TOWARDS AN ECOSYSTEMIC UNDERSTANDING OF SUICIDAL BEHAVIOUR

by

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submitted in part fulfilment of the requirements for the degree of

MASTER OF ARTS IN CLINICAL PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

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MARCH 1999
ACKNOWLEDGEMENTS

I thank my family, friends and colleagues for their interest and support during the course of this work. I am particularly indebted to the following people:

- Professor David Fourie, my supervisor, for providing me with an opportunity to establish a "way of being" with which I feel so much more comfortable.

- My clients at TARA and Johannesburg Hospitals who "talked suicide" with me; for sharing an intensity that made me fall in love with this topic, making me aware of a medium through which I could appreciate life.

- James Kitching and the UNISA library personnel for their assistance in obtaining reference material.

- Claudette Nothnagel, for helping me with the APA guidelines.

- Danie, for financial assistance and emotional support.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title Page</td>
<td>i</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>ii</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>iii</td>
</tr>
<tr>
<td>Summary</td>
<td>vi</td>
</tr>
</tbody>
</table>

## CHAPTER 1: INTRODUCTION

1

## CHAPTER 2: THE PSYCHIATRIC PARADIGM

2.1 Introduction

2.2 The Psychiatric Paradigm and Suicidal Behaviour

2.2.1 The Biological Perspective

2.2.2 The Psychoanalytic Perspective

2.2.3 The Behavioural and Cognitive Perspective

2.3 Conclusion

5

## CHAPTER 3: THE SOCIOLOGICAL PARADIGM

3.1 Introduction

3.2 Microlevel Explanations

3.2.1 Poor Family Communication and Problem Solving

3.2.2 Scapegoating of the Suicidal Child

3.2.3 Attachment Theory

3.2.4 Marital Dysfunction

3.2.5 Parental Psychopathology

3.3 Social-Psychological (Exolevel) Explanations

3.4 Sociocultural (Macrolevel) Explanations

3.5 Conclusion

16

## CHAPTER 4: THE ECOSYSTEMIC PARADIGM

4.1 Introduction

30
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2</td>
<td>The shift to an Ecosystemic Epistemology</td>
<td>31</td>
</tr>
<tr>
<td>4.3</td>
<td>Characteristics of Ecosystemic Thinking</td>
<td>31</td>
</tr>
<tr>
<td>4.4</td>
<td>Cybernetics</td>
<td>33</td>
</tr>
<tr>
<td>4.4.1</td>
<td>Feedback</td>
<td>33</td>
</tr>
<tr>
<td>4.4.2</td>
<td>Self-regulation and Homeostasis</td>
<td>34</td>
</tr>
<tr>
<td>4.4.3</td>
<td>Self-organization</td>
<td>34</td>
</tr>
<tr>
<td>4.5</td>
<td>Cybernetics of Cybernetics</td>
<td>34</td>
</tr>
<tr>
<td>4.5.1</td>
<td>Autonomy and Self-reference</td>
<td>35</td>
</tr>
<tr>
<td>4.5.2</td>
<td>Structure Determinism</td>
<td>35</td>
</tr>
<tr>
<td>4.5.3</td>
<td>Structural Coupling and Non-purposeful Drift</td>
<td>36</td>
</tr>
<tr>
<td>4.5.4</td>
<td>Consensual Domains and Language</td>
<td>36</td>
</tr>
<tr>
<td>4.5.5</td>
<td>Objectivity-in-parentheses</td>
<td>37</td>
</tr>
<tr>
<td>4.5.6</td>
<td>Autopoiesis</td>
<td>37</td>
</tr>
<tr>
<td>4.6</td>
<td>Implications for Family Systems</td>
<td>38</td>
</tr>
<tr>
<td>4.7</td>
<td>A Reconceptualization of Suicidal Behaviour</td>
<td>40</td>
</tr>
<tr>
<td>4.8</td>
<td>Implications of Ecosystemic Thinking for Psychotherapy</td>
<td>43</td>
</tr>
<tr>
<td>4.8.1</td>
<td>Introduction</td>
<td>43</td>
</tr>
<tr>
<td>4.8.2</td>
<td>No Unitory Theory</td>
<td>43</td>
</tr>
<tr>
<td>4.8.3</td>
<td>First-order vs Second-order Cybernetics</td>
<td>44</td>
</tr>
<tr>
<td>4.8.4</td>
<td>Epistemology</td>
<td>46</td>
</tr>
<tr>
<td>4.8.5</td>
<td>Redefining &quot;Therapist&quot;</td>
<td>48</td>
</tr>
<tr>
<td>4.8.6</td>
<td>Diagnosis vs Meaning</td>
<td>50</td>
</tr>
<tr>
<td>4.8.7</td>
<td>Language and Meaning</td>
<td>51</td>
</tr>
<tr>
<td>4.9</td>
<td>Criticism</td>
<td>52</td>
</tr>
<tr>
<td>4.10</td>
<td>Conclusion</td>
<td>53</td>
</tr>
</tbody>
</table>

CHAPTER 5: RESEARCH ON SUICIDAL BEHAVIOUR

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Introduction</td>
<td>55</td>
</tr>
<tr>
<td>5.2</td>
<td>Methodological Problems in Suicide Research</td>
<td>55</td>
</tr>
<tr>
<td>5.2.1</td>
<td>Defining Suicidal Behaviour</td>
<td>55</td>
</tr>
<tr>
<td>5.2.2</td>
<td>Methods of Investigation</td>
<td>61</td>
</tr>
<tr>
<td>5.2.3</td>
<td>Conclusion</td>
<td>68</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>5.3</td>
<td>Implications of a Second-order Perspective for Research</td>
<td>69</td>
</tr>
<tr>
<td>5.3.1</td>
<td>Introduction</td>
<td>69</td>
</tr>
<tr>
<td>5.3.2</td>
<td>The Legitimization of Knowledge</td>
<td>70</td>
</tr>
<tr>
<td>5.3.3</td>
<td>An Ethic of Participation</td>
<td>71</td>
</tr>
<tr>
<td>5.3.4</td>
<td>Moral Issues and New Paradigm Research</td>
<td>72</td>
</tr>
<tr>
<td>5.3.5</td>
<td>A Proposal: Public Discussion of Professional Values</td>
<td>72</td>
</tr>
<tr>
<td>5.3.6</td>
<td>An Example: Exploration of Individual Values and how it can Impact Therapy with Suicidal Individuals</td>
<td>74</td>
</tr>
<tr>
<td>5.4</td>
<td>Conclusion</td>
<td>77</td>
</tr>
<tr>
<td>CHAPTER 6: ETHICS AND SUICIDAL BEHAVIOUR</td>
<td></td>
<td>78</td>
</tr>
<tr>
<td>6.1</td>
<td>Introduction</td>
<td>78</td>
</tr>
<tr>
<td>6.2</td>
<td>Towards an Understanding of the Current Perception of Suicide</td>
<td>78</td>
</tr>
<tr>
<td>6.3</td>
<td>Preventing Suicide</td>
<td>80</td>
</tr>
<tr>
<td>6.4</td>
<td>Professional Liability</td>
<td>80</td>
</tr>
<tr>
<td>6.5</td>
<td>Responsibility for Suicide</td>
<td>85</td>
</tr>
<tr>
<td>6.6</td>
<td>The Right to Suicide</td>
<td>86</td>
</tr>
<tr>
<td>6.7</td>
<td>An Ethic of Participation</td>
<td>87</td>
</tr>
<tr>
<td>6.8</td>
<td>Conclusion</td>
<td>90</td>
</tr>
<tr>
<td>CHAPTER 7: CONCLUSION AND RECOMMENDATIONS</td>
<td></td>
<td>91</td>
</tr>
<tr>
<td>7.1</td>
<td>Theories on Suicidal Behaviour</td>
<td>91</td>
</tr>
<tr>
<td>7.2</td>
<td>Discussion</td>
<td>92</td>
</tr>
<tr>
<td>7.3</td>
<td>Implications for the Treatment of Suicidal Behaviour</td>
<td>95</td>
</tr>
<tr>
<td>7.4</td>
<td>Recommendations for Future Research on Suicidal Behaviour</td>
<td>96</td>
</tr>
<tr>
<td>7.5</td>
<td>Conclusion</td>
<td>97</td>
</tr>
</tbody>
</table>

REFERENCES                                                                 | 100 |
SUMMARY

In this dissertation the literature on suicidal behaviour is reviewed, with particular emphasis on professional conceptualizations and understanding as informed by the psychiatric and sociological paradigms. Basic postulates of the Ecosystemic paradigm, as it is informed by Maturana's second-order cybernetic approach was discussed. The effect of such an approach on therapy with suicidal individuals was pointed out.

It became clear that perceived methodological problems experienced when researching suicidal behaviour from a Newtonian/realist paradigm can be side-stepped when viewed from an Ecosystemic paradigm.

It was finally proposed that an ethic of participation, as informed by a second-order cybernetic approach, be adopted when viewing the suicide situation. In the process ethics was reconceptualized as an awareness of the therapist's participation in whatever is created, and not in finding the "right" way when working with suicidal individuals.

Key terms:

Suicidal behaviour; Psychiatric paradigm; Sociological paradigm; Ecosystemic paradigm; Second-order cybernetic approach; Ethics of participation; Reconceptualization; Methodology of suicide research; Theories of suicide; Ethics; Moral issues; Professional liability; Right to suicide.
I declare that

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is my own work and that all the sources that I have used or quoted have been indicated
and acknowledged by means of complete references.
CHAPTER 1

INTRODUCTION

As our technology develops, as our populations strain the world economy, as alienation becomes part of our existence, and violence in every form confronts mankind, it is not surprising that the violence of suicide has become epidemic (Richman, 1986). Still, suicide is one of our most powerful taboos. It threatens both our individual connectedness with others and also our collective connection as a social community. Individually and collectively our instinct is to avoid the term as a way of distancing ourselves from the reality it spells out (Alexander, 1991). Although death has recently become a popular subject, a great difficulty can still be seen in thinking about it rigorously in relation to psychological theory (Lifton, 1991). This can be seen as a symbol of our own conceptual denial of death as well as of suicide.

The proliferation of literature and research regarding the assessment of suicide risk as well as the prevention of it emphasize the last statement. Although a lot has been written about suicidal behaviour it seems to represent a limited way of looking at the phenomenon, especially with regards to the professional’s role in dealing with it. A very definite behavioural approach is usually therapeutically prescribed, with assessment and prevention as its main aims to the professional. It does not allow any in-depth understanding of individual and wider system behaviour and subsequently hampers therapeutic maneuverability. This view is held firmly in place by a society that imposes both a moral and legal obligation on the clinician to act responsibly.

It is against this background of limited understanding of suicidal behaviour specifically as it includes the clinician, that it was decided to do a theoretical study on the implications of an ecosystemic epistemology for understanding suicidal behaviour. The idea being, that an epistemology which not only includes the investigation of wider systems (including the therapeutic one) but also higher orders of thinking, could illuminate this phenomenon.
The aim of this dissertation is, therefore, to focus professional and clinical attention on suicidal behaviour by means of a theoretical study to eventually illuminate the phenomena. This is done because of the following reasons:

- Suicidal behaviour represents the "ultimate behavioural action" (Wagner, 1997, p.246) a therapist sooner or later has to face.

- Although we cannot claim to be the exclusive authority on or guardian against suicidal behaviour (Lifton, 1991) societal expectations on our profession to deal with it is huge.

- Carnes states that suicidal behaviour is seen by some as the only philosophical question worth pursuing (in Diekstra & Moritz, 1987) because it not only addresses obvious questions about death but is also concerned with life continuity and the meaning of life on all levels (Lifton, 1991).

- Suicidal behaviour presents a philosophical question with paradoxical characteristics. It is seen by some (Diekstra & Moritz, 1987) as the most supreme expression of human freedom as well as the expression of "hopeless longing to regain a lost paradise" (p.8). This characteristic makes it ideal content for epistemological evaluation and practices.

- Suicidal behaviour represents an extremely appropriate metaphor for therapists to explore their own theoretical biases and informal theories, something which an ethic of participation strongly advocates.

To succeed with the above this dissertation will:

- Bring together the theories historically used to understand suicidal behaviour in order to obtain a more comprehensive picture of the current state of theory about this phenomenon. This also represents the main aim of this dissertation. Atkinson and Heath (1987) propose that we as researchers retrace the distinctions we have drawn in constructing a specific phenomenon. This is done so that the reader can
do the same. The reader is therefore taught the process of constructing a view. In doing so a more comprehensive picture of the current state of theory about suicidal behaviour would be presented. "To understand any realm of phenomena, we should begin by noting how it was constructed, i.e., what distinctions underlie its creation" (Keeney, 1983a, p.21). In light of this, "research becomes a task of re-examining (i.e., re-searching) what one did to construct a particular reality" (Keeney & Morris, 1985, p. 548). Chapter 2 will focus on the theories making up the psychiatric paradigm, while Chapter 3 focuses on sociological theories.

Propose the ecosystemic view on suicidal behaviour as a more appropriate way of dealing with this distressing behaviour. Auerswald (1987) says that the ecosystemic paradigm is more than a paradigm. He describes it as an epistemology "sufficiently developed to be used as a basis for solutions of even larger human problems" (p.329). This epistemology is also congruent with the new science view and provides the basis for a technology of transformation (Auerswald, 1985). It would thus be sufficient to be used with the universal problem that suicide provides. The ecosystemic paradigm will be presented in Chapter 4.

Explore various methodological issues regarding research into suicidal behaviour. Research into suicidal behaviour as informed by the Newtonian epistemology with related methodological problems will be followed by a discussion of the new research paradigm in Chapter 5.

Discuss the ways in which therapists can remain ethical in their therapy with suicidal individuals. Maturana (1988) states that the development of ethical dilemmas are inevitable if we choose a dialectic approach and become interested in the conversation between structure and organization, change and stability, order and chaos, subsystem and ecosystem. In Chapter 6 the writer will give a brief overview of the development of suicidal behaviour and ethics.

Chapter 7 will point out how this whole endeavor represents an exercise important for theory building in the new science paradigm and will also act as a conclusion to this dissertation.
As can be seen from the above, this review of the literature on suicide will be presented as it is subsumed in three paradigms. The specific paradigms will be discussed in some detail to contextualize the theories chosen. The Psychiatric paradigm will be discussed in Chapter 2, the Sociological paradigm in Chapter 3, and the Ecosystemic paradigm in Chapter 4. Although Auerswald (1987) proposes five paradigms specifically applicable to family therapy theory, it will not be used here for the following reason. Most of social conversation around suicidal behaviour started when there was no formal family therapy movement. Because this exercise is part of an ecological understanding of suicidal behaviour and because actions by many medical professionals dealing with suicidal behaviour is still influenced and informed by the first (although outdated according to the family therapy movement) paradigm, it will be discussed here. The three approaches most often used in sociology were chosen because they represent more distinctly the wide range of social conversation around suicide. It also represents the epistemological shifts that this researcher would want to include in her study.
CHAPTER 2

THE PSYCHIATRIC PARADIGM

2.1 Introduction

Auerswald (1987, p.321) describes the term “paradigm” as a “set of rules… used by a specific group, to define a sub-unit of a universal reality”. Dell (1985, p.2) uses Scheflen’s (1981) more specific definition of paradigm as “a body of theories, methods and findings about a particular phenomenon”. The three paradigms as well as their theories used in this dissertation are included to provide a more holistic view of suicidal behaviour. They need not be seen as mutually exclusive but rather as complementary. The paradigmatic distinctions used in this dissertation and named in Chapter 1, are not clear-cut and would thus not be presented in a rigid way, but rather serve as an attempt to present the data in a more orderly fashion.

The psychiatric or medical paradigm has been the dominant worldview in western civilization for many years and focuses on empiricism, with its assumptions about external forces of prediction and control (Aarons, 1995). The assumption is that there is a real world “out there” and if we are rigorous enough in our observations, we will be able to obtain an accurate and objective map of this reality (Atkinson & Heath, 1987). An atomistic view of society is held, whereby all phenomena are understood by analyzing their separate components. Reality is static and conceptualized through the process of reductionism. Human behaviour is perceived as independent of context and as the result of lineal causes and effects (Schwartzmann, 1985). The focus of therapy is therefore to label the individual intrapsychically, to the exclusion of context, with the therapist as an objective observer who has the ability to cause a desired effect.

2.2 The Psychiatric Paradigm and Suicidal Behaviour

Explanations of suicide discussed in this section rest on the basic assumption that suicide is caused by inherent or acquired qualities of the individual concerned. Suicidal behaviour is considered qualitatively different from “normal” behaviour, and this
difference is ascribed to the psychological, biological or genetic make-up of a relatively small number of people (Erasmus, 1988). Suicidal individuals are seen as born with a biological inclination toward depression. Their internal personality needs and drives may or may not be able to be expressed within their environment. The cognitive set of the individual and his/her thoughts about the current situation can serve to increase or decrease suicide susceptibility. In these susceptible people, increased stress can result in changes that increase the likelihood of depression. When these chemical changes occur, an increase in depression-related cognition may result. Such negative cognition may well increase the subjective impression of stress, which in turn will have a continuing effect on the chemistry of the brain (Stillion & McDowell, 1996). It is therefore believed that biology, psychology, cognition, or a combination of all three intra-individual characteristics produces a suicidal individual. Three different perspectives within the psychiatric paradigm will be discussed, pointing out their most popular postulates.

2.2.1 The Biological Perspective

Winchel, Stanley and Stanley (1990) state that most efforts aimed at identifying the potentially suicidal individual focused on demographic, psychosocial, and personality factors. Schifano (1994), for example, stresses the use of the "risk factor" model to assist physicians in determining those patients who are most at risk of committing suicide. The presence of certain contributory factors like hopelessness, impulsiveness, inadequate social support, diminished central serotonin turnover and a family history of suicidal behaviour, increases the risk of suicide. Winchel et al. (1990) believe that although several of these factors have been found to be associated with suicide, they offer too weak a prediction to be of substantial clinical utility. Suicide risk indicators tend to overpredict suicide potential, and consequently, many more patients are identified falsely as suicide risks (Pokorny, 1983). These observations led them to emphasize the importance of finding an approach that examines suicide from a biochemical perspective.

There is no doubt that on the whole the biology of suicides is different from that of most nonsuicides. In an edited work by Maris (1986), various contributors claim that
there are a dozen or so broad types of major biological differences in suicides compared to nonsuicides. These differences come to the fore in the following areas:

- alcoholism (Robins, 1981)
- neurochemical factors (Stanley, Virgilio & Gershon, 1982)
- lutenizing hormones (Dietz, Mendelson & Ellingboe, 1982)
- endocrinology (Rich, 1986)
- menstrual cycle (Young, 1986)
- ECT effects (Tanney, 1986)
- irregular EEGs (Struve, 1986)

Although major differences have been found in various physiological areas when suicides are compared to non-suicides, two major areas have been studied more vigorously. These studies involve examining (1) the biological correlates of depression and (2) its genetic base.

Although depression is not synonymous with suicide, most find the relationship between the two sufficiently close to justify an examination of the research on the biological bases of depression (Stillion & McDowell, 1996). Winchel et al. (1990), however, propose that suicidal behaviour should not be seen as a symptom of another disorder such as depression or psychosis, but as a disturbance in and of itself. They see the pharmacological manipulation of the serotonergic system as the logical point at which to initiate treatment studies, with the hope that some drug with anti suicidal effects that are independent of its antidepressant or antipsychotic effect would be discovered. The emergence of drugs that are more specific for the serotonergic system (e.g., fluoxetine, citalopram) makes such research more practical.

Deficiency of serotonin has been found in the brains of some people who have completed suicide and in the cerebrospinal fluid of suicide attempters (Asberg, Nordstrom, & Traskman-Bendz, 1986). Since serotonin is instrumental in regulating emotion, some researchers suggested that a deficiency of serotonin may be implicated both in depression and in suicide attempts, especially impulsive suicide attempts. Researchers have found that low serotonin, as measured by one of its main metabolic
products (5-HIAA), was correlated with both depression and the seriousness of suicide attempts (Asberg, Traskman, & Thoren, 1976; Nordstrom et al., 1994). Furthermore, these studies showed that among patients who had been hospitalized in conjunction with a suicide attempt those who had less 5-HIAA were more likely to have died from suicide a year later than those who had higher levels of the substance. Van Praag (1983) notes, however, that the low levels of 5-HIAA in the cerebrospinal fluid of depressed patients are more closely related with disturbed aggression regulation (i.e., violent suicidal attempts and outwardly directed aggression) than with depressed mood per se.

Although the last studies indicate that the direct biochemical treatment of suicidal behaviour unrelated to depression can be foreseen in the near future, interest in the preventive effect of drugs on suicidal behaviour alone has increased only recently (Schifano, 1994; Winchel, et al., 1990). Present pharmacological intervention includes the use of antipsychotics, benzodiazepines, carbamazepine and lithium, with the use of antidepressants as the most popular. How and what biochemical effect antidepressants have on suicidal behaviour will be discussed briefly.

Over the past three decades the pharmaceutical industry has developed three major groups of medications for the treatment of unipolar depression. They are monoamine oxidase (MAO) inhibitors (e.g., moclobemide), tricyclics (e.g., amitriptyline) and the selective serotonin-reuptake inhibitors (SSRIs) (e.g., Prozac). Lithium is also used in cases of bipolar or manic-depressive affective disorder. Although each drug has a different biochemical effect on the central nervous system, the functional result is to increase the level of serotonin at the synaptic junctions of the neurons in the brain (Atkinson, Atkinson & Hilgard, 1983).

Some clinical observations regarding the use of pharmacological intervention should be noted, however. The risk of suicide may increase in the first few days following the initiation of antidepressant treatment. This apparent but undocumented risk has been speculatively tied to the increased energy and agitation that often occurs before the onset of improved mood. Furthermore, patients often use prescribed medications to end their lives. A drug overdose is the mechanism of death in 25% of
male suicides and 50% of female suicides (Schifano, 1994). Specific biological measures may also not ultimately provide very sensitive "markers" for the prediction of suicidal behaviour in large numbers of potential attempters. Despite this limitation Winchel et al. (1990) still feel that the identification of biological factors associated with suicidal behaviour holds promise for the development and application of pharmacological treatments as part of suicide prevention.

A second area of research on the biology of suicide involves examining its genetic bases. Blumenthal and Kupfer (1986) reviewed the literature on family history and genetics and reported that the incidence of suicidal behaviour is higher than usual in relatives of persons who exhibit suicidal behaviour. Also, the closer these genetic relationships are, the higher are the suicide concordance rates. Lester (1986) also found that the concordance rate for completed suicide is higher in monozygotic twin pairs raised together than in dizygotic twin pairs raised together. While these studies are far from definitive, they are suggestive of the biological position that maintains that at least a portion of suicidal behaviour may be attributed to genetic traits interacting with biology. To conclude this section, Maris (1989, p.453) observed:

Except in rare instances biology alone does not cause suicide. Suicide is, as Schneidman claims, multidimensional. We can all think of individuals with the supposed biological profile of suicides who in fact were not suicidal. Nevertheless, few suicides do not have the usual biological antecedents — depression, alcoholism, agedness, maleness, aggressiveness, and so on.

So where does this perspective leave the professional working with the suicidal person? Maris (1989) points out two essential points about suicide that the biomedical and existential perspectives share and which illuminate their stance when working with people exhibiting suicidal behaviour. Both the biomedical and existential perspectives tend to see life problems as empirical and not definitional. Life problems (e.g., suicidal behaviour) are therefore "real" and not just considered to be existing in language or definitions. They see suicides as sick, not just labeled so or created by doctors and medical care. Secondly, they both tend to be skeptical about how much we can do to help would-be suicides, since certain understandable irresolvable problems inhere in life
itself. The combination of the two points paints an almost impossible picture of dealing with suicidal behaviour. The professionals working within the biomedical perspective have an interesting way of dealing with this "impossible" situation. An obligation to enhance and maintain, what they call the "life-force" is emphasized by medical professionals. This is usually done through preventing suicide at all cost. In view of this Maris (1989) rightly states that suicide prevention often tells us more about the needs of the helper than about the needs of the suicidal individual. Preventing suicide at all cost without understanding the individual meaning around it emphasizes some physicians' compulsion to meddle with other people's lives. "A compulsion to save their souls, to tell them how to live (and die), even if it makes them miserable" (Maris, 1989, pp.435-436).

The multi-dimensional aspects of suicide are, although recognized by this perspective, not directly used in treating an individual exhibiting suicidal behaviour. It seems to come in handy, though, when trying to explain failure to enhance "life-force" by means of biochemistry.

2.2.2 The Psychoanalytic Perspective

Psychoanalytic writers have been concerned with understanding suicide within the framework of the individual examining the intrapsychic forces that could give rise to suicidal behaviour, the unconscious fantasies expressed by it, and the developmental conditions out of which it may spring. Earlier psychoanalytic theory was primarily concerned with the role of instinctual forces and the mechanisms by which these become subverted into suicidal impulses. More recent psychoanalytic writing has concerned itself with the effects of critical childhood experiences on ego structures, the development of object relations, and the self (Adam, 1990). Considering the importance of the subject and the centrality of the issues to psychoanalytic theory, it is surprising how little attention psychoanalysts have given to suicide in recent years (Adam, 1990; Buie & Maltzberger, 1989; Stillion & McDowell, 1996)

Freudian theory views suicide as a failure to cope. The failure may arise out of a collapse of ego defense mechanisms; or of an overdeveloped, demanding superego; out
of prolonged intrapsychic conflict; or out of regression to or fixation at a particular psychosexual stage. All of these causes have two things in common: they use up energy, and they result in disequilibrium between Thanatos (the death instinct) and Eros (the life instinct), a situation in which Thanatos takes command. The direct result might be a suicide attempt (Stillion & McDowell, 1996). Hendrick (Stillion & McDowell, 1996) and Friedlander (Stillion & McDowell, 1996) however, published case reports of patients with strong suicidal impulses, which they felt were motivated primarily by libidinal (Eros) rather than aggressive (Thanatos) wishes. These authors proposed that their patients' actions were associated with pleasurable rather than aggressive fantasies, which suggests that the life instinct, as represented by erotic or libidinal aspects of oral regressions were as important in some suicidal patients as the aggressive aspects.

Morse (1973) suggested that the common element in suicidal fantasy is a gratification of a wish in relation to a loved object. The main condition leading to suicide is a disturbance in reality testing, which allows the individual to believe he or she will live after death and experience the "after pleasure" of the suicidal action and its effects on others. Menninger (1933, 1938) and Klein (1935) saw the origins of the aggression arising from the death instinct and the fear that one's aggression could annihilate a good object. While these formulations represent a restatement of Freud's original views on suicide in depressed patients, both Menninger and Klein extended these by emphasizing the primary role of the death instinct, which had been speculatively advanced by Freud. Menninger felt that every suicide entailed three distinct elements: the wish to kill, which had its basis in the death instinct; the wish to be killed, which arose out of the superego in response to a need for punishment; and the wish to die, arising from a more fundamental desire to return to the womb. Melanie Klein pointed out that while she agreed with Freud's assertion that suicide represented an attack on an internalized object, this attack was directed primarily at the bad part of the object and was motivated by a wish to preserve the good internal object, which was a valued part of the self.

Several authors, using object relations concepts derived from the theories of Margaret Mahler, have conceptualized the developmental problem in suicidal patients as a failure to negotiate the transition from the symbiotic phase of development, where
mental representations of the infant self and mother are undifferentiated, to the rapprochement subphase of separation individuation, where self and object representations are differentiated. The end result of this failure is a tendency to become involved in relationships later in life where individuals are treated as parts of the self rather than as unique (Adam, 1990). Asch (1980) equates this situation, called "symbiotic object choice", with Freud's concept of narcissistic object choice. Asch, like Klein (1935), sees the primary goal of suicidal behaviour as getting rid of bad internal objects, but differs from her in viewing the principal aim of this as fusion with the symbiotic mother of infancy. Masterson (1976) used Mahlerian concepts to explain suicidal behaviour in borderline patients, while Richman (1979) applied it in understanding family dynamics in suicidal patients.

The essential characteristics of psychoanalytic treatment involves the following:

- two to three face-to-face sessions per week, over many months and even up to seven years
- interpretation of the transference, particularly of primitive or part-object relations in the transference, mostly in the "here and now," with "genetic" interpretations reserved for advanced stages of the treatment
- interpretation of primitive defensive operations, particularly as they enter the transference
- systematic integration of the analysis of current conflicts in external reality and of long-range treatment goals with transference interpretation
- repeated reinstatement, via interpretation of a position of technical neutrality (Kernberg, 1984).

Kernberg (1984) states that clarification and confrontation are important preliminary phases of transference interpretation. It is advantageous that severely self-mutilating or suicidal behaviour be controlled by a hospital or day-hospital setting, or other social structuring, so that it is only necessary for the therapist to intervene psychotherapeutically. The expectation is that suicidal behaviour will gradually be transformed into more direct, verbally communicated behaviour patterns in the transference, and will be resolved by means of transference interpretation. The theory
suggests that only through in-depth analysis can a person obtain the insight necessary to understand and cope with unconscious material and with energy-draining intrapsychic conflict.

In a study done by Lester (1994) on the utility of theories of suicide on suicidal lives, he found that the psychoanalytical theory seemed relatively inappropriate for the task. Kernberg (1984) also mentions that one of the most serious criticisms of metapsychological theorizing has been that these theoretical explanations are far removed from the patient's internal experience. It is quite extraordinary when one realizes that an intra-individual theory, like the psychoanalytical one, cannot take immediate direct statements regarding patients' inner experiences at face value. Such statements are seen to be defensive distortions of deeper motivations that patients attempt to hide from themselves and/or from others.

2.2.3 The Behavioural and Cognitive Perspectives

The behavioural perspective would maintain that suicidal behaviour, like all behaviour, is learned. Whether it is learned by imitation and modeling or through unavoidable loss (which can lead to learned helplessness), it can be manipulated. What is learned can be unlearned and relearned. It is clear that the role of the therapist in the behavioural model is as a teacher, utilizing the powerful principles of learning to help clients develop new and healthier ways of coping (Stillion & McDowell, 1996).

In the past decade, increasing attention has been paid to cognitive factors that may contribute to suicidal behaviour. The impetus for examining the role of cognitive processing in suicide has come largely from the paradigm shift in behaviour therapy to the cognitive domain (Weishaar & Beck, 1990). This has occurred in conjunction with research on cognitive aspects of depression and suicide dating from the early 1960s (Beck, 1976; Beck, Rush & Shaw, 1979). Cognitive therapy research has also yielded a taxonomy of suicidal behaviour; scales for measuring suicidal ideation, suicidal intent, and hopelessness; and evidence that hopelessness is an important precursor of suicide (Weishaar & Beck, 1990).
Efforts have also been made toward developing explanatory models of suicidal behaviour. These models incorporate factors that have been found to correlate independently with suicidal behaviour. Clum and colleagues (Clum, Patsiokas & Luscomb, 1979; Schotte & Clum, 1982) developed a model of suicidal behaviour in which poor problem solving is a mediator between life stress and suicide attempts. The authors suggested that the combination of life stress and poor problem-solving ability led to hopelessness, which in turn discourages the individual from trying to solve problems. A later study (Schotte & Clum, 1987) suggested that hopelessness and problem-solving deficits are independent factors, both worthy of treatment. Bonner and Rich (1987) developed a model in which alienation, cognitive distortions, and deficient adaptive reasons for living predispose an individual to suicidal behaviour while stress and increased hopelessness are more immediate precipitants to lethal suicidal behaviour.

The above research has revealed common cognitive characteristics of suicidal individuals, including dichotomous thinking, cognitive rigidity, problem-solving deficits, hopelessness, and the acceptance of suicide as a desirable solution. Cognitive therapy targets these features to foster more fundamental changes in the patient, thereby decreasing the chance of future suicidal behaviour. The elements of cognitive therapy with suicidal patients are similar to those of standard cognitive therapy: (1) establishing a collaborative relationship between therapist and patient; (2) using questioning as a means of assisting the patient to reach his/her own conclusions; and (3) testing the validity of the patient’s assumptions. However, in working with suicidal patients, the therapist is much more active and directive. Collaboration does not mean that the therapist, at any time, agrees that suicide is an acceptable alternative. Rather, patient and therapist work together to generate other perspectives, interpretations, and solutions to presenting problems. As in standard cognitive therapy, the ultimate goal is to modify the patient’s maladaptive assumptions, which in this case predispose the patient to self-destruction.
2.3 Conclusion

The main aim of treatment for these approaches is focused on identifying the potentially suicidal individual and preventing the act from occurring through various intra-individual means. The Biological perspective, although recognizing various contributory factors for suicidal behaviour, focuses on pharmacological intervention as the most effective way to prevent the suicidal behaviour from recurring. The Psychoanalytic perspective aims at rectifying unconscious drives through insight. Since this goal usually takes years, if at all to accomplish, physical restraints in the form of hospital stay is necessary. The Behavioural and Cognitive perspectives target the patient's cognition with the aim of modifying maladaptive assumptions. The latter is replaced by values objectively viewed as more adaptive and which would preclude suicidal behaviour as an option when confronted with life stressors. Within the Psychiatric paradigm, elaborate, intra-individual theories have been developed with the main aim of preventing suicidal behaviour from taking place. Almost ironically none of these "intra-individual" theories are concerned with the meanings the individual attaches to the chosen (in this case suicidal) behaviour, but more with the "objective" perceptions of the therapist. The focus on prevention emphasizes this point even further.

From this chapter it becomes clear that research and theories have greatly, and for a long time, focused on the suicidal individual's characteristics and experience. Over the years, however, the psychological community recognized the importance of understanding suicide within a broader context. Research gradually started to include the direct family as well as a focus on societal meanings around suicide. In the next chapters an even more inclusive, holistic view will be proposed where the therapist also becomes part of the creation of meaning around this topic. This will be done with the realisation that the questions we choose to ask, as well as the way in which we choose to answer them, greatly influence what we see in the end.
CHAPTER 3

THE SOCIOLOGICAL PARADIGM

3.1 Introduction

The approach discussed in this section differs from the psychiatric paradigm in its basic assumption that the source of suicidal behaviour is to be found in the relationships between the individual and his/her social environment. It differs from the systemic paradigm in that it arises from a mechanistic worldview, which seeks to explain human behaviour by identifying linear-causal relationships between objectively observable elements (Erasmus, 1988). This dualistic punctuation of reality is considered characteristic of a Western/Newtonian view of science in general (Auerswald, 1987) and research and theory arising from it is often characterized by a commitment to empiricism.

A three-fold classification of theories according to the level of explanation will be adopted here, following the classification used most often in the sociological literature. Microlevel theories or explanations focus mainly on relationships between individuals within the family system. Social-psychological explanations (exolevel explanations) focus on the interaction of the individual with the social environment, that is, with other individuals, groups and organizations. Sociocultural or macrolevel explanations examine social structures or arrangements such as norms, values, institutional organization, or systems operations to explain individual behaviour. These categories of theories are obviously not mutually exclusive and boundaries between them are not always clear (Erasmus, 1988).

3.2 Microlevel Explanations

Family systems theory examines how family members influence and are influenced by one another. Family therapists focus on the family system as the root of problematic behaviour of any individual member and advocate work with the family system to solve the problem (Osgood, 1989). The family therapy movement originated
during the nineteen-forties and evolved out of a continuing search for a useful paradigm to understand human systems and to work with human problems. The search progressed beyond the traditional boundaries of psychotherapy into other scientific areas such as general systems theory, cybernetics, quantum theory, and biological theories (Anderson, Goolishian & Windermand, 1986). Various people unrelated to psychology or sociology influenced this search as can be seen in Chapter 4 where the ecosystemic paradigm is discussed in more depth.

Auerswald (1987) describes these developments in terms of five paradigms as it emerged in the field of family therapy research and treatment. The first is the psychodynamic paradigm, which is seldom used today. "The family is defined as a group made up of the interlocking psychodynamics of its members who are at various developmental stages" (Auerswald, 1987, p.321). Secondly, there is the family systems paradigm, "which defines a family as a system that operates independently, and from which individual psychodynamics, including those that create symptoms, emerge" (Auerswald, 1987, p.321). The third is a general systems paradigm in "which a family is defined as a system that shares isomorphic characteristics with all systems, and which arranges systems in a hierarchy" (Auerswald, 1987, p.321). The fourth is a cybernetic systems paradigm, "which defines a system, including a family system, in terms of circular information flow and regulatory mechanisms" (Auerswald, 1987, p.321); the fifth is an ecological (or ecosystemic) paradigm, "which defines a family as a coevolutionary ecosystem located in evolutionary timespace" (Auerswald, 1987, pp.321-322). He states that "paradigms 2 through 4 have been merging into what is being called family systems therapy" (Auerswald, 1987, p.322), while paradigm 5 is seen as having a different epistemological base.

Chapter 2 of this dissertation corresponds to Paradigm 1 of Auerswald's (1987) classification, and the current chapter corresponds in varying degrees to his Paradigms 2 to 4. Chapter 4 will be an introduction to his Paradigm 5. The whole of this dissertation aims to be an exercise in viewing the family as "an ecosystem located in evolutionary timespace" (Auerswald, 1987, p.322) and would therefore compare with his Paradigm 5.
In a comparison study to determine the major precipitants and conflict areas in an attempted suicide group, Richman (1979) found family conflicts and arguments as the most significant area. Most suicide researchers agree that when focusing on the childhood of a suicidal adult, it would probably be marked by an unusual amount of economic deprivation, neglect, and disharmony between his/her parents. Many suicidal adults grew up in families in which parents had psychiatric problems and were suicidal themselves (Orbach, Gross & Glaubman, 1981), where there was conflict among members (Wright, 1985), parental rejection (Hussain & Vandiver, 1984), little expressiveness (Lester 1997a) and sexual and other abusive patterns (Pfeffer, 1986). Jacobs (1971) also documented that family trauma and disruptions were more extensive for suicidal adolescents than for nonsuicidal adolescents.

Richman (1979) proposes characteristics of the families that can produce a suicidal individual and which could help with the identification and assessment of suicidal behaviour. He stresses, however, that no evaluation of suicide potential is complete without taking into account individual factors, the family, and social milieu as well as the current situation or crisis. The main characteristics of such families are shown in Table 3.1 and was developed mainly to serve as an easy way to identify “suicidal” families. Richman’s (1979) model can be seen as an example that belongs to Auerswald’s (1987) psychodynamic as well as family systems Paradigms. There is a focus on the individual’s psychodynamics as well as an emphasis on the family as a closed system.

Table 3.1
The Family Assessment of Suicidal Potential (Richman, 1979, p.132)

<table>
<thead>
<tr>
<th>I.</th>
<th>An inability to accept necessary change.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>An intolerance for separation.</td>
</tr>
<tr>
<td>(b)</td>
<td>A symbiosis without empathy</td>
</tr>
<tr>
<td>(c)</td>
<td>A fixation upon infantile patterns and the primary relationships</td>
</tr>
</tbody>
</table>

| II. | Role conflicts, failures, and fixations. |

<table>
<thead>
<tr>
<th>III.</th>
<th>A disturbed family structure.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>A closed family system</td>
</tr>
<tr>
<td>(b)</td>
<td>A prohibition against intimacy outside the family</td>
</tr>
</tbody>
</table>
(c) An isolation of the potentially suicidal person within the family
(d) A quality of family fragility

IV. Affective difficulties.
   (a) A one-sided pattern of aggression.
   (b) A family depression

V. Unbalanced or one-sided intrafamilial relationships.
   (a) A specific kind of scapegoating.
   (b) Double-binding, sado-masochistic relationships.
   (c) The potentially suicidal individual becomes the bad object for the entire family.

VI. Transactional difficulties.
   (a) Communication disturbances.
   (b) An excessive secretiveness.

VII. An intolerance for crises.

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In his critical evaluation of the strength of the emerging body of empirical research regarding family risk factors for suicidal behaviour in adolescents, Wagner (1997) mentions five different, though somewhat overlapping, conceptual foundations. They include (a) poor family communication and problem solving, (b) scapegoating of the suicidal child, (c) disturbance in parent-child attachment, (d) marital dysfunction, and (e) parental psychopathology. Wagner presents a more applicable model that moves away from a purely psychodynamic focus on individual family members and would thus correspond with Auerswald's (1987) Paradigms 2 to 4. Since his classification represents a more inclusive model of the current family characteristics associated with suicidal behaviour Wagner's (1997) model will be discussed in broader detail. This discussion will also point out the obvious focus on not only family characteristics but also a shift to a description of the relationships and communication between members. Stressing a distinctive move to another paradigm.
3.2.1 Poor Family Communication and Problem Solving

Richman (1986) states that the suicidal act is a desperate communication that only makes sense in the light of the ineffectiveness of any alternative effort to communicate with family members. He goes on to say that families of suicidal people avoid direct verbal communication, but that they instead rely on indirect, nonverbal gestures. They also tend to walk out on arguments, ignore one another, and remain impervious to suicidal intentions expressed by one another. Bonnar and McGee (1977) found that the quality of interpersonal communication between spouses significantly deteriorated as the degree of suicidal behaviour increased. Other researchers (Orbach, 1986; Peck, 1984; Pfeffer, 1981, 1986; Richman, 1986) point out that family members are strongly discouraged from openly expressing their emotions, despite the fact that they often have strong feelings of hostility toward one another. Because of this high degree of secretiveness, the suicidal person may perceive that he or she is left completely alone to carry the emotional burden of unsolvable problems for the entire family. Pfeffer (1981) emphasizes that it is these communication deficits that prevent the family from flexibly coping with change of any sort. Problems therefore linger, resulting in chronically high levels of stress and frequent crisis.

3.2.2 Scapegoating of the Suicidal Child

Pfeffer (1986) suggested that suicidal behaviour emerges as the person's mechanism of last resort to escape from his/her own negative perceptions. These perceptions are introjections of those of a hostile parent that are then felt as self-hatred. Scapegoating occurs when parents direct hostile or critical emotions specifically toward the suicidal child, as a way of alleviating the tension in another family subsystem. Sabbath (1969) believed that some parents perceive a child as a threat to his/her well being, to such an extent that the parent wishes to be rid of the child or for the child to die. The "expendable child" perceives this message even though the parent may not verbalise it. Richman (1986) also observed that in suicidal families it is often as if one of its members must fail to ensure the success of the other(s). Other suicide theorists have described how parents send strong messages of rejection to children who become
suicidal, so the children come to feel burdensome and that they have no right to live (Hendin, 1975; Orbach, 1986; Schrut, 1964).

In the case of physical abuse, the child is not only left with the message of severe rejection, but also that the caretaker is unpredictable (Carlson, Cicchetti & Braunwald, 1989). Some physically abused children may come to believe that they deserve severe punishment, so they may punish themselves with self-destructive acts (Pfeffer, 1986).

3.2.3 Attachment Theory

The studies of relevance to attachment are grouped into several categories. After Bowlby’s (1980) theory (discussed later in this paragraph) researchers have investigated the impact of loss or unavailability of an attachment figure due to several causes, including death, separation or divorce, child living apart from one or both parents, or medical illness of a parent. According to the following theories, suicidal behaviour is seen as ineffective and self-destructive attempts to seek revenge or to achieve closeness and caregiving. Bowlby argued that the motives for a completed suicide typically revolve around a deceased attachment figure. Revenge, a wish to reunite, a wish to destroy oneself for contributing to the death, and/or a feeling that one cannot go on without the deceased person can all be motives for completed suicide. In contrast, a wish to signal distress and elicit a caregiving response from a living attachment figure, or a wish to punish, so as to coerce a neglectful caregiver into being more attentive, are named as motives for attempted suicide (Molin, 1986).

Other researchers have similarly argued that suicide attempts represent the youths’ efforts to have their parents feel the same sense of frustration or injury that they believe the parents have caused them to feel (Adam, Sheldon-Keller & West, 1996; Hendin, 1975; Schrut, 1964; Shaw & Schelkun, 1965; Toolan, 1962). Unfortunately, it rarely results in more consistent parental caretaking over the longer term.

Several theorists (Pfeffer, 1986; Richman, 1986; Sabbath, 1969) feel that parents of a suicidal child could identify the child with an attachment figure in the parents’ prior generation, especially if the parent felt mistreated by this person. It often happens that
parents would turn to their children to fulfill their needs in this regard. A suicide attempt may represent an effort to coerce the parent into the caretaker role.

3.2.4 Marital Dysfunction

Pfeffer (1986) describes a high degree of inflexibility in the spousal relationship of parents of suicidal children, marked by ambivalence and threats of separation. She also described a pattern in which conflict between spouses is displaced onto the suicidal child. Marital discord might be associated with youths’ suicidal behaviour because of two reasons. Overhearing parental arguments or parents threatening to separate can be highly stressful. Parents in unhappy relationships might also be less emotionally available to their child (Coyne, Downey & Boergers, 1992; Downey & Coyne, 1990).

3.2.5 Parental Psychopathology

Clinicians have long observed psychopathology in the parents of suicidal youths. Four areas which show supposed links with suicidal behaviour include suicidal symptoms, affective disorder, substance abuse, and antisocial behaviour (Wagner, 1997). No researcher or theorist has yet specified a coherent model of the mechanisms by which parental psychopathology may play a role in the development of suicidal behaviour in their offspring (Wagner, 1997). Shaffer, Garland, Gould, Fisher and Trautman (1988) state that children may inherit a predisposition to psychopathology, which in turn puts them at higher risk of suicidal behaviour. Bandura (1969) theorised that children exposed to parents who model disturbed behaviour may learn to use the sorts of coping mechanisms that are characteristic of suicidal individuals. Field (1984) feels that parents with psychopathology tend to be harsh, inconsistent, or neglectful, which in turn places the child at risk for depression, including suicidal symptoms.

Wagner (1997) states that there is very little firm evidence that supports the finding that several aspects of poor family functioning are risk factors for suicidal behaviour. He mentions that a reason for this can be the research designs used. The only conclusion that he thus makes is that family variables are correlates of suicidal symptoms. Richman (1979) says that it may not be possible to eliminate many of the
destructive and exploitative patterns through family therapy. He continues to say that the sheer fact of entering family therapy can, however, help to open up a closed system in many suicidogenic families. Hawton (1986, p.113) also believes that the broadening of the perspective in which suicidal behaviour is viewed within the family system makes family therapy “the treatment approach of choice”, while Richman (1979) states that family therapy represents the optimal treatment of serious suicidal behaviour. When suicide is viewed as a psychosocial event and especially when it is understood to be a need of the family to maintain a specific pattern of relationships, the entire family must be regarded as the client in therapy. A multitude of different schools resides within the family therapy movement, each with its own emphasis on approach and intervention strategies. Only a few of them has specifically written about the therapeutic treatment of suicidal behaviour though. Broad ideas of what family therapy with suicidal individuals entail will be mentioned briefly.

Trautman, Stewart and Morishima (1993) focuses on the fact that people, especially adolescents exhibiting suicidal behaviour, are likely to keep fewer appointments and remain in treatment more briefly, to suggest short-term family therapy. Kerfoot, Harrington and Dyer (1995) developed a short term, focused, intensive and home-based intervention programme for family therapy that proved to be successful. Although it is recognized that a comprehensive understanding of suicidal behaviour requires a knowledge of social, psychological and biological factors, assessment and treatment takes place within the family context. The family is encouraged to develop skills, to recognize stress and to deal with it within the family.

With the recognition of the broader system and relationships around the suicidal individual it was thus recognized that the whole family should be the unit of treatment of suicidal behaviour. This approach is, however still rooted in a paradigm that stresses the objective identification and assessment of these factors as well as an attempt to remove or replace such characteristics with “better” ones.
3.3 Social-Psychological (Exolevel) Explanations

People are members of systems other than the family, such as school, work, peer group and community. Communicative acts, such as suicidal behaviour, are not restricted to the family per se. Shulman and Margalit (1985) emphasize the systemic point of view, that suicidal acts outside the family can be perceived in the context of the system where the acts take place. As in the family, the system dynamics and structure of the broader system may enhance suicidal tendencies in the child or adolescent to such an extent that suicidal acts be a means of controlling the system processes. Little literature is available where suicidal behaviour is explained on the basis of interaction of individuals with his/her immediate social environment, excluding the family. This might be attributed to the fact that there are a large number of variations in any person's mesosystems (Henry, Stephenson, Hanson & Hargett, 1994). However, Thurman, Martin and Martin (1985) have focused on stress resulting from the transitions between various microsystems of Native American adolescents to explain the high suicide rate among them. Their explanation is that this stress results from the transitions between life on reservations, in boarding schools, and on the outside, and from the divergent expectations in these different environments.

3.4 Sociocultural (Macrolevel) Explanations

Theories at this level of explanation emphasize variables such as social structures, functions, subcultures or social systems to explain suicide. They also include concepts and relationships existing at the microlevel and social psychological level though (Gelles & Straus, 1979). Different norms and values of social groups and cultures have been associated with variations in the prevalence of suicide (Bankston, Allen & Cunningham, 1983; Headley, 1984) and have also been touched upon briefly in Chapter 5. Farber (1986) suggested that the attitude of a given society or dominant group may make a difference in the suicide rate. Differences in learned attitude may account, therefore, for the low suicide rate among Roman Catholics as compared to Protestants, and for the variations that we see in the suicide rate among the Scandinavian countries.
Osgood (1989) gives another example of how an attitude of a given society may influence suicide rates, when she reviewed cultural explanations for the high suicide rate among the elderly. The cultural explanation posits a strong relationship between level of modernization (based on level of technology, degree of urbanization, rate of social change, and degree of westernization) and status of the elderly. She goes on to say that in western technologically advanced societies, the elderly are devalued and hold less power, status, and economic control than in less advanced societies. In such a culture the old lose status and their self-concept suffers. Suicide may therefore represent a personal expression of their reaction to negative cultural images.

Emile Durkheim, a major figure in sociology, developed the most comprehensive theory in an attempt to explain suicidal behaviour. He hypothesized that suicides occur as a result of the kind of "fit" an individual experiences in his/her society (Lester, 1997a). His landmark work *Le Suicide*, which was first published in 1897, was based on a comparison of the suicide rates of a number of European countries with that of the United States. A number of social variables were isolated in an attempt to arrive at some generalizations about society as a whole. It is therefore as much a study of sociological method as it is a study of suicide (Adam, 1990). Observing that suicide appeared to vary inversely with the degree of integration of the individual into religious, domestic, and political society, he arrived at the following basic hypothesis: "Suicide varies inversely with the degree of integration of the social groups of which the individual forms a part" (Durkheim, 1952, p.209).

He described four types of suicide categorized according to the degree to which the individual was integrated with and regulated by society. "Egoistic suicide" occurred when excessive individuation or insufficient integration into society led to life weariness and depression. "Altruistic suicide", by contrast, occurred when there was insufficient individuation and excessive integration into society and led the individual to see his/her social group as more important than the self. "Anomic suicide" occurs where the individuals feel they have been abandoned by a society that no longer provides them with the regulation that they need. Such suicides were felt to occur during periods of abrupt social change, like depression, unemployment and divorce. "Fatalistic suicide" occurs when the individual's life is subject to excessive social
regulation beyond his/her choice or control so that the individual despairs of any life of his/her own (Adam, 1990).

The interpretation most accepted by American sociologists of Durkheim’s theory suggests social behaviour as the cause of social meanings and hence suicide. The structure of society therefore shapes the patterns of social interaction, which in turn determine the degree of social integration, which would determine the type and frequency of suicidal behaviour (Lester, 1997a). Douglas (1967), however, took a different view. He suggested that social meanings cause social behaviour and hence suicide.

Lester (1997a) pointed out that Durkheim interpreted information in ways that would support his theory. He continues to say that his statistical analyses were naïve by modern standards, and that he failed to give clear definitions of his concepts or to provide guidelines for operationalizing the theoretical elements. He also assumed that social meanings are always immediately obvious to the sociologist, and that there was no need to provide empirical support for the conclusions reached by them. Phillips, Ruth and MacNamara (1994) state that the theory was so flexible that it was irrefutable. Durkheim’s approach can be criticized in many ways, although the faults can be attributed more to his era than to his ideas (Lester, 1997a).

Several theorists have tried to reformulate Durkheim’s ideas and make his theory a testable one (Lester, 1997a). They confirmed many of his general findings and have attempted to take more account of the way in which social variables impact on the individual. Only a few of the more significant ones will be discussed here. Henry and Short (1954) found that suicide increased more during periods of economic depression than it decreased in periods of prosperity and that these relationships impacted more strongly on men than on women. According to them, the external restraints imposed by society that produce frustration and aggression interact with the internal restraints (psychological) of the individual. They therefore used Dollard’s frustration-aggression hypothesis to build their theory (Lester, 1997a). The balance of these forces of internal and external restraint determines whether aggression will be expressed outwardly in homicide, or inwardly in suicide. Gibbs and Martin (1964) extended Durkheim’s
hypotheses to examine role functioning in society, concluding that it was the degree of the individual's "status integration" that governed vulnerability to suicide. The more integrated individuals in a society are into their occupational roles, the higher their status integration and the lower their suicide risk (Adam, 1990).

Other sociological studies examined the dynamics of social change in relation to suicide (Adam, 1990). Breed (1963) and Maris (1975) found that suicide is more directly related to loss of social status and downward mobility than to social status in itself. In an attempt to overcome some of the difficulties involved in the more traditional sociological studies based exclusively on suicide rates in large populations, researchers have designed more detailed ecological studies of the social environment of suicidal individuals. The one difficulty that Maris (1969) cautioned against with regards to suicide research involves taking the characteristics of a society to explain the characteristics of individuals or of subsets of individuals within these groups. It is beyond the scope of this work to investigate the more specific ecological studies done on suicide.

3.5 Conclusion

The basic argument within the sociological paradigm as it is applied to suicidal behaviour, is that a variety of factors at interpersonal level, intra-family level, or socio-cultural level give rise to suicidal behaviour. A broader understanding of suicidal behaviour is therefore offered. A microlevel explanation of suicidal behaviour emphasizes the influence family members have on one another and subsequently suicidal behaviour. Exolevel explanations focus on the fact that individuals are part of significant systems other than the family where suicidal behaviour might fit their role. Macrolevel explanations look at broader systems and their impact on individual behaviour. Suicidal behaviour is seen as either cause or effect of social structure and/or social meaning. Not only does it call for a broader perspective than that found in most psychological approaches, but it also opened up the debate around the structure vs. meaning of social systems. Suicidal behaviour becomes more meaningful when examined against the social fabric of society (Stillion & McDowell, 1996).
Sociological theories as a whole have, however, been left open to a number of criticisms. These criticisms can broadly be grouped into firstly criticism against methodology and secondly criticism against the concept of social structure used in sociology. It seems that a great deal of time has been spent trying to clarify Durkheim’s theory, while the investment of energy could have been better employed in the development of new concepts. In addition to a tendency to make the interpretation of data fit preexisting assumptions, there have been biases of subject matter (e.g., studying only completed suicide) that may have hampered the formation of sound theories. Sociologists have too readily accepted categories of subgroups provided by government agencies (such as whites and nonwhites), that do not make sense from a theoretical point of view. They have also often used official suicide statistics that may not be sufficiently reliable (Lester, 1997a). The gap between Protestant and Catholic suicide rates in the Netherlands (1905-1910) appears to be the result of nothing more mysterious than differences in how deaths of Catholics and deaths of Protestants were recorded.

A few researchers also share criticism targeted at the concept of social structure. Bogdan (1984) states that family structure is “simply the name of a class of patterns of communicative behaviour between people” (p.383). Family structure can thus not explain a pattern of communicative behaviour between people, “because it is the pattern” (Bogdan, 1984, p.383). He goes on to say that when the behaviour of family members is characterized as a response to certain abnormal family structures, or to a particular organizational context, it implies the existence of entities – structures, contexts, rules – which is distinguishable from patterns of communicative behaviour between individuals. The result is that the image of the group as “extraordinarily mental creatures” is obscured (Bogdan, 1984, p.376). Anderson et al. (1986) agree with this observation in their statement that the assumptions of family therapy theory are predicated on concepts of role and structure. They go on to say that the advantages of the field have turned to disadvantages, blinding us in our search for answers.

Social theories have so influenced our commonly shared beliefs about social role, socialization and the functioning of social systems, that we in the mental health
field rarely question their logical consistency, their influence, nor their implications for theory and practice. (Anderson et al., 1986, p.2)

They therefore challenge the traditional views of social structure as a foundation underlying current psychotherapy practice and theory and present the concept of meaning and language systems, problem-determined systems, as an alternative (Anderson et al., 1986).

A reductionistic error is, however, still committed when suicidal behaviour is viewed from this perspective. Suicidal behaviour is seen as lineally caused by objectively observable relationships residing in various social structures. Family and other systems are being viewed as black boxes with clearly demarcated input and output relationships. Therapy is seen as an attempt at "opening up" or making overt problematic systems that will then discard suicidal behaviour in favor of other more acceptable forms of communication. The complex system of human relationships is being investigated without seeing the therapist as part of the therapeutic system. Luhmann (in Anderson et al., 1986, p.3) believes that the therapist can only be seen as collaborator in therapy when social action and systems changes to "collaborative action and discourse". How therapist became collaborator will be examined more fully in the next chapter.
CHAPTER 4

THE ECOSYSTEMIC PARADIGM

4.1 Introduction

A lens, or frame of reference, determines the pattern we see, whether it is up or down, distorted or not. A change of lens always invokes a period of initial confusion or transition. If an observer can endure the crisis of transition, a new frame will result in an alternative order. The task of epistemological change; although dramatically more difficult, is comparable. Through the lens of cybernetic epistemology, an alternative world will eventually emerge. (Keeney, 1983a, p.155)

In this chapter it is aimed to give an overview of the Ecosystemic perspective. To understand this perspective would entail a change of lens. A process, which as Keeney (1983a) points out in the above quotation, is a confusing one. It is not merely a rearrangement of concepts, but it involves the breakdown of our everyday conception of reality (Von Glasersfeld, 1984), something, with which Maturana’s theory and concepts can greatly assist us. A second-order, constructivist approach, in the form of Maturana’s theory was therefore chosen to illuminate the focus the writer wishes to convey regarding the ecosystemic paradigm as it applies to suicidal behaviour.

A reconceptualization of suicidal behaviour will be given which will provide an alternative view of it, a view where the therapist’s perspective and way of knowing becomes part of an investigation and understanding of suicidal behaviour. The implications of an ecosystemic perspective on the therapy of suicidal behaviour will also be discussed in some depth. Through this process it will become clear why it was necessary for the family therapy movement not to ignore epistemological transitions that took place in other sciences, but to apply it to the social systems they work with.
4.2 The shift to an Ecosystemic Epistemology

The major assumptions of a Cartesian-Newtonian epistemology were discussed in Chapter 2 and would thus not be repeated here. It is, however, important to mention that this paradigm consists of a number of entrenched ideas and values, among them, the view of the “universe as a mechanistic system composed of elementary building blocks, the view of the human body as a machine as well as the view of social life as a constant struggle for existence” (Capra, 1996, p.6). Although the change from a mechanistic to an ecosystemic epistemology has proceeded in different forms and at different speeds in various scientific fields, it has, in a “seemingly random” way resulted in “forming a complex, highly organized pattern” (Capra, 1996, p.17).

4.3 Characteristics of Ecosystemic Thinking

The most general characteristic of ecosystemic thinking is the shift from parts to whole. Living systems are seen as integrated wholes whose properties cannot be reduced to those of smaller parts. Their essential properties “arise from the organizing relations of the parts” (Capra, 1996, p.37). The shift from the parts to the whole can also be seen as a shift from a focus on objects to a focus on relationships, and from the metaphor of knowledge to that of the “network”. For most scientists such a view of knowledge as a network with no firm foundations is extremely unsettling, and it is therefore not generally accepted. The implications of such a view make this unsettlement clear. The first implication is that physics are not the most fundamental level of science. When the material universe is seen as a dynamic web of interrelated events, the properties of any part of the web follows from the properties of the other parts, and the overall pattern (not fundamental physics) determines the structure of the web. The second implication is that scientific descriptions are not objective, it can never be independent of the human observer or the process of knowing in a context of interrelation. An understanding of the process of knowing has to be included explicitly in any description of natural phenomena. Ecosystemic thinking therefore involves “a shift from objective to epistemic science, to a framework in which epistemology – the method of questioning – becomes an integral part of scientific theories” (Capra, 1996, p.40).
Another key characteristic of ecosystemic thinking involves the shifting of focus between system levels. Different systems nest within other systems. The same concepts can thus be applied to different system levels to gain insight, if it is remembered that these different system levels represent levels of differing complexity (Capra, 1996).

An important question that arises with this approach to science involves our understanding of the world we live in. How can we ever hope to understand anything, if everything is connected to everything else? Capra (1996) states that the discovery of “approximate knowledge” makes it possible. Science can therefore never provide complete and definitive understanding, but can only provide limited and approximate knowledge. “No matter how many connections we take into account in our scientific descriptions of a phenomenon, we will always be forced to leave others out” (Capra, 1996, p.42). We are forced to realize that we are never dealing with the “truth”, but with limited and approximate descriptions of reality. According to Louis Pasteur (in Capra, 1982, p.101) “Science advances through tentative answers to a series of more and more subtle questions which reach deeper and deeper into the essence of natural phenomena”.

Ecosystemic epistemology, like other nonlinear approaches, therefore challenges Newtonian epistemology (Keeney, 1982) and is founded on the principles of ecology, systems theory and cybernetics (Keeney, 1983a). It represents a shift in focus from isolated individual units to a more in-depth focus on the whole ecosystem; it even shifts to the system’s way of knowing, that is, “a way of thinking about one’s thinking” or thinking about “one’s way of knowing” (Keeney & Sprenkle, 1982, p.6). It attempts to see the interrelationships of whole systems rather than dividing the world up into segments. There is thus an emphasis on interrelation, context, ecology, relationship and a sensitivity to holism and complexity (Keeney, 1982). Certain cybernetic and second-order cybernetic concepts will make the basic characteristics of ecosystemic thinking clear and will now be elaborated on.
4.4 Cybernetics

Cyberneticians began in the early 1940's to study inanimate machines to ultimately compare it with living organisms in an effort to understand and control complex systems. Their main focus was not only on feedback mechanisms, but on how this forms the basis of information processing and patterns of communication. Wiener (in Capra, 1996) named this unified approach to problems of communication and control, "cybernetics" and defined it as the science of "control and communication in the animal and the machine" (Capra, 1996, p.51). Various researchers who were drawn from several disciplines, for example, mathematics, neurology, sociology and engineering, were led in their search to the concepts of feedback and self-regulation and then later to self-organization (Capra, 1996).

4.4.1 Feedback

The skill of steering a boat or riding a bicycle is reliant on the concept of feedback. When a boat, for example, deviates from a preset course, the helmsman assesses the deviation and counter-steers to correct it. Continual feedback is therefore necessary to keep the boat on course. A feedback loop as the most fundamental (sic) part of this process is described by Capra (1996, p.56) as "a circular arrangement of causally connected elements, in which an initial cause propagates around the links of the loop, so that each element has an effect on the next, until the last feeds back the effect into the first element of the cycle". When "input" is therefore affected by "output" of the same system it results in the self-regulation of a particular system. Information about past behaviour is fed back into the system in a circular manner. On the level of simple (first-order) cybernetics two kinds of feedback can be distinguished.

Positive feedback acknowledges that a change has occurred in a system. Information about a deviation from a previously established norm is fed back into the system and is responded to in such a manner that the difference is accepted (Becvar & Becvar, 1996). Negative feedback indicates that the status quo is being maintained in a system. Fluctuations or disturbances are being opposed and a particular level of stability is being maintained.
4.4.2 Self-regulation and Homeostasis

Although self-regulating machines existed long before the formal conceptualization of cybernetics, the pattern of circular causality was never recognized. The centrifugal governor of a steam engine invented by James Watt in the eighteenth century is a classic example of this (Capra, 1996). When a machine is therefore controlled by its actual performance being fed back to it, it can be understood as a self-regulating system. Wiener and his colleagues (Capra, 1996) also recognized feedback as the essential mechanism of homeostasis, the self-regulation of living organisms and social systems that allows them to maintain themselves in a state of dynamic balance.

4.4.3 Self-organization

Self-organization refers to the spontaneous emergence of new structures and new forms of behaviour in open systems characterized by internal feedback loops. Various researchers studied self-organization in many different systems, for example, Ilya Prigogine in Belgium on physical and chemical systems, Manfred Eigen in Germany on catalytic cycles and Humberto Maturana and Francisco Varela in Chile on organismic, biological systems (Capra, 1996), not knowing at the time that a whole new view of the organization of living systems will eventually emerge. At this stage it seems appropriate to introduce the concept of second-order cybernetics (cybernetics of cybernetics) and to discuss Maturana and Varela's theory in more depth.

4.5 Cybernetics of Cybernetics

"The contribution of Maturana and Varela is that they proposed a description of whole systems from the perspective of a whole system itself, without any reference to its outside environment" (Keeney, 1982, p.159). Since the organization of living systems or the nervous system is informationally closed (Maturana, 1975). In- and outside of the organizationally closed nervous system, therefore, only exists for the observer who beholds it, and not for the system (Johnson, 1993).
According to second-order cybernetic thinking, reality can never be examined from an outside perspective if it is constructed. Or as Maturana (1975) puts it, it is not possible to be in both the domain of experience and the domain of description at the same time. The subject matter of second-order cybernetics (or cybernetics of cybernetics), therefore, becomes (true to the constructivist concept of self-reference) "about you, about me, about you/me, about subject matters, about thinking, about how we know what we know (epistemology), and about what constitutes knowledge" (Becvar & Becvar, 1996, p.345). Second-order concepts will now be discussed to illuminate this introduction and Maturana's theory.

4.5.1 Autonomy and Self-reference

Autonomy refers to the highest order of recursion or feedback processes of a system, the end result of which will be the organization of the whole system. To speak of the distinctive wholeness of a system is therefore a way of speaking of that system's autonomy. A system's autonomy requires no reference to its outside environment, but instead must be described through reference to itself. Self-referentiality of a system therefore becomes a way of emphasizing a system's autonomy (Varela, 1976). No part of what we do to an autonomous system ever gets inside the system but rather interacts with the wholeness of the system. Maturana and Varela call these interactions "perturbations" rather than inputs (Keeney, 1982). This leads us to the idea of systems as structure-determined entities.

4.5.2 Structure Determinism

Maturana's ontological claim is that the world is structure-determined. In short what he means by this, is that the behaviour of all, in this case living systems, are fully determined by their structures (i.e., by the components of the unity and by the relations among those components). This is the case, because the system has to maintain its circular organization in order to remain a living system (Maturana & Varela, 1980). The structure of an object determines its behaviour by specifying all of the interactions it can undergo, that is, which events in its environment it can interact with, and how it will behave under each and every one of these interactions (Dell, 1985). This structure also changes with
every encounter and interaction. Interactions can, however, never be “instructive”, but can only consist of a fit, match or structural coupling (Dell, 1985).

4.5.3 Structural Coupling and Non-purposeful Drift

Structural coupling refers to the sufficiency of fit between systems. If the fit between two systems is insufficient it can ultimately cease to exist. If two systems are able to mutually coexist they will continuously change structurally in their co-drifting as long as organization and correspondence with a medium is conserved (Maturana, 1975). This process is “historical”, because each structural change is a modification of a previously existing structure and forms the basis for the following one. Maturana uses the term ontogeny to refer to this history, where the course of structural changes is contingent upon the interactions it undergoes in its medium.

4.5.4 Consensual Domains and Language

In the interaction of two individual organisms the co-ordination of their actions is referred to as their co-ontogeny. If the structural changes that each organism undergoes correspond, the result of the ontogenic structural coupling is a consensual domain. A domain of behaviour is therefore created in which the “structurally determined changes of state of the coupled organisms correspond to each other in interlocked sequences” (Maturana, 1975, p.326). This is the case because of the consequences of their respective actions for each other in the medium. Their behaviours become consensual because of the moment to moment co-ontogenic structural interactions of their systems in its medium (which is also comprised of the other). This consensual co-ordination of behaviour refers, according to Maturana (1978), to linguistic behaviour.

Language is linguistic behaviour about linguistic behaviour, or as Maturana chooses to conceptualize it: “the recursive mutual co-ordination of actions (distinctions) of consensual co-ordinations of actions (distinctions)” (Maturana, 1988, p.48). The phenomenon of language also introduces the observer. By being in language we make distinctions or descriptions of descriptions and become observers and self-observers. “Everything said is said by an observer to another observer” (p.315). In language we can
therefore reflexively describe ourselves and describe ourselves describing ourselves and so on. Maturana and Varela (1987) call this “self-consciousness” (p.375).

4.5.5 Objectivity-in-parentheses

Maturana and Varela (1987) believe that prior to language no object exists. Objects become specified through the co-ordinations of co-ordinations of consensual actions, that is, through language. As soon as the operations of distinction which an object stands for are obscured, it becomes an object. Because of this reification, objects seem to exist independent of everything. Maturana (1978), therefore, puts objectivity in parentheses mainly because of the failure of the science of neurophysiology to find a way to explain our perception of objects external to us. Objectivity in parentheses entails that “existence is constitutively dependent on the observer and that there are as many domains of truth as domains of existence (a person chooses to) bring forth in his/her distinctions” (Maturana, 1978, p.332). Focus should thus not be on the “world out there”, but on the ontology of the observer, that is, what the observer does to bring forth objects in a realm of existence, through consensual operations of distinction (Johnson, 1993). Before looking at the implications of these concepts for family systems and family therapy it is necessary to discuss the application of them to systems representing larger orders of inclusion.

4.5.6 Autopoiesis

Autopoiesis (“self-making”) is the name jointly decided by Maturana and Varela which characterized their search for a more complete description for the concept of circular organization (Capra, 1996). Their interest was not in the properties of the components of living systems, but in the processes and relations between the processes as they are realized through their components. A given organization can thus be embodied in many different manners by many different components. The term “autopoiesis” was finally defined as the “network of production processes, in which the function of each component is to participate in the production or transformation of other components in the network” (Capra, 1996, p.99). Although their focus on organization as opposed to structure seems almost overly emphasized, it must be remembered that science in the Newtonian/Cartesian
paradigm was until then very focused on the characteristics of physical components or the actual relations between physical components.

Autopoiesis has been defined for systems in physical space and for computer simulations in mathematical spaces. To apply the concept to human social systems has been debated quite extensively and have produced various answers. Maturana and Varela themselves have different answers to this question. Maturana does not see human social systems as being autopoietic, but rather as the “medium in which human beings realize their biological autopoiesis through languaging” (Capra, 1996, p.212). Varela (1989) agrees that the concept of a network of production processes may not be applicable beyond the physical domain, but feels that a broader concept of “organizational closure” can be defined for social systems. He went on and generalized the concept of autopoiesis to systems representing larger orders of inclusion such as social groups, nations and even ecological systems like beehives (Hoffman, 1985). What Varela basically did, was to propose that mind-like activity exists at a level above our own individual minds. The processes of interaction that define these higher-order unities he referred to as “conversational domains” (Varela, 1989). Higher-order unities are thus also instances of autonomous systems, although they are not directly accessible to consciousness (Hoffman, 1985).

4.6 Implications for Family Systems

The Ecosystemic paradigm is rooted in an alternative reality system as was pointed out in the previous section. It was realized that not only does it have major implications for how we humans organize knowledge, but also how we organize our thinking about families and family therapy. Family therapy that uses this paradigm is thus very different from family therapy that uses the Western/Cartesian/Newtonian epistemology. Within an Ecosystemic epistemology the family is described “as a coevolutionary ecosystem located in evolutionary timespace” (Auerswald, 1987, p.322). This means that the family’s organization is the outcome of an evolutionary process by which some ideas are encouraged or confirmed and others die or become extinct. The ideas each family member has, lead him/her to behave in ways that confirm or support the ideas of every other family member (Bogdan, 1984). First-order as well as second-order cybernetics have both
provided concepts which could successfully be applied to the family system to understand different phenomena and will therefore be discussed briefly.

When we view human behaviour from the perspective of first-order cybernetics we think in terms of "recursion and feedback, morphostasis and morphogenesis, rules and boundaries, openness and closedness, entropy and negentropy, equifinality and equipotentiality, communication and information processing, relationship and wholeness" (Becvar & Becvar, 1996, p.83). These terms were all developed in relation to the attainment of stability or change, and can only really be understood in a context of stability and change. It is beyond the scope of this dissertation to go into any depth into any of these terms. The cybernetic concepts of stability and change as it is maintained through negative and positive feedback will, however, be discussed in some detail as they have provided rich ground for theorizing around various family systems phenomena.

From this first-order perspective mutual influence and interaction in systems take place in a context of stability and change. Bogdan (1984) therefore states that a model of family organization must account for both stability and change. "Cybernetics proposes that change cannot be found without a roof of stability over its head. Similarly, stability will always be rooted to underlying processes of change" (Keeney, 1983b, p.48). Theorists differ on the emphasis they put on either stability or change or both in their theories, depending on what phenomena they want to explain. Speer (in Bogdan, 1984) and Hoffman (in Bogdan, 1984) noted that the theory of family homeostasis accounts for the absence of change in families, but appears vague about the processes by which change occur. Many therefore believe that the theory of family homeostasis does not have enough of a language to account for change (Bogdan, 1984). Progression of the family life cycle, personal conflict that leads to change, and the fact that therapy sometimes leads to change is related to such vague notions as "recalibrating the rules of the system" (Bogdan, 1984, p.379). This might be the case because the impetus for the theory of homeostasis was mainly to account for "resistance" in therapy. Haley (1978), although adhering to the homeostatic model, focuses on the fact that change is more the rule than the exception in families. Keeney (1983a) introduced the view that a therapist with a cybernetic worldview will know that, what to others appear as an either/or issue, is often an analogue or metaphor of a system's underlying complementary relation between change and stability.
Bateson (Anderson et al., 1986) believed that there was a basic epistemological flaw in the cybernetic concept of negative feedback and “the related concepts of homeostasis, continuous change, symptom functionality, and structural defect” (p.3). Second-order cybernetics is a natural development from this homeostatic model and answers the questions of the above dilemma.

Although Varela seemed quite keen to apply Maturana’s theory of “organization of living systems” to social systems, it still took a while to apply in more detail to family systems. Luhmann (in Capra, 1996) developed the concept of social autopoiesis in considerable detail. His central point is that social systems use communication as their particular mode of autopoietic reproduction. A family system from this point of view is defined as a network of conversations with intrinsic circularities. Conversations usually generate further conversation and can in such a way form feedback loops. A result of such a closed process can be a shared system of beliefs, explanations, and values that is continually supported by further conversation. Family roles and boundaries are continually maintained and renegotiated by the autopoietic network of conversations, and is therefore continually self-produced (Capra, 1996).

In sum, cyberneticians basically see people and events in the context of mutual interaction and influence and therefore study relationships and how each individual interacts with and influences the other (Becvar & Becvar, 1996). Every system influences and is therefore being influenced by every other system and every individual influences and is being influenced by every other individual. Meaning is derived from this relation between individuals and elements as each defines the other. How this view of families affects therapy will be dealt with Section 4.8.

4.7 A Reconceptualization of Suicidal Behaviour

Although the perspective of first-order cybernetics provided us with concepts describing interaction and relationships in the context of stability and change, the stance is still a realist one which sees reality as “out there”, able to be observed without being influenced. Suicidal behaviour from this perspective is understood as connected to the family system and its organization (Becvar & Becvar, 1996). The family is seen as a
closed information system feeding information back on itself in the form of a symptom. Suicidal behaviour will thus be understood to operate as a kind of servomechanism that prevents change and in that way to serve a primary family function by maintaining stability, continuity, and relationship definition (Anderson et al., 1986).

Keeney (1983a) believes that “in general, we can view symptomatic behaviour as striving toward higher orders of self-correction” (p.165). Suicidal behaviour would thus start this process by attempting to change the distorted premises organizing the problematic sequence of experience and interaction. It would thus lead its “victim” to cybernetic self-correction. Symptomatic behaviour therefore provides the cybernetic system with an opportunity to communicate that a particular epistemological premise is distorted, erroneous, or ineffective. Correction of this would, according to Keeney (1983a) be through unconscious and conscious processes, unconscious ones being respect for the ecology of the symptom, and conscious ones through higher-order processes that need to include the therapist as well. A few theorists, including Bateson, were not satisfied with this explanation of homeostasis and stability to describe living and changing systems and the subsequent role of symptoms in it (Anderson, et al., 1986).

“If you want to understand some phenomenon or appearance, you must consider that phenomenon within the context of all completed circuits which are relevant to it” (Bateson, 1972, p.244). All completed circuits necessarily imply a consideration of the therapeutic one. From a second-order perspective it is realized that the observer is part of that which is observed and that any explanation is self-referential. Hoffman (1985) states that the old epistemology implies that the system creates the problem as a way of attaining some form of homeostasis. The new epistemology implies that the problem creates the system. Problematic behaviour is thus understood to be whatever the “original distress consisted of plus whatever the distress on its merry way through the world has managed to stick to itself” (Hoffman, 1985, p.387). Suicidal behaviour can thus not be seen as fitting a fixed definition focused on individual properties such as intent or degree of consciousness, or as having a function of maintaining family homeostasis, but on whatever the system, brought together by the suicide, through shared meanings defines it to be.
Membership in these problem determined systems are not bound by existing social structures. Problem determined systems might be formed through communications based on familial relationships; they may be formed through communications such as legislative mandate; or they may be formed through communications based on accident or chance relationships (Anderson et al., 1986). The therapist is included as part of the problem determined system. "Merely by accepting a referral, the therapist begins to participate in a discursive process, and therefore becomes an active communicating member of the problem determined system" (Anderson et al., 1986, p.8)

Anderson et al. (1986) go on to say that through language individuals interact with and coordinate behaviour with others in a variety of ways. Languaging around what is identified as a problem defines the components of systems that must be worked with in treatment. Repairing defective social structures, as determined by a therapist’s theoretical orientation of descriptions of health, pathology, and deviance is therefore not the task anymore. “The problem to be diagnosed and treated, and the membership of the problem system, is determined by those in active communication regarding the problem” (Anderson et al., 1986, p.7).

Suicidal behaviour and whatever reactions it brought about might therefore be the “problem” that connects and brings a specific system into therapy. That system will not necessarily be representative of any existing social structure like the family, but will be constituted of everyone that is connected through language around the suicidal behaviour. Those in therapy, including the therapist, will through an active discursive process decide what the problem will be that will continue to be the focus of therapy. This implies that suicidal behaviour might not be the “problem” to be discussed or conversed about at all. An exploration of the system’s meanings around suicidal behaviour and its repercussions will thus be the focus of therapy only in so far as those in active communication regarding the problem decides it to be the focus. Since this system includes the therapist as an active collaborator, an exploration of his/her meanings and how these are informed and maintained by other systems would also be an interesting endeavor.

The implications of this second-order cybernetic perspective on therapy with suicidal behaviour will now be discussed.
4.8 Implications of Ecosystemic Thinking for Psychotherapy

4.8.1 Introduction

"What a man desires to know is that (i.e. the external world) but his means of knowing is this (i.e. himself). How can he know that? Only by perfecting this."

(Keeney, 1983a, p.200)

This statement by Kuan Tsu illustrates the main postulate of second-order cybernetics. To “know” any external act, like suicidal behaviour, it is crucial to “know” the more internal act of the observation of it. We will therefore only really understand suicidal behaviour when we recognize, research and come to an understanding of the observer of such an act. Besides the fact that second-order cybernetics provides a way of constructing alternative and more complex patterns in the ecology of our experience, it also acknowledges the observer’s inclusion in the system and therefore the self-referential nature of any description. How these basic tenets affect the family therapy field, this therapy, as well as the role of the therapist will now be elaborated on.

4.8.2 No Unitary Theory

The second-order cybernetic view holds that all knowledge is a construction of the mind, and not a fact of reality out there. The consequences for the family therapy field are that there are “no set facts about family, family theory, or family therapy that are independent of our observations or our mode of engagement” (Anderson et al., 1986, p.4). There is thus no single “truth” about a family and its problem that needs to be discovered. Every intervention is thus seen as part or a broader creative unfolding (Keeney, 1983a).

Keeney (1983a) goes on to say that when a theorist argues that any one perspective or model is more correct than others he/she is admitting to choosing “a way of being inflexible” (p.144). Such a therapist’s clients will ultimately suffer if they do not fit into this punctuated frame of reference. Cybernetic self-correction provides the therapist with feedback, which allows him/her to decide which model is useful, or not, as well as to what
extent that model needs reshaping to fit the unique therapy experience. Keeney (1983a) acknowledges that we can only, and must therefore, choose a partial view, model or theory and hold to its premises. The process of trying to fit a model to suicidal behaviour will generate conversation which will itself provide the feedback necessary to drive the therapeutic process. These encounters we have with others' views generate the more encompassing perspective that is important. Only through dialogue then can we "get" to this higher order of learning.

Not only must the second-order therapist subscribe to a theory around suicidal behaviour that makes sense to him/herself, but also allow conversation around it, conversations in various systems which include dialogue with his/her fraternity as well as with his/her clients around the topic. Throughout this endeavor a more encompassing view and understanding of suicidal behaviour will therefore come to the fore.

4.8.3 First-order vs. Second-order Cybernetics (To be or not to be part of therapy)

Pragmatically, you do not need cybernetics of cybernetics to be a family therapist. Becvar and Becvar (1996) name many reasons why you may not want to be a systemic family therapist at a second-order level, while Hoffman (1985, p.394) adds that "nonneutral, 'linear' attitudes and actions are often 1) necessary, 2) appropriate, 3) what you are paid for". It is, however, necessary to realize that, while at the level of simple cybernetics you may be "doing good", at the same time you may be contributing to escalating pathology in society. You could be feeding the illusion of certainty and the status quo of existing social relationships and structures (Becvar & Becvar, 1996). If you decide to incorporate a higher order of cybernetics in your therapeutic life, you accept the responsibility for participating in developing the problems experienced by our society, the same problems you must subsequently attempt to solve. Being consciously aware of this paradox forces you to live a rather schizophrenic life (Becvar & Becvar, 1996).

Many theorists provide ways of dealing with this paradox when the decision is made to utilize the position of self-reference and participation flowing from this approach. Keeney (1983a, p.82) states that "we do not throw away the pragmatic advantages gained by a first-order view", but that we rather contextualize the pragmatics of it. He suggests
that a perspective that brings the therapist fully into therapy can do this. Atkinson and Heath (1987) believe that any existing family therapy model can be applied in a way that is or is not consistent with the implications of second-order cybernetics. They therefore agree with Keeney that therapists must continue to draw upon the more pragmatic first-order models as long as they do not become too attached to their clients' acceptance of their suggestions and interventions. Bateson (1972) also states that we may continue committing epistemological errors as long as we know we are committing them. He labeled this awareness “wisdom”. Dell (1985) takes the position that as long as we are aware that we are always operating in the context of a self-recursive network, it does not matter what epistemologies we use or what theories we adopt. Efran, Lukens and Lukens (1988) say that constructivist therapists can claim professional expertise in their ways of working with a family. They are, however, not entitled to claim that they are fixing objective problems that have an existence independent of the human language community. It is agreed among various theorists that as therapists we cannot get away from the fact that we operate in a first-order way. The fact that we realize this, that we have conversations around it and that we constantly try to 'better the situation makes therapy a second-order endeavor.

Historical data suggest that higher-order problems can emerge when we attempt pragmatic solutions to problems without examining the underlying framework that defines the problem as a problem, thus having a limited awareness of the context in which the problem exists (Becvar & Becvar, 1996). When dealing with suicidal behaviour in therapy it would entail the following. We need to invest in developing theories and models to deal with suicidal behaviour in a pragmatic and effective way. We also need to be aware of the context in which these models and theories exist. We need to be aware that most of our theories around suicidal behaviour focus on assessment and prevention, not because it is the only and “right” way that we can deal with it, but because we as therapists live in a society where we have taken the responsibility for trying to control such behaviour through these means. We as therapists should be aware that we are part of the suicide business. We should be aware that by evolving theories to prevent suicide and in a first-order way to solve the problem of suicide, we are on a higher level creating a context where suicidal behaviour is allowed. We are therefore feeding the realist illusion of certainty and the status quo of existing social relationships. We are communicating that we can effectively
assess, predict and prevent suicide, that we as experts “know better”. “Know better”, not because we actually know better on all levels, but mainly because we are in a society that frantically wants us to know better, as well as part of a fraternity that frantically wants to communicate that they know better.

We should thus be aware that by effectively taking responsibility for and preventing suicide, we as professionals are on a higher level communicating another message to society, a message which should be investigated and become part of higher-order conversations. We can thus see that higher-order cybernetics confronts us with our finiteness, with uncertainty, and with the demand to define our own essence (Watzlawick, Beavin & Jackson, 1967), something with which the analysis of our own epistemology can greatly assist us.

4.8.4 Epistemology

The fundamental act of epistemology is to draw a distinction. All that we know, or can know, rests upon the distinctions we draw. Bateson referred to this activity as punctuation (Keeney, 1982). The task of epistemology in therapy entails knowing how clients construct their world of experience. At the same time therapists follow systems of punctuating that prescribe how they describe. A complete epistemology of family therapy must therefore look at how both client and therapist construct a “therapeutic reality” (Keeney, 1982, p.157). Therapy therefore becomes a study of epistemology, not only of the client, but also a study of the therapist’s epistemology.

The “study of epistemology in therapy” entails that a therapist not only join his/her clients in the social construction of a therapeutic reality, but also take responsibility for the world of experience that is created (Keeney, 1983a). Coming to know your own epistemology, be it revealed through deconstruction of narrative, metacommunication or dialogical dialectic, is no easy process (Maranhao, 1990). So difficult a process is it, that Auerswald (1985) remarks that “only a handful of people in the field have thought seriously enough about epistemological issues to transform their thinking into print”. This higher-order view, or as Keeney (1982) refers to it, a metaepistemology or metapunctuation, requires a dialogue between constructing and seeing. Epistemology can
thus be seen to be a recursive process. Keeney (1983a) describes the cybernetic therapist as a practitioner, theorist, and researcher all at the same time. A therapist must therefore be able to "construct models, package them as interventions, and discern what happens" (p.172). He refers to this recursive process, where the facets of therapeutic process are reconnected, as sociofeedback.

The consciousness of one's productions provides a context of reflexivity. It allows for new alternatives regarding oneself and one's relationships. "Knowing about mind through mind(ing) or communication through (meta)communication is a self-referential process where the dualistic framing of ontology and epistemology coalesce" (Keeney, 1983b)

Becvar and Becvar (1996), with their focus on the therapist's epistemological development, compares therapy to Zen, in that it becomes a context of higher order learning for a therapist. Therapy is thus seen as a vehicle for the therapist's epistemological change, a context for practice that could be reflected on. They also state that a therapist who realizes and acknowledges that he/she is part of such a learning context will eventually experience his/her world in a profoundly different way. Such a therapist will have learned to construct patterns that connect. It is thus necessary for a therapist to be "selfish" sometimes. A therapist needs to be aware that only when he/she acknowledges his/her position in therapy by conscious exploration of his/her own premises, as metaphors for his/her epistemological position, will his/her client ultimately benefit from a therapeutic endeavor.

When dealing with suicidal behaviour we as therapists should make a conscious effort to know how it is that our clients and ourselves view suicidal behaviour, as well as how these views came about. We should not only join in, but also take the responsibility for this process. We should therefore use narrative and metacommunication to "talk suicide" in an explorative and investigative way. When we adopt this attitude it will become clear very quickly that we do not really "know" what individual suicidal behaviour is. That although we have definitions and demographics to help us assess and predict (sometimes very effectively) suicidal behaviour, we lack an in-depth understanding of the individual phenomenon. That we are therefore also learners in this process.
4.8.5 Redefining "Therapist"

During the first-order cybernetic movement, it was believed that the therapist had a "duty" to alter pathological family homeostasis (Hoffman, 1981), that the therapist would be able to adopt a "metaposition" or external position to the system (Hoffman, 1990), and that the therapist could control or manipulate a system he/she was working with, in order to "cause" change (Dell, 1985; Hoffman, 1990; Keeney, 1983a). The position with regards to the role of therapist in second-order cybernetics is not so clear, however.

Evans (1992) says that it seems that the therapist's role might have become vague and slightly confused with the constructivist trend toward doing away with the "power" or "authority" of the therapist. Anderson and Goolishian (1988) advocate a position of "not knowing", and Hoffman (1993, p.127) "a kind of deliberate ignorance". Most researchers realize that the role of the therapist within this paradigm is very different from what it was in the past, and offers descriptive suggestions to this new role. Anderson et al. (1986) say that the role of the therapist needs to be redefined to "one who co-creates through his or her own theoretical lenses what facts there are to be observed" (p.6). The therapist is therefore described as an active communicating member in the problem-determined system. Keeney (1983a) also chooses to include the therapist more directly in the therapy by pointing out that a context must be structured where both therapist and client can successfully respond to the self-corrective communication of symptomatic behaviour and thereby create sociofeedback.

Auerswald (1985) describes the therapist as a "nonblaming ecological detective" (p.6). The task of such a therapist would thus be to seek out and identify the ecological event that led the family to the position they are in. Anderson et al. (1986) suggest that the therapist do this by simply engaging in conversation with those who are relevant to the problem situation. They therefore view the disruption of families as coercive and choose not to define their therapy in that way. When therapy requires languaging with the family within their domain of understanding, every course of therapy is different and commonalities across problems, diagnoses or solutions do not exist (Anderson et al., 1986). "Packaged cookbook cures" would be worthless if they are not "adequately
coupled to the ecology” (Keeney & Sprenkle, 1982, p.16) of the client. Hoffman (1990) also believes that rather than providing strategies, interpretations, or suggestions for behavioural change, the therapist’s job is to create a context for epistemological change.

Hoffinan (1985) gives the most applicable summary of this vague new description of a second-order therapist and refers to it as no more than a second-order stance. She makes it clear that any therapy that respects a cybernetic epistemology will not be focused on a specific method, but would rather be characterized by a certain attitude. She mentions the following characteristics of such a stance (Hoffinan, 1985, p.393):

- An “observing system” stance and inclusion of the therapist’s own context.
- A collaborative rather than a hierarchical structure.
- Goals that emphasize setting a context for change, not specifying a change.
- Ways to guard against too much instrumentality.
- A “circular” assessment of the problem.
- A nonpejorative, nonjudgmental view.

Hoffinan (1985) continues to say that a second-order approach also promotes a high tolerance for diversity in therapy. A therapist would thus feel comfortable with including methods from other therapeutic schools if he/she is clear about the way and the reasons why it is done.

A vague non-directive stance like the above makes it extremely difficult to apply to therapy with specific problematic behaviour (in this case suicidal behaviour). How a therapist “is” in therapy with specifically suicidal behaviour appears not to be the issue anymore. Suicidal behaviour has mostly been (and sometimes still is) seen as irrational, mad or bad. This view has made it easier for the professional dealing with it to act in a controlling, preventative and sometimes even coercive manner. When a second-order stance is adopted, a linear excuse for therapeutic behaviour is not sought anymore, but the emphasis is on understanding the meaning of the suicidal behaviour in a specific context. One almost gets the idea that therapeutic behaviour is divorced from the problematic (suicidal) behaviour. This would ask for a nonjudgmental, collaborative, exploring attitude.
Although the severity of suicidal behaviour is realized, it is still treated in a non-controlling manner. For this to happen it would also be necessary for the therapist to explore his/her own context. His/her meanings around suicide, death, and responsibility for suicidal behaviour in therapy (to name just a few) would thus be the topic of much higher-order conversations, something with which epistemology can greatly assist us. Auerswald (1987) states that if we become aware of our epistemological premises we can then also decide if family therapy is “simply another modality of treatment among the many”, or if it would represent “a radically different way of thinking” (pp.324-325).

4.8.6 Diagnosis vs. Meaning

Another consequence of second-order cybernetic thinking involves the focus of our attention and energy in therapy. Hoffman (1985, p.390) says that if we abandon the “expert-dummy model, we have to throw away the idea of diagnosis as well”. The emphasis would shift “from a concern with the etiology of the problem to a concern with the meanings that are attached to it” (Hoffman, 1985, p.390). This means an exploration of what Bateson (Anderson et al., 1986) calls the “ecology of the mind” or “ecology of ideas” which determine the behaviour and problems for which therapy is requested.

When exploring meanings the treatment unit necessarily changes in that the “system doesn’t create the problem” anymore, but the “problem creates the system” (Hoffman, 1985, p.386). To think of therapy in terms of a “conversational domain” would imply that therapists focus not on the client (symptom carrier) as the unit of attention, but would therefore see the entire group or family, including professionals, as a small evolving meaning system (Hoffman, 1985). The goal of therapy is to provide, through conversation, a context wherein the actors in the “problem determined system” no longer distinguish what they are thinking and talking about as a problem. The language used by the system is thus changed. In such a context the problem-determined system would think and talk differently about their problem. No change is necessarily sought in the structure of the social system or in observed behaviour, but in the language used to describe the problem (Anderson et al., 1986).
A consequence of such a stance in therapy would be that much less time would be spent in determining how lethal, intentional, conscious a specific behaviour is and more of a focus on the meaning of it in a specific context. Definitions or descriptions of suicidal behaviour would thus be situational and only applicable to a specific unique context. The exploration of context would also not be directed at finding a "cause" for the behaviour to ultimately remove the "cause" and therefore stop the behaviour from occurring, but to get to an understanding of it. A change would be sought in how the problem is languaged about. This entails that suicidal behaviour might not cease, but that the meanings around it and how it is spoken about would be different. This applies not only to the client or system's meanings around it, but also to that of the therapist. Only when therapist meanings around suicidal behaviour change, will subsequent therapeutic behaviour be different.

When a therapist understands that he/she is an active epistemological operator, he/she also realizes that he/she is always participating in the construction of a world of experience. The view of participatory universe suggests that ethics, rather than objectivity, is the foundations of family therapy. The therapist is thus responsible for contributing to the construction of therapeutic realities (Keeney, 1982).

4.8.7 Language and Meaning

From a constructivist perspective, what is observed in living systems, is constructed, partly by the observer and partly by the observed (Von Glasersfeld, 1984). This construction is done in language, both internally by the observer to him-/herself, and externally, in communication with others (Efran et al., 1988). Language, a digital representational system of our experience, therefore not only represents our experience to ourselves but "re-presents (communicates) our representations of our experience to others" (Keeney, 1983b, p.46). Internally, the observer makes distinctions between what is observed and what is known through the use of personal constructs, that is, meanings. Externally meanings are exchanged by means of verbal and non-verbal language (Anderson & Goolishian, 1988). This continued exchange of meaning leads to the construction of a particular reality for that system.
The ways in which we form these representations or descriptions reflect implicit epistemologies (i.e., "the rules for describing, categorizing and knowing our experience") (Keeney, 1983b, p.46). Bateson and Von Foerster (Keeney, 1983b) suggest that we restructure our linguistic patterning when talking about systems and cybernetics. They state that we have to be careful in how we pattern our observations and descriptions, and to not demarcate the circuitry into isolated elements or mechanisms. A constructivist epistemology would imply that we always remain aware of the context in which behaviour occurs.

4.9 Criticism

By stating that all "realities" are constructed, constructivists make a realist claim, turning their epistemology into merely another form of realism. This paradox has been recognized and described by others, for example, Held and Pols (in Fourie, 1996), and emphasizes that the constructivist epistemology is as much a construction as they claim realism or any other perceived perspective to be. Criticism against second-order cybernetics as a way of illuminating constructivist postulates will therefore also include variations of the above basic criticism and will be elaborated on.

The main criticism directed at second-order cybernetics involves doubts concerning its most relevant contribution, namely the ethical stance of collaboration. Becvar and Becvar (1996) point out that the context of therapy necessarily transforms observing systems to observed systems in spite of the best intentions of the therapist. It is this fact about second-order cybernetics with which some theorists have a problem. They believe that it is more ethical for the therapist to assume the expert role and move the client system toward "normal functioning" than to manipulate it by "unconscious persuasion of second-order therapies" (p.293). Golann (in Becvar & Becvar, 1996) represents one of those theorists. He criticizes second-order cybernetic models as representing a form of manipulation and thus of acquiring power in therapy by denying it. "Power obscured eventually emerges – a therapeutic wolf clad as second-order sheep" (p.292). He states that "unconscious persuasion" could be viewed as ethically more objectionable than excessive and explicit strategic intervention, because it is potentially dishonest and
therefore creates an even greater power hierarchy in favour of the therapist than other forms of therapy.

Becvar and Becvar (1996) focus on the “use” of second-order theories and say that these models are just as seductive as traditional models to therapists who are in search of the “best” way to do respectful, non-manipulative, non-normative therapy. The problem is therefore seen in how the theories are used, and not in the theories per se. They suggest that part of the problem may lie in the process of transforming the philosophy that is second-order cybernetics into a formal, pragmatic model for therapy, a process that necessarily transforms observing systems to observed systems. This process is confusing mainly because epistemologies are used inconsistently (Auerswald, 1987). “Ecosystemic writers revert back to the thought system in which they are originally programmed” (Auerswald, 1987, p.324). Auerswald goes on to say that there is no “error” in the new thought system, but that the both-and rule replaces any such dichotomous thinking. To therefore want to develop a theory (which is basically a linear way of explaining behaviour) could never violate the circular epistemology of second-order cybernetics if you apply this both-and rule consistently.

The both-and rule however does not imply that “anything goes”, a criticism often made against constructivism. Constructivists maintain that some realities are more valid or useful than others. The usefulness or validity of a theory can be determined by the way it fits with the wishes, attributions, ideas and conceptions of the people involved in co-constructing it and not by any objective norm (Fourie, 1996).

4.10 Conclusion

In this chapter it has been shown how the theory of second-order cybernetics provided concepts which changed how living systems were talked about and in that way represented an ecosystemic perspective on living systems. It provided a perspective where living systems are seen as autonomous and structure-determined and can attain structural plasticity with other organisms in consensual domains. Through this view it was realized that objectivity could only exist in parentheses since all language is self-referential and represents attempts to maintain an organism’s circular organization. Cybernetics, with its
emphasis on feedback mechanisms, extended the notion of co-ontogeny with concepts such as recursiveness and reciprocal causality and in that way emphasized the circular organization of living systems. Although the homeostatic concepts of stability and change are very useful in describing patterns of communication in living systems, they do not fully take into account the autopoietic nature of living systems. It took theoretical concepts of cybernetics to do this in a theoretically sound way. It was realized that, since living systems are autopoietic and that we as therapists enter into a consensual domain with our clients, all our observations, although influenced by this co-ontogenic structural drift, are still self-referential. Our observations can never address an objective world “out there” but are only representative of how our structure allows us to “see” reality.

Suicidal behaviour, like all “problematic behaviour” brought to therapy, would thus not be an “easy” assessment with “easy” answers and ways of working. Suicidal behaviour would not be seen as residing in the individual’s (1) biochemistry, (2) psyche, (3) cognition, (4) family, (5) other systems including the therapeutic one, or in (6) society as a whole, but in all of it. Special significance will also be given to how the individual exhibiting suicidal behaviour understands and organizes all of the mentioned factors to understand his/her behaviour. Implications for the therapist include realizing all the above, but to refrain from “controlling” the life-threatening behaviour by focussing on one aspect in an attempt to change it to make the suicidal behaviour disappear.

Psychotherapy becomes a conversational or narrative process in which the entrenched constellation of meanings around a problem is facilitated to evolve in a direction where the consensual definition of the problem as a problem is no longer central. A different “reality” is therefore co-constructed by all those partaking in therapy (Hoffman, 1990).

In the next chapter the process of researching suicide will be discussed. An ecosystemic perspective also has implications for research. This will also be addressed.
CHAPTER 5

RESEARCH ON SUICIDAL BEHAVIOUR

5.1 Introduction

In any research area, problems of design and interpretation must be solved before valid conclusions can be drawn. Some of these problems are general to all research, while others are unique to a particular topic. In this chapter, some of the specific methodological difficulties of investigating suicide will be discussed. It would also be suggested that a second-order (as informed by a constructivist) perspective on suicide research makes some of the perceived issues irrelevant. This chapter will be concluded with a proposal for a qualitative research project applicable to moral and ethical issues that suicide presents us with.

5.2 Methodological Problems in Suicide Research

It is not infrequent in behavioural research for researchers to use a particular term or name to describe a phenomenon. When results are compared to those of others, they, however, find apparent contradictions because the same label was used for different things or different labels for the same thing. Although most researchers agree that the greatest methodological issue in suicide research concerns the adequate definition of the behaviour, related issues such as data gathering and reliance on official data to provide demographic information also has it flaws. The mentioned difficulties will be discussed in some depth in this section.

5.2.1 Defining Suicidal Behaviour

At the outset suicide appears clear and obvious. As Shneidman (1985, p.10) puts it, "there is a dead person, a gun in his hand, a hole in his head, and a letter lying open on the table". He also goes on and offers a less concrete definition of suicide as "an act of self-inflicted intentional cessation" (p.11). The Concise Oxford Dictionary (Sykes, 1982, p.1067) describes the noun "suicide" as "when a person intentionally kills himself/herself,
intentional self-slaughter”, while the Collins Cobuild English Dictionary (Sinclair et al., 1995, p.1672) states that “people who commit suicide deliberately kill themselves because they do not want to continue living”. Lester (1997a, p.1) mentions another dictionary definition where suicide is described as the act or instance of voluntarily or intentionally taking one’s own life.

Although the above definitions are relatively obvious and simple to understand, most researchers agree that when trying to understand an individual suicide, the definitions show a lack of fit with the actual suicidal behaviour. Several aspects of suicide make the process of fitting a specific suicide with a definition a difficult process. The (a) actual suicidal behaviour (Farberow, 1980; Lester, 1997a); (b) intent of the person engaging in the behaviour (Farberow, 1980; Lester, 1997a); (c) degree of consciousness preceding the suicidal act (Farberow, 1980; Lester, 1997a); (d) basic criteria for defining death (Kalish, 1968; Lester, 1997a); (e) variations of the meaning of suicide when considering the context in which it takes place (Lester, 1997a; Stillion & McDowell, 1996); and (f) definition of the self (Smart, 1980) are all aspects that make it difficult to conceptualize suicidal behaviour. The mentioned issues and how they influence the process of defining behaviour as suicidal or not, will be discussed very briefly. Although important to realize the extent of conceptual difficulties experienced, it is the writer’s point of view that getting stuck in the classification of behaviour as suicidal or not, becomes part of the context where a therapeutically more meaningful understanding of suicidal behaviour will elude us.

(a) Actual Suicidal Behaviour

Lester (1997a) describes six categories of overt suicidal behaviour namely: completed suicide, attempted suicide, suicide threats, thoughts of suicide, no preoccupations with suicide, and suicidal gesture. The last refers to attempts that do not involve a real intent to die. Subdivisions of the above categories have been proposed by a few, while some have objected to many of the terms describing the categories and have suggested renaming some of them.
The "attempted" category of the classification has conceptually received the most attention by researchers. Dorpat and Boswell (1963) subdivided the "attempted suicide category" into gestures, ambivalent attempt and serious (potentially lethal) attempts. Kreitman, Philip, Greer and Bagley (1969) suggested renaming the "attempted suicide", "parasuicide" to get away from the notion that attempters are really trying to kill themselves. Nowadays however, many researchers favour the more specific "self-injury", "self-poisoning" and "deliberate self-harm", and therefore do not use the term "parasuicide" much (Canetto & Lester, 1995). Some outrightly objected to the "attempted" category, saying that this term implies that attempters have somehow failed to finish the act, while completers have succeeded. They suggested referring to these behaviours as "nonfatal" and "fatal" suicide respectively (Canetto & Lester, 1995). Lester (1997a) continues by stating that dividing the protagonists into "attempters" and "completers" is a gross simplification, because all suicidal acts occur along a continuum that ranges from highly lethal to non-injurious.

(b) Intent

The one common denominator of the definitions of suicide, is the use of the word "intentional" to describe the act. Most researchers see this as the most valuable way of categorizing suicidal behaviour (Lester, 1997a). Beck and his colleagues (Beck, Weissman, Lester & Trexler, 1976) proposed a scale of suicidal intent based on the "objective circumstances" of the suicidal act (such as whether the suicidal person isolated himself/herself and whether he/she left a suicide note) and, in the case of attempters, on their answers to questions posed to them. Smart (1980) observed that "objectively" determining the intent of specific behaviour is a very difficult process, particularly if the person under investigation is already dead. Seriousness and intent are also rarely reported. To complicate the case of intention even more, Lester (1997a, p.8) correctly points out, that "just because a suicide implies voluntary action, does not mean that the person really want(ed) to die". More often than not, a suicidal person simply wants to escape and sees death as the only way out of a painful situation.
(c) Consciousness or Awareness of Suicidal Behaviour

Another important dimension of the definition of suicidal behaviour concerns a person's degree of consciousness or awareness preceding the suicidal act (Lester, 1997a). This implies that not all forms of suicide are consciously planned, but that the impulse toward suicide can be unconscious and that this may result in unplanned "accidental" deaths. This idea is historically associated with Menninger and his book "Man Against Himself" (1938). He considers asceticism, alcoholism, and martyrdom as "chronic suicide", self-mutilations, malingering, and purposive accidents as "social suicide", and psychological factors in organic disease as "organic suicide" (Smart, 1980). Others believe that a variety of self-destructive behaviours are, if only in part, suicidally motivated. Such acts will include chronic overeating, anorexia, self-mutilation, medication abuse and repeated risk-taking (Lester, 1997a). Farberow (1980) calls this "indirect self-destructive behaviour", and goes on to say that although the suicide event at first seemed clearly identifiable, it is not the case anymore.

(d) Definition of Death

For centuries people believed that there is a definite moment when the transition from life to death occurs. Advances in medicine have raised legitimate questions about exactly when death occurs. This has led us to reexamine not only our understanding of physical death and when it occurs, but also our understanding of psychological death and when it takes place (Lester, 1997a). When a person partakes in behaviour that makes the likelihood of death increase, it again raises the question of exactly when death occurs. Life and death is thus not such a black and white issue anymore. It is almost as if people exhibiting suicidal behaviour also struggle with this exact issue, their game is, however, not only academic, but dangerously experiential.

Menninger (1938) described suicide as a peculiar form of death that entails three elements: the element of dying, the element of killing, and the element of being killed. No matter how one looks at it, suicide involves death, intended or not. It is therefore expected that the study of suicide and specifically the definition of the behaviour should include an understanding of death itself.
To allow for a more meaningful understanding of death, a few classifications of death states will be mentioned and described. The first classification defines physical death as it is experienced by the dying person and those caring for the person, and includes the subcategories of (1) cessation (i.e., the stopping of any conscious experience); (2) termination (i.e., the end of the body’s physiological functioning); (3) interruption (i.e., the temporary stopping of conscious awareness) and (4) continuation (i.e., the ongoing continuation of conscious experience (Shneidman, 1968). The established medical scheme for classifying states of death include the following four self-explanatory modes: accidental death, homicide, suicide, and natural death (Lester, 1997a). This scheme stresses the causes and the modes of death and is utilized for the ascription of responsibility for death to the right source or cause. Lester believes that it does not allow fine enough distinctions for use when a person has been motivated to seek his own death though.

Shneidman (1968) provides a classification that does involve the role of the deceased in his/her own death. Subcategories include (1) intentional death, when the person plays a direct and conscious role in his/her own death; (2) subintentional death, when the person plays an indirect, covert or unconscious role in his/her death; (3) unintentional death, when the person plays no significant role in his/her own death; and (4) contraintentioned death, when the person acts as if he/she is about to die or threatens to commit suicide, but has no intention of doing so.

From a study done by Kalish in 1965 (Lester, 1997a) it became clear that self-destruction would be more likely if a person were considered subjectively dead even though he/she was still living and conscious. Although the mentioned classifications are important for an understanding of death and suicidal behaviour, the most applicable classification would therefore be the one by Kalish (1968). This is the case because it considers the “subjective judgement” of the conditions under which a person is considered dead. Kalish names four basic criteria for defining death. Physical death refers to either biological death, when the organs stop to function, or clinical death, when the organism no longer functions but the organs continue to live. When the individual ceases to be aware of his/her own existence, it is considered to be psychological death. Social death can be
self-perceived or perceived by others. When self-perceived, the individual accepts the 
notion that he/she is, for all practical purposes, dead. **Other-perceived social death** 
involves behaviour by people who know the individual as if he/she is dead or nonexistent. 
Lastly, **anthropological death** refers to the individual being cut off from a particular 
community and referred to as being dead.

In his introduction of the concept of the “appropriate death” Lester (1970) states 
that in personal communication with Gene Brockopp, she suggested that a death could be 
considered “appropriate” when these different kinds of death coincide in time. If a person 
therefore dies anthropologically, socially, psychologically and physically at the same time, 
then his/her death may be considered “appropriate”. With this in mind he suggested that a 
therapist’s duty would thus be to make sure a person dies an “appropriate” death. He 
however realized that this process is a judgemental and subjective one and that before this 
stance is taken one must be aware of one’s own as well as other’s concepts around this 
issue.

(e) **Meanings of Suicide**

Depending upon the dominant thinking in any given society, the act of suicide has 
been deemed a crime, a rational and honorable act, evidence of insanity, a sin, and a 
failure to cope. (Stillion & McDowell, 1996, p.38)

Suicidal behaviour has had different meanings at different times and in different 
circumstances throughout Western culture. The existence of all these views of suicide 
points up both the complexities inherent in understanding an individual act of suicide and 
the need for examining the context within which suicide is studied. Stillion and McDowell 
(1996) recognized the importance of understanding suicide within a cohort or generational 
setting. They accepted Strauss and Howe’s (in Stillion & McDowell, 1996) definitions for 
each of the existing cohorts alive today to illuminate suicidal behaviour. Cohler and 
Jenuwine (1995) see suicidal behaviour as a function not only of cohort, but ads aging, 
gender and ethnicity as functions influencing its meaning.
A few researchers have focused on the social, situational, and family contexts to understand suicidal despair (Aldridge, 1984; Aldridge & Dallos, 1986; Chamberlain, 1995; Haley, 1978; Miller, 1995; Osgood, 1989; Pfeffer, 1981; Richman, 1986). Others have understood suicidal behaviour by focusing on the communication and interaction predominant in these families (Chamberlain, 1995; Kerfoot, 1980; Pfeffer, 1981; Pillay & Wassenaar, 1995; Richman, 1979; Wagner, 1997; Wassenaar, 1987). These theories were elaborated on in Chapter 3.

Why is it important for theorists to distinguish between categories of suicidal behaviour? Lester (1997a) says that attempted (nonfatal) suicides and completed (fatal) suicides should be regarded as different forms of behaviour. There is also the longstanding belief that the different labels created to describe suicidal behaviour refer to different kinds of people (Lester, 1997a). A further deduction was that the classification of suicidal behaviour in one of the categories would alter the choice of treatment and intervention (Orbach, 1988). The fact that either category of behaviour may accidentally turn out into its opposite indicates that although helpful to know about, definitions can never replace a true understanding of individual behaviour.

5.2.2 Methods of Investigation

Research on suicide almost always involves correlational rather than experimental methods (Lester, 1997a). Demographic studies are relied upon to provide the data and therefore make up a large volume of research done on the subject. Before a few demographic facts are mentioned, the problems with these methods will be discussed briefly.

(a) Gathering Data

Because researchers studying completed suicide cannot get information from dead individuals, they must rely on two less satisfactory methods of investigation, namely (1) the study of residual evidence or (2) the study of substitute subjects, for example, people who have attempted suicide.
Residual evidence can be obtained from examining written material or other evidence left behind, for example, suicide notes, diaries, letters and results of previously obtained psychological tests. Another option is to gather information from the suicide’s friends and relatives. Although some researchers have devised structured methods like “psychological autopsies” (Maris, 1986) for interviewing the friends and relatives of people who committed suicide, observational distortion and lack of validity of the information is named as problems with this method (Lester, 1997a). Another problem with using residual evidence is the proper establishment of control groups. With what, for example, can suicide notes be compared?

When substitute subjects (e.g., people who have attempted suicide), as representative of completed suicides, are used as a means of studying suicidal behaviour, problems of reliability and validity come to the fore.

(b) Demographics

The study of the distribution of suicide in a population allows for the establishment of general associations between suicide and the characteristics of individuals who kill themselves. Variables such as age, gender, marital status, religious affiliations, and occupational status can be examined (Blumenthal & Kupfer, 1990). The rates obtained from epidemiological studies of the general population is most often utilized to supply public health officials with the necessary information to set up programs of prevention among high-risk groups and to establish centers in those areas where the problems are most severe (Buda & Tsuang, 1990).

The reason for including this section is twofold. Firstly it will provide the reader with an overall idea of the basic characteristics and magnitude of what we are dealing with when talking about suicidal behaviour. It would become clear that no person is exempt from this behaviour, and that proportions are becoming endemic (Richman, 1986). Secondly it is included to show that although the study of demographics makes up a huge percentage of research done on suicidal behaviour, it does not necessarily provide acceptable solutions to the problem. Some will go so far as to say that it is in effect becoming part of the problem. The demographics and the subsequent use of it to develop
programmes to prevent suicidal behaviour have become part of the social discourse around it. It emphasizes the powerlessness of professionals to prevent it from occurring, and has lead to the imagery of hopelessness and extinction of our species. As Lifton (1991, p.467) notes, "it is hard to tell whether there is an actual increase of suicide in our time, and if there is, whether this imagery of extinction plays a significant part".

(i) The relationship between suicide and attempted suicide

National statistics on attempted suicide are not available for the majority of countries. Diekstra and Moritz (1987) report that research centres in several countries have collected data on attempted suicide over a considerable period of time from which deductions could be made. Attempted suicide rates in Third World countries, however, almost always go unreported, mainly because it was deemed a punishable legal offence until very recently in some of them (e.g., India) (Latha, Bhat & D'Souza, 1996). The data-collection in connection with attempted suicide is usually a problem and is therefore mostly obtained from individual reports.

Data suggests an enormous increase in attempted suicide from 1960 onwards. The figures are 200/year/100 000 population for males and 350/year/100 000 populations for females in the USA (Diekstra & Hawton, 1987). Approximately two thirds of these statistics apply to people under the age of 30 years. Diekstra and Hawton go on to say that according to results of three sample surveys (two in the Netherlands and one in Great Britain) these figures make up less than one third of the total attempted suicides.

Once an attempt has been made the likelihood of subsequent death by suicide increases. Approximately ten percent of people with previous unsuccessful attempts eventually do commit suicide (Diekstra & Hawton, 1987). Data thus reveals that the phenomenon of suicidal behaviour has assumed the proportions of a major health problem in many countries. The burden on medical services of caring for suicideattempters is obviously of growing concern to medical and mental health professionals (Latha et al., 1996).
(ii) Age and suicidal behaviour

Shneidman (1989) states that suicide rates gradually rise during adolescence, increase sharply in early adulthood, and parallel advancing the age of 75 to 84 years. Vaillant and Blumenthal (1989) report that over the past 20 years the percentage of deaths due to suicide in the United States of America by persons between 15 and 25 years of age has increased, while the percentage of total suicides by persons over 44 years of age decreased. In their epidemiological report Rosenberg, Smith and Davidson (1987) point out that from 1950 to 1980 suicide rates for white males aged 15 to 19 increased by 305 % while the rate among 20 to 24 year old males increased by 196 %. Diekstra and Hawton (1987) also report that suicide by adolescents amounts to about a fifth of all suicides committed yearly in the Western World, while 60 percent of suicide attempts are also made by persons younger than 35 years (Latha et al., 1996). There is thus a shift in suicides where it is now committed at an earlier stage than before.

Kalafat and Elias (1995, p.124) summarize a few disturbing characteristics of youth suicides as found by researchers in the last twenty years:

- Harkavay, Friedman, Asnis, Boeck and DiFiore; Ritter; as well as Smith and Crawford (in Kalafat & Elias, 1995) found that an average of 10% of adolescents in the USA has made a suicide attempt.

- Harkavay-Friedman et al.; Kosky, Silburn and Zubith; as well as Shaffer, Bacon, Fisher and Garland (in Kalafat & Elias, 1995) discovered that no clinical or demographic data exists which distinguishes attempters from completers.

- Kleiner (in Kalafat & Elias, 1995) points out that suicide attempts can produce serious injuries such as brain damage or paralysis.

- The seriousness of the attempt does not reliably distinguish those who subsequently complete suicide (Kalafat & Elias, 1995).
Brent, Perper, Kolko and Goldstein; Shafii, Whittinghill, Dolen, Parson, Derrick and Carrington; as well as Spirito, Overholzer, Ashworth, Morgan and Benedict-Drew (in Kalafat & Elias, 1995) found that suicidal adolescents most often reveal their thoughts and feelings to peers.

The phenomenon of youth suicide is a troubling one to most of us. Although documentation of child suicidal behaviour date back to the turn of the century, many still find it hard to believe that children as young as five or six can wish to die, and that some on them actually do commit suicide (Orbach, 1988). There are similarities, but also very distinct differences in patterns between adult and child suicide.

(iii) Gender and suicidal behaviour

Suicide rates have been shown to be higher for men than they are for women. The fluctuation of suicide rates over time in males is also greater when compared to females (Blumenthal, 1990). There is however an increase in female suicidal behaviour over the last 20 years which Diekstra and Hawton (1987) relate to the phenomenon of attempted suicide. Schmidtke (1997) reports that the average male suicide rate in Europe is 27.9/year/100 000 population and for females 8.9/year/100 000 population.

Of all that is known about the phenomenon of suicide, few things are as clear as the fact that men and women differ in their suicidal behaviour. It seems clear that men complete suicide much more frequently than women do, while women make the majority of nonfatal suicide attempts. These differences do not appear to be related to differences in choice of method used to commit suicide. Even when women use the same method as men they still do not succeed as often as men do (Lester, 1997a).

(iv) Income and suicidal behaviour (the socioeconomic hypothesis)

In a macro comparison among different nations, Lester (Ferrada-Noli, 1997) found a positive correlation between gross national product and suicide rate. Demographic areas (with distinct socioeconomic constellations) within a country, however, may have suicide
rates quite divergent from the average of that particular nation. Despite the fact that many studies show a covariation of certain primarily negative sociodemographic or socioeconomic conditions with at least attempted suicide, simple sociodemographic explanations (e.g., different unemployment rates, different participation of women in the labour force, and social security systems) also do not explain the variations in European suicide and suicide attempt rates (Schmidtke, 1997).

(v) Suicidal behaviour and culture

Official death rates from suicide vary considerably between countries. The range varies from 3 to 45/year/100,000 population (Diekstra & Moritz, 1987). Some subgroups have particularly serious suicide problems that differ from those found in the general population. Although Lester (1997a) mentions young Americans as a group for whom suicide is a leading cause of death, Martin, Rozanes, Pearce and Allison (1995) cite Australia as the country with the highest suicide rate amongst youths in the industrialized world at 16.4/year/100,000 population.

Suicide rates amongst European countries differ widely. Also within countries, some regions or states, like the former Yugoslavia, Hungary or Germany, often have significantly varying suicide rates (Schmidtke, 1997). Lester (1997a) reports that the suicide rate in the United States of America has remained remarkably constant over the last twenty years at mostly around 12/year/100,000 population. He cites Norway as a country that had a dramatic increase in their suicide rate of 6.5 to 16.8/year/100,000 population. The United Kingdom and Wales are countries that have dramatically decreased their rates from 12.1 to 7.4/year/100,000 population. The suicide rate of Sweden has historically been known as high, contributing to the common belief that Swedes are a suicide-prone nation (Ferrada-Noli, 1997). However, when cross-sectional, cross-cultural studies were performed there emerged the fact that Swedes were actually underrepresented in these studies. Although there is also a widely held belief that suicide is extremely common in Japan, it is not unusually high compared to other nations. This myth is probably due to the overemphasis of hara-kiri, kamikazi pilots, and suicides of well-known Japanese novelists (Takahashi, 1997). Qualitative analysis of many of the epidemiological studies reveals
more gross simplifications, emphasizing that death by suicide is a very individualistic and complex human behaviour not easily predicted.

Lester (1997b) emphasizes the strong influence of acculturation upon the individual in his study on the suicide patterns of immigrants to the USA. Studies show that suicide rates in native countries covary with differences of the same cultural groups in other countries (Lester, 1972; Sainsbury & Barraclough, 1968; Schmidtke, 1997). Although this is the case Lester (1997b) still shows with his study that culture conflict and acculturation plays a role and affects the rate, meaning of, and circumstances of suicidal behaviour. He says, however, that acculturation does not lead in a direct linear way to an increased incidence of suicide. Takahashi (1997) agrees with Lester and states that numerous papers have focused on culture and suicide to such an extent that they have over-emphasized cultural differences and in this way increased the risk of increasing prejudice toward such cultures. He goes on to say that most cases of suicide reflect complex human factors that are found universally among cultures. Despite the fact that some cultural differences in suicide admittedly exist in different societies and that these are important, they cannot explain every aspect of suicide. Similarly, the hypotheses with regard to ethnic differences in suicidal behaviour are numerous, ranging from biological to nutrition and attitude factors, they do, however, not provide sufficient enough explanation (Schmidtke, 1997).

The reliability and validity of death certificates as a means of reporting has been raised by a few (Sainsbury, 1983; Schmidtke, 1997). European countries differ widely with regard to their death certification procedures, ranging from a coroner system in the United Kingdom, to the possibility that any general practitioner can sign a death certificate in Germany. The rate of autopsies also varies greatly, with high rates in Austria and very low rates in Germany (Schmidtke, 1997). The quality and reliability of official mortality reporting varies tremendously and comparison and interpretation of these figures must therefore be made very carefully.

Despite the fact that differences in suicidal behaviour and suicide rates seem to exist between various subgroups of the human race, no hypothesis can fully explain these differences. Schmidtke (1997) states that to date, the most convincing hypotheses are those based on different attitudes toward suicidal behaviour.
5.2.3 Conclusion

A large number of descriptive concepts and definitions have been used to try and simplify the complexities inherent in the social situation of human behaviour. This has been done to find the "true" underlying reality. Shorthand ways to describe particular types of behaviour has through a process of reification changed into semi-concrete entities with fixed characteristics. Hypothetical constructs originally used to describe behaviour were more and more used to explain that which they were intended to describe (Fourie, 1996).

The usual procedure in sociology has also for a long time been to assume that the definitions of suicide are non-problematic and then to analyze the official statistics to invent preventative strategies (Lester, 1997a). This represents a realist or conventional scientific way of viewing human behaviour. Definitions intended to describe suicidal behaviour is seen as explanations and used accordingly. Various theories of suicide have seen the light in this manner. When one realizes the complexities inherent in defining suicide as well as grasps the implications of the relativity of the meaning of suicide, it becomes obvious that to take unknown but assumed definitions of officials and the statistics accompanying that regardless of context, to test sociological or any theory of suicide, has serious flaws. Realizing the often-deliberate attempts to conceal suicidal death make it an even more pointless endeavor. Douglas's (Lester, 1997a) solution to this dilemma is to get away from a position where research relies on official data, or abstract definitions of suicide which developed from this data, to a position where the situated meanings of suicide becomes significant. Smart (1980) suggests that the definitions used in individual research projects therefore be accepted at face value.

It would be suggested that a constructivist epistemology makes the utilization of research findings easier and can in that way circumvent some of the problems traditionally ascribed to "the supposed research/practice gap" (Fourie, 1996, p.7). The way we think about science and human functioning influences what we see and how applicable it is to human dilemmas we face. From a constructivist point of view psychological problems are not seen as semi-concrete entities existing within the person exhibiting problematic
behaviour, but as social constructions in language which can not only be constructed, but deconstructed as well (Fourie, 1996). Definitions of suicidal behaviour should thus be taken at face value, in that they are co-constructions in language and not something "real" out there.

Qualitative research has been accepted by the scientific community as a viable way to explore and understand social phenomena for a while now, and characteristics of such a paradigm and its research has been presented (Atkinson & Heath, 1987; Cook & Reichardt, 1979; Hoshmand, 1989; Lincoln & Guba, 1985; Moon, Dillon & Sprenkle, 1990). It is beyond the scope of this dissertation to present all of it here. The writer wishes to focus on the second-order concepts of "ontology of the observer", "participation of the observer" and an "ethic of participation" as proposed by Atkinson and Heath (1987) and Atkinson, Heath and Chenail (1991) to inform research on suicidal behaviour.

5.3 Implications of a Second-order Perspective for Research

5.3.1 Introduction

The conventional scientific paradigm assumes that a real social world exists independently of our observing of it and that this independently existing world is singular, stable, and predictable. It further assumes that if we apply the correct methods, we can have increasingly accurate views of what "really" happens in the world. From such a realist perspective it is believed that research can aid in discovering reality, while from a constructivist perspective it is believed that research findings are created by the way and circumstances in which the research is conducted (Fourie, 1996). Although the new research paradigm has a fundamentally different perspective from which social phenomena is viewed, a survey of the field of qualitative research revealed that some assumptions have not changed (Atkinson et al., 1991). This is the case especially with regards to the legitimization of qualitative research findings.
5.3.2 The Legitimization of Knowledge

Like conventional researchers some qualitative researchers maintain that the use of specific, systematic methods of data collecting and recording make the insights of some qualitative researchers more valid and therefore more trustworthy. Atkinson et al. (1991) believe that assumptions like these are still rooted in positivist conceptions about the nature of knowledge. The fact that one set of results is seen as more trustworthy than the other, reflects a way of thinking rather than the true reality (Fourie, 1996). This judgment is usually also made regardless of the context in which such research was done.

Atkinson et al. (1991) go on to say that individual researchers cannot establish the trustworthiness of their explanations, but that they require the judgment of an entire community of observers. Kuhn's ideas are very applicable to this endeavor. Kuhn (Atkinson & Heath, 1987) states that theory choice is an open process in which general criteria are applied uniquely by individual scientists in different situations. How this is done will therefore depend on the person's specific history, values, and life situation. Establishing the trustworthiness of research therefore becomes the job of those consuming the research and not the social science researchers. “In the absence of certainty, knowledge is an ethical matter, one in which the judgment of each stakeholder must count” (Atkinson et al., 1991, p.163).

An ethical stance of participation is therefore suggested where a researcher realizes and explains his/her position in the research process. This is also in accordance with a constructivist stance where it is realized that the act of observation influences the behaviour. This makes it easier for readers of the work to understand and get to their own interpretations of the research, something that is necessary when the trustworthiness needs to be established by a community of observers. These ideas will be elaborated on in the next section.
5.3.3 An Ethic of Participation

It is clear that the social sciences are experiencing a shift "from a monological paradigm where the observer is not allowed to enter his/her descriptions, to a dialogical paradigm where descriptions reveal the nature of the observer" (Keeney & Morris, 1985, p.549). Atkinson and Heath (1987) believe that we as researchers might also benefit from a situation where it is shown more clearly how we as researchers draw distinctions. "Research becomes a task of re-examining (i.e., re-searching) what one did to construct a particular reality" (Keeney & Morris, 1985). Atkinson and Heath (1987) propose that a researcher's patterns of organizing experience should be open for scrutiny. In this way readers can decide for themselves the legitimacy of a specific way of organizing experience. This is also the reason why McDermott, Gospodinof and Aron (in Atkinson & Heath, 1987) propose ethnographic research methods to be the most useful for the constructivist researcher. It is presented in an open way that leaves the reader to decide whether a specific account is believable or not.

Atkinson and Heath (1987) think that it is time to move research in a direction that encourages researchers and readers to experience the research process. They predict that the result will be that everyone realizes that no one individual is in a better position to pronounce legitimacy than another is. This could lead to a renewed sense of community. In a context where research is seen as a collaborative experience the goal of research changes to one of creating novel observational experiences from which new views about the social world can emerge. Research thus cease to aim at finding universal "truths", but "enter the contextually messy arena of clinical work" (Fourie, 1996, p.18). A shift in focus on research is thus foreseen. Research becomes the "making sense" of a total circumstance, including contextual elements and not the finding of uncontaminated "truths" (Fourie, 1996). As Moon et al. (1990) have pointed out, most of the major insights and theoretical models used in the field of family therapy have been generated through informal, exploratory, qualitative research.
5.3.4 Moral Issues and New Paradigm Research

Marriage and family therapists have especially struggled over how to deal with moral and ethical issues, personal values, and individual beliefs as they enter the therapy and research process. The struggle's history started in the 1970s and early 1980s, when the dominant proposition was for "value free" research and therapy (Volker, 1996). Neutrality was considered an important concept of several family therapy approaches as well (Haley, 1978; Selvini-Palazzoli, Boscolo, Cecchin & Prata, 1980). Examining predominant metaphors used by family therapists Stein, in 1983 and later Doherty and Boss, in 1991 (in Volker, 1996), however, did not find neutrality. Stein therefore argued that unless therapists examined their own values they would continue to resocialize families to the dominant culture of the time. Doherty and Boss (in Volker, 1996) concluded that what was necessary now was to move on from an agreement at the theoretical level about value positions to self-examination and dialogue which would examine our values.

It almost seems as if the new research paradigm is especially suited to apply to ethical and moral issues. This might be the case because a constructivist as opposed to a realist ontology is much closer to the clinical circumstance and is therefore more likely to provide clinicians with usable information (Fourie, 1996). By re-examining what one did to construct a specific reality could just as well include examining your own values in a dialogical way. Maturana (1988) states that the development of ethical dilemmas are inevitable if we choose a dialectic approach and become interested in the conversation between structure and organization, change and stability, order and chaos, subsystem and ecosystem. It is also suggested that to examine ethical and moral dilemmas in a dialogical way by including the therapist's values seems to be the best answer for a novel observational experience that can broaden our understanding of suicidal behaviour.

5.3.5 A Proposal: Public Discussion of Professional Values

Volker (1996) presents a model to initiate the process of self-examination and public discussion of professional values. This model provides a dynamic, process-oriented framework for family therapists to reflect on their professional conduct in relation to their clients regarding the beliefs and preferences both hold on an evaluative, existential, and
affective level of the counseling process. This model is presented here because it represents:

- a starting point for professional dialogue around suicide and in that way involves the professional personally in the research process
- a vehicle to bring the researcher's values into the open
- an example of a qualitative approach which will provide "news of difference" and hopefully a new understanding of suicidal behaviour
- a dialectic process involving interaction between the client and the therapist
- an ecosystemic awareness of the ecological environment which removes the focus from the individual exhibiting suicidal behaviour
- a view where the plurality of contexts of knowledge is acknowledged

Suicide is an issue that commonly generates value clashes within the microsystem of the therapist, within the microsystem of the family, and also within the mesosystem when these two microsystems meet in the therapy process (Volker, 1996). Each microsystem is also structurally coupled and part of larger exo- and macrosystems that inform and are being informed by the particular individual. Suicide will be discussed against the four values of responsibility, integrity, freedom of choice, and empowerment. These four values are part of the six mentioned by Volker and are selected arbitrarily and subjectively. The discussion is also subjective and only represents the writer's understanding of these values, how it informs and is being informed by systems it might be a part of, and how it impacts on the therapeutic system. This exercise must be seen as an example of how impasses in therapy might be used to generate discussion around personal values and how it influences therapy. It can thus be used to get to an understanding of meanings around these values and how it can affect therapy. These discussions can take place in any system a therapist sees it fit to take place in and can represent higher orders of mind.
5.3.6 An Example: Exploration of Individual Values and how it can Impact Therapy with Suicidal Individuals

(a) Responsibility

Responsibility on the individual level of developing therapists means to care about themselves, to take into account their personal limitations and further their personal growth and to take into account their personal lives (Krasner & Houts, 1984). On the professional level the responsibility may include (a) membership in professional organizations; (b) compliance with the code of ethics; (c) ongoing supervision and education; (d) awareness of their professional limitations; and (e) understanding of the societal contexts present. MacIntyre (in Volker, 1996) states that some see responsibility as a political quality that dialectically bridges the gap between the individual level of personal development and the level of professional ethics. As responsibility is a shared endeavor in the therapy process, the question becomes who is responsible for what. Co-responsibility therefore includes (a) family members ultimately responsible for their own well being; (b) therapist responsible for structuring the treatment process, methods and professional attitudes; (c) both sharing responsibility for defining the goals of the counselling process.

When a therapist becomes involved in therapy with suicidal behaviour a few values clashes can be envisioned. On the individual level, therapists may find themselves in a clash between their personal and professional value system and the legal obligation they have as mental health professionals. More will be said on the legal obligations of therapist towards clients with the discussion on suicide and ethics in Chapter 6. A therapist may hold the belief that clients have the ultimate responsibility for their lives, where the right to commit suicide is accepted. This attitude clashes with the legal obligations to have clients committed to treatment if they are in imminent danger of harming themselves (Volker, 1994). The value where clients are ultimately responsible for their own lives coupled with the legal obligation to intervene and take over that responsibility when the therapist sees fit, creates a bind, illusion and almost impossible expectations for all involved. These expectations may hinder the therapy process and is thus necessary to explore in discussion.
(b) **Integrity**

Therapists maintain integrity on the individual level by protecting themselves from intrusions of personal boundaries. Nurturing confidence and self-esteem, and standing up for their rights that are compatible with their personal values and beliefs also secure integrity according to Volker (1994). On the professional level therapists protect their integrity by preventing other professionals or clients physically and emotionally harming them. In the therapy process one can imagine that in order to protect the clients and therapist’s integrity it is necessary for both to define clear boundaries between them, by being committed to creating a context where respect, self-confidence and assertiveness is encouraged in both.

When legally obligated to intervene when serious suicidal behaviour is present in therapy, the client’s integrity is violated. The therapist has to pretend that they know better than their client does when considering what is best for the client’s well being.

(c) **Freedom of choice**

Freedom of choice on a personal level implies that a therapist or client will feel that he/she can do whatever he/she chooses and not to feel enslaved unless chosen to be. This is seen as an essential part of personal being, and enables a person to be responsive to others (Volker, 1994). On the professional level, freedom of choice can be seen to reflect the dialectical character between the individual values and professional ethics. A therapist can therefore choose to select or exclude clients if there is an apparent value clash, as long as the ethical and legal guidelines of the profession is followed. The concept of freedom of choice helps to balance clients’ personal well being and their value system with the therapist’s (Volker, 1994). Either party in the therapy process can therefore choose to disengage from the therapy when an obvious value clash is eminent.

When a therapist is legally obliged to intervene coercively, the client’s freedom to choose and in that way be part of the therapy process, is violated. Aware of this contradiction in value, some clients can be understood to engage in therapy for exactly this
reason: to not exercise their freedom of choice. Knowing that the therapist will be obliged to act in a way that goes against respecting the client's freedom of choice.

(d) Empowerment

Strategies and information that strengthen the way we feel about ourselves and others can be seen to be empowering. Professionally therapists engage in various activities like supervision, consultation and continuing education to enhance professional growth and feelings of empowerment. Acknowledging powerlessness from the client as well as the therapist can also be seen as empowering. This acknowledgement also protects both from getting trapped in omnipotent fantasies and inappropriate rescue efforts (Volker, 1994).

The decision to coerce a suicidal client into methods that prevent suicidal behaviour from occurring can lead to clients feeling more powerless than before they entered the therapy process.

(e) Conclusion

Volker (1994) believes that a suicidal client should have the right to commit suicide when, in accordance with the therapist's personal and professional value system, the suicidal client is able to make a conscious decision within the basic values mentioned. He, however, almost immediately mentions that there are limitations to this right and cites psychotic episodes or any behaviour that could be regarded as a sign of inability "to take on the responsibility for his or her (well-) being" (Volker, 1994, p.203) as indicative of the therapist having to take control! The writer does not propose that this model be used to decide what and how therapeutic action be taken when working with suicidal patients, but proposes like Volker that this model be used to generate a process of self-examination of professional values to open it up for public discussion.
5.4 Conclusion

In this chapter it became clear why research on suicidal behaviour is sometimes counterproductive and is seen by some as just another way to “conceptually deny death”. Although a lot has been learned about suicidal behaviour in the conventional scientific paradigm, not much new meaning has come to light around individual suicidal behaviour. Some characteristics have been isolated and have helped immensely in generating various suicide prevention programs throughout the world. No direct causes of suicidal behaviour has however been found which could be worked at directly to make the prevention of suicide more effective.

The new research paradigm has provided interesting openings for research in suicidal behaviour. With its emphasis on the inclusion of a community of observers to judge the legitimacy of knowledge as well as the subsequent dialogical approach to assist in this process, the new research paradigm has provided an excellent tool in examining a highly ethical and moral issue like suicidal behaviour. The new research paradigm has also drawn our attention to the fact that how we look at research data ultimately determines the utility of it clinically. Demographic data as well as various efforts at defining suicidal behaviour is therefore not pointless if it is viewed contextually. When the aim of research on suicide, however, remains focused on discovering the “truth” about suicidal behaviour to ultimately prevent it from occurring, the same and more methodological difficulties can be expected.

In the next chapter the issue of ethics and how it affects and impacts on being in therapy with suicidal individuals will be dealt with.
CHAPTER 6

ETHICS AND SUICIDAL BEHAVIOUR

6.1 Introduction

According to Maddock (in Volker, 1994) "ethics" refers to the process of reflecting on human conduct in order to achieve clarity with regard to the value aspects of human experience. The defining characteristic of therapy consistent with the assumptions of social constructivism and a second-order approach is its emphasis on ethics (Becvar & Becvar, 1996). We will see, however, that the concept of ethics has a slightly different emphasis when viewed from a second-order perspective.

In this chapter the concept of ethics as it relates to suicidal behaviour will be discussed. The dominant image of suicide today as well as its subsequent emphasis on prevention as a way of treatment will be presented. The issues of professional liability, responsibility, and the right to suicide will be discussed, before the second-order perspective of an ethic of participation will be introduced. With this perspective it will be shown that a whole new set of ethical issues emerges, ethical dilemmas which are inevitable if we choose a dialectic approach (Maturana, 1988).

6.2 Towards an Understanding of the Current Perception of Suicide

A dramatic change in the perception of suicide occurred in roughly the year 1800. Before that time, suicide was considered to be both a sin and a crime for which the actor was responsible (Szasz, 1986). Since then suicide has increasingly been regarded as a manifestation of madness for which the actor is not responsible (Fedden, 1938). Long before suicide was decriminalized, the responsibility of suicidees for their deeds was annulled by declaring them, posthumously, non compos mentis. "Although Blackstone foresaw and forewarned against such use of the idea of insanity, it is precisely the elastic and strategic character of the concept that makes mental illness so attractive to the modern mind" (Szasz, 1989, p.439).
Since that time several highly rational and elaborate theories have been developed to convince us that the source of suicidal behaviour is to be found in either the psychological, biological or genetic make-up of an individual or the relationships between the individual and his/her social environment. This is known as the traditional view of suicide, called "determinist", where suicidal behaviour is seen as caused by factors beyond the individual’s control (Battin, 1982). Szasz (1989, p.440) states that the "psychiatric matrimony" between mental illness and suicide is connected strongly by a legal tradition of distinguishing between sane and insane suicides. This tradition is supported by a perspective viewing suicide as a "symptom" of mental illness, and mental illness as a "cause" of suicide. To a large extent, our current laws and mental health system are based on this determinist view. The patient’s decision to commit suicide is not rational or autonomous and the patient is not responsible and is therefore not faced with a moral decision. It is therefore easy to see why society believes that it has a moral obligation to intervene. This obligation is directed to the health professional who, usually very willingly, accepts the task of saving the patient, often not realizing the ethical implications (Amchin, Wettstein & Roth, 1990).

Szasz (1986) believes that the modern "scientific"/determinist view of suicide represents a secularized version of the Judeo-Christian tradition concerning the unacceptability of the act. Suicide as self-murder originates from the idea in which taking one’s life is a most grievous offense against God. This perspective is therefore thought to prohibit suicide. Although this view of suicide is prevalent in society today, the validity of it has been debated on several grounds. Persuasive arguments can be advanced so that this tradition does not absolutely prohibit suicide. There are alternative theological traditions that permit suicide, such as release of the soul, self-sacrifice, avoidance of sin, and attainment of a higher spiritual state (Battin, 1982). Social arguments also support both sides of the suicide issue. Suicide hurts society by harming family and friends, depriving society of that person’s contribution, and undermining society’s system of laws. Suicide might also benefit society when it is perceived as martyrdom or as a way of removing social burdens (Amchin et al., 1990).

The dominant image of suicide today, though, is as a mental abnormality or illness or as a symptom of such a condition. People prefer to explain suicide by viewing it
“scientifically”, creating an image of it as a combination of sin, sickness, crime, irrationality, incompetence, and insanity. Szasz (1986, p.807) states that the result of this is a “stubborn unwillingness to view suicide as we view other morally freighted acts – like abortion or divorce – as good or bad, desirable or undesirable, depending on the circumstances in which they occur and the criteria by which they are judged”.

6.3 Preventing Suicide

Although important arguments challenge the presumption of preventing suicide in all cases, suicide is still viewed as an undesirable act. People will therefore insist on holding someone or something responsible for it (Szasz, 1989). Once the clinician has assumed the professional responsibility for treating a patient, society imposes both a moral and a legal obligation on the clinician to act responsibly in treating that patient (Amchin et al., 1990). Amchin et al. (1990) conclude their discussion by emphasizing that the ethical issues presented by suicidal behaviour are complex and require at least two levels of analysis. One such level addresses the moral right of the client to act. Society currently avoids this issue by considering a suicidal patient incapable of a moral choice because the patient suffers form a mental disorder. The other level of analysis addresses the moral right and professional obligation of the clinician.

6.4 Professional Liability

“Failure to prevent suicide is now one of the leading reasons for successful malpractice suits against mental health professionals and institutions” (Szasz, 1986, p.806). Until the 1970’s, lawsuits against the mental health profession of psychology were relatively few. Simon & Sadoff (in Vesper, 1996) states that recently there has been an increase in litigation against therapists. According to the American Psychological Association’s Insurance Trust, suicide of a client is the sixth most common category for a claim but second in the total cost to the insurance carrier. There is speculation that many of the other claims may subsume damage claims for suicide and self-harm (Vesper, 1996). This points to the fact that all mental health practitioners run the risk of being accused of professional negligence for failing to prevent a client’s suicide.
The main reason mental health professionals and institutions are found liable for a client’s suicide is because they assume the duty and responsibility of preventing suicide. Szasz (1986) says that although they sometimes complain about the burden this duty entails, they clearly enjoy the extra power and prestige that go along with it. He believes that if these professionals did not want to engage in coercive suicide prevention, they could say so and refuse to participate in such work. When they choose, though, ethical principles can be used to guide their therapy.

The three key ethical principles of autonomy, nonmaleficence, and beneficence seem to have the greatest impact on decisions related to suicidal behavior. They speak directly to the difficult issues of independence of personal choice, defining harm, causing harm, and benefiting another person (Albright & Hazier, 1995). The concept of beneficence refers to any action that prevents harm or removes harmful conditions and positively benefits a client, while the concept of nonmaleficence refers to the therapist’s duty to “do no harm” (Albright & Hazier, 1995). The principle of autonomy refers to the integrity of clients as well as the recognition of their need for freedom of choice.

Although no general principle in any of the ethical codes obviously advocates preventing suicide, some of the principles can be interpreted in that way. Abstracts of the ethical code of (1) the American Psychological Association (APA) and (2) the Psychological Society of South Africa (PsySSA) will be presented. It will firstly be shown that some of these principles can be interpreted to emphasize taking responsibility for preventing suicide and therefore of honoring the principles of nonmaleficence and beneficence. It will secondly be shown that some of the principles can be interpreted to emphasize not preventing suicide and, therefore, honoring the principle of autonomy.

<table>
<thead>
<tr>
<th>Table 6.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethical Principles from APA and PsySSA which support the Ethical Concepts of Nonmaleficence and Beneficence</td>
</tr>
</tbody>
</table>

| The American Psychological Association's PRINCIPLE C: PROFESSIONAL AND SCIENTIFIC RESPONSIBILITY | Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for |

| 81 |
|---|---|---|
| **PRINCIPLE E:** CONCERN FOR OTHERS' WELFARE | Psychologists seek to contribute to the welfare of those with whom they interact professionally. In their professional actions, psychologists weigh the welfare and rights of their patients or clients, students, supervisees, human research participants, and other affected persons, and the welfare of animal subjects of research. | Psychologists are aware of their professional and scientific responsibilities to the community and the society in which they work and live. They apply and make public their knowledge of psychology in order to contribute to human welfare. |
| **PRINCIPLE F:** SOCIAL RESPONSIBILITY | As practitioners, psychologists have the responsibility to serve the welfare and best interests of the people and groups with whom they work. They have a dual responsibility: to their clients and to the broader society in which they work. | |
community and the society; the responsibility to serve the welfare and best interests are all examples that manifests the ethical principles of beneficence and nonmaleficence.

Table 6.2
Ethical Principles from APA and PsySSA which support the Ethical Concept or Autonomy

<table>
<thead>
<tr>
<th>The American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct</th>
<th>PRINCIPLE D: RESPECT FOR PEOPLE'S RIGHTS AND DIGNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists accord appropriate respect to the fundamental rights, dignity, and worth of all people. They respect the rights of individuals to privacy, confidentiality, self-determination, and autonomy, mindful that legal and other obligations may lead to inconsistency and conflict with the exercise of these rights.</td>
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<tr>
<th>Psychological Society of South Africa (PsySSA) - Ethical Code for Psychologists</th>
<th>PRINCIPLE 3: MORAL AND LEGAL STANDARDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists avoid any action that will violate or diminish the legal and civil rights of clients or others who may be affected by their actions.</td>
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</table>

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<tr>
<th>Psychological Society of South Africa (PsySSA) - Ethical Code for Psychologists</th>
<th>PRINCIPLE 5: INFORMED CONSENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists respect the autonomy of all people who may be affected by them in the exercise of their professional roles. They avoid the use of coercion in treatment and assessment or when involving others in research projects and, as far as possible, encourage joint decision-making regarding procedures to be adopted.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Psychological Society of South Africa (PsySSA) - Ethical Code for Psychologists</th>
<th>PRINCIPLE 6: WELFARE OF CLIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists respect the integrity and protect the welfare of the people and groups with whom they work.</td>
<td></td>
</tr>
</tbody>
</table>
Phrases like: respect the rights of individuals to privacy, confidentiality, self-determination, and autonomy; avoid any action that will violate or diminish the legal and civil rights of clients; respect the autonomy of all people as well as respect the integrity, manifest the principle of autonomy.

Under ideal circumstances adherence to all these principles is not only desirable but also possible. Given the complexity of clinical phenomena, like suicidal behaviour, conflicts between these principles frequently occur, ethical dilemmas therefore arise. When this happens therapists are advised to apply several principles and to consider the likely outcome of various courses of action (SA Institute for Clinical Psychologists). Good clinical practice requires recognition that none of these principles is absolute and that each can be overridden by another under certain circumstances (Rosenbluth, Kleinman & Lowry, 1995). The need for dynamic rather than rigid application of ethical principles is thus necessary for the successful management of the suicidal patient.

Albright and Hazler (1995) say that therapists first have an obligation to respect the integrity of their clients and to recognize their need for freedom of choice. The principle of autonomy can thus mean that refusing a competent person's request for cessation of therapy, or cessation of life for that matter, could show disrespect for that person's deliberate choices. The judging of a person to be legally competent or not is a difficult process. “The phenomena of ambivalence, fluctuating affect, depressed mood, disorganized cognition, and transference in suicidal clients are highly relevant to decisions that are both clinically and ethically appropriate” (Rosenbluth et al., 1995, p.920).

The assumption is traditionally made that since persons normally value life, the wish to end it must first be considered evidence of incompetence on psychiatric grounds. Until proven otherwise the client's judgement is therefore considered distorted. Rosenbluth et al. (1995) advocate that the management of an acutely suicidal compared to a chronically suicidal client differs. Treatment of the acutely suicidal client entails the vigorous preservation of the suicidal person's life while the "underlying disorder" is treated. In this case the principle of beneficence and nonmaleficence can be seen to take precedence over the principle of autonomy. Applying the same ethical reasoning to the management of chronically suicidal clients could be seen to be unnecessarily rigid and can prove to be
counterproductive. Rosenbluth et al. (1995) stress that the treatment of these clients can be seen to have two objectives, namely to preserve the life of the vulnerable person and to promote the growth of the individual to the maximum extent possible. Treating these clients as though they are acutely suicidal by arranging hospitalization to protect them and thus be motivated by therapeutic beneficence only, would overlook the other clinically important issue of autonomy. It is therefore needed to distinguish when which ethical principle be given primacy.

Rosenbluth et al. (1995) warn that rigid adherence to the principle of autonomy would unnecessarily risk the lives of acutely suicidal clients. Rigid interpretation of the principle of beneficence and nonmaleficence “would unnecessarily risk consigning many chronically depressed clients to lives of dependency and chronic patienthood” (p.921). The successful management of the suicidal patient thus illustrates the need for flexible dynamic application of ethical principles.

6.5 Responsibility for Suicide

The term “responsible” is used to describe a person’s accountability for the conduct and welfare of another person or himself/herself. Szasz (1989) goes on to say that responsibility is intertwined with two other concepts namely that of liberty and control. Adults are moral agents endowed with free will. A person cannot be held responsible for something he/she does not control. It follows, then, that anyone who assumes the task of preventing another person from committing suicide must assume the most far-reaching control over that person’s capacity to act. It is no wonder then that most efforts at preventing suicide have an unmistakable coercive character however subtly put. Since it is virtually impossible to have so much control over a person as to prevent that person from committing suicide, and since “forcibly imposed interventions to prevent suicide deprive the patient of freedom, the use of psychiatric coercion to prevent suicide is not only impractical, but also immoral” (Szasz, 1989, p.439).

What then is the health professional’s responsibility for in this regard? Szasz (1986) says that the most obvious answer to this question would probably be that the therapist’s responsibility for his/her client is whatever the law and social custom say it is. He goes on
to say that it should, however, be more than that. The mental health professional’s responsibility concerning the suicidal patient should be the same as any other health professional’s concerning his/her competent adult patient. If the person wants to or is willing to accept help for being suicidal, the health professional has a moral obligation to provide that. If the person on the other hand does not want such help and actively rejects it, then the health professional should leave such a person. It should therefore be the same as with any other competent adult client.

The writer agrees with Szasz (1986), but would like to further. The therapist’s responsibility should even be more than treating a suicidal person as any other competent adult client, and in that way emphasize the right of every responsible adult to consider and do suicide. It should also entail participation on the part of the therapist, something that will be elaborated on in section 6.7.

### 6.6 The Right to Suicide

Several authors have written about the “right to suicide” and the idea of “rational suicide” under particular circumstances (Battin, 1982; Clements, Sider & Perlmutter, 1983; Humphry, 1987; Kjervik, 1984; Maris, 1982, 1983; Werth, 1992). These views argue that it is morally wrong to stop someone from committing suicide. Szasz (1986) states that a person has a fundamental right to commit suicide. Beauchamp and Childress (1983) state that this right comes from the increasing emphasis placed on the principle of autonomy. A legally competent individual has therefore the right to control his/her own life. This might also have developed from a libertarian philosophy where a competent individual has the right to do as he or she freely chooses provided others are not harmed. Suicide might still not be seen as morally right, but this right to suicide would override other moral arguments about suicide. If the fundamental right to commit suicide is recognized under the determinist view, suicide would be permitted, and suicide prevention would become the exception. This approach will have significant implications for the mental health professional.

Although the clinician may treat the patient, he/she would not be empowered to prevent the suicide act. Szasz (1989) says that it does not mean that health professionals
may not assume specific moral or legal responsibilities concerning people deemed to be suicidal. They would, however, have no more responsibility for preventing other people's suicidal behaviour than any ordinary person has for preventing the lawful behaviour of total strangers. Taking refuge in the scientific determinist view, most practitioners, however, argue that suicidal behaviour by a mentally disordered patient represents a manifestation of the mental disorder, not the exercise of a fundamental right (Amchin et al., 1990). Szasz (1989, p.438) sees this attitude as "typical of a medieval priest...only his views on suicide are valid, only his policies for preventing suicide are moral (compassionate, humane, therapeutic)".

Although the typical case provided for a rational suicide is a person with a terminal illness (Siegel, 1982), the problem with this approach still lies with defining and identifying suicides that are truly rational. Amchin et al. (1990) also state that an understanding of the consequences of one's decision are needed to make a rational choice with regards to the continuation of life. If a mental health professional adheres to a view of psychiatric patients as those who do not have the ability to reason, then the idea of rational suicide will not apply to that category of people. In a study done by Werth and Liddle (1994) on psychotherapists' attitudes toward suicide it was found that 81 percent of the respondents believed in rational suicide. A majority of psychotherapists apparently believe that suicide is, in some cases acceptable and that the client's situation would to some extent dictate the amount of action taken to prevent suicide.

6.7 An Ethic of Participation

Psychological associations across the world develop guidelines to safeguard clients and uphold the highest standards of professional behaviour. It is essential that all practitioners be familiar with and follow such codes to the best of their ability. Becvar and Becvar (1996) state that the code of ethics published in August 1991 by the American Association for Marriage and Family Therapy (AAMFT) deals, like that of most other professional groups, primarily with pragmatic issues at the level of simple cybernetics. Suggestions of how this is done, were presented by Rosenbluth et al. (1995) and Albright and Hazler (1995) and were discussed in section 6.4.
An ethical and responsible stance from a second-order perspective can be seen not to stop at this point however, but are much more inclusive. This is the case because the nature of the concerns and the types of questions asked changes when viewed from this perspective. They will arise out of the same ecological awareness that allows us to punctuate relationship, recursion, and a constantly conjoined universe (Becvar & Becvar, 1996).

Ethical issues will, therefore, not only be centred around pragmatic questions dealing with the ascription to a specific ethical principle in a given situation, but with higher-order ones as well. Higher order issues involve the inclusion of the therapist and his/her being in society as well as an awareness of this “being in society”. When there is an understanding and awareness of yourself as always participating in the construction of a world of experience, you realize that what you perceive is drawn by how you behave, and how you behave follows from what you perceive (Keeney, 1982). A therapist’s view of a symptom (e.g., suicidal behaviour) presupposes a particular preference, intent, and ethical base. Any description a therapist chooses to indulge in would thus say more about him/herself than it says about what is being described. Being concerned with objectivity or subjectivity or (from a moral perspective) “right” or “wrong” should therefore rather be replaced by a concern with responsibility (Howe & Von Foerster, 1974). A responsible stance would be much more interested in an exploration of how the observer participates in what he/she is observing (Keeney, 1983a), something which an exploration of epistemology is part of. Some theorists have mentioned areas which therapists should be aware of when considering an ethical stance of participation.

The ethical imperative, according to Becvar and Becvar (1996), is “to avoid pathologizing, avoid the implications that we have access to the truth, and avoid narrowing the range of health to the point where there is little we do that is not illness” (p.118). If we apply this to the ethical view of dealing with suicidal behaviour, it could imply that we therefore avoid moralizing therapeutic behaviour. It could also imply that we avoid narrowing the range of therapeutic behaviour to the point were three ethical principles be used to determine if what we do is ethically “right”. The “right” way of doing therapy can be seen to be just as objectionable an endeavor as finding the “truth”. Hoffman (1991)
stresses the need to be aware of hidden power relations and says that it is usually obscured within the assumptions of our social discourse.

We will always be part of a context that defines acceptable and unacceptable behaviour, because we live in a society that, of necessity, evolve appropriate rules of conduct. As perceivers and creators of systemic and cybernetic reality we should therefore realize and become aware that suicidal behaviour is defined as an ethical issue only because we choose to define it as such (Keeney, 1983). We should also realize that juggling ethical concepts in deciding how to therapeutically deal with suicidal behaviour are not the "right" and "moral" way, but a way that makes sense in this day and age. It makes sense now, because it can be seen as an extension of the psychiatric paradigm, which means that it basically still represents a determinist view. Although an ethical emphasis therefore represents an inclusion of a larger context, that is, society’s expectations and needs, it is still focused on finding the "real world". A search for "truth" is replaced by a search for the "right" way of doing therapy. We should also be aware that our responses to situations defined as problems have as much potential to maintain those problems as to solve them. The very act of punctuating therapeutic behaviour as ethical or unethical can, in some people’s eyes, add weight to rationales that keep certain practices going or not. It can therefore help ward off in-depth exploration of the phenomena, and in that way help to maintain the problematic behaviour. The punctuation of therapeutic behaviour should therefore not keep us from questioning it relentlessly as researchers.

An ethic of participation differs from being ethical in the traditional way. An ethic of participation entails that you are not concerned with being “objective” or “subjective”, “right” or “wrong”, “acceptable” or “not acceptable”, but that you are aware. You are aware that when you choose whatever punctuation to define a situation, it will surely turn out to be that way, because we are part of constructing what we see. What you perceive is drawn by how you behave, and how you behave follows from what you perceive.
6.8 Conclusion

In this chapter it was shown that the image of suicide as a sin and a crime for which the suicidal person took responsibility has through the years changed to one where suicide is seen as a manifestation of madness, a determinist view of suicide where the *cause* of suicide is beyond the individual's control. This view is founded in a Judeo-Christian tradition where the act of suicide is seen as unacceptable and must therefore be prohibited. From this image of suicide it is not surprising that most efforts at understanding suicide was based around efforts to prevent it from occurring in the first place. Since suicidal behaviour is seen as a manifestation of madness the suicidal individual is not seen as responsible for it. The moral right of an individual to commit suicide is therefore not analyzed in so much depth as the moral right and responsibility of the mental health professional, the one taking on, and on whose shoulders the burden fell.

The ethical codes and principles guiding therapists in their dealings with suicidal individuals were described. It was stressed that the flexible and dynamic application of the principles of autonomy, beneficence and nonmaleficence is necessary for successful management of the suicidal individual. The right to commit suicide or rational suicide was debated on the grounds that it is morally wrong to stop someone from committing suicide. It was, however, stressed that identifying and defining the truly rational suicide still presented professionals with problems.

An ethic of participation was lastly proposed where it became clear that finding the ethically "right" way of doing therapy, although representing a more inclusive perspective, still has as its basis a Newtonian/Cartesian assumption of "truth" as existing "out there" and as attainable. It was shown that an ethic of participation as it is provided by a second-order cybernetic perspective punctuates it very differently in the process.
CHAPTER 7

CONCLUSION AND RECOMMENDATIONS

7.1 Theories of Suicidal Behaviour

In Chapter 2 the Psychiatric paradigm has been described using the biological, psychoanalytical and behavioural/cognitive perspectives on suicidal behaviour. These perspectives can be seen to inform one another and is mostly used together in "multi-disciplinary" format. Suicidal individuals are seen through this approach as having a psychological, biological, cognitive or genetic make-up that predisposes them to exhibit suicidal behaviour.

This view is a result of the influence of the Newtonian/Cartesian paradigm on medical thought. Through this approach the human body is regarded as a machine that can be analysed in terms of its parts and the health practitioner's role is seen as intervening, physically or chemically, to correct the malfunctioning of a specific mechanism. Before Descartes, most healers have treated their patients within the context of their social and spiritual environment. With his strict division between mind and body, physicians were led to concentrate on the body machine and to neglect the psychological, social, and environmental aspects of illness. Medical problems are mostly reduced to molecular phenomena with the aim of finding a mechanism that is central to the problem. In this way practitioners limit themselves to partial aspects of the phenomena they study (Capra, 1982).

In spite of great advances in medical science, we are still witnessing a profound crisis in the health care of suicidal behaviour. Explanations of why this could still be the case centre around the fact that (1) biology alone does not adequately explain, and can therefore never be used to control suicidal behaviour; (2) a perceived hierarchy keeps medical practitioners as the decision-makers in the treatment of suicidal behaviour; (3) the realisation of the multi-dimensional, interpersonal characteristics of suicidal behaviour would entail a complete change in current medical practice; (4) society is still hesitant in dealing with any behaviour relating to death or taking responsibility for it.
In Chapter 3 it was shown that a broader focus which includes wider systems and related relationships around suicidal individuals provides a more in-depth understanding of the behaviour. Even though most realize this, there is still a tendency specifically in the social sciences to model concepts and theories after those of Newtonian physics. The basic error that the social sciences fall into is to divide the social fabric into fragments and not to realize and apply the fact that humans are multi-faceted beings. Identification of the "suicidal" family, or even in Durkheim's (1952) case the "suicidal" society, can be seen as an example of this. All in all, the sociological paradigm represents (1) a realisation that more and wider systems need to be considered to understand suicidal behaviour better and (2) a shift away from physical structures in their emphasis on values and meanings as constructions of the human mind.

From a holistic perspective on health, suicidal behaviour can be seen as an organism's attempt to heal itself and achieve a new level of integration. Standard psychiatric and medical practice interferes with this process by suppressing the symptoms. Seeing ill health in the broad context of the human condition recognizes that suicidal behaviour can be understood only in relation to the whole network of interactions in which that person is embedded.

7.2 Discussion

No single theory provides answers to our current dilemma around suicidal behaviour. Treatment following from specific approaches does not achieve what it sets out to do, namely to prevent suicide from happening, simply because no single "cause" of suicidal behaviour exists. Attempts to rectify isolated, perceived "flaws" sometimes cause even more damage (Capra, 1982). The researcher proposes that these difficulties do not lie in the specific theories themselves, but in the way they are used. Medication is prescribed in order to control suicidal behaviour; psychoanalysis is attempted to rid the unconscious of conflict, cognitive therapy to alter mindsets; family therapy to open closed structures and introduce better ways of communication. All of the above is done to stop the suicidal behaviour from occurring and in that way it restrains the system from evolving in an idiosyncratic way true to the nature of autopoietic systems. It also communicates a
"dissatisfaction" with some chosen factor connected to the suicidal behaviour. This perceived "dissatisfaction" is rooted in a paradigm which has as its aims to find absolute "truth" and to rectify "wrongs". It also assumes that if these "wrongs" are removed or altered that suicidal behaviour will disappear.

An interesting development is perceived when dealing with morally complex situations which, for example, suicidal behaviour presents us with. Finding "objective" truth about suicidal individuals and behaviour shares the limelight with and is sometimes replaced by finding the ethically "right" way to act therapeutically. The traditional ethical way can be seen as adopting to a situation where the responsibility of controlling suicidal behaviour is progressively put on mental health practitioners as well as progressively assumed by them. Although such an approach emphasizes human values of the therapist it still originates from a Newtonian paradigm fixed on viewing a dichotomous reality. Finding the "right" way can be seen as just as objectionable as finding the "truth".

When theories are used to perceive "truth" and "falseness" or "right" and "wrong", that is exactly what will be perceived. When we want to control suicidal behaviour with medication we will perceive it as either under control or not. If we attempt to rid the unconscious of conflict, we will either succeed or not. We will either alter cognitive mindsets or not. We will be able to open closed family systems or they will remain closed. With such a perspective of dichotomy we will always be confronted with a reality existing of "right" or "wrong" responses. Not because they are necessarily "right" or "wrong", but because we choose to punctuate our reality in that way. We will therefore need to deal with the fact that cases can be perceived as "failures", to ourselves as well as those that we work with. This will be the case because we are primed to see the world as either achieving that which we hope to achieve, as informed by our theories, or not.

It is no wonder then that when viewed from this limiting perspective:

- Suicidal behaviour still presents as a huge public health issue which developed countries spend enormous amounts of money to research.
- The more demographics unconnected to context are explored, the more worrying the picture of suicidal behaviour gets.

93
The more appeals are made to health professionals to provide understanding of and answers to the treatment of suicidal behaviour, the more these helping professionals feel pressurised to find ways of controlling and preventing suicidal behaviour rather than understanding it. The pressure from society to take responsibility, therefore, forces many health professionals to respond in a preventative first-order way.

Suicidal behaviour and its therapeutic treatment has developed into an ethical issue, dedicated to give professionals guidelines to help with this inability to change the “status quo” of not being able to control suicidal behaviour.

Not only will a comprehensive understanding of suicidal behaviour elude the clinician operating from such a paradigm, but such a therapist can feel restricted therapeutically.

When suicidal behaviour is viewed from a higher-order or second-order cybernetic level, all of the above theories can be used to understand suicidal behaviour more completely. This becomes possible because the approach recognizes the fact that the way we perceive informs and is just as important as what we perceive about phenomena. The fact that some theories and explanations are thus seen as more applicable is framed within a paradigm that chooses to view explanations as more or less applicable, and not because they are more or less applicable. In fact, the whole debate sometimes conducted by researchers to emphasize the usefulness/applicability/legitimacy/validity/reliability of their own theories becomes quite futile and is, therefore, replaced in the ecosystemic paradigm by an ethic of participation.

All explanations of suicidal behaviour are useful when seen in context and all contribute to a more comprehensive understanding of suicidal behaviour. Any explanation becomes more or less relevant depending on the specific context in which the behaviour exists. This of course originates from a constructivist perspective which realizes that whatever we construct is self-referential. What we, therefore, perceive, we construct and what we construct, we perceive. Systems are not seen as sociological structures existing independently, but as systems organized around a perceived problem, as it is languaged by
that system. Problem-determined systems are, in adherence to Maturana’s concepts of
structure determinism and structural coupling, described from within the system, not from
outside. It was shown that this view informs an ethic of participation where the therapist
realizes that he/she is a co-constructor of such a reality.

With an ethic of participation the therapist/researcher/observer becomes part of and
participates in that which is observed. No idea or perception pressurises the clinician into
acting, plainly because it is realized that he/she, even if the “right” way does exist
“objectively”, does not have access to it. When suicidal behaviour is presented we, as
clinicians, are part of the problem system. The fact that a person presents suicidal
behaviour as a problem to the clinician makes it as much that of the clinician than that of
the patient. No easy answer or method exists with which we can “rectify” suicidal
behaviour. Suicidal behaviour therefore becomes a “dilemma”/point of access/sign of
need for change which could be utilized to get to higher connection in our disjointed
society.

No claims to objective facts as informed by the traditional paradigm can be made
about suicidal behaviour, nor can any single perspective be viewed as the only correct one.
Clinicians will of course act in ways which fit with a specific context. They will therefore
sometimes feel the need to act coercively or in any first-order preventative way possible
when presented with a suicidal individual. They should, however, realize that on higher
levels they might attain the exact opposite of that which they aim for on a first-order level.
Through this approach multiple ideas and distinctions evolve through the process of co-
creating a reality to fit a specific system.

7.3 Implications for the Treatment of Suicidal Behaviour

One of the most important consequences of adopting an ecosystemic approach to the
study and treatment of suicidal behaviour is the fact that the cause of a particular problem
as located within the physical, psychological, sociological or a combination of these fields
becomes irrelevant. All domains of human behaviour are recognized as presenting a
holistic framework from which suicidal behaviour can be viewed. When “techniques” or
“methods” are described as “effective” with suicidal individuals, it is not advocated as the
only way of working with suicidal behaviour, but serves as a way to (1) give better access to the research process and (2) provide an understanding of the researcher's frame of reference. Various techniques from different schools of therapy could thus have been included in this study, without changing the legitimacy of the project.

An ecosystemic therapist does not focus on the prevention of suicidal behaviour in a direct, linear manner, as is usually done from a medical, intrapsychic or sociological perspective. Not only does it, therefore, help the therapist to avoid focusing on a reductionist solution to the problem of suicidal behaviour, but it also minimizes the risk of perpetuating the suicidal behaviour.

When suicidal behaviour is understood as a way for the system to conserve its autonomy, the therapist is more likely to adopt a respectful as opposed to a blaming stance. An ethical approach would not focus on finding the morally "right" way to do therapy, but would centre around a realization that the only ethical way to proceed entails an awareness of the therapist's participation in constructing a reality around the presented suicidal behaviour.

7.4 Recommendations for Future Research on Suicidal Behaviour

The literature on suicidal behaviour is packed with studies which adhere to a realist epistemology in which contextual factors and researcher values are mostly excluded so that the "truth" or "right" way of doing therapy with suicidal individuals may be discovered. Although this is the case for many research fields, it appears more so with suicidal behaviour. Explanations for this observation centre around the troubling nature of suicidal behaviour. Suicidal behaviour might at any time result in intentional death, which could legally implicate the therapist. An ethical approach that keeps the therapist "objective" in order to determine the "right" way of handling suicidal behaviour seems to most the safest way to proceed and, therefore, stimulates research projects centred in a realist epistemology.

Sociological studies (as were shown in Chapter 3) show that if contextual factors are studied, it is generally done from a realist stance. Despite an impressive array of theory
and research, suicidal behaviour escapes full prevention. It is, therefore, suggested that further research on suicidal behaviour be carried out from an ecosystemic/constructivist perspective. Not only would it provide a more holistic understanding of suicidal behaviour and provide research that is more applicable to ethical and moral issues, like suicide, but also satisfy the outcry for new science research which include an exploration of therapist values.

Benefits from such an approach will include:

- Research relevant to clinical work with ethical issues like suicidal behaviour.
- Societal awareness of the interconnectedness of all systems in ethical and moral issues like suicidal behaviour
- An increasing awareness that suicidal behaviour is a metaphor for a whole network of complex interactions in which the suicidal individual finds him/herself. Expensive medical efforts at preventing suicidal behaviour from occurring could thus be re-evaluated.
- Research, which investigates the values and epistemologies of all health professionals and the interconnectedness of it, could be performed.

7.5 Conclusion

With an ethic of participation it is realized that those who consume research ultimately determine the trustworthiness of it. In this document, however, it was aimed to emphasize:

- the complexity of suicidal behaviour,
- the amount of research and theorising as informed by a Newtonian/Cartesian epistemology,
- the broad spectrum of systems involved in attaining a more comprehensive understanding of the behaviour,
- the importance of including the clinician when dealing with suicidal behaviour, and
- the fact that an ethic of participation as informed by an ecosystemic perspective is the most comprehensive way of dealing with the issue of suicidal behaviour.
Because this review is based on ecosystemic epistemology, it adopted a radically different way of thinking (Auerswald, 1987) which differs from the traditional reductionistic conceptualisations which form the basis of most research done on suicidal behaviour. One of the strengths of this review is therefore that it took context into account. Each theory presented was done so in the context of its paradigm as well as against a background of varying theories focusing on different aspects of suicidal behaviour.

By recommending that suicidal behaviour be understood as a socially co-constructed reality which exists in a wide range of varying communication networks (Capra, 1996) the determinist view of suicidal behaviour as residing in the individual only was side-stepped. Collaboration between professionals in a non-hierarchical way could, therefore, also be propagated and supported by this view.

The fact that this review is informed by a constructivist as opposed to a realist epistemology, showed it to be more applicable to a morally freighted issue like suicide. Ethics as it relates to therapeutic behaviour was reconceptualized as an awareness of the therapist's participation in whatever is created, and not in finding the "right" way of doing therapy.

With this dissertation it was not proposed that:

- we do more biological studies to attempt to isolate a "suicidal" gene, or to find the exact nerve ending which a serotonin boost could rectify, or that
- we delve even deeper into the unconscious of the individual with the aim of extracting the specific psychic conflict into transference that we can then address through insight, or that
- we investigate individual problem-solving skills, or any cognitive mindset to isolate that specific cognitive deficit which could be altered, or that
- the family system of a suicidal individual be described even when it is in a language that emphasize neutrality, circularity and interconnection, or that
- the dynamics of social integration be studied as it leads the individual to commit suicide, or that
societal values be dissected to understand the individual's suicidal behaviour in such a society.

It was, however, proposed that:

- the suicidal individual as sole focus be dropped from our attempts at understanding suicidal behaviour if it does not take the social context of the specific individual into account,
- the investigation of ever widening and complex systems be dropped from our attempts at understanding suicidal behaviour if it does not take the individual context into account,
- the complex attempts at integrating individual suicidal behaviour with all its systems be dropped from study if it does not take into account the epistemology of the one that observes and describes the specific behaviour, as well as
- post-modern, second-order, qualitative, new science research on suicidal behaviour be dropped from our investigations if it does not reiterate the approximate nature of knowledge and understanding.

It is further proposed that we as ecosystemic therapists:

- investigate ourselves as clinicians and researchers in the Suicide-business.
- investigate our language and values around suicide.
- investigate how we know what we know about suicide.
- explore the ways in which the language we use when talking about suicidal behaviour has progressively informed the behaviour
- lead the way in discussions with other health-professionals around these issues.

To be truly constructivist requires that we know what our theoretical biases and informal theories are. Only then can we as therapists meet our clients in their meaning systems and start talking constructively about suicidal behaviour and its implications. This dissertation attempted not only to explore those historical biases and their outflows, but also to understand how they came about.
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