This chapter is forthcoming in the *Oxford Handbook of the Philosophy of Suicide*, edited by Michael Cholbi and Paolo Stellino.

Suicide and Mental Illness

Hane Htut Maung

Abstract

Suicide is widely considered to be a mental health problem. This is a view that was shaped by various cultural and intellectual developments throughout history, including the establishment of psychiatry as an independent discipline. Often, the relation between mental illness and suicidality is suggested to be a causal relation that can be confirmed empirically. However, underpinning this claim are assumptions about the nature of mental disorder, the nature of causation, and the proper domain of psychiatry. Hence, philosophical analysis has much to contribute to the understanding of the relation between mental illness and suicide. In this chapter, I argue that the claim that suicide is a mental health problem is not a straightforward empirical hypothesis, but also involves a normative judgement that suicidal behaviour is mentally disordered behaviour. Accordingly, a philosophical justification is also required for considering suicide to be a mental health problem. I propose such a philosophical justification based on the ethical and pragmatic benefits of bringing suicidality under the purview of mental health care. I also examine the limitations of this approach and argue that a narrow framing of suicide as exclusively a mental health problem risks drawing attention away from other ways of understanding suicide and other factors that are important contributors to suicide.

Keywords

suicide, mental illness, psychiatry, health, disorder, philosophy of medicine

1. Introduction

Suicide has been viewed in a diverse variety of ways throughout history. These include, among others, suicide as a spiritual practice, as a moral problem, as an irrational act, as an exercise of freedom, as an expression of anguish, and as a response to social adversity. Cultural and intellectual developments that led to the establishment of modern psychiatry as an independent discipline influenced a transition toward viewing suicide as an outcome of mental illness. Such a view continues to be influential in the present day and suicide is now widely considered to be a mental health problem. Often, the relation between mental illness and suicidality is suggested to be a causal relation that can be confirmed empirically. However, underpinning this claim are assumptions about the nature of mental disorder, the nature of causation, and the proper domain of mental healthcare. Therefore, philosophical analysis has much to contribute to the understanding of how suicide and mental illness are related.

In this chapter, I offer such a philosophical analysis. After giving a brief historical overview of how suicide has become discursively linked with mental illness, I consider how the association between suicide and mental illness has been defended in contemporary psychiatry. I then argue that the claim that suicide is a mental health problem is not a wholly empirical hypothesis, but also involves a normative judgement that suicidal behaviour is mentally disordered behaviour. Hence, a philosophical justification is also required for the claim that suicide is a mental health problem. After critically examining some theories of health and disease from the philosophy of medicine, I consider a pragmatic justification based on the benefits of bringing suicide under the purview of mental healthcare. Finally, I examine the limitations of this approach and argue that a narrow framing of suicide as exclusively a mental health problem risks attention being drawn away from other ways of understanding suicide and other factors that are important contributors to suicide.

2. Historical overview

The contemporary characterization of suicide as a mental health problem that falls within the domain of psychiatry gradually took form through a series of historical, cultural, intellectual, and scientific developments. As far back as antiquity, there are examples of suicidal acts being attributed to psychological disturbances (van Hooff 1990). In ancient Greece, suicide was often considered to be condemnable, but some suicidal acts were linked to *mania* and *melancholia*, which were respectively claimed to involve excesses of yellow bile and black bile. In ancient Rome, suicidal acts by soldiers were usually judged to be treasonous, but there were lesser punishments for soldiers whose suicidal acts were motivated by *morbus* (illness), *taedium vitae* (weariness of life), *furor* (madness), and *luctus* (sorrow) (van Lommel 2013).

In medieval Europe, the dominant religious attitude considered suicide to be a prohibited act that is deserving of punishment. Although this attitude mostly continued to be upheld in the early modern period, there were developments in the seventeenth century that contributed to new ways of viewing suicide which align more with the secular and nontheistic worldview that is accepted today. For example, in keeping with his rationalist approach to philosophy, René Descartes viewed suicide as a problem not of morality but of reason:

> It is also true that knowledge of the soul's immortality and of the felicities it will be capable of outside of this life could provide those who are weary of this life with reasons to leave it, if they were sure that they really would enjoy all those felicities in the afterlife. But no reason assures them of this. (Descartes 1645, 35)

While Descartes accepted the truth of the immortality of the soul, he argued that the uncertainty regarding whether the next world would be any better than this world makes suicide an unreasonable act. This is in stark contrast with the religious moralizing that was prevalent at

the time. For Descartes, suicide is an error of judgement and not a punishable sin. It is also in contrast with the view that immortality makes it unreasonable to fear death. An example of this can be found in Plato's *Phaedo*, where Socrates proposes that death is not to be feared because it would free the soul from bodily attachment (Cooper and Hutchinson 1997). For Descartes, however, suicide can still be an unreasonable act regardless of the acceptance of immortality.

The view that suicide is irrational became associated with the view that suicide is a medical problem. As noted by the historian Georges Minois (1999), the dualism between mind and body that was advanced by Descartes reinforced the theory that irrationality associated with madness has a physiological cause, while the soul itself remains unaffected. For example, the physician Thomas Willis, in his posthumously published *Opera Omnia* (1680), suggests that suicidal crises can result from melancholia and mania, which are claimed to be caused by disrupted movements of vapours in the brain. Accordingly, it was suggested that people who die from suicide due to illness or madness may be exempted from moral condemnation.

The discursive link between suicide and mental illness was further secured throughout the eighteenth, nineteenth, and twentieth centuries as asylums expanded and the discipline of psychiatry became established as an epistemic authority (Jansson 2013). For example, Jean-Étienne Dominique Esquirol, in his classic textbook *Des Maladies Mentales* (1838), suggests that suicide is always a symptom of mental illness whose cause can be biologically explained. Four decades later, in the third edition of Henry Maudsley's *The Pathology of the Mind*, suicidal thoughts and behaviours had become classified as core symptoms of melancholia, 'so much so that one suspects their actual or possible existence even when they have not been openly manifested' (Maudsley 1879, 384). Similarly, Maurice de Fleury, in *L'Angoisse Humane* (1924), suggests that suicide is always due to a pathological condition.

Hence, the establishment of modern psychiatry strengthened the transition from viewing suicide as a moral problem to viewing suicide as a medical problem. Such a

characterisation of suicide as a mental health problem remains influential in the present day, as it is now accepted that people who struggle with suicidal thoughts and acts should not be morally condemned but should be offered care. This is reflected in practices and policies concerning suicide prevention. For example, in the World Health Organization's report on *Preventing Suicide*, suicide prevention is considered an 'integral part' of the Mental Health Action Plan (World Health Organization 2014, 7). Likewise, the Department of Health's *Preventing Suicide in England* initiative states that suicide prevention begins with 'better mental health for all' (Department of Health 2012, 4). Accordingly, psychiatry is considered to have an important role in suicide prevention and risk assessment, as reflected in the Royal College of Psychiatrists' recommendation that 'new trainees in psychiatry should receive training in risk assessment including managing suicide risk' (Royal College of Psychiatrists 2004, 22).

3. Empirical research

In contemporary psychiatry, the claim that suicide is a mental health problem is usually presented as an empirical claim that can be supported with evidence that suicide is usually preceded by mental illness. A common research methodology for demonstrating this association is the psychological autopsy study (Appleby *et al*. 1999; Barraclough *et al*. 1974; Cavanagh *et al*. 2003). Psychological autopsy studies retrospectively examine the circumstances surrounding suicide cases, including whether any diagnosable mental disorders were present. Such information is gathered through interviews with informants who were close to the victims and by examining health records.

A commonly reported finding of psychological autopsy studies is that most people who had died from suicide were suffering from some form of mental illness when they died (Appleby *et al*. 1999; Barraclough *et al*. 1974). In a systematic review of psychological autopsy

studies, Jonathan Cavanagh and colleagues estimate that mental illness may be present in up to ninety percent of suicide cases (Cavanagh *et al*. 2003). In these cases, the most commonly reported diagnoses are affective disorders, such as major depressive disorder and bipolar disorder. As I shall discuss further below, this reported figure of ninety percent is now disputed and is very likely to be a gross overestimate. Despite this, however, the figure continues to be cited in suicide prevention policy, such as the World Health Organization's report on *Preventing Suicide* (2014).

The observed association between suicide and mental illness is sometimes suggested to indicate a causal connection. Under this view, suicide is considered to be a causal outcome of mental illness. For example, Göran Isacsson and Charles Rich suggest that 'a simple and testable hypothesis can be stated: depression is a necessary cause of most suicides' (Isacsson and Rich 2003, 457). Accordingly, Cavanagh and colleagues claim that 'improving the detection and treatment of all disorders, particularly in primary care, may be the most effective way of reducing suicide rates' (Cavanagh *et al*. 2003, 402).

Such claims might be criticized for underplaying the complexity of suicide causation. As with all complex behaviours, suicide is widely understood to be a contingent outcome of multiple interacting factors at individual, interpersonal, and wider social levels (Maung 2020a). Indeed, most people who are diagnosed with affective disorders do not engage in suicidal acts. Therefore, while mental illness may be a contributory factor in suicide causation, it is certainly not a sufficient cause. If we want to account for why some people with affective disorders engage in suicidal acts but other people with affective disorders do not, other factors will be much more relevant as difference makers.

It could be contended that the aforementioned claims are not necessarily denying the roles of interpersonal and social factors in suicide causation. Rather, they are suggesting that interpersonal and social factors are causal factors insofar as they exacerbate or contribute to

the development of mental illness. That is to say, the interpersonal and social factors are assumed to be remote causes of suicide, while mental illness is assumed to be the proximate cause through which these remote causes exert their influences. Notably, Isacsson and Rich (2003) suggest that the relation between depression and suicide is analogous to the relation between atherosclerosis and myocardial infarction. While there are multiple biological and social risk factors for myocardial infarction, these exert their influences by contributing to the development of atherosclerosis. Accordingly, it has sometimes been suggested that depression is the 'common final pathway' to suicide (Akiskal 2007; van Heeringen 2012). However, this picture also fails to capture the complexity of suicide causation, because it overlooks the dynamic and reciprocal ways in which depressive symptoms interact with other factors. For example, a depressed mood may be exacerbated by social isolation, but depressed mood may also exacerbate social isolation, which in turn may motivate suicidal behaviour. Here, it would be reasonable to claim that mental illness is a remote cause and social isolation is a proximate cause.

The results of psychological autopsy studies have also been contested on empirical and methodological grounds. Critics have argued that psychological autopsy studies are confounded by numerous biases, including recall, temporal, confirmation, and attribution biases (Hjelmeland *et al*. 2012; Pouliot and De Leo 2006). Hence, the commonly reported figure of ninety percent is believed to be a gross overestimate for the proportion of suicide cases that are preceded by mental illness. This is corroborated by the fact that the figure was found to be much lower at twenty percent when blinding was used to mitigate some of aforementioned biases (Freuchen *et al*. 2012).

Further to the above problems, I argue that the empirical defence of the association between suicide and mental illness is also confounded by a conceptual issue. The hypothesis that suicide is a causal outcome of mental illness seems to treat suicidal behaviour and mental

illness as if they are distinct events that are only contingently related. However, there is a tighter conceptual connection between suicidality and mental illness that makes the correlation between them *a priori* more likely (Maung 2022b). As I hope to show, the claim that suicide is associated with mental illness is not a straightforward empirical hypothesis, but is in part a normative judgement that suicidal behaviour is disordered behaviour.

4. Diagnostic criteria

The conceptual connection between suicide and mental illness is perhaps most apparent in the way that suicidality is built into the diagnostic criteria of some mental disorders. As noted earlier, affective disorders, such as major depressive disorder and bipolar disorder, are the most commonly reported diagnoses in the suicide cases examined by psychological autopsy studies (Barraclough *et al*. 1974; Cavanagh *et al*. 2003). However, this correlation may partly be due to the fact that suicidality is a criterion that counts toward an affective disorder diagnosis.

According to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*-5), major depressive disorder is diagnosed if a person exhibits at least five out of nine symptom criteria over a period of two weeks, with at least one of the symptoms being ‘depressed mood most of the day’ or ‘markedly diminished interest or pleasure’ (American Psychiatric Association 2013, 160–161). The same criteria also count toward a diagnosis of bipolar disorder, although the diagnosis of bipolar disorder also requires the presence of a manic episode or a hypomanic episode. According to *DSM*-5, a manic episode is defined as a ‘distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently goal-directed behavior or energy, lasting at least one week and present most of the day, nearly every day (or any duration if hospitalization is necessary)’ and a hypomanic episode is defined as a ‘distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy,

lasting at least four consecutive days and present most of the day, nearly every day' (American Psychiatric Association 2013, 124).

One of the listed criteria for an affective disorder diagnosis is 'recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide' (American Psychiatric Association 2013, 161). Although the presence of suicidality is neither necessary nor sufficient for an affective disorder diagnosis, it does nonetheless count toward such a diagnosis. Given that an affective disorder diagnosis can at least partly be based on the presence of suicidality (in conjunction with other symptoms), it is to be expected that affective disorder diagnoses are common among people who die from suicide.

Another diagnosis that is often associated with suicide is borderline personality disorder. This is characterized in *DSM*-5 as 'a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts' (American Psychiatric Association 2013, 663). Chronic childhood trauma has been shown to be a causal factor in the development of the pattern of behaviour associated with borderline personality disorder (Porter *et al*. 2020). Accordingly, the way the diagnosis often gets characterized in psychiatric practice has been criticized for stigmatizing survivors of abuse (Nicki 2016). Under *DSM*-5, borderline personality disorder is diagnosed if a person exhibits at least five out of nine symptom criteria. One of the listed criteria is 'recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior' (American Psychiatric Association 2013, 663). Again, while the presence of suicidality is neither necessary nor sufficient for a borderline personality disorder diagnosis, it does nonetheless count toward such a diagnosis.

Two concessions must be made here. First, there are many mental disorders that do not include suicidality among their diagnostic criteria, yet are associated with increased suicide risk. For example, people diagnosed with schizophrenia are more likely to die from suicide

than people without schizophrenia (Palmer *et al*. 2005). According to *DSM*-5, schizophrenia is diagnosed if a person exhibits at least two out of five symptom criteria, which are delusions, hallucinations, disorganized speech, disorganized behavior, and diminished emotional expression (American Psychiatric Association 2013, 99). Importantly, suicidality is not included in the diagnostic criteria for schizophrenia. Therefore, the association between suicide and schizophrenia cannot be attributed to any explicit conceptual connection between them, but must be empirically established. Indeed, the symptoms of schizophrenia can have causal roles in the development of suicidality by contributing to psychological distress and by interacting with other causal risk factors, such as social deprivation, isolation, and stigma (Ventriglio *et al*. 2016). However, although schizophrenia is associated with increased suicide risk, cases of schizophrenia comprise a minority of suicide cases that are linked to psychiatric diagnoses. As noted above, the majority of suicide cases that are linked to psychiatric diagnoses involve affective disorders, whose diagnostic criteria explicitly include suicidality.

Second, although suicidality is built into the diagnostic criteria for an affective disorder, this conceptual connection is not the only reason why affective disorder diagnoses are associated with increased suicide risk. The symptoms of an affective disorder may reinforce one another via causal relations, such that the presence of a given symptom makes other symptoms more likely to be present (Borsboom 2009). For example, Angélique Cramer and colleagues note that 'fatigue may lead to a lack of concentration, which may lead to thoughts of inferiority and worry, which may in turn lead to sleepless nights, thereby reinforcing fatigue' (Cramer *et al*. 2010, 140–141). Likewise, suicidality may be reinforced by symptoms such as depressed mood and hopelessness, which would partly account for why an affective disorder diagnosis is associated with increased suicide risk. Nonetheless, even without such causal relations between the symptoms, the presence of suicidality could still make an affective

disorder diagnosis more likely, simply in virtue of the fact that suicidality is built into the diagnostic criteria for an affective disorder (Maung 2022b).

5. Rescue hypotheses

I have, so far, been considering cases where the conceptual connection between suicide and mental illness is made explicit by the inclusion of suicidality in the *DSM*-5 diagnostic criteria for some mental disorders. However, in other cases, the conceptual connection may be more implicit. When suicidality is present but the full criteria for a *DSM*-5 diagnosis are not satisfied, there may remain an eagerness to attribute the suicidality to some form of mental illness. For example, Thomas Joiner and colleagues suggest that 'death by suicide among humans is an exemplar of psychopathology' (Joiner *et al*. 2016, 235). Similarly, John Burnside suggests that 'intent to commit suicide is prima facie evidence for a disease of the mind' and that 'difficulty in assigning an appropriate DSM number in no way excuses failure to act on a fatal symptom' (Burnside 1998, 142). The above suggests that suicide is still often considered to be a mental health problem even if a formal *DSM*-5 diagnosis cannot be made.

Sometimes, when a person dies from suicide but did not exhibit any depressive symptoms, it may retrospectively be suggested that the person had masked depression. An example of such a case is presented by the psychiatrist Juan José López Ibor:

> All that the patient said was that she had been suffering from some "strange" headaches, which had begun some months previously, and which she had treated with the usual analgesics. One day … she told her mother, who happened to be in the house, that she was going to the bathroom to wash her hair. Her mother heard the water running for a short time; after a few minutes of silence she heard a strange noise—a bathroom stool that had fallen over. She ran to the bathroom door to see what was happening, and was

> horrified to discover that her daughter had hanged herself; using a nylon clothes-line … we quickly appreciated the fact that she was depressed and that the attempt at suicide was the consequence of her depression, which until then had not been apparent to the members of her family, to her family doctor or even to the neurologist who had examined her. Frequent headaches were the only disturbance that the patient had been complaining about for some months past. There is no better name for this case than that of *masked depression*. (López Ibor 1972, 245)

Here, masked depression appears to be serving as what Imre Lakatos (1977) calls a rescue hypothesis. The fact that the person did not exhibit any depressive symptoms would seem to undermine the claim that the suicide was attributable to a mental illness. Hence, to salvage the claim that the suicide was attributable to a mental illness, it is claimed that the person had depressive illness whose symptoms were being masked.

This use of masked depression as a rescue hypothesis makes the claim that suicide is associated with mental illness somewhat unfalsifiable. This was criticized by the psychiatrist Louis Appleby in a lecture delivered at the Royal College of Psychiatrists, where he commented on the unexpected suicide of the Linkin Park singer Chester Bennington:

> Lots of people talked about it and their general conclusion was that it is evidence of masked depression, the self-fulfillment that's intrinsic to psychiatry. Depression's there really, but it's masked depression. I'll just suggest to you that there's an alternative explanation and that is he wasn't depressed at all. (Appleby 2017, 44:00–44:20)

According to Appleby, suicide may often occur in the context of rapidly escalating distress rather than in the context of a depressive illness. However, he notes that there is a common

assumption in psychiatry that any person who dies from suicide must have been mentally unwell and that masked depression is sometimes invoked to accommodate this assumption.

Another example of a potential rescue hypothesis is the putative category of suicidal behaviour disorder. This is not currently in clinical use, but it appears in *DSM*-5 under the section on 'Conditions for Further Study' (American Psychiatric Association 2013). The following criteria are suggested by *DSM*-5:

> A. Within the last 24 months, the individual has made a suicide attempt;
>
> B. The act does not meet criteria for nonsuicidal self-injury;
>
> C. The diagnosis is not applied to suicidal ideation or to preparatory acts;
>
> D. The act was not initiated during a state of delirium or confusion;
>
> E. The act was not taken solely for a political or religious objective. (American Psychiatric Association 2013, 801).

Much of the discussion about whether suicidal behaviour disorder should or should not be included as a diagnostic category has focused on empirical aspects. For example, Kara Fehling and Edward Selby (2020) argue that suicidal behaviour has demonstrable antecedent validators (social, cultural, and demographic risk factors), concurrent validators (cognitive, emotional, and personality correlates), and predictive validators (future course and response to treatment). However, while these empirical considerations may support the classification of suicidal behaviour as a distinctive behavioural category, they are insufficient to justify its inclusion specifically as a mental disorder. Indeed, as Richard Bentall notes in his satirical article 'A Proposal to Classify Happiness as a Mental Disorder' (1992), happiness has demonstrable antecedent, concurrent, and predictive validators, but we would consider its inclusion as a

mental disorder to be inappropriate. Hence, the proposed inclusion of suicidal behaviour disorder still requires further justification over and above the empirical considerations.

As noted above, suicidal behaviour disorder is not currently in clinical use. However, if suicidal behaviour disorder does become included in a future diagnostic classification system, then a far greater number of people who engage in suicidal acts could be formally diagnosed with a mental disorder. Hence, in a case where a person exhibits suicidal behaviour but does not satisfy the criteria for any other psychiatric diagnosis, the category of suicidal behaviour disorder could potentially serve as a rescue hypothesis to salvage the claim that the suicidal behaviour is attributable to a mental illness (Maung 2022b).

In this section, I have discussed two ways in which suicide and mental illness are conceptually connected. First, suicidality is built into the diagnostic criteria for some mental disorders. Second, in the case where the criteria for a formal psychiatric diagnosis are not satisfied, a rescue hypothesis may be invoked to attribute the suicidality to a putative mental illness, such as masked depression. An implication of this conceptual connection is that the claim that suicide is a mental health problem is not a wholly empirical hypothesis that can be justified solely by observing a correlation between them. Such a justification would be partly circular, because it is already presupposed, prior to the observation, that suicidality is a symptom of mental illness. This is a normative judgement that warrants a philosophical justification. I should stress that I am not suggesting that an empirical justification is irrelevant. As noted earlier, there are important ways in which the symptoms of mental disorders contribute causally to suicidal thoughts and acts. However, given that the connection between suicide and mental illness is also partly conceptual, a more complete justification also requires a philosophical defence of the judgement that suicidal behaviour is disordered behaviour.

6. Philosophical justification

A philosophical justification of the claim that suicide is a mental health problem might involve an analysis of the concept of health. This concerns the issue of what makes a condition specifically a medical problem, rather than a healthy state or a different sort of problem. In the philosophy of medicine, various theories of health and disorder have been proposed, including naturalistic (Boorse 1977), hybrid (Wakefield 1992), and normativistic (Nordenfelt 2007) theories. Herein, I consider some prominent examples of these theories and argue that they do not provide adequate analyses of suicide. Instead, I defend a different philosophical defence based on the ethical and pragmatic benefits of bringing a condition under the purview of healthcare (Kukla 2020).

Naturalism suggests that whether a condition is healthy or disordered is determined by biological facts. An influential naturalistic theory is Christopher Boorse's biostatistical theory:

1. The reference class is a natural class of organisms of uniform functional design; specifically an age group of a sex of a species.
2. A normal function of a part or process within members of the reference class is a statistically typical contribution by it to their individual survival and reproduction.
3. Health in a member of the reference class is normal functional ability: the readiness of each internal part to perform all its normal functions on typical occasions with at least typical efficiency.
4. A disease is a type of internal state which impairs health, i.e., reduces one or more functional abilities below typical efficiency. (Boorse 1977, 555)

The biostatistical theory assumes a teleological account of function, according to which the function of a part of a system is whatever that part does that contributes towards the goals of

the system. In organisms, the goals are assumed to be survival and reproduction. Under the biostatistical theory, health is statistically typical functional ability relative to the appropriate reference class, while disease is a substandard deviation from statistically typical functional ability relative to the appropriate reference class. For example, haemoglobin contributes to survival by transporting oxygen. A haemoglobin concentration of 15g/dl is considered healthy in a young adult because the efficiency of oxygen transportation at this concentration is within the statistically typical range for young adults. However, a haemoglobin concentration of 10g/dl is considered disordered in a young adult because the efficiency of oxygen transportation at this concentration is below the statistically typical range for young adults.

Suicidality would be a disease or disorder under the biostatistical theory iff it involves the failure of some internal part to contribute to survival or reproduction at statistically typical efficiency. While suicidality clearly decreases the chance of survival, it is doubtful whether this is due to a failure of an internal part to perform its proper function. As noted earlier, suicide is widely understood to be a complex outcome of multiple interacting factors at individual, interpersonal, and wider social levels, and so it often cannot straightforwardly be attributed to the activity of some internal part (Maung, 2020a). Indeed, while there may be some biological features that are loosely correlated with suicidality, there are currently no validated biomarkers that reveal internal mechanisms for the mental disorders that associated with suicide (Nugent *et al*. 2019; Tabb and Lemoine 2021). Therefore, the biostatistical theory is currently unable to justify the claim that suicide is a mental health problem.

Hybridism suggests that whether a condition is healthy or disordered is jointly determined by social values and biological facts. A prominent hybrid theory is Jerome Wakefield's harmful dysfunction analysis:

> A condition is a disorder if and only if (a) the condition causes some harm or deprivation of benefit to the person as judged by the standards of the person's culture (the value criterion), and (b) the condition results in the inability of some internal mechanism to perform its natural function, wherein natural function is an effect that is part of the evolutionary explanation of the existence and structure of the mechanism (the explanatory criterion). (Wakefield 1992, 384)

There are two important differences between the harmful dysfunction analysis and the biostatistical theory. First, the harmful dysfunction analysis assumes an aetiological account of function based on evolutionary theory, according to which the proper function of a part of an organism is whatever that part did in the organism's ancestors that contributed to their reproductive successes and enabled the part to be inherited across generations. Second, according to the harmful dysfunction analysis, the failure of a part to perform its proper function is, on its own, insufficient for a condition to be a disorder. For a condition to be a disorder, there also must be a social value judgement that the condition is harmful to the person.

Suicidality would be a disorder under the harmful dysfunction analysis iff (a) it is judged to be harmful to the person and (b) it involves a failure of an internal part to perform its evolutionarily selected proper function. Indeed, suicidality satisfies the evaluative criterion. However, it is doubtful whether it satisfies the factual criterion. As noted above, the causal complexity of suicidality suggests that it cannot straightforwardly be attributed to the activity of some internal part and there are currently no validated biomarkers that reveal internal mechanisms for suicidality (Nugent *et al*. 2019; Tabb and Lemoine 2021). Moreover, the reliance of the harmful dysfunction analysis on evolutionary theory results in a further problem. Behavioural traits leave no unambiguous fossil evidence, and so it may not be possible to establish whether suicidality is a failure of an evolutionarily selected proper function or an

evolutionarily neutral response, such as an ontogenetic product of the modern social environment (Lilienfeld and Marino 1995; Smith 2020). Therefore, the harmful dysfunction analysis is currently unable to justify the claim that suicide is a mental health problem.

Further to the above theoretical challenges, a more general problem with naturalism and hybridism is that they fail to capture ordinary intuitions about what renders suicidal behaviour disordered. Often the claim that some behaviour is abnormal or disordered is not determined by some fact about function or mechanism, but expresses a value judgement that the behaviour is undesirable (Amundson 2000; Rost 2020). As Derek Bolton notes, 'the judgment of disorder is typically made on other grounds—such as radical incomprehensibility or social unacceptability—and the objective basis for the condition is then assumed' (Bolton 2000, 145). This is perhaps most apparent with psychiatric diagnoses that are associated with behaviours which are deemed morally wrong, such as antisocial personality disorder and pedophilic disorder. For example, the claim that pedophilic disorder is abnormal or disordered does not express a biological fact, but expresses a value judgement about the abusiveness and harmfulness of the associated behaviour. Of course, suicidal behaviour is associated with very different social and moral judgements from antisocial personality disorder or pedophilic disorder, as it is now acknowledged that suicide is not a moral failure but is a tragic outcome of suffering, and so it is accepted that people should not be morally condemned for struggling with suicidal thoughts and acts. Nonetheless, the relevant point here is that ordinary intuitions about what renders suicidal behaviour disordered have little to do with considerations about biological function, evolutionary fitness, and so on, but tend to reflect value judgements about its unacceptability. This suggests that a normativistic theory may fare better at capturing the relevant considerations.

Normativism suggests that whether a condition is healthy or disordered is determined by social values. A notable example is Lennart Nordenfelt's holistic theory of health:

> A is completely healthy if, and only if, A has the ability, given standard circumstances, to reach all his or her vital goals. … A has a disease if, and only if, A has at least one organ which is involved in such a state or process as tends to reduce the health of A. The disease is identical with the state or process itself. (Nordenfelt 2007, 7)

Unlike the biostatistical theory and the harmful dysfunction analysis, the holistic theory of health does not require a failure of function for a condition to be a disorder. Rather, whether or not a condition is a disorder depends on whether or not one is able to fulfil one's vital goals, which are defined according to personal and social values.

Suicidality would be a disorder under the holistic theory of health iff it comprises a state or process that impairs one's ability to fulfil one's vital goals. Indeed, suicidality often does involve the loss of hope regarding one's vital goals, insofar as it is very often marked by distress, despair, and the sense that meaning has been lost. The trouble, though, is that the holistic theory of health is too permissive. There are many conditions that could impair people's abilities to fulfil their vital goals but which are not considered to be disorders. For example, age-related fertility decline may impair one's ability to fulfil one's goal of becoming a parent, but age-related fertility decline is not generally considered to be a disorder or an illness. A potential reply is that goals can be thwarted to different degrees, and so whether or not a condition is a disorder depends on the extent to which it thwarts one's goals. This would accommodate suicidality as a disorder insofar as it thwarts nearly all goals, but could exclude other conditions that thwart one's goals to much lesser extents. However, a problem with this reply is that there are conditions which are widely considered to be disorders even though they thwart people's goals to lesser extents than some conditions which are not considered to be disorders. For example, age-related fertility decline may thwart one's goal of becoming a parent considerably more than mild eczema or seasonal rhinitis, yet eczema and seasonal rhinitis are

considered to be disorders while age-related fertility decline is not. And so, while the holistic theory of health can accommodate the claim that suicide is a health problem, it does not provide a reason why some other conditions that thwart people's goals are not deemed to be health problems.

The criteria that are stipulated by the above three theories of health and disease are features that pertain to individuals. However, a potential problem with this sort of approach is that it does not capture the diverse institutional roles that these concepts serve in healthcare and society. A different sort of approach is Quill Kukla's institutional definition of health:

> A condition or state counts as a *health condition* if and only if, given our resources and situation, it *would be best for our "collective" wellbeing* if it were medicalized—that is, if health professionals and institutions played a substantial role in understanding, identifying, managing and/or mitigating it. In turn, *health* is a relative absence of health conditions (and concomitantly a relative lack of dependence upon the institutions of medicine). (Kukla 2014, 526)

The institutional definition of health emphasizes the social roles of the concepts of health and disorder rather than the features of individuals. It emphasizes the ethical and pragmatic benefits of bringing a condition within the purview of healthcare. This can be illustrated with the aforementioned example of pedophilic disorder. Pedophilic acts are considered to be immoral and unlawful acts which fall within the purview of the criminal justice system. Additionally, however, it is also recognised that pedophilic disorder is often a distressing condition and clinicians have recently shown that offering therapeutic interventions to people with pedophilic urges could help them to reduce their unwanted urges, change their behaviours, and decrease the risk of offending (Engel *et al*. 2018; Federoff 2016; Wild *et al*. 2020). Hence, it has been

argued that bringing pedophilic disorder within the purview of healthcare could benefit our collective wellbeing by helping to prevent harmful offenses against children, as well as by allowing people who are struggling with pedophilic urges to access therapeutic interventions that could help them to modify and overcome these harmful and unwanted urges (Beier *et al*., 2015).

Of course, the social and moral issues raised by suicide are entirely different. Nonetheless, the institutional definition of health can provide a useful philosophical framework for justifying the claim that suicide is a mental health problem. Under the institutional definition of health, suicide counts as a health condition iff it would be best for our collective wellbeing for healthcare professionals and institutions to have substantial roles in understanding, assessing, managing, and mitigating it. Indeed, there is empirical evidence that mental healthcare interventions can decrease suicide risk in certain groups of people (Mann *et al*. 2021). With regards to pharmacological therapy, selective serotonin reuptake inhibitors and tricyclic antidepressants have been shown to decrease suicide risk in people diagnosed with major depressive disorder (Gibbons *et al*. 2007), lithium has been shown to decrease suicide risk in people diagnosed with bipolar disorder (Baldessarini *et al*. 2006), and clozapine has been shown to decrease suicide risk in people diagnosed with schizophrenia (Meltzer *et al*. 2003). With regards to psychological therapy, cognitive-behavioural therapy has been shown to decrease suicide risk in people diagnosed with major depressive disorder (Brown *et al*. 2005) and dialectical-behavioural therapy has been shown to decrease suicide risk in people diagnosed with borderline personality disorder (Linehan *et al*. 2006).

The fact that psychiatric and psychological interventions can decrease suicide risk in certain groups of people suggests that it is beneficial for our collective wellbeing for mental healthcare professionals and institutions to have substantial roles in understanding, assessing, managing, and mitigating suicide in these groups. Bringing suicide under the purview of mental

healthcare can allow people who are struggling with suicidal thoughts and behaviours to access certain forms of support and care that may be helpful. Therefore, under the institutional definition of health, suicide justifiably counts as a mental health problem. Importantly, this does not require there to be some underlying dysfunction or specific mechanism that causes the suicidality. As noted above, suicide is a complex outcome of multiple interacting factors at individual, interpersonal, and wider social levels, and so may not be straightforwardly attributable to some internal dysfunction or biological mechanism. Rather, suicide is a mental health problem insofar as bringing suicide under the purview of mental healthcare is beneficial for our collective wellbeing.

7. Explanatory pluralism

While there are benefits of bringing suicide under the purview of mental healthcare, this approach to understanding suicide also has limitations. Given the complexity of suicide causation, it is unlikely that suicide can be adequately understood through any single approach on its own. In some contexts, it may be inappropriate to view suicidality as a symptom of mental illness. Hence, although the claim that suicide is a mental health problem is justified, it would be wrong to claim that suicide is exclusively a mental health problem.

Suicide's characterization as a mental health problem highlights tensions between the duties of psychiatrists to prevent suicide and the provision of assisted dying for people who are suffering from terminal health conditions (Burgess and Hawton 1999). The ethical justification of assisted dying is usually based on the person's moral right to avoid the suffering associated with a severe and irremediable condition (Schüklenk and van de Vathorst 2015). However, the characterization of suicide as a mental health problem seems to confound this by suggesting that the person's wish to die could be a symptom of mental illness. For example, Reginald Deschepper and colleagues note that it can be 'difficult to differentiate between a request based

on a genuine and constant form of unbearable suffering and a request as a symptom of a severe depression' (Deschepper *et al*. 2014, 617). What seems to be suggested here is that a request for assisted dying may be deemed invalid if it is the symptom of a mental illness. This is potentially problematic because it could amount to the denial of one's moral right to control one's death when one's suffering is severe and irremediable.

In response, the above suggestion seems to rest on the false assumption that mental illness entails a lack of agency. While mental illness can be associated with impaired decisional capacity, such an association is contingent and far from universal. As Werdie van Staden and Christa Krüger note, incapacity cannot be inferred solely from the presence of mental illness, but must be demonstrated independently 'by the consideration of conditions necessary to give informed consent' (van Staden and Krüger 2003, 43). Thus, given that mental illness does not necessarily undermine agency or decisional capacity, a person's request for assisted dying in the context of unbearable and irremediable suffering may still be valid and reasonable even if the person is considered to have a mental illness (Maung 2020b). It is worth noting, however, that assisted dying, especially its extension to nonterminal conditions, has also been criticized on more social and political grounds. For example, it has been argued that the extension of assisted dying to nonterminal conditions without redressing the relevant social inequities perpetuates harmful ableist structures by allowing people with disabilities to die because of suffering that is in part socially mediated (Maung 2022a; Wilson and Barker 2020). Likewise, it has been argued that the extension of assisted dying to old age may partly be influenced by problematic ageist attitudes which fail to properly acknowledge that old age has value (Richards 2017). These criticisms still allow us to accept that there are circumstances where voluntary assisted dying is ethically justified and that its provision could have a role in a compassionate society. However, they highlight that the ethical permissibility or

impermissibility of any system of assisted dying is contingent on the wider social and political context wherein it is put into practice.

Characterizing suicide exclusively as a mental health problem also risks drawing attention away from other causal factors that are important contributors to suicide. Ever since Émile Durkheim's (1897) research on the variations in suicide rates in Europe, several epidemiological studies have shown that a range of interpersonal and social factors have roles in suicide causation. At the level of the interpersonal environment, causal factors include abuse (Afifi *et al*. 2008), bullying (Hertz *et al*. 2013), prejudice (Hong *et al*. 2010), loneliness (McClelland *et al*. 2020), and unemployment (Gunnell *et al*. 1995). At the level of the wider society, causal factors include government austerity (Stuckler and Basu 2013) and social deprivation (Whiteley *et al*. 1999). Furthermore, while psychiatric and psychological interventions may decrease suicide risk in certain groups of people, the overall impact that they have on the suicide rate in the general population is relatively small (Barnhorst *et al*. 2021). By contrast, social interventions to restrict access to methods of suicide, such as firearms, poisons, and jump sites, have been shown to be among the most effective strategies to decrease the suicide rate in the general population (Yip *et al*. 2012).

In response, it might be claimed that the view of suicide as predominantly a mental health problem can accommodate the multiplicity of causal factors. For example, as noted earlier, it might be suggested that interpersonal and social factors are remote causes of suicide that exacerbate or contribute to the development of mental illness, which is the proximate cause. Under such a view, suicide could be considered a health problem akin to any other multifactorial illness with remote social causes, such as myocardial infarction (Isacsson and Rich 2003).

However, the above response is inadequate because it fails to acknowledge the active roles that these interpersonal and social factors have as proximate difference makers in the

development and maintenance of suicidality. Suicidal behaviour does not subsist in isolation, but is always embedded in a social environment that enables and shapes it. This is perhaps most salient with suicides in marginalised communities. For example, research in China has shown that suicidality among sex workers is occasioned and sustained by social stigma, economic disempowerment, and a legal system that fails to properly acknowledge the rights of sex workers as workers (Hong *et al*. 2010). In Australia, recent research on the high suicide rates among indigenous communities, asylum seekers, and refugees has highlighted how lost communal practices and exclusion from society result in conditions that make unliveability thinkable among these oppressed groups (Cover 2016). Relatedly, research on the high suicide rates among international adoptees in Sweden has suggested that thwarted belongingness is a significant contextual factor, which has underscored the need to properly acknowledge the connections that adoptees have with their birth kin and the importance of respecting the rights of adoptees to access information about their histories (Hjern *et al*. 2020; von Borczyskowski *et al*. 2006). Even when there is a psychiatric diagnosis, suicidality is profoundly shaped by interpersonal and social processes. For example, people diagnosed with borderline personality disorder suffer considerable stigma and are sometimes treated unjustly by public services, which can influence cycles of distress, helplessness, and suicidality (Aviram *et al*. 2006; Sheehan *et al*. 2016). And so, given the active roles they have in enabling and shaping suicidality, interpersonal and social factors cannot merely be considered remote causal factors, but can sometimes be proximate causal factors.

Given the complexity of suicide causation, scholars have recently endorsed a pluralistic approach to understanding suicide (Barnhorst *et al*. 2021; Maung 2020a; Rogers and Lester 2010). While it is certainly legitimate to approach suicide as a mental health problem, there are also other legitimate approaches to understanding suicide that may be more relevant in other contexts. For example, viewing suicide as a political problem is more relevant for addressing

the injustices that make suicide more prevalent among oppressed groups (Button 2016; Cover) and viewing suicide as a social problem is more relevant for addressing the environmental conditions that influence the suicide rate at the population level (Gunnell *et al*. 1995; Whitely *et al*. 1999). Each single approach only provides partial knowledge of a limited aspect of suicide causation. A more comprehensive understanding of suicide would need to acknowledge the roles that the multiple different approaches have in different contexts.

8. Conclusion

The characterization of suicide as a mental health problem has a long history and became secured by the establishment of psychiatry as an independent discipline. Contemporary defences of this characterization suggest that the association between suicide and mental illness can be verified empirically. However, this is confounded by the presence of a closer conceptual connection between suicide and mental illness, both explicitly in the definitional criteria for some psychiatric diagnoses and implicitly in the uses of rescue hypotheses to accommodate suicidal acts that do not meet the criteria for formal diagnoses. This reflects a prior normative judgement that suicidal behaviour is disordered behaviour. And so, the characterization of suicide as a mental health problem also warrants a philosophical justification.

I have argued that traditional theories of health and disease in the philosophy of medicine, which focus on notions of biological function and dysfunction, fail to capture intuitions about what renders suicidal behaviour disordered. Instead, I have defended a different sort of philosophical account that focuses on the ethical and pragmatic benefits of bringing suicide under the purview of mental healthcare. Suicide can justifiably be considered a mental health problem because mental healthcare interventions can decrease suicide risk in certain groups of people and allow people who are struggling with suicidal thoughts to access support. However, I have also argued that there are important limitations to this approach.

Suicide is a contingent outcome of complex interactions between multiple factors at individual, interpersonal, and wider social levels, and so a narrow framing of suicide as a mental health problem risks neglecting other important contributors to suicide causation and other ways of viewing suicide. In some contexts, it may not be useful or appropriate to characterize suicide as a mental health problem. This indicates the need for a pluralistic approach that recognizes multiple legitimate approaches to understanding suicide that are relevant to different purposes.

References

Afifi, Tracie O., Murray W. Enns, Brian J. Cox, Gordon J. G. Asmundson, Murray B. Stein, and Jitender Sareen. 2008. "Population Attributable Fractions of Psychiatric Disorders and Suicide Ideation and Attempts Associated with Adverse Childhood Experiences." *American Journal of Public Health* 98(5): 946–952.

Akiskal, Hagop. 2007. "Targeting Suicide Prevention to Modifiable Risk Factors: Has Bipolar II Been Overlooked?" *Acta Psychiatrica Scandinavica* 116(6): 395–402.

American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition. Washington, DC: American Psychiatric Association.

Amundson, Ron. 2000. "Against Normal Function." *Studies in History and Philosophy of Biological and Biomedical Sciences* 31: 33–53.

Appleby, Louis. 2017. "Things We Know About Suicide Prevention but Aren't True" [video]. *Royal College of Psychiatrists*. https://www.rcpsych.ac.uk/discoverpsychiatry/presidentslectures/pastlectures.aspx

Aviram, Ron B., Beth S. Brodsky, and Barbara Stanley. 2006. "Borderline Personality Disorder, Stigma, and Treatment Implications". *Harvard Review of Psychiatry* 14: 249–256.

Baldessarini, Ross J., Leonardo Tondo, Paula Davis, Maurizio Pompili, Frederick K. Goodwin, and John Hennen. 2006. “Decreased Risk of Suicides and Attempts During Long-Term Lithium Treatment: A Meta-Analytic Review.” *Bipolar Disorders* 8(5): 625–639.

Barnhorst, Amy, Hilary Gonzales, and Rameesha Asif-Sattar. 2021. “Suicide Prevention Efforts in the United States and Their Effectiveness.” *Current Opinion in Psychiatry* 34(3): 299–305.

Beier, K. M., Dorit Grundmann, Laura F. Kuhle, Gerold Scherner, Anna Konrad, and Till Amelung. 2015. “The German Dunkelfeld Project: A Pilot Study to Prevent Child Sexual Abuse and the Use of Child Abusive Images.” *Journal of Sexual Medicine* 12(2): 529–542.

Bentall, Richard P. 1992. “A Proposal to Classify Happiness as a Mental Disorder.” *Journal of Medical Ethics* 18: 94–98.

Bolton, Derek. 2000. “Alternatives to Disorder.” *Philosophy, Psychiatry, and Psychology* 7(2): 141–153.

Boorse, Christopher. 1977. “Health as a Theoretical Concept.” *Philosophy of Science* 44: 542–573.

Borsboom, Denny. 2008. “Psychometric Perspectives on Diagnostic Systems.” *Journal of Clinical Psychology* 64(9): 1089–1108.

Brown, Gregory K., Thomas Ten Have, Gregg R. Henriques, Sharon X. Xie, Judd E. Hollander, and Aaron T. Beck. 2005. “Cognitive Therapy for the Prevention of Suicide Attempts: A Randomized Controlled Trial.” *Journal of the American Medical Association* 294(5): 563–570.

Burgess, Sally, and Keith Hawton. 1999. “Suicide, Euthanasia, and the Psychiatrist.” *Philosophy, Psychiatry, and Psychology* 5(2): 113–126.

Button, Mark E. 2016. “Suicide and Social Justice: Toward a Political Approach to Suicide.” *Political Research Quarterly* 69(2): 270–280.

Cavanagh, Jonathan T. O., Alan J. Carson, Michael Sharpe, and Stephen M. Lawrie. 2003. “Psychological Autopsy Studies of Suicide: A Systematic Review.” *Psychological Medicine* 33(3): 395–405.

Cooper, John M., and D. S. Hutchinson (eds.). 1997. *Plato: Complete Works*. Indianapolis: Hackett.

Cover, Rob. 2016. “Suicides of the Marginalised: Cultural Approaches to Suicide, Minorities and Rationality.” *Cultural Studies Review* 22(2): 90–113.

Cramer, Angélique O. J., Lourens J. Waldorp, Han L. J. van der Maas, and Denny Borsboom. 2010. “Comorbidity: A Network Perspective.” *Behavioral and Brain Sciences* 33(2–3): 137–150.

Department of Health. 2012. *Preventing Suicide in England: A Cross-Governmental Outcomes Strategy to Save Lives*. London: Department of Health.

Descartes, René. 1645. “Letter to Princess Elisabeth of Bohemia, 3 November 1645.” In *Some Texts from Early Modern Philosophy*, edited by Jonathan Bennett, 2019. https://www.earlymoderntexts.com/assets/pdfs/descartes1643.pdf

Durkheim, Émile. 1897. *Le Suicide: Étude de Sociologie*. Paris: Félix Alcan.

Engel, Jannis, Mandy Körner, Petya Schuhmann, Tillmann H. C. Krüger, and Uwe Hartmann. 2018. “Reduction of Risk Factors for Pedophilic Sexual Offending.” *Journal of Sexual Medicine* 15(11): 1629–1637.

Esquirol, Jean-Étienne Dominique. 1838. *Des Maladies Mentales*. Paris: J. B. Bailière.

Fedoroff, J. Paul. 2016 “Managing Versus Successfully Treating Paraphilic Disorders: The Paradigm is Changing.” In *The Handbook of Clinical Sexuality for Mental Health*

Professionals, edited by C. B. Levine and S. E. Althof, pp. 345–361. New York: Routledge.

Fehling, Kara, and Edward A. Selby. 2020. "Suicide in DSM-5: Current Evidence for the Proposed Suicide Behavior Disorder and Other Possible Improvements." *Frontiers in Psychiatry* 11: 499980.

Fleury, Maurice de. 1924. *L'Angoisse Humane*. Paris: Edition de France.

Freuchen, Anne, Ellen Kjelsberg, and Berit Grøholt. 2012. "Suicide or Accident? A Psychological Autopsy Study of Suicide in Youths Under the Age of 16 Compared to Deaths Labeled as Accidents." *Child and Adolescent Psychiatry and Mental Health* 6: 30.

Gibbons, Robert D., C. Hendricks Brown, Kwan Hur, Sue M. Marcus, Dulal K. Bhaumik, and J. John Mann. 2007. "Relationship Between Antidepressants and Suicide Attempts: An Analysis of the Veterans Health Administration Data Sets." *American Journal of Psychiatry* 164(7): 1044–1049.

Gunnell, David J., Tim J. Peters, Robert M. Kammerling, and Jane Brooks. 1995. "Relation Between Parasuicide, Suicide, Psychiatric Admissions, and Socioeconomic Deprivation." *British Medical Journal* 311(6999): 226–230.

Hertz, Marci Feldman, Ingrid Donato, and James Wright. 2013. "Bullying and Suicide: A Public Health Approach." *Journal of Adolescent Health* 53(1): S1–S3.

Hjelmeland, Heidi, Gudrun Dieserud, Kari Dyregrov, Birthe L. Knizek, and Antoon A. Leenaars. 2012. "Psychological Autopsy Studies as Diagnostic Tools: Are They Methodologically Flawed?" *Death Studies* 36(7): 605–626.

Hjern, Anders, Jesús Palacios, Bo Vinnerljung, Helio Manhica, and Frank Lindblad. 2020. "Increased Risk of Suicidal Behaviour in Non-European International Adoptees

Decreases with Age – a Swedish National Cohort Study." *EClinicalMedicine* 29–30: 100643.

Hong, Yan, Xiaoyi Fang, Xiaoming Li, Yang Liu, Mingquiang Li, and Tom Tai-Seale. 2010. "Self-Perceived Stigma, Depressive Symptoms, and Suicidal Behaviors Among Female Sex Workers in China." *Journal of Transcultural Nursing* 21(1): 29–34.

Isacsson, Göran, and Charles L. Rich. 2003. "Getting Closer to Suicide Prevention." *British Journal of Psychiatry* 182(5): 457.

Jansson, Åsa. 2013. "From Statistics to Diagnostics: Medical Certificates, Melancholia, and 'Suicidal Propensities' in Victorian Psychiatry." *Journal of Social History* 46(3): 716-731.

Joiner, Thomas E., Melanie A. Hom, Christopher R. Hagan, and Caroline Silva. 2016. "Suicide as a Derangement of the Self-Sacrificial Aspect of Eusociality." *Psychological Review* 123(3): 235–254.

Kukla, Quill R. 2014. "Medicalization, 'Normal Function,' and the Definition of Health." In *The Routledge Companion to Bioethics*, edited by John D. Arras, Elizabeth Fenton, and Quill R. Kukla, pp. 515 – 530. London: Routledge.

Lakatos, Imre. 1977. "Science and Pseudoscience." In *Philosophical Papers*, vol. I, 1–7. Cambridge, United Kingdom: Cambridge University Press.

Lilienfeld, Scott O., and Lori Marino. (1995). "Mental Disorder as a Roschian Concept: A Critique of Wakefield's 'Harmful Dysfunction' Analysis." *Journal of Abnormal Psychology* 104(3): 411–420.

Linehan, Marsha M., Katherine Anne Comtois, Angela M. Murray, Milton Z. Brown, Robert J. Gallop, Heidi L. Heard, Kathryn E. Korslund, Darren A. Tutek, Sarah K. Reynolds, and Noam Lindenboim. 2006. "Two-Year Randomized Controlled Trial and Follow-

Up of Dialectical Behavior Therapy vs Therapy by Experts for Suicidal Behaviors and Borderline Personality Disorder.” *JAMA Psychiatry* 63(7): 757–766.

López Ibor, Juan José. 1972. “Masked Depressions.” *British Journal of Psychiatry* 120(556): 245–258.

Mann, J. John, Christina A. Michel, and Randy P. Auerbach. 2021. “Improving Suicide Prevention Through Evidence-Based Strategies: A Systematic Review.” *American Journal of Psychiatry* 178(7): 611–624.

Maudsley, Henry. 1879. *The Pathology of Mind*, 3rd edition. London: Macmillan.

Maung, Hane Htut. 2020a. “Pluralism and Incommensurability in Suicide Research.” *Studies in History and Philosophy of Biological and Biomedical Sciences* 80: 101247.

Maung, Hane Htut. 2020b. “Psychiatric Euthanasia and the Ontology of Mental Disorder.” *Journal of Applied Philosophy* 38: 136–154.

Maung, Hane Htut. 2022a. “Externalist Argument Against Medical Assistance in Dying for Psychiatric Illness.” *Journal of Medical Ethics*, online before print. DOI: 10.1136/jme-2022-108431

Maung, Hane Htut. 2022b. “Mental Disorder and Suicide: What's the Connection?” *Journal of Medicine and Philosophy* 47: 345–367.

McClelland, Heather, Jonathan J. Evans, Rebecca Nowland, Eamonn Ferguson, and Rory C. O’Connor. 2020. “Loneliness as a Predictor of Suicidal Ideation and Behaviour: A Systematic Review and Meta-Analysis of Prospective Studies.” *Journal of Affective Disorders* 274: 880–896.

Meltzer, Herbert Y., Larry Alphs, Alan I. Green, A. Carlo Altamura, Ravi Anand, Alberto Bertoldi, Marc Bourgeois, Guy Chouinard, M. Zahur Islam, John Kane, Ranga Krishnan, J. P. Lindenmayer, and Steven Potkin. 2003. “Clozapine Treatment for

Suicidality in Schizophrenia: International Suicide Prevention Trial (InterSePT).” *JAMA Psychiatry* 60(1): 82–91.

Minois, Georges. 1999. *History of Suicide: Voluntary Death in Western Culture*, translated by Lydia G. Cochrane. Maryland, MD: Johns Hopkins University Press.

Nicki, Andrea. 2016. “Borderline Personality Disorder, Discrimination, and Survivors of Chronic Childhood Trauma.” *International Journal of Feminist Approaches to Bioethics* 9(1): 218–245.

Nordenfelt, Lennart. 2007. “The Concepts of Health and Illness Revisited.” *Medicine, Health Care, and Philosophy* 10(1): 5–10.

Nugent, Alison C., Elizabeth D. Ballard, Lawrence T. Park, and Carlos A. Zarate Jr. 2019. “Research on the Pathophysiology, Treatment, and Prevention of Suicide: Practical and Ethical Issues.” *BMC Psychiatry* 19: 332.

Palmer, Brian A., V. Shane Pankratz, and John Michael Bostwick. 2005. “The Lifetime Risk of Suicide in Schizophrenia: A Reexamination.” *Archives of General Psychiatry* 62(3): 247–253.

Porter, Carly, Jasper Palmier-Claus, Alison Branitsky, Warren Mansell, Helen Warwick, and Filippo Varese. 2020. “Childhood Adversity and Borderline Personality Disorder: A Meta-Analysis.” *Acta Psychiatrica Scandinavica* 141(1): 6–20.

Pouliot, Louise, and Diego De Leo. 2006. “Critical Issues in Psychological Autopsy Studies.” *Suicide and Life-Threatening Behavior* 36(5): 491–510.

Richards, Naomi. 2017. “Old Age Rational Suicide”. *Sociology Compass* 11(3): e12456.

Rogers, James R., and David Lester. 2010. *Understanding Suicide: Why We Don’t and How We Might*. Cambridge, MA: Hogrefe Publishing.

Rost, Michael. 2020. "'To Normalize is to Impose a Requirement on an Existence.' Why Health Professionals Should Think Twice Before Using the Term 'Normal' With Patients." *Journal of Bioethical Inquiry* 18: 389–394.

Royal College of Psychiatrists. 2004. *Assessment Following Self-Harm in Adults*. London: Royal College of Psychiatrists.

Schüklenk, Udo, and Suzanne van de Vathorst. 2015. "Treatment-Resistant Major Depressive Disorder and Assisted Dying." *Journal of Medical Ethics* 41(8): 577–583.

Sheehan, Lindsay, Katherine Nieweglowski, and Patrick Corrigan. 2016. "The Stigma of Personality Disorders." *Current Psychiatry Reports* 18: 11.

Smith, Subrena E. 2020. "Is Evolutionary Psychology Possible?" *Biological Theory* 15: 39–49.

Stuckler, David, and Sanjay Basu. 2013. *The Body Economic: Why Austerity Kills*. London: Allen Lane.

Tabb, Kathryn, and Maël Lemoine. 2021. "The Prospects of Precision Psychiatry." *Theoretical Medicine and Bioethics* 42(5–6): 193–210.

van Heeringen, Kees. 2012. "Stress–Diathesis Model of Suicidal Behavior." In *The Neurobiological Basis of Suicide*, edited by Y. Dwivedi, pp. 113–124. Boca Raton: CRC Press.

van Hooff, Anton J. L. 1990. *From Autothanasia to Suicide: Self-Killing in Classical Antiquity*. London: Routledge.

van Lommel, Korneel. 2013. "The Recognition of Roman Soldiers' Mental Impairment." *Acta Classica* 56: 155–184.

van Staden, Cornelius Werendly, and Christa Krüger. 2003. "Incapacity to Give Informed Consent Owing to Mental Disorder." *Journal of Medical Ethics* 29: 41–43.

Ventriglio, Antonio, Alessandro Gentile, Iris Bonfitto, Eleonora Stella, Massimo Mari, Luca Steardo, and Antonello Bellomo. 2016. "Suicide in the Early Stage of Schizophrenia." *Frontiers in Psychiatry* 7: 116.

von Borczyskowski, Annika, Anders Hjern, Frank Lindblad, and Bo Vinnerljung. 2006. "Suicidal Behaviour in National and International Adult Adoptees." *Social Psychiatry and Psychiatric Epidemiology* 41: 95–102.

Wakefield, Jerome C. 1992. "The Concept of Mental Disorder: On the Boundary Between Biological Facts and Social Values." *American Psychologist* 47(3): 373–388.

Whitely, Elise, David Gunnell, Daniel Dorling, and George Davey Smith. 1999. "Ecological Study of Social Fragmentation, Poverty, and Suicide." *British Medical Journal* 319(7216): 1034–1037.

Wild, Tamara S. N., Isabel Müller, Peter Fromberger, Kirsten Jordan, Lenka Klein, and Jürgen L. Müller. 2020. "Prevention of Sexual Child Abuse: Preliminary Results from an Outpatient Therapy Program." *Frontiers in Psychiatry* 11: 88.

Willis, Thomas. 1680. *Opera Omnia*. Geneva: Samuel de Tournes.

Wilson, Robert, and Matthew Barker. 2020. "Letter in Opposition to Bill C-7." *Biopolitical Philosophy* 30 January 2020. https://biopoliticalphilosophy.com/2021/01/30/letter-in-opposition-to-bill-c-7-from-robert-wilson-and-matthew-barker/

World Health Organization. 2014. *Preventing Suicide: A Global Imperative*. Geneva: World Health Organization.

Yip, Paul S. F., Saman Yousuf, Shu-Sen Chang, Eric Caine, Kevin Chien-Chang Wu, and Ying-Yeh Chen. 2012. "Means Restriction for Suicide Prevention." *Lancet* 379(9834): 2393–2399.