing youth suicide; (6) suicide problems exist at times in combination with other self-destructive behavior, such as drugs and alcohol; (7) suicide prevention programs for children and youth should emphasize cooperation involving educational and health programs at the State and local levels with local community resources, including private nonprofit agencies; and (8) existing funds for prevention of suicide among children and youth is inadequate at all government levels.
(b) It is therefore the purpose of this Act to establish a commission to conduct a study **and develop a national plan, both short and long range, which will address the causes of suicide, will** identify the most promising crisis intervention strategies, and will recommend national policy to assist States and communities in implementing effective programs.	101. PURPOSE. It is the purpose of this title to establish a commission (A) to conduct a study **which will address the causes of suicide among children and youth and** identify the most promising crisis intervention strategies, and (B) to develop a short and long-range national plan to assist States and communities in implementing effective **youth suicide** programs

Table 2-4, continued

By April, there is yet another hearing, again in front of the Senate's subcommittee on Juvenile Justice, on the "Federal Role in Addressing the Tragedy of Youth Suicide" (1985). The opening statement is given by Senator Denton of Alabama who introduced the "Youth Suicide Prevention month" bill. Denton makes an especially powerful appeal:

> I would like to commend Senator Specter[19] for his leadership in calling attention to the nationwide tragedy of youth suicide. Today's hearing, as well as the hearings conducted during the 98th Congress, forcibly addresses the phenomenon of children taking their own lives.
>
> American children, adolescents, and young adults are killing themselves in ever-increasing numbers. The rate of suicide has increased more than threefold in the last 20 years and is still continuing to rise. In my own home State of Alabama, the rate of suicide has increased 122 percent during the same time period. This year alone, more than 5,000 young Americans can be expected to take their own lives. (…) One of those tragic deaths involved a young student at the University of Alabama, Nix Handley, who shot himself on June 23, 1984. In a letter to me, dated March 20, 1985, Nix's parents detailed the agony which they suffered as a result of their son's death. (…)
>
> Youth suicide is a phenomenon that is so perplexing, contradictory, frightening and troubling that our Nation avoids addressing it. As individuals and as a nation, we refuse to believe that young people emerging from childhood can feel the degree of sadness, hopelessness and despair that leads to suicide. (Federal Role in Addressing the Tragedy of Youth Suicide, 1985, pp. 1-2)

In his speech, Denton utilizes a few strategies to stress the tragedy of suicide: e.g. referencing 'children,' pointing to a specific instance of parental suffering due to a loss of a child to suicide, and finally critiquing the nation itself for avoiding to address suicide—the troubling nature of suicide and the inaction itself become a problem to be surmounted. Unlike the previous hearings,

[19] Arlen Specter is the chairman of the subcommittee, and has also chaired the 1984 Hearings.

which featured not only crisis-workers but also bereaved parents, or even teenagers themselves, the witnesses at this hearing are mostly individuals representing specific organizations: the Department of Health and Human Services, NIMH (including Susan Blumenthal of the SRU), AAS (Pamela Cantor, president at the time) and NCYSP (Charlotte Ross), accompanying a single suicide attempt survivor. Much of the emphasis of the hearings is on the existing knowledge, as well as efforts and services already well under way. While some general claims are being made with respect to needs for more research or funding, there is also a general sense that the problem is, our should be, under control. Senator Specter reflects on this specifically with respect to the role of science in addressing the problem:

> There has been a **certain amount of frustration by everybody on the panel this morning**, and that is the purpose of a legislative hearing, to have our ideas tested against what you are doing on the research and/or in the executive branch. But Senator McConnell is concerned about the absence of statistics and Senator Simon is looking for some patterns, and I am looking for some hard indicators. And the testimony you have given is as scientifically accurate as you can provide, **but it seems to me that the problem has gone on so long and there has been so much research that we have come to a point where you ought to say what does our research tell us that as we can best generalize,** and how can we use our research to date with the crisis intervention centers, what can we do to advise parents about the danger signals? Perhaps it boils down to saying on a public announcement [:] teenagers, if you feel depressed, or if you feel like you are going to take your own life, for God's sake, tell somebody, and then to the parents or the teachers, if somebody has brought you a danger signal or has told you something, let us get somebody into the picture who can provide psychiatric help. But the pace is less than a snail's pace. (Federal Role in Addressing the Tragedy of Youth Suicide, 1985, p. 50)

Beyond the demands on scientific research, what is also notable here is that Specter's focus is on intervention strategies in the moments of crisis—conversations regarding different structural factors that seemed to dominate the 1983 hearing on "Teenagers in Crisis" seem to have been

moved off the table and the Federal responsibility is primarily negotiated with respect to funding research-supported crisis intervention strategies, not broader prevention initiatives.

September and October 1985 bring even more hearings (Hearings on Youth Suicide Prevention Act of 1985, 1985), which consider the bills introduced by Lantos and Ackerman together, and include statements by various congressmen, as well as DelBello and Ross, stressing the lack of funding for suicide research and programs. The hearings no longer feature members of the public sharing their experiences. The problem and the necessary action are well established, so the conversation has moved towards funds appropriation. By April 1986, the two bills are combined into a singular "Youth Suicide Prevention Act" (99 H.R. 4659, 1986a), jointly introduced by Lantos and Ackerman. The bill is further amended in July (Youth Suicide Prevention Act, 1986b), cutting down the original $10 million authorization down to $1 million (cca $2.4 mil in 2020). The bill is reintroduced in January 1987 (100 H.R. 457, 1987), asking for the amendments to the Education Consolidation and Improvement Act of 1981 that would include $1 million to carry out the Youth Suicide Prevention Act. This reintroduction is followed by yet another hearing, in May (Hearing on H.R. 457, The Youth Suicide Prevention Act, 1987). Finally, in April 1988, the "Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988" (1988) takes up some of the recommendations from the 1987 hearing and includes suicide prevention in various acts, but the inclusion is mostly nominal, listing 'programs for youth suicide prevention' as an example, among many others, of possible innovative projects that can receive some funding, or listing 'has attempted suicide' among a series of factors that would designate an individual as a 'high risk youth' and would make programs targeting such youth more eligible for specific kinds of funding. While this bill was a far cry from the original

demands that built up around youth suicide, it was the endpoint of the 1980s political efforts. The bill, together with the publication of the Secretary's Youth Suicide Task Force Reports in 1989 (ADAMHA, 1989a, 1989b, 1989c, 1989d), marked the end of States direct engagement with youth suicide and apparent (at least temporary) dissolution of the problem.

7.4. Section summary

Hilgartner and Bosk (1988), in the public arenas model of social problems, emphasize the novelty of a problem and its ability to generate strong emotions as factors that increase the attention to the said problem. The problem of youth suicide in the 1980s was well-positioned to succeed on both of those accounts. Not just the increasing suicide rates among the youth, but a whole new phenomenon—that of suicide clusters— emerged as a novel and emotional issue, distinct from concerns regarding suicide in general that had been quite peripheral for decades. Furthermore, the fact that it was young people that were dying and worries about 'outbreaks' clearly had a strong emotional component to them, one that was likely made louder in the public discourse by the class and race of the perceived victims.

The success of the problem of youth suicide was evident in the fairly rapid proliferation of organizational and legislative efforts to address it. As evidenced by the congressional hearing records, the conversation quickly shifted from claims regarding the existence of a problem to detailed discussions of what should be done about it. The first part of the process incorporated the experiences of the public, and the suicide bereaved, and as such it drew on the affective dimension, which seems to have played a role in establishing youth suicide as a problem. The later stages, however, included only politicians and professionals, who seem to be considered the relevant

experts in shaping policy. In these conversations, however, some tensions between political needs and scientific process become evident. The hearings come to focus not on the understanding of the (potentially complex) causes of the problem, but rather on specific actions that can be taken in the short term in order to address the problem, which would fulfill the government's political responsibility for doing something about the issue.

This development of the youth suicide problem, from early professional claims to broader public concern, to formation of organizations, taskforces and legislative changes, follows a very expected progression of events. What might be more interesting is actually the 'fall' of the problem out of immediate attention, though it is also a process much more difficult to track. By the end of the 1980s, the two youth-suicide organizations pretty much end their activities, and legislative efforts stop even though the only product of the years of hearings and bills, the "Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988" (1988) hardly delivers the kind of material support for suicide research and prevention that was originally demanded. Even though the proportion of suicide research that focuses on youth stabilizes at the level it reached by mid 1980s (around 15% see Figure 2-9), the funding for youth suicide research and prevention peaks at around 60% of all suicide funding in 1990s and then quickly drops right after (Figure 2-11). Did claims regarding suicide stop being made, or did they simply lose the public attention? Did the stabilization of youth suicide rates through 1980s have anything to do with it? By the end of the decade, there isn't a clear sense of the *resolution* of the problem, and it doesn't disappear. Rather, the production of a variety of findings, reports and initiatives in themselves, seems to have been a good-enough answer to the claims—something was indeed being done—and might have successfully contained the problem, at least for the time being.

8. Survivors and Grassroots Activism in the 1990s

The 1980s saw the Federal Government acknowledging and responding to the problem of youth suicide. However, concerns regarding suicide in general—which were sidelined in the focus on youth specifically, sometimes very explicitly—have yet to go through the same process. Professional efforts in 60s and 70s, while concerned with suicide, did not seem to have a political stake in establishing suicide as a specific matter of concern—even within the field of suicidology, despite its name, the emphasis was on states of 'crisis.' It is in the 90s that we finally see the crystallization of 'suicide as a problem,' and this occurs though a different process—grassroots activism—and due to claims made by a new group—suicide survivors. In this section, I first review the emergence of this new group, and then I examine their organized efforts and some of the results of these efforts.

8.1. Survivors of suicide

Survivors of suicide, that is individuals who lost a loved one to suicide have been peripheral to the problem of suicide through most of the 20th century, and most of the 'history of suicide' as well. Barring some rare examples, such as concern for the 'suffering of those left behind" expressed in that 1909 New York Times Letter to the editor (Ingram, 1909), or an occasional study of suicide bereavement, such as Lindemann and Greer's (1953) article in Pastoral Psychology, for most of the century, or even for most of the history of suicide as a problem, the conversation revolves primarily around individuals dying by suicide. This starts to change in the 70s, as exemplified by some early books on suicide loss, written by loss survivors, such as Samuel E. Wallace's *After Suicide* (Wallace, 1973), and Harriet Sarnoff Schiff's (1977) *Bereaved Parent.* 'Suicide survivor'

emerges as a new kind of person one can be (Hacking, 2007) and an identity around which individuals can organize and on the basis of which they can make claims.

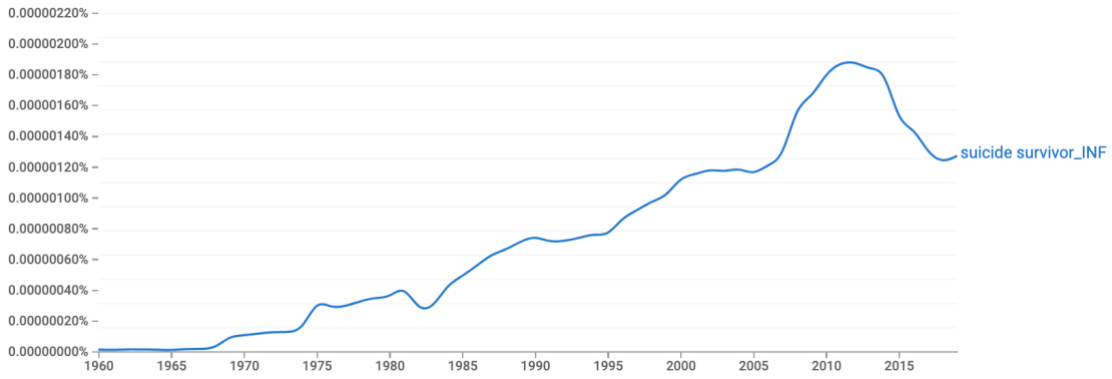


Figure 2-13. Mentions of "suicide survivor" and "suicide survivors" in Google Ngram viewer (Jean-Baptiste, et al., 2011)

In the 1980s, survivors start establishing an organizational presence in AAS. First mentions appear in reference to 'Grief Groups' (AAS, 1981), which are by next year designated as "'Grief Group[s]' for survivors of suicide" (AAS, 1982). In 1983, the Newslink introduces a new column for "Survivors of suicide" (Perlman, 1983), by 1985 there is a Survivor's Committee (AAS, 1985), and by 1987 there are at least 132 Suicide Survivor support groups throughout the US (Dunne, McIntosh, & Dunne-Maxim, 1987, pp. 283-285). In 1989, AAS also starts a new conference, *Healing After Suicide Loss,* as well as a new newsletter, "Surviving Suicide." The first two issues of the newsletter set a particular agenda of recognizing and making use of the size of the survivors' community. Writing on the front page of the inaugural issue, John McIntosh, in an article titled 'How many Survivors of Suicide Are There," (McIntosh, 1989) includes the following graphic:

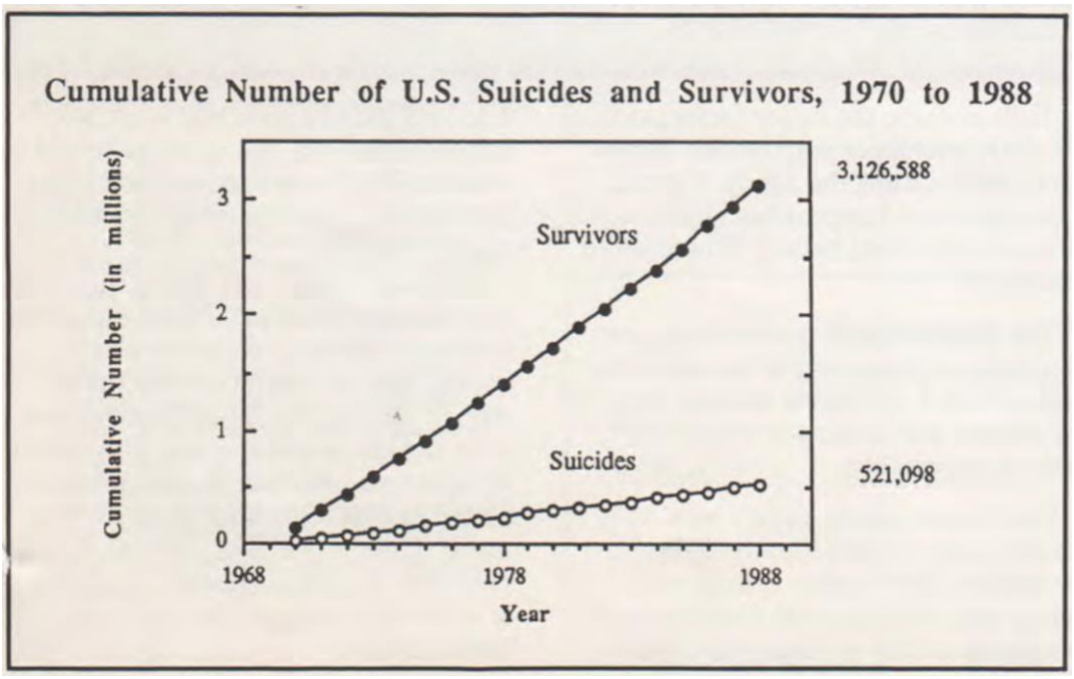


Figure 2-14. Plot from 'How Many Survivors of Suicide Are There' by John McIntosh, on the cover page of the first issue of the 'Surviving Suicide' bulletin published by the American Association of Suicidology (McIntosh, 1989)

Note the emphasis both on 1) the cumulative number on the y axis, in contrast to the yearly numbers usually presented in plots on suicide, and 2) the ratio of survivors to suicides, which is exactly 6 (a figure that survives in discourse for at least 30 years, when it is estimated as much higher, see Cerel, et al., 2019) and which produces an exact figure for the total number of survivors, a move conferring an additional air of authority and importance to the claim (see Gusfield, 1981, pp. 48-49). In the following issue, in 'How many Survivors of Suicide Are There - Part Two' Jay Callahan further highlights the political aspect of the numbers:

> Knowing how many others share their problem may give survivors a sense of power that motivates them to band together for their own emotional healing as well as to work on society-wide programs dealing with suicide prevention. (Callahan, 1989)

As if following this exact call, suicide survivors start organizing in mobilizing throughout the decade. Although the survivor community includes individuals who have lost siblings, parents, friends etc., the group that leads these efforts are parents who have lost children:

- 1989: SAVE (Suicide Awareness Voices of Education) is founded by Adrina Wrobleski, who lost her **daughter** to suicide 10 years earlier, and five other concerned individuals. (SAVE, n.d.)
- 1994: Light for Life foundation/Yellow Ribbon Suicide Prevention Program founded by the Emme family, who lost their **son** Michael that year.(Yellow Ribbon, n.d.)
- 1995: SPAN (Suicide Prevention Advocacy Network) is established, as "the grief's journey-end of a father who lost his 34 year old physician **daughter** to suicide" (SPAN, 1999b)
- 1997: Jason Foundation is established by Clark Flatt after his youngest **son** Jason, "an average 16-year-old," "became a statistic of the 'Silent Epidemic' of youth suicide" (Flatt, n.d.)
- 1997: NOPCAS (National Organization for People of Color Against Suicide) is founded by Donna Holland Barnes and Lois Pimienta Taliaferro, both of whom lost their **sons** to suicide in the 1990s. (Holland Barnes, n.d.)
- 1998: The Kristin Brooks Hope Center (KBHC), best known for creating the 1-800-SUICIDE network of suicide hotlines, founded by H. Reese Butler II after the death of his **wife**, Kristin. (Kristin Brooks Hope Center, n.d.)
- 2000: JED foundation, founded by Donna and Phil Satow after the loss of their youngest **son** Jed. (The Jed Foundation, n.d.)

This high-level of engagement by parents who have lost children to suicide is not surprising. The 'suicide survivor' identity emerges in the 1980s, alongside the problem of 'youth suicide' which mobilizes the survivor parents. In fact, one of the survivors who made an appearance at the Lantos' 1984 hearing, Iris Bolton, who lost her son to suicide and authored a book on healing after a suicide in the family (1983), was a central figure in establishing a Survivors' division in AAS (interview I conducted with John McIntosh). Suicide survivors are, then, better understood not as new claims-making group in the 90s, but rather as an expansion and a solidification of the 1980s public voices, who had shifted strategies.

8.2.Activist efforts and results

Within the contexts of activism specifically, the most notable of the organizations listed above is SPAN (the Suicide Prevention Advocacy Network), as it is the group responsible for leading the efforts to recognize suicide as a national problem.[20] Starting in 1995, inspired by the recent WHO call for Nations to develop their suicide prevention programs, SPAN led the grass-root movement that advocated for suicide awareness and prevention. Their efforts were framed as actions of "those who had to do 'something' to prevent others from becoming survivors; to be permitted to be honest, forthright, and outspoken about this need; and to find an 'easy, convenient and relatively inexpensive" way to do that (AAS, 1996). It connected with over 300 Survivors of Suicide groups across the country (AAS, 1996), and made it easy for individuals to contact their representatives

[20] SPAN is also the one organization on the list that no longer exists as an independent entity. It merged with AFSP in 2009 as its "public policy and advocacy division" (CCHRINT, n.d.)

by providing template letters (see Figure 2-15 for a similar template, produced after the 1997 Resolution was passed).

The organization also served to establish an identity for suicide survivors, as it highlighted advocacy as a way of performing this identity and even as a way of dealing with grief. Again, we see a strong tie here between emotions and the claims-making practices. In a column titled "From Hopelesness to Life" (SPAN, 1997a) the June 1997 issue of the SPAN Newsletter, for example, shares the words of Lucy Davidson, the primary Professional Advisor of SPAN who also served on AFSP's national board of directors at the time (emphasis mine):

> Your being here is a beautiful testimony to the **ugly, frightening, soul-battering places** you have traveled. You have taken your journey to a place that leads **to advocacy and awareness**. Advocacy and awareness are the two pillars of the bridge that can have the structural integrity and strength to carry the span. And we know that span crosses from hopelessness to life. Your **advocacy and your awareness are the strengths that can make a difference**...in reducing suicide when what goes into advocacy and awareness programs is sound, strong and tested.
>
> (…)
>
> It takes a mighty big heart to support research. I hope that a strong part of your advocacy work will be to support the research it takes **to make survivors--lifesavers**.

Advocacy, here is offered as an explicit way for survivors to transform their "ugly, frightening, soul-battering" experiences into the work of *saving* lives.

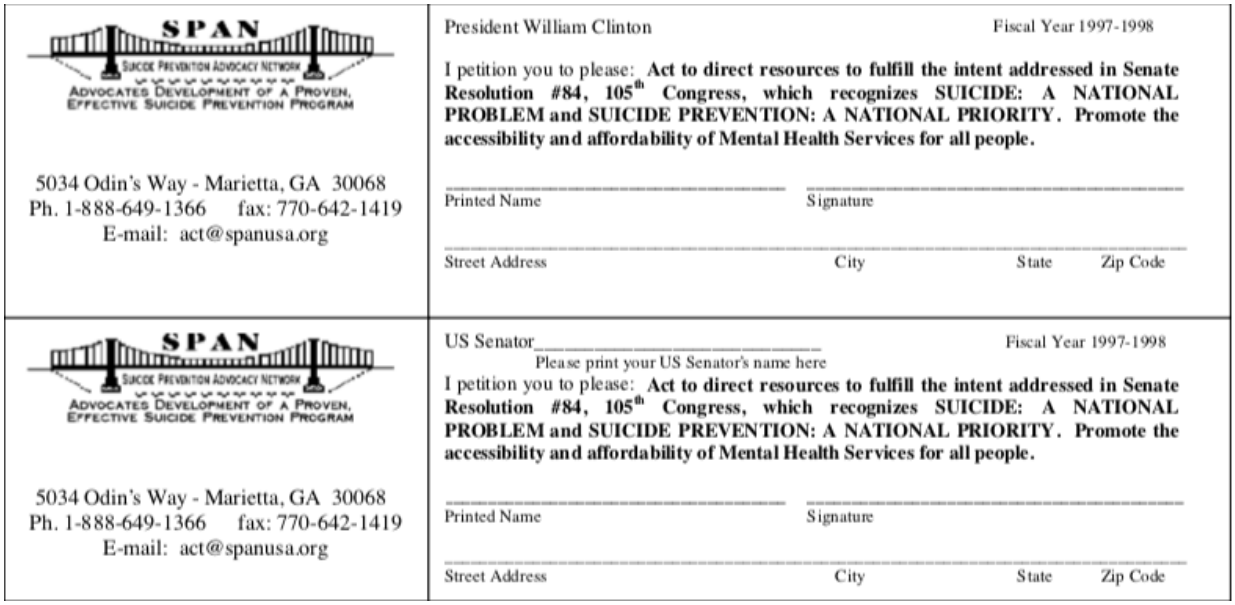


Figure 2-15. An example of SPAN's printable petition template for year 1997-1998 (SPAN, 1999a)

SPAN's tagline was "Advocates the development of a proven, effective suicide prevention program," and the majority of its advocacy efforts were oriented towards the national recognition of suicide as a problem, as a basis on top of which demands for prevention could be made. On May 10, 1996, SPAN Organized the "First Annual National Awareness Day for Suicide: A National Problem" the purposes of which were:

> 1) to increase public/congressional awareness of suicide as a NATIONAL problem;
>
> 2) to advocate for a NATIONAL suicide prevention policy; and
>
> 3) to remember those who died by suicide (AAS, 1996)

The entanglement of advocacy and loss is clearly evident here, and it clearly distinguishes the current efforts from, for example, events of the 1980s. The event was attended by survivors and supporters from 40 states.

By 1997, when the second Annual National Awareness Event was held, SPAN had collected and delivered to Capitol Hill over 32,000 signed letters calling the legislators to action to prevent suicide (SPAN, 1997b). A resolution to recognize suicide as a national problem was introduced in 1997 into the Senate by Harry Read, who had lost his father to suicide and spoke about it openly (SPRC, 2016). It was passed on the same day. Two months later the same resolution was introducing in the House by John R. Lewis (the congressman of Elsie and Jerry Weyrauch', founders of SPAN) (The Sophie Fund, 2020) and it was passed the following year.

Comparing the 1997 Resolution with Lantos' Commission for the Study of Suicide Act of 1984, significant differences are evident, not only in the type of claim being made—the 1984 Act specifically asked for funding, while 1997 Resolution is oriented towards a symbolic recognition only—but also in the framing of suicide as a problem (see Table 2-5).

Commission for the Study of Suicide Act of 1984	Recognizing Suicide as a National problem (1997)
SEC. 2. (a) The Congress finds that— (1) suicide is a significant national health problem affecting all age groups, as demonstrated by the following facts: (A) suicide is currently **the tenth leading cause of death** in the United States, the **third leading cause of death among adolescents**, and the second leading cause of death among college and university students; (B) the rate of suicide in this country during the last 25 years among individuals 15 to 24 years of age has increased approximately 300 per-cent; and (C) suicides in the **elderly comprise approximately 40 percent** of all suicides committed in this country;	Whereas suicide, the **ninth leading cause of all deaths** in the United States and the **third such cause for young persons ages 15 through 24**, claims over 31,000 lives annually, more than homicide; Whereas the suicide completion rate per 100,000 persons has remained relatively stable over the past 40 years for the general population, **and that rate has nearly tripled for young persons;** Whereas that suicide completion rate **is highest for adults over 65;**

Table 2-5. Comparison of the Commission for the Study of Suicide Act of 1984 (1984) and the Resolution Recognizing Suicide as a National problem (1997) (the latter is re-arranged to facilitate comparison; I place comparable sections next to one another and emphasize key points in bold)

Commission for the Study of Suicide Act of 1984	Recognizing Suicide as a National problem (1997)
(2) research and national statistics on the **physical, psychological, and social conditions** associated with suicide have not been coordinated or integrated to provide an adequate data base for solving this national health problem; and (3) additional **research and demonstration treatment models,** emphasizing multidisciplinary approaches, are needed to provide the most successful and cost-effective solutions to this problem.	Whereas suicide **attempts**, estimated to exceed 750,000 annually, **adversely impact the lives of millions of family** members; Whereas suicide completions annually **cause over 200,000 family members to grieve over and mourn** a tragic suicide death for the first time, thus creating a population of over 4,000,000 such mourners in the United States; Whereas the **stigma associated with mental illness** works against suicide prevention by keeping persons at risk of completing suicide from seeking lifesaving help; Whereas the stigma associated with suicide deaths **seriously inhibits surviving family members from regaining meaningful lives;** Whereas suicide deaths impose a **huge unrecognized and unmeasured economic burden** on the United States in terms of potential years of life lost, medical costs incurred, and work time lost by mourners; Whereas suicide is a complex, **multifaceted biological, sociological, psychological, and societal problem;** Whereas even though many suicides are currently preventable, there is still a need for the development of **more effective suicide prevention programs**; Whereas suicide prevention opportunities continue to increase due to **advances in clinical research, in mental disorder treatments, and in basic neuroscience**, and due to the development **of community-based initiatives** that await evaluation; and Whereas suicide prevention efforts should be encouraged to the maximum extent possible

Table 2-5, continued

Specifically, the new resolution discusses suicide not only as a problem of unnecessary death, but as a problem for others: the families of suicide attempters and suicide victims, as well as the nation as a whole, which is suffering a 'huge unrecognized and unmeasured economic burden" due to suicide. This framing is very reminiscent of the 1955 Mental Health Act:

> Whereas the direct economic cost of mental illness to the taxpayers of the Nation, including pensions to veterans with psychiatric disabilities, is over $1,000,000,000 a year and has been increasing at a rate of $100,000,000 a year; and
>
> Whereas the emotional impact and distress suffered by millions of our people anxiously and justifiably concerned about the welfare, treatment, and prospects

> of mentally afflicted relatives is incalculable and is one of the most urgent concerns of our people (Mental Health Study Act of 1955, 1955):

Furthermore, there are some differences in the framing of the problem with respect to the causes of suicide. Both documents emphasize the complexity of suicide, but the language use is different and this is especially evident with respect to social factors. While the 1984 bill references "social conditions associated with suicide"—alluding to a causal relationship between social conditions and suicide, the 1997 resolution offers a vaguer notion of a "sociological" and a "societal" problem—is suicide here understood as a problem caused *by* society or a problem *for* society? Notably, in the rest of the text, 'metal illness' is emphasized multiple times, as a sort of a 'causeless' entity in itself.

Even though the resolution did not specify further action, nor request funding the way the 1984 Commission for the Study of Suicide Act did, it did seem to prompt further action. SPAN continued to exercise political pressure—the letter template in Figure 2-15 makes explicit calls for the government to "direct resources to fulfill the intent addressed in the Senate Resolution #84," specifically to "[p]romote the accessibility and affordability of mental health services or all people"(SPAN, 1999a). Furthermore, as a result of SPAN's effort, the resolution is followed by a National Suicide Prevention Conference in Reno in 1998, which brought together the public and the private sector to discuss evidence-based suicide prevention strategies, and which is often referred to as the beginning of contemporary suicide prevention in the US (ethnographic notes). The conference informed the 1999 Surgeon General's "Call to Action to Prevent Suicide," and later produced the first National Strategy for Suicide Prevention (Center for Mental Health Services; Office of the Surgeon General, 2001), which was updated in 2012 (Office of the Surgeon General (US); National Action Alliance for Suicide Prevention (US), 2012). While it is unclear

the extent to which these events shaped the following two decades of suicide related work, it is certain that they did play an important role in solidifying the position of suicide in the public arena.

8.3.Section summary

The developments of the 1990s appear both as outgrowths of and reactions to the events in the 1980s. On one hand, as concerns regarding youth suicide were being managed through organizations and legislative proceedings, those most affected by youth suicide were coming together around a new shared identity of 'suicide survivors,' and it is these groups that led the grassroots efforts that put suicide on the legislative agenda. On the other hand, these efforts in the 90s can also be read as responses to some perceived insufficiencies or failures of the 80s. The various non-profits and their fundraising and services worked to address the problem of suicide without the mediation of federal programs and funding, while the calls to recognize suicide as a national problem took up the same efforts that got sidelined in the 80s by the emphasis on youth suicide.

'Suicide survivors' played a dual role in establishing the 'suicide problem' of the 1990s. More concretely, they provided a core of a grassroots movement, gathering a large number of voices that exerted political pressure in a way no prior organization did. These efforts harnessed the strong emotions that surround suicide and successfully brought attention to the problem. More conceptually, the identity of a 'suicide survivor' constructed a new and easily mobilizable category of those negatively affected by the problem of suicide (beyond the deceased themselves), which exponentially increased the size of the problem—from 31,000 lives lost annually, to 200,000 new bereaved and 750,000 of those affected by suicide attempts. Furthermore, the emphasis on the

unique experience of suicide loss also extracted suicide from other related concerns that it frequently got entangled with in professional discourse—crisis, stress, drugs and alcohol, mental illness, etc.—and successfully isolated it as a problem in and off itself, to be recognized by the State.

9. Discussion

In this chapter, my goal was to understand claims-making regarding suicide as a problem across the 20th century, as a way of conceptualizing and coming to terms with 'suicide' in the modern context. I have traced suicide from a relatively dispersed set of concerns at the beginning of the century, through thre development of institutions that will come to organize much of the discourse on suicide in the period of 1940s to 1970s, to pointed claims about and responses to the problem of youth suicide in the 1980s and finally to a grass-roots movement and the recognition of suicide as a national problem by the U.S. government in the 1990s. Across this period, understandings of what kind of a problem suicide is—for whom it is a problem and why— shifted. Around the turn of the 20th century, the significant concerns emerged about regarding the health of the Nation and broader issues in society that were indexed by high suicide rates. In the 60s and 70s, professionals are calling attention to suicide often as a part of a broader class of phenomena that, regardless of their causes, can and should be prevented. In the 1980s, concerns are about youth dying, and the 1990s emphasize the burden of suicide on those left behind. Instead of a single 'suicide problem,' it might be more appropriate then, to discuss different 'suicide problems' that emerged across the 20th century.

However, despite the different framing and a variety of stakeholders, there are also important commonalities and trends. First, throughout this period, we see the 'suicide problem' emerging not with the respect to the idea of suicide in general, but rather with respect to a perceived 'excess' of suicide. Numbers of different kinds play a significant role throughout—overall rates of suicide deaths, rates for particular demographic groups (especially youth), exact number of deaths in a small community in a short period of time, rankings of causes of death, modeled numbers of years lost, and approximated total numbers of those who lost someone to suicide. It is always made clear through the rhetoric that the number quoted is *too high* though it is never made explicit what an 'unproblematic' number would be—it might be 0, but it might not, and this is not relevant to the claims regarding the problem. Instead, like it has been the case earlier in history, numbers provide an easy frame through which the novelty or the severity of the problem are communicated and that work to garner attention for the problem in the public arena.

Second, the calls for something to be done about this 'excess' suicide are also entangled with the idea about the causes of the problem. In the previous chapter, I have already discussed the politics in cases of causally-complex phenomena, such as ipsal deaths, and we see these in action across the 20th century developments. Specifically, both on the long-term scale (across the period) and more short terms scale (e.g. 1980s hearings), we see a shift in focus as the conversation moves away from the question of 'why' and towards the question of 'what can we do about it?'. That is to say, general social factors are understood as contributing causes, but rarely emerge as sites of intervention. The only exception here has to do with media reporting, which is seen as controllable through guidelines and legislation. As a result, when asked to help answer the calls to 'do something about suicide,' scientific research is mobilized first to understand the problem, and then

to evaluate feasible and cost-effective interventions, two goals that are not necessarily congruent with one another.

Third, in terms of the shape of the claims, it is interesting that among both professional groups and the more general public, suicide-related claims are overwhelmingly directed at the State, and focused on getting the State to establishing its political responsibility for the problem through recognition and funding. Overall, there is a quite an absence of attempts to pursue the goal of fixing causal responsibility on some agent (other than, maybe, the media). Even though I initially posited 'public problem' as a way of holding 'society' accountable, and even though we see the concerns over social conditions discourse incorporated into claims regarding suicide, the 'social problem' still does not function as a vehicle of social blame. The distinction between 'society' and the State, the limits of State power, as well as the ability of the State to take political but not causal responsibility mean that the framework of 'social problems' cannot, in itself, demand social change.

Finally, in terms of the 'success' of suicide as a public problem, it is notable that the suicide problem gains traction in the 1980s and 1990s, with the involvement of community members and suicide survivors. The discourse over the two decades transforms from more general concerns about suicide rates, to narratives imbued with strong emotions, be it the parents and schools worried about losing youth to suicide, or survivors processing their grief and wishing to prevent others from feeling the same way. These narratives are highlighted in the congressional hearings, as well as the grassroots efforts of the 1990s and it seems that it is exactly this emotional weight of the issue that plays one of the essential roles in recognizing suicide as a national problem.

Some of these developments above were also tied to particular professional and disciplinary trends. Interestingly, even though throughout the discussions of the problem, there is a focus of 'suicide rates' and the problem of suicide at the level of society, social sciences such as sociology seem to play little role in conversations overall and there is no evidence of significant professional efforts within these fields to make claims regarding suicide and to establish professional authority over the problem. Furthermore, within political discussions over suicide, factors at the level of society seem to be repeatedly sidelined in favor of more individual-level intervention. At the same time the second half of the century sees a development of 'suicidology' that, even if not developing into an actual discipline, does provide an organizational structure for a multidisciplinary engagement with suicide. In the next chapter, I focus specifically on knowledge production patterns over this period and to today, to examine in more detail any trends in that particular realm.

Chapter 3: The (Multi/Inter)disciplinarity of the Production of Knowledge on Suicide

1. INTRODUCTION

In 2019, the 52nd AAS Conference was assigned the theme of "Converging Fields, Expanding Perspectives." The call for papers explains the vision for the conference as follows (emphasis mine):

> With US mortality data showing consistent increases in the general suicide rate, we have the chance to respond boldly by acknowledging what we do well and what we need to do better. **This requires us to continue to break down the silos within our own field** and work shoulder-to-shoulder with one another (continuing the themes of past conferences). We echo the theme of the 50th Annual Conference that called for us to think differently about the challenge of reducing suicides in the US. This calls for an openness to new ideas and new approaches, **and an engagement with unfamiliar scientific and non-scientific fields** that can examine or highlight suicide in ways we never would have imagined**. Such collaboration across scientific domains**, or divergent nonprofit groups, will not only expand our perspective about suicide, but could lead to insights and discoveries that will benefit our work for years to come. (APA Division of School Psychology, 2018)

In the call, the envisioned convergence expands beyond scientific research, but a significant part of the concern is with barriers within the research community. In my interview with the conference chair Chris Drapeau (a Clinical Psychologist), I asked him about the lack of collaboration across different sectors and realms involved in suicide research and prevention, and as he responds he emphasizes the constraints faced by researchers (emphasis mine):

> I think those who are typically doing research ... **you have so many, so many hats you have to wear that it's difficult to make time to collaborate.** You're focused on getting your research done and getting it out. And as a result, it can be easy to forget about everyone else around you and the unique partnerships that may exist right in your own department. A lack of collaboration **has been a concern in AAS, people have been talking about wanting to break down the silos and, you know, not wanting the divisions to become literal divisions** throughout the organization. Collaboration has been, if you look at the AAS conferences, going back to when they started doing conference themes, collaboration is in there so many times.

Collaboration across disciplines definitely has been an important idea within suicidology from its beginning in the late 1950s and early 60s. Shneidman and Farberrow (both clinical psychologists), emphasized the nature of suicide as an important "psychiatric, psychologic, sociologic, cultural, and medical phenomenon" (Shneidman & Farberow, 1957, p. viii), and their Suicie Prevention Center seemed to advance a multi-disciplinary agenda, inviting research fellows who were interested, among others, in phenomenological, cognitive and sociological approaches (Shneidman & Farberow, 1965). The Handbook for the Study of Suicide (Perlin, 1975), compiled for the use in the John Hopkins University's postgraduate Fellowship Program in Suicidology, contained one chapter each on History, Literature, Morality, Anthropology, Sociology, Biology, Medical Sociology, Psychiatry, Community Psychiatry and Epidemiology; and in the early 1980s, through its "Sociology liaison sub-committee," AAS actively worked to forge close ties with sociologists, encouraging them to join the organization and organizing suicide-themed sessions at sociological conferences (Linden, 1980). These efforts are, indeed, also evident in different conference themes, both in the US and abroad:

- AAS 1993: "Controversial Issues in Suicidology: Creating Bridges and Understanding,"

- AAS 2006: “Science and Practice in Suicidology: Promoting Collaboration, Integration, and Understanding"
- AAS 2012: “Collaborations in Suicidology: Bridging the Disciplines”
- IASP (International Association for Suicide Prevention) 2003: “Crossing Borders in Suicide Prevention — From the Genes to the Human Soul”
- IASP 2009: “Breaking Down Walls, Building Bridges”
- IASR/AFSP (International Academy for Suicide Research/American Foundation for Suicide Prevention) 2017: “New Horizons for Suicide Research: From Genes to Communities”

These calls for collaboration, however, are not aimed at everyone, and are tightly entwined with the understanding of what kind of a phenomenon suicide is and who should be addressing it. In 1993 — the same year as the “Creating Bridges and Understanding” AAS conference, in an article in *Suicide and Life-Threatening Behavior* Edwin Shneidman writes explicitly against attempts at the time to locate the suicide in the physical body and emphasizes suicidology as a “mentalistic discipline” which needs “a new pioneering breed of mentalistically oriented psychologists and of psychopsychiatrists (as opposed to the somatopsychiatrists who have, as agents of larger forces, captured the marketplace and the academy, and the forum)” (Shneidman, 1993). Historically, AAS stays committed to distancing itself from these large forces—specifically the pharmaceutical industry (as per my interview with Alan Berman, past AAS president and its executive director from 1995-2004). And despite the strong ties between suicide and the medical profession that I have discussed in the previous chapter, AAS’s conferences also do not seem to attract many psychiatrists or physicians, especially compared to, for example, the IASR/AFSP conference,

which has a ‘medical-grade’ regular registration fee of about $800 and features frequent industry funding disclosures at the beginning of individual presentations.

This snapshot of professional and epistemological concerns in AAS, itself only a part of knowledge production about suicide, demonstrates the importance of mapping out the broader disciplinary landscape of suicide research for our understanding of how ipsal deaths are contained in the modern times. ‘Suicide’ has existed as an object of inquiry for a long time, and has been addressed from a variety of perspectives. As an object of scientific inquiry, it predates many of the disciplinary divisions that exist today—as opposed to being produced by a particular existent discipline—and it has never been in its entirety ‘claimed’ by any one field. In fact, there is a general agreement in the scientific community that suicide is a complex phenomenon and that, in order to understand it and address it, it is necessary to bring together a wide variety of experts. However, as I have discussed in Chapter 1, the complexity of suicide as a problem presents an issue in the context of relative resource scarcity, when it becomes necessary to determine the ‘primary cause’ for the sake of most appropriate intervention. Furthermore, in Chapter 2, I have noted various events and processes through which different disciplines did work to establish ownership over the ‘suicide problem,’ and have highlighted a powerful presence of psychiatrists and psychologists in conversations on suicide. Even if perspectives of different disciplines can easily fit together, the practical needs of suicide prevention can easily work to drive approaches apart. At the same time, as described above, at least some groups in the field have been invested not just in the ‘multidisciplinarity’ of suicide research, that is the study of suicide within multiple disciplines, but ‘interdisciplinarity’ of the field, that is the integration between different perspectives.

This context raises important empirical question regarding suicide knowledge production: What disciplines participate the most in the process? Does the composition or diversity of knowledge producing disciplines change over time? And how well are different perspectives integrated, that is, how 'interdisciplinary' is the field? Answers to these questions inform our understanding of how 'suicide' might be shaped by and contained within the structures of scientific knowledge, while also providing some insight into more general trends in modern knowledge production.

In answering the large-scale questions noted above, I use a computational approach to build and analyze a comprehensive set of publications on suicide. While I could have, instead, conducted a close reading of specific publications, e.g. handbooks, top cited articles etc., this approach would not be able to characterize larger trends and cumulative flows of knowledge in a way that analysis of publications can. In this I do lose context and detail, but it is an important step that will also lay the foundation for any future analyses.

I organize my chapter as follows. First, I review relevant previous work, including the studies of publications on suicide and computational studies of interdisciplinarity. Then, in the methods section, I give an overarching description of my approach and introduce some of the analytical frameworks that I will be using. I present my analysis and results in two sections. The first analytical section focuses on the question of disciplinary diversity, which I answer by analyzing both suicide publications and their references. In this I determine that diversity is increasing over time, which likely aligns with broader trends in scientific publishing, I identify the main disciplinary producers of knowledge on suicide and find some clear changes over time. The second analytical section engages with the question of disciplinary integration through a series of

approaches, revealing significant integration across certain fields (e.g. Medicine/Psychiatry and Clinical Psychology), and less integration between others (e.g. Neuroscience or Biochemistry and genetics). Finally, in the discussion, I tie some of my findings to the trends that I have identified in my previous chapters.

2. Previous Work

Having laid out the theoretical foundations of my interest in disciplines overall in the *Literature Review*, below I provide a more detailed discussion of relevant concepts of 'discipline' and 'interdisciplinarity.' Then, I make note of specific studies that I am in conversation with: I review existing research on suicide-related publications, noting their main findings and highlighting the main differences between this prior work and my own, and then I examine a few notable sociometric approaches to studies of multi/interdisciplinarity, conducted on other fields. I make note of the aspects of this work that do fit my analytical goals and which drive some of my analytical approach.

2.1. Disciplines and Interdisciplinarity

Despite the understood importance of 'disciplines,' scholars have highlighted the overall vagueness of the term, and difficulties defining 'disciplines' as meaningful analytical units. For example, it might be important to distinguish disciplines as 'domains of teaching' and specialties as 'domain of research,' the later making up an institutionally less-visible but epistemologically more coherent units (Chubin, 1976). Woolgar (1976) similarly emphasizes a focus on a 'research network' as a kind of a 'scientific collectivity' that is of central interest to sociologists of science. While in my work, I focus on established disciplinary units, following some practices in research

on interdisciplinarity (see following section), I do keep these critiques in mind, and I further explore them below specifically with respect to science on suicide.

The instability of 'disciplines' is especially evident when one considers the idea of 'interdisciplinarity.' Scholars of interdisciplinarity highlight that boundary-crossing between disciplines is more of a rule than an exception. While there are stakes in maintaining disciplinary identities, disciplines do not exist in isolation and they frequently share ideas, tools and methodologies. High degree of permeability between disciplines is especially common in particular contexts, for example in fields emphasizing application, and those facing problems that are considered to be 'highly complex' (1996, pp. 38-40). Furthermore, Klein (1996, p. 53) cautions us about examining the fields of knowledge through the lens of disciplines alone—two subspecialties of a single disciplines, such as molecular biology and field biology, might be much more distinct that neighboring subspecialties of different disciplines, such as molecular biology and biochemistry.

In thinking about interdisciplinarity, it is important to note that terms such as 'interdisciplinarity', 'multidisciplinary' and 'transdisciplinary' do not have clearly established meanings and are frequently used interchangeably in many contexts. Scholars of various kinds of 'disciplinary boundary crossing' might therefore speak of '*interdisciplinarities'* in the plural (Klein, 1996) or of "interdisciplinary assemblages" that are "mobilising in any instance an array of programmatic statements, policy interventions, institutional forms, theoretical statements, instruments, materials, and research practices" (Barry & Born, 2013). At the same time, the literature does offer some useful schemas with which it is possible to more clearly specify what one is examining when they

are examining ‘interdisciplinarity’ and related constructs. Barry and Born (2013, pp. 8-13) offer a concise discussion of terminology and a useful set of distinctions. First, they identify three terms commonly used when referring to ‘cross-disciplinary practice’: multidisciplinary, interdisciplinarity, and transdisciplinarity. *Multidisciplinarity* generally describes a state in which “several disciplines cooperate, but continue to work with standard disciplinary framings” (Barry & Born, 2013, p. 8). In contrast, in *interdisciplinarity*, there is an “attempt to integrate or synthesize perspectives from several disciplines” (Barry & Born, 2013, p. 8). *Transdisciplinarity* has a more specific intellectual tradition, it is not as common in the Anglo-American world and is often used with more radical implications compared to interdisciplinarity, as it can be taken “to involve a transgression against or transcendence of disciplinary norms” (Barry & Born, 2013, p. 9). In my work, I utilize mainly the distinction between ‘multidisciplinary’ and ‘interdisciplinarity’ to emphasize the presence or lack of integration between different disciplines.

Additionally, Barry and Born distinguish between different *modes* of interdisciplinarity, highlighting that fields can interact and integrate in distinct ways that can occupy very different places in production of knowledge. First mode is *integrative-synthesis*, a relatively symmetrical integration of two or more existing disciplines. This mode is one that is frequently imagined in discourse of interdisciplinarity, and one that has the potential to develop into a new field. The second mode is that of *subordination-service,* in which a hierarchy of disciplines is evident, and the subordinate disciplines—oftentimes the social sciences—have to adopt the dominant disciplinary view of the issue and provide their insights accordingly. In contrast, to the second, there is the third, *agonistic-antagonistic* mode, in which the cross-disciplinary engagement is not collaborative, but is critical (Barry & Born, 2013, pp. 10-13).

I make note of this rich texture of 'interdisciplinarity' as a disclaimer regarding my work ahead. Quantitative work on interdisciplinarity, especially when it comes to publication analysis, often has no choice but to 'collapse' highly heterogenous 'disciplines' into singular categories, and is quite blind to the mode of boundary crossing—it is impossible to tell from a citation whether a publication is incorporating concepts, methods, or data from another publication in any meaningful way, if it is briefly mentioning it, or if it is, in fact, explicitly critiquing it. With that in mind, I move on to examine some of the previous work that is relevant to my current project.

2.2. Existing work on suicide research

Within suicidology, a few smaller studies of publications have been conducted. Cardinal (2008) examined articles published in *Suicide and Life-Threatening Behavior* during three 5-year periods over thirty years. He considered various characteristics of the articles, such as their geographic origin, co-authorships, citations, as well as age and gender of research participants. He highlights a few trends—(1) the increase in the proportion of articles from non-US countries (from 9% to 27.6%), (2) A great focus on adolescents that is not proportionate to distribution of suicide in population, and (3) a steady increase in the average number of references, mirroring developments in other fields. Additionally, Cardinal also lists out the top ten most cited articles (see also Stack, 2012), and the top 15 journals cited (*SLTB* in the first place at 8.4% of citations, followed by the *Journal of the American Academy of Child and Adolescent Psychiatry* with 4.2%)

In contrast, Goldblatt et al.'s (2012) bibliometric study of suicidology compares all three major suicidology journals (*Suicide and Life-threatening Behavior*, *Archives of Suicide Research* and

Crisis) from 2006-2010, classifying their articles based on the abstract into one of 16 different categories: 'epidemiology,' 'prevention,' 'editorial,' 'ethics,' 'research,' 'risk factors,' 'survivors,' 'clinical,' 'forensic,' 'phenomenology,' 'culture,' 'media,' 'theory,' 'internet,' 'genetics/biology' and `other.` They find the journals to be fairly similar in composition—the majority of the articles was categorized as epidemiological (32.7-40.1%), followed by prevention (5.8-15.3%) and research (8.3%-10.6%). This study, though flawed in its haphazard choice of categories, illustrates a way one could determine relative importance of particular agendas within suicidology.

A significant downside of above work, however, is the focus on suicidology journals— or *a* suicidology journal— only. Within my publications dataset, publications in suicidology journals comprise only about 7% of all publications overall, and at most around 12% of all publications in any one given year. Further, most significant—that is most cited—publications on suicide have not been published in suicidology journals (See Appendix B: Additional Tables and Figures, Table B-6). Additionally, even though Goldblatt et al.'s article categories do partially overlap with disciplinary domains (e.g. 'culture,' 'clinical,' or 'genetics/biology'), and Cardinal's (2008) work makes note of the common sources or references, neither study engages with the questions of disciplinary participation in knowledge production.

2.3. Scientometric studies of interdisciplinarity

Scientometric methods offer very valuable tools for analyzing researcher networks and flow of knowledge through analysis of publications. Especially over the past decade, large online databases of publications and powerful computational tools have made possible new visualizations and understandings of science, mapping out different disciplines, tracing research dynamics and

trends over time, etc. Most large-scale work seeks out to map out all of science, often using citation patters to build networks (e.g. undirected co-citation networks, or directed citation networks) and looking for clusters in those networks (see Leydesdorff & Rafols, 2009 for a review of these efforts and their challenges), but scholars are frequently more interested in specific fields. As my own questions fit within this narrower realm, I focus on examples of the latter work.

For example, Morillo et al. (2001) focus on subfields of chemistry and use both Institute for Scientific Information journal designation and Chemical Abstract Service designations to classify specific journals of interest and then examine which journals are assigned to more than one category, to what extent articles from particular journals reference one another, and other questins. The authors propose a set of analytics to explore the diversity of codes that particular journals have been assigned to in order to capture the degree of interdisciplinarity within different areas of chemistry. More specifically, they contrast journals which are assigned only one code with '*multi-assigned*' journals, which can be '*internally multi-assigned'* (assigned to two or more codes within the same disciplines), '*externally multi-assigned'* (assigned to two or more codes in different disciplines), or both. I draw on their approach, specifically on their multi-assignment analytic, but I cannot fully replicate it as I miss the equivalent of the arguably richer of their two data sources—the Chemical Abstracts.

Sinatra et al. (2015) in their 'Century of Physics,' tackle interdisciplinarity in a different way. Starting with a defined set of 242 physics journal, they define the 'Core Physics literature', and then use the references and citations of the papers in that core to build an additional set of 'interdisciplinary physics' papers. Papers are designated as 'interdisciplinary physics' if they cite,

and are cited by physics core papers significantly more frequently than by chance. The authors then examine the patterns in publication over the two groups over time, as well as citation-relationships across the two groups. While this is an attractive approach, it does not fit my question well. Although I could use the suicidology journals to identify 'core suicidology', this approach would not be empirically grounded—there is no evidence of a 'core suicidology' or 'suicidology' as a discipline. Furthermore, my interest is not in the field of 'suicidology' as much as the set of work on the topic of suicide. However, the authors' method of identifying 'interdisciplinary physics' paper by effectively controlling for the overall proportion of all publications that are in physics, inspired me to similarly control for different levels of disciplinary productivity in some of my analyses.

An approach that does take a topic—as opposed to a field— as a starting point of the analysis is developed in a study by Rafols and Meyer (2010). Building on their qualitative research on bio-nanoscience, Rafols and Meyer (2010) focus on 12 articles in their analysis. They build a 'network of knowledge' based on each article's references-of-references and for each of those networks they produce metrics of coherence and diversity in order to characterize the interdisciplinarity of each article. Conceptually, they contrast four distinct network arrangements as follows (note that 'low' and 'high' in this context are relative measures):

		Network Coherence	
		Low	High
Network Diversity	Low	Potential integration within a discipline	Specialized disciplinary
	High	Potential interdisciplinary integration	Specialized Interdisciplinarity

Table 3-1."Disciplinary diversity vs. network coherence," based on Rafols & Meyer, 2010, p. 270

The general approach above fits with my questions regarding multi-disciplinarily and inter-disciplinarily in work on suicide, but the scale does not fit, as the main unit of analysis is a single article. However, I ultimately mobilize this general framework by imagining *a single article* (standing in for 'the field of knowledge on suicide') that references all possible publications on suicide. I am also able to build networks for different decades—again, imagining a single article that references all suicide publications that were published in a particular decade—which allows me to compare the networks of coherence and diversity over time.

3. METHODS

Building on the literature above, I present an overview of my approach here, while I offer a more detailed discussion of my data collection methods and analysis in Appendix A: Methods. As necessary, I explain aspects of specific analyses throughout the chapter.

3.1. Data

I collected my data using the Scopus API, in two steps. First, I looked for publications that had the root "suicide*" in the title (e.g. "suicide" or "suicidal"), filtering out non-suicide related items (e.g. "cell-suicide" or "non-suicidal self-injury") and then cleaning the data once collected. While not all publications[21] that focus on the topic of suicide necessarily feature "suicide" in the title, this is the case for the vast majority of publications due to publishing conventions. Second, based on the

[21] I use 'publications' as a generic term to refer to different items indexed by Scopus, including articles, editorials, book reviews etc. Majority of these (75.23%) are articles. See Appendix A for more detail.

dataset of publications, I have built my references dataset, that is the set of all publications that are cited by the suicide publications. As I will discuss, this dataset is less complete (some publications are missing reference records, many references are not in the Scopus database and have little information associated with them), but I approach it keeping these potential biases in mind.

While I have collected the publication data ranging from 1850-2020, due to a relatively small number of publications prior to 1960 (see Appendix A), I limit my analysis of trends over time to the 1960-2020 period. Additionally, Scopus contains reference information only for publications published in or after 1970, so any analysis of references is contained to the 1970-2020 period due to data constraints. My final dataset contains N= 55,461 publications (across 7275 unique sources) and their N= 1,499,070 references.

3.2. ASJC codes

In order to categorize publications by discipline, I utilize All Science Journal Classification (ASJC) codes, provided by Scopus/Elsevier (Elsevier, 2020). The ASJC codes are not assigned to individual items, but to their sources, that is whole journals or conferences. According to the Elsevier website, "Classification is done by in-house experts at the moment the serial title is set up for Scopus coverage; the classification is based on the aims and scope of the title, and on the content it publishes." (Elsevier, 2020) There are 314 different codes, grouped in 27 'groups' (e.g. "Medicine", "Arts and Humanities", "Psychology", "Social Science") and 4 'super groups' ("Health Sciences, Life Sciences, Social Sciences, and Physical Sciences). All ASJC codes have four digits, with the first two digits (ranging from 10-36) designating a specific group. The first code in any group, _ _00, codes for a General category, with subsequent codes assigned to more

specific disciplines. For example, '2700' is "Medicine (all)," while '2738' is "Psychiatry and Mental Health." Each source can be assigned to more than one code, that is they can be multi-assigned: *Suicide and Life-Threatening Behavior*, the main suicidology journal, has been classified as "2738; 2739; 3203," that is "Psychiatry and Mental Health; Public Health, Environmental and Occupational Health; Clinical Psychology."

My analysis utilizes three levels of granularity. Most fine-grained one utilizes the ASJC codes themselves, and I discuss these as 'ASJC codes' in my analysis. This analysis omits some of my data as ASJC codes are available for journals and conferences only—other sources, like books and books series, are instead classified by the 27 groups designations. The exact classifications according to the 27 'groups' are the basis for the second level of my analysis. For example, Suicide and Life-Threatening Behavior is classified as "Medicine; Psychology," as 2738 and 2739 are codes in the group 'Medicine' and 3203 is in the group "Psychology." I discuss these specific combinations of groups as 'classifications.' Finally, in my most coarse analysis examines all publications in sources that have been designated to some group, no matter whether the journals are multi-assigned or not, and I talk about these as 'fields.'

There are both theoretical and practical issues with using the ASJC codes. It is unclear how well the designations 'pick out' disciplines (see also Woolgar, 1976), or capture what might be a wide variety of articles in a journal. In fact, the existence of the code "1000: Multidisciplinary" is evidence enough of inherent difficulties classifying whole journals. At the same time, distinctions between fields exist at different levels—psychology is contrasted with social sciences at a group level, while sociology and political science share an ASJC code and are not distinguished from

one another at all. Even with these concerns aside, there are many inconsistencies in the designations: for example, not all suicidology journals are coded the same, and various journals (e.g. “Acta Psychologica” or “Archives of General Psychiatry”) are coded “1201: Arts and Humanities (miscellaneous).” This likely affects my analysis, but unsure of the exact issues in the whole corpus, I left them as is so as not to introduce further bias. I keep these in mind while engaging with my data, while focusing on broad trends that should be resistant to various idiosyncrasies.

3.3. Quality of the references dataset

Furthermore, I have encountered significant challenges in building and classifying the references dataset. My data contains N=1,499,070 publication-reference pairs, and N= 508,278 unique references IDs. Note that this figure does not most accurately capture the data as singular texts can appear under different ‘reference’ codes in the Scopus data. Durkheim’s Suicide, for example appears under at least 160 different IDs. Further, in the database itself, N= 52,217 IDs lack any source information (around 3.5% of the publication-reference pairs) and of the rest, the source information does not contain a unique source identifier and has to be matched with source classification via title character strings. This process introduces additional errors and leaves many references without classifications, even after significant data-cleaning, as Scopus only offers classifiers for the sources they themselves index (many reference IDs are ‘dummy’ records). Additionally, many referenced items are not pieces of scholarly literature, but might be different governmental reports and statistics, newspaper articles etc., and as such are not classifiable within the ASJC framework.

Overall, I am able to match around 60% of all publication-reference pairs to a 'group-level' classification, and the average proportion of classified references for any one publication is 56.67% (sd = 24.61%). The data loss is, therefore significant, especially when we consider the lack of reference records themselves. Even more concerningly, the missingness is not randomly distributed across fields of the citing articles (see Figure A-4 in Appendix A for classification coverage in the top fields). At the same time, it is important to note that the types of materials with missing classifications are diverse, and are not necessarily obscuring the contribution of any particular field. As evident in Table B-7, 'Most frequently cited individual publications,' three of the top sources are missing a classification, and they are in the fields of Clinical psychology, Public health, and Psychiatry. Other notable missing sources are various psychiatric and clinical psychology measures. While one of my concerns is that literature in the humanities and the social sciences might be less likely to be classified, it is possible that the missingness does balance itself out.

Due to the concerns as listed above, I utilize the reference data with caution and in concert with other data. For example, while I have conducted a more detailed analysis of reference diversity (some of which I include in Appendix B for illustrative purposes) I do not include it in the main discussion due to my concerns about uneven missingness biasing trends over time.

3.4. Analytic approach

Once I have classified both publications and references, I first ask 'How diverse/multidisciplinary is knowledge production on suicide, and how does this change over time?" I examine the way the proportion of publications in specific ASJC codes, classifications and overall fields has been

changing over time, and I use the Shannon Diversity Index to capture overall trends in diversity. When I can, I also compare some of the trends in publications on suicide with overall trends in Scopus publications, so as to control for changes not specific to suicide. For example, I look not only at the proportion of publications on suicide classified (according to the classification of their sources) in Psychology, but I also look at the proportion of publications in Psychology that are on suicide, so as to determine how important a topic is within a field. Finally, I examine overall diversity over time in both publications as well as references (following Rafols & Meyer, 2010).

Having examined the disciplinary diversity of suicide knowledge production, I turn to the question of disciplinary integration, which I approach in three different ways. First, I follow Morillo et al. (2001), and I look at patterns of multi-assignment of sources in which work on suicide is published, over time. Second, I consider overall trends in citations, by different classifications and fields, to determine the degree to which knowledge is flowing between them. Third, I modify the approach used by Rafols & Meyer (2010), and build bibliographic coupling networks (in which two publications are connected if they share references, with the links weighted by the number of shared references) so as to characterize overall integration in the field over time. I then take another step and look for clusters in these networks, to investigate whether they map onto some disciplines or are, instead, more topical.

4. Disciplinary Diversity

I approach the question of disciplinary diversity in knowledge production around suicide mainly by examining the relative proportion of publications in differently classified sources, and I present this data at three different levels of granularity—unique classifications, overall fields and specific

ASJC code designations. I explain each again at the beginning of their respective sections. I finalize the section by examining the overall diversity of both suicide references and publications over time, using the Shannon Diversity Index.

4.1. Diversity of publications by unique group classifications

In the first step of my analysis, I focus on the 27 groups within the ASJC schema, as opposed to more detailed ASJC codes, both to examine the general patterns and to use my full dataset (some items are only assigned to the 27 groups, not the individual codes). To clarify, I use 'unique classification' to indicate a specific combination of groups that the source of a publication is assigned to. A classification "Medicine" here means that the publication source is classified *only* under Medicine, while "Medicine;Psychology" means that it is classified under *both* of those fields.

Classification	No. publications	Total percent	Cumulative percent
Medicine	25393	46.23	46.23
Medicine;Psychology	7540	13.73	59.96
Psychology	2618	4.77	64.72
Medicine;Neuroscience	2555	4.65	69.37
Social Sciences	1549	2.82	72.19
Medicine;Social Sciences	1325	2.41	74.61
Medicine;Nursing	1086	1.98	76.58
Nursing	1050	1.91	78.50
Arts and Humanities;Social Sciences	916	1.67	80.16
Psychology;Social Sciences	873	1.59	81.75
Biochemistry, Genetics and Molecular Biology**;Medicine**	717	1.31	83.06
Arts and Humanities;Psychology	704	1.28	84.34
Medicine;Psychology;Social Sciences	698	1.27	85.61
Medicine;Pharmacology, Toxicology and Pharmaceutics	612	1.11	86.72
Other	7292	13.28	100

Table 3-2. Top unique group-combinations in the publications dataset

Overall, out of 325 unique classifications, 14 contain at least 1% of the whole corpus each, and together account for over 86% of the corpus, as shown in Table 3-2. I consider these to be the significant producers of knowledge on suicide, and I group the rest under "Other." It is notable that a single classification "Medicine" accounts for about 46% of the corpus, and the next largest contributor, publications classified as both "Medicine" and "Psychology" account for nearly 14%. Together with the third largest contributor, "Psychology", these account for nearly 65% of the whole corpus.

However, these proportions are not static over time, as I show in the two figures below (Figure 3-1 and Figure 3-2). The proportion of publications in Medicine decreases significantly over time, from around 75% in 1960 to about 30% in 2020. This is likely due both to 1) increased publication in journals assigned to another field in addition to medicine—such as "Medicine; Psychology" which increases from a few percent in 1960s to around 15% in 2020, or "Medicine; Neuroscience" which steadily increase in 2000s— as well as 2) increase in the proportion of publications in other fields (see next section for more detail). In contrast, many classifications are quite stable over time. Some of this might be an artifact of idiosyncrasies in designations—e.g. classifications that include "Arts & Humanities" seem to be assigned to older journals and simply represent a specific set of journals—but others might indicate a steady but low interest within specific areas of inquiry (e.g. Nursing, or Social Sciences)

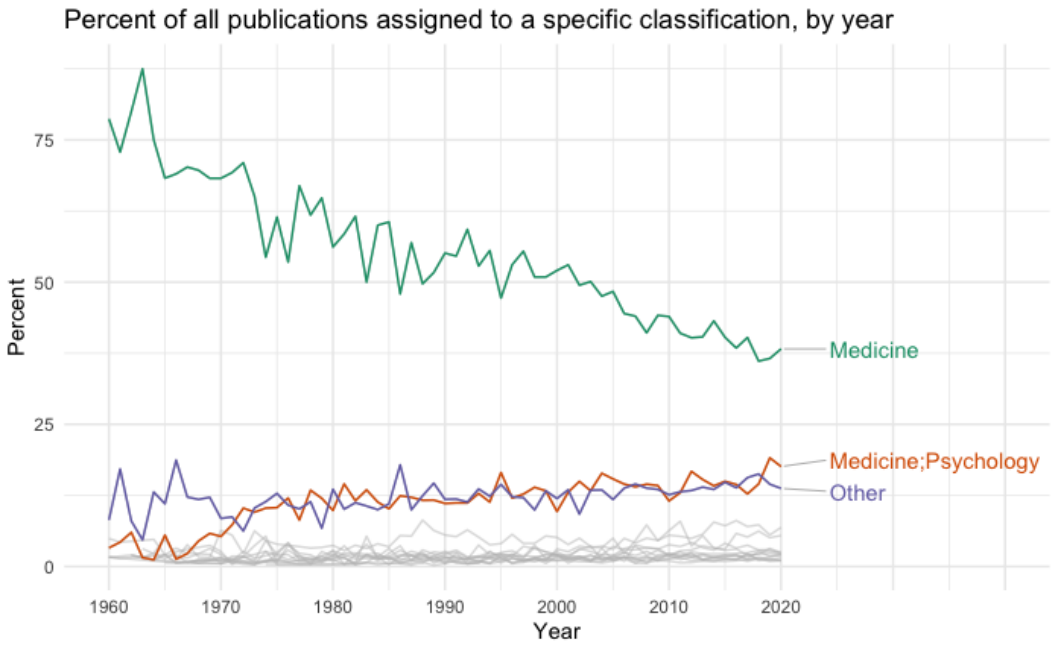


Figure 3-1. Percent of all publications assigned to a specific classification by year, highlighting top three classifications.

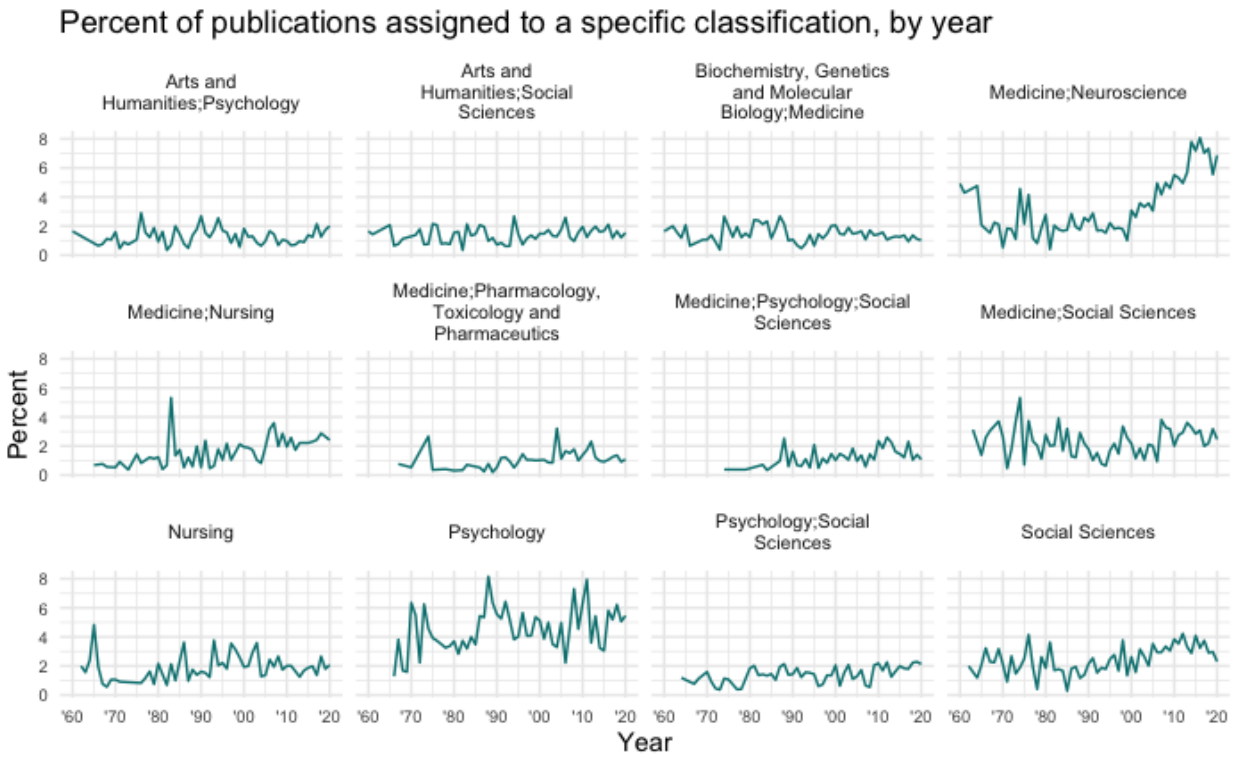


Figure 3-2. Percent of publications assigned to a specific classification by year, less common classifications

In interpreting the trends above, it is also important to keep in mind that there are significant differences in the *overall* amount of publishing across disciplines. In 2020, for example, there were over half a million publications in sources designated as "Medicine," while the number was more than five times lower for "Social Sciences" and nearly 35 times lower for "Medicine; Psychology." Therefore, in addition to asking how important certain disciplines or combinations of disciplines are to suicide knowledge production, it is worth asking how important suicide is to particular disciplines, that is what proportion of all publications within a classification is on suicide. To capture this, I look at the percent of all publications within a particular classification that are on suicide.

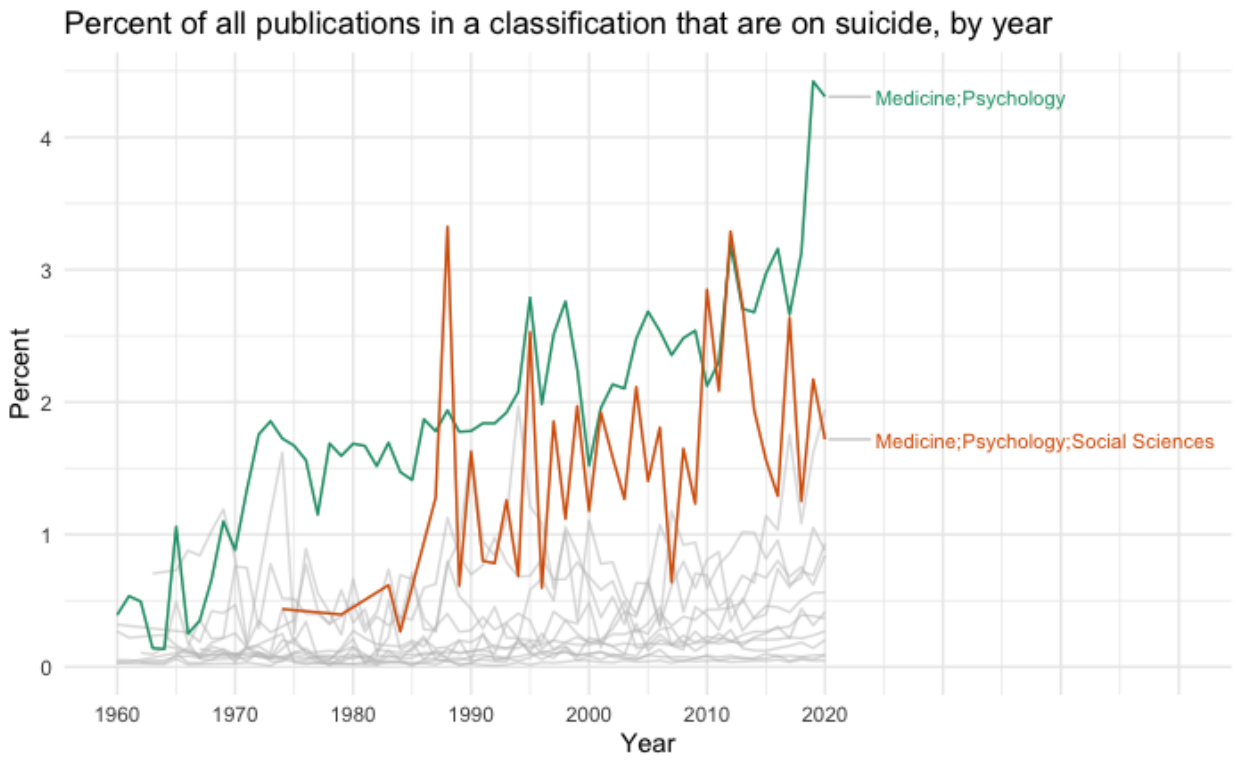


Figure 3-3. Percent of all publications in a classification that are on suicide, by year, highlighting top two classifications

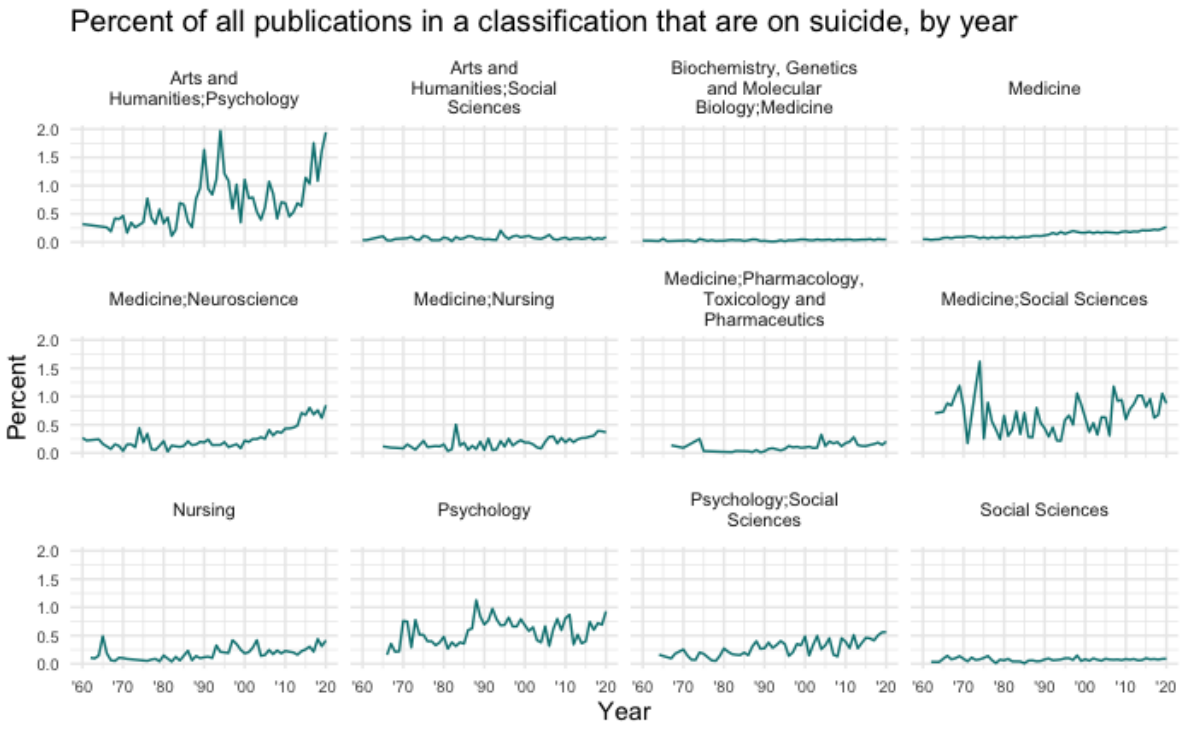


Figure 3-4. Percent of all publications in a classification that are on suicide, by year, focus on less prominent classifications

Examining the trends in Figure 3-3 and Figure 3-4, we see that as a topic, suicide is of increasing and significant interest to the publications classified as "Medicine; Psychology," which is not surprising given that two out of the three main suicidology journals (SLTB and ASR) have this classification. There is also an evident increase in Medicine, but the overall proportion is low, as would be expected in the context of the size of the field, which prompts a more detailed investigation into the subdivisions of Medicine (see Section 4.3). We also see an increase interest in suicide in "Medicine; Neuroscience", especially starting around year 2000, and some significant variability in "Arts and Humanities; Psychology" (the journal with the greatest share of publications in this classification is *Death Studies*, followed by the *Journal of Clinical Psychology*)

Overall, a large proportion of all publications on suicide appears in sources designated as Medicine, though this proportion steadily decreases across the period, with increasing participation of other fields and sources that are assigned to another field in addition to Medicine. The most notable amongst these are the sources co-assigned to both Medicine and Psychology, which not only steadily increase their share in the publications on suicide over time, but which also publish the most work on suicide, relative to their overall number of publications. I explore some of the more detailed trends in this interaction in section 4.3, but first I take a step back to examine the overall domain of each field, irrespective of multi-assignment.

4.2. Diversity of publications by overall field contributions

What really stands out in Table 3-2 is that "Medicine" is not just the most common unique classification, but that it features in the majority (7/13) of other top unique classifications. Therefore, in addition to focusing on unique classification combinations, I also examine the proportions of all publications assigned to a specific group. This means that a publication classified as "Medicine; Psychology" will count towards the total in both fields, and the sum of all proportions will be greater than 100%. In Figure 3-5 and Figure 3-6, I look at occurrence of all the fields which are assigned to at least 0.05% of articles within a year. We do see a steady increase in publications designated under "Psychology," that we would expect based on the increase in "Medicine; Psychology" classification above, but note that the decrease in Medicine is a lot less steep than we might expect based on Figure 3-1. This indicates that the drastic decrease in the proportion of publications in Medicine-only is mostly due to an increase in the proportion of publications in multi-assigned journals, as opposed to those shares being captured by new or

separate fields. In 2020, over 75% of all publications on suicide was published in a source that had at least one classification in Medicine.

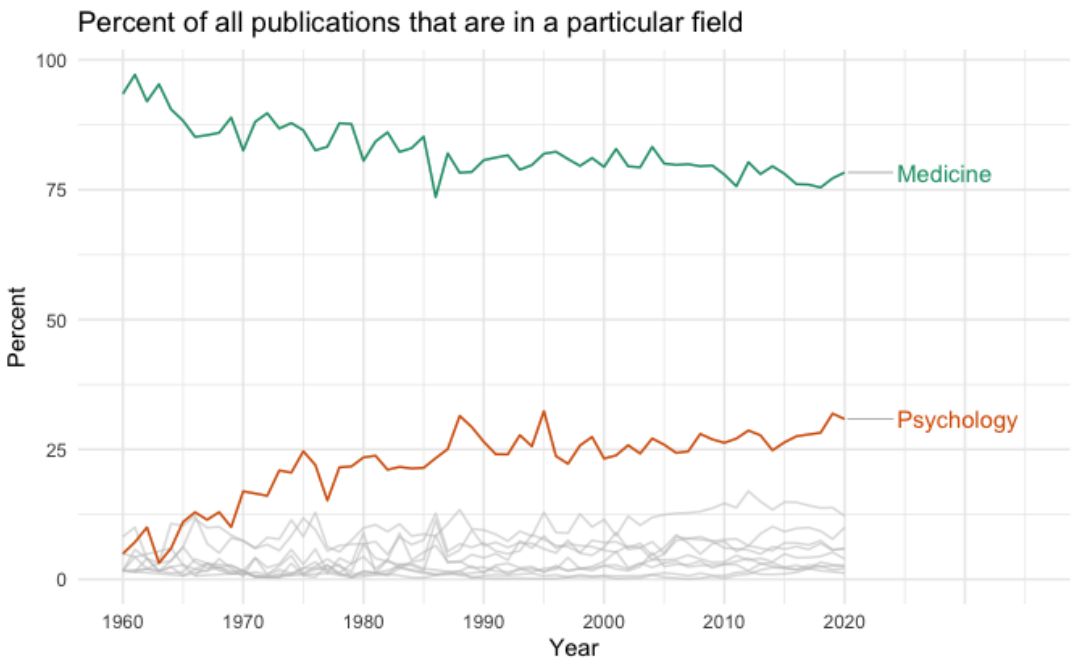


Figure 3-5. Percent of all publications in a particular field, by year, highlighting top two fields

That said, Figure 3-6. does show what appears to be an increasing diversification of the field, including an overall increasing share of publications classified in Neuroscience, Social Sciences, Nursing, as well as Other, the last one indicating increasing interest in suicide across fields less central to suicide knowledge production. "Arts and Humanities" overall show a decrease, but this, again, might be an artifact of the older journal designations. Interestingly, both "Biochemistry, Genetics and Molecular Biology," and "Pharmacology, Toxicology and Pharmaceutics" show relatively little change over time, and therefore not showing clear evidence of 'somatization' of suicide.

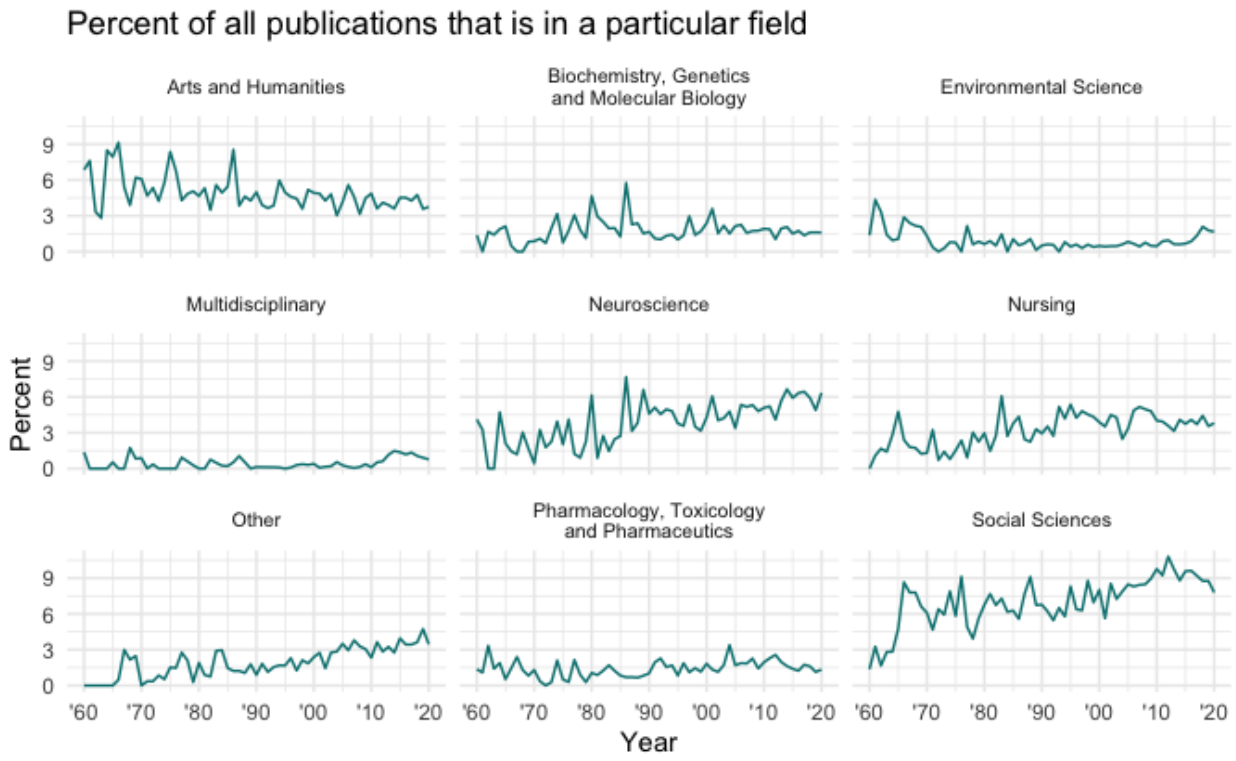


Figure 3-6. Percent of all publications in a particular field, by year, focus on less prominent fields

Looking at the relative prevalence of suicide publications within each field (Figure 3-7. and Figure 3-8.), we see a significant difference between Psychology and other fields, with the proportion of suicide publications in Psychology and Psychology-co-assigned sources drastically increasing across the period and now making up over 1% of all publications.

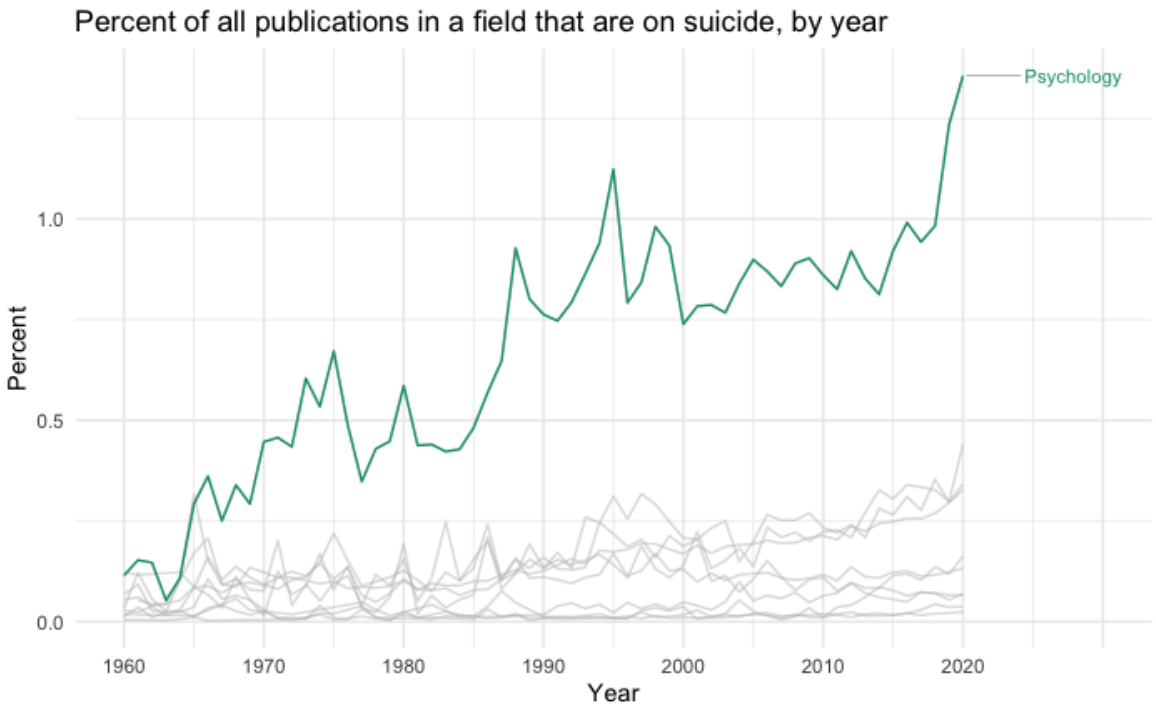


Figure 3-7. Percent of all publications in field that are on suicide, by year, highlighting the top field.

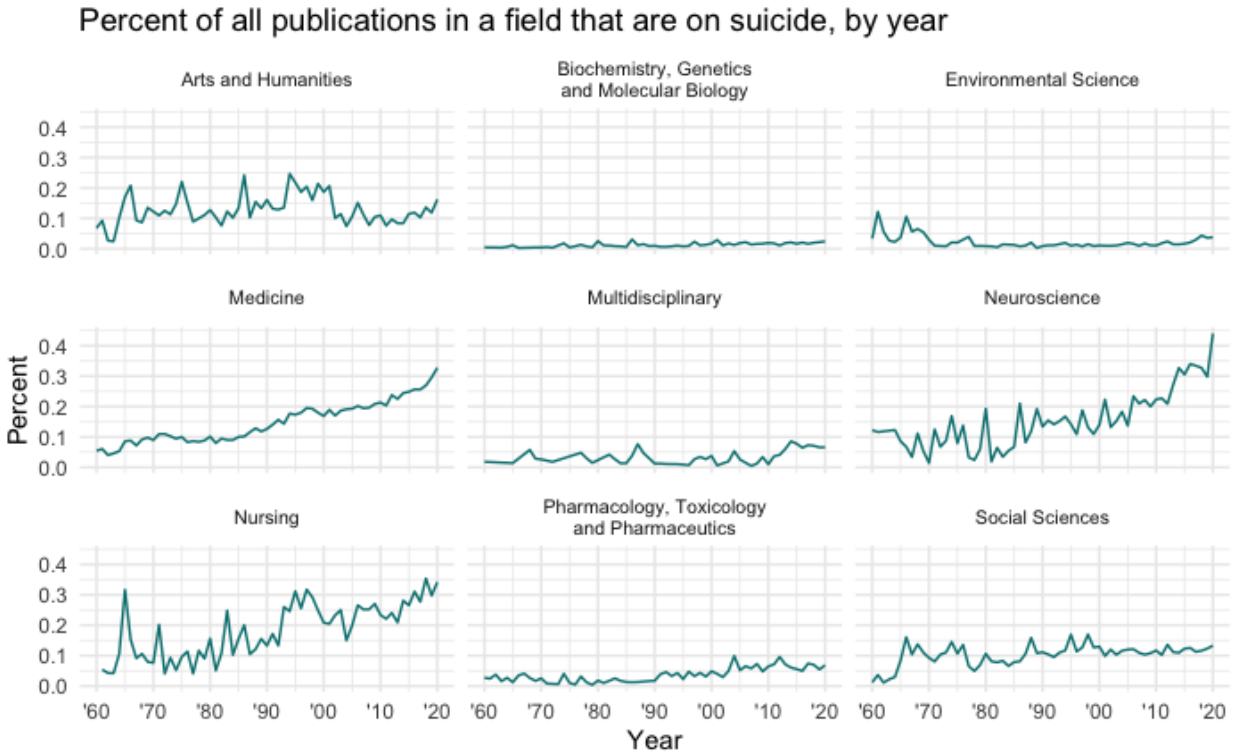


Figure 3-8. Percent of all publications in field that are on suicide, by year, focus on less prominent fields

While publications on suicide make up a much smaller portion of fields other than psychology, we do see some interesting trends, especially in Medicine, Neuroscience and Nursing, all of which seem to be taking an increasing interest in suicide over the period.

Overall, then, we see that throughout the period, majority of suicide publications appear in sources assigned or co-assigned to "Medicine." This does not necessarily mean that the main producers of this knowledge are themselves medical professionals, but serves as evidence of the phenomenon of suicide and the knowledge produced about it understood as falling under the purview of Medicine and/or being of interest to Medicine. Furthermore, as a topic within Medicine, suicide seems to capture an increasing share of the overall publications in the field. At the same time, however, over time, we see suicide becoming of increased concern to some other fields, such as Psychology and Neuroscience, as well, and an what appears to be an increasing diversity of fields suicide work is published in.

4.3. Diversity of publications by specific ASJC codes

While examining the trends based on the broader fields does allows us to see broader trends, it might be obscuring important detail, with regards to specific disciplines (e.g. Sociology within "Social Science") or sub-disciplines (e.g. 'Psychiatry" in "Medicine"). To investigate trends across these more fine-grained units of analysis, I take a closer look on specific ASJC designations, considering both unique code combinations (Table 3-3.) and all occurrences of a code in a designation (Table 3-4.). Note that detailed ASJC data is available for around 94% of the whole publication corpus.

Examining the overall distribution of specific code combinations (Table 3), we see that General Medicine (2700) tops the lists. This is not entirely surprising given that this classification includes top medical journals such as *The Lancet*, *British Medical Journal*, and the *Journal of the American Medical Association*, which publish across all medical fields and it is likely that many of these publications are authored by psychiatrists. The same might be true of the "Multidisciplinary" code (1000), which is assigned to general journals, such as the high-profile *Nature*, *Science* and the prolific *PLOS One*. The high ranking of "Psychiatry and mental health; Clinical Psychology" (2738;3203) as well as "Psychiatry and Mental health; Public Health, Environmental and Occupational Health; Clinical Psychology" (2738;2739;3203) is very likely at least in part due to the main suicidology journals which are assigned those codes.

asjc	class	n	%
2700	General Medicine	8510	16.02
2738	Psychiatry and Mental health	8083	15.21
2738;3203	Psychiatry and Mental health; Clinical Psychology	3450	6.49
2738;2739;3203	Psychiatry and Mental health; Public Health, Environmental and Occupational Health; Clinical Psychology	1894	3.56
2738;2803	Psychiatry and Mental health; Biological Psychiatry	1431	2.69
2739	Public Health, Environmental and Occupational Health	1276	2.40
3200	General Psychology	1127	2.12
2734	Pathology and Forensic Medicine	1060	1.99
2700;2738	General Medicine; Psychiatry and Mental health	677	1.27
1000	Multidisciplinary	537	1.01
1201;3203;3204	Arts and Humanities (miscellaneous); Clinical Psychology; Developmental and Educational Psychology	400	0.75
2735	Pediatrics, Perinatology, and Child Health	390	0..73
2900	General Nursing	374	0.70
2738;3204	Psychiatry and Mental health; Developmental and Educational Psychology	373	0.70
1201;2738	Arts and Humanities (miscellaneous); Psychiatry and Mental health	357	0.67

Table 3-3. Top unique ASJC code combinations of suicide publications (assigned to at least 0.5% of publications)

asjc	class	n	%
2738; 3207; 3306; 2713;	Psychiatry and Mental health; Social Psychology; Health(social science); Epidemiology	335	0.63
2739; 2700;	Public Health, Environmental and Occupational Health; General Medicine	311	0.59
3203;	Clinical Psychology	303	0.57
2739; 2713;	Public Health, Environmental and Occupational Health; Epidemiology	291	0.55
2307; 2739;	Health, Toxicology and Mutagenesis; Public Health, Environmental and Occupational Health	278	0.52

Table 3-3, continued

Looking at all publications that are assigned particular codes (Table 3), what stands out the most is that around 40.94% of all publications are in sources whose classification contains "Psychiatry and Mental health" (PMH), with the next most frequent classifications being significantly less common. Despite this 'dominance' of PMH, however, there is clear evidence of the knowledge also being dispersed over a variety of different ASJC designations—not only are there just four codes that are assigned to more than 10% of all publications, but there are 29 codes that are assigned to at least 1% of all publications, and there are overall 299 different codes that make an appearance in the corpus, indicating a significant diversity of disciplines and specializations in the production of knowledge about suicide.

ASJC	Description	Group	%
2738	Psychiatry and Mental health	Medicine	40.94
2700	General Medicine	Medicine	23.24
3203	Clinical Psychology	Psychology	14.17
2739	Public Health, Environmental and Occupational Health	Medicine	10.10
2803	Biological Psychiatry	Neuroscience	4.10
2734	Pathology and Forensic Medicine	Medicine	4.01
3306	Health(social science)	Social Sciences	3.94
3204	Developmental and Educational Psychology	Psychology	3.51

Table 3-4. Top ASJC codes by overall occurrence across suicide publications (assigned to at least 1% of all publications)

ASJC	Description	Group	%
1201	Arts and Humanities (miscellaneous)	Arts and Humanities	3.20
3200	General Psychology	Psychology	3.08
2728	Clinical Neurology	Medicine	2.73
2735	Pediatrics, Perinatology, and Child Health	Medicine	2.58
3207	Social Psychology	Psychology	2.42
3202	Applied Psychology	Psychology	2.40
3312	Sociology and Political Science	Social Sciences	2.17
3308	Law	Social Sciences	2.13
2713	Epidemiology	Medicine	2.02
2736	Pharmacology (medical)	Medicine	1.90
2719	Health Policy	Medicine	1.78
2921	Psychiatric Mental Health	Nursing	1.71
3304	Education	Social Sciences	1.50
2717	Geriatrics and Gerontology	Medicine	1.41
2900	General Nursing	Nursing	1.39
2808	Neurology	Neuroscience	1.32
3004	Pharmacology	Pharmacology, Toxicology and Pharmaceutics	1.32
3301	Social Sciences (miscellaneous)	Social Sciences	1.17
2307	Health, Toxicology and Mutagenesis	Environmental Science	1.08
2701	Medicine (miscellaneous)	Medicine	1.04
3205	Experimental and Cognitive Psychology	Psychology	1.00

Table 3-4, continued

Again, these percentages are not stable over time. As evident in Figure 3-9, there is a significant decrease in the proportion of publications classified with “General medicine” — likely due to an increased specialization of journals over time, and maybe more specific classification practices. This is captured, at least in part, by the increasing proportion of publication in “Psychiatry and Mental health.” At the same time, we also see more publication in Clinical Psychology as well as Public Health, with a most significant growth in proportion between 1960s and 1980s. Additionally, the increase in the proportion of publication in “Other” is evidence of increasing engagement from different disciplines and specialties.

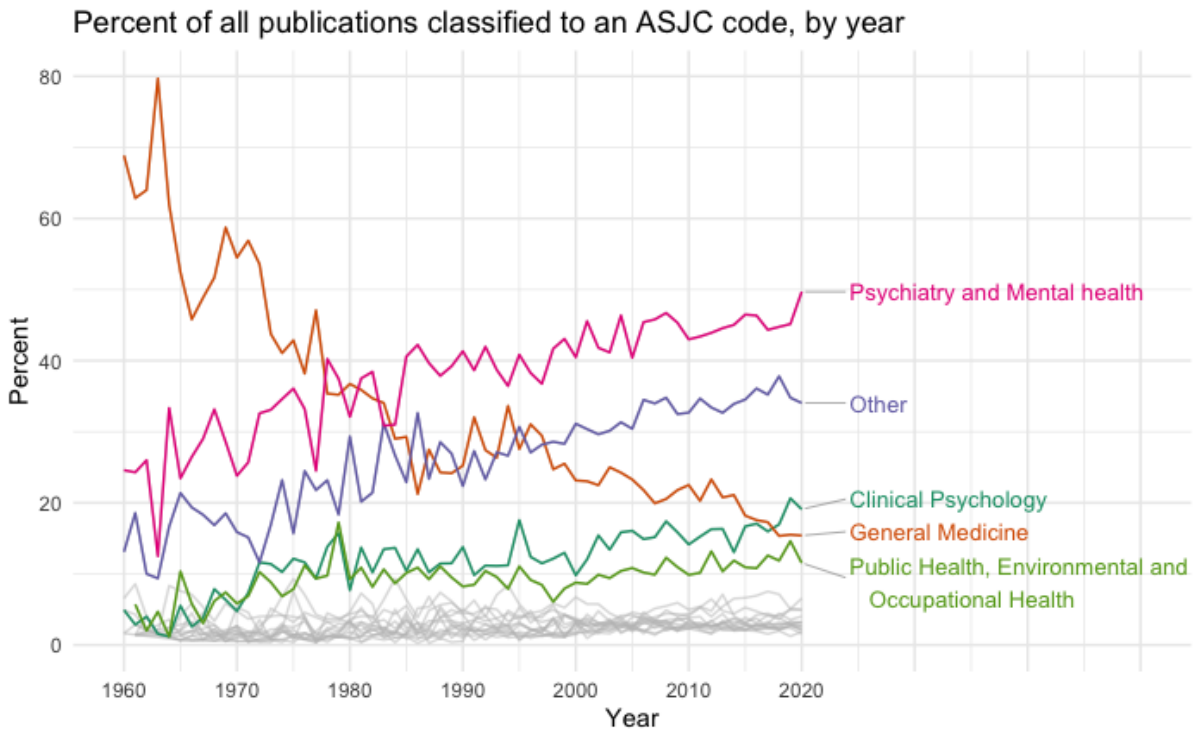


Figure 3-9. Percent of all publications classified to an ASJC code, by year, focus on top five codes

A closer look at the less prominent codes (Figure 3-10) also shows important trends. For example, the increase in "Biological psychiatry" and "Health (social science)" likely indicate the development of those specialties, while trends in "Developmental and Educational Psychology" as well as "Pediatrics, Perinatology and Child health" seem to map onto increased concern about youth suicide in the 80s and 90s, showing that engagement with suicide across disciplines is sensitive to contextual factors. Additionally, thinking back to the patterns across larger groups in the previous section, we can now see that these seem to be driven by specific sub-fields, e.g. "Biological Psychiatry" in "Neuroscience," "Clinical Psychology" in Psychology, and "Health(social science)" in Social Sciences.

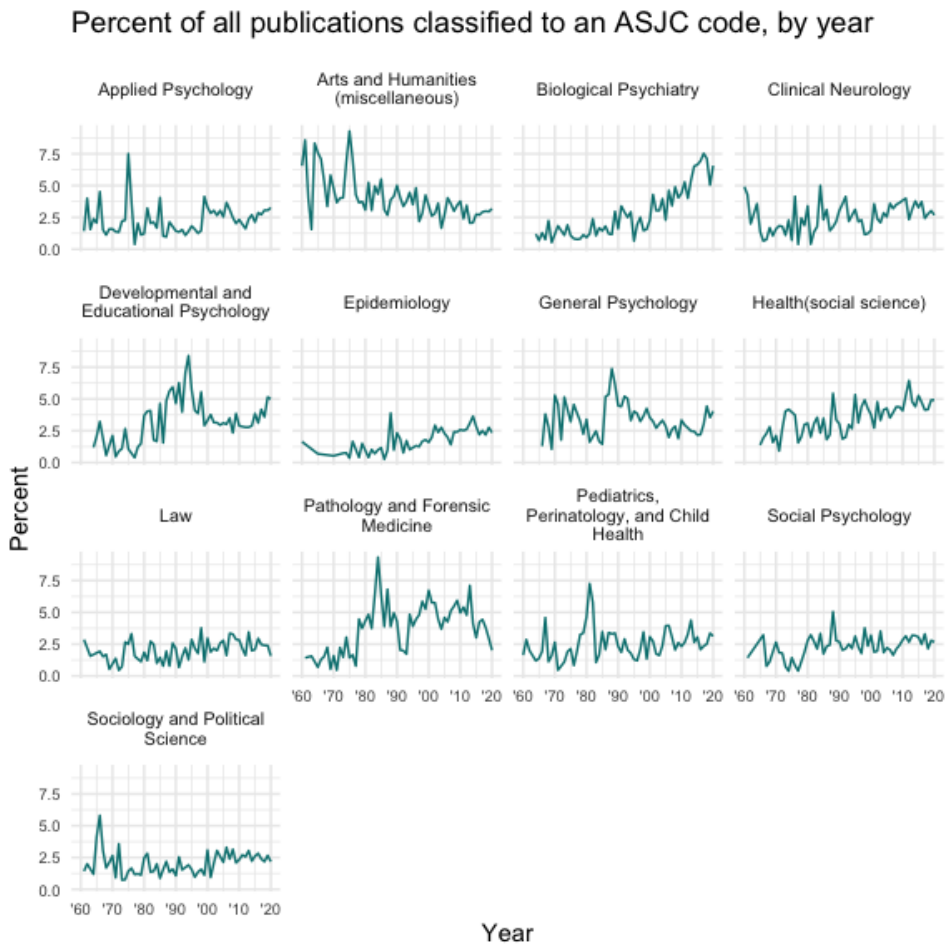


Figure 3-10. Percent of all publications classified to an ASJC code, by year, focus on less common codes

In exploring the relative importance of suicide to publications under a specific code, I focus on the three specific disciplines, "Psychiatry Mental Health" (PMH), "Clinical Psychology" (CP) and "Public Health, Environmental and Occupational Health" as the most significant knowledge producers. First, I consider the proportion of publications of suicide within the overall publication record for all sources assigned at least one of the three codes (as a reminder, multi-assigned journals count towards the total for each of the codes they are assigned to), as shown in Figure 3-11. While the proportion of publications on suicide increases across all three fields, it is much more significant in case of "Psychiatry and Mental health" and "Clinical Psychology" than "Public health."

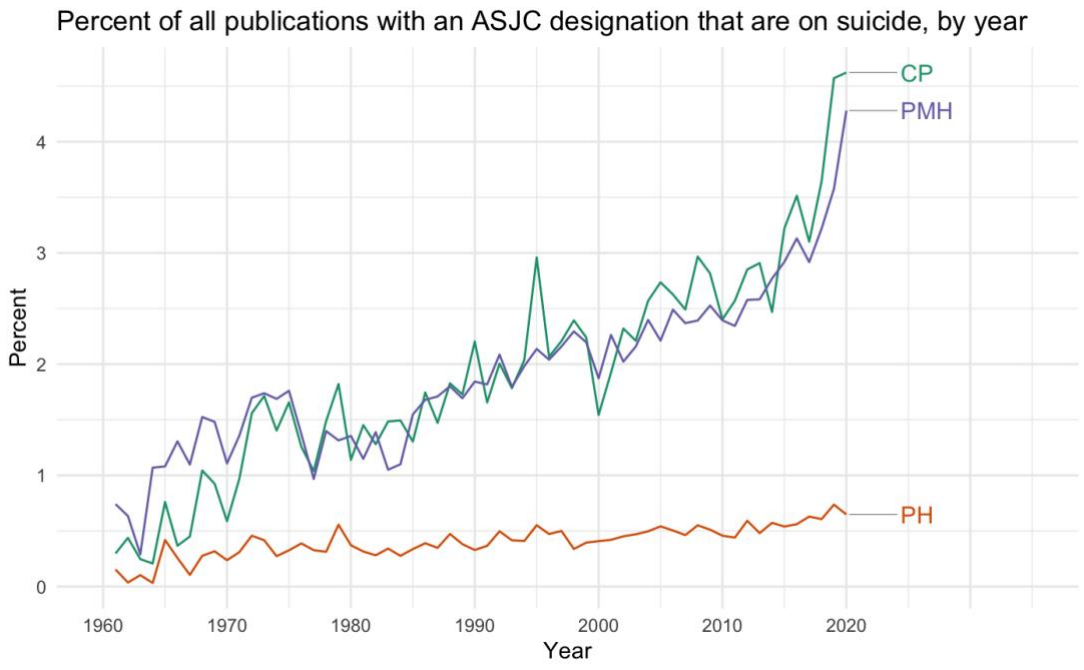


Figure 3-11. Proportion of publications on suicide in sources that feature a PMH, CP or PH designation in the ASJC codes

Examining the interactions between the three fields in more detail in figures bellow, we see that the growing presence of suicide in the Public health literature occurs almost exclusively in the sources that are also co-assigned with one or both of the psy-fields, and is likely strongly driven by the suicidology journals (Figure 3-12). Within the two psy-fields, there is an increasing presence of suicide both within the literature assigned under PHM (allowing for any other designations, but CP) and that under CP (allowing for any other designations, but PMH). However, the increase is the most evident in the *overlap* between PMH and CP (sources assigned to both PMH and CP, allowing for any other designations as well). Again, the later increase is not surprising, given that it is where we find two suicidology journals, but the increase in the two fields separately is interesting, and this is especially the case for a relatively significant increase in the

CP share in the mid 2010s which does seem to align with the proliferation of clinical psychologists' theoretical engagement with suicide during that time.

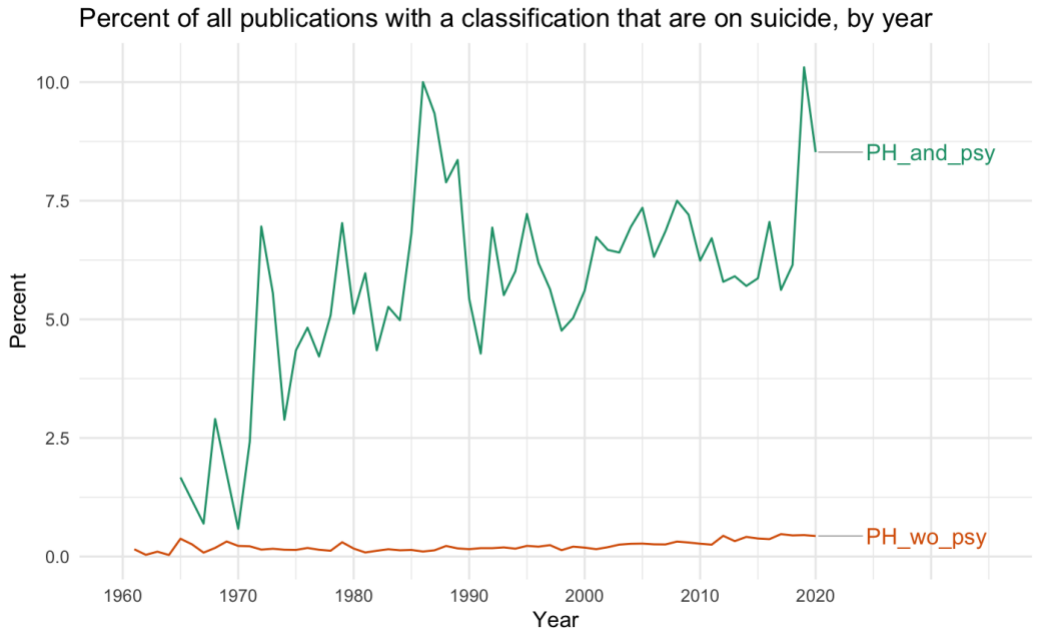


Figure 3-12. Proportion of publications on suicide in sources that feature a PH designation, contrasting those multi-assigned in MPH/CP (_and_psy) and those not assigned to those codes (_wo_psy)

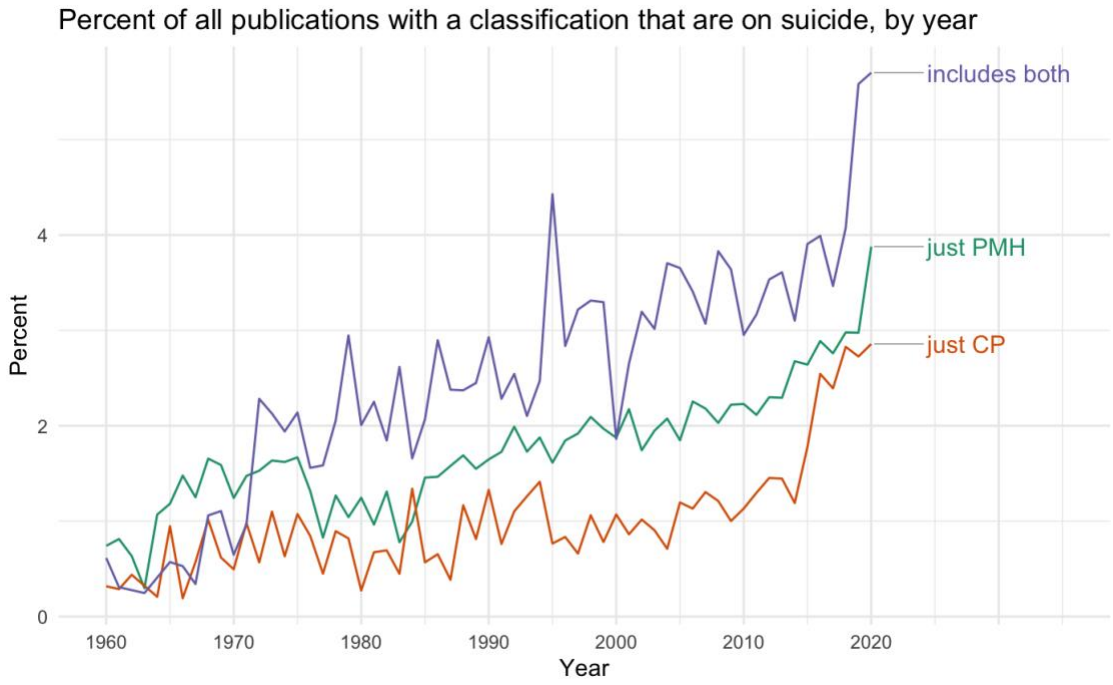


Figure 3-13. Proportion of publications on suicide in sources that feature a PMH, CP or both designations in the ASJC codes

Overall, a closer look at the ASJC codes renders visible some details in the changing landscape suicide production over time. A significant change is likely an increased specialization of publishing—e.g. decreasing share of 'General Medicine" is accompanied by an increasing share of "Psychiatry and Mental health" and "Public health," or even "Biological psychiatry." At the same time, there is also evidence of an increasing participation by specific fields, which likely accounts for the trends that emerged in the analysis by overarching groups: it is Clinical Psychology that seems to drive the increasing participation of suicide production within Psychology, and "Biological Psychiatry" doing the same in Neuroscience. Even though these specialties are placed under different disciplines, they do seem to have more in common that other specialties within the same discipline (c. Klein, 1996, p. 53).

4.4. Overall Diversity

Although the analyses above do indicate an overall increased diversity of sources in which work on suicide is published, they are not able to examine this trend more generally. To better capture changes in the overall diversity of knowledge production on suicide, I use the Shannon Diversity Index. Shannon Diversity Index (H) is a common measure of diversity that is constructed using proportions of individual items within some set of classes or groups (see Appendix A: Methods for more information). The value of H is dependent on the number of available classes: calculating an index for a system with 27 possible classes (assuming work on suicide could possibly be published in any of the existing 27 classes), H could range from 0 in case of no diversity (all publications in a single class) to 3.296 in case of completely uniform distribution across all classes.

In addition to calculating H for the classifications of all publications in a given year, I also calculate H for the classification of all items referenced by publications in a given year. Keeping in mind that less that only about 38.4% of all references are to publications on suicide, I want to capture any changes in the diversity of knowledge that suicide publications draw on.

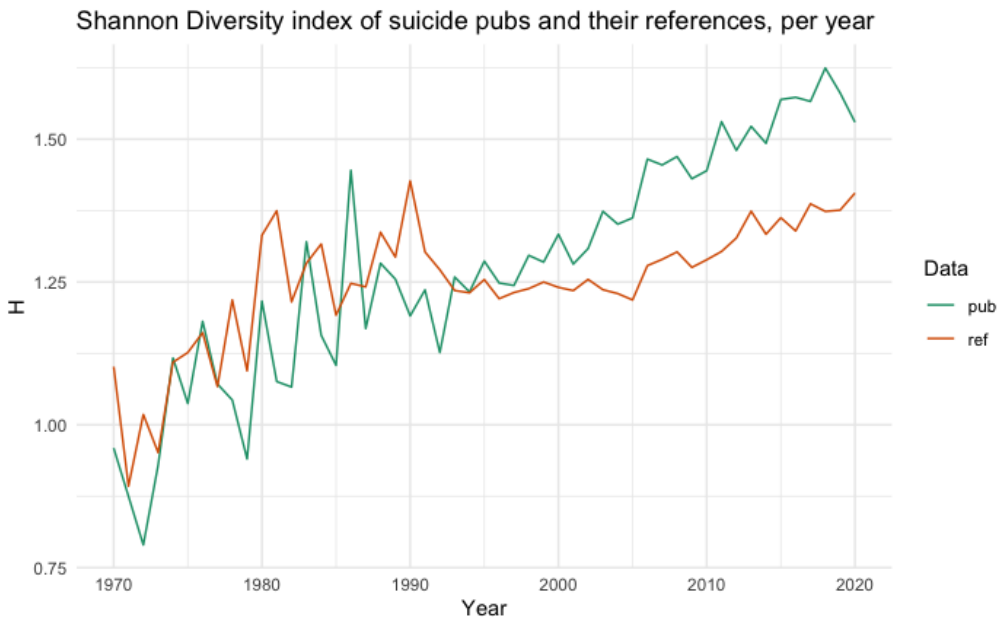


Figure 3-14. Shannon Diversity Index of suicide publications and references, aggregated by the year of citing publication

As can be seen in Figure 3-14, work on suicide is, over time, published in increasingly diverse sources. This could be due to both an increasing proportion of publications being in externally multi-assigned journals (see next section) as well as due to increasing proportion of publications in "newcomer" fields, such as Neuroscience, as we have seen above. References follow a similar trend, up until the 1990s, only for the diversity to level off and then start increasing again in the later 2000s. Overall, the references are less diverse than the publication, the average $H_{refs} = 1.33$ compared to $H_{pubs} = 1.43$. However, it is possible that the two are not comparable due to the general

trend of increasing interdisciplinarity—publications frequently cite older work, which might appear less diverse simply because of the earlier publishing landscape.

4.5. Section Summary

Having examined the diversity of publications on suicide in depth, it becomes clear that a significant majority of the work on suicide is published in sources that are under the umbrella of Medicine—whether it be sources in specific specialties of medicine (specifically "Psychiatry and mental health" as well as some work in "Public health"), general medical sources, or interdisciplinary sources with an assignment in Medicine. Additionally, work published in other broad fields, even when not co-assigned in Medicine, is often published in sources that still have ties to health and medicine, such as "Biological Psychiatry" (in Neuroscience) and "Health (Social Science)" in Social Sciences or Nursing.

However, over time, we do see evidence of increasing diversification, both in terms of increasing proportion of work published in a variety of multi-assigned sources and increasing participation from non-medical fields. This increase is most evident within Clinical Psychology, though it is unclear to what extent Clinical Psychology is distinct from Psychiatry and Mental Health within Medicine—publications in sources that share the two designations make up a significant proportion of suicide publications, and it is for those sources that suicide seems to be a topic of most interest, relative to their publication record.

It is difficult to answer the question of whether suicide research is multidisciplinary, or how multidisciplinary it is, in absolute terms as there are no established thresholds. What we can say is

that there clearly is more than one discipline or field are engaged in knowledge production on suicide, and that over time, the diversity does increase, even if it increasing within a constrained (broadly medical) realm. Additionally, various smaller contributors, including some social sciences, while not increasing their share of in the overall publications, are keeping up with overall increases in the volume of publishing and maintaining their presence, that is they are not 'pushed out' by the Medicine(-adjacent) literature.

5. Interdisciplinary Integration

In the previous section, I have established that suicide work is published in a variety of sources and now I turn to investigating the degree of integration across this literature. I have already noted that, oftentimes, sources themselves seem to be integrating specialties and disciplines, and in fact, work published across these sources seems to make up a significant proportion of all publications. Therefore, I first examine the trends in publications across different kinds of multi-assigned journals and compare some of these trends across the whole of Scopus's record to see whether this kind of journal-interdisciplinarity is an artifact of broader changes or if there is something there that is specific to suicide.

After looking at publications alone, I then draw on my reference dataset through two sets of two analyses. In the first set, I focus on the references as classified into the 27 groups by ASJC codes. I ask about the extent to which individual articles on suicide draw on diverse literatures, and I examine article-level diversity of references, over time and across specific fields. Then, interested in how much different fields and unique classifications draw on one another, I look at citation flows across those categories.

In the second set of analyses, I move away from ASJC classifications altogether, and I use network analysis to empirically reveal the structure of knowledge production without imposing external categories onto it. I first build a series of bibliographic coupling networks—one for each decade of the 1970-2019 period, and one for the complete dataset—to characterize overall network coherence and examine any trends over time. Then, I look for clusters in the complete networks, characterize them based on differences across their titles, abstracts and keywords, and compare them with the ASJC code-based structure to see whether they map onto one another or not, which would indicate either less integration across disciplines, or differentiations in the knowledge productions that transcend disciplines (e.g. specific topics).

5.1. Multi-assignment of publication journals

To start examining the trends in interdisciplinarity, I focus on the section of my data that has full ASJC codes and I build three metrics as per Morillo et al. (2001). Interested in 'multi-assignation' of journals, they distinguish between 'internal multi-assignation', that is journals assigned to different codes within the same category, and 'external multi-assignation' that is journals assigned to codes in different categories. The multiple classifications that we have seen above, e.g. "Medicine; Psychology" are an example of 'external multi-assignation', while "Psychiatry and Mental health; Pharmacology(medical)" would be a case of 'internal multi-assignment' as both of the classifications are within the 'Medicine' group. Out of my dataset, N=53,132 publications can be matched to specific ASJC codes, which is about 94% of the whole publication dataset. I am interested in the proportion of publications, per year, which appear in multi-assigned journals.

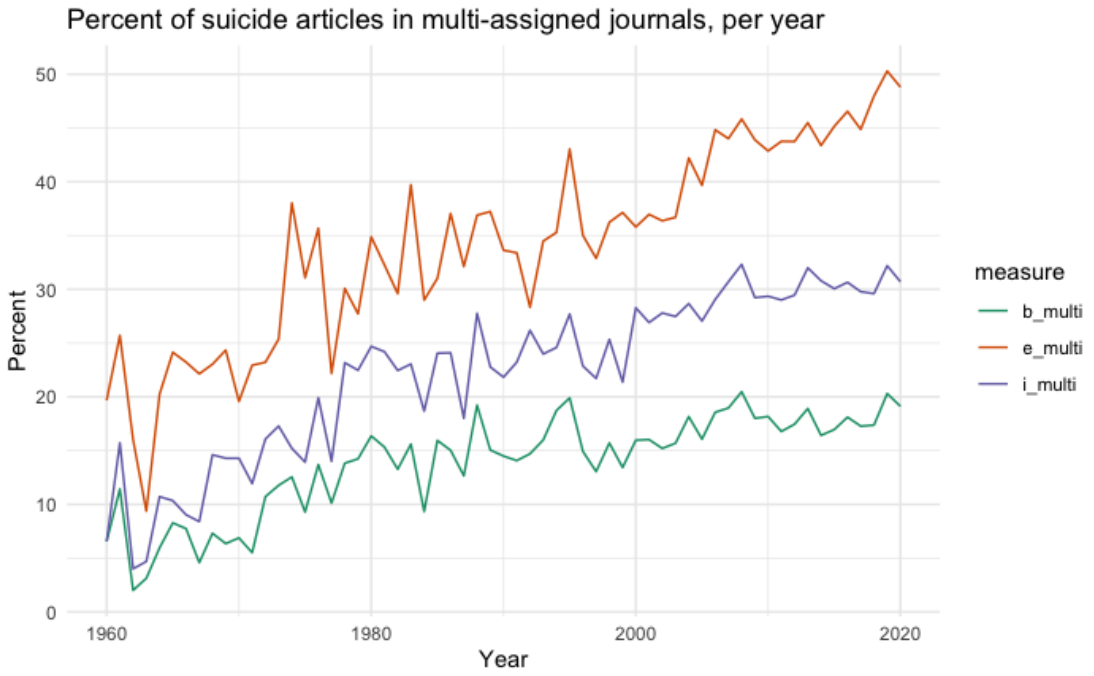


Figure 3-15. Journal multi-assignment in suicide publications over time

Over time, we see clearly that an increasing proportion of articles is published in externally multi-assigned (*e_multi*), internally multi-assigned (*i_multi*) or both externally and internally multi-assigned journals (*b_multi*). The proportion of articles in externally multi-assigned journals is the greatest, which is not surprising considering the composition of the top unique-classifications as presented in Table 1.

This apparently increasing interdisciplinarity, however, is not necessarily a trend in suicide research, but might be an artifact of overall publication trends over time. While I am unable to use the Scopus database to estimate the proportion of articles published in internally multi-assigned journals, I am able to examine more general trends in externally multi-assigned journals. To do so, I use the total numbers of articles indexed by Scopus per year, and also the number of articles

classified to one group only, and calculate the proportion of articles assigned to at least two groups in any given year. I compare the overall trends to those in suicide research.

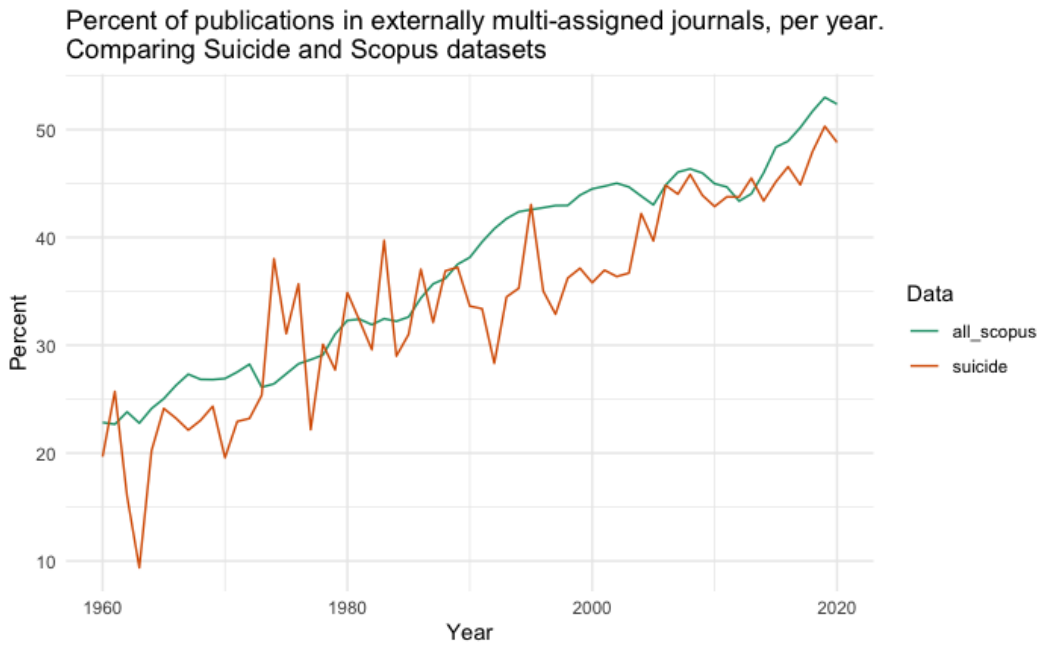


Figure 3-16. Comparison in proportion of publications in multi-assigned journals, all of Scopus vs. Suicide research

Considering the results above, we can say that suicide research has been becoming increasingly interdisciplinary over time. However, in this, it seems to be following overall trends in research and publishing, rather than showing evidence of independently driven integration.

5.2. Publication reference diversity and citation flows

While the Shannon Diversity index of references that I discussed in Section 4.4 does indicate an overall increasing diversity of the suicide research knowledge base, this trend does not take into account either 1) differences across fields of the citing publications or 2) within-publications reference diversity. With respect to the later, it is important to note that even if a journal is multi-disciplinary, that does not mean that articles within it are multidisciplinary themselves—in order

to investigate this, it is important to examine the diversity of references within individual publications. I therefore use the reference classifications to build a 'reference classification vector' for each publication, and then calculate the Shannon Diversity Index (H) for each of those vectors.

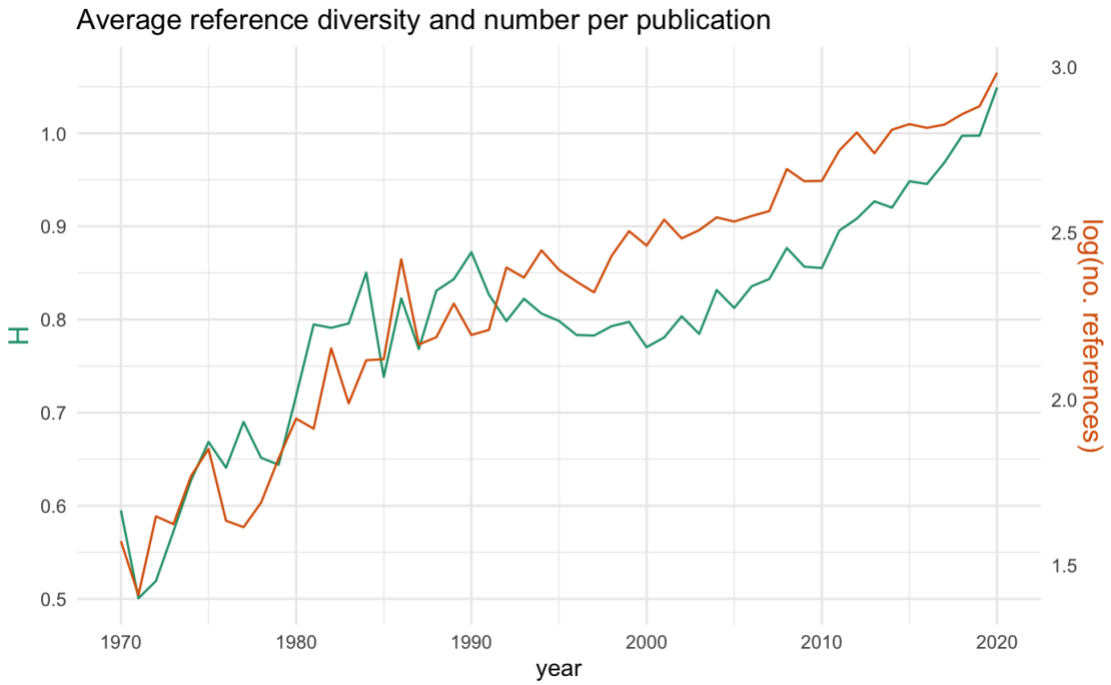


Figure 3-17. Average within-publication reference diversity and average log of the number of references per publication, over time

Taking the average of the H-values for all publications within a year, there seems to be a general increase in diversity of references by publication over time, especially in the period prior to 1990 though this might be in part the artifact of the missingness in the references dataset. The slower but steady increase in the period since 2000 is more likely indicative of actual trends in the literature, as the data coverage is much better in that period. This increase in diversity seems to overall follow the increase in (the log of) the number of references in the record as well, indicating

a relationship between the two (correlation coefficient = 0.536 across the whole dataset). The overall average H-value across the period is 0.9

With the above benchmarks in mind, I look at average diversity across specific publication classifications. The results for the top publication classifications (those that average >1% of publications) are shown in Table 3-5.

Top Classification Publications	Mean number of refs	H	sd(H)	H/ log(n.refs)
Medicine	19.31	0.75	0.405704	0.296951
Medicine; Psychology	27.01	1.00	0.288463	0.328898
Medicine; Neuroscience	29.13	1.03	0.32814	0.352295
Psychology	27.80	1.02	0.324873	0.339026
Social Sciences	20.48	1.02	0.387352	0.399997
Medicine; Social Sciences	20.42	0.97	0.337288	0.364373
Medicine; Nursing	17.58	0.85	0.391074	0.352932
Psychology; Social Sciences	25.56	1.12	0.410238	0.388294
Arts and Humanities; Psychology	23.61	1.12	0.440354	0.426371
Medicine; Psychology; Social Sciences	30.58	1.01	0.285398	0.377683
Nursing	16.81	0.95	0.414288	0.345819
Arts and Humanities; Social Sciences	16.37	0.95	0.244176	0.390471
Biochemistry, Genetics and Molecular Biology; Medicine	16.16	0.82	0.298379	0.322363
Medicine; Pharmacology, Toxicology and Pharmaceutics	23.51	0.89	0.455462	0.336162
Multidisciplinary	26.88	1.05	0.386822	0.343181

Table 3-5. Overall diversity of references by unique field of publication

There are clear differences in the average diversity of references across fields, though some of this is likely due to differences in the number of references (correlation coeff. = 0.63). Accounting for unequal number of references (dividing H by the log of the average number of references), publications in Social Sciences and Arts/Humanities and interdisciplinary Psychology seem to be the most diverse, while the publications in Medicine are the least diverse. That is to say, the former seems to be more interdisciplinary than the latter. Interdisciplinarity on the level of the article is not equally distributed across, or even within unique classifications.

5.3. Flow of citations

After examining interdisciplinarity within individual publications as indicated by the Shannon diversity index, I take a closer look at citation flows across fields and classifications, as I ask what kind of knowledge, if any, is being integrated within particular fields. I examine the patterns of referencing across three combinations of categorization: 1) Field of reference to field of publication (that is what percent of references are in a particular field, per field of publication), 2) Unique classification of publication to unique classification of reference, and 3) Unique classification of publication to field of reference. I plot two version of each of these heat-maps, first one contains raw percentages, and the second one is normalized by the relative proportions of classifications or fields in the references dataset, to better make visible any deviations from the average proportion.

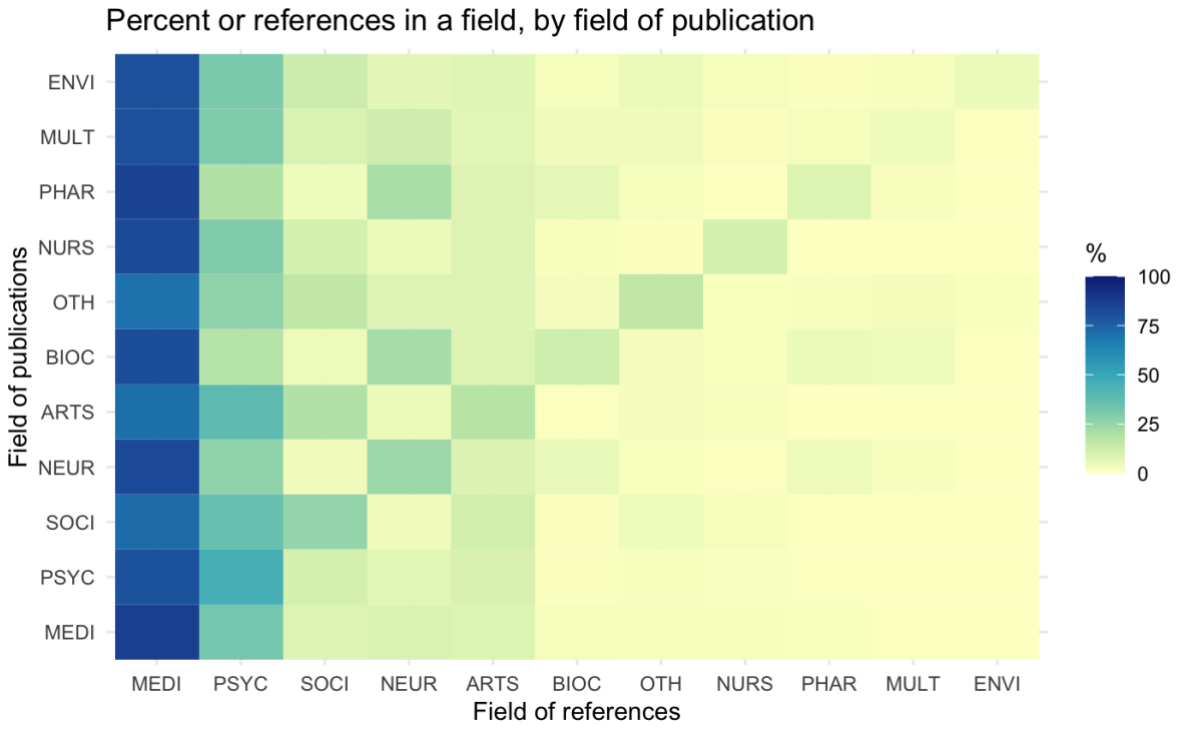


Figure 3-18. Distribution of references, by field of publication and field of reference

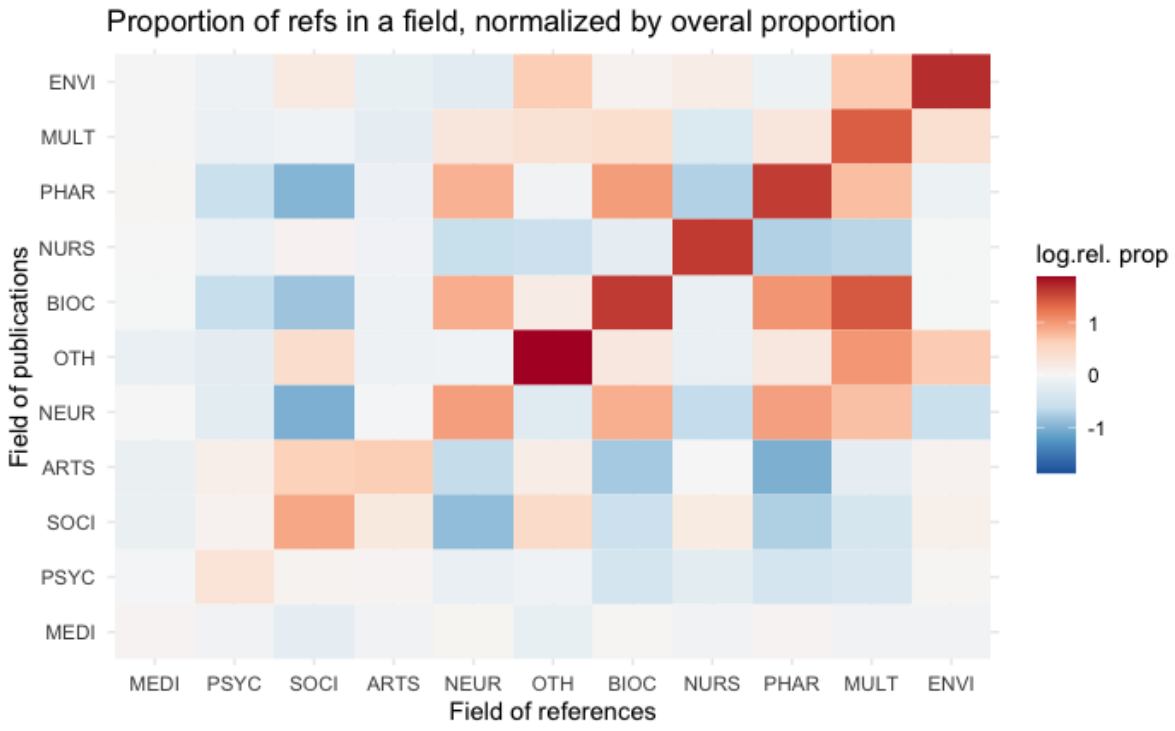


Figure 3-19. Distribution of references, by field of publication and field of reference, normalized by overall reference distribution

A large proportion of the referenced works across all the fields are assigned to Medicine and, to a lesser extent, Psychology, which is not surprising. Taking into account these overall distributions of references, the most significant trend here is that fields disproportionately cite their own work, which is not surprising. Biochemistry/Genetics (BIOC), Pharmacology (PHAR) and Neuroscience (NEUR), are also more likely to cite each other, as well as the Multidiciplinary (MULTI) sources, while they are less likely to cite Nursing (NURS), Social Sciences (SOCI), and Psychology (PSYC).

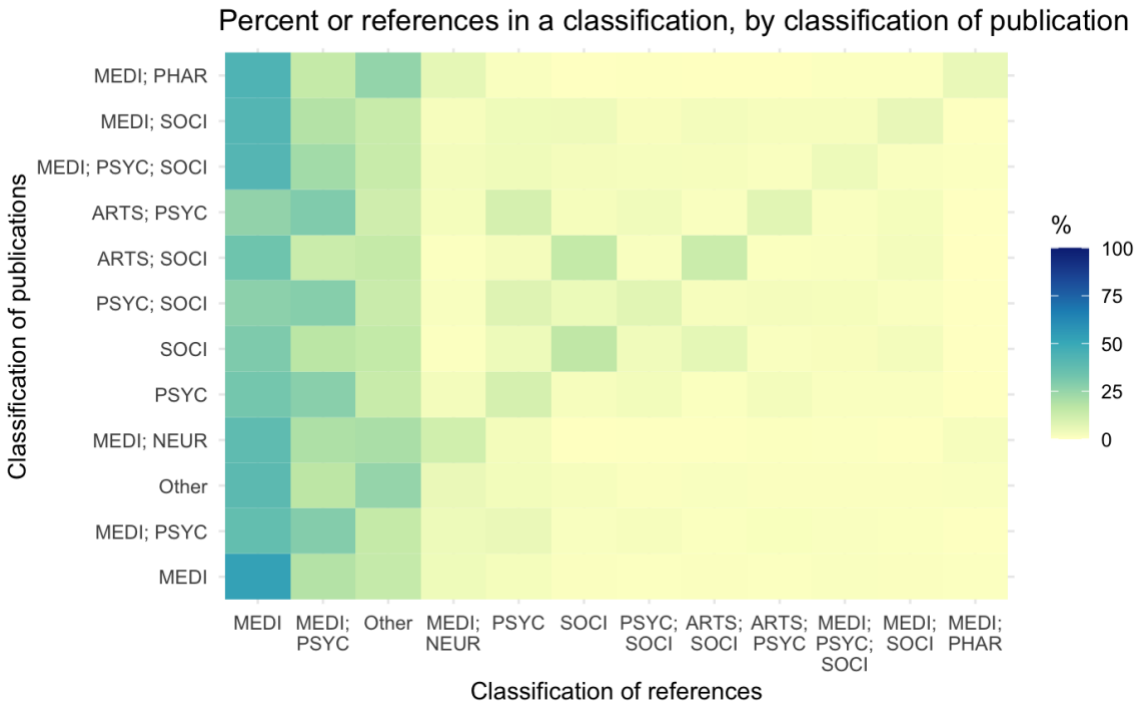


Figure 3-20. Distribution of references, by classification of publications and classification of references

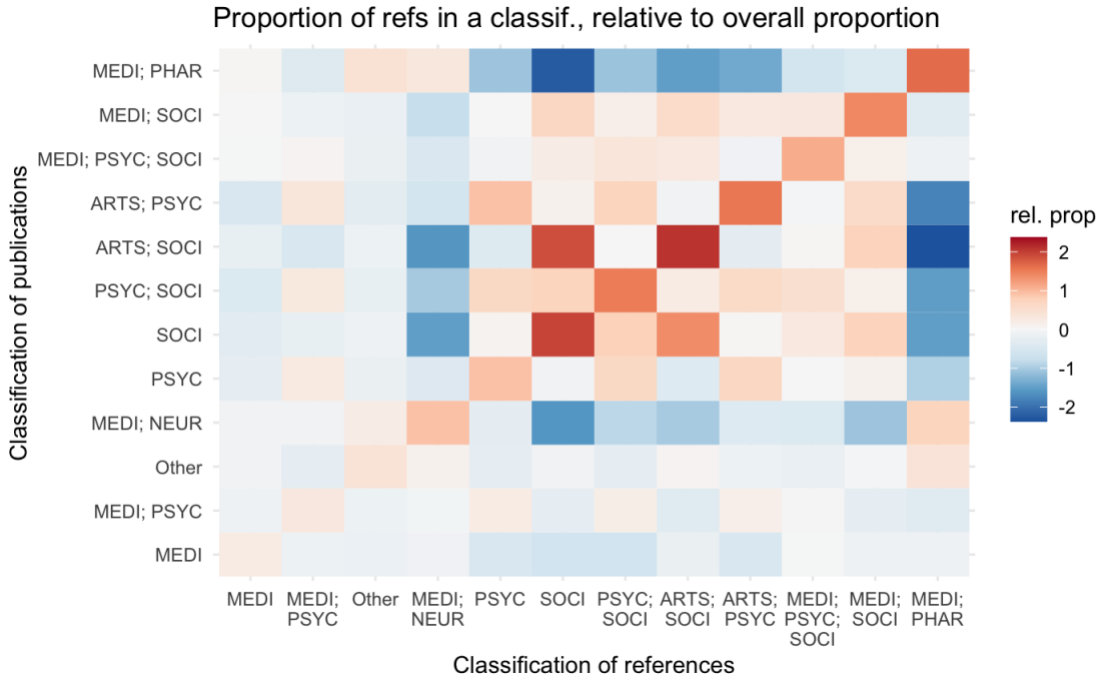


Figure 3-21. Distribution of references, by classification of publications and classification of references, normalized by overall reference distribution

In terms of specific classification, we see further pulling-apart of literatures, with Arts and Humanities and Social sciences on one end, and Neuroscience and Pharmacology on the other. The trends among most common categories, including "Medicine," "Psychology" and "Medicine; psychology" are less extreme, but noticeable. "Medicine; Psychology" is, for example, more likely to cite any classifications with "Psychology" and less likely to cite both Social Sciences and Pharmacology.

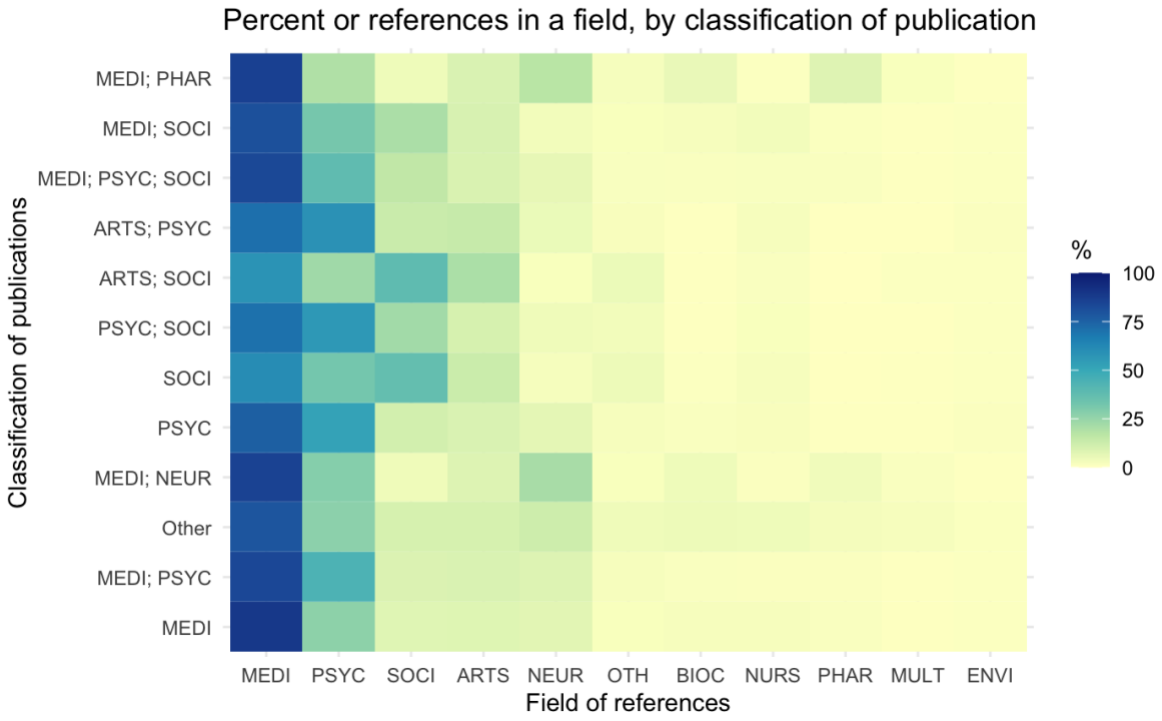


Figure 3-22. Distribution of references, by classification of publications and field of references

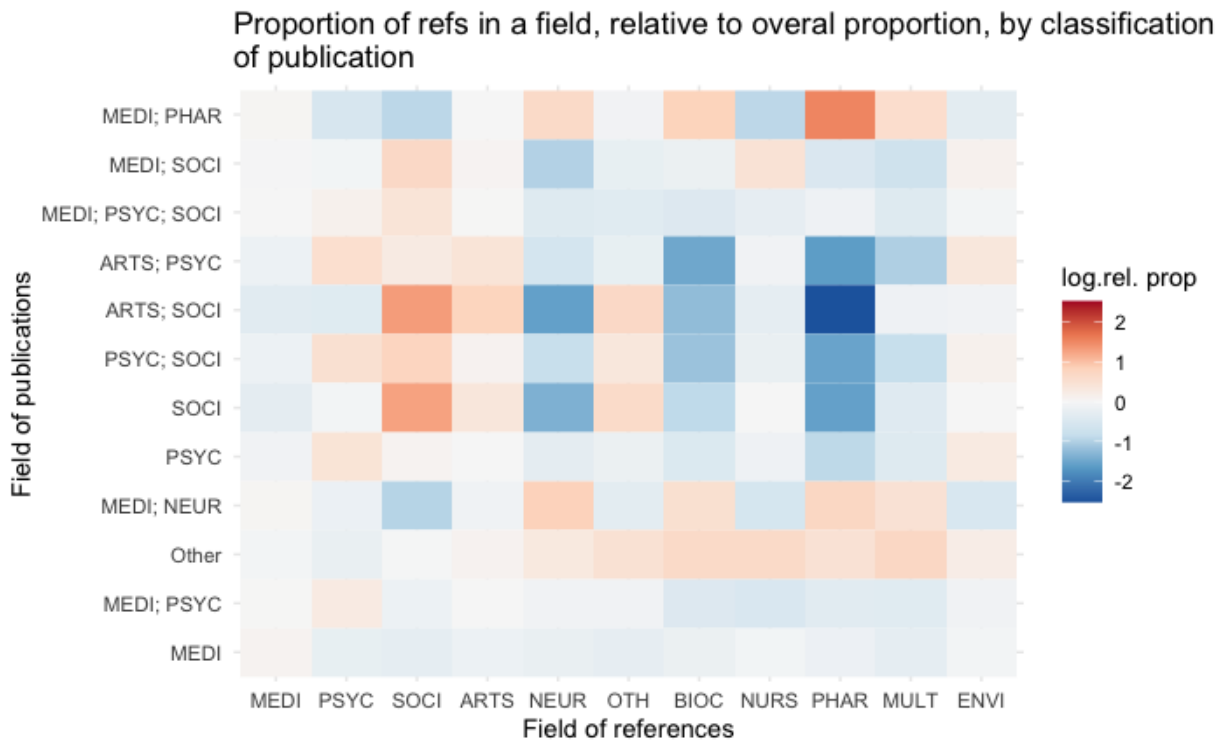


Figure 3-23. Distribution of references, by classification of publications and field of references, normalized by overall reference distribution

Finally, examining the fields of references, across specific classifications of publications, same trends emerge. What might be most visible in this case are the differences between differently co-assigned journals. For example, the publications in "Medicine; Psychology," like those in "Psychology" only, are more likely (compared to Medicine) to reference Psychology, and less likely to reference Biochemistry and Pharmacology. Similarly, "Medicine; Sociology," like "Sociology" is more likely to reference "Sociology" and less likely to reference "Neuroscience" but also, interestingly, is more likely to reference "Nursing" than either of the two fields on their own. This shows that in the spaces of these interdisciplinary source, there might be both mixing of and innovation on the knowledge production practices that characterize the more disciplinary sources.

Overall, the analysis of citation flows shows that different fields do tend to draw on literature from some disciplinary areas more than others. At the same time, they all unavoidably reference work from sources (co)assigned to "Medicine" the most, which is not surprising given that that is where much of the work on suicide is published. While the fact of a work being referenced does not reveal the way it is used—is it simply mentioned, is it integrated, or is it critiqued?—we do see evidence of interdisciplinarity in the data. That said, there are also clear discontinuities, in that the literature in Social Science/Arts and Humanities is not very likely to engage with the literature in Biochemistry/Genetics, Neuroscience (most of the work here is in 'Biological Psychiatry') and Pharmacology, or vice-versa. Ultimately, Medicine and Psychology seem the best position to actually integrate across those two more separate literatures.

5.4. Network Analysis – Coherence

My analyses above reveal some important trends, but they also rely heavily on the ASJC code classifications, which are not just a potential source of error, but also impose existing ideas of and assumptions about disciplines and disciplinary knowledge production, onto the data. To explore the structure of knowledge production about suicide without relying on these designations, I utilize network analysis. In this, I conceptualize disciplines, or relevant "scientific collectivities" primarily not as institutionalized professional entities, but as communities that exist through interaction and knowledge integration (Woolgar, 1976). The network analysis approach, also enables me to examine integration across the field as a whole through measures of network coherence (Leydesdorff & Rafols, 2009)

The network I focus on is the bibliographic-coupling network, that consists of publications (as nodes) connected to one another via edges that indicate the number of shared references. That, is, if a publication 'A' and publication 'B' cite have the same two items appear on both of their reference lists, they are connected with an edge, with a weight = 2. There are two important caveats to this approach. First, due to the Scopus data structuring, some connections might not be detected, even assuming the references of each publication are fully indexed. A single source might have multiple IDs assigned to it and because I use these IDs to build my network, this means that many publications that are in fact connected do not appear as such in the final network, that is I underestimate the connectivity. Second, not all connections are substantive—common data sources or governmental reports might be references without substantive engagement (e.g. simply to say that suicide is the 10th leading cause of death). I adjust for this by excluding edges of weight 1 in a step of my analysis.

Keeping in mind these limitations, I first examine the network coherence by computing a set of metrics for the full bib-coupling network, as well as for the networks that include only the publications in specific decades. I do this both for the network as-is (Table 3-6), and for a network in which I erase all edges with the weight = 1 to focus on more substantive connections (Table 3-7). The variables included in the tables are the following:

- **n.pubs**: number of publications with available references used to build the network
- **bib_nodes**: nodes connected into the network. Nodes without any connection are excluded
- **bib_edges**: number of all edges in the network

- **strength**: strength is calculated for each node, and is the sum of the weight of all of its edges. The table lists the mean and the standard deviation of all node strengths in the network.
- **mean_distance**: this is the average path length, that is the average length of the shortest path between any two nodes in the network (distance between two neighboring nodes = 1). Lower distance indicates an overall better-connected network.
- **density**: this is the proportion of existing edges to all possible edges in the network. Higher density indicates more connections.

network	n.pubs	bib_nodes	bib_edges	mean_strenght	sd_strength	mean_distance	density
1970s	704	617	13702	44.415	44.095	2.368	0.072
1980s	1275	1187	57299	96.544	84.814	2.213	0.081
1990s	3989	3845	458741	238.617	225.368	2.229	0.062
2000s	9929	9587	2520684	525.855	534.372	2.226	0.055
2010s	19778	19390	12606051	1300.263	1231.848	2.105	0.067
full	39759	38950	33548134	1722.626	1759.236	2.166	0.044

Table 3-6. Bibliographic network metrics for complete networks, full and by decades

network	n.pubs	bib_nodes	bib_edges	mean_strenght	sd_strength	mean_distance	density
1970s	704	617	2974.	9.640	14.894	2.955	0.016
1980s	1275	1187	17701	29.825	38.172	2.710	0.025
1990s	3989	3845	132780	69.066	94.995	2.769	0.018
2000s	9929	9587	619200	129.175	193.051	2.679	0.013
2010s	19778	19390	2619784	270.220	389.686	2.549	0.014
full	39759	38950	6629004	340.385	517.384	2.635	0.009

Table 3-7. Bibliographic network metrics for networks, edge weight >1, full and by decades

Over time, the mean strength is clearly increasing, while the mean distance is decreasing, indicating more connectivity. However, this could also be an artifact of a smaller number of well-connected nodes (for example, review-articles), as might be evidenced by the large standard deviation in strength. At the same time, density does not show clear trends, though it seems to be the highest in the 1980s, which might not be surprising given the increase in the size of the

networks (30-fold from 1970s to 2010s) which increases the number of possible edges exponentially.

The different network sizes here represent a significant problem for interpretation, which is why I also compare the 1970s network to the simulated networks of the same size. I do this by sampling the same number of nodes from each of the other networks 100 times, calculating the metrics, and then averaging over the 100 samples. I examine both the complete network (Table 3-8) and the network with edges of weight = 1 removed (Table 3-9).

network	n.pubs	bib_nodes	bib_edges	mean_strenght	sd_strength	mean_distance	density
1970s	704	617	13702.000	44.415	44.095	2.368	0.072
1980s	704	640.4	17170.800	53.624	46.039	2.244	0.084
1990s	704	646.5	14323.520	44.306	40.001	2.378	0.069
2000s	704	631.02	12579.880	39.871	37.872	2.425	0.063
2010s	704	642.29	15869.180	49.414	43.562	2.297	0.077
full	704	624.58	10309.700	33.008	30.778	2.490	0.053

Table 3-8. Bibliographic network metrics for complete simulated networks, full and by decades

network	n.pubs	bib_nodes	bib_edges	mean_strenght	sd_strength	mean_distance	density
1970s	704	617	2974.000	9.640	14.894	2.955	0.016
1980s	704	640.4	5285.050	16.505	20.844	2.810	0.026
1990s	704	646.5	4158.090	12.862	17.255	3.102	0.020
2000s	704	631.02	3081.990	9.769	14.047	3.172	0.016
2010s	704	642.29	3294.990	10.261	14.188	3.116	0.016
full	704	624.58	2015.750	6.454	9.351	3.477	0.010

Table 3-9. Bibliographic network metrics for simulated networks, edge weight>1, full and by decades

Comparing the simulated networks, the 1980s seem to stand out as the overall most cohesive decade, with the largest number of edges, highest density and mean strength, and the shortest mean distance. The cohesion seems to decrease in the 1990s and 2000s, but shows a slight increase in the 2010s. It is likely that, the work in the 1980s drew on what was, at the time, a relatively small literature that most publications cited, and that with the rapid growth of the field in the 1990s and 2000s, including the growing proportion of publications in new fields, the knowledge base got more dispersed. The reversal of the trend in the 2010s might indicate that some shared knowledge base is being established. Compared to the decade networks, the full network is, predictably, the least cohesive as it includes a small number of publications over a large period of time.

As there are not any benchmarks that would allow us to discuss network cohesion in absolute terms, given the data above, we can conclude that the cohesion in the literature has been decreasing across much of the period, and that only in the past decade has is started to increase. This contrasts with the trends towards 'interdisciplinary' publishing that I have identified in the previous section and indicates that multi-assignation of journals, might simply be indicating the development of more specialized journals, rather than increased interaction between fields. Additional analyses could further explore these trends, and could also compare networks of work across different fields.

5.5. Network Analysis – Community detection

Having examined the bibliographic coupling network as a whole, I turn to the question of communities within the network, and ask whether these align with particular disciplines or some other factors, such as topical interests or geographic areas. To identify these communities, I use a multi-level modularity optimization algorithm (function by Gregorovic & Nepusz, n.d. based on Blondel, Guillaume, Lambiotte, & Lefebvre, 2008), which groups well-connected nodes together

through an iterative approach. The driving assumption behind this approach is that papers that cite similar work constitute a particular sphere of knowledge.

The algorithm finds 43 clusters, with the modularity = 0.255. Modularity is positive if there are more connections within nodes of the same kind than we would expect by chance. Comparing this structure to the ASJC unique classifications (291 'clusters', modularity = -0.0045), it is clear that empirically determined communities capture knowledge communities better. Out of the 43 clusters, the vast majority contain only a few articles that do not really belong to the suicide literature and are an artifact of imperfections in the data cleaning process—they feature articles discussing, for example, 'suicide lanes' or 'suicide left ventricle' or 'chromium suicides' (it is supposed to be 'silicides'). The biggest of these 'mistake' clusters numbers 172 articles and contains articles on cancer and suicide genes. These 'mistake' clusters in serve as a proof of concept, as the algorithm successfully identified them as distinct, which is what we would expect due to an overall lack of shared references.

Of the 43, there are 8 significant clusters, the smallest containing 1406 articles and the largest containing 9578 articles. Reading through a random sample of titles within each cluster, I roughly characterized them as noted in Table 3-10. To characterize these clusters, I examine random samples of titles from each cluster and conduct simple topic modeling using articles titles, abstract and keywords, if any. I look at the most frequently used words (excluding stop words and "suicide*"), and also words with the highest tf-idf (term frequency–inverse document frequency), as shown in the Appendix, Figure B-7 and Figure B-8.

Cluster	No.of articles	Selected most common words	Selected most unique words	Characterization
1	8311	risk, patients, health, factors, depression, psychiatric, mental	epilepsy, fda, comorbidity, congential	medical, International/European?
2	6443	ideation, risk, health, depression, attempts, behavior, mental	IPTS (Interpersonal Theory of Suicide), NSSI (non-suicidal self-injury), thwarted belongingness, dbt	Interpersonal Theory of suicide/ Suicide Ideation/ personality/relationships
4	4301	risk, adolescents, ideation, attempts, youth, depression, school, prevention	Latinas, bully, perpetration, lgb, adhd,	Adolescents/youth
5	9587	patients, risk, ideation, depression, rates, social, factors, psychiatric	bombers, terrorist, martyrdom	General/mixed
6	1406	risk, prevention, health, patients, mental, depression, rates,	GKT (gatekeeper training), MVEG (moto vehicle exhaust gas), ADSRA (adolescent depression and suicide risk assessment)	Epidemiology/risk/guide lines/prevention
8	3349	patients, risk, depression, disorder, association	(5-)HIAA, allele, genotype, polymorphism	Genetics/neuroscience
10	2104	risk, ideation, health, prevention, mental, factors, rates	myplan, agrarian, weibo	Epidemiology/ Incidence in different populations
11	3860	assisted, death, physician, euthanasia, patients, media, life, support	eas (euthanasia assisted suicide), requests, pentobarbital, kevorkian	Assisted suicide/euthanasia (bereaved?)

Table 3-10. The largest clusters identified in the bibliographic-coupling network

The clusters seem to represent different foci of research, some of which I would expect to map onto a discipline. Thematically clearest clusters are 4—"Youth and adolescence," 8—"Genetics/neuroscience" and 11—"Assisted suicide/euthanasia" (and possibly work on suicide bereaved), as well as Cluster 2, which seems to be is characterized by the relatively frequent discussion of Thomas Joiner's Interpersonal Theory of Suicide. Clusters 6 and 10 are a bit less clear, but they seem to overall discuss epidemiology and prevalence of suicide, with 6 maybe focusing more on prevention. Finally, Clusters 1 and 5 are the least clear. Cluster 1 seems to

include a lot of work published in medical and psychiatric journals, as well as work in international journals. Cluster 5 seems the most mixed, and, looking at Figure 3-24, seem to contained the vast majority of the early literature, which is why I classify it as 'General'

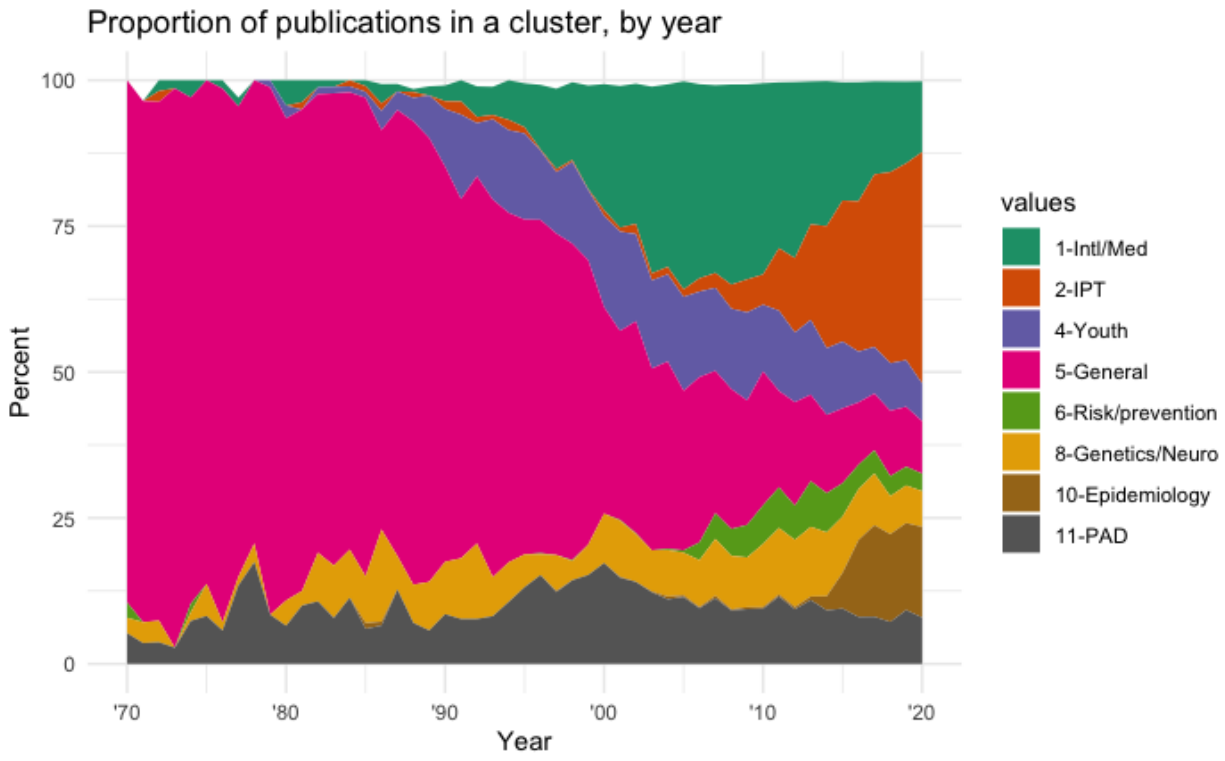


Figure 3-24. Proportion of publications in each of the main clusters over time

The overall trends in proportions of publications that are in each cluster intuitively make sense, as the work published in the 1970s and 1980s likely cited a smaller shared literature, while newer publications, drawing on a much larger field of more recent data, are less connected to some of that older literature. This is especially evident in the growth of the "2-IPT" cluster after 2005, when Joiner's book first laying out the theory was published. Similarly, the "4-Youth" cluster starts appearing in the 1980s with a whole new set of research conducted as the "youth suicide problem" was emerging at the time. This apparent specialization in the literature around particular topics or

approaches likely accounts for the decreasing network coherence that was evident in the previous section. The possibly increasing coherence in the 2010's might be a result of works increasingly connected to one another with respect to Joiner's IPT work, and further investigation should examine the role single publications or sets of publications can have on the network structure of publications.

The eight clusters that I have identified in the suicide literature represent eight sets of publications that are more likely to share references with one another than they are to share references with publications in other clusters. As such, they exist in the literature much in the way we would expect 'disciplines' or 'specialties' to, and based on how I have characterized them through topic-analysis and reading through samples of titles, it does seem that at least one cluster, "8—Genetics/Neuro," does, in fact, map onto a set of disciplines.

To examine the overlap between these empirically determined clusters, and the ASJC classifications, I look at the distribution of publications across the top 18 fields within each cluster (Figure 3-25), and then also normalizing by the overall distribution (Figure 3-26). Right away, it is evident that publications in cluster 8 are, more likely to be in sources (co)assigned to "Neuroscience," "Biochemistry, Genetics, Molecular Biology" and "Pharmacology, Toxicology and Pharmaceutics," and "Immunology and Microbiology" while less likely to be in sources (co)assigned to "Social Sciences," "Arts and Humanities," "Nursing" and "Math." Another cluster that shows some interesting disciplinary trends is 10, which I have designated as 'Epidemiology' and which seems more likely to be in sources (co)assigned to field such as "Environmental

Science," "Multidisciplinary", "Economic," "Computer Science" and "Math," possibly pointing to a focus on quantitative methodology, as compared to Cluster 6 which seems otherwise similar. While there a variety of other trends that can be read off of the chart below, however, what maybe stands out the most is that most of all the clusters do contain publications from across the participating fields, indicating that they are more likely to be, in part, 'thematic' than 'disciplinary,' though different themes might draw more strongly on some disciplines rather than others. "11-PAD," for example is less likely than average to draw on Neuroscience and Psychology, while more likely to draw on Nursing, Social Sciences, Arts& Humanities and Biochemistry, while "4-Adolescence" is less likely to raw on Neuroscience, Biochemistry, Arts& Humanities and Nursing, while more likely to draw on Psychology, Social Sciences, and Health Professions.

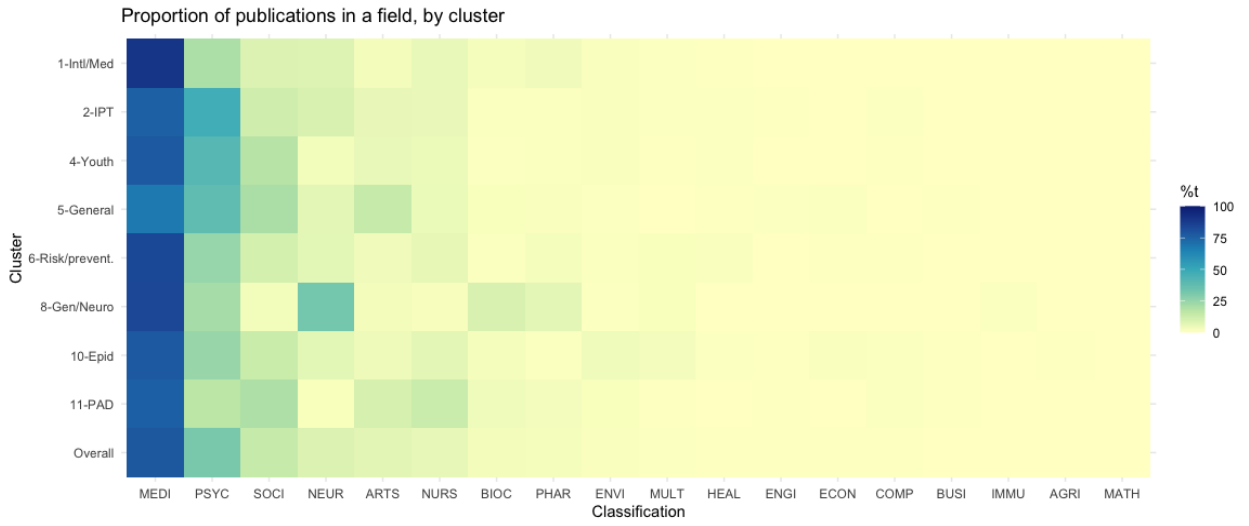


Figure 3-25. Distribution of publication across fields of publication, by cluster

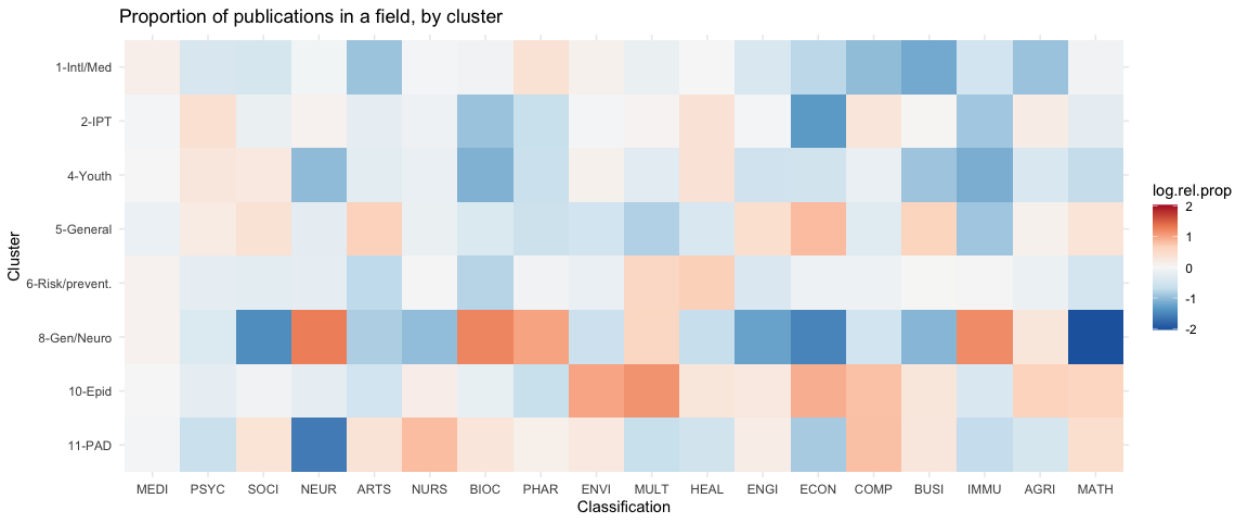


Figure 3-26. Relative distribution of publication across fields of publication, by cluster

5.6. Section Summary

Based on the series of analyses above, there is little evidence of 'disciplinary silos' in the overall literature on suicide, with the exception of work in the realm of Neuroscience and Genetics that seems less integrated with the rest of the literature. Most evident clusters within the knowledge production on suicide seem to be thematic and, while not uniformly drawing on all different disciplines, are not overwhelmingly discipline-specific. It is this diversification in specific interests within suicide that also decreases the overall cohesiveness of the knowledge production over time, which we would expect in a growing area of inquiry.

However, this lack of evidence of silos is not necessarily evidence of lack—the fact that such a large proportion on literature is published within medicine, psychology, or the combination of the two, affects both the production of knowledge in other fields, as well as the analysis itself. In terms of knowledge production, any works outside of these fields likely has to position itself within the existing literature by citing it and therefore integrating itself into the existing structure, as the

situation here is not of different fields already producing knowledge on the topic coming together. In terms of analysis, in order to reveal differences in trends, I compare each field or classification to an 'average publication' which is ultimately very similar to a publication in Medicine/Psychology, which makes it difficult to visualize any patterns within those two fields. Therefore "Medicine" appears to cite works from fields other than medicine a bit less frequently that an average article would, but the average article has limited engagement with these other fields. Integration is, therefore, limited by the availability of things to integrate.

6. DISCUSSION

In this chapter, my goal was to examine the diversity of disciplines that participate in the production of knowledge on suicide, to characterize the interaction between these disciplines and look for any patterns over time. My analysis reveals that majority of the work on suicide in published under a broad umbrella of Medicine, and especially psychiatry, though this umbrella, overtime diversifies with specialties that form in interaction with other fields (e.g. Neuroscience, Clinical Psychology, etc.) following broader trends in science. At the same time, there is also evidence of overall diversification, especially with the growing proportion of literature being published in Clinical Psychology. Some of the diversification also appears to be topical as the literature develops in clusters seemingly centered about particular interests, while still being spread out across different fields. This kind of distributed participation of various fields around a common interest is not uncommon in fields that are built around solving a perceived problem (Klein, 1996, pp. 38-40).

Characterized as such, if we were to think of suicide research within the framework offered by Rafols and Meyer (2010) as presented in Table 3-1, increasing network diversity and decreasing coherence indicate a move from a more 'specialized disciplinary' space to that of 'potential interdisciplinary integration,' or maybe a specialty existing mainly at the intersection of Medicine and Psychology (Psychiatry and Clinical psychology), if two fields is enough to constitute diversity.

In this context, the discussions of interdisciplinarity in suicidology seem a bit pre-mature, in that the calls for bridging perspectives assume established independently operating perspectives that can be bridged, but the field still seems to be developing this diversity. This is not to say that this move necessarily has to occur through the development of separate fields that come to integrate, but might occur through increasing diversification while keeping coherence high, which seems like a likely pathway in an era in which the knowledge production seems to increasingly occur in interdisciplinary journals, and in case of suicide as a 'problem' which encourages interdisciplinary interaction (Klein, 1996, pp. 38-40).

Of course, the volume of publications is not the only important factor. Future work should consider the number of citations an article has received and pay attention to publications with high centrality. Furthermore, the question of where work is published is one part of the landscape, the question of who is producing the knowledge might be more relevant. Examining co-authorships and publication trends based on the authors' disciplines will reveal additional patterns, both with respect to the kinds of knowledge that is being produced, as well as the practices of publishing.

Overall, my findings are consistent with previous work that underlines the importance of medicalization for contemporary 'suicide' (e.g. Kushner, 1991; Marsh, 2010). However, they also show that the medicalization is not and end-state, but a part of the process. The context in which knowledge about suicide is produced, as well as who is producing is continuously shifting, and — if we are to judge by the apparent success of Joiner's (Joiner, 2005; Van Orden, et al., 2010) Interpersonal Theory of Suicide—the field as a whole is susceptible to significant changes as a result of impactful individual contributions. Considering the various calls for change within suicidology, and multiple critical voices, it will be interesting to see how the field continues to develop.

Conclusion

My dissertation, in its current form, emerged through a series of twist and turns. My initial experience in the field made me feel like I was witnessing a particularly interesting moment: the debates regarding best ways of studying suicide, or even the definition of suicide itself, heated discussions regarding the role of mental illness on the suicidology listserv, coordination among new stake-holders and political rallies, they all pointed to some change on the horizon, a tipping point I was determined to catch. However, as I endeavored to better understand some of these new developments—and there definitely is something *new* about them—I also came to realize that there are in no way unique. Looking through old newspaper articles, scientific publications and historical texts, I have come to notice patterns and repetitions, similarities in arguments and tensions. The more I looked at it, 'suicide' seemed more and more like a continuous project of coming to terms with some deeply existential and moral questions, albeit one shaped by the values, technologies, and social structures of any one time.

To think about this project of constructing 'suicide,' I started to theorize it as a practice of 'containment,' a communal endeavor to take that which is anomalous or threatening, bad or painful and make it manageable through imposition of boundaries and offered explanations. I have also proposed a new analytical term—ipsal deaths—so as to avoid the specific and quite charged meanings of 'suicide' as well as the definitions embedded in other commonly used terms such as 'self-inflicted' or 'voluntary death.' I use ipsal deaths as a neutral and purposefully vague term

that refers to a complete set of deaths that could be understood in a given context as caused, in part, by the deceased. To grasp contemporary suicide, I reasoned, I would need to take a few steps back, I would need to understand it as an instance of these attempts to contain more general—if not ubiquitous—concerns about particular kinds of ipsal deaths, and I would need to understand some of the specificities of the current context that shape this containment in a particular way.

The existing literature on suicide offers insight into some of my questions, but also opens additional ones. The extensive historical and cross-cultural analyses of suicide, for example highlights two things: 1) concerns about individuals playing a role in their own death (what I have called ipsal deaths) exist and have existed across history and across the world and 2) how people categorize these ipsal deaths and the attitudes they have towards them differ across these contexts, revealing that categories like 'suicide' are socially constructed. None of these analyses, however, ask about the similarities in these differences, or patterns that transcend temporal and geographic boundaries. If ipsal deaths emerge as matters of concern at many different times and in various places, are there any commonalities in how they are categorized or understood? Is contemporary 'suicide' *sui generis*, or are there aspects of it that are shared across human cultures?

Much of this previous work has focused specifically on the Western history, showing how contextual understandings of ipsal deaths in Ancient times were replaced by a condemnation of self-murder by the Church in the Middle Ages, which with time transformed to the highly medicalized notion of 'suicide' that is prevalent in the US, and much of the world, today. This change in conceptualization of certain ipsal deaths over time provides clear foundation for our understanding of contemporary suicide, but it also does not tell the whole story. Most histories end

with medicalization of suicide in the late 19th c, or at best follow suicide into the 1980s and emphasize the dominance of psychiatry, or the amalgam of psychiatry and clinical psychology, over suicide as a phenomenon. However, the story does not end there, and it does not explain how the medicalized suicide became a 'national problem' nor does it capture the full extent of the disciplinary developments over the past 40+ years. Building on the existing literature, my work fills some of these gaps that I have identified and makes the following contributions.

First, examining large set of texts on ipsal deaths I have identified the central tension that makes ipsal deaths problematic: the conflict between the expectations that an individual should live (and even their duty to do so *vis a vis* their community) and an understanding that in some cases the individual can be justified in bringing about their own death. Discourses on ipsal death frequently affirm the former, and then draw moral boundaries with respect to the latter, containing any concerns to a specific circumscribed set. Many scientific efforts to define 'suicide' have this same function—even if this work is less explicit—and reveal the moral aspect of scientific endeavors. The resulting categories of the unjustified ipsal death, as a bad event, is entwined with the understandings of what caused it and who or what is responsible for it. Again, this appears to serve to 'contain' concerns over ipsal deaths by making sense of them and providing guidance for social action – namely *to prevent suicide*. I posit a set of possible loci of causality in these cases, and argue that some trigger blame or social sanctions more easily than others, noting that they relate to broader cultural beliefs and values. Specifically, identifiable social agents can be blamed for acting a certain way, but if the primary cause is understood to be outside of the reach of social action, such as supernatural entities or mental illness, responsibility to mitigate these external influences can be more diffuse. Additionally, I also argue that the discourse about *society* causing

suicide that emerges at the end of the 19th century in Europe and North America represents a unique development that effectively intervenes in the central tension of ipsal deaths by positing, in addition to the individual's duty to live, the society's duty to enable the individual to live well. It is this additional dimension that, I argue, plays an important role in the emergence of suicide as a 'public problem,' and also contributes to disciplinary tensions within the scientific study of suicide, with different disciplines emphasizing different loci of causality. In this context, scientific claims about causes of suicide emerge as inherently political.

Second, in tracing the developments of suicide as a public problem in the 20th century US, I show that central to the concerns about the problem of suicide are the suicide rates, which make suicide visible in the aggregate, and make the idea of 'too much suicide' imaginable. The problem of the 'suicide excess,' already emerging as a concern at the end of the 19th century, however, does not seem to have been a powerful enough force to successfully hold the public attention. Rather, it was 'suicide' understood as affecting large numbers of people—in additional to the deceased—that finally saw it recognized as a national problem at the end of the 20th century. This understanding developed, at least in part, due to concerns with youth suicide and youth suicide clusters that peaked in the 1980s and the related political mobilization of the suicide bereaved in the 1990s. A variety of professional organizations and governmental institutions that have developed during that time, as well as in the preceding decades, did provide the infrastructure and the data necessary to make particular claims about suicide. However, the emotional dimension of suicide—grief after a loss or fear of loss—seem to have played an equally significant role in establishing it as a matter of national concern. The processes through which suicide was recognized as 'national problem' as well as related activities, could, therefore, be understood as containing and directing the emotions

produced by ‘suicide.’ Additionally, I argue that in offering a structure through which claims can be made, and taking on political responsibility for suicide, the State also becomes an arbiter of ascribing causal responsibility for suicide. As such, it can deflect any claims that emerge out of the understanding of suicide as caused by society.

Finally, I also turn my gaze to the science of suicide specifically, as I ask how ‘suicide’ exists within the scientific knowledge production of suicide as a whole, and what role particular disciplines might be playing in containing it. By leveraging the power of computational analysis, I am able to capture large-scale patterns in publications on suicide. While previous studies have relied on much more limited samples, focusing on suicidology journals (Cardinal, 2008; Goldblatt, Schechter, Maltsberger, & Ronningstam, 2012) or have discussed broad conceptual differences irrespective of the volume of contributions or changes over time (Fitzpatrick, Hooker, & Kerridge, 2015; Maung, 2020), my analysis characterizes the literature on suicide as a whole. Consistent with previous work, I find Medicine, and Psychiatry especially, to dominate the literature in volume, though with increasing disciplinary and thematic diversification in the past two decades. Some of this trend can be accounted for by general trends in research and scientific publishing, but there is clear evidence of increasing participation of Clinical Psychology and, to a lesser extent, fields like Neuroscience and Nursing. My analysis also shows that, within Psychiatry and Clinical Psychology, the interest in suicide has been increasing over time, possibly paralleling increased public and political interest in suicide, as well as—in case of Clinical Psychology—developments within suicidology. Furthermore, in examining any boundaries that emerge in citation flows, I found there to be a clear lack of integration between Social Sciences and Arts and Humanities on one side, and Neuroscience and Pharmacology on the other. This would indicate that it is actually

the large producers of knowledge, Medicine and Psychology—which already draw on both of these poles—might be best positioned to integrate knowledge from those two sides.

Taken as a whole, my dissertation also reveals what I would characterize as struggles in grappling with the social, especially within the modern Western context. Throughout my chapters, the place society has within the discourse around suicide continuously emerges as complicated and strained. Within the moral problem of ipsal deaths themselves, the social represents an important pole—ipsal deaths can be seen as a transgression against others, or society as a whole, but they can also be understood as caused by others or society as a whole. In the 20th century suicide is emerging as a public—as a National—problem, predominantly out of concerns with social rates of suicide, and occasionally framed with respect to some social processes (e.g. media influence) or more general social conditions (e.g. destitution, family stability, values etc.) At the same time, the frames that ascribe causal responsibility to society do not seem to find purchase, and the interest in suicide within the social sciences is very limited—the vast majority of knowledge production about suicide occurs within disciplines that focus on the individual. In the context of this dissertation, I do not highlight this as a form of critique necessarily but as an observation, as I contemplate the political aspects of 'containment.' There is clearly something to be said here, about 'suicide' being contained within the individual—after all, the alternative might be, as Charles Wilfred Mowbray encouraged one to do over 125 years ago, striking at society itself (Mowbray, 1894, p. 49).

Limitations

The current project, while revealing some interesting patterns and providing more detail to the story of contemporary suicide, is limited in its scope and the certainty with which it can make any claims.

The data that each chapter is based on is not comprehensive. While extensive, the Ethics of Suicide Digital Archive and the additional work that I have added to the corpus do not contain samples of every kind of possible discourse on suicide, nor is this necessarily a closed set that could be analyzed. In Chapter 2, I draw conclusions based only on singular media publication, the New York Times, and have been mostly restricted to working with already digitized documents. In order to confidently discuss trends in the public discourse on suicide, it would be prudent to examine a greater diversity of sources. Additionally, I have encountered significant difficulties in some of my investigation and am aware of various gaps I have simply not been able to fill as of yet. For example, while a very interesting endeavor, there is little information available about the Committee for the Study of Suicide that operated in the 1930s (more might be available in the Gregory Zilboorg Papers, n.d. archive at Yale), including the specific circumstances of its formation and dissolution. The factors behind the organizational 'collapse' in the late 1980s, when youth suicide oriented NCYSP, YSNC and the Suicide Research Unit at the NIMH disappear, are also very unclear. Given the importance of 'youth suicide' for the development of suicide as a public problem, it would be important to understand exactly how and why these groups stopped their operations. Finally, as I have already discussed in Chapter 3, my publication dataset, and especially my references dataset, are certainly not complete. Scopus does not index all journals, and it does not index many books, while its coverage of references is quite limited, especially prior

to 2000s. While some of the missingness might be random (see Appendix A) there might also be systemic biases that impact my analysis.

Furthermore, there are also limitations inherent in my analyses. My engagement with historical texts is based on only lightly contextualized translations and is as such susceptible to misinterpretations. As much as I try to make up for that lack of context in Chapter 2, where I engage with suicide in the US in significant detail, here I still omit—or only briefly discuss—important factors and developments. Most notably, turn of the century discussions show clear ties to concerns about 'the good of the race' and 'eugenics,' which are topics I have not yet had time to familiarize myself with and did not feel comfortable tackling in detail. Then, in Chapter 3, I do base much of my analysis on ASJC codes, while noting various inconsistencies in the existing system. While a convenient analytical tool, the codes might be skewing or obscuring relevant trends, and present only a part of the picture. I propose alternative approaches in the next section.

Future directions

In many ways, my current project seeks to lay the foundation for future discussions and analyses. Each section can be expanded on its own, and there is space to move forward with the project as a whole as well. There are four directions that I feel could be very productive for further investigation.

First, in terms of ascription of blame and responsibility for bad ipsal deaths, my analytical frame emphasized these processes as important to the position suicide takes in society. While there has been some work published on blame as a response to suicide deaths (e.g. Matthews, 2008; Kendall

& Wiles, 2010; Testoni, Francescon, De Leo, Santini, & Zamperini, 2019), this is overall a very underdressed topic within the field. This kind of an investigation is clearly sensitive, especially with respect to the well-being of the suicide bereaved, however that might make it an even more important object of study. Further studies of suicide loss, as well as detailed case-studies of relevant legal cases, media coverage and political action can illuminate the way blame is—or is not—activated following particular suicides. Are there attempts to ascribe blame to particular actors, or society as a that turn out unsuccessful? If so, how are they made ineffective? Or, maybe more broadly, what is the relationship between the medicalization of suicide and social blame? In that vein, it might be fruitful to further explore some of the broad differences I noticed between the Western and the non-Western tradition, the former being less likely to ascribe responsibility for ipsal deaths to other social agents.

Second, thinking further about suicide as a public problem, the most obvious next step would be to examine developments after the year 2000. The past 20 years have been packed with activity and I stopped my analysis with the passing of the *Resolution recognizing suicide as a national problem*, in part due to constraints of space and time. I hope, however, to expand this part of my study into the current times, examining in more detail the actual effects of the resolution, centering of new concerns (e.g. suicide in veterans) as well as tracing the emergence of new stakeholder groups (specifically suicide attempt survivors). It is these recent developments that truly shape contemporary suicide and that can illuminate the way concerns about suicide are intersecting with movements that emphasize lived experience, identity, importance of marginalized voices as well as structural factors that shape a variety of outcomes, including suicide. In this context, suicide can

again prove to be an interesting case through which the relationships between individuals, as well as between individuals and society, are being worked out.

Third, having acknowledged the limitations of my publication analysis with respect to the analytical categories of 'disciplines' I would like to conduct further analyses that approach the questions of disciplines from multiple directions. For example, I could use each author's corpus of publications to infer individual author's discipline, and I could also take advantage of network analysis to examine co-authorship relationships. These additional analyses would not only provide further insight into the production of knowledge about suicide but, compared to the current analysis mostly based on established ASJC codes, could also be used to critique to ASJC-code approach in itself, which would be of more general significance to the field of publication analysis.

Finally, having engaged extensively with suicide, it would likely be very productive to test some of my insights and conclusions against other phenomena. How do patterns of blame in cases of suicide compare to blame in response to some other events? How does disciplinary engagement with suicide compare with patterns of research on something like violence and homicide, or depression and mental illness, poverty and suffering, or moral dilemmas and ethics? Is 'containment' a useful analytic and if so how could we investigate it more empirically and in what contexts?

The last question stands out particularly in the current context—as the world is grappling with worries over the current and future pandemics, global warming, structural inequalities and the economic order (among many others), we are regularly confronted with the questions of life and

death, of our duties towards one another, of the value of individual existence and the future of humanity as a whole. At the same time, culture and social organizations have come under increased scrutiny as obstacles to, rather than facilitators of, our collective ability to grapple with today's challenges. Work that helps us better understand the tensions between certainty and clarity that might be necessary for successful containment on one hand, and uncertainty and ambiguity that characterize scientific exploration on the other, might aid us—as scientists and as people—in navigating the current and future landscape.

Appendix A: Methods

1. ETHNOGRAPHY

I conducted my ethnographic observations in both physical and virtual spaces. Suicide-related conferences, as sites at which new knowledge is communicated and different perspectives are negotiated. I have attended the following conferences:

- American Association of Suicidology: 2018, 2019 and (virtually) 2020
- International Academy of Suicide Research: 2017
- Kevin's Song Conference: 2017 (Note, Kevin's Song is a non-profit organization in Michigan, founded by parents who have lost their son, Kevin, to suicide)
- Suicide Prevention Coalition of Colorado's "Bridging the Divide: Suicide Awareness and prevention Summit" (2018)

At the conferences I attended all the main events, and have selected sessions based on the topic, often looking for the sessions that were oriented at some new developments, technologies, controversies or theories, while also making sure I cover different kinds of sessions, including those oriented at survivors, or crisis workers. I took notes on the content of the sessions, also utilizing photography to capture relevant slides, as well as approximate audience size and participation. Throughout the conference, I also visited all exhibition tables and the bookstore, cataloguing the kinds of materials available, and have gathered conference room information when possible so that I could later study patterns of room allocation. My participation was the most intensive at the AAS conferences, where I also volunteered prior to the conference and during

registration (which helped me make connections with individuals who are highly engaged with the organizations), helped moderate a keynote debate, served as a 'conference buddy,' volunteered during the abstract selection process, spoke on a student panel and presented my own work. I took notes throughout, frequently reflecting on my own experience in the space.

Outside of the conferences, I was also subscribed to the AAS-affiliated suicidology listserv (and have also conducted some analyses of its archives) as well as the critical suicidology listserv, so as to keep track of ongoing developments in the field. I have browsed through AAS social media, and have conducted two rounds of LivingWorks ASSIST training,

2. INTERVIEWS

In addition to my ethnographic work, I conducted interviews with 16 individuals, including current and past presidents of AAS, some influential researchers or other relevant figures. I have reached out to those specific individuals due to their organizational knowledge and/or unique perspective on the field of suicidology. All but one of these interviews were conducted over the phone/Skype or Zoom and they lasted 60-120 minutes. They were recorded and later transcribed with the assistance of TEMI software (Temi, n.d.). The interviews were semi-structured, and inquired about the participant's background and career as related to their work on suicide, thoughts about the current state of suicidology, assumptions about suicide and hopes for the future of suicide prevention.

3. HISTORICAL TEXTS

My corpus of texts that id raw on in Chapter 1 consists of:

- 230 documents from the Ethics of Suicide Archive, 130 original texts dated historical texts and 100 excerpts from ethnographic sources
- 67 complete texts, the excerpts of which are present in the archive. Many of these are volumes written with the sole purpose of discussing 'self-murder' or 'suicide' etc.
- About a dozen texts that do not appear in the archive, that I have come across in my research, including, for example, Murasaki Shikibu's *Tale of Genji* written in 11th c Japan, the *Dialogue on miracles* by Caesarius of Heisterbach written in the early 13th c in Germany, and some early 17th c Christian 'self-help books.'
- 39 'contemporary' texts, including explicit discussions of definitions, theory-establishing papers and books, critiques of the said theories as well as sources on 'suicide' as manslaughter and 'overwork suicide' in Japan.

To analyze these texts, I have imported all of them into MaxQDA11 (VERBI Software, 2015) and conducted multiple rounds of qualitative coding. I used a mix of focused coding for theoretically-inspired themes and open-coding for emergent themes, following the framework of abductive analysis (Timmermans & Tavory, 2012). In the first round, I read through the sources and coded for general themes I was interested in, such as "evaluation good/bad", "boundary drawing", "causes", "goal/framing of work." In the following reads, focusing on a select part of my corpus that featured relevant themes, I developed a more elaborate focused coding scheme to 1) differentiate types of text ("legal", "religious", "philosophy", "science" - they can overlap) 2) to capture some of the rhetoric, e.g. references to "unnatural act," "against god," "against

society/others," "right to die" 3) trace specific kinds of cases that were distinguished, including "widow," "disease/old age," "insanity/madness," "wish to die," and 4) to capture a sort of 'genre' of a text on suicide, I followed specific pieces that would frequently appear, especially in more modern literature, including "definition," "typology," "suicide problem," "reflection on history," "mentions of other places," "explanations." I use these codes to orient myself in the text, though they are currently not exhaustive enough for enumeration to be appropriate.

4. ARCHIVAL RESEARCH

In my investigation of the developments in the 20th century, I draw on a variety of sources including

- Congress bills and hearings, accessed through ProQuest Congressional (ProQuest, n.d.), and occasionally Google Books (Google, n.d.)
- Different institutional reports, as accessed through ERIC (n.d.) and CDC Stacks (CDC, n.d.a)
- Documents and publications as archived by the Internet Archive (Internet Archive, n.d.)
- Relevant books and articles
- The New York Times Archive (NYT, n.d.a)
- Suicidology Bulletin and AAS Newslink as obtained from the AAS
- Conference programs, proceedings and other organizational publications and documents that I have digitized myself at the AAS office

I have imported many of these documents or their selection into MaxQDA11 (VERBI Software, 2015) and used the qualitative coding option to keep track of relevant stakeholders, events, mentions of different issues etc.

To explore some trends, I have also used the Google Ngrams viwer (Jean-Baptiste, et al., 2011) for some of my visualizations, including screenshots of existing outputs. The Ngram viewer utilizes the extensive Google Books corpus to plot mentions of a word or a word sequence (so-called n-gram) relative to other words in the corpus.

5. COMPUTATIONAL ANALYSES

I conduct all of my computational work in R (R Core Team, 2019) and utilize the following packages:

- **tidyverse** (Wickham, et al., 2019) for data wrangling and generating visualizations
- **RColorBrewer** (Neuwirth, 2014) for specific color pallets
- **jsonlite** (Ooms, 2014) API data retrieval
- **rvest** (Wickham, 2019) for html scraping
- **igraph** (Csardi & Nepusz, 2006) for network analysis
- **tidytext** (Silge & Robinson) for topic modeling

5.1.The New York Times

To generate plots of the NYT publication trends over time, I utilized the New York Times API (NYT, n.d.b), looking for 1) any publications whose headline included any of the following terms "suicide," "kill* himself," "kill* herself", "kill* oneself," "take|took own life," excluding mentions of terrorism or bombings; and 2) total number of articles per year, which allowed me to determine the percent of articles per year that mentioned suicide.

To examine trends by theme, I looked for different keywords in the available article content (headline, snippet, and lead paragraph), as follows:

- **Youth**: adolesc OR youth OR schoo OR juvenile OR teen-age OR teenage
- **Military**: military OR army OR veteran OR soldier OR marine
- **Econ**: economy OR finance OR poo OR poverty OR destitu OR money OR unemploy OR out of work OR bankrupt OR debt
- **Insane:** insane OR insanity OR mad OR madness OR depressed OR melanchol

5.2. Suicide rates

I have generated plots on US suicide rates over time using a Shiny application I have developed (Miklin, 2020) based on CDC data that I have compiled. For more information about the data and the processing, see the "Data" section of the application.

5.3. Funding

Suicide research and prevention funding over time, combining data from the following sources:

- American Foundation for Suicide Prevention grants (AFSP, n.d.)
- National Institutes of Health (NIH, n.d.)
- Department of Defense's Defense Health Program (DOD, n.d.)
- US Health and Human Services (HHS, n.d.)
- National Institute of Justice Awards (NIJ, n.d.)
- National Science Foundation (NSF, n.d.)
- USA Spending website (USA Spending, n.d.)

There is overlap within the governmental data, with USA spending website listing many projects also available in other databases, and I utilized this redundancy to better ensure comprehensiveness. While there are other private funding sources, AFSP is the largest non-governmental body funding suicide-related research and is therefore included on the list. See a report by the National Action Alliance for Suicide Prevention (2015) for a more detailed overview of the funding in the period 2008-2013

5.4. Publication Analysis

5.4.1. Building the 'publications on suicide database'

Working in R, I used the Scopus API (Elsevier, n.d.) to build the database of sources ranging from 1850 to 2020 (N= 56484) that have "suicid*" in the title (to include suicide/suicidal/suicidality) and exclude articles that are on the topics of 1) cell suicide/apoptosis, 2) silicides (silicon-based compounds, which somehow keep creeping into my search results) or 3) non-suicidal self-injury.

There are some issues with strategy, including

- Not all sources on suicide have to have 'suicide' in the title, but I assume that vast majority do.
- My search does capture some articles not on suicide, but rather on 'suicide lanes', 'suicide ventricles,' with a few still on 'cell suicide' or even 'silicides' (a type of silicon compound). I cleaned most of these out by hand after scraping but have some 'leftovers.'
- Not all indexed 'publications' are of the same kind, which on one hand does allow me to capture greater variety of content. I proceed with the full dataset in my analysis

subtype	n
Article	42494
Review	4204
Letter	3043
Note	1777
Chapter	1644
Editorial	1119
Conference Paper	1009
Short Survey	621
Erratum	369
Book	166

Table A-1. Publications in Scopus by type

- Considering only the articles (N= 42,494) for which I have reliable language data, we also see that many of these items are not in English. Looking at the information about the journals provided by Scopus, the top ten most frequent language designations are shown below. While I understand that language matters in knowledge flows, I proceed with the full database.

language	n
ENG	31227
NA	6055
GER	885
FRE	704
SPA	498
ENG, FRE	292
FRE, ENG	247
POL	202
POR	186
DUT	168

Table A-2. Articles in Scopus by language

With the set of publications on suicide, I use information provided by Scopus to match these to "All Science Journal Codes" (ASJCs) as provided by Scopus (Elsevier, 2020). There are altogether 314 different codes, grouped in 27 'groups' (e.g. "Medicine", "Arts and Humanities", "Psychology", "Social Science") and 4 'super groups' ("Health Sciences, Life Sciences, Social

Sciences, and Physical Sciences). Each source can be assigned to more than one code. Journal and Conferences are categorized by specific ASJC codes, but book and book series only use the 27 group designations and most of my analysis focuses on those. Due to some irregularities in the Scopus data, about 2.7% (N= 1556) of the publications could not be matched to a classification and have been excluded from my analysis.

In addition to these classifications of my suicide data-set, I also ran a series of queries so as to get total numbers of publications indexed by year by single classification group (or the combinations of classification groups most frequent in the suicide data) that are indexed by Scopus. I use this data to normalize any trends I might be seeing within the suicide data itself.

For example, consider the following two plots—the first is the total number of publications on suicide over time, and the second is the proportion of publications of suicide within each year of total publications on Scopus:

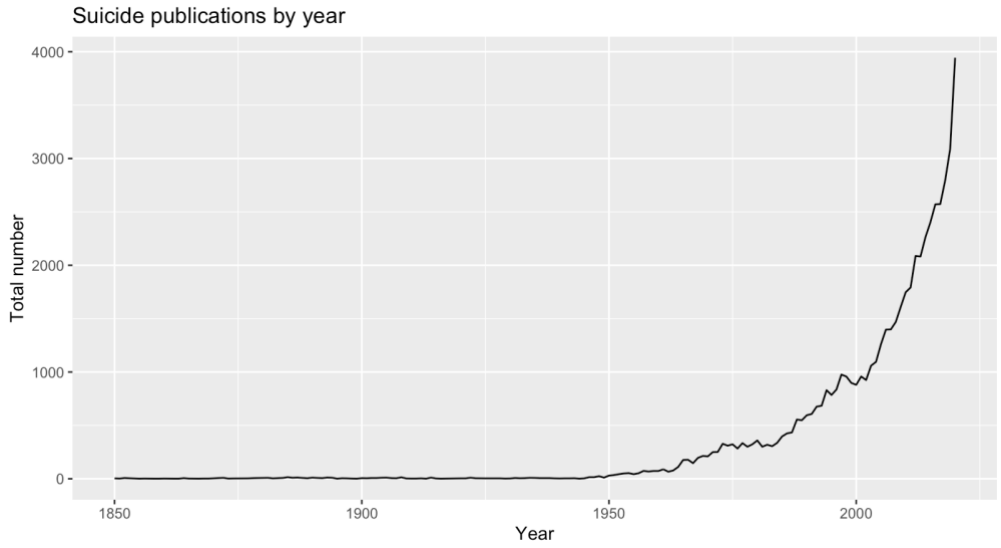


Figure A-1. Total number of publications on suicide in Scopus

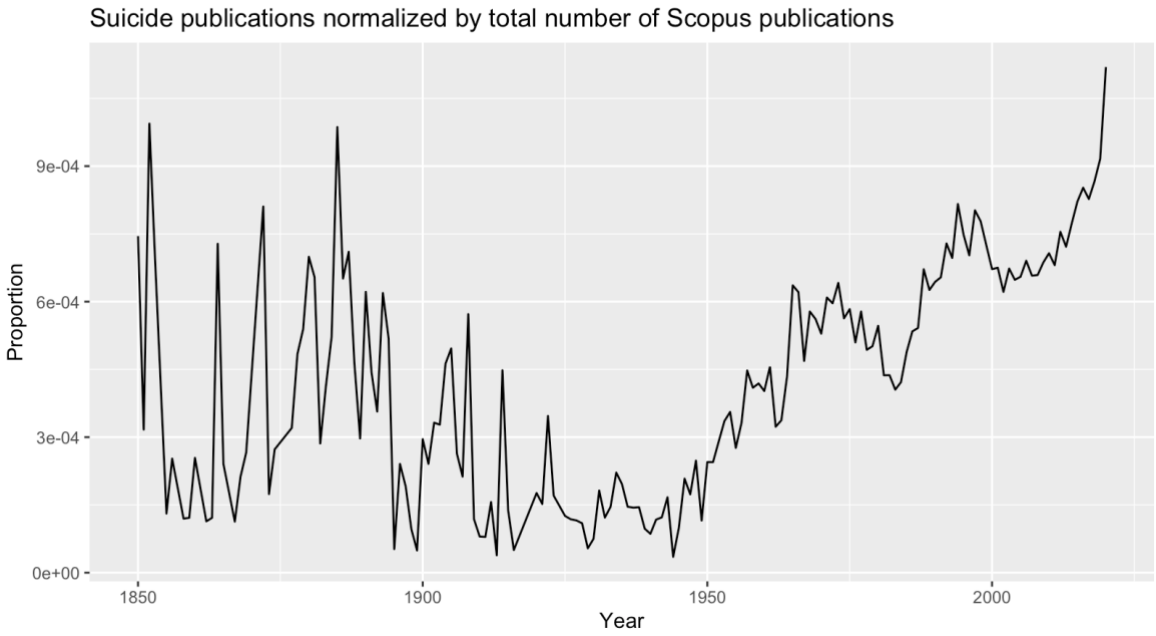


Figure A-2. Publication on suicide as a proportion of all publications in Scopus

We can clearly see that not only is the number of articles on suicide rapidly increasing over time, but that even controlling for the general expansion of research (and the extent of indexing in Scopus). Also note the relatively small numbers of articles published prior to the 1960s (<75 or so), which is why in the rest of my analysis I focus on the period 1960-2020.

5.4.2. Building the 'references database'

To look at the flows of knowledge in more detail, I use the Scopus API to get information on the references of each publication. Note that Scopus indexes references only starting only in 1970 (though the number of publications prior to that time is also limited) and that the coverage is not great in the earlier years. Altogether around 70% of all sources and 71.3% of all article have references indexed in Scopus. The coverage is uneven over time (Figure A-3) and, to a lesser extent, across different classifications of publications (Figure A-4).

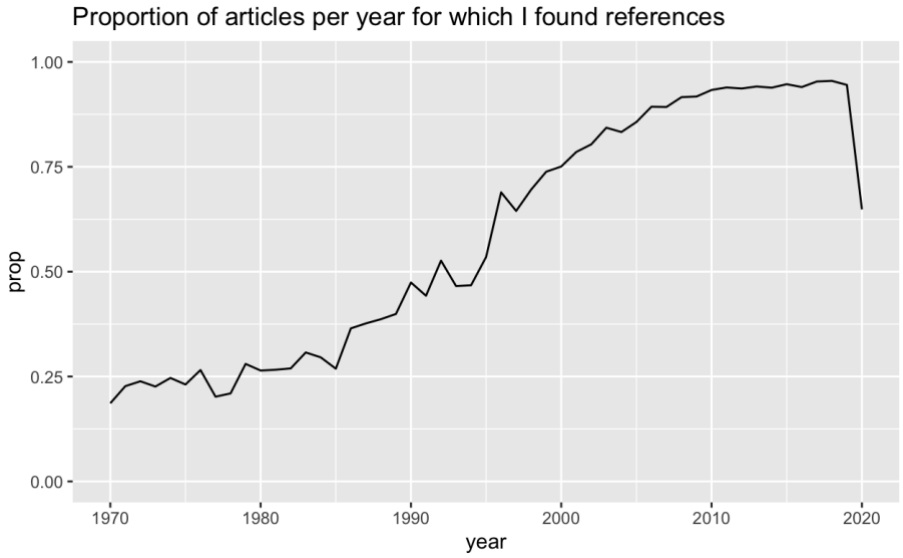


Figure A-3. Proportion of publications for which Scopus lists references, by year

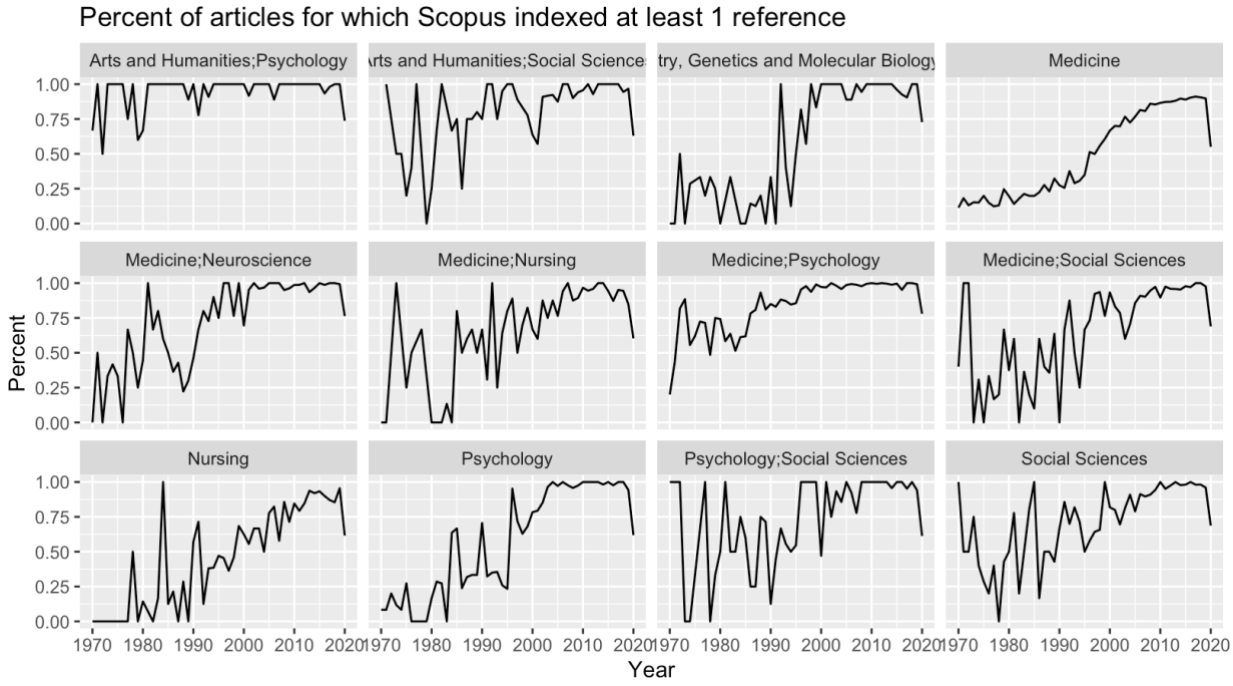


Figure A-4. Proportion of publications for which Scopus lists references, by year per unique field classification

Notably, the average number of references also increases over time (Figure A-5) and though does not differ significantly by classification (Figure A-6)

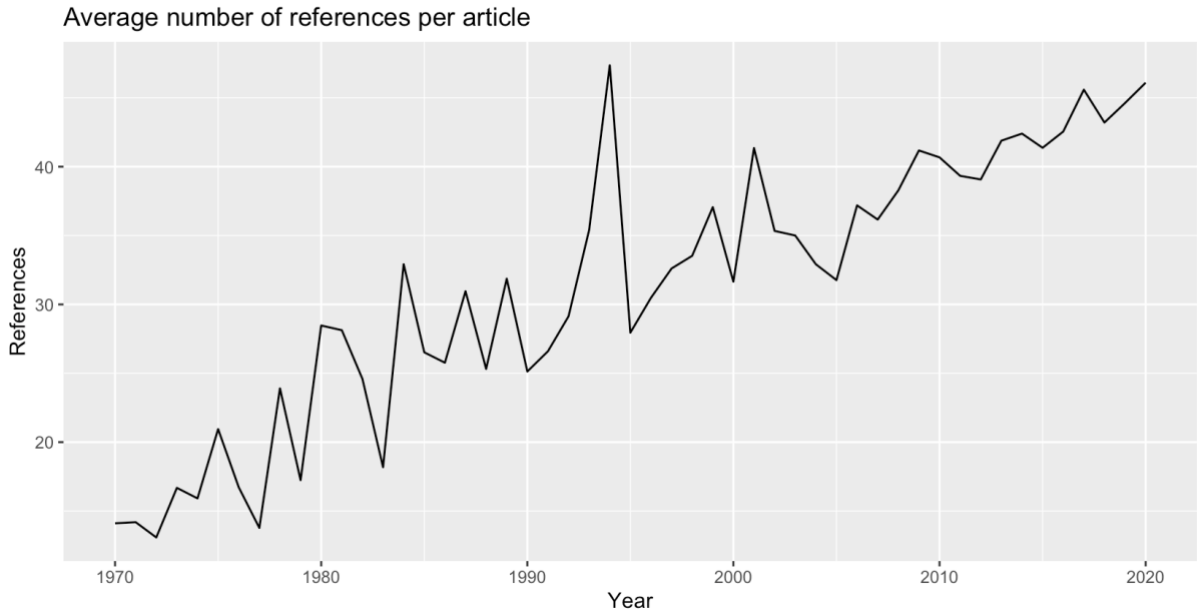


Figure A-5. Average number of references per publication, over time

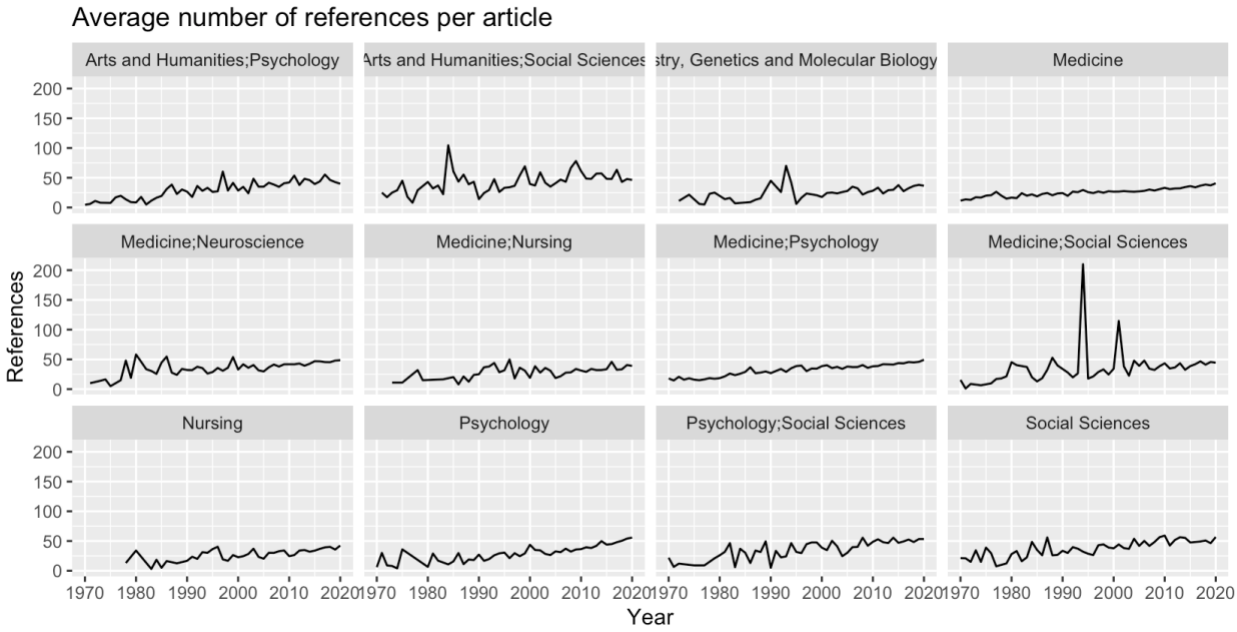


Figure A-6. Average number of references per publication, over time per unique field classification

5.4.3. Shannon Diversity of Classifications

I examine the diversity of publications using the Shannon Diversity Index, that I calculate in the following way:

1. Constructing a classification vectors for each item

- Produce a classification vector for each item (publication or reference), that takes a value 0 or 1 for each of the 27 ASJC groups. For example, if an item is classified as "Medicine; Psychology," the vector would have the value 1 for each of those fields, and 0 for the other 25
- Divide the vector by the number of fields in a classification. "Medicine; Psychology" vector would, therefore, take a value 0.5 for each "Medicine" and "Psychology"

2. Aggregate the vectors at a desired level of analysis

- Group the set of publications or references, if necessary, for desired level of analysis (e.g. by year)

3. Calculate Shannon Diversity Index

- Divide the (aggregate) vector by the sum of the vector to calculate the proportion p_i of classifications in each of the 27 classes
- Calculate H using the proportions, p_i

$$H = -\sum_{i=1}^{R} p_i \times \log\left(p_i\right)$$

- Average as necessary for unit of analysis (e.g. year, classification)

Appendix B: Additional Tables and Figures

1. TABLES

Table B-1. Financial Information of the twelve organizations represented at the 2018 National Rally, based on their 2018 Form 990.

Organization	Revenue	Program expenses	Revenue – Total Expenses	Assets
AFSP	$42,370,512	$24,688,551	$12,378,987	$21,306,285
TWOLHA	$3,074,024	$1,617,673	$991,533	$1,650,499
Samaritans Boston	$2,943,283	$1,616,561	$813,470	$1,274,524
Samaritans	$842,336	$547,142	$159,521	$752,327
SAVE	$1,254,050	$757,039	$390,600	$1,201,730
AAS	$1,601,192	$1,081,027	$101,354	$2,24,629
Trevor Project (period ending July 2018)	$12,749,141	$5,857,530	$5,361,495	$9,727,797
JED Foundation	$8,944,334	$4,539,708	$3,361,795	$8,764,060
Jason Foundation	$1,442,068	$1,189,655	$102,575	$3,298,092
NCBH (period ending Sept 2018)	$53,607,741	$46,073,235	$2,870,859	$24,846,231
Cohen Veterans Network (form 990-PF)	$47,009,945	$16,190,120[22]	$28,219,623	$51,768,698
RI International	$79,382,112	$65,885,335	$2,561,906	$17,553, 730
Total	$255,220,738	$153,853,456	$44,934,731	$124,590,243

[22] Based on Part I 25(d)

Table B-2. Lists of recipients of suicide research awards—Morselli Medal

IASR Morselli Medal, for "an individual who has made an outstanding and important lifetime contribution to the study of suicidal behaviour and/or suicide prevention"(IASR)		
Year	Name	Field
2003	Marie Asberg	MD Psychiatry (PhD?)
2005	Aaron Beck	Psychiatry
2007	Edwin Shneidman	Clinical psychology
2007	Norman Farberow	Clinical psychology
2010	J. John Mann	(Neuro) Psychiatry
2013	Keith Hawton	Psychiatry
2013	Marsha Linehan	Clinical Psychology
2015	Mark Williams	Clinical Psychology
2015	David Brent	MD Psychiatry
2017	Diego De Leo	MD Psychiatry
2017	Victoria Arango	Clinical Neurobiology (in Psychiatry)
2019	Yeates Conwell	Psychiatry
2019	Robert Goldney	Psychiatry

Total: 13; Psychiatry 9, Clinical Psychology 4.

Table B-3. Lists of recipients of suicide research awards—Shneidman award

AAS Shneidman Award, "presented to a person under 40 years of age, or not more than 10 years past their highest degree earned, who has made outstanding contributions in research in the field of suicidology" (McIntosh, Awards, 2020)		
Year	Name	Field
1973	Albert Cain	Psychology
1974	Ronald Maris	Social Psychology and Psychiatry (?)
1975	Dan Lettieri	Psychology
1976	Michael Hheiman	Psychiatry MD
1977	Alton Kirk	Clinical Psychology
1978	Thomas Welu	PhD MPH ?
1979	Pamela Cantor	Psychiatry MD
1980	Joe Thigpen	Education
1981	Cynthia Pfeffer	Psychiatry MD
1982	Lanny Berman	Clinical Psychology
1983	David Phillips	Sociology
1984	Denys de Catanzaro	Psychology
1985	Stephen Stack	Sociology
1986	Paul Holinger	Psychiatry, MD MPH
1987	Barry Garfinkel	Psychiatry
1988	Antoon Leenaars	Clinical Psychology
1989	David C. Clark	Psychology
1990	John McIntosh	Psychology
1991	Madelyn Gould	Epidemiology, MPH, PhD
1992	Patrick O'Carroll	Epidemiology, MD, MPH,

Table B-3, continued

Year	Name	Field
1993	Bruce Bongar	Clinical Psychology
1994	Yeates Conwel	Psychiatry, MD
1995	David Jobes	Clinical Psychology
1996	Sharon M. Valente	Nursing
1997	Silvia Sara Canetto	Clinical Psychology
1998	Julia Shiang	Clinical Psychology
1999	M. David Rudd	Clinical Psychology
2000	Paul R. Duberstein	Clinical Psychology
2001	Thomas Joiner	Clinical Psychology
2002	James Rogers	Clinical Psychology
2003	Kenneth Conner	Clinical Psychology
2004	James Werth	Clinical Psychology
2005	Peter Gutierrez	Clinical Psychology
2006	Annette Beautrais	Psychiatric Epidemiology
2007	Gregory Brown	Clinical Psychology
2008	Maurizio Pompili	Psychiatry
2009	Sean Joe	Social Work
2010	Matthew Nock	Clinical Psychology
2011	Marnin Heisel	Clinical Psychology
2012	Jennifer Muehlenkamp	Clinical Psychology
2013	Jeremy Pettit	Clinical Psychology
2014	Kelly Cukrowicz	Clinical Psychology
2015	E. David Klonsky	Clinical Psychology
2016	Craig Bryan	Clinical Psychology
2017	Courtney L. Bagge	Clinical Psychology
2018	Michael Anestis	Clinical Psychology
2019	Kimberly Van Orden	Clinical Psychology
2020	Anna Mueller	Sociology

Total: 48; Psychiatry 7, Clinical Psychology 30.

Table B-4. Lists of recipients of suicide research awards—Dublin award

AAS Dublin Award, for “lifetime achievement in the field of suicide” (McIntosh, Awards, 2020)		
Year	Name	Field
1971	Karl Menninger	Psychiatry
1972	Edwin Shneidman	Clinical Psychology
1973	Norman Farberow	Psychology
1974	Chad Varah	Priest
1975	Robert Felix	Emergency Medicine, MD
1976	Theodore Curphey	Coroner
1977	Avery Weisman	Psychiatry MD
1978	Seymour Perlin	Psychiatry MD

Table B-4, continued

Year	Name	Field
1979	Jerome Motto	Psychiatry MD
1980	Richard McGee	?
1981	Robert Litman	Psychiatry MD
1982	Herb Hendin	Psychiatry MD
1983	Aaron Beck	Psychiatry MD
1985	Ronald Maris	Social Psychology and Psychiatry (?)
1986	Gerald Caplan	Psychiatry MD
1987	Norman Kreitman	Psychiatry MD
1988	John Mack	Psychiatry MD
1989	Joseph Richman	Psychiatry MD
1990	Marie Asberg	Psychiatry MD (PHD?)
1991	Jan Fawcett	Psychiatry MD
1992	Alex Pokorny	Psychiatry MD
1993	Alec Roy	Psychiatry MD
1994	John T. Maltsberger	Psychiatry MD
1995	Eli Robins	Psychiatry MD
1995	George Murphy	Psychiatry MD
1996	John Mann	(Neruro) Psychiatry, MD
1997	David Lester	Clinical Psychology
1998	Iris Bolton	Community counseling, MA (?)
1999	Marsha Linehan	Clinical Psychology
2000	David A. Brent, MD Psychiatry	Psychiatry MD
2001	Keith Hawton	Psychiatry MD
2002	Israel Orbach	Clinical Psychology
2003	Steven Stack	Sociology
2004	Bruce Bongar	Clinical (Community) Psychology
2005	Morton Silverman	Psychiatry MD
2006	Lanny Berman	Clinical Psychology
2007	Robert Goldney MD Pscyhiatry	Psychiatry MD
2008	Yeates Conwell	Psychiatry MD
2009	M. David Rudd	Clinical Psychology
2010	Frank Campbell	Social Work
2011	Diego DeLeo, MD Psychiatry	Psychiatry MD
2012	David Jobes	Clinical Psychology
2013	Madelyn Gould	Epidemiology
2014	Jie Zhang	Sociology
2015	David Litts	Optomertry
2016	Thomas Joiner	Clinical Psychology
2017	Eric D. Caine	Psychiatry MD
2018	John McIntosh	Psychiatry MD
2019	Jerry Reed	Social Work (MSW), Health-related Sciences (PhD)
2020	Sylvya Canetto	Clinical Psychology

Total: 50; Psychiatry 27, Clinical Psychology 11.

Table B-5. Lists of recipients of suicide research awards—Stengel award

IASP Stengel award, for "for outstanding active research with at least 10 years of scientific activity in the field, as evidenced by number and quality of publications in internationally acknowledged journals and indicators of esteem and reputation." (IASP, n.d.)		
Year	Name	Field
1977	René Diekstra (Netherlands)	Clinical Psychology
1979	Menno Boldt (Canada)	Sociology
1981	Jean Pierre Soubrier	Psychiatry
1983	Jouko Lönnqvist(Finland)	Psychiatry
1985	Gernot Sonneck (Austria)	Physician/Psychotherapist
1985	Jan Beskow (Sweden)	Psychiatry
1987	Robert Goldney (Australia)	Psychiatry
1987	Cynthia Pfeffer (USA)	Psychiatry
1989	Paul Cosyns (Belgium)	Psychiatry
1989	Jean Wilmotte (Belgium)	Psychiatry
1991	Diego De Leo (Italy)	Psychiatry
1993	Danuta Wasserman (Sweden)	Psychiatry
1995	Keith Hawton (UK)	Psychiatry/Forensic medicine
1997	Armin Schmidtke (Germany)	Clinical Pscyhology MD/PhD (?)
1999	Alec Roy (USA)	Psychiatry
2001	Antoon Leenaars (Canada)	Clinical Psychology
2003	Israel Orbach (Israel)	Clinical Psychology
2005	Kees van Heeringen (Belgium)	Psychiatry
2007	John Mann (USA)	Psychiatry
2009	Mark Williams (UK)	Clinical Psychology
2011	Paul Yip (HK)	Social Work
2013	Maria Oquendo (USA)	Psychiatry
2015	David Gunnell (UK)	Epidemiology
2017	Steven Stack (USA)	Sociology
2019	Jane Pirkis (Australia)	Epidemiology/Psychology

Total: 25; Psychiatry 15, Clinical Psychology 5.

Table B-6. Top publications on suicide by number of times cited, per Scopus (data collected in 2019)

Title	Source	Year	Citations
Suicide as an outcome for mental disorders. A meta-analysis	British Journal of Psychiatry	1997	1771
Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey	Archives of General Psychiatry	1999	1524
Assessment of suicidal intention: The Scale for Suicide Ideation	Journal of Consulting and Clinical Psychology	1979	1424
5-HIAA in the Cerebrospinal Fluid: A Biochemical Suicide Predictor?	Archives of General Psychiatry	1976	1068
Hopelessness and eventual suicide: A 10-year prospective study of patients hospitalized with suicidal ideation	American Journal of Psychiatry	1985	1059
The Interpersonal Theory of Suicide	Psychological Review	2010	1028
A hundred cases of suicide: clinical aspects	British Journal of Psychiatry	1974	968
Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the adverse childhood	Journal of the American Medical Association	2001	943
Psychiatric diagnosis in child and adolescent suicide	Archives of General Psychiatry	1996	905
The Columbia-suicide severity rating scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults	American Journal of Psychiatry	2011	858

Table B-7. Most frequently cited individual publications

Publication	Type	Citations	Classification
Why People Die by Suicide (Joiner, 2005)	Book	1918	NA
Preventing suicide: A global imperative	Report	1680	NA
Diagnostic and Statistical Manual of Mental Disorders, 3rd Edit.	Book	1599	NA
Suicide prevention strategies: A systematic review	Article. JAMA	1588	Medicine
The Interpersonal Theory of Suicide	Article. Psychological Review	1439	Psychology
Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey	Article. Archives of General Psychiatry	1408	Arts and Humanities; Medicine
Suicide as an outcome for mental disorders. A meta-analysis	Article. British Journal of Psychiatry	1384	Medicine
Assessment of suicidal intention: The Scale for Suicide Ideation	Article. Journal of Consulting and Clinical Psychology	1240	Medicine; Psychology
Suicide: A study in sociology (Durkheim, 1897)	Book	1187	NA
Toward a clinical model of suicidal behavior in psychiatric patients	Article. American Journal of Psychiatry	1078	Medicine
The measurement of pessimism: The Hopelessness Scale	Article. Journal of Consulting and Clinical Psychology	1072	Medicine; Psychology
Suicide and suicidal behavior	Article. Epidemiologic Reviews	1043	Medicine
Cross-national prevalence and risk factors for suicidal ideation, plans and attempts	Article. British Journal of Psychiatry	1002	Medicine

Table B-8. Most frequently cited publication sources (e.g. journals and books)

Source	Classification	no.refs	perc.refs
american journal of psychiatry	Medicine	44110	2.94
suicide and life threatening behavior	Medicine;Psychology	43724	2.92
archives of general psychiatry	Arts and Humanities;Medicine	32207	2.15
british journal of psychiatry	Medicine	30142	2.01
journal of affective disorders	Medicine;Psychology	29680	1.98
acta psychiatrica scandinavica	Medicine	23226	1.55
journal of the american academy of child and adolescent psychiatry	Medicine;Psychology	21495	1.43
psychological medicine	Medicine;Psychology	18165	1.21
journal of clinical psychiatry	Medicine	14571	0.97
journal of consulting and clinical psychology	Medicine;Psychology	13941	0.93
crisis	Medicine	13516	0.90
lancet	Medicine	13193	0.88
jama journal of the american medical association	Medicine	12498	0.83
bmj	Medicine	12017	0.80
psychiatry research	Medicine;Neuroscience	11981	0.80
american journal of public health	Medicine	10257	0.68
biological psychiatry	Neuroscience	10152	0.68
archives of suicide research	Medicine;Psychology	10054	0.67
social psychiatry and psychiatric epidemiology	Medicine;Psychology;Social Sciences	8942	0.60
social science and medicine	Arts and Humanities;Social Sciences	8400	0.56
journal of nervous and mental disease	Medicine	8216	0.55

Table B-9. Average number of citations per article on suicide by journal, per Scopus (data collected in 2020)

row_id	Publication	mean_citation	sd_citation	max
1	Psychological Review	946.33	897.50	1844
2	Nature Reviews Neuroscience	520.00	554.37	912
3	Epidemiologic Reviews	340.20	528.47	1275
4	Journal of Neuroscience	319.50	207.16	558
5	Developmental Psychology	285.00	195.16	423
6	American Political Science Review	266.00	412.62	742
7	Psychological Bulletin	242.67	290.77	806
8	Archives of Dermatology	225.67	206.14	436
9	Annals of Neurology	203.00	178.24	348
10	IEEE Transactions on Biomedical Engineering	192.00	110.31	270
11	British Journal of Preventive and Social Medicine	177.50	221.32	334
12	Psychological Science	174.00	159.94	323
13	Journal of Leukocyte Biology	169.50	38.89	197
14	Archives of Biochemistry and Biophysics	156.25	241.30	517
15	Archives of General Psychiatry	153.79	229.30	1787
(…)				

Table B-9, continued

row_id	Publication	mean_citation	sd_citation	max
317	Suicide and Life-Threatening Behavior	30.96	49.16	659
(…)				
802	Archives of Suicide Research	15.62	36.37	822
(…)				
849	Crisis	14.56	23.00	276

Table B-10. Comparison of most frequent unique classification combinations across publications and references (shaded cells are ones in the top 14 of each list)

Classification	Perc of pubs	Perc of refs
Medicine	46.22	42.02
Medicine;Psychology	13.72	21.34
Psychology	54.77	4.17
Medicine;Neuroscience	5.65	4.63
Arts and Humanities;Medicine	0.81	3.90
Social Sciences	2.82	2.20
Medicine;Social Sciences	2.41	1.40
Medicine;Nursing	1.97	0.84
Nursing	1.91	0.50
Arts and Humanities;Social Sciences	1.67	1.62
Psychology;Social Sciences	1.59	1.65
Biochemistry, Genetics and Molecular Biology;Medicine	1.30	0.82
Arts and Humanities;Psychology	1.28	1.54
Neuroscience	0.49	1.50
Medicine;Psychology;Social Sciences	1.27	1.47
Multidisciplinary	0.97	0.99
Medicine;Pharmacology, Toxicology and Pharmaceutics	1.11	1.03
Other	10.99	8.13

Table B-11. Average proportion of references classified, by unique group classification, per Scopus (data collected in 2020)

field	proportion of references with a source		proportion of references with a classification		no.pubs	no.refs
	mean	sd	mean	sd		
Medicine	0.97	0.09	0.59	0.25	15266	458125
Medicine;Psychology	0.98	0.06	0.64	0.19	6858	278378
Medicine;Neuroscience	0.99	0.04	0.67	0.19	2268	97751
Psychology	0.99	0.07	0.58	0.22	1969	90245
Social Sciences	0.95	0.15	0.38	0.24	1258	64413
Medicine;Social Sciences	0.96	0.11	0.52	0.24	1060	41117
Medicine;Nursing	0.93	0.17	0.52	0.25	857	26114
Psychology;Social Sciences	0.98	0.05	0.51	0.20	740	34449
Nursing	0.95	0.14	0.47	0.23	684	21492
Arts and Humanities;Social Sciences	0.97	0.09	0.29	0.27	675	32991
Arts and Humanities;Psychology	0.98	0.05	0.59	0.18	657	25653
Medicine;Psychology;Social Sciences	0.98	0.06	0.61	0.19	652	31709
Biochemistry, Genetics and Molecular Biology;Medicine	0.97	0.09	0.50	0.26	545	16254
Medicine;Pharmacology, Toxicology and Pharmaceutics	0.97	0.10	0.53	0.25	500	19102
Arts and Humanities	0.96	0.14	0.13	0.18	409	22532
Multidisciplinary	0.99	0.06	0.59	0.22	381	17011

Table B-12. Distribution of bibliographic coupling clusters across top unique ASJC group classifications

Classification.	% in 1	% in 2	% in 4	% in 5	% in 6	% in 8	% in 10	% in 11	% other	n
Overall distribution	21.26	15.56	11.01	24.44	3.59	8.44	5.37	9.87	0.45	38972
Medicine	29.63	11.68	10.68	18.40	4.59	7.29	5.93	11.48	0.32	14912
Medicine;Psychology	15.46	23.35	15.25	28.76	3.09	6.70	4.10	3.28	0.01	6835
Medicine;Neuroscience	24.58	20.14	4.21	16.46	3.11	24.09	5.06	2.35	0.00	2254
Psychology	9.05	27.51	12.17	31.29	2.91	3.27	4.75	9.05	0.00	1956
Social Sciences	8.78	11.99	12.64	47.13	2.55	0.41	4.43	12.07	0.00	1218
Medicine;Social Sciences	18.51	12.98	11.74	22.33	5.15	2.77	5.63	20.90	0.00	1048
Medicine;Nursing	22.65	15.78	8.92	18.67	4.46	3.25	5.30	20.96	0.00	830
Psychology;Social Sciences	3.79	26.96	30.35	25.07	1.63	2.44	2.98	6.64	0.14	738
Nursing	15.86	15.71	15.11	17.22	3.63	2.72	10.42	19.34	0.00	662
Arts and Humanities;Psychology	4.57	29.98	8.37	38.05	1.98	0.91	3.81	12.33	0.00	657
Medicine;Psychology;Social Sciences	27.50	14.13	14.29	26.88	2.00	4.92	6.30	3.99	0.00	651
Arts and Humanities;Social Sciences	7.90	4.58	6.64	63.51	1.90	0.47	3.79	10.27	0.95	633
Biochemistry, Genetics and Molecular Biology;Medicine	27.51	4.36	3.80	15.18	1.90	15.56	4.36	23.15	4.17	527
Medicine;Pharmacology, Toxicology and Pharmaceutics	37.13	7.17	7.38	13.92	1.90	19.41	2.95	9.49	0.63	474
Multidisciplinary	18.04	16.18	8.22	10.88	6.37	15.12	16.71	5.04	3.45	377
Arts and Humanities	1.91	2.73	1.09	68.31	0.00	0.00	1.64	23.22	1.09	366
Arts and Humanities;Medicine;Psychology	15.32	15.92	13.21	35.14	1.20	8.41	2.70	7.81	0.30	333
Arts and Humanities;Medicine	17.83	3.18	9.87	46.18	3.50	13.69	1.27	4.46	0.00	314
Environmental Science;Medicine	17.58	24.61	11.72	6.64	4.30	3.91	23.05	7.81	0.39	256
Neuroscience	7.38	5.33	2.87	18.85	0.82	62.70	1.64	0.41	0.00	244
Medicine;Nursing;Social Sciences	20.61	5.26	2.63	30.26	0.88	0.88	2.19	37.28	0.00	228
Medicine;Nursing;Psychology	34.31	14.22	2.94	27.94	2.45	7.35	5.39	5.39	0.00	204
Biochemistry, Genetics and Molecular Biology;Medicine;Neuroscience	5.15	6.70	1.03	8.25	0.00	73.71	4.64	0.52	0.00	194
Medicine;Neuroscience;Psychology	12.57	23.56	4.71	26.70	2.09	26.70	3.66	0.00	0.00	191
Neuroscience;Psychology	11.41	7.38	4.70	55.70	4.03	14.77	0.67	1.34	0.00	149
Arts and Humanities;Medicine;Social Sciences	16.36	4.55	28.18	27.27	0.91	3.64	3.64	15.45	0.00	110
Arts and Humanities;Psychology;Social Sciences	7.22	15.46	10.31	49.48	4.12	0.00	7.22	6.19	0.00	97

Table B-13. Distribution of bibliographic coupling cluster across select journals

source	% in 1	% in 2	% in 4	% in 5	% in 6	% in 8	% in 10	% in 11	% other	n
Overall distribution	21.26	15.56	11.01	24.44	3.59	8.44	5.37	9.87	0.45	38972
suicide and life threatening behavior	10.02	20.43	14.83	42.95	2.77	2.32	2.04	4.64	0.00	1767
journal of affective disorders	22.93	24.04	6.48	16.62	4.69	15.43	7.08	2.73	0.00	1173
archives of suicide research	17.19	27.10	11.30	29.99	3.23	6.69	1.73	2.77	0.00	867
crisis	21.84	17.58	11.13	16.62	8.24	3.43	10.03	11.13	0.00	728
psychiatry research	17.39	34.78	6.12	12.40	3.70	18.04	5.64	1.93	0.00	621
acta psychiatrica scandinavica	21.59	1.66	7.20	52.95	1.29	10.89	3.69	0.74	0.00	542
death studies	4.56	24.66	8.85	35.66	2.41	0.27	4.29	19.30	0.00	373
social psychiatry and psychiatric epidemiology	37.93	7.84	8.46	26.33	2.51	5.02	8.78	3.13	0.00	319
journal of clinical psychiatry	40.26	13.74	4.15	16.29	4.79	16.61	1.92	2.24	0.00	313
american journal of psychiatry	28.66	10.10	6.84	27.04	2.61	18.24	1.95	4.56	0.00	307
journal of the american academy of child and adolescent psychiatry	2.73	11.95	57.68	23.21	0.34	1.37	0.34	2.39	0.00	293
plos one	21.40	18.60	9.47	8.07	7.72	11.93	15.79	5.61	1.40	285
british journal of psychiatry	46.79	6.07	3.57	19.29	5.36	8.21	4.29	6.43	0.00	280
psychological medicine	30.88	16.18	7.35	30.15	2.21	6.99	3.31	2.94	0.00	272
australian and new zealand journal of psychiatry	27.04	10.74	11.48	22.59	4.07	5.93	10.74	7.41	0.00	270
bmc psychiatry	26.89	22.35	9.09	6.44	7.95	9.85	16.67	0.76	0.00	264
journal of psychiatric research	16.87	27.31	2.41	12.45	4.42	30.52	4.42	1.61	0.00	249
journal of nervous and mental disease	21.19	13.98	9.32	41.10	2.97	6.36	2.97	2.12	0.00	236
comprehensive psychiatry	16.96	22.61	5.22	35.65	3.04	10.00	5.65	0.87	0.00	230
international journal of environmental research and public health	15.93	26.55	11.95	6.64	4.87	3.98	21.68	8.41	0.00	226
psychological reports	13.68	3.77	4.25	66.04	0.47	3.77	1.42	6.60	0.00	212
social science and medicine	20.92	8.16	13.27	39.29	4.59	0.51	4.59	8.67	0.00	196
journal of clinical psychology	4.30	39.78	4.30	44.62	0.54	2.15	4.30	0.00	0.00	186
forensic science international	17.83	0.00	3.18	12.10	0.64	5.10	1.27	58.60	1.27	157
american journal of forensic medicine and pathology	16.88	0.65	6.49	17.53	0.00	1.30	0.00	57.14	0.00	154
journal of adolescent health	2.70	19.82	65.77	3.60	2.70	0.00	2.70	2.70	0.00	111
perceptual and motor skills	12.50	1.92	4.81	72.12	0.96	6.73	0.00	0.96	0.00	104

Table B-13, continued

source	% in 1	% in 2	% in 4	% in 5	% in 6	% in 8	% in 10	% in 11	% other	n
bmj online	50.00	7.95	4.55	1.14	5.68	6.82	3.41	14.77	5.68	88
molecular psychiatry	6.67	8.00	1.33	2.67	0.00	77.33	4.00	0.00	0.00	75
journal of american college health	1.64	70.49	18.03	0.00	4.92	0.00	3.28	1.64	0.00	61
forensic science medicine and pathology	11.86	0.00	5.08	3.39	0.00	0.00	5.08	74.58	0.00	59
cognitive therapy and research	0.00	69.39	0.00	26.53	0.00	2.04	2.04	0.00	0.00	49
american journal of medical genetics part b neuropsychiatric genetics	2.08	2.08	0.00	10.42	2.08	83.33	0.00	0.00	0.00	48
journal of abnormal psychology	10.42	62.50	6.25	18.75	0.00	0.00	2.08	0.00	0.00	48
journal of medical ethics	4.26	2.13	0.00	6.38	0.00	0.00	0.00	87.23	0.00	47
european journal of public health	65.85	0.00	7.32	7.32	2.44	4.88	4.88	7.32	0.00	41
social forces	0.00	0.00	0.00	94.59	0.00	0.00	2.70	2.70	0.00	37
international medical journal	63.64	0.00	3.03	12.12	3.03	12.12	3.03	0.00	3.03	33
journal of social psychology	0.00	0.00	0.00	93.94	0.00	0.00	0.00	6.06	0.00	33
journal of palliative medicine	5.56	0.00	0.00	5.56	5.56	5.56	0.00	77.78	0.00	18

2. FIGURES

Figure B-1. Examining the contribution of suicidology journals to publications on suicide (as indexed by Scopus)

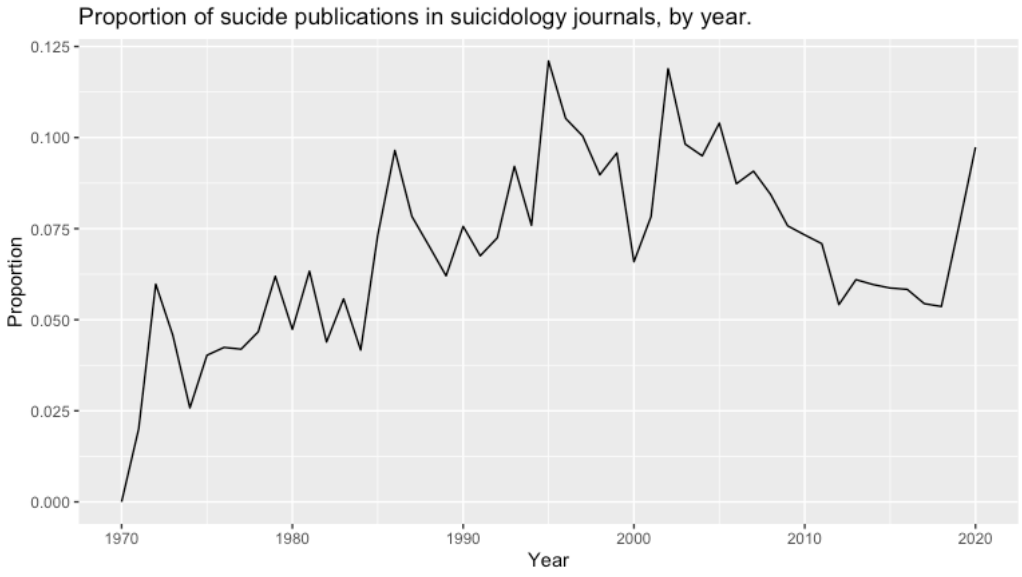


Figure B-2. Number of Publications with an ASJC code over time, top 8 code

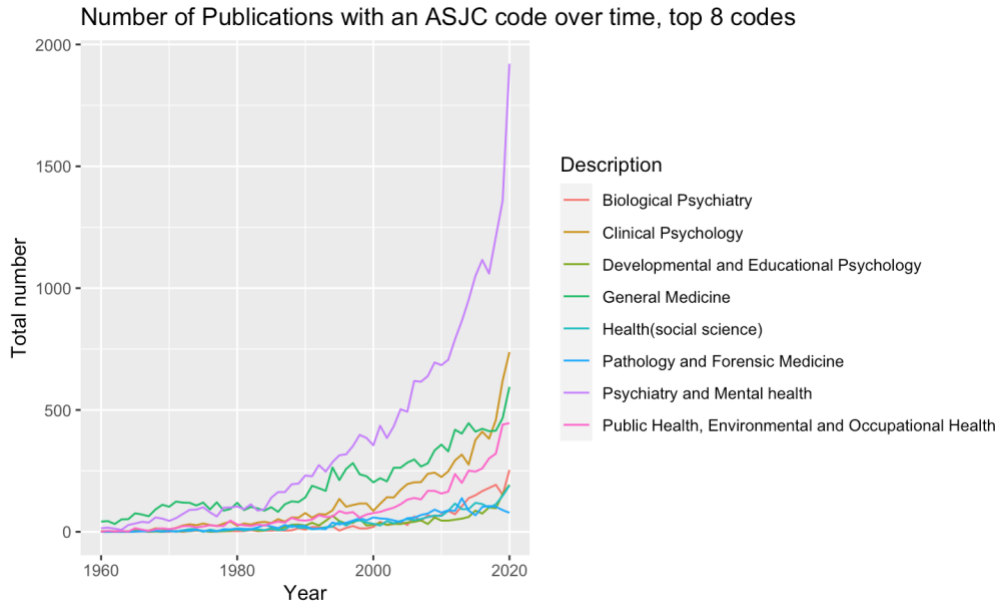


Figure B-3. Number of Publications with an ASJC code over time, top 9:16 codes

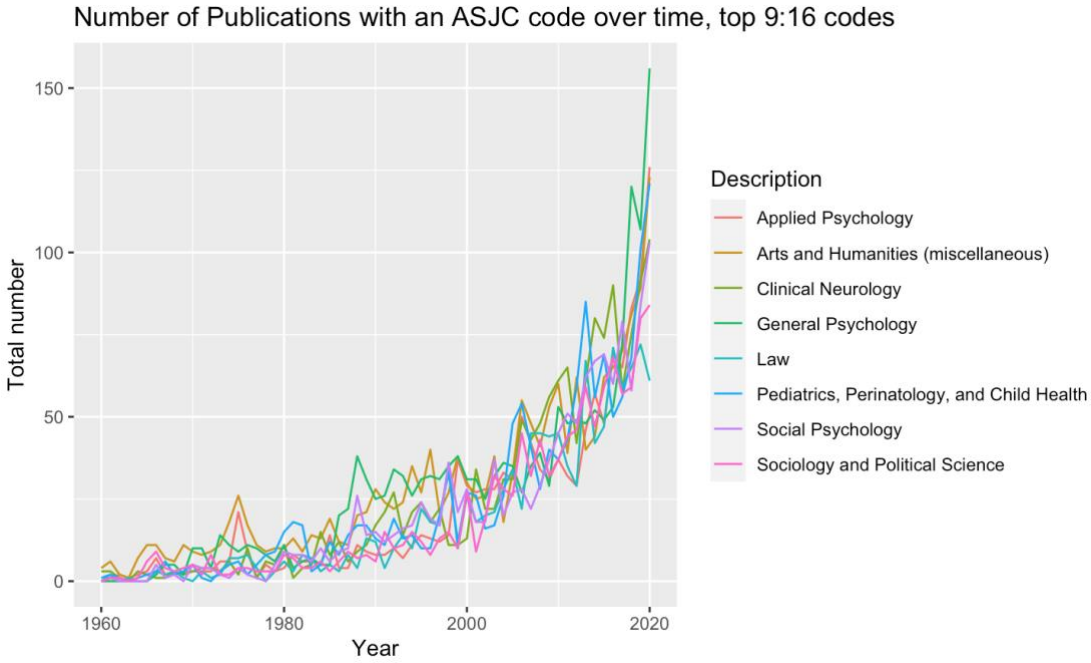


Figure B-4. Number of publications in Psychiatry & Mental Health and Clinical Psychology, on suicide

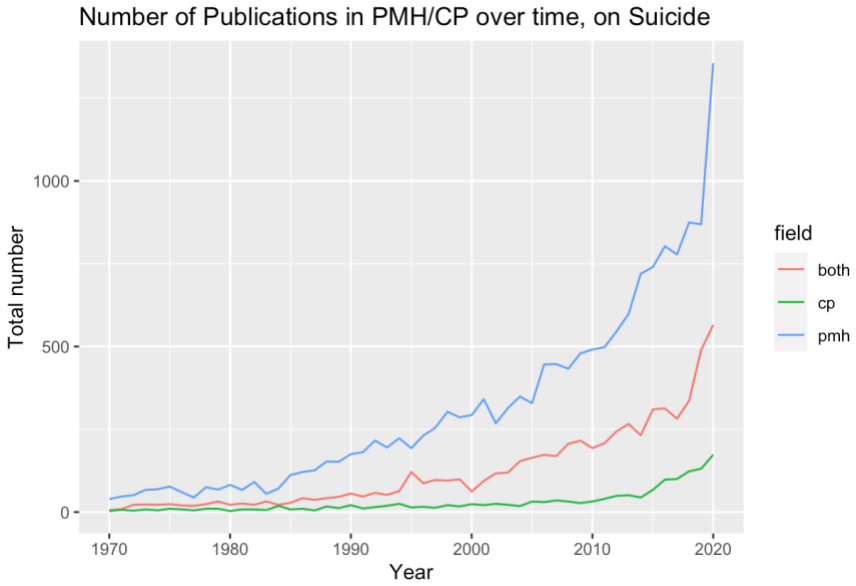


Figure B-5. Number of publications in Psychiatry & Mental Health and Clinical Psychology, in Scopus overall

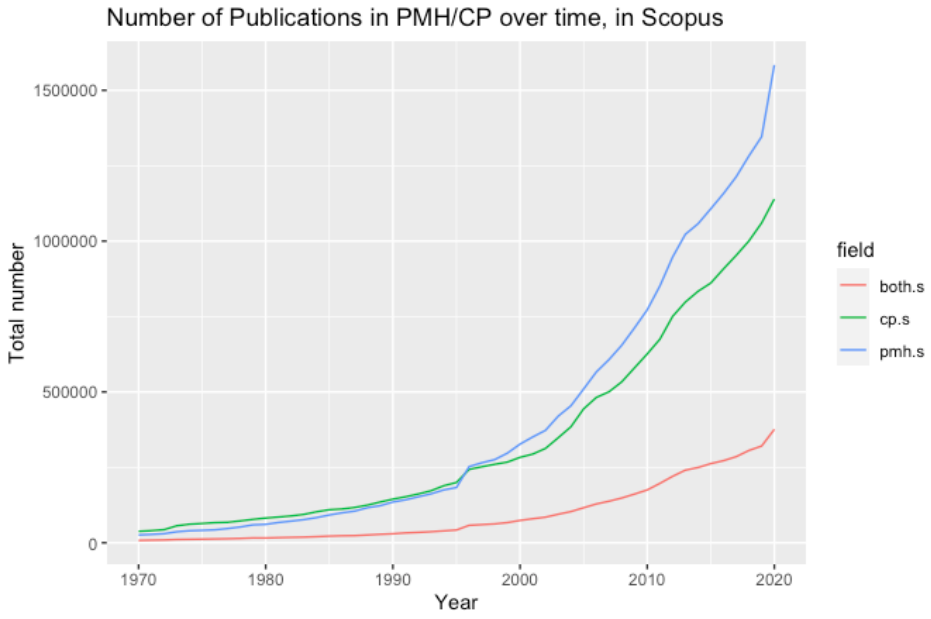


Figure B-6. Comparing the Shannon Diversity Index of suicide publications and their references over time

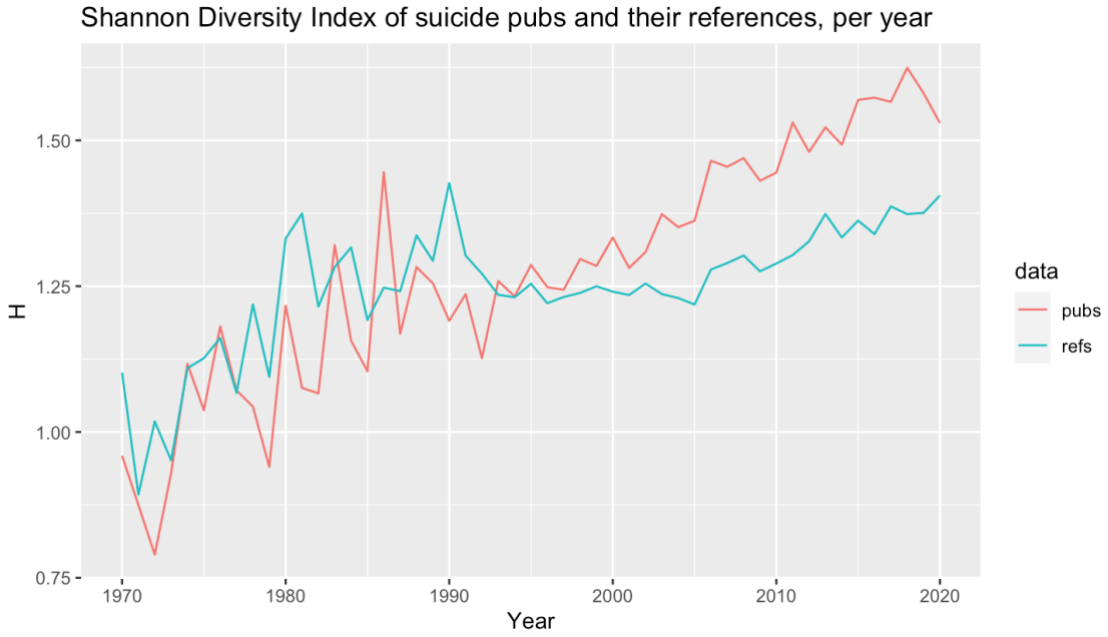


Figure B-7. Most frequent words in each cluster, considering title, abstract and keywords

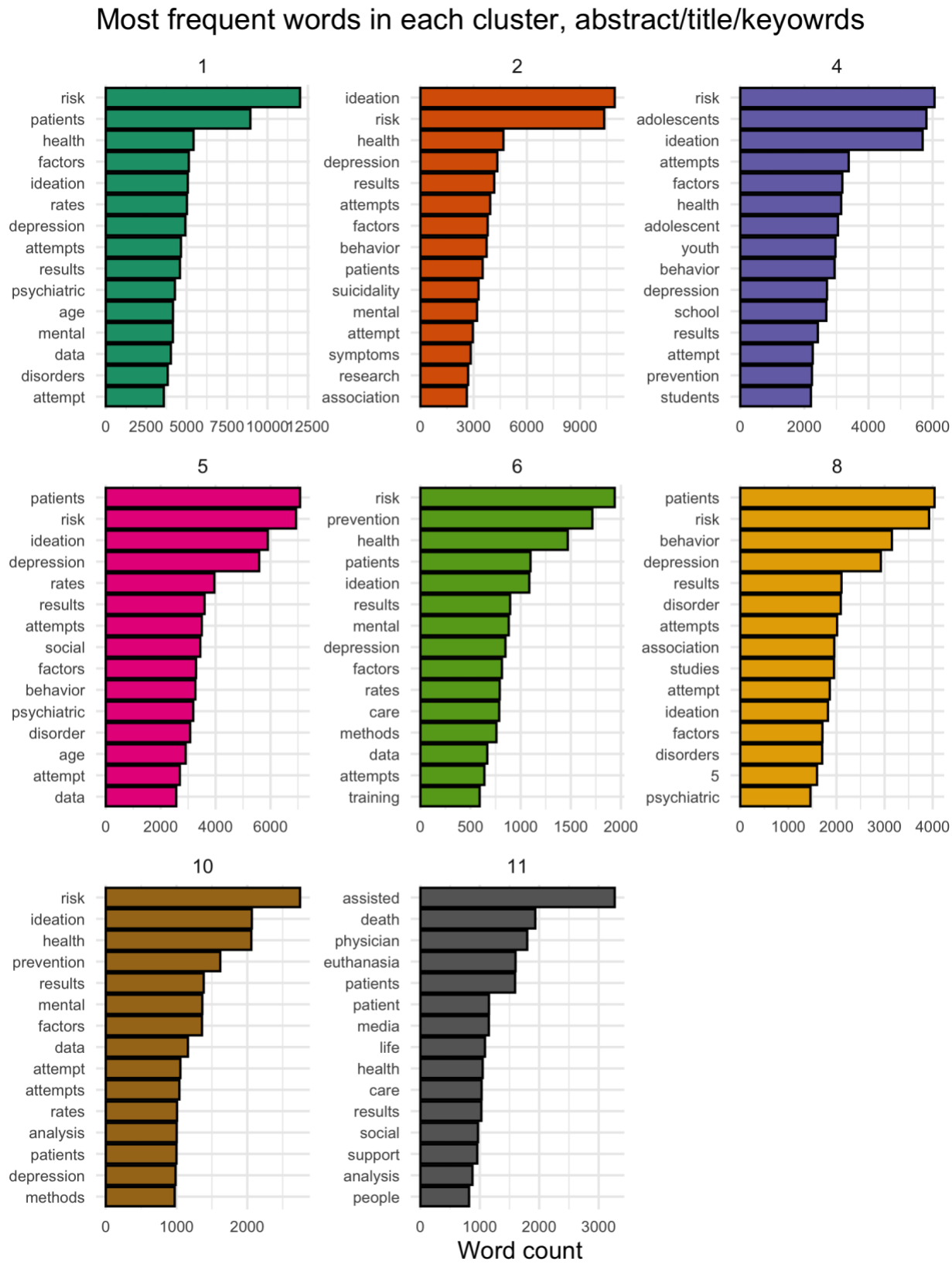
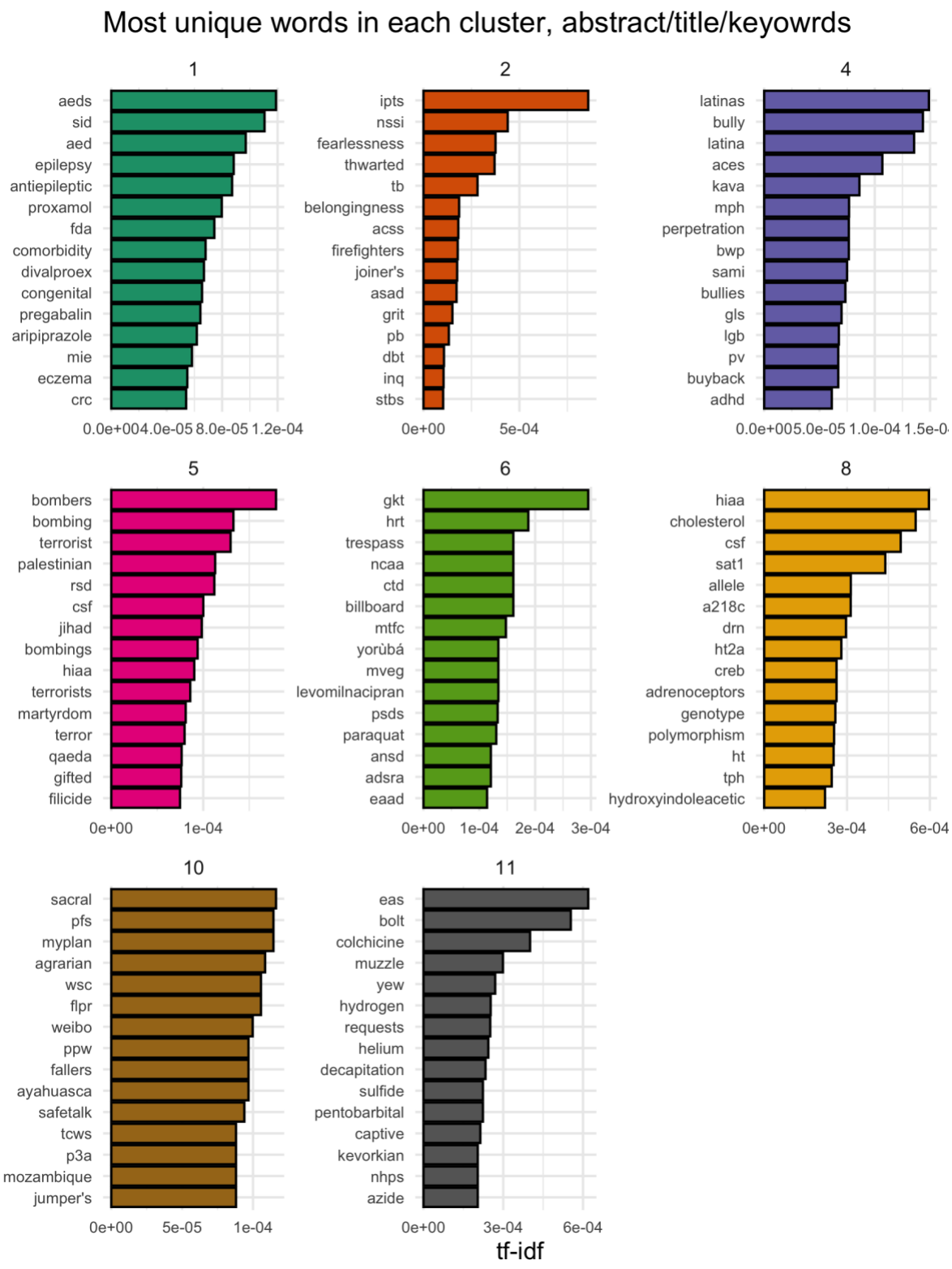


Figure B-8. Most distinct words in each cluster (relative high within-cluster frequency compared to overall frequency)



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