Colin Tatz
Simon Tatz

The Sealed Box of Suicide

The Contexts of Self-Death

Springer

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In memory
of
great-uncle (and great-great uncle) Dotke,
who talked and looked like a poet
but sold chicken-feed instead;
a bad book-keeper,
he took his life
because he misread his healthy credit column
—as a debit.

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Chapter 1
Explanations

Suicides often, by the very nature of their death in our society, put their skeletons in their survivors' closets.

—Edwin Shneidman [American clinical psychologist and suicidologist, 1918–2009]

Suicide is a form of murder – premeditated murder. It isn't something you do the first time you think of doing it. It takes getting used to. And you need the means, the opportunity, the motive. A successful suicide demands good organisation and a cool head, both of which are usually incompatible with the suicidal state of mind.

—Susanne Kaysen [American novelist]

Abstract The purpose of the book is to examine why society reacts so strongly and so badly to suicide; to evoke fresh thinking about a taboo by bringing to light the external and contextual factors that impinge on self-death; to canvass the conventional biomedical model of suicide as illness.

Keywords Provocation · Spurs to this book · Social change

Readers need to know what this book is and what it isn't.

It is not a textbook but it could be instructive for the professionals who deal with suicide and for the families who have lost a member. We hope that it speaks to a public that is curious or simply interested in finding out more about this bewildering behaviour. The book is not a polemic in the diatribe sense, nor an attack on the medical profession and the suicide prevention agencies. Some may read it that way and some will do so, but to question, even sharply, is not to attack. It is not a treatise on suicide theory, nor a research essay based on systematic investigation (apart from the chapter on Australian coroners and aspects of Australian Aboriginal genocide). It is not the outcome of a set of clipboard questionnaire responses. It is not based

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on official suicide statistics and their analyses, much of which is dubious rather than contentious. In no way is it a belittling of religious beliefs.

The essence of suicide, if it is to be found, requires looking at individual cases and circumstances, not in official figures. But this is a critical work that examines the merits and faults of professions that purport to comprehend the nature of suicide and insist they can prevent the phenomenon.

While suicide has been part of the human experience in most cultures, the biomedical world has managed to imprison suicide for more than a century. Supporters of that vision of health have come to portray the behaviour as an 'epidemic', a scourge, a blight and a 'curse' on our society, an inevitable outcome of mental illness, certainly of depression. No longer the domain of philosophers, poets, priests and lawyers, medicine has command of a behaviour that used to be customary, traditional and very normal. Suicide is so much more than a manner of death. It has, as American scholar Jack Douglas tells us, social meanings (Douglas 1967). As such, there is space enough to cope with some new suggestions, ideas and judgements about a topic so overwhelmingly simplified, unhelpfully boxed in as 'depression = suicidal thoughts = medication'.

Is the study of suicide a science? Through the travails and sorrows of his tragic character Werther, the great German writer Johann Wolfgang van Goethe (1749–1832) insisted that suicide is part of human nature. Each generation, he reminded us, needs to come to terms with this reality. Based on that perspective, the controversial Hungarian-American psychiatrist Thomas Szasz (1920–2012) was adamant that suicide is a moral issue: 'Dying voluntarily is a choice intrinsic to human existence. It is our ultimate, 'fatal freedom" (Szasz 1998). The French sociologist Jean Baechler defined suicide as 'a human privilege' (Baechler 1979: 42). The French novelist and philosopher Albert Camus (1913–1960) declared that 'there is only one really serious philosophical problem and that is suicide' (Camus 1955).

Suicide is unquestionably a moral, philosophical and existential matter. But, despite extensive efforts, the study of suicide is *not* a province of science. Assuredly, it is not capable of systematic observation and experiment lending itself to empirical measurement, analysis, replication and validation. The most studied of all human behaviours, libraries of journals and monographs examine suicide and go to great methodological lengths in search of measurable criteria to explain it. Certainly, patterns can be discerned, impressions gained, theories developed and disciplinary perspectives pondered. But regression coefficients, chi-square correlations and age-standardised rates notwithstanding, what, for example, do we learn from a table that tells us that the suicide rate for two decades (1970–1990) across several nations varied as follows: Hungary at 39.9 deaths per 100,000 of the population, Denmark 24.1, Australia 23.6, Spain 7.7, Italy 7.5, Chile 5.6, Greece 3.5 and Mexico 2.3 (Lester 1996: 100)? Is it really likely that Magyars in Hungary are 17 times more prone to suicide than Mexicans? These statistics don't tell us how much these comparisons depend on the differences in registering and reporting between national practices, given the widespread belief in Catholic and Eastern Orthodox nations that suicide

is both a sin and a taboo subject. And the Danish figure completely masks the fact that Greenland Inuit, whether on home soil or in Denmark, have a rate of 83 per 100,000—among the world's highest figure (WHO 2011).

Reporting/registering criteria differ markedly, even in a small population country like Australia, with its federal system of governance and its eight separate coronial jurisdictions.[1] The British–American social scientist Lester (1996: 11) reported on a study of 40 case files presented to coroners in eight countries, with no significant difference between their verdicts. 'Coroner biases are not related to national suicide rates', he concluded. That was hardly a controlled laboratory test, and one has to ask serious questions about national cultures, ruling religious canons and suicide reporting before one can accept those rates as statistical 'gospel'. In the Australian research study discussed in Chap. 11, we show how inconsistent the determination of suicide is across the Australian jurisdictions. Herein lies an inherent flaw in suicide studies, namely, the acceptance of official reports—the very bases on which practically all suicidology rests—as realistic, reliable and comparable. Our contention is that no reputable science can operate on premises or baselines such as these. Further, statistics have yet to show that their analysis produces a better *understanding* of suicide than examination of individual case studies.

Suicide is fraught with faith, fear, folklore, demonology, dogma, dread, mystery, secrecy and speculation. Given the myriad conjectures and suppositions surrounding the behaviour, we offer several insights based on three decades of limping towards a contextual anthropology of suicide among Australian Aboriginal youth, a group within which suicide was unknown half a century ago and in which it is now rampant (Tatz 2005). That kind of anthropology is not hard science but rests rather on, among other things, observation, participant observation, and the intuitive knowledge and understanding of the meaning of an action from the actor's point of view. Based on the concept of German sociologist and philosopher Max Weber (1864–1920), it is called *verstehen* in German (Dilthey 1989).

Most critical analyses provoke responses from those who see value only in the past and immediate present. In which case, this book is a positive provocation—not to incur anger but to stimulate thinking outside the sealed box in which suicide is confined. In an ironic sense, this book is something of an inquest, an inquisitorial look at why suicide creates such angst and anger, even hysteria, when compared to homicide and other violent causes of death. The text examines, at some length, why a century or more of prevention activity has not worked and why there can be no vaccination against self-elected death. Intervention in crisis time is something quite different. The medical profession, and those who specialise in psychiatry (and psychology), has been addressing suicide for over two centuries now, and have yet to unlock the enigma of why the living choose to die.

[1]Each of six states and two territories has its own coronial system, as discussed in Chap. 11 of this book. But there is a cross-jurisdictional committee attempting to create national consistency in reporting, definitions, involving health personnel, coroners and police.

We offer suggestions about alleviating suicide, activities that deflect the immediacy of ending one's life. We look at the professions of coroner and doctor and ponder their levels of tuition about suicide. In the book, and in the final chapter particularly, we discuss some 32 topics that bear directly on suicide but which are almost always left out of the conversations. Hopefully, the book will be a gainful road to comprehension (and perhaps an accommodation) of why people kill themselves.

Our intellectual traditions, and certainly the professions—like medicine, law, architecture, accountancy and engineering—don't like untidiness. Neat laws, formulae, rules and principles govern their working lives by providing order and reasonably predictable outcomes. Suicide is the enemy of tidiness, of conformity, of scientific truths. Rarely are there predicting signs of an intent to take a life, of attempts to end life, of doing so. (Later we discuss research that has found family awareness of signs that are not reported to health care professionals). Shock and bewilderment are common responses to suicide, indicative of the unexpectedness of the deed, the violence inherent in the act of cessation, the dying so suddenly and so quickly.

A new tidiness has entered coronial practice in England. Until now coroners there have had to prove suicide beyond a reasonable doubt (98–99%). The British High Court has ruled (in the *James Maughan* case, 2018) that a balance of probabilities, 51%, will suffice. Given the serious under-reporting of suicide over the decades, the new standard of proof will likely double the existing rates, perhaps even treble them. Other jurisdictions, such as Australia, have used the 51% standard for some time now, and that lower standard has a significant impact on official rates. In sum, there is a great deal more suicide than we believed to be the case.

On hearing that we were working on this book, an immediate response was 'but you're not doctors! You're not psychiatrists!' Such indignation tells us where Western society is on the matter of suicide—it is deemed to be, implacably believed to be, *solely* in the medical domain. But suicide is not the sole province of medicine. In Australia, at least, there are three or four tiers of persons who deal with the matter: they range from the 12-year trained psychiatrist to the thousands of formally untrained persons involved in non-government organisation (NGO) activity as 'preventionists' of suicide. Why that is so and why it shouldn't be so is a major theme of this volume by two seemingly unlikely authors. One is an elderly academic versed in political science, public administration, sociology and law. The other is a social science graduate, a mid-life administrator with long service as a federal political parliamentary staffer and in medical and mental health agencies. They are father and son. Suicide is hardly the exclusive right of any one -ology, any one set of lenses among the many that come under the umbrella of science. There is a science of birth and death; there is also an art of living and dying.

The impetus for the fascination with suicide comes from several sources. One was the discovery that at least ten members of our relatively small family had taken their lives, a remarkable statistic. Another was that a great-uncle, a grain merchant, had confused his accounting ledgers (thin cardboard sheets folded into eight leaves), and wrongly believing he was bankrupt, adjourned to his adjacent barn and hanged

himself with his trouser braces. Uncle 'D' wasn't mentally ill: he simply couldn't face the ignominy of insolvency, a monumental *shanda*, shame, in his day, age and context. The point of his story is not just his death, but that it took the family almost 50 years to reveal his manner of death, the skeleton in our closet. Yet another prompt was the research finding that there was no suicide in Australian Aboriginal life before 1960—after which came an irruption that placed several communities among the highest rates on the planet. Why? had to be the obvious response.

Cesare Pavese, a noted Italian poet and social critic, once wrote that no one ever lacked a reason for suicide. We believe that. We also accept fully the neuroscientific verdict that reason and emotion are both indicators of *thinking* that both travel the same neural pathways in the brain. Does a suicider—the term we use for the actor—*think*? Do they form an intent, however wrong an intent society deems it to be? In an hallucinatory state, a person may believe they can fly and jump from an apartment balcony. But, for the most part, the suicider has a reason and it is the inability to fathom it that both confronts and affronts society. Suicide runs counter to the truism that 'life is precious'.

The suicider is the agent of their demise, and it is a reasonable assumption that the medical profession should focus on the 'inside' of that agency in order to find out why that pathway was chosen (Broz and Münster 2016; Douglas 1967). But the agent can never be devoid of context, that is, an 'outside' existence that involves a social setting, a physical place, a set of relationships, a cultural and religious milieu, a welter of connections that give one a sense of belonging. For many, for the million who commit suicide every year, their outside world goes awry; their centres fall apart and cannot hold together. At present, there is an obstacle: those who look inside have little if any training in looking outside, and to date, the inside vision has shown itself incapable of putting a stop to self-cessation. Even those few with inside/outside skills find it extremely difficult to 'engineer' solutions for those displaying suicidal symptoms.

There is always some room for optimism. Social change can be inordinately slow, and sometimes it can happen in a rush. Smoking was an indelible norm, was then implicated in cancer and finally is accepted as the killer that it clearly is. Divorce was once rare and deplored, but today the rate is between 38 and 50% in Canada, the UK and the USA—a strange but common badge of dubious 'pride'. Homosexuality was always an abomination in the eyes of many religions and became a mental disorder in the eyes of American psychiatry in the middle of the last century. Today we celebrate same-sex marriages. Suicide was, in turn, a form of badness, madness and sadness. For as long as history is, suicide has been traditional, expected in most cultures. We await the day governments cease declaring 'zero suicide' wars and society accepting it as a social and human fact.

Baechler has a nice phrasing of a sad sentiment in his *Suicides*. He says all books on suicide end with recommendations or, rather, exhortations about humankind needing to get rid of such calamities—'but such pieties change not a whit the reality of suicide,

no more than the incessant advertisements in newspapers and on radio and television influence the number of highway accidents' (Baechler 1979: 34).

This work seeks to change, even a whit, the conventional thinking about suicide. It offers a much broader understanding of suicide, a wider perspective from the professional health carers, and a more realistic approach to suicide alleviation. Our Western society may well medicalise practically everything, but a dose of philosophy and a touch of sociology can do so much better than antidepressants.

Colin Tatz (Sydney)

Simon Tatz (Melbourne)

June 2019.

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Chapter 2
The Sound of Suicide

Suicide. A sideways word. A word that people whisper and mutter and cough: a word that must be squeezed out behind cupped palms or murmured behind closed doors. It was only in dreams that I heard the word shouted, screamed.

—Lauren Oliver [American novelist, author of *Before I Fall* (Oliver 2010)]

Taboos, though unadmitted, are potent. What is it that people fear? What they don't understand. The civilised man is not a whit different from the savage in this respect. The new always carries with it the sense of violation, of sacrilege. What is dead is sacred; what is new, that is, different, is evil, dangerous, or subversive.

—Henry Miller [American writer Henry Miller (1891–1980), *The Air-Conditioned Nightmare* (1970)]

Abstract We explore the 'for' and 'against' arguments about suicide; we compare other causes of death and the extraordinary responses to suicide; the frustration of unravelling the causes of suicide; the taboos and stigmas of suicide as shown by the medical examiners' verdicts in the Twin Towers disaster of 9/11.

Keywords Suicide debates · The suicide enigma · 'Falling' vs 'jumping'.

The *hissing* sound of suicide evokes emotions and passion in most Western societies: consternation, discomfit, dismay, exasperation, sorrow and sometimes relief and sympathy. American writer Jennifer Niven noted that people rarely bring flowers to a suicide (Niven 2015). Objectivity and dispassion are not in the vocabulary when it comes to self-destruction.

'You wouldn't call it normal, would you?' is a common rhetorical question, one we have heard from the medical profession. The history books tell us otherwise. Suicide is an ineluctable feature of life in almost all societies. It was first documented in Egypt about two millennia Before the Common Era (BCE). Assisted suicide wasn't

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far behind. As far back as the second century CE, the Greek philosopher Celsus wrote: 'For it is the part of a prudent man first not to touch a case he cannot save and not to risk the appearance of having killed one whose lot is but to die' (Warraich 2017: 232). While suicide is now high on the list of public enemies—alien, alienating, confronting and, above all, affronting—it is still shrouded by taboo. It is to be resisted and prevented, nay, eliminated—so declaim some governments. And assisted suicide is close behind, with only a handful of Western jurisdictions legalising euthanasia, more commonly called assisted dying.

The World Health Organization documents 800,000 suicides annually. Thousands more are classified as 'unknown' cause (see Appendix for the statistics of 41 nations). Suicide is almost three times as common as murder—and would be more common if coronial systems were not so disposed to avoiding suicide verdicts whenever possible. Yet suicide is denounced and deprecated as an affliction, a malediction. It was criminalised and made punishable until recent times in some societies. It is regarded as an outrage in many religions yet honoured in others. But whatever the mood swings in societies across the generations, suicide is standard behaviour. Unacceptable, certainly undesirable to many, yes, but it is a stark social reality.

Given the reactions, and taking account of the taboos that still enshroud suicide, can there be, or should there be, 'sides' to the question? The 'pro'-argument—which is our stance—is that individuals have dominion over their bodies, not the state, not society, and that the taking of that life is—in the phrase of the late psychiatrist Thomas Szasz—'the fatal freedom' (Szasz 1998). Natascha Kampusch—a Viennese girl abducted for eight years from 1988—said of her ordeal that 'suicide seemed to me the greatest kind of freedom, a release from everything, from a life that had been ruined a long time ago' (Kampusch 2010, see Footnote 1).

The body as property, over which ownership or control is or can be vested, is of importance in this age of organ transplants (Johnstone 2007). We discuss this later. We will also look at the views of Holocaust prisoner Jean Améry and his proposition that it is appropriate that people end lives lived in ignominy, in desperate physical or mental pain or in hopelessness. In his opinion, the suicide should not be considered 'the last great outsider' (Améry 1999: xii). Améry is important to us: yes, he killed himself—not amidst death in Auschwitz but some 16 years later amid life. In Chap. 6, we discuss categories of suicide and the importance of differentiating between kinds of suicide (especially for those in prevention work). Améry's suicide illustrates both a genre and a category of suicide. The genre is Baechler's *oblative suicide*, that is, transfigurational in the sense that one state of being, or one life, is exchanged for another, another state called death. The category, shared with the celebrated suicider poet Sylvia Plath, may well be an example of one of the 36 categories we discuss: in these cases, *validation* or *authenticity suicide*.

The 'anti'-perspective has long been basic canon in several major religions, beginning with Judaism and taken up with great vigour by Christianity, certainly from the time of St. Augustine of Hippo (354–430 CE). From him came the doctrine that only God giveth and only God taketh, making it sinful for anyone else to end a life

(Battin 2015: 174–181). Centuries later, the English Catholic cleric and writer G. K. Chesterton (1874–1936) would proclaim that 'not only is suicide a sin, it is *the* sin … It is the ultimate and absolute evil … the refusal to take the oath of loyalty to life' (Chesterton 1908). The 'anti'-side talks about 'wasted life', 'senseless actions', but also about the aftershocks of a suicide: the impacts on the immediate family and circle of friends and on the number of official and professional people who have to deal with the aftermath. In this sense, the suicider's[1] pain has ended, but it has been passed on in a ripple effect to those close to them.

There is also a somewhat conventional view, long held in Europe, that suicide is not only deviant but an assault on the ways people are expected to die, something that contradicts 'the natural instinct' to live (Morrisey 2006: 1). Suicide is seen as an insult and an affront, a crucial matter we address.

We treat the *for* and *against* views. We don't see suicide in the sin sense, but fully accept that many religious persons do. We don't subscribe to the view that suicide is a form of murder or that one suicide inexorably leads to another in a contagious way. Nor do we accept that suicide is always (or mainly) associated with mental illness. And we see little prospect of success in current suicide prevention programmes. Rather, we hope to elicit more concentration on external factors, the contextual elements, the connections and lost connections that operate in so many suicides. A major dilemma, certainly, but our inclination is to regard the suicider's right to end their pain as more important than the repercussions for the living. Why is the grief at loss of a loved one by suicide viewed, or felt often enough, as a greater grief than a loss by cancer?

Yet another dilemma faces us: is not the whole framework of today's suicide a false or at least an artificial construct that has resulted in disproportionate responses? Given the role and place of suicide in human history, and given that suicide is not some alien attack on our society or an 'epidemic' within it, why do we have such emotional (and financial) investment in strategies to prevent it? There are other causes of death of similar number that do not attract anything like the reactions to suicide, nothing like the money raised for prevention and awareness. We argue that in most Western societies suicide is more affronting than confronting.

Nobody knows for certain why people kill themselves (Bering 2018; Lester 1987, 1988, 1989, 1996). If we did, we'd be able to address what Western society deems a serious, if not a momentous, problem. We have before us a remarkable book by two former Metropolitan Life Insurance Company (New York) statisticians, Louis Dublin and Bessie Bunzel. Written in 1933, and with an enormous database to hand, they concluded that 'there is no single factor responsible for suicide':

[1]Correct grammar indicates that a person who takes their life is a 'suicide'. To distinguish the verb from the noun, we have used 'suicider' rather than 'a suicide' for such a person.

> even when some one cause would seem to dominate the picture, closer investigation discovers that it never stands in isolation but is bound up with various other considerations lying hidden or confused below the surface. (Dublin and Bunzel 1933: 14).[2]

Jennifer Michael Hecht's *Stay* is an admirable analysis of suicide across the ages, and she exercises her right and judgment to come out against the behaviour. But she is inappropriately generalising when she asserted that suicide 'is the tragic end result of depression' (Hecht 2013: 18). In some circumstances, suicide makes sense, as when a person or a group faces impossible choices, as discussed fully in Chap. 7. We show just how many bases there are for suicides in different cultures and eras, none of which have any relationship to or origins in 'depression'. Most often society engages in a form of syllogism: since we can't explain why people take their lives, the reason they do so must lie beyond reasoned explanation and thus resides in the realm of the surreal, the irrational, in the 'disturbed mind'. There is now good reason from research to question the common 'truth' that 90% of all suicides are caused by mental illness (Hjelmeland and Knizer 2017; Shahtahmasebi 2013).

Margaret Pabst Battin's superlative volume—*The Ethics of Suicide* (2015)—takes us on a global suicide journey from Egyptian Didactic Tales some 2050 years Before the Common Era (BCE), to the Hebrew Bible, to Homer, Thomas Aquinas in the thirteenth century, to Martin Luther, John Donne, Voltaire, David Hume, Georg Hegel, Sigmund Freud and to the present. From early scripture lessons, one recalls a vengeful Samson who, with rational premeditation, brought the temple of the Philistines down upon himself in about 1078 BCE; that some 25 years later King Saul wittingly chose to fall upon his sword rather than be run through by an uncircumcised enemy; that at the death of Jesus, the apostle Judas hanged himself.[3] Ahitophel was a supporter of Absalom, King David's third son, who revolted against his father. He, too, went home, set his house in order, and hanged himself (*2 Samuel* 17:23). And, memorably, in about 30 BCE, Cleopatra knowingly clutched a venomous asp to her bosom. [The remarkable English metaphysical poet John Donne (1572–1631) treated these biblical suicides in his famous *Biathanatos* (published in 1608)]. Neither biblical testament discussed suicide, neither condemned it, and neither had a word for self-death other than to describe the act, as in 'Judas hanged himself'.

Historically, suicide has been applauded, then outlawed, excoriated and punished. It has been posited as the only truly philosophical problem (Camus 1955). It has been explained as the ultimate refuge for those who find life not worth living, and it has been hailed as mankind's final or 'fatal freedom'. To the question 'what counts as suicide?, a younger American philosopher Peter Windt answered: 'not so easy to say' (Windt in Battin 2015: 711–716). In Chap. 6, we categorise the several genres of suicide and the many forms or types of self-cessation, some 36 that we know of. Yes, suicide is suicide, but many suicides are very different in motive, nature, form,

[2] Many life insurance policies were void if the insured suicided or suicided within one year of taking out a policy. Insurance 'detectives' like Dublin and Bunzel would have been the most painstaking of all death investigators.

[3] *Judges* 16:30 for Samson; *1 Samuel* 31:4 for Saul; *Matthew* 27:5 for Judas.

context, in 'the conditions hidden and confused below the surface' (Dublin and Bunzel 1933; Durkheim 2013 edn). We discuss the failure of prevention strategies to distinguish these differences—akin to asking medical professionals to treat some hundred forms of cancer as if it were one affliction.

'Of all the escape mechanisms', the acerbic social critic H. L. Mencken once wrote, 'death is the most efficient' (Mencken 1916). The resort to that mechanism is today widely presented as quintessentially a 'mental health issue', an 'illness' commonly and often dogmatically defined as 'depression', the 'black dog', and a condition 'beyond blue'. Such illness is commonly seen as a consequence of vulnerability to an early traumatic experience such as childhood sexual abuse, misuse of drugs or alcohol, employment history, a broken relationship, and to genetics. On rarer occasion, some official bodies—like Britain's National Health Service (NHS)—added external elements to the list of mental health conditions of schizophrenia, borderline personality disorder, anorexia, bipolar disorder and severe depression (*NHS Choices*, online). The addendum on 'other risk factors for suicide' comes across as if an asterisked, marginal footnote: being a war veteran, an armed forces member, gay, homeless, working close to suicide modes (meaning doctors and pharmacists), or on discharge from prison, or exposure to those who have taken their lives. In 2018, the Australian media brought to light the high number of distressed and self-deceased ambulance officers (especially in New South Wales) who have resorted to stealing Fentanyl[4] vials from their emergency kits to dose themselves and 'overdose' in some cases.

Few people talk about history, the legacies of history, geography, space, access to social institutions, social or racial discrimination and alienation, physical illness or disability (see Critical Response Pilot Report, University of Western Australia 2017). In Chaps. 4 and 7, we talk about history, about those who took their own lives rather than have a tyrannical regime take them, about the barely known misfortunes of African slaves in America who suicided rather than suffer their mistreatment (Snyder 2015) and the South American tribes who killed themselves *en masse* rather than live under Spanish colonial repression (Stannard 1993).

A respected investigative writer talked learnedly about the 'epidemic' of mental illness (Whitaker 2010)—but even epidemics trail history and have a continuing presence. It is rare for anyone to discuss the myth of 'happiness', let alone question the unreality that we have a God-given human right to be happy, that not to enjoy that status on a permanent basis is both an aberration and a symptom of unwellness.

No one knows with certainty how many people suicide. The world-wide estimate is that each year between 800,000 and one million people wilfully end their lives. The data may be 'volatile', according to the authors of the 2016 'Causes of Death' report (Richie and Roser 2016), but 817,148 persons ended their lives in 2016. That represents 1.49% of all deaths. As discussed later, this figure is an underestimation—because coroners and medical examiners are reluctant to determine suicide in less

[4] A strong opioid used for pain.