

## 2 Historical Perspectives on Suicide and the Emergence of the Medical Model

### Chapter overview

Given that a counsellor's own views and beliefs about suicide are important in how they respond to and intervene with suicidal clients, it is helpful to place current perspectives on suicide in a historical context. Suicide has not always been seen as fundamentally and inextricably linked with 'madness', yet the development of psychiatry and the emergence of the medical model have seemed to reinforce this link. This chapter will provide a brief overview of changing perspectives on suicide, the emergence of the medical model, and how these now shape and inform current responses to suicidal people.

It is important to place our current work with suicidal clients in some historical perspective. Attitudes towards and beliefs about suicide have changed over the centuries; our current perspectives are informed by factors that are only relatively recent. Later in this book, particularly in Chapters 14 and 15, 'The Counsellor and Suicide Risk: Personal Perspectives and Professional Actions' and 'Potential Dangers and Difficulties', I argue that the counsellor's perspective on suicide is centrally important in how they then work with and respond to suicide risk in counselling sessions. Understanding the context of that perspective in historical terms can be helpful.

Here I will provide a brief overview of how attitudes towards suicide have changed over the centuries, and latterly how the emergence of psychiatry and the dominance of the medical model have affirmed suicide inextricably in the realms of 'madness'. There is insufficient space to fully explore the dimensions and dynamics in the changing face of suicide. For that, I would recommend Minois's (1999) work, *History of Suicide: Voluntary Death in Western Culture* (translated by Cochrane), which provides a thorough consideration of suicide through the ages. Also helpful in writing this chapter, I would recommend Pritchard (1995) and O'Connor and Sheehy (2000).

### Changing views on suicide

O'Connor and Sheehy (2000) note that the term 'suicide' has only a relatively recent history, with no recorded use before 1634. Previously the act of suicide was referred to in various forms, but included 'self-destruction' or 'self-killing' for

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example. In the Old Testament and New Testament of the Bible, there are several examples of 'self-killing' described. Barraclough (1990) noted that these instances were purely descriptive, with no positive or negative interpretations applied. We might therefore assume that the act of suicide at this time was not, in itself, viewed as morally repugnant. It seems that suicide has, over the centuries, been viewed differently at different times by society: sometimes as sinful, at other times not.

For the ancient Greeks, suicide was seen as acceptable if it were undertaken for reasons that were viewed as justifiable, such as grief or to avoid dishonour. Ancient Greek society was less tolerant of suicide for reasons less than these. Suicide was therefore seen as an acceptable death 'provided it was reasoned and reasonable' (O'Connor and Sheehy, 2000: 2). The Romans too viewed suicide without judgement, and instead saw it as an acceptable means of death in the context of 'justifiable reasons', similar to the ancient Greeks. O'Connor and Sheehy note that some suicides were not tolerated and were outlawed by the Romans, but these were usually related to suicide being seen as a loss of property, e.g. suicide of a slave or soldier.

From around AD 400, the Christian Church began to express disquiet about the act of suicide, and in AD 566 the Council of Bragga 'prohibited masses to be said for the souls of those dying by suicide and the comfort for them of a Christian burial in hallowed ground' (Pritchard, 1995: 10). The last 'unhallowed' burial took place in Britain as late as 1823, according to Wymer (1986). There were exceptions to the condemnation of suicide, principally when the person was viewed as 'deranged', or when 'honour' was at stake, such as the victim of rape taking her own life. In 1330 the priory for the sisters of the Order of the Star of Bethlehem became a hospital, to be known as the Bedlam Hospital (now the Bethlem Royal Hospital, although in a different location), and in 1357 it began to admit patients who were 'deranged', offering them sanctuary and care; it became a full psychiatric hospital later.

In the fifteenth century suicide led to severe sanctions, partly due to the influence of the Christian Church, including loss of absolution, loss of property and entering Dante's Third Circle of Hell. The Church's moral objection to suicide seemed to centre on what was believed to be a loss or rejection of hope, and thus taking a 'stand' against God. However Donne's prose work *Biathanatos*, written in 1608 and published in 1644, argued that suicide and faith could be compatible, citing examples such as Samson, Saul and Iscariot.

The corresponding development of psychiatry as a discrete discipline within medicine brought suicide into the realm of illness once again. However, from the sixteenth century onwards, perspectives on suicide have continued to shift, influenced by literature and art. Pritchard (1995) notes three main contributors to these changes, namely Shakespeare (1564–1616), Donne (1571–1631), who we have already briefly considered, and Burton (1577–1640) who in 1621 wrote *The Anatomy of Melancholy*. Much of the work of these writers and poets challenged the accepted beliefs of suicide as 'them and us' (still prevalent today perhaps), and called for greater tolerance and care. It might be argued that some of their writing was so progressive that it would still be experienced as challenging by those working with suicidal people today. Burton wrote in *The Anatomy of Melancholy*, 'His picture keep still in thy presence: Twixt him and thee there's no difference' (Burton, 1883).

Perhaps one of the most influential writers on suicide was Durkheim (1951 [1897]). The French sociologist asserted that suicide did not take place in isolation, but was instead a consequence of interplay between the individual and societal pressures and influences. In his writing he proposed four 'types' of suicide:

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- *Egoistic suicide*. Suicide occurs due to marginalization, with little social support and a sense of estrangement from society. The greater the disconnection between individual and society, the greater the risk of suicide.
- *Altruistic suicide*. It might be accurate to describe altruistic suicide as the opposite of egoistic suicide, in that suicide occurs when the individual has become too integrated within society. That is, the experience of societal expectation and pressure becomes too great, with the individual feeling unable to meet these demands.
- *Anomic suicide*. An individual is in need of stability – to be in equilibrium with his or her state (and status) within society. External change, such as redundancy or loss of status, causes emotional distress for the individual, who no longer has a sense of containment and clarity regarding their role. O'Connor and Sheehy (2000) make the link between this type of suicide and the increase in suicides during times of economic recession, for example.
- *Fatalistic suicide*. Opposite to anomic suicide, fatalistic suicide occurs when an individual feels excessively controlled, with little or no sense of control over their own future or destiny.

While the specific theories of suicide as proposed by Durkheim were important, what was of equal importance was the principle on which they were based: that suicide might be the consequence of external pressures, as opposed to simply being psychopathological. Durkheim exerted a major influence over the understanding of suicide for a long time, and his work is still considered to have relevance to current thinking.

Suicide has prominence in other cultural and spiritual beliefs. In the Hindu faith, views are heavily influenced by gender. Suicide is not seen as acceptable for males, whereas for females the idea of suicide as honourable is held, for example, following bereavement. Pritchard (1995) questions whether in the UK this is an important factor in the higher rates of suicide amongst Hindu women compared with Hindu men. Pritchard also notes that the Koran contains three very specific sanctions against suicide or 'self-killing', and that the Prophet Mohammed 'assigns suicides to the third or lower levels of Hell' (1995: 11).

### The emergence of psychiatry and the medical model

Greek and Roman sources can be seen to be heavily influential on Western beliefs about mental health and functioning. Causation of mental ill-health, and cure, was typically seen as coming from the gods. Additionally, a belief persisted of insanity being the result of moral failure, the former being the punishment for the latter by the gods. During the sixth and fifth centuries BC there was a move against this relationship between madness and the gods, and during the fourth century BC the work of Hippocrates became heavily influential. He believed that mental illness resulted from imbalance in the four bodily humours – blood, black bile, yellow bile and phlegm, corresponding to the four basic qualities of matter, namely heat, cold, moisture and dryness – and was specifically a disturbance of black bile, or *melaina chole*, later *melancholia*; whereas hysteria was related to movement of the uterus, for example (Merkel, 2003).

Consequently, treatment of mental illness focused on restoring balance in the humours, through diet, vapours, baths and purges. Aristotle, building on the work of Hippocrates, suggested a division between mind and body, arguing that bile

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mediated between mind and body; whereas Plato instead considered a division between mind/soul and body. The work of Hippocrates and his influence on medicine continued well into the seventeenth century.

Galen (AD 130–200), a Roman physician, described several ‘syndromes’, including dysthymia, paranoia and hysteria, linked to sexual tension and anxiety. As opposed to Hippocrates’s view of mental illness as being imbalance in the body humours, Galen instead proposed a view that it was due to an imbalance between aspects of the soul, ‘which had rational, irrational and lustful parts’ (Merkel, 2003: 3). Treatment centred on confinement, reading, education, and decreased exposure to stimuli. However, Hippocrates’s influences can still be seen, with sufferers undertaking purification and dietary changes and using substances to induce sleep.

During the Middle Ages, sin became central in the view of mental illness, with the rise of the dominance of the Church. Mental illness alienated the sufferer from God, and, as has already been highlighted, suicide was seen as a rejection of God because of a rejection of hope. The centrality of the Church in mental illness saw the use of monasteries as venues for treatment through the practices of confession and penance.

During the later Middle Ages, Islamic culture influenced what was happening in the West. As opposed to the Western Church view that the mentally ill were against God, the Koran taught that they were important to God, with the establishment of asylums in the eighth and ninth centuries. Merkel describes these asylums as providing ‘a calm and relaxed environment, with fountains, gardens, and the use of soothing baths, perfumes, music and special diets’ (2003: 4). From Plato’s mind/soul and body separation came a further separation of mind and soul, with the mind being associated with the Greek ‘psyche’.

The fifteenth and sixteenth centuries saw a movement towards science and a steadily declining influence of the Church. Descartes (1596–1650) proposed a division between the soul and mind, with the soul having spiritual aspects and the mind mental ones, although he did acknowledge an interaction between the two. According to Merkel (2003), the body was seen as primarily mechanical, materialistic and quantifiable, whereas the mind was seen as unbounded, non-material and limited to the realm of consciousness and thought.

In the 1600s there was an increasing awareness of the body as a mechanical ‘entity’, with greater use of anatomical studies. Thomas Sydenham (1624–1689) wrote of hysterical and neurotic disorders, thus reinforcing ideas that mental illness had clinical rather than spiritual origin. This continued into the seventeenth and eighteenth centuries, with greater numbers of people seen as mentally ill. Merkel (2003) speculates whether this was due to an actual increase in numbers, or the loss of traditional supports. Additionally perhaps might be the idea that mental illness was increasingly being viewed within clinical and therefore diagnosable constructs.

During the nineteenth and twentieth centuries further important developments occurred. Attempts were made to end witchcraft trials and greater efforts were made to differentiate people with mental illness in institutional settings. Such institutional settings were also viewed as opportunities to treat the mentally ill, as opposed to just accommodate them. Battie (1704–1776) was a key figure in these reforms.

New understandings of mental illness continued, with a greater acknowledgement of possible organic as opposed to environmental causes. Treatment

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included restraint and control. Psychiatry, an emerging discipline within medicine, began to focus on categorization of mental illnesses, with less emphasis on new treatment development. In Germany there was a growing linking of mental illness and physiology. The German school of experimental psychology became interested in consciousness, perception and memory. Key figures in the development of psychiatry include Kraepelin (1856–1926) and Janet (1859–1947). Kraepelin developed concepts such as incidence, anatomy and outcome – furthering the clinical standing of psychiatry. His work focused on psychosis, while Janet instead was interested in neurosis.

Merkel (2003) notes that by the nineteenth century, two schools of understanding of mental illness had emerged: the somatic and the psychic. The former saw mental illness as rooted within physical causation, e.g. brain disturbance, whereas the latter school, the psychic, linked mental illness to emotional stress. Interestingly, these two divisions are still debated amongst mental health professionals today: whether mental illness is more symptomatic of physical causation, or whether mental illness instead originates in psychological functioning. Clients often ask me whether I think their depression is ‘psychological or physical’ – so this dichotomous thinking has been internalized by us all.

Psychiatry has therefore developed from several strands: psyche verses soma debates; the humoral ideas of Hippocrates; and the development of psychoanalytic theories, heavily influenced by Darwin, Freud, Adler and Jung, for example. The latter theories, with which as counsellors we will be more familiar, focus on ‘illness’ as instead the manifestations of interpersonal relationships, attachment, the unconscious and the meaning of these things. Psychiatry has tried (and arguably continues to try) to integrate these ideas.

Psychiatry as practised today is still heavily influenced by its past, although perspectives and treatments have continued to develop significantly. The categorization of mental illness was formulated into diagnostic manuals, two of which are still central to psychiatric diagnosis: the *International Classification of Diseases and Related Health Problems* (World Health Organization, 1992; currently in its 10th revision, and first published in 1893 as the *International List of Causes of Death*), and the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association (1994) (currently in its fourth revised edition). These manuals inform all diagnostic decision making, and are therefore pivotal in understand ‘disorder’ models.

Counsellors will accept or disregard these models depending upon their own theoretical orientation. For example, the humanist movement and the work of psychotherapists such as Rogers would reject the notion of mental illness, and not take into account diagnostic understanding in their work. I discussed the importance of counsellors having at least a general understanding of diagnostic categories in Chapter 1.

### The medicalization of suicide

In considering the changing views of suicide over the centuries, the changing explanations for mental illness, and the emerging discipline of psychiatry and the medical model, it becomes clearer how suicide has been increasingly framed

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within the culture of mental illness. Szasz (1971) disputed the idea that suicidality always equates to mental illness, and in doing so questioned the prevailing assumptions of the time. The naming of social and interpersonal factors as important and potentially relevant in suicide research provides further momentum for such questioning. It has been argued that the prevailing assumptions at an intervention level with suicidal people have been the preference for hospital admission and/or psychotropic medication to 'treat' suicidality (Newnes et al., 1999). By including social and interpersonal factors in the theoretical construct of suicide, other treatment options, such as counselling and psychotherapy, have greater validity.

While in the US suicide is intrinsically linked with mental illness (in that anyone reporting suicidal thoughts can be hospitalized), in the UK this is not the case. It is essential that counsellors keep in mind that under UK legislation suicidality does not *necessarily* mean that the client is suffering from mental illness. This is discussed more fully in Chapter 7, 'Confidentiality, Capacity and Consent'. It is difficult to determine how responses to suicide risk and policy development might have been shaped differently without writers such as Szasz, but some studies provide scope for talking-based approaches to be considered alongside more traditional treatments such as medication. The outcome of anti-psychiatry practitioners such as Szasz might be that suicidal thoughts cannot be dismissed necessarily as the product of an insane mind and, as such, suicide prevention and intervention strategies need to include bigger considerations.

### Discussion questions

- 1 How relevant do you consider historical influences are in shaping what we understand about suicide now, and how we respond?
- 2 What do you consider to be the influences of religion and medicine in how suicide is currently constructed?
- 3 What role does the counselling profession have in informing and influencing society's views on suicide?
- 4 What role do you have as an individual counsellor in informing and influencing views on suicide amongst other professional groups, if any?