Suicidology prevents the cultivation of suicide

Klaus Feldmann

2016

Abstract

Suicide is a socio-cultural phenomenon. Reports about suicide from different cultures and eras support the opinion that suicide can be a cultivated and normatively recognized act. International widely accepted scientific use of the term suicide produces, conveys and suggests a narrowing of reflection. A medical deficit viewpoint has been established, and corresponding theories constructed and 'verified' to justify the paternalistic interaction with suicidal people. The (self-)identified suicidal person is discriminated and isolated on multiple levels in social contexts. Psychological autopsy studies try to reconstruct the process of suicidal behavior, but they are driven by deficit- and illness-based approaches and are designed and conducted on a low methodological level.
When suicidal actions are recognized as normal actions, or even interpreted as morally sound, medical, political, religious and other guardians of morality and the ruling order oppose such understanding and demand sovereignty of interpretation. The conflicts in the field of suicide discourses result from diverging values and interests, whereby open, controversial and empirically-based public discussions are generally avoided. There is a lack of reference in psychiatric and suicidology texts to the fact that 'free will', 'free choice' or 'free mind' in modern society are not restricted primarily by mental illness, but by socio-economic disadvantage and economic and political decisions that lead, among other things, to mental disorders. This paper claims the suicidological heterodoxy, that cultivation of suicide is not in contradiction with prevention of suicide.

Keywords: suicide, suicidology, psychiatry

Suicide, a significant form of dying, is generally excluded from works and introductory overviews on thanatology (e.g. Howarth, 2007; Clavandier, 2009). Suicidology, which is in essence a part of a part (psychiatry) of the medical system, "neither a science nor a discipline" (Conwell, 2010, p. 59), but a field or a hierarchically ordered system of subfields (Bourdieu, 1998, 2000), sets store by boundaries and exclusion, has its own journals and textbooks and does not concern itself with general thanatological theories and research. The term suicidology as used in this text refers to mainstream suicidology. A typical sentence encountered in the dominant doxa, the self-evident discourse on practices: "The focus of suicidology is not necessary completed suicide but above all treatment of suicidal individuals" (Pompili, 2010, p. 1).
In Ancient Greek and Latin, there was no one specific term for the act referred to in all modern-day advanced languages as suicide (van Hooff, 1990; Marsh, 2010, p. 79). The 'matter' was simply addressed and referred to in different ways depending on the context, which also provided people with greater flexibility in dealing with it. Commandingly protected and professionally watched over, the unwavering international use of the term suicide in its modern form in contrast produces, conveys and suggests pathologization and incapacitation. A medical deficit viewpoint has been established, and corresponding theories constructed and 'verified' to justify the paternalistic interaction with suicidal people. "…a desperate person is not only feeling despaired, but her reflective abilities are altered. This feature of suicidal people is usually named as "narrowing" in psychiatric and psychological models and received empirical evidence" (Schlimme, 2013, p. 214). While the 'narrowing (of consciousness)' construct might be applicable to residents of nursing

homes (cf. Whitaker, 2010), it does not really constitute a valid generalized description of the mental states of suicidal individuals (Feldmann, 2010, p. 199).

"The stories we tell about acts that come to be labeled as suicidal are influenced by the impoverished language and conceptual apparatus that is available to us. In most 'suicide talk' whether among professional or lay people, the whole range of acts engaged in by those whose behavior is actually or potentially self-destructive are subsumed under the umbrella concept suicide and a few variants: parasuicide, attempted suicide, failed suicide, and threatened suicide, along with expressions like 'cry for help'. This poverty of language and concepts reflects rather a limited model of suicidal self-harm in which fine distinctions are not made, even in theory, perhaps because they are difficult to make in practice. It is misleading and unhelpful in deciding upon courses of action in relation to those who act in actually or potentially self-destructive ways or are thought to be at risk of doing so" (Fairbairn, 1998, p. 157).

The catalog of terms and theories used to address actions and events that cause destruction to the self or to others remains antiquated and unreflected: suicide, murder, death by natural causes, accident, etc. The users of this semantic field share the illusion that suicide is a homogenous phenomenon that can thus be unambiguously described, explained and assessed. "This fatal reduction in complexity favors the simplification and ideologization of suicide that is encountered not only in the medical debate, but also in the publications of legal and medical practitioners, theologists and psychologists. Above all, the minority of suicide cases that could provide a positive lesson for some people are 'drowned' by the easily diagnosable majority." (Feldmann, 2010, p. 179; translation by the author)

Attempts to differentiate the term suicide (or killing oneself) are avoided in the legal, philosophical, theological and other debates, while the use of a whole range of terms to refer to the act of killing someone else (e.g. murder, manslaughter, death penalty, act of self-defense, fatal use of force, euthanasia, etc.) in turn adds greater flexibility to the debate. To surmount the difficulties raised by the heterogeneity in case structures, contexts and views of the world, suicide and its mainstream debate are subjected to a restricted actor model and decontextualized by opinion leaders (cf. the reductionist context, theory and culture abstinent attempts at definition in Silverman 2011). The psycho-social events that precede a suicide are operationalized into normatively prescribed concepts and variables, while their communicative and interactive processes and field structures are deconstructed and reconstructed using simple causal models. Most suicide experts thus neglect methodological differences and theoretical options in their claims that the vast majority of suicides are 'caused' by mental illness (cf. Hjelmeland et al. 2012; Hjelmeland 2013, p. 7 - 8). Given the problems associated with the operationalization of the term 'mental illness', the lack of diagnosis and other factors, this constitutes an only seemingly well-proven hypothetical supposition or view, reinforcing the assumption that the dominant construct of suicide based on the professional doxa of psychiatry lacks critical scientific rigour, serves primarily to keep authority and professional privileges in place and is increasingly losing its scientific and everyday viability. Indeed, we can now talk of a globalized hegemony, orthodoxy and monopoly view in which science and symbolic capital is abused as legitimate means of symbolic and structural violence.

The argumentation below primarily targets the scientific and professional 'treatment' of suicide. But before we can discuss this further, we must first take a brief look at the state and governing framework without which suicidology would not be able to consummate its work in a quasi-fundamentalist manner. Western states have adopted elements of traditional moral and governance ideology, which are administrated by various institutions (the law, education, medicine, social work, etc.). "Laws against suicide or assisted suicide thus represent coercive action by the government that imposes the rules of a particular morality, one that derives from religion, over another morality with more secular derivations." (Rubin, 2010, p. 811)

Bayatrizi (2008), Lester (2003, 2006) and Marsh (2010) deliver insights into the development and establishment of the psychiatric 'regime of truth' based on functionaries and on suicide as an

intercultural and transdisciplinary phenomenon. With their largely symbolic capital, the main advocates of mainstream suicidology in contrast promote their basic ideology as universal, evidence-based, culturally, politically and economically neutral, and without alternative; they dominate the debate in literature and in the quality media. Dogmatic statements and statements of commitment are to be expected from the prominent players: "Suicide at any age is a tragedy for the individual, his or her family and friends, and the communities of which they are a part" (Conwell, Van Orden & Caine, 2011, p. 1).

A further observation concerns the reductionist (meta-)theory of suicide found in literature. The following example refers to the group of patients who are 'at the end of their lives': "Yet for the vast majority of these patients, the reason for suicide is not a decision made of their own free will, but a frequently treatable mental disorder." (Vollmann et al., 2008, p. 205; translation by the author). This argument is clearly based on a simple 'theory': suicide is either a decision that is made of our own free will or is caused by a mental disorder. The operationalization of the terms suicide, mental disorder, free will and decision conforms to the prevailing medical and ruling order, and the 'theory' that was 'confirmed' by partisan research is not subjected to any further critical examination.

To the constant chagrin of the representatives of powerful institutions, including above all medicine, the state, religion and the law, suicide is a battlefield in society that is not as well ensnared in their professional grip as cancer or childbirth. "The ultimate threat to a legal order built on death control is the individual who refuses to accept law's prohibition and seeks to self-style her death." (Hanafin, 2009, p. 85). While people who commit suicide are no longer subject to criminal prosecution, most countries still punish people who help to organize a suicide without the statutory authority or professional legitimation to do so. Furthermore, even in countries like Germany where some forms of assisted suicide are formally exempted from official punishment, ostracism, informal punishment, medicalization, stigmatization (Sudak et al., 2008) and mystification are still demanded by many experts (psychiatrists, suicidologists, lawyers, etc.) and public speakers (functionaries, journalists, etc.). The suicidal person is discriminated and isolated on multiple levels. The people affected – and that can be quite a lot of people if suicidality is taken as an overall phenomenon – maintain their silence in "doxic submission" (Bourdieu, 1998, p. 67, 81; 2000), or their attempts to communicate ultimately peter out. To strengthen the ideology, selected examples are pushed through the filters and transformers of medicine, the media and other modern forms of censorship and presented to the general public as deterrents.

Resistance to the pathologization, medicalization and depreciation of suicide was – and still is – generally provided by outsiders, and ignored and symbolically destroyed by state and experts. The people and groups who provide resistance are usually denied access to and denounced in the media as sick or criminal (c.f. the attempts to bring criminal charges against the German branch of the Swiss assisted suicide organization Dignitas) or classified as cultural, ethnic oder ideological deviants, whereby this categorization must be gleaned from debate and practices, since any public discussion is heavily restricted. Some of these deviants, literati, artists and intellectuals, are occasionally granted a 'moderated' niche platform, thus facilitating their segregation and exclusion from 'normal citizens'. They are also deemed to be irrational and romantic, while the members of the white-coated suicide brigade are praised for their scientific, rational and professional merit and have the financial backing to secrete their ritual claims into the media and relevant commissions.

A counter-debate of romantic glorification and scientific marginalization that suits the representatives of the fields of medicine and power is constructed. "However, the glorification of suicide – suicide as rebellion and opposition against the dominant values of society – may also be found in popular culture in the 20th and 21st century, such as rock music and film. The glorification of individual resistance communicated by pro-suicide messages on the internet today may be traced back to Stoicism and Romanticism, albeit in new forms and with new adversaries" (Westerlund, 2012, p. 766). In contrast to this very restricted and calculating willingness to 'recognize" the

counter-debate, commendable scientific works offering a different understanding of suicide (e.g. by Thomas S. Szasz, David Lester, Jack Douglas, Ursula Baumann or Dagmar Fenner) are ignored in journals and medical education because they are not compatible with the prescribed modelling and economics of suicide. Despite this suppression of alternative perspectives by the professionals and the state, they are still being represented and applied in many different forms by various individuals and groups. When such heterodox representations reach the media, the messages they contain are written off by the experts as prejudicial, incorrect, immoral, irrational and/or sick.

The effect of hidden power should also not be ignored. The following message to potential suicides continues to remain effective: *Do it in a way that is as off-putting and repulsive as possible!* (c.f. Feldmann, 1998). A further implicit message that is supported even by the high priests of suicidology is as follows: *When you commit suicide, you die a dishonorable death, no matter how you do it!* Different variations on these themes are transmitted in the messages sent by different senders: medicine, religion, the law, the media and politics. These implicit and explicit messages have so far succeeded in developing their stabilizing effect on prevailing discourse and practices to a sufficient extent to prevent alternative discourse and practices from becoming the center of attention. These assumptions and the hypotheses that can be derived from it have as yet not been the subject of any quality empirical studies, and this situation is unlikely to change in the short- and medium term.

Notwithstanding this professional narrowing of the discourse, the study by Weaver (2009) delivers excellent material for the description of suicide as socio-cultural phenomenon. Weaver draws a multidimensional and multiparadigmatic network image of suicides in New Zealand and Queensland in particular in the first half of the 20th century. He connects the manifold contexts, motives, mental, social and physical conditions, (semi-)professional interventions, etc. in impressive detail "…providing an intimate understanding of the personal and social circumstances surrounding suicide…" (Bayatrizi, 2010, p. 171) and makes this information available to readers for further interpretation. Prevailing perspectives and theories are thereby relativized and make their way into semantic and pragmatic fields of conflict. "A myriad of factors from temperament and personality to environment, learned coping mechanisms, biology and life circumstances all create a complicated web of individuality. In light of this fact, perhaps our concept of suicidality could be more appropriately viewed as a metaphorical tree." (Mitchell, 2009, p. 30)

If depression and suicidal tendencies are recognized and categorized as 'products' of social culture (cf. Pilgrim & Bentall, 1999; Yur'yev et al., 2013; Minagawa, 2013; Hjelmeland, 2013, p. 6), the evidential authority of medical and psychological theories diminishes (cf. Marsh, 2010, p. 74 f). Depression is activated and changed by environmental factors and social processes (cf. Rosenquist et al., 2011; Petersen, 2011). The environmental factors that encourage depression include: social inequality, lack of high-quality democracy in political and economic institutions, legal, education and healthcare systems based on privilege, etc. The reduction of social and economic inequality and of symbolic violence and other favorable developments in society could alleviate most depressions to the extent that far fewer people would require medical treatment and the number of suicide and attempted suicides would be significantly reduced. In the current social setting, pathologization and medicalisation serve both to treat the afflicted and sustain the illness and thus also to support the ruling order, 'social stability', ideologization and growth in the participating manufacturing and services sectors. The fact that modern medicine and clinical psychology have been successful not only in treating the afflicted but also in their humanization and normalization efforts should by no means be denied. Likewise, the dependence of medicine and psychology on the field of power and the shortcomings in scientific education and professional practice when it comes to changing prejudices and stereotypes should also be taken into account in the assessment of the arguments presented in this article.

Cultural and social change and suicidology

There are sufficient reports about suicide from different cultures and eras which do however support the opinion that suicide can be a cultivated and normatively recognized act (cf. Baechler,

4

1979; Marsh, 2010; Tomasini, 2012). Many such examples can be found in Roman history and, despite censorship, enough corresponding examples have also made it into public view in the 20th and 21st centuries. However, no group of scientists has as yet dared (or been given the resources) to study this thesis from an intercultural and modern society perspective.

The physical or symbolic violent course of action against people who commit suicide and the people who 'sympathize' with them stems from Western and other cultural traditions (c.f. Baechler, 1979; Baumann, 2001; Bayatrizi, 2008; Feldmann, 2010, p. 192; Marsh, 2010). In Western cultures, suicide generally has negative connotations: politics, the law, organized religion, medicine and psychiatry are the most important institutions and subsystems which set corresponding binding sanctions, prescribe debates and apply physical and symbolic force. Emancipation efforts by organized and heterogeneous opponents of this militant truth regime have achieved partial successes through the battles between the powers that define the debate and practices. However, these successes are, of course, always at risk, since the disciplining of suicide and (at least symbolic) destruction of its non-conformist supporters still remains on the agenda of powerful conservative groups and organizations.

"… a contemporary 'regime of truth', one centering on a compulsory ontology of pathology in relation to suicide" (Marsh, 2010, p. 4) or the contemporary approach to suicide in expert and power debates and practices can be compared to the 19th century middle-class attitude to sexuality: lack of reflection, over-policing and prudery on the one hand, inadequately cultivated and correspondingly brutal social practices on the other, in what was, above all, a largely unexplored territory.

In Western cultures, the concept and practice of suicide was formed and used to discipline and stigmatize. Authoritarian regimes and groups, e.g. fundamentalist religious communities or national socialism, condemn(ed) self-determined suicide that does (did) not serve the powers that be draconically and without reflection. In contrast, 'sacrificing' oneself for the 'true collective', for the 'true god' or for the 'true leader', which was officially not permitted to be referred to as 'altruistic suicide', was – and is – glorified. Mass murder at the orders of the respective ruling elite was praised as being morally good and was also linked with varying good 'chances of suicide'. Representatives of state nobility, law lords, religious and medical leaders continue to regard a suicide that is not linked to approved homicide with skepticism and hostility, since the person committing suicide is ultimately being insubordinate and abusing his limited authority of self-determination. These representatives of 'order' use withdrawal of capital, defamation of character, stigmatization and other tried and tested techniques to battle against people and groups who openly support and publicly show acceptance for forms of suicide, e.g.physicians who provide assistance with suicide in Oregon, where assisted suicide is legal.

Many psychiatrists and suicidologists have established justification systems in cooperation with religious and state institutions to deny people who want to commit suicide symbolic capital and the ability to make their own decisions (cf. Szasz, 1999). This approach has been more successful in Europe and North America than in Japan, where certain forms of suicide have long been cultivated and normalized (cf. Kitanaka, 2009). Educated Japanese can and may talk more openly about suicide in public than their Western counterparts. "Traditionally, suicide has been considered an expression of an individual's free will in Japan (Cho, 2006; Takahashi, 1997, 2001). The rhetoric of a 'suicide of resolve', still a very popular notion, suggests that suicide can be the result of a rational decision by a freely choosing individual, and therefore is an option to be respected when necessity calls for it (Kitanaka, 2006, 2008). Kitanaka argues 'though psychiatry has been institutionally established in Japan since the late nineteenth century, psychiatrists have had little impact on the way Japanese have conceptualized suicide. This may be because Japanese have long normalized suicide, even aestheticizing it at times as a culturally sanctioned act of individual freedom' (Kitanaka, 2008, 1)" (Ozawa-de Silva, 2010, p. 21-22).

The 'understanding' sold as 'objective truth' not as inadequately confirmed hypothesis that only a few suicides – e.g. one to five percent – are the result of 'free will' gives state bodies the legitimization they need to take hold of suicide and bring fear and terror to the people involved. This fear and barbarization of the field is being instrumentalized theoretically and empirically by many psychiatrists and suicidologists to obtain 'objective findings' – a typical linking of 'applied science' and power.

The suicide experts in the medical system have 'civilized', modernized and medicalized the custom of post-mortem degradation of people who commit suicide. Even after death, they are named and shamed as mentally ill, i.e. as inferior, irresponsible people, and are used as a dishonorable and deterring reminder, albeit one mixed with pity. Their relatives are encouraged to also place themselves in the care of physicians or psychiatrists. This 'professional', ideological and economic context fosters a world view in which suicide as such – regardless of social and cultural setting – has in almost all cases seriously disturbing and no positive effects on surviving relatives or persons of reference. The confirmation of this normative hypothesis, which has never been adequately tested, was questioned, for example, in the study by Barraclough and Hughes (1987) (cf. Jordan, 2001, p. 97). Through social normalization and medicalization, suicides and the mourning processes of the people they leave behind become events that distract from or complicate the resolution of social and hegemonic problems. Psychosocial disorders can, of course, emerge, when a person's passing and death are not compatible with the interpretive systems and practices of the people left behind. While suicides probably cause "complicated grief" for many survivors, a successful cultivation and liberalization of self-determined dying could reduce this potential strain (cf. Swarte et al., 2003). People are physically, mentally and socially damaged and weakened by the social conditions, only to then receive 'aid' that doesn't make them 'healthy' and 'happy' but dependent and submissive.

When suicidal actions are recognized as normal actions or even interpreted as morally sound, political, religious and other guardians of morality and the ruling order vehemently oppose such understanding and demand sovereignty of interpretation (cf. Bayatrizi, 2008, p. 121). Suicide messages that could be understood as a protest or criticism of the social, political or economic regime should be ignored or reinterpreted – a process that has been seen in different forms throughout European history (ibid., p. 117).

23 France Télécom employees took their own lives or attempted to commit suicide in 2008 and 2009. The suicide notes and the statements of the survivors clearly indicate that the working environment was a central factor in their decision to commit suicide. Economic and social exclusion (e.g. unemployment) contribute to raising suicide rates (cf. Yur'yev et al., 2013).

Suicide is a socio-cultural phenomenon (c.f. Chu et al., 2010; Hjelmeland, 2010) like war, financial transactions, divorce and unmarked graves. Most people would shake their heads if physicians and scientists were to say that war, financial transactions, divorce and unmarked graves are inextricably linked with illness and incapacitation and assign them to the realms of medicine and clinical psychology. The socio-cultural perspective is confirmed in intercultural studies (cf. the reports in Culture, Medicine and Psychiatry, No. 2, 2012). "In conclusion, our findings suggest that the 'monolithic' psychiatric discourse (Marsh 2010, p. 168) that dominates Western suicidology, and that has been built largely on the basis of psychological autopsy interviews, is not supported by a close reading of the personal narratives that are woven by bereaved kinfolk in the course of those interviews." (Owens & Lambert 2012, p. 369).

The autopsy of suicides

By studying suicides after the event, researchers endeavor to find out more about the causes of such actions. Specific interpretations of the results of such 'autopsy studies' are used to 'legitimize' the dogmatic claim and taken for granted belief that mental illness is the cause in almost all cases (Jamison, 1999, 100; Cording & Saß, 2009; Jox, 2011, p. 169). Psychological autopsy studies are

driven by deficit- and illness-based approaches, i.e. they deliver the results from the desired perspectives (cf. Rogers & Lester, 2010, p. 13), and are designed and conducted on a low methodological level. "PA [psychological autopsy] studies can therefore not serve as an evidence base for the claim that most people who die by suicide are mentally ill." (Hjelmeland et al., 2012, 621) Competence, reflection, contextual relevance, alternative constructions of meaning and the world and other epistemic, cultural and social aspects are blanked out or 'neutralized' from the start (cf. Fincham et al., 2011), and the narrow and theoretical weak operationalization serves to justify scientifically dubious claims (cf. Pompili, 2011, p. 10 ff). "Cavanagh et al.'s (2003) systematic review of psychological autopsy studies noted that evidence from these studies on psycho-social factors is limited." (Scourfield et al., 2012, p. 467)

Even the term 'autopsy' is itself deceptive: as if diffuse, prejudiced 'gleanings' might be comparable to a (ideally) scientifically based post-mortem examination. Through this 'scientific tradition' supported and sanctified by an illusion of validity (Kahneman, 2011, p. 211), valuable information is hidden in constricted interpretative mantles or not made available to the public. Through the autopsy of suicide, a living context is treated as a pathologized corpse. It is to be presumed that one function of the psychological autopsy of suicides is to provide an 'epistemic cleansing' of a dangerous alternative field for the doxic structures of medicine, politics and the law.

In comparison to other studies from developed nations, autopsy studies in China find that mental disorders account for a significantly lower proportion of the 'causes' of suicides (cf. the references provided in Phillips, 2010). Phillips (2010) discusses this discrepancy in the expected ideological and dogmatic manner. First, he sticks to the fiction of a universally objective definition of 'mental disorder' and, second, he confirms without reflection the supervision postulate: 'suicide must be prevented regardless of its individual and group-specific interpretation, even when it is not caused by a mental disorder!'

Epistemic and normative front and back stages in suicidology

In this section, the behavioral norms for psychiatrists and psychologists outlined in expert literature or encountered in the attitudes and expectations of other people are confronted with the assumed actual behavior of suicide therapists (behavior which still needs to be studied empirically).

- The values of the potential suicide victim should be recognized. – Yet they are 'interpreted' and 'transformed' by the experts.
- The context should be determined. – Yet it must be boiled down to the "clinical conditions'.
- The potential suicide victim should be taken seriously. – Yet all tricks should be used to alter the meaning and system that supports the suicidal tendencies.
- The potential suicide victim is cognitively and emotionally capable of carrying out a project that the majority of people would not be able to do. – Yet in line with the professional doxa, he/she must be 'understood' to be cognitively and emotionally deficient and incompetent.
- Some people in positions of responsibility recognize some acts of suicide as dignified and purely personal. – Yet an orthodox suicidologist cannot recognize an act of suicide as dignified and purely personal under any circumstances.
- The act of suicide can be planned and carried out on the basis of a strong moral decision. – The suicidologist must class the moral and the conscience of the potential suicide victim as secondary to the illness construct and thus devalue them.
- Each potential suicide victim and each suicide is unique, and hence a set of predefined actions for professionals based on a model that offers no alternatives must be rejected. – Yet suicide prevention has to address all suicides, regardless of understanding, context, values and other aspects.

Values and freedom

The conflicts in the suicide field result from values and diverging interests, whereby open, controversial and empirically based public discussions are generally avoided, even though suicide is an important, multifunctional aspect of the life world especially in pluralistic knowledge societies.

Some psychiatrists and suicidologists seek to preserve a sector-specific monopoly when it comes to assessing freedom to act. Freedom is transformed into ability or competence, which is established and measured by psychiatrists. They can then set standards, stigmatize people legitimately as not free to exercise their own will and thus also recruit them for purposes of political or economic gain as (forced) clients. The valuable 'energy of suicidal tendencies' is medicalized through mainstream therapy and thus used to preserve the medical system, not to further society.

A psychiatrist cannot 'freely' perceive and accept a potential suicide candidate. Psychiatrists are forced to apply prescribed professional and institutional theories and practices. These constrained secular priests protect and armor plate the prevailing 'truth', the law, the organization and other powerful institutions from the 'demons'.

Many suicidologists and psychiatrists unduly claim to have brought clarity to the 3,000-year-old debate on free will. All the ignorant have to do is to contact them, and they will tell them if they and others are acting of their own 'free' will or not. The 'free will experts' ignore the fact that free will, ego, self, identity, person, subject, etc. are precarious, changing concepts and constructions steered by money and power, dependent on perspectives, habitus, socio-cultural and other conditions. The 'theories' they use, and the 'empirical evidence' they produce – when forced to do so – do not of course meet the strict scientific criteria that should be applied in such existential matters (cf. Wedler, 2008, 319). There is a lack of reference in psychiatric and suicidology texts to the fact that 'free will', 'free choice' or 'free mind' in modern society are not restricted primarily by mental illness, but by socio-economic disadvantage, the consolidation of structures of privilege and economic and political decisions that lead, among other things, to mental disorders. Guardians and protectors of suicide sell their specific 'technologies of free will and the self' without drawing attention to (un)desired side effects (cf. Rose, 2007). There is also a lack of recognition in psychiatry and suicidology that free will and autonomy discourses also constitute goods, capital and weapons in a capitalist society – e.g. in the political or medical business – framed by habitus and field, and that heteronomy and autonomy do not mill around separately anywhere. A person can achieve autonomy through 'restriction' of awareness and can be made dependent or turned into a submissive producer and consumer and defender of social inequality by the purchase of freedom, e.g. in therapy.

'Unfreedom' of will and loss of self are achieved to a far greater extent by medical measures, above all those to prolong dying, than they are by suicide. In dying processes in hospitals, care homes, hospices and palliative wards, organizational reasons and the artificial prolongation of life result for the clients in a forced reality and strong restrictions on their actions – a favorable climate for suicidal thoughts. High quality empirical studies into this subject have so far been avoided. The usual story told by the caregivers is that suicidal wishes do not arise under these conditions. Yet these "experiences" are the result of a combination of the following elements: firstly, that the patients no longer have the energy and courage for deviation and self-determination, secondly, that they are no longer being heard (or should no longer be heard) and thirdly, the dismantling and destruction of their social and mental life world. Suicidal tendencies in old people are often signs of a highly developed social and mental identity – which is usually linked to an above-average 'freedom as competence' (cf. Applbaum, 2012; Baudelot & Establet 2008, p. 33-34). An important factor that favors suicidal tendencies is namely the obstruction of autonomy and independence as a result of the context (cf. Ehrenberg, 1998). In care homes, the competences required to live and die with dignity are already reduced to such an extent that only suicidal quasi-acts remain possible, the interpretation and symbolic conversion of which is left to the responsibility of the care staff.

Insights into the pathology of the psychiatric profession

8

Many physicians and psychiatrists are pulled in by their professionally laced corsets, and act in an unreflective and ritualized manner. The following citations offer examples:

"It is estimated that close to 90% of people who suicide have a psychiatric diagnosis at the time of their death … But, argue those in favour of physician-assisted suicide, this does not apply to those with terminal illness. These are not people with despairing emotional states but rather rational human beings wanting a sensible degree of control over the circumstances of their death (Tucker and Steele, 2007). Again, the data simply do not support this. Patients with terminal illness wanting to hasten their own death have been found to have higher rates of depressive symptom scores, lower family cohesion and a greater sense of being a burden on their families (Kelly et al., 2004). The strongest predictive factor for a wish to hasten death in those with terminal illness is not pain, or health status, but hopelessness (Akechi et al., 2001; Breitbart et al., 2000; Chochinov et al., 1998)." (Vamos, 2012, p. 85)

Elements of the ritualized argumentation: 90%, data, depression, burden, hopelessness. That it is not about "data" but about doxa, that depression can also be a resource, that hopelessness does not 'exclude' rational thought and behavior – these are all things that are not allowed to be thought and written. According to a study by Kogan, Tucker & Porter (2011), social economic burden is a central attitude factor, while psychiatrists vilify it as a symptom of illness – not least because it serves only too well as a reminder of their own economic interests and those of their clients.

"Patients who desire death during a serious or terminal illness are usually suffering from treatable depression (Breitbart, 1987; Breitbart, 1990)" (Sher, 2012, p. 87). Implicit postulate: What's treatable, must be treated, even if the treatment is not adequate for the habitus or has a depersonalizing effect. Implicit value judgment: if a depression is a 'cause' of the desire to shorten the process of dying, the physician must act dogmatically against this wish regardless of other considerations. Implicit scientific norm: deviating hypotheses must be concealed and symbolically destroyed.

"A request for assisted suicide is usually a call for help and a sign of depression (Greene, 2006). It is a call for positive alternatives as solutions for real, difficult problems." (Sher, 2012, p. 87) Implicit dogmatic understanding of reality (sign of inadequate scientific theory and professional training): the physician knows better than the patient about the latter's 'whole person'. The physician is a priest, only he can interpret such calls for help correctly.

"The wish to die is not stable over time. Suicidal intent is typically transient. Of those who attempt suicide but are stopped, less than 4% go on commit suicide in the next 5 years (Rosen, 1976) and less than 11% will kill themselves over the next 35 years (Dahlgren, 1977)." (Sher, 2012, p. 88). Implicit insight: if stopped from committing suicide, a person who only has a few weeks left to live would not kill himself/herself over the next 35 years. Implicit value judgment: instable patient wishes should be disregarded by physicians.

"In some countries, governments and insurance companies may put pressure on physicians and hospital administrators to avoid life-saving measures or recommend euthanasia or assisted suicide." (Sher, 2012, p. 88) Implicit unverified factual claim: in most cases, physicians act without external social pressure primarily in the interests of their clients. Implicit standard: external social pressure on physicians should be categorically assessed as negative.

The suicidologist Wolfersdorf (2007) lists overlapping types or forms of suicide without convincing theoretical basis, but omits to name "rational suicide"or "accepted suicide" (p. 20). The type of suicide discussed in this section (suicide that is legally and socially worth protecting) corresponds most to Wolfersdorf's category of "so-called *Freitod*" (killing oneself in the absence of mental, somatic or social need)". It goes without saying that this type is de facto non-existent. Why suicide cannot be committed "of free will", "rationally" and "socially accepted" 'in the presence of mental, somatic or social need' remains a secret of the experts. "…the data do not support the idea that

suicide cannot be chosen rationally or that it is never chosen rationally, or even that it is rarely chosen rationally." (Luper, 2009, p. 181).

The following quote further emphasizes the professional tunnel vision: "Those people who frequently encounter older people in suicidal crises or following an attempted suicide in their work know that acts of suicide by older people are practically always caused by situations of emotional suffering, frequently in combination with external misery, and are not the result of a level-headed, rational decision (cf. Teising, 2001). What is dangerous is that the person who interprets the suicidal considerations of an older person as 'rational' is less willing to provide help." (Wächtler, Erlemeier & Teising, 2008, p. 134; translation by the author)

The usual prejudices and stereotypes return: the intention to commit suicide is not 'rational'. Only if a suicidologist were to confirm the 'rationality' would acceptance perhaps be an option. Only professional helpers can define what 'help' means. People who provide help that does not conform to the dogma, e.g. who help someone to commit suicide, are threatened.

Even a suicidologist at the Max-Planck-Institute for Psychiatry submits to the accepted dogmatic frame of reference: "It is ultimately the ambivalence of the actual person at risk of suicide that contradicts the prerequisite for a suicide, namely a decision for death and against life that is made of one's own free will." (Bronisch, 2007, p. 124; translation by the author). Bronisch uses the term 'ambivalence' in an individual psychology or personality theory context. As the typical suicide in line with the psychiatric construction, Bronisch champions a restricted (monodisciplinary) perspective. Ambivalence and ambiguity are now normal phenomena in the dying process (cf. Valentine, 2008, 36 f; Broom & Cavenagh, 2011). In this intricate situation, insight is not gained from a psychiatric prophesy that indicates the profession's conservative ideology and epistemic dogmatic, but from multiperspective, transdisciplinary reflection. Constitutive is an anthropological or existential ambivalence that has been worked on in all cultures and for which there is no categorical 'solution' (cf. Hadders, 2011, p. 231). A cultural ambivalence can be discerned in the two key Western death scenes, namely those of Socrates and Jesus Christ (the latter of which was discussed by John Donne (1647/1982) as a suicide): a high share of suicide with a simultaneous official emphasis on the legitimate or illegitimate killing depending on the perspective. Social ambivalence would appear to be more relevant for today's situation, and is demonstrated in the fact that killing has been monopolized by the state and its loyal servants, which is why killers who are not commissioned by state officials are subject to the threat of severe punishment, while suicide is now no longer liable to prosecution. The professional ambivalence can be seen in the attitudes and behavior of many psychiatrists and suicidologists: officially providing help, unofficially misleading, punishing, humiliating, constricting and weakening. These socio-cultural ambivalences are reflected in the appreciations of many people and also emerge in study findings: an increasing number of people accept active euthanasia, thus advocate individual mercy killing in a state-controlled setting, yet still have concerns when it comes to suicide (cf., for example, Tännsjö, 2006). Tännsjö expresses his astonishment over this result with social scientific naivety and philosophical arrogance: "My interpretation of this discrepancy is that people generally have no well thought out opinion on these matters." (ibid. 44; translation by the author). Brock (1992, p. 21) maintains that people seek active euthanasia or active assisted suicide because an (unassisted and unauthorized) suicide would bring stigmatization to them and their loved ones.

Dogmatists, paternalists and believers in verification do not want or are unable to recognize that more and more people are ambivalently and multivalently rejecting the purity ideals and restrictions of autonomy in theological, medical, legal and philosophical treatises, church and other pamphlets, medical association communiques and soap-box oratories (cf. Dawson, 2012). A representative longitudinal study of the population over the age of 64 carried out in The Netherlands from 2001 to 2009 shows that an increasing number of old people support actively assisted suicide and easier access to the 'end-of-life pill'. (Buiting et al., 2012).

10

We would like to close this section with another illustrative comparison. The findings of empirical research into the attitudes of teachers to migrant children (Auernheimer, 2008, p. 461), can be transferred astoundingly well to the attitudes of many psychiatrists and suicidologists to people who (attempt to) commit suicide:

1. Fixation on other 'mentalities',
2. Blindness to difference (differences between groups and individuals),
3. Global suspicion of 'fundamentalism' (own 'fundamentalism' is transferred to the client),
4. Demand for assimilation and normalization,
5. Exclusive 'tolerance',
6. Mission (cure, prevention),
7. No questioning of individual perception and assessment patterns,
8. Infantilization, assumption of irrationality and immaturity.

Result of the diagnosis of the suicidological framework in psychiatric organizations: ritualized practices and a dogmatic doxa are legitimized through a body of knowledge with an inadequate theoretical and methodological base that is designed to maintain relations of power which promote inequality and is immune to criticism.

The field of self-determined and externally-determined dying

Self-determination and external determination are analytical concepts, i.e. they can be changed and adapted in accordance with theories, the context and personal semantics. When a person in a care home refuses to eat, experts describe this as self-destructive behavior, although it could be seen from a personal and from a scientific perspective as self-fulfilling behavior. Self-descriptions provided by elderly, ill people, particularly those who have to live in total institutions, are generally ignored and rarely recognized by the professionals, who reinterpret them in line with their own 'theories' and interests. The apparently objective 'diagnosis of reality' by professionals or even by other regulatory bodies, e.g. police officers or judges, transpires to be a dogmatic, pseudo universal, perspectival external description.

From a critical, interdisciplinary perspective, suicidality is not just a consequence of the effect of 'inner powers' (psychology, medicine) or 'external powers' (sociology), it is a relation or habitus disposition within a field (Bourdieu, 1998, 2000). Accordingly, understanding and explaining suicidality is a pragmatic, dynamic and multiperspective activity on the micro-, meso- and macro-levels, the scientific observation of which is poor and lacking in current psychiatric theories (cf. Rogers & Lester, 2010). A critical debate on suicide and its diversities attacks political, economic and professional relations and demands a fair context for autonomy and humanization to unfold.

The recognition of self-determined planning of dying, in which suicide, assisted suicide and euthanasia were options, would be a step on the path towards destigmatization, humanization and liberalization. The rational suicide construct is, however, hardly suitable for such a cultivation discourse, since it is used in the literature and expert debate in an oscillatory, interest-dependent manner that dismisses empirical evidence (cf. Wittwer, 2003, 49; Fenner, 2008, p. 283).

Ultimately, the determining factor is not how rational a decision to commit suicide is to the experts, but that the circumstances of life allow people to make decisions in their own interest – either alone or with their loved ones or persons of reference – about whether to extend or shorten their physical, psychic and social lives (cf. Feldmann, 2010, p. 126-139). Yet a structural approach of this kind is marginalized in suicidology and psychiatry.

Prevention: There is no alternative! There is an alternative: Cultivation!

Applbaum, A. I. (2012). All foundings are forced. *HKS Faculty Research Working Paper Series 12*(42). Retrieved February 3, 2014 from http://dash.harvard.edu/bitstream/handle/1/9804489/RWP12-

042_Applbaum.pdf?sequence=1

Auernheimer, G. (2008). Lehrer-Schüler-Interaktion im Einwanderungsland. In M. K. Schweer (Ed.), *Lehrer-Schüler-Interaktion: Inhaltsfelder, Forschungsperspektiven und methodische Zugänge* (Vol. 2, pp. 455-478). Wiesbaden: VS Verlag für Sozialwissenschaften.

Baechler, J. (1979). *Suicides.* New York: Basic Books.

Barraclough, B., & Hughes, J. (1987). *Suicide: clinical and epidemiological studies.* London: Croom Helm.

Baudelot, C., & Establet, R. (2008). *Suicide. The hidden side of modernity.* Cambridge: Polity.

Baumann, U. (2001). *Vom Recht auf den eigenen Tod. Die Geschichte des Suizids vom 18. bis zum 20. Jahrhundert.* Weimar: Böhlau.

Bayatrizi, Z. (2008). *Life sentences. The modern ordering of mortality.* Toronto: University of Toronto Press.

Bayatrizi, Z. (2010). John Weaver, A Sadly Troubled History: The Meanings of Suicide in the Modern Age. *Canadian Journal of Sociology, 35*, 169-172.

Bourdieu, P. (1998). *Practical reason: On the theory of action.* Cambridge: Polity Press.

Bourdieu, P. (2000). *Pascalian meditations.* Stanford, CA: Stanford University Press.

Brock, D. W. (1992). Voluntary active euthanasia. *Hastings Center Report, 22*(2), 10-22.

Bronisch, T. (2007). *Der Suizid* (5th ed.). München: Beck.

Broom, A., & Cavenagh, J. (2011). On the meanings and experiences of living and dying in an Australian hospice. *Health, 15*(1), 96-111.

Buiting, H. M., Deeg, D. J., Knol, D. L., Ziegelmann, J. P., Pasman, H. R., Widdershoven, G. A., et al. (2012). Older peoples' attitudes towards euthanasia and an end-of-life pill in The Netherlands: 2001–2009. *Journal of Medical Ethics, 38*(5), 267-273.

Cavanagh, J. T., Carson, A. J, Sharpe, M., & Lawrie, S. M. (2003). Psychological autopsy studies of suicide: a systematic review. *Psychological Medicine, 33*(3), 395-405.

Chu, J. P., Goldblum, P., Floyd, R., & Bongar, B. (2010). The cultural theory and model of suicide. *Applied and Preventive Psychology, 14*, 25-40.

Clavandier, G. (2009). *Sociologie de la mort.* Paris: Armand Colin.

Conwell, Y., Van Orden, K., & Caine, E. D. (2011). Suicide in older adults. *Psychiatr Clin North Am, 34*(2), 451-468.

Cording, C., & Saß, H. (2009). Begutachtung der „freien Willensbestimmung" bei Suizid in der Lebensversicherung. *Der Nervenarzt, 80*(9), 1070-1077.

Dawson, M. (2012). Reviewing the critique of individualization: The disembedded and embedded theses. *Acta Sociologica, 55*(4), 305-319.

Donne, J. (1982). *Biathanatos.* New York.

Douglas, J. . (1976). *The social meanings of suicide.* Princeton: Princeton University Press.

Ehrenberg, A. (1998). *La Fatigue d'être soi – dépression et société.* Paris: Odile Jacob.

Fairbairn, G. (1998). Suicide, language, and clinical practice. *Philosophy, Psychiatry, & Psychology 5*(2), 157-169.

Feldmann, K. (1998). Suizid und die Soziologie von Sterben und Tod. *Österreichische Zeitschrift für Soziologie, 23*(4), 7-21.

Feldmann, K. (2010). *Tod und Gesellschaft. Sozialwissenschaftliche Thanatologie im Überblick.* Wiesbaden:

VS-Verlag.

Fenner, D. (2008). *Suizid - Krankheitssymptom oder Signatur der Freiheit? Eine medizinethische Untersuchung.* Freiburg: Karl Alber.

Fincham, B., Langer, S., Scourfield, J., & Shiner, M. (2011). *Understanding suicide: A sociological autopsy.* Basingstoke: Palgrave Macmillan.

Hadders, H. (2011). Negotiating leave-taking events in the palliative medicine unit. *Qualitative Health Research, 21*(2), 223-232.

Hanafin, P. (2009). *Rights of passage: law and the biopolitics of dying.* Retrieved from eprints.bbk.ac.uk/820/1/Phanafin820.pdf

Hjelmeland, H. (2010). Cultural research in suicidology: Challenges and opportunities. *Suicidology Online* 1, 34-52.

Hjelmeland, H. (2013). Suicide research and prevention: the importance of culture in "biological times". In E. Colucci & D. Lester (Eds.) with H. Hjelmeland & B.C.B. Park, *Suicide and culture. Understanding the context* (pp. 3-23). Cambridge, MA: Hogrefe.

Hjelmeland, H., Dieserud, G., Dyregrov, K., Knizek, B. L., & Leenaars, A. A. (2012). Psychological autopsy studies as diagnostic tools: Are they methodologically flawed? *Death Studies, 36*(7), 605-626.

Howarth, G. (2007). *Death and dying. A sociological introduction.* Cambridge: Polity Press.

Jamison, K. R. (1999). *Night falls fast: understanding suicide.* New York: Vintage Books.

Jordan, J. R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behavior, 31*(1), 91-102.

Jox, R. J. (2011). *Sterben lassen. Über Entscheidungen am Ende des Lebens.* Hamburg: edition Körber-Stiftung.

Kahneman, D. (2011). *Thinking, fast and slow.* New York: Farrar, Straus & Giroux.

Kitanaka, J. (2009). Questioning the suicide of resolve: medico-legal disputes regarding ,overwork-suicides' in twentieth-century Japan. In J. Weaver & D. Wright (Eds.), *Histories of suicide. International perspectives on self-destruction in the modern world* (pp. 257-280). Toronto: University of Toronto Press.

Kogan, N., Tucker, J., & Porter, M. (2011). Extending the human life span: An exploratory study of pro- and anti-longevity attitudes. *The International Journal of Aging and Human Development, 73*(1), 1-25.

Lester, D. (2003). *Fixin' to die. A compassionate guide to committing suicide or staying alive.* Amityville, New NY: Baywood.

Lester, D. (2006). Can suicide be a good death? *Death Studies, 30*, 511-528.

Luper, S. (2009). *The philosophy of death.* Cambridge: Cambridge University Press.

Marsh, I. (2010). *Suicide. Foucault, history and truth.* Cambridge: Cambridge University Press.

Minagawa, Y. (2013). The social consequences of postcommunist structural change: An analysis of suicide trends in Eastern Europe. *Social Forces, 91*(3), 1035-1056.

Mitchell, E. A. (2009). *Phenomenological psychological autopsies: a survivor driven model for understanding suicide.* Master's thesis. The University of Texas at Arlington.

Owens, C., & Lambert, H. (2012). Mad, bad or heroic? Gender, identity and accountability in lay portrayals of suicide in late twentieth-century England. *Culture, Medicine, and Psychiatry, 36*, 348-371.

Ozawa-De Silva, Ch. (2010). Shared death: Self, sociality and internet group suicide in Japan. *Transcultural Psychiatry, 47*(3), 392-418.

Petersen, A. (2011). Authentic self-realization and depression. *International Sociology, 26*(1), 5-24.

Phillips, M. R. (2010). Rethinking the role of mental illness in suicide. *The American Journal of Psychiatry, 167*(7), 731-733.

Pilgrim, D., & Bentall, R. (1999). The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of Mental Health, 8*(3), 261-274.

Pompili, M. (2010). Suicidology: a new discipline for preventing suicide. In M. Pompili (Ed.). *Suicide in the word of suicidologists.* (pp. 1-8). New York: Nova Science.

Pompili, M. (2011). Evidence-based practice in suicidology: what we need and what we need to know. In M. Pompili & R. Tatarelli (Eds.), *Evidence-based practice in suicidology: a source book* (pp. 3-26). Cambridge, MA: Hogrefe.

Rogers, J.R., & Lester, D. (2010). *Understanding suicide. Why we don't and how we might.* Cambridge, MA: Hogrefe.

Rose, N. (2007). *The politics of life itself. Biomedicine, power, and subjectivity in the twenty-first century.* Princeton: Princeton University Press.

Rosenquist, J. N, Fowler, J. H., & Christakis, N. A. (2011). Social network determinants of depression. *Molecular Psychiatry, 16*, 273–281.

Rubin, E. (2010). Assisted suicide, morality, and law: Why prohibiting assisted suicide violates the establishment clause. *Vanderbilt Law Review, 63*, 763-811.

Schlimme, J. E. (2013). Sense of self-determination and the suicidal experience. A phenomenological approach. *Med Health Care and Philos, 16*, 211-223.

Scourfield, J., Fincham, B., Langer, S., & Shiner, M. (2012). Sociological autopsy: An integrated approach to the study of suicide in men. *Social Science & Medicine, 74*, 466-473.

Sher, L. (2012). What should we tell medical students and residents about euthanasia and assisted suicide? *Aust N Z J Psychiatry, 46*(2), 87-91.

Silverman, M. M. (2011). Challenges to classifying suicidal ideations, communications, and behaviours. In R. O'Connor, S. Platt & J. Gordon (Eds.), *International handbook of suicide prevention* (pp. 9-25). New York: Wiley.

Sudak, H., Maxim, K., & Carpenter, M. (2008). Suicide and stigma: A review of the literature and personal reflections. *Academic Psychiatry, 32*, 136-143.

Swarte, N. B., Van der Lee, M. L., Van der Bom, J. G., Van den Bout, J., & Heintz, P. M. (2003). Effects of euthanasia on the bereaved family and friends: a cross sectional study. *Brit Med Journal, 327*, 189-193.

Szasz, T. (1999). *Fatal freedom. The ethics and politics of suicide.* Westport: Praeger.

Tännsjö, T. (2006). *Zur Ethik des Tötens.* Münster: LIT.

Tomasini, F. (2012). A stoic defence of rational suicide. *Medicine Health Care and Philosophy.*

Valentine, C. (2008). *Bereavement narratives. Continuing bonds in the twenty-first century.* London: Routledge.

Vamos, M. J. (2012). Physician-assisted suicide: Saying what we mean and meaning what we say. *Australian and New Zealand Journal of Psychiatry 46*, 284-286.

Van Hooff, A. J. L. (1990). *From autothanasia to suicide. Self-killing in classical antiquity.* London: Routledge.

Vollmann, J. (2008). *Patientenselbstbestimmung und Selbstbestimmungsfähigkeit: Beiträge zur klinischen Ethik.* Stuttgart: Kohlhammer.

Wächtler, C., Erlemeier, N., & Teising, M. (2008). Alte Menschen und Suizidalität – Entstehungsbedingungen, therapeutische Strategien, Prävention. In M. Wolfersdorf, T. Bronisch & H. Wedler (Eds.), *Suizidalität. Verstehen – Vorbeugen – Behandeln* (pp. 129-143). Regensburg: Roderer.

Weaver, J. C. (2009). *A sadly troubled history. The meanings of suicide in the modern age.* Montreal: McGill-Queen's University Press.

Wedler, H. (2008). Ethische Aspekte der Suizidprävention In M. Wolfersdorf, T. Bronisch & H. Wedler (Eds.), *Suizidalität. Verstehen – Vorbeugen – Behandeln* (pp. 311-337). Regensburg: Roderer.

Westerlund, M. (2012). The production of pro-suicide content on the internet: A counter-discourse activity. *New Media & Society, 14*(5), 764-780.

Whitaker, A. (2010). The body as existential midpoint—The aging and dying body of nursing home residents. *Journal of Aging Studies, 42*(2), 96-104.

Wittwer, H. (2003). *Selbsttötung als philosophisches Problem: Über die Rationalität und Moralität des Suizids.* Paderborn: Mentis.

Wolfersdorf, M. (2007). Suizid aus klinischer psychiatrisch-psychotherapeutischer Sicht. In J. E. Schlimme (Ed.), *Unentschiedenheit und Selbsttötung* (pp. 17-28). Göttingen: Vandenhoeck & Ruprecht.

Yur'yev, A., Värnik, P., Sisask, M., Leppik, L., Lumiste, K., & Värnik, A. (2013). Some aspects of social exclusion: Do they influence suicide mortality? *International Journal of Social Psychiatry, 59*(3), 232-238.

Klaus Feldmann, retired Professor of Sociology, University of Hanover, Germany.

Kontakt: k.feldmann@ish.uni-hannover.de