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Thinking About Suicide

Contemplating and Comprehending Suicidality

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[Examiners: please read Thesis Preface in accompanying Exegesis first]

This book is dedicated to all who struggle with life.

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Prologue

Let's Talk About Suicide

If you've picked this book up because you are currently thinking about suicide for yourself then you are the first and most precious audience that I seek for this book. But this is not a self-help book with a 'cure' for suicidal thoughts and feelings in seven easy steps. I know of no such easy remedy for the pain of suicidality. Instead, this book invites you to honour and respect your thinking about suicide as real, legitimate and important. I denied my own suicidality for so long, but suppressing these feelings ultimately did not work. So please, honour this agonising struggle and then, with the respect for yourself that this struggle deserves, talk about it.

This conversation begins with your own self-talk. In the first instance, only you know if you are feeling suicidal so be honest with yourself about it. If you're at all like I was then there is probably some ambivalence. But if killing yourself begins to surface more and more as the *only* way out of your pain, then I urge you to acknowledge these special feelings. Contemplating suicide is a sacred part of the human story. Ignore the shame and stigma that an ignorant culture imposes on these contemplations and honour this sacred time if it has arisen in your life. We all ponder our own death at some time and a great many of us think seriously about taking our lives. Ignore those who say you are suicidal because you are mad, bad or somehow broken. Instead, honour your life story that has brought you to this moment, however sad and painful it might be. Talk to yourself about it, maybe in a journal or just in the privacy of your own mind. And then, when you are ready, share your story and talk about it with someone you feel safe with – preferably sooner rather than later.

Before outlining the major themes of this book and addressing its wider audience, I feel a need to briefly speak a little further directly to my suicidal soul-mates. I do this now because of the potential finality of suicidality, and the doubts some of you may have about whether you will get to the first chapter, far less read the whole book. I have said that this is not a self-help book and I am in general very wary of giving advice. Not only am I not a professional therapist, but I also recall how much good advice I received during my suicidality that was totally out of reach for me. I was advised to "hang in there, Dave, the pain will pass". This was true enough – it's just that it's not believable when you're feeling actively suicidal. Then there

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was the advice for the various problems that I was struggling with, which never quite made sense until I saw that my ‘problem’ was in fact my life. My problem was that I could not bear being me. Then there’s the advice from those mostly well-intentioned people who believed, and sometimes insisted, that what worked for them (with whatever their ‘problem’ was) would also work for me. This became tiresome. But not as tiresome as those who would be my saviour. I’m even more wary of saviours than I am of giving advice. So I will try to honour your unique struggle with suicidality, as I would like you to yourself, and resist the very human temptation to dispense advice. This is not what this book is about.

But I have, of course, already given some advice in urging you to please honour and respect your suicidal feelings, and then to talk about them. I must qualify this now with some further advice (and then hopefully shut-up with the advice). Although I endorse and encourage spending time with and getting closer to your suicidal feelings, I do not endorse or in any way encourage *acting* on those feelings. To do so can not only kill you, it can also maim you. It is also *not necessary*. So it is important to distinguish between allowing yourself your suicidal thoughts and acting on these thoughts. Our culture, with its taboos and ignorance, would typically have us suppress these feelings in our struggle to resist ‘indulging’ them. My advice – my final advice to anyone contemplating suicide – is to *neither suppress nor indulge* any suicidal inclinations. There is a space that can be found between suppressing and indulging these urges. This is a space where we can honestly meet our pain and honour our suicidality without engaging in a furious fight with it. It is a space where our suicidality can be felt, spoken of and heard. If we neither suppress nor indulge these feelings, then it can be a safe space where we can begin a conversation about these feelings, first with ourselves, then with others if need be. It can also be a creative space from which we might find a path away from and beyond our all-consuming suicidality. If you are feeling suicidal then I invite, encourage and, yes, ‘advise’ you, to seek out and spend some time in this space. And perhaps my story in this book might help you to find this space. I have no further specific advice for my suicidal soul-mates.

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It is almost a cliché in suicide prevention programs that we need to encourage the suicidal to come forward and speak of their suicidal feelings, as I have already urged my suicidal soul-mates to do above. This brings us to some of the other audiences for this book. Who can we talk to? Although I encourage anyone contemplating suicide to talk about it, to do so

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can be quite hazardous. As a society, we are not very good at talking about suicide. This is understandable because two of our greatest fears converge in suicide – our fear of death and our fear of madness. In our culture, death and madness are also ugly to us, so we tend to look away from them. Confronting these fears, facing the ugliness, and talking about suicide does not come easily. But we must face them and talk about them – all of us – for silence creates a toxic stigma and taboo around suicide and suicidality in which ignorance and prejudices thrive. The invitation of this book to think and talk about suicide is therefore not solely to urge the suicidal to speak up, but is extended to everyone touched by suicide in our communities – which is all of us.

The primary aim of this book is to call for, encourage and contribute to a broad community conversation on suicide, suicidality and suicide prevention. It seeks to do this through another aim of the book, which is to give voice to the first-person experience of suicidality so that we might better understand what it means to those who live it. It is hoped that this might help others to find their own voice for their suicidal feelings but, more than just this, the aim is to help bring suicide out of the closet as a public health issue. This requires hearing from the suicidal in order to break the cultural taboos and toxic shame around suicide and suicidality, which in turn requires the whole-of-community conversation that this book calls for in order to hear these voices. It must also be a whole-of-community conversation because societies, not just individuals, can be suicidal too. Our collective suicidality is not a major theme of this book, which focuses on the individual experience of suicidality. But the need to attend to our collective suicidality is highlighted in the Epilogue as essential for any truly effective approach to suicide prevention.

I have said that this is not a self-help book. Nor does it propose some new 'treatment' for suicidality. Another thing the book is not is yet another analysis of risk factors, protective factors, high-risk populations or other statistical parameters to suicidality – the ubiquitous epidemiological studies of suicide prevention. But a few statistics are appropriate to draw attention to suicide and suicidality as a major public health issue. First, the death toll in Australia is about 2,500 per year. This has to be seen as a minimum as there are quite a few deaths that are perhaps suicides but not recorded as such for various reasons. As just one example, I once asked my doctor, who works a lot with heroin users, how many heroin deaths he thought were actually suicides. To my surprise his guess was the same as mine – about half. And there are others, such as suicides that are concealed to look like accidents to protect the family from shame or perhaps to prevent voiding a

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life insurance policy. But even without these unregistered suicides, the death toll is approaching double the road toll. Suicide also claims many more deaths than other public health issues, such as AIDS, asthma and SIDS, to mention just a few, which get much more public attention – and resources – than suicide prevention. Our efforts on suicide prevention have to be compared with the campaigns we have on these public health issues.

But this is just the death toll. Official estimates, which I think we can take as fairly conservative, are that about 40,000 Australians make a serious suicide attempt (i.e. warranting medical treatment) each year and another 400,000 give it some serious thought. Some experts in suicide prevention say that we must focus on the death toll as the key indicator, but this often leads to flawed thinking and therefore flawed policies. I'll elaborate on this later, but for now I'll just say that we need to be addressing suicidality, not just suicides. Suicide and suicidality are the tip of a very large iceberg of despair in our society. I'll also postpone discussion of the relationship between suicidality and depression, another visible tip on this iceberg of despair, which does get some public attention but is also a source of much confusion and misinformation. Suicidality needs to be recognised as its own public health issue and not lost in the fog of current depression awareness campaigns.

These few 'big picture' statistics, along with the need to break our toxic cultural taboos about suicide, highlight the need for suicide to come 'out of the closet' and become a major public health issue. This requires nothing less than a campaign similar in scope to the one that has been so successful in reducing the road toll in the last decade or so. But what would such a campaign look like? Our current thinking about suicide has some fundamental flaws, which are reflected in the inadequate suicide prevention campaigns we have today. I would not want to see just bigger versions of these flawed efforts. The broad community conversation called for here is required to expose and address these flaws. I have already mentioned the focus on suicides rather than suicidality as one of these flaws. But there are other serious flaws.

One of these is that the dangerous silence around suicide is reinforced by official guidelines for reporting on suicide in the media. There is much fear in these guidelines. There is the fear that any talk of suicide could tip someone 'over the edge', and the fear of 'contagion' or copycat suicides. And there is the fear of sensationalising or romanticising suicide that might make it more attractive to vulnerable or impressionable people, especially young people. Although each individual guideline perhaps makes sense, collectively they have the effect of making it difficult to talk about suicide

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in anything but the most controlled and constrained manner, if at all. If you add to this the taboos and fears that are also invariably present in the newsrooms, we find that the media is often quite timid in talking about suicide and typically avoids it altogether. Almost the only time we hear about suicide in the media is after a high profile or celebrity suicide, which I would suggest is perhaps the worst time for the public discussion we need to have about suicide as a health issue.

We certainly need to be careful *how* we talk about suicide, but not *whether* we talk about it. The continued silence encouraged by these guidelines from the experts is not, however, a sensible or healthy option. There are greater risks in perpetuating the silence around suicide than in talking about it. We know this from other successful public health campaigns, from AIDS to cancer to drug and alcohol abuse. The media have a vital role to play in the community conversation that is required and they must be informed about the issues and encouraged to engage with them, rather than frightened off the topic by expert opinion. Central to this is the need to break the stigma around suicide by hearing from those who know suicidality 'from the inside'. The conversation we need to have cannot be left solely to the professional experts, which is another fear that I see in the current media guidelines. This is not a healthy, cautious fear, but one that promotes more silence, more fear, more taboo, more stigma and more toxic and potentially lethal shame.

At the very core of our suicide prevention programs is a fundamental failure to understand suicidality *as it is lived* by those who experience it. This is clear to me not only from my own personal experience of suicidality but also from my research since my recovery. After my recovery, I still felt a need to make sense of my suicidal history, which led me to explore the current thinking about suicide in the public domain and to my first encounter with the academic and professional discipline of *suicidology*. Suicidology seeks to make sense of suicide and suicidality in a comprehensive, scholarly and rigorous manner. It represents our current 'collective wisdom' on these issues and therefore has a crucial role in advising policy makers in suicide prevention strategies and in setting the agenda for the public debate on them. Suicidology also seeks to identify and develop the best 'evidence based' treatments and services for those suffering suicidality. But the evidence base that suicidology draws on is incomplete and inadequate, and its understanding of suicidality is correspondingly flawed, largely through its determined failure to appreciate and comprehend adequately what suicidality means to those who live it.

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This is a serious criticism, which needs to be justified. In this book, I do this first and foremost by sharing some of my story of suicidality. But this is not an autobiography. Each chapter addresses a specific topic related to my journey into and out of suicidality. And in each chapter there are two distinct voices. The first is a *narrative* voice – a first-person voice through which I share some of my personal story. The second voice, indicated by a different font (the same font as you are reading now), is a *commentary* voice. This is a more reflective and considered voice that looks back on my story with the benefit of hindsight, but which is also informed by my research into suicide – informed, that is, by the current collective wisdom of suicidology.

The aim of sharing my first-person voice narratives is not to offer them as some typical suicidal story. I don't believe there is any such thing. To paraphrase Alfred Alvarez in *The Savage God*, any decision to take your own life is as vast and complex and mysterious as life itself. Rather, my aim is to assert the legitimacy of this voice and, through it, the legitimacy of suicidality. It is also to assert that thinking about suicide and feeling suicidal is a genuine and authentic human experience to be honoured and respected. My wish is that it might also help other suicidal thinkers to distinguish between respectfully allowing themselves these thoughts and feelings and acting upon them. And to know that you are not totally alone and that survival is possible. Perhaps the most useful contribution this voice can therefore make is that it might assist others to find their own voice and to speak of their suicidality.

But more than this, I actually need this narrative voice in order to write this book. It is impossible for me to speak solely as the dispassionate, detached, objective student of suicide. The lived experience of suicidality is chaotic and confused, full of ambiguity and doubt. Anger, fear and other passions are also tangled with the paralysing hopelessness and helplessness. All of this and more must be spoken of. The dispassionate, scholarly voice has its place, but by itself it cannot adequately capture and articulate these essential elements of the suicidal experience as it is lived. For this I need my first-person, narrative voice. This voice cannot be constrained or encumbered by the rigours of academic discourse. With this voice I am free to be angry, confused, contradictory, passionate, maybe even poetic at times. Sure, this can only ever be an approximation of the “storm in the mind” that is suicidality. But it cannot be left out altogether. To do so is to look away from the ugly and to neglect much that is important and relevant to a better understanding of suicidality. The narrative voice puts all this ‘noise’ on the agenda.

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The second, commentary voice in each chapter is the voice of my subsequent 'making sense' of my suicidality, including my recovery. It is the voice of my *current* thinking about suicide, which is very different to my thinking about it when I was actively suicidal. This voice, with the benefit of hindsight and informed by current thinking about suicide, speaks of trying to comprehend rather than contemplate suicide. Through the commentaries that follow each narrative, this voice does more than just reflect on the personal story found in these narratives. It is here where the current thinking about suicide is analysed and the fundamental flaws in it identified. And it is this voice that calls for the community conversation to expose and address these flaws.

It is also with this second, commentary voice that the major themes and arguments of the book are made and developed. The structure of the book falls roughly into two major parts. The first four chapters, which I sometimes call the Bad News part of my story, tell of the suicidal struggle. It starts in Chapter One with a little of my personal history, followed by a commentary on some of the major myths, misunderstandings and misinformation that can be found in contemporary thinking about suicide. The narrative of Chapter Two tries to convey some sense of what it *feels* like to be suicidal, while the commentary explores the personal efforts that we make, but which are frequently overlooked, to deal with these feelings before (and alongside) any formal therapy. Chapter Three tells of escaping my pain through drugs, which was a major distraction from the real issues, as were the drug addiction therapies. Most current thinking about suicide sees it as a mental health issue, but Chapter Four describes and explains how this approach was mostly not very helpful and, at times, harmful.

The theme that emerges in these Bad News chapters is that suicidality is a *crisis of the self* rather than some mental illness. This seems obvious as the self is the 'sui' in suicide, and it is the self which is both the victim and perpetrator of any suicidal act. But this theme is a heresy within the current thinking about suicide, which sees suicidality largely in terms of mental illness. I don't dispute that mental health issues are relevant to understanding suicidality. It's just that assumptions are already being made when we look at suicidality only through the mental illness window. First, the mental illness approach pathologises this sacred crisis of the self and sees only a 'broken' individual with symptoms of 'illness' that need to be 'treated'. Although it is life-threatening, suicidality is not a sickness in this sense and this assumption needs to be challenged. Second, viewing suicidality as a crisis of the self is more useful than the mental illness approach because it invites questions and lines of enquiry that can lead to a

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deeper understanding of suicidality. In particular, it forces us to ask what is the nature of this self that is in crisis. Once again this seems obvious, but our notions of selfhood are barely considered in the current thinking about suicide. Contrary to the assumptions behind the mental illness approach, it is possible to see thinking about suicide as a *healthy* crisis of the self, full of opportunity, despite its risks. Third, viewing suicidality as a crisis of the self corresponds more closely to the lived experience of it, which is where I insist any enquiry must begin. And finally, as we will see, asking these questions about the self that is in crisis has the potential to open up possibilities for a deeper experience of the self, which for some, such as myself, can be a pathway out of suicidality.

The book pauses after the Bad News chapters to explore further this theme of the self in crisis as central to understanding suicidality. This Interlude – a commentary without any preceding narrative – asks the question “Who Am I?” and looks at contemporary thinking about the self, but not just as it relates to suicide. It shows that modern psychiatry reduces the self to little more than a biochemical robot, which is woefully inadequate for understanding what suicidality means to those who live it. Psychological ideas about the self see the mind as the source and essence of our sense of self, a view that is generally also held in the wider community. This Cartesian notion of the self as “I think therefore I am” has been challenged on many grounds, and the analysis and discussion in the Interlude concludes that it is perhaps more accurate to say “I am therefore I think”. That is, we are not who we *think* we are. We are human *beings*, not human thinkings (or human doings) and our enquiry into the self requires that we look into our ‘beingness’. Such enquiry can seem somewhat ‘academic’ at times and indeed western academic thinking struggles to come to grips with questions about the self and subjectivity. But there is nothing academic about deciding to kill yourself. The Interlude concludes with the observation that at precisely the point where current academic thinking is unable to proceed, spiritual teachings and wisdom have much to say that is useful. This is the launching pad for describing, understanding and explaining both my suicidality and my recovery in the chapters that follow.

This vital “Who Am I?” question was the key to my recovery. The final three chapters – the Good News chapters – tell of this journey. As described and explained in Chapter Five, it is what I now call *spiritual self-enquiry* that finally set me free of my suicidality after all the mental ‘illness’ treatments had failed. Chapter Six looks at the obstacles faced in this

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enquiry, essentially our attachment to who we *think* we are, and how to overcome them. Chapter Seven then celebrates the fruits of this enquiry.

In the Good News chapters, the second major theme of the book emerges. This is the theme that spirituality has a relevant, useful and important contribution to make to our thinking about suicide. Along with the mental illness bias, this absence of spirituality is the most serious flaw in current thinking about suicide. Although exploring spirit and entering into a deeper relationship with it inevitably takes us beyond the rational (and the mental), this does not mean that we cannot talk about it sensibly and rationally. Spiritual self-enquiry revealed to me a great inner peace and freedom so that my suicidality (and my drug addiction) simply fell away like a snake shedding a no-longer useful skin. I feel obliged to share this story as my contribution to a better understanding of suicidality, and in the hope that it may be of some help to my suicidal soul-mates. But I am not evangelical about this story. The spirituality described here has nothing at all to do with any faith-based religion. Nor is it some New Age 'born again' fundamentalism. There are many paths for cultivating a deeper relationship with spirit (which some might call God), which includes but is not limited to the many religious traditions. The path I walked is but one of these paths. Furthermore, I am not proposing spirituality as some universal panacea or 'treatment' for suicidality. Naturally, I feel that it may help others as it helped me. But more than this, spirituality, and particularly spiritual self-enquiry, can help us understand and appreciate more fully the crisis of the self that typically lies at the core of suicidality. We cannot continue to exclude spiritual wisdom and spiritual teachings from our thinking about suicide.

The book then concludes with an epilogue that considers some suggestions for how we might move forward in our thinking about suicide and suicide prevention. It argues that the key to suicide prevention is healthy communities. And central to this is another theme that runs through the book, which is the importance of story-telling. We need to hear the stories of those who know suicidality 'from the inside'. We need this to break the cultural taboos and shatter the toxic silence that surround suicide. We need to hear these stories so that others can speak of their despair, preferably sooner rather than later, and seek help. Such story-telling can in itself be very healing – indeed it is the foundation of most psychotherapies. We also need to hear these stories so that we can learn how to help. But for this we need to create spaces – safe spaces – where these stories can be told and heard. This is a job for all of us. Societies, not just individuals, can be suicidal too and to fail to hear the despair of our neighbours is a symptom of

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this. Healthy communities also have soul and spirit. Spiritual wellbeing must be on the agenda, alongside mental, emotional and social wellbeing, as part of any healthy community programs. My story tells of a journey into and out of suicidality that was ultimately an enquiry into the fundamentally spiritual question, “Who am I?”. Effective suicide prevention requires that we ask ourselves the equivalent, collective spiritual question, “Who are we?”

Chapter 1

My Suicidal Career and Other Myths

*We must at all times remember,
That the decision to take your own life
Is as vast and complex and mysterious
As life itself.*

(Al Alvarez, *The Savage Mind*)

When I opened my eyes all I could see was whiteness all around me. But I knew immediately that this was not heaven and that I had failed. I knew that I was still alive and that something terrible had happened. My body felt stiff and rigid like I'd been lying still for a long time. But I was able to bend my elbows and when my hands came into view I somehow knew exactly what had happened. They were burnt, terribly burnt, though I could feel nothing. Several fingers were shrivelled and bent; the dry, blackened skin looking like it had melted onto the bones. I moaned and a nurse, more whiteness, appeared in my peripheral vision. She said something like "Are you OK?" and I said I was going to be sick. I shattered the whiteness by throwing up the most awful black, stinking vomit. A huge spew, all over my white nurse who vainly tried to catch it in a pathetically small kidney dish. Then I passed out.

This was in 1979, in England, and I still remember it vividly. I didn't know that I had been unconscious for a couple of days. I was not yet aware that the real damage was not to my hands, but to my shoulder and neck. My poor parents were to receive a call from the hospital saying that I had tried to kill myself and that I might lose my arm. I lost a thumb and both index fingers, though they did manage to brilliantly fashion a sort of thumb from the leftovers of one of my index fingers. But they saved my arm. The burns there had gone through skin and muscle to the collar-bone where they had to scrape away some charred bone before figuring out how to cover the hole into my chest. It took eight weeks of intensive care and about a dozen operations, but they managed to patch me up. I was very lucky.

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Except I didn't want to be there at all. I wanted to be dead. One doctor asked me if he was wasting his time working on me - was I going to have another go as soon as he fixed me up? I don't recall my answer. I think I shrugged. Part of my luck in the hospital was that I had virtually no infections, the scourge of any recovery from serious burns. I can clearly recall figuring out that it was going to be very hard to finish off the job of killing myself while in intensive care, so the first thing I had to do was get out of there. Preferably as quickly as possible. I still believe that this decision, along with the excellent surgery and care that I got, was a significant factor in my unusually quick and complete recovery from the burns.

This suicide attempt was not my first. I had tried a few weeks previously but had only woken up with an awful hangover. My preferred method was to try and overdose using heroin, a drug I had played with a little some years before. So I tried again, this time with what I was sure would be a lethal dose, approximately ten to fifteen times what I would take to just get thoroughly stoned. And it may have worked except for the fire. I still don't know how it started but those who found me said that it was not a raging fire but more of a slow, smouldering one - just my bed and me. I had planned it carefully, I thought, waiting till the others in the house were asleep before taking my OD. But our early rising neighbours had seen smoke coming from my bedroom window and they woke up my housemates. A couple of days later I woke up in the whiteness that was definitely not heaven. Maybe that fire saved my life - I don't know. But I'd learned that heroin is a fickle drug - it will kill you when you don't want it to, and won't kill you when you do want it to.

I returned to Australia in September 1979 with my fastest-ever passage through customs in a wheelchair pushed by my mum, off my face with the medications I'd taken during the flight. I was still a sick boy and we weren't sure what we were going to do next. Sometimes a suicide attempt is carefully planned, like the one that was interrupted by the fire. At other times, like my next attempt, it is a spur of the moment thing. I think I was still intending to finish off the job but had not yet formulated a plan. Nor did I want to impose on those who were looking after me, especially my parents, so I was patiently waiting,

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I think, until I could get away from them. But then I woke up one morning and felt so awful that, without thinking, I swallowed all the pills that I had with me. This was a crazy mixture of about 200 pills, tablets and capsules which included antibiotics and antihistamines, as well as a lot of sleeping pills and very strong pain killers.

This spontaneous (and stupid) attempt was foiled by that sixth sense mothers can have about their kids. She looked in on me and somehow sensed that I wasn't asleep. An ambulance was called and I got to hospital just in time. I believe I was technically dead for a short while - but they managed to revive me. Again, it was a day or so before I came to, this time with a couple of tubes into my chest connected to one of those beep-beep monitors that I had apparently 'flatlined' for a while. While I was unconscious, my parents had been negotiating with the doctors to try and prevent me being committed to a psych hospital. They were doing pretty well too, I was told later. Until I woke up, that is. There was no-one in the room, but there was a pen and paper beside my bed, perhaps left deliberately by the hospital staff. When I realised that I had failed - again! - I wrote on the paper, "When are you bastards going to let me die!" This, of course, blew my parents' negotiations out of the water so that, when I was well enough to move, I found myself being escorted to Royal Park Psychiatric Hospital as an involuntary patient. Who'd have thought that I'd be making this same trip again, under similar circumstances, some twenty years later?

It was a comical episode for me, this time in the psych lockup. My very own "One Flew Over the Cuckoo's Nest" experience. Although still drugged and dazed by my overdose and hospitalisation, I was indignant about being locked up and went on a non-cooperation campaign. I refused any medications except my pain-killers and went on a hunger strike. This worked a treat. No, it didn't get me discharged, but after two days of my hunger strike I had the most enormous crap that somehow purged my system and, I have to say, cleared my head. Thinking more clearly now, I was able to figure that the best way out of there was to appear sane. This wasn't too hard. I simply turned on that educated, articulate, middle-class 'charm' I'd learned at the posh

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private school I'd gone to as a boy. It took a few days but, with the support of my family, I was soon discharged.

I felt pretty bad about what I'd done and all the pain and hassles I was causing my family. I moved in with my sister and tried to put suicide out of my mind. I was also booked in for some more surgery on my hand so I soon found myself back in the familiar territory of a hospital plastics ward. During this time I was encouraged to consider what I might do when I got out. My first decision was that I didn't want to be an 'invalid', that if I was going to live then I still wanted to be responsible for my own livelihood. Next, I looked at my disfigured hands and realised I wasn't going to make much of a living out of them any more, so I thought about going to uni. Computers were the talk of the day so I started looking around for computer courses. I also thought that I might find some training assistance for such a high demand field - which I did, from the Commonwealth Rehabilitation Service, a brilliant scheme that has unfortunately been largely dismantled over the years by the economic rationalists.

I fell out of hospital into Computer Science at RMIT (Royal Melbourne Institute of Technology, later to become RMIT University), which seemed to me to have the best course in town. The first year was a daze, taking regular handfuls of pain-killers and wondering what the hell I was doing here with all the fresh-faced kids straight out of school. But I graduated and made some great friends, and some of them are still among my closest friends today.

The next fifteen years were a fascinating and rewarding time. My hunches back in hospital were correct. The course at RMIT was just what I wanted (and needed), and the computer software industry at the time was exciting and full of opportunities. I had some great jobs, including a year in New York, and worked with some wonderful people. Then in the early 90s I found myself back at RMIT, this time working as a lecturer in the same Computer Science department where I'd been a student a decade earlier. I think I'd lost a bit of interest in the commercial software world but, as my great good luck would have it, I found at RMIT that I really loved teaching. And still do - a fascinating, rewarding and noble vocation.

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But I left RMIT at the end of 1994 when it became apparent that, in its efforts to become a university, teaching was dismissed as unimportant and I would have to take on some research if I wanted to stay. It's amusing now to find myself doing a PhD when I didn't want to do one then, but I guess I was never really quite that interested in computers. So I left - with a sense of freedom and adventure. I was about to turn 40, with no family or other dependents and with plenty of money in the bank, so I set out to rediscover life after computers. My first step was a trip to India starting with a 'pilgrimage' to the *kumbha mela*, a huge spiritual gathering on the Ganges, with my old yoga buddy of many years, Susan. I also wanted to revisit the wonderful handloom weaving centres, especially the raw silk ones, that I had known from when I lived and worked in India in 1977-78. And I had a fantasy of maybe writing a novel based on the historical silk road. What fun!

But silly me, my exciting plans were upset by foolishly falling in love not long before I left for India. I found I missed this woman awfully and so returned to Australia after just four weeks. Within a few months we had fallen out of love and suicidality came rushing back into my life.

After fifteen years, I guess I had come to regard my suicidality of 1979 as some youthful aberration. But even with this history, I didn't initially recognise that it had truly returned. I was broken-hearted and adrift, and also homeless and jobless, though these were both deliberate choices. I should have recognised this pain. And I definitely should have recognised it when I turned to heroin for pain relief. Apart from one brief, silly play with it a few years earlier, I'd not used heroin since the suicide days of '79, and it was not a part of my life or something I pined for. I knew I loved the high of heroin, but I also knew that it came with a very high price, and that life was better without heroin than with it. I had even come to regard it as a 'death drug' - that is, I associated it with suicide. Despite this, I found myself seeking it out but still didn't recognise it as suicidality returning. I just wanted some temporary relief from this relentless pain of my broken heart.

That first hit after all those years was delicious and for the few hours that I was stoned I got the pain relief I was looking for. But in

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the morning the pain was back. And it wasn't too long before I 'needed' another hit of heroin. The roller-coaster ride had begun. A ride that was to take four years, most of my worldly wealth, and very nearly my life.

As I sank deeper into the isolation and loneliness of suicidality - the 'closed world' of the suicidal mind - I started planning my suicide but still without actually accepting that I was suicidal. Finally, I set a date and collected all the necessary ingredients. I still wanted to do it by overdose as I basically wanted to just go to sleep and not wake up. But I remembered the fickleness of heroin and so accumulated an assortment of over the counter drugs that I would add to the heroin and alcohol. The chosen evening came and I assembled and prepared the ingredients. Along with the mega dose of heroin, I broke open the capsules and crushed the tablets and mixed all these powders together for easy swallowing. I started on the whisky as I settled down to write my suicide notes.

Clearly I must have been ambivalent, or I became ambivalent as I got drunk, because these notes became lengthy and dragged into the night. As the first light of dawn started to appear, I finally realised what I was doing and that, yes, I was suicidal again. It sounds absurd, but right up until then I don't think I had accepted that I was about to die. I hesitated. I tried to muster up all the 'maturity' of my 40 odd years and to think about it sensibly. I decided to go for a walk on St Kilda pier before taking my life. I still felt committed to the decision I'd taken, but allowed myself this moment's hesitation.

St Kilda pier at dawn can be beautiful. I recall that morning as cool with a light breeze, just enough to blow away some of the now fairly drunken cobwebs in my mind. When I got home and saw all my preparations I knew I had to take them now or do something else. Somewhere in the back of my mind I heard a voice saying something that I never heard back in '79. It was a message that you often hear said when people talk about suicide or other emotional trauma. It said simply "ask for help". Again I tried to think what was the sensible thing to do. It was very hard. I don't know where this little voice was coming from - it wasn't actually a voice that I heard, it seemed to be some uninvited echo that was almost haunting me. Perhaps it was some

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lingering 'good sense' within me that I had lost contact with. When I consciously thought about it, it didn't make sense, it was pointless and I didn't want to be alive. But it seemed to be demanding attention.

Almost as some kind of negotiation with this 'voice', I argued with myself that there was no-one I could turn to, that there was no-one and nothing that could help me. But I have this most wonderful sister, Barbara. We have always been close and she is an extraordinary person, strong and compassionate, full of love and fun. When I thought of Barbara, I thought that possibly she is someone I could at least say "Help!" to even though I didn't believe any help was possible. I phoned my sister.

Barbara knew immediately that my call for help was real. I was not a lad who cried wolf and she knew it. She told me not to do anything, just stay there and that she was on her way round, *now*. I knew that I would not do anything with Barb on her way, but it must have been a terrifyingly slow and tortuous journey across town for her.

My suicidality was now officially out of the closet. By confessing it to my sister I could no longer pretend to myself that I wasn't deeply in the shit. My roller-coaster ride into madness was now a public affair.

Poor Barb, she didn't really know what to do. Who does? But she knew how to just be there for me, which is probably the most important thing of all. It is deeply embarrassing to admit to being so totally lost and hopeless, but thankfully I could do this with Barb without too much sense of shame. I don't actually recall what she said at this first encounter for her with my returned suicidality. She would certainly have been reassuring and probably had some advice and suggestions. But I don't remember. I do recall a period around that time when family and friends regularly kept me company, even a period where there was a roster of people to stay with me overnight. There would have been some family discussions, I'm sure, but again I don't recall. Now that others had become involved, I tried to keep myself together. It was tough for everyone.

The first concrete consequence of 'coming out' like this was that people saw that I was using the heroin again and so inevitably their first thoughts were that I had to get off that. This battle with the heroin was to become a major focus for the next few years as I tried

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to get off the smack so that I could then attend to the deeper issues. This focus on my drug addiction was to become a major obstacle to my recovery. It was nearly four years later before I finally realised that I was never going to get off the drugs while I was suicidal. It was four years before I properly dealt with what was at the core of my despair. And when I did, both my suicidality and the heroin addiction fell away and simply disappeared from my life, like a snake shedding a no longer useful skin. But in the meantime, I had a pretty wild roller-coaster to ride.

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One theory you'll find in the literature of suicide prevention is that of the 'suicidal career'. It is perhaps a bit harsh to suggest that this is a myth as it has some merit as a metaphor. Indeed my own story is perhaps a good illustration of this tendency for suicidality to be a persistent theme in the life of someone who has episodes of being actively suicidal. The persistent sadness, the feelings of inadequacy no matter how unjustified they might be, the recurring fundamental doubts about whether life is worth living, perhaps some risk-taking behaviour that is life-threatening though not obviously deliberate, and, of course, the occasional deliberately life-threatening behaviour, are just some of the many facets of such a 'career'.

This career metaphor is an attempt to bring together not only the many facets of a suicidal history but also the numerous explanations that are offered for how and why suicidality arises. It is a theory that seeks to encompass the physical, mental, emotional and social dimensions of living a life, all of which are simultaneously active within the individual contemplating suicide. As a metaphor it has some merit, as there is a tendency to look for single explanations and/or causes for suicidality, such as 'mental illness', which are invariably inadequate. A consequence of this tendency is to look for some single 'silver bullet' remedy for suicidality, which is not only inadequate but can also be dangerous. The suicidal career metaphor therefore represents a more holistic, *biopsychosocial* (i.e. biological, psychological and social) approach to understanding suicide, which is probably the 'state of the art' in current thinking about suicide.

Despite its merits, I am personally uncomfortable with the career metaphor. I feel it defines me too much in terms of my suicidality so that it feels like one of those very sticky labels so prevalent in the mental health industry, where it becomes hard to see the person behind the labels. But if we can keep it in perspective as a metaphor, then it can be a useful idea, unlike some of the other myths about suicidality.

There are many such myths and they tend to fall into two categories – popular myths in the general community, and the more dangerous professional myths. The popular myths tend to be based on ignorance and fear which, given the taboos around suicide, is hardly surprising though still a hazard for anyone experiencing suicidality. The professional myths are of more concern because the professions I'm referring to particularly are those we might turn to for help – doctors, psychiatrists, psychologists and counsellors of many kinds – where these myths often lead to inadequate and sometimes harmful interventions, as we will see. We will also see that the professional suicide experts fail to see how their own myths are often the

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source of some of the most worrying popular myths, including some which promote the widespread stigma around suicidality.

The first myth that needs to be challenged is both a popular and a professional one that the only genuine suicide attempt is a 'successful' one.

As an aside, it is worth noting now some of the many language problems we will encounter in discussing suicide. There are some who argue – including the media guidelines from the experts for covering suicide stories in the news – that we should refer to 'completed' rather than 'successful' suicides. The reasoning here is to avoid presenting killing yourself as some sort of success which, at first glance, seems an understandable sentiment. Except that this language denies my experience of suicidality. I felt I had failed. And I was not happy that I had failed, far less grateful to those who revived me (another mythical expectation that you might encounter). A consequence of this carefully managed language about suicide, this very controlled conversation, is that it renders the likes of me invisible. My perspective, my language, my experience of suicidality is not permitted in this conversation. This might seem like semantic, nit-picking petulance, but I have encountered this censorship of my suicidal language again and again. And it is hurtful. It is also not helpful. The exclusion of the first-person perspective is a major problem in the current thinking and the current debate about suicide. I have had to wonder whether this exclusion of the first-person voice of those who have lived suicidality is deliberate. Looking into this has shown to me that, yes, to a large extent it is very deliberate and at some stage we must ask why. But first, we need to return to the myths, which are part of the answer to these questions.

The myth that the only genuine suicide attempt is a completed, successful, fatal one has several companion myths, of both the popular and professional kind. One of these is the popular, uninformed one that it can't really be that hard to kill yourself. Even a good friend, who knew my history, was tactless enough to once boast that if he was going to kill himself then he'd make sure he got it right first time. The truth is that we humans are made of pretty tough stuff and are not so easy to kill at all. While occasionally we hear of stories where the slightest mishap (not just a suicide attempt) turns out to be fatal, usually the life force within us is not so easily extinguished. This is true for car crashes, shootings and stabbings as well as suicide attempts, especially with today's modern ambulance services and emergency hospital procedures. One of the hot topics in suicide prevention is the *lethality* of suicide methods and the related issue of access to lethal means. Firearms are considered one of the most lethal means for suicide and this is reflected in the suicide statistics in the U.S.

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where there's a gun under virtually every bed. But even firearms are not a guarantee of success. I've met two people who have put a rifle under their chins and fired. One was severely disfigured by his wounds and struggling with the consequences of his survival. I hope he's still with us and doing OK today. The other, who shot himself about twenty years ago, now has barely visible scars after much bridgework to his mouth and nose, and his mates tease him about what a lousy shot he was as a lad. He's now a minister of the church, at peace with himself and a shining light for us all. Guns, and also hanging, car exhaust and jumping from high places do not guarantee success, though they do have a high risk of severe, permanent injuries.

I know nothing about guns and have no access to them so they were not an option for me, perhaps fortunately. But even if I did have access to them, I may not have chosen to kill myself this way. The choice of suicide method has been much studied and some people, like myself, don't want violence or pain – we just want to go to sleep and never wake up. This puts me in a demographic dominated by women, who try to suicide more frequently than men but are not as 'successful'. I also share with women the less reliable drug overdose as my preferred suicide method. The explanations for some of these apparent gender differences remain speculative but, for me, physical violence is not part of my personality. And I don't like pain. I didn't have the courage to jump from a high place and my attempts to hang and cut myself were pathetic. Some of my overdoses were major and by rights should have been lethal. But they weren't. Overdoses also carry the risk of permanent injury and my burn scars are one example of this. The risk of brain injury is another. But the simple truth is that it is not that easy to kill yourself.

The professionals usually have a much better understanding of just how difficult it is to kill yourself. But the myth that it is easy still finds its way into the professional thinking about suicide and may be the source of, or at least contribute to and reinforce, popular versions of this myth. I first met it after my recovery when I went searching the Internet as part of my enquiry into making sense of my own suicidality. This was my first real encounter with formal 'suicidology' – the academic and professional discipline that represents our 'collective wisdom' on suicide – and what I found on this occasion I have met many times since. I found numerous learned articles, full of scholarly authority, but I found myself starting to feel more and more uneasy about what I was reading. Eventually I realised that my uneasiness was that whoever these distinguished experts were talking about it certainly

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wasn't me. I could not recognise myself in any of their authoritative articles on suicidality. I had that invisible feeling again.

One of the central themes in the literature of suicidology is to distinguish between contemplators, attempters and completers of suicide, which I saw as one of the sources of my unease. As I studied this tripartite taxonomy, the reasons for my unease became clearer. They were talking about these three stages in the pathway to suicide as though they were three different types of suicidality or three different kinds of people. And I was none of them. This classification system seemed very significant in the literature, but it was not what I felt when I reflected on my own experience. Most of all, I detected an implicit message that the study of suicide required a dead body. Some authors argued for this in a very legalistic way, saying that the word itself is about the *death* of someone by their own hand. This is unarguable in a strict, literal sense but it implies, and some authors explicitly assert, that unsuccessful suicide attempts have very little to tell us about 'real' suicides. The message here is that real suicidality requires a real death. This pervasive and perverse myth, the professional denial of 'unsuccessful' suicidality as genuine, is at the very least an obstacle to a better understanding of suicidality. But it can actually increase the risk that someone contemplating suicide faces if we encounter this myth from those we seek help from.

Let's look at the consequences of this kind of thinking about suicide. When the same literature moves its attention to the category of suicide attempter a whole range of explanations, and more myths, come into play. First of all we encounter some of the popular myths found in the general community. The most popular of these is that a suicide attempt, an unsuccessful one that is, is a cry for help. There are a couple of variations on this such as that it is attention-seeking behaviour or, the most pernicious of all, that it is *just* a cry for help. You might think these myths are just of the ignorant, popular kind, but not so. I was once told by a counsellor to stop talking about my suicidal feelings because "it's bullshit, just a cry for help". His denial of my suicidality, almost daring me to prove it, was a very dangerous game of bluff. Of even more concern, this person was someone I had reached out to for help, perhaps the most difficult step of all, and his response was to deny my expressed feelings.

I have learned that responses like this are common, but that they usually say more about the person who utters them than the person they are about. It may be true that it is a cry for help, but a fairly serious one you would think, and worthy of a more considered response. An extreme, but all too common, variant of this is to call it *just* a cry for help, which is invariably an

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indication of fear and denial, as well as being just plain insulting. When these myths that deny our suicidality are the first and immediate, almost reflex, response then you can be pretty sure that this person is probably incapable of facing up to suicidality because of their own fears and denial about it. This is the taboo at work. While this is understandable and regrettably to be expected from the uninformed person in the street, it is not acceptable from the professionals we seek help from.

A similar myth is that suicide is a cowardly act. A slight variation of this is that it is taking the easy way out. This is mainly a popular myth. I've rarely heard it from professionals, though I heard another variant of it from my psychiatrist the day after my last serious suicide attempt. He told me, almost shouting in his frustration, that my problem was that I wasn't prepared to take responsibility for myself. This struck me as a most peculiar thing to say to someone who had tried to suicide the night before. It seems a waste to spend time debunking such obviously silly myths but their continued prevalence makes it necessary. First of all, yes it's true that I, like many others, am quite cowardly about violence and pain, but this has very little to do with contemplating *whether* to die. If anything, suicidality can have elements of heroic struggle about it. Fears about pain and violence, cowardice if you want to call it that, might be a part of your deliberations on *how* to die. But what I think these people really mean is the second variation of this myth, that suicide is the easy way out. I find this an interesting one because it reveals some recognition and awareness of the desire to want 'out' and that staying 'in' (i.e. alive) takes effort. No argument from me so far. But suggesting that suicide is the *easy* solution is hardly plausible. Suicide attempts occur when suicide becomes the *only* solution, and reaching this point of despair is not in any way easy. What this myth hints at is the old 'pull your socks up' myth as the remedy to these difficulties, though we usually hear this more in relation to depression than suicidality. We'll look at some of the myths about depression later, but this 'sock therapy' myth is thankfully almost universally discredited these days, although it still lingers surreptitiously in some of the other myths.

One myth that has popular currency and also some credibility in the professions is that suicide is an impulsive behaviour, like some extreme temper tantrum. While this may be true for some people – the truly spur of the moment act – I suspect this is rarely the case and know that it was certainly not true for me. The emergence of my suicidality was a long, slow brewing process even before I became aware that I was suicidal. Suicidality emerges from a life history. Even after I became actively suicidal, I struggled with it for more than six months in my impetuous youth in 1979,

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and for more than three years in my more recent episode, before actually making any serious attempts. It was not an easy decision, nor was it made lightly or suddenly. I find it odd that people think that it would be otherwise – it's a pretty major decision, somewhat bigger than quitting a job, for instance. This myth puts too much emphasis on the actual suicidal act rather than on the suicidality preceding an attempt. It is true that the moment of decision to take your life *right now* can arise spontaneously but this can lead to clumsy, half-hearted attempts such as some of mine were. But then, even my more serious attempts took only a day or so, perhaps a week, to plan and put in place, which some might still see as impulsive. Suicidality, though, is much more than the brief period between making the decision to act and then the act itself. If suicide prevention focuses on trying to reach people during this small window of opportunity then I am not optimistic about our capacity to help. Apart from the small time window, once this decision has been made we tend to go deep underground at this stage and can be pretty hard to identify and/or reach.

Another common, and somewhat related, myth is that suicide is a violent act. Again, this may be true for some people, but it wasn't for me, and I know I'm not unique in this regard. People have this image of taking your life as some sort of frenzied, manic violence against yourself. There is a little truth in this with those clumsy, spontaneous attempts I made where I was frantic and obsessed with the need to die now, immediately. But again, the carefully planned attempts were quite cool, calm and deliberate. Another aspect of this myth is that a person must be in a chaotic state of mind to take their life. Again, with my carefully planned, most effective (i.e. *nearly* successful) attempts, the actual moment of taking that 'killer hit' was really a moment of extraordinary calm. Once the decision has been made and all the preparations taken care of, a sense of relief and even peace can arise when at last the moment comes when all your struggles are finally over. I have heard of others who report a similar feeling of calm at this critical moment – indeed this brief moment of peace can sometimes be enough to change your mind. But the myth of the violent, suicidal frenzy persists.

A variant of this myth of violence is Menninger's theory of *Selbstmord*, or 'self murder'. As a psychoanalyst in the Freudian tradition, Menninger described suicide as "murder in the 180th degree". The argument here, which Freud also alluded to, is that suicide is the murderous urge towards someone else, typically the father or mother, that is frustrated and turned back on oneself. As a line of psychoanalytic enquiry this theory perhaps has some merit, particularly to help unearth cases where the suicidality arises

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from some childhood abuse – one of the most common causes of suicidality. But to suggest it as some general theory and to emotively portray suicide as a violent murder seems extreme and inappropriate to me.

Another myth that I find particularly annoying has both popular and professional currency. It is the myth that we must teach our kids that suicide is not an option. I first heard this on the radio from a psychologist who is a well-known and highly regarded commentator on youth issues. At first blush it seems a reasonable enough statement, almost one of those mum and apple pie home-truths. But not from where I viewed it. I was aghast at this silly and dangerous remark. The problem with it is that it is just not true. Suicide *is* a solution. If you kill yourself the pain will stop. Guaranteed! In saying this, I am not in any way advocating suicide, but anyone who is seriously contemplating suicide already knows that this advice is a lie. He should have said that we need to teach our kids that there are *better* solutions. This may seem like hair-splitting, but consider the consequences. I know that I would never seek help from someone with this attitude. This myth is another denial of what I am feeling. If I am seriously considering suicide then I already know that it is a very real option. And I also know that a person who does not recognise this cannot help me. To try and deal with it by denying it with some bold but obviously untrue assertion will only make me withdraw deeper into my 'closed world'. By making this assertion, the psychologist has automatically and immediately made himself totally inaccessible to those that he, quite genuinely I'm sure, seeks to help.

There are some popular myths that apply to population subgroups rather than to individuals. The first is the widespread myth that suicide is a youth problem. This myth arises from the inaccurate portrayal of suicide in the media, where youth suicide has got most of the attention, though this is beginning to change. The statistics actually show that in Australia the incidence of suicide is highest in men aged between 25 and 44. As an aside, another thing this book is not about is *assisted* suicide – i.e. the 'euthanasia debate' about the ethics of helping someone to suicide, which is currently illegal, rather than killing yourself unassisted, which is not illegal.

Returning to the youth suicide myth, although the actual data do not show our youth to be the most at risk of suicide, it is an understandable concern in the community for two reasons. The first is that a youth suicide is seen as particularly tragic. A second legitimate concern is that, among some sectors of our youth, suicide does seem to be increasing at an alarming rate in recent years. This is most significant among young men (15-24 years old) living in rural and regional Australia. This book does not focus specifically on youth suicide nor any other particular demographic group so

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I'll restrict myself to just a few observations here. First, the situation with young men in the bush highlights that there are social and cultural factors at work in the suicide rates, which reinforces the central argument of this book that suicide prevention has to be a whole-of-community issue, requiring a whole-of-community conversation. Secondly, this conversation must not only focus on young people and their problems but requires us to examine our role, our participation, our contribution to suicidality in our communities. It cannot be a them-and-us conversation. Communities, not just individuals, can exhibit suicidality and an attitude of 'healer, heal thyself' must become part of our efforts to understand and prevent suicide. Again, a whole-of-community response is required.

Before we leave the demographic data, another myth that is sometimes heard is that suicide is a gendered issue, specifically that it is a predominantly male issue. In a keynote address at a suicide prevention conference in 2002, a psychiatrist asserted that "suicide was definitely a male issue". This remark was made as something of an aside at the close of his address (his topic was suicide and the elderly), but it illustrates the denial of attempted suicides as real suicidality mentioned above. He was referring to data that showed roughly four times as many men die by suicide as women. This is a large and significant difference, so it might seem a reasonable interpretation of the data. But the data also show that about three to four times as many women *attempt* suicide (i.e. failed suicide attempts) than do men. Although he must have been aware of the data, this expert did not mention the equally significant – but opposite – gender ratio with failed suicide attempts. Overall, we can say that more women make a serious suicide attempt than do men but that men are more successful in their attempts. This phenomenon is significant and interesting and needs to be investigated. But it is not sufficient to claim that suicide is predominantly a male problem. Unless, of course, you regard failed suicide attempts as not genuine. Again I argue that we need to be looking at *suicidality*, not body counts.

There are a couple of 'societal' myths about suicide that need to be mentioned briefly. These are the legal and moral ones. First, legally, suicide is no longer against the law. This is a good thing. But some legal anachronisms still exist, such as the laws on assisted suicide mentioned above. Another is that you can still be locked up if you are suicidal, as I was, or have treatment forced upon you, which I didn't – though I was deceived into taking one particularly nasty drug, so a related issue is that of genuine informed consent. Anachronistic laws like these raise many complex and contentious issues about the rights of the 'mentally ill'. All the

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arguments I have heard to justify the use of forced detention and forced treatment boil down to them being “for their own good”. This is not a sufficient legal or ethical argument for the denial of such fundamental human rights, as has been clearly demonstrated in recent times by the revelations of the Stolen Generation when “for their own good” was used to justify taking Aboriginal children from their families.

These important legal and human rights issues have become prominent in a growing social and political campaign that is being vigorously pursued by many mental health activists around the world. Although mostly outside the scope of this book, one aspect of these issues is worth mentioning here. This is the important distinction between forced detention and forced treatment that was first made clear to me by Mary O’Hagan, a psychiatric survivor herself, who is now one of New Zealand’s three Mental Health Commissioners and an eloquent voice for human rights in mental health. Mary points out that forced detention controls *where* you are but that forced psychiatric treatments control *who* you are. This observation by Mary makes it clear that, like suicidality and spirituality, human rights issues in mental health touch the very core of our sense of self.

Briefly, my view on these two issues is that, firstly, forced treatment is never justified. I agree with the slogan seen on placards at mental health protest rallies that says, “If It’s Not Voluntary, It’s Not Treatment”. Forced psychiatric treatments with potent psycho-drugs or other interventions that radically alter your personality, sometimes permanently, need to be seen as an assault on the self that causes immense harm of a kind that can often provoke suicide. Forced treatment can be understood as a form of torture, which is the view of mental health activists at the United Nations convention on the rights of people with disability. On the other hand, I used to think that there was a place, in extreme situations, for forced detention in our mental health system. But I have changed my mind on this because I now believe that this policy causes more harm than good. That is, although forcibly detaining a suicidal person may help prevent some deaths, I fear that forced detention is actually causing more deaths than it prevents.

The broad community discussion on suicide that this book calls for must include a thorough and proper debate of these contentious human rights issues. One thing is already clear. This public debate cannot be limited to or controlled by the medical profession, but must include experts in the law and ethics of human rights and civil liberties, as well as psychiatric survivors, their families, clinicians and other practitioners in the mental health. Indeed human rights in mental health have to become, like suicide prevention, a whole-of-community conversation. We cannot continue to

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allow people who have committed no crime to be locked up and forcibly 'treated' (i.e. assaulted, tortured) based on the prejudices of psychiatrists who judge that the denial of such basic human rights is "for their own good".

The moral arguments against suicide are, for me, simply irrelevant. There was no moral anguish in my suicidal deliberations. There was no right or wrong, good or bad. I was simply looking for a way out of my pain. Moral taboos are not a good protection against suicide, at least not for people such as myself. Furthermore, most of the moral taboos against suicide can be traced back to some religious notion of it being a sin. While religious fears of sinning may protect some believers, though clearly not all, they are simply irrelevant to many of us these days. The notion of suicide as sin is also an obstacle to a better understanding of suicidality. For instance, I would never seek help from anyone who regarded suicide as sinful. Unfortunately, the professionals we seek help from are not required to disclose their own moral or religious beliefs about suicide. This can be a very big problem.

The next popular myth is that suicidality is 'madness'. Madness is another topic that has long been an issue of both fascination and fear in most societies, and perhaps never more so than today. There is a popular belief that mad people are dangerous and we understandably fear the image of the out of control lunatic wreaking havoc, unconstrained by the social norms that most of us observe. But this myth, much loved by Hollywood movies and sensationalist tabloid media, is not supported by reality. It is outrageous when we see this myth being cynically exploited to justify and promote the use of forced detention and forced treatment of the mad. But those who support forced interventions know the power of this myth for their public relations campaigns, because our fears about madness are strong. We fear the crazed lunatic but the fear of going mad ourselves is also strong. I once asked an elderly woman who was going through a bit of a hard time if she was afraid of dying. She said yes. I then asked if she was also afraid of going mad, of losing her mind. She said yes again. So I asked which she was more afraid of and her answer was madness. Madness is not an adequate explanation for suicide. But the *fear* of madness is an important part of the conversation we need to have about suicide if we are to break the taboos that surround it. Two of our greatest fears merge in suicide – our fear of death and our fear of madness.

The professional equivalent to the popular myth of suicidality as madness is the myth of 'mental illness'. This medical myth has so permeated our culture that it has now become a popular myth also. But it

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makes no sense. I can no longer use this widely used phrase because I have come to see it as an oxymoron. The usual and reasonable understanding of the word 'illness' is as a medical, biological problem. That is, an illness (or sickness or disease) is something that affects some biological organ such as the heart, the liver or, indeed, the brain. If we talked about 'brain illness' then I would have no complaint. But the mind is not a biological organ. The mind is not a 'thing' like these bodily organs, but a psychological term for the subjective experience of thoughts and feelings. Indeed, we will see later that the mind can be seen as a collective noun for these psychological – not biological – thoughts and feelings. This is not to deny the influence of biology on the experience of 'having a mind'. It's just that the mind is a psychological, not a biological, concept. We cannot therefore use 'mental' and 'illness' in the same phrase any more than we can talk about a thought being red or solid or, indeed, chemical. 'Mental illness' makes as much sense to me as a square circle.

Of course we can and regularly do mix our terms in this way when we create metaphors. 'Mental illness' is perhaps useful as a metaphor, though I would suggest that it is at best a weak metaphor for the difficult thoughts and feelings we might experience. And an even weaker metaphor for explaining why these difficulties occur. But its greatest weakness is that it is now being used literally rather than metaphorically. The literal interpretation of this metaphor has inevitably led to these difficult times in our lives being seen solely in medical terms. We begin to see only the biology of the brain and become blind to the psychological, emotional, social and spiritual dimensions of what it is to be human. We see only the visible symptoms and behaviour and fail to notice the invisible, subjective, feelings of these difficult experiences and what they mean to those who actually live it. Indeed, we fail to see the person behind the symptoms and behaviour. The mystery of what it is to be human is diminished and mechanised by the technological colonisation of the psyche by biology and medicine. The 'mental illness' metaphor, now out of control as a medical myth masquerading as a literal truth, is the current status quo in the mental health industry in Australia.

As another aside, and another instance of the language difficulties we encounter on these issues, I have come to prefer the language of madness to the medical language of mental illness. Many people regard mad or madness as pejorative terms – and indeed I do use it in this way myself when I speak of the madness of psychiatry. But many people who have stories not dissimilar to mine are embracing the language of madness – and celebrating Mad Pride – as the most appropriate first-person language for

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expressing the depth, subtlety and mystery of what we have experienced. Indeed, for many people these days, myself included, it is the medical language of mental illness that is seen as stigmatising and offensive.

The origins of the myth of mental illness can be traced to the pioneers of psychiatry and psychology in the late 19th century, who sought to understand madness as a medical, health issue rather than a religious, superstitious one. This was a huge step forward. The study of the mind and the brain then became one of the many great scientific enterprises of the 20th century. Unfortunately, the distinction between mind and brain has become blurred in some circles where the brain is seen simply – and simplistically – as the organ of the mind. This narrow ‘scientific’ view claims that we will understand the mind by understanding the brain. Or to say this another way, understanding the biology of the brain will tell us everything there is to know about the experience of ‘having a mind’. This is patently absurd nonsense, as many scholarly arguments have demonstrated. Such a ‘hard science’, extreme reductionist view of the mind is easily, and frequently, shown to be based on false assumptions that depend on dogmatic, ideological prejudices rather than good science. The myth of ‘mental illness’ rests on and is sustained by these false assumptions and ideological prejudices.

The consequences of this medical myth of ‘mental illness’ can be seen all around us in the mental health industry we have today. Medicine and psychiatry, and in particular biological psychiatry, dominate this industry. The vast bulk of public funding on mental health goes to the professions that promote and sustain the ‘mental illness’ myth. With devastating consequences. ‘Mental illness’ locates the mythical illness in the individual. This pathologising of the individual fails to recognise the social, cultural and historical contexts that are invariably significant factors. Social isolation is a common feature of this suffering and this myth that denies the social context makes us feel even more isolated and actually nourishes the toxic stigma that surrounds ‘mental illness’. Furthermore, ‘mental illness’ locates this pathology in the brain and seeks to treat it by manipulating the biology of the brain, usually with potent psychiatric drugs and often with disastrous consequences. Believers in this myth also tend to be blind to the psychological, emotional, relational and spiritual dimensions of the psyche so that they neither look to these for an understanding of the origins of the ‘illness’ nor for a way out of the suffering. Furthermore, a belief in the ‘mental illness’ myth – by professionals, by governments and public mental health bureaucrats, and by the wider community – creates a collective

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blindness to the possibility that it is perhaps our society that is 'sick' rather than the individual person.

The creation of the myth of 'mental illness' is a creation of the medical and psychiatric professions based on their false assumptions and ideological prejudices. The promotion of the myth serves these professions rather more than it does those who struggle with madness or, indeed, of society in general. We will look more closely at the madness of modern psychiatry in a later chapter. But this medical madness itself depends on one other myth that needs to be mentioned.

This is the myth or fallacy of 'objective science'. I have alluded to the false assumptions and ideological prejudices behind the madness of psychiatry and 'mental illness'. There are many of these, some of which have nothing to do with science at all, such as the vested interests of medicine, psychiatry and the big drug companies. The primary false assumption of the 'scientism' described above is the great myth of modernity that privileges objective knowledge to the exclusion of all other forms of knowledge. A full critique of this myth is beyond the scope of this book, but it is one that has been exposed many times by many scholars and accepted by most of the human sciences for a generation or more. But it seems this 'news' has not yet reached medicine and psychiatry. Scientism works only with the observable, measurable world of physical reality and has been spectacularly successful at putting rockets on the moon and revealing the physical structure of DNA. Its spectacular achievements in the world of observable objects have been matched by its spectacular failures in trying to understand and explain our inner, invisible worlds of subjective *experience*.

The colonisation of the psyche by medicine and psychiatry is one of these spectacular failures. Objectifying subjective experience has reduced us to little more than biochemical robots. Blind faith in the myth of objective science – with its false assumptions and ideological prejudices – is the source of this medical colonisation of the psyche and its spectacular failure. The narrow, limited science of medicine and biological psychiatry does have a role to play, but it will never give us more than a partial, incomplete understanding of the lived experience of human suffering for the simple reason that it is incapable of doing so. Objective science is unable to reach into the invisible, unmeasurable depths of subjective experience. Other methods of enquiry are needed for this, and such methods exist in abundance. The problem is that these methods are largely – and deliberately – excluded from the mental health industry by the dominance and influence of medicine and its myths of 'mental illness' and 'objective

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science'. This is most apparent in the call, so frequently heard – almost a chant or mantra – for 'evidence based' practice in health, including mental health. This phrase is part of the objective science myth and more to do with the medical profession's public relations than good scholarship and research. 'Evidence based' science (which is just the familiar prejudice of the superiority of scientism's strictly quantitative methods dressed in sheep's clothing) is a good sales pitch for winning research grants and public funding for your projects. But the narrow definition of what constitutes evidence in this sales pitch is based on the false assumptions and ideological prejudices of the myth of objectivity. To understand *psychosocial wellbeing* it is necessary to engage with subjective, lived experience, a place where objective scientism with its inadequate evidence criteria simply cannot go.

This begs the question, how do we research lived experience? Many qualitative methods exist to help us in this enquiry, but this is not a book for surveying these methods. My particular research interest is in 'phenomenology', which asks the question "What is it like to be this or that?" And a vital key to this enquiry is to hear the stories of those who know the lived experience 'from the inside'. Knowledge such as these stories represents an expertise that can be found nowhere else. The first-person stories of the subjective, lived experience, in the words of those who have lived it, are the starting point of this enquiry. Story-telling is a central theme throughout this book. My story now continues, beginning with the phenomenological question, "What is it like to be suicidal?"

Chapter 2

What Is It Like To Be Suicidal?

*You'll never know the hurt I've suffered
Nor the pain I've rised above
And I'll never know the same about you
Your holiness or your kind of love
And it makes me feel so sorry.*

(Bob Dylan, *Idiot Wind*)

I was with my GP once when he wondered aloud what addiction feels like. It was a relevant question for him to ask himself because, as an authorised Methadone doctor, he has many patients who are struggling with addiction. While I pondered how I might describe it to him, he answered it himself. He said that he thought it must be something like holding your breath.

I'm sure you know this feeling but I invite you to do it now. Just hold your breath until you start to really need to take a breath. Then keep holding it a bit longer ... then a bit more. You will reach a point where you absolutely must take a breath. Your whole body will be demanding that you take in some air. Don't injure yourself but, if you can, hold your breath just a little longer. The demand for air will become all important. It will dominate your consciousness. Everything else in your life will become irrelevant. You are obsessed with the desire for some air. Don't overdo it, but for those of you who have never experienced a serious drug addiction, that all-consuming craving, then this little exercise will give you some idea.

Suicidality is much like this.

My doctor was not enquiring about what it felt like to be addicted to heroin, and certainly not about what the heroin high felt like. This craving where everything else becomes secondary seems to be much the same regardless of your preferred drug. Similarly, this craving seems to be much the same regardless of the circumstance that led to

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your addiction. Each person's pathway to addiction is probably unique, as each life is unique, though similarities can often be found. Frequently there are some life events on this pathway that led to your taking refuge in drugs (we must include alcohol here as it is just another drug). We can also often identify that some people seem to be particularly vulnerable or susceptible to addiction. The choice of drug (or alcohol) is also quite individual and idiosyncratic. But the craving when you are seriously hooked is much the same.

Suicidality is much like this.

How do you convey a feeling to someone who has never experienced it? How do you describe redness to someone who has been blind since birth? In teaching yoga, I have posed similar questions to the class to make the point that yoga is about doing the practices, not talking about them. I point out that we could study everything there is to know about water and interview at length all the great Olympic swimmers, but we wouldn't really know much at all about swimming until we actually jumped into the pool.

So how do I describe suicidality - *feeling* suicidal - to you? If you have been suicidal then my efforts to describe it here would be shallow compared to what you already know. If you have never been suicidal, then what chance do I have of giving you any real sense of it? And besides, would I really want to be successful in evoking such a feeling in you?

It seems to me that suicidality is a complete mystery for many, maybe most, people. As far as I can tell, my dear sister Barbara, for instance, doesn't have a suicidal cell in her body. I know that she's had hard times in her life, at least as hard as I've had, and I suspect she's had times when she probably wished she were dead. Hasn't everyone? But moments when you wished you were dead are not suicidality. Barbara and I have been very close all our lives and there's probably no-one who knows me better than she does. But I suspect I could talk to her about my suicidality till I was blue in the face and this desire to take your own life would still be a mystery to her. I know she has known extreme emotional anguish and there have been times when we have been able to share this intense feeling with much mutual recognition and great empathy. But not suicidality. As an aside, I must

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acknowledge that part of my sister's great wisdom is that she never feigns empathy when it is not really present. This is so important because there are few things less 'therapeutic' than someone pretending they know just how you're feeling when it is so obvious that they don't ... and we suicidals have very sensitive antennae to such phoney empathy.

I could flip this around and say that I don't understand those for whom suicidality is so totally incomprehensible or out of bounds. Some people might say that I have failed to acquire the necessary social or religious values, but I suspect that dogmatic taboos are actually of little value here. I do not see suicidality as immoral, certainly not a sin, nor do I see it as madness. Never have and I doubt if I ever will. It has always seemed a perfectly legitimate option that everyone undeniably has available to them. Of course, I would much prefer it that no-one, including myself, felt such despair that they chose to exercise this option, and I would like to do whatever I can to prevent people, including myself, from reaching such a point of despair. But suicide has always made sense to me. Still does.

Suicidality is a legitimate human experience. That is, it is something that some people feel at some times in their life. This is simply undeniable to me. To declare it bad, mad or illegal is to deny a valid human experience. It is valid because it happens and it is real. Sure, some people never have this experience and good luck to them. I could say that I envy these people. But actually I wouldn't say that because I am in fact grateful for my suicidality. It has been such an important part of my life's journey that I could not imagine myself being where I am today without it. And I'm so happy to be me these days.

Which brings me back to the *feeling* of suicidality. For about 45 years I basically couldn't bear being me. That's not to say that it was 45 years of constant misery - far from it. The best description I can come up with is that there was a constant sadness in me that I could escape from through various life adventures such as school, travel, lovers or work. But this constant sadness - which I now sometimes call a divine discontent - seemed to be the place I always returned to from these adventures. I don't know why this sadness is within me but it

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seems to have been there since forever. It has always been a part of me. It has always been a part of my sense of who I am, a part, and a significant part, of my sense of self.

Most of the time I travelled with this sadness as a quiet companion. Indeed sometimes I could even pretend that it wasn't there. But it was - always. Sometimes, though, this sadness surfaced in quite powerful ways. It could surface as anger. It could surface as shyness, sometimes an extreme, painful shyness. It could surface as disappointment or feelings of being let down. Most of the time it would surface in response to something that had happened, though sometimes it would seem to rise up for no apparent reason at all. All this seemed pretty ordinary to me. Isn't it the same for everybody? Or so it seemed to me ... and still largely does.

But sometimes - twice so far in this life - this sadness was unleashed in all its force. For me, both these occasions were after a very special love relationship had fallen apart. I have always been quite clear in my own mind, both at the time and still now, that these relationship breakups were the trigger, not the cause, of my suicidality. As a trigger, they released the floodgates on my sadness and I was overwhelmed. Despite my best efforts and all my years of practice living with and managing this sadness, I was not strong enough when it was unleashed in all its power.

So first of all, for me at least, my suicidality comes from very deep within my being. It may look like an impetuous, spontaneous tantrum, but its source lies deep within me. It might also seem sudden and out of the blue, but it is actually a slow-brewing tide that is only noticed when it overflows the defences. It cannot adequately be described simply in terms of the feelings that are aroused within you when you are actively contemplating suicide. These feelings have a history, they are old, even ancient.

But when these 'actively suicidal' feelings are aroused, the addiction metaphor is not a bad one. There is a craving, a deep, urgent craving. And the holding your breath analogy is not bad either. It is like you're gasping for air, unable to breathe. But it is not air that you are gasping for, it is life. And it is not heroin or alcohol that you crave but peace, some freedom from this anguish. When the suicidality is burning hot

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inside you, any freedom at all will do. I tried to go to sleep so that I would never wake up - to die by mentally deciding to die. Dammit! I couldn't do it. I begged, even prayed to some Higher Power that I didn't believe in, for my 'madness' to be complete. Lord, let me be a blithering, dribbling idiot in the corner of some loony bin, just let me be free of this pain. Again I was unsuccessful. I tried so many things but none of them worked. Eventually the suicide option became the only option. And, in time, that moment of decision comes.

* * * * *

Some time about half way through my four years of madness I said to a friend that I simply couldn't see a way out of the mess I was in without some change in consciousness that I was unable to imagine. To make my point to this friend I said that it would have to be comparable to the change in consciousness that takes place at puberty. And just as the pre-pubescent child cannot imagine sexual maturity, I was unable to imagine any way that I might ever be comfortable being me again.

I say 'again' because I had enjoyed many times and periods in my life when I felt that life had been very good indeed. I'd had many happy times. I'd had some wonderful adventures and great good fortune. I grew up in a wonderful family with parents who remained happily together for more than 50 years. I'd had a first-class education and some exciting and rewarding years in a career as a professional software developer and university lecturer. I had close and trusted friends who I knew cared for me as I cared for them. And I'd had some truly wonderful intimate love relationships with people who were and remain very special to me.

There was pain and disappointment, of course, during all these aspects of living a life. But no more so than for many others, as far as I could see. There were also plenty of high times, and more opportunities than most people get, I reckon, for relationships, travel and work. By and large I made the most of these opportunities and reaped some pretty good rewards from them. In summary, you could

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say that my life had been mostly safe and abundant. So what the hell was the problem with me?

I met people in the drug detox and rehab circuit who longed to return to some earlier time in their lives prior to the ravages of their addictions. But I knew that there was no time in my history that I wanted to return to. I knew that, despite many fond memories, even the best times from my past could not satisfy me now. I knew that even the intimate love relationships that had broken my heart when they collapsed, and that perhaps I still pined for to some extent, could not mend the wound that was bleeding inside me now even if such an impossible reconciliation became possible. More than that, I knew that it was impossible for any such intimacy to mend or soothe or overcome this black hole of hopelessness inside me, this pain of being me. There was no way out. In my wildest fantasies there was nothing I found that I could hope for.

My thoughts about some unimaginable change in consciousness were to prove prophetic, but it was way out of reach for me at the time. It was like the encouragement I had received a couple of years earlier, and so many times since, that it will pass, Dave, if you can just hang in there. This good advice is probably true. The problem with it though is that I was unable to believe it - unbelievable, inconceivable, and impossible.

At the time of these prophetic observations I had already done several laps of the drug rehab circus, with a few more laps still to come. I'd also spent nearly a year living in a yoga ashram, which was safe and healthy and wonderful. But only if I stayed there. Each time I stepped out of the ashram and visited Melbourne I immediately fell into despair and drug-taking again. I was now living with some friends in beautiful forest country in New South Wales. Like the ashram, it was safe and healthy and wonderful and I felt that I was maybe getting over my woes.

But I should have known better. During this wonderful year I was taking anti-depressant medication and seeing a psychologist each week and I was not the only one thinking that things were on the improve. You so desperately want to believe that this intolerable life is slowly, bit by bit, becoming tolerable again. You want to believe that being me

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does not have to be so bloody awful. That somehow I will learn how to live in this skin. You want to believe this so much because you want it to come true. You also want to believe it because the people around you want to believe it too. You really really want to believe it, so sometimes you actually do.

But with hindsight I can say that even at the time, in my heart of hearts, I knew that it wasn't true. During this year in this beautiful place, living a simple, healthy life with wonderful friends, I was largely a recluse. I enjoyed the company with these two dear people, but beyond that I socialised little. I did not want to participate in the world and had fantasies about becoming some sort of a monk, perhaps a yoga swami (although I had already ruled this out many years before). I would talk of being in 'retreat' but I was really hiding from the world. I did not want to get too close or be too close to anyone. It was not so much a retreat as an escape.

But I could not escape from myself. Not all the time. I could put on a pretence of being 'sane' as I worked to not disengage altogether from the world around me. I could present a personality to this outer world that most people could tolerate as acceptable, but it was an effort and I felt it was false and unreal. I could talk to the psychologist, as well as friends, about my feelings and 'progress'. I was intelligent, honest and articulate about my feelings and circumstances and tried hard - oh so hard - to be open to the possibility that I was actually getting 'better'. I tried to accept that this bottomless bucket of shit that I lived in within myself was just the human condition and that I had to learn to accept that. I tried so hard to believe this. If I could just let go of my unrealistic expectations of life being anything other than a bucket of shit, then I might actually find some useful meaning and purpose to being me. I didn't have a clue. Deep down, in the privacy of solitude, there was no meaning to it at all and, more than that, no meaning was possible. But I tried hard to believe otherwise, and at times I managed to convince myself of this. I believed it because I wanted and needed to and because those around me wanted and needed to believe it too. But it wasn't true.

In many ways it was a very good year for me, and I treasure the memory of it, but it was bloody hard work. And it didn't work. I left

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there at the start of 1998 thinking that I was OK or close to it. I was soon back on the heroin and the worst was yet to come.

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Before looking at the professional help I received, it's important to draw attention to the efforts we make ourselves to resolve these problems before (and during) professional treatment. We are all constantly attending to all sorts of stresses and difficulties in our lives, but only occasionally do we go to the doctor or some other professional for assistance. The question often arises, even with physical illnesses, at what stage do we seek help? Before then, we usually prefer to try and deal with it ourselves.

My suicidality was triggered by a relationship breakup, but even before I was aware that I was feeling suicidal, I tried to do what you would normally do to get over such a disappointment. Even before the breakup became final, we tried to find a way that the relationship might be able to continue, which included some relationship counselling for a brief while. We both got upset and sometimes angry, and we both felt hurt by the other at times. We examined ourselves looking for whatever it was within us that seemed to be making this relationship that we both wanted so impossible. Passionately in love but with irreconcilable differences seems too simple and superficial, but is probably pretty close to the truth. I certainly felt inadequate and somehow flawed – I even felt cursed or doomed to somehow always fail in love. In the difficult negotiations leading up to the final breakup (and breakdown), much soul-searching had already taken place.

This soul-searching continued after the breakup – but this time I was struggling with it on my own. The sense of aloneness at these times becomes another difficulty that you have to deal with. You do what most people do at such times and talk with sympathetic friends and family. You try and distract yourself from the anger and sadness that are wreaking havoc inside you. Maybe you throw yourself into your work or studies, or perhaps your favourite hobbies or pastimes. You tell yourself that you'll get over it, just be patient. Perhaps you tell yourself that there's more fish in the sea and there's another lover down the road waiting for you, one that will truly last forever (or at least longer/better). You might also take refuge in socialising and partying, possibly looking for your next lover (or maybe just for some sexual distraction – and some poor sucker gets you on the rebound). But maybe the partying is, or becomes, just dulling the pain with your favourite intoxicant. Alcohol is a favourite for many at such times and it can be a very useful drug to take the edge off acute emotional pain. I recall knocking down a few large brandies many years ago when I heard that my girlfriend at the time had just died in a car crash. These drinks were an excellent 'tonic' for me at the time. But taking refuge in intoxication can, if prolonged, become its own trap.

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By my own choice, I was not working at the time of the breakup. Nor did I have anywhere to live because, as my peculiar fate would have it, I had moved into her place not long before. I still wonder if it might have been very different if I'd not been homeless and/or unemployed at the time. Let's be clear, this was not an impoverished, sleeping under the bridge homelessness. I had a flat in Melbourne that I was renting out, plenty of money in the bank and a nice car, so I could have made a new home for myself pretty easily. I could also have found a new job if I'd wanted, but that was not what I wanted, at least not initially. Free of this relationship, I was now also free to go wherever I wanted and do whatever I wanted. I considered returning to India and resuming my travels that I had interrupted to come back to my lover. I considered teaming up with some friends who were creating a wonderful life for themselves in the countryside, which I eventually did a year or so later.

So I talked with friends, got drunk with one or two of them a few times and had a good cry into my beer, and tried to see some way forward. But I couldn't. With hindsight I can see that the hopelessness I felt about this wonderful relationship failing was revealing, and also unleashing, the hopelessness I felt about my whole life. The deep discontent that had lurked within me all my life was rising to the surface and starting to overflow. Even at this early stage I recognised that the breakup was just a trigger for the release of feelings that were so much more than the pain of this lost love, huge though that was.

Today, this is very clear to me. I now see that my search for intimate relationship was in fact my attempt to resolve, overcome, cure, expel, cover up, or perhaps deny, a lifelong inner discontent. To this extent, there were some escapist qualities in this quest for intimacy. But there was also a yearning, a hope, that through intimacy I might be able to become more whole, more complete – less incomplete, perhaps – which is what I felt as the source of my discontent. Some people do seem to grow into fullness through intimacy, but this didn't happen for me. Maybe this was just bad luck or inappropriate choices on my part. Maybe some vital stage of my psychological development had been overlooked, neglected or gone haywire. I didn't know and couldn't figure it out. Neither could anyone else. One popular pearl of wisdom you hear at these times is that you cannot love another until you can first love yourself. This seemingly obvious wisdom annoyed me as it created a conundrum where I couldn't really love myself without loving another, but couldn't really love another until I loved myself. My conclusion, again, was that I must be some sort of misfit.

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These questions around the search for love and intimacy are often questions about our sense of self. They are similar – and not unrelated – to the questions that arise with suicidality. They are questions about what it is to know and love the self, and also how we can come to know, and love, ourselves. If intimacy with another first requires an intimacy with the self, then how might we develop this intimacy? And what does knowing yourself intimately even mean, anyway? And how would I know? Maybe experiencing a meaningful intimacy with another is one way that we might come to know this. But in the stark absence of this for me after yet another failed love, I could see no way out of this conundrum. I was hurting, lonely and bewildered, with no visible way out of this pain. Suicidality was not far away.

The agonising self-enquiry into why I seemed doomed to suffer this lonely fate can lead to feelings of the most awful inadequacy. There must be something intrinsically wrong with me. Despite my very best efforts – and I truly felt that I had tried as hard and as well as I possibly could – I was simply lacking in whatever it took to sustain intimate love. I had had some counselling around these issues in the past because this was not the first time I had felt this. Twice before in my life I had been in love in this way. The suicide attempt in 1979 marked the end of the first of these. The other, although equally upsetting (we were talking about marriage and family before she got scared and ran off), did not lead to suicidality when it came to an end. A notable difference on this occasion was that I had a home at the time and a good job, which I threw myself into. The importance of a home and a job, or some other meaningful activity, cannot be overstated as a protective factor against suicidality. But there is more, much more, to feeling suicidal than no home and no job.

The two key words that we hear time and again in relation to suicidality are hopelessness and helplessness. There is almost unanimous agreement about the significance of these two emotions, which is one of the few occasions that I am in complete agreement with the experts of ‘suicidology’ – the academic and professional discipline that represents society’s ‘collective wisdom’ on suicide. Hopelessness to me is the ‘black hole’ of despair, also described sometimes as a profound feeling of utter emptiness inside. Helplessness is the belief – I would now argue a false belief – that this empty, black hole is forever, that it could never be otherwise. One personal image of it that I have is of being at the bottom of this black hole of meaningless emptiness. This is the hopelessness. And the exit to this hole is so far up that you can’t see it, and the walls are so dark and smooth

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and greasy that it's impossible to get any hold on them at all. This is the helplessness.

I suspect that both these ingredients are probably necessary for suicidality to arise, but that hopelessness is the critical one. It is hopelessness that says life is not worth living. It is hopelessness that is the source of the agony and despair. And underneath the hopelessness is the feeling that life is meaningless – hopelessness and meaninglessness go hand in hand for me. The helplessness then says that this agony will last forever, that nothing but meaningless hopelessness is possible.

It is necessary to stress that what we are talking about here are *feelings*. It is these subjective feelings of hopelessness and helplessness that lead us to suicidal despair. It is these feelings, so intimately personal, that we struggle so hard to overcome and resolve. It is not because I cannot get out of bed in the morning or am unable to hold down a job. It is not because I am unable to resist taking refuge in drugs. It is not because I have lost interest in doing things. All these *external behaviours*, although perhaps significant as symptoms, are insignificant, even trivial, compared to the inner, invisible feelings. These feelings are central to understanding suicidality for the simple reason that they are what are most important to those who live them. It is these feelings that lead us to decide to take our lives. Feelings matter. We cannot reasonably look into suicidality, whether it be our own personal struggle or as a professional suicidologist, without also looking into these invisible, subjective feelings.

In our attempts to resolve these distressing feelings we look for explanations and causes for why we feel this way. Again we meet another introspective, invisible, subjective process. Some counselling techniques seek to develop and/or guide this introspective process so that we might acquire some therapeutic insights into our circumstances. But often, too often, our subjective feelings and introspection are denied or dismissed when they fail to conform to the particular therapeutic model that the counsellor practises. Difficult feelings and personal introspections are far too often pathologised and dismissed as part of some 'mental illness' rather than given the legitimacy and respect that they deserve. But I'm getting ahead of myself again – we'll meet these therapies in more detail in a later chapter.

When I looked for possible explanations or causes for my distress, so many possibilities arose. Some were pretty unpleasant to contemplate, such as I was just being a spoilt brat having a middle-aged tantrum because I wasn't getting what I wanted. Some of the therapists I later saw clearly thought this, and I confess I still feel there was perhaps an element of this in

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some of my behaviour at the time. But, unlike my suicidality, tantrums pass and by themselves explain very little. Another suggestion offered was a typical mid-life crisis, which is perhaps just slightly sanitised language for a middle-aged tantrum. I think it was around this time that I read *Manhood* by Steve Biddulph and much of what he said about the male mid-life crisis made sense to me. But it didn't explain, at least not sufficiently to me, why I sometimes felt so rotten or why I then sometimes beat myself up because of these feelings. These two questions – why do I sometimes feel *such* despair, and why do I sometimes respond to this so self-destructively? – I now see as persistent or recurrent themes throughout my life. These questions still remain in my life today, although I do have some (but only some) sense of the answers to them. The good news is that a complete answer to these questions is not necessary in order to find peace with yourself. This is very good news.

Notice again that the key feature of these questions is their essentially subjective quality. That is, we ask ourselves questions that have personal meaning and relevance for us. And, most importantly, any answers we might come up with have to make sense in ways that satisfy us personally – they have to *feel* right, not just be a persuasive argument. There is a kind of knowing that we all recognise as that 'gut feel' kind where we just *know* it is right because it *feels* right. We can be misled by these feelings, that's for sure, and sometimes what initially seems true turns out to be only a partial truth or a stepping stone as we explore it more deeply. We need to be mindful of these pitfalls, especially when we are distressed, confused, chaotic and vulnerable. Good friends or a skilled counsellor can help us with this, but this sense of 'knowingness' that arises from deep within will ultimately be necessary to fully satisfy us, or these questions will linger and perhaps haunt us. Again, these invisible, inner, subjective feelings and thoughts – directly experienced and then reflected upon through introspection – are important for the simple reason that they are what matter most to us.

Another possible explanation or cause of my despair that must be mentioned in my case is that of the male menopause. This is a controversial topic as many people deny that such a thing exists. My own feeling is that it has some merit as I've no doubt that all sorts of biological changes occur throughout life and that significant (but perfectly natural) hormonal changes in mid-life could be at least part of the explanation for the all too common male mid-life crisis. These explanations (and we'll meet some other similar ones) have a certain appeal for they allow us to say that it's all due to biology, that it's not because I'm a mad, bad person or that I have some

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horrible character flaw – “it’s just my hormones playing up”. This can be very reassuring. But it was never a convincing explanation for me, if only because it didn’t explain my suicidality from 1979 when I was only 24. Although I don’t rule it out completely, I have never given it much credence.

My personal introspections at the time came up with all sorts of possible explanations for why I felt so rotten. But none of them was ever quite adequate, either by itself or in combination. This is not an autobiography so I’ll only briefly mention some of the key, illustrative thoughts that surfaced in these introspections. These thoughts usually come up by trawling through your personal history, looking for significant events or circumstances that might reveal the sources of your despair. Many ‘deep psychology’ techniques are based on a similar enquiry into your past and some try to delve a little deeper into your subconscious via dreams, hypnosis or other methods. Indeed, once you get on the therapy merry-go-round, you get quite tired of being asked about your family history (especially your mum). This ‘guided introspection’ by a skilled therapist can be a useful aid to your own all-important making sense of your feelings, but I would emphasise again that it is the inner, subjective feelings that we are working with here.

Several things stand out immediately for me when I look at my personal history and personality. First, I have always felt shy and, second, I have always felt something of a misfit. Whether one is the cause of the other has always been impossible to tell. I’ve just never quite felt that I’ve ever fitted in anywhere. To some extent, this remains true today, but is of much less concern to me now than it used to be. I was also clever, always being close to the top of the class, and good at sport. Perhaps because of these talents, I often felt somewhat burdened by expectations that I could not possibly live up to. I was also always a thoughtful, sensitive kid, naturally introspective and reflective in the privacy of my own time and mind. But to some this was contradicted by the vigour with which I enjoyed my sport and also by the fact that I was not infrequently in trouble at school as a ‘naughty boy’. I think I was often pretty bored and used to ‘play up’ to amuse myself and perhaps also as a clumsy attempt to make friends and fit in. With hindsight, I can see that there had always been a mismatch between my inner, private world and the apparent exuberance of my sporting activities and naughty entertainments.

There are many possible explanations for these characteristics, far too many and mostly far too uninteresting to dwell on here. These include my genetic inheritance – yes, my dad was known as a bit of a maverick, but

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whether that's genes or learned, who can tell? Of more interest to psychotherapists is the early family history, especially my relationship with my mum. But this is not a 'tell all' autobiography where I publicly air the family laundry – dirty or otherwise. It is necessary to say very clearly though, that in no way do I blame my family or anyone else for my 'madness'. This story is not about blaming anyone for anything. The story of this book – eventually – is about recovery from persistent suicidal despair by growing into a new psychospiritual territory.

Further introspection on and by this shy misfit, both as a child and as an adult, leads to some other features of my story that I do feel are relevant. I have always felt something of a square peg in a round hole – the misfit feeling – and attempts to squeeze me into a hole that is completely the wrong shape have always hurt and often makes me angry. I still feel this today, though I have learned many 'tricks' to live with this more comfortably now than I have in the past. Any efforts to change my shape so that I might fit into this round hole have always met with considerable resistance from me. Whether this is arrogance, pride, or self-indulgent vanity, as some might suggest, is not really relevant, although I have agonised over these and other uncomfortable possibilities many times over the years. My rebellion against pressure to conform to something that I don't believe in has been a constant battleground. I'm sure that many times I have rebelled needlessly and probably inappropriately. But I am equally sure that I often rebelled for perfectly legitimate and appropriate reasons, such as when I refused to allow a teacher at school to hit me. This conflict with the world around me, along with the anger that often goes with it, has arisen again and again for me. I've often felt that I've been asked to accept the unacceptable and I then flounder, and sometimes flail about, as I try to reconcile this conflict. And I've often found myself wondering whether it is me or the world that is mad?

Closely related to this 'misfit in the world' feeling is another conflict, a more personal and private one. This is the mismatch between the 'in-here' feeling of being me and the 'out-there' perception of who I was, as best as I could judge it. For example, I've said that I was shy but was often seen as extrovert, boisterous, even aggressive and perhaps a little 'wild'. In contrast, I have always thought of myself as thoughtful, gentle and sensitive. I guess I'm saying that these were the qualities that I valued most about myself. I've wondered sometimes whether I was just living up to expectations around me, but I've never got very far with trying to see me through other people's eyes. What I have felt strongly, from my earliest childhood to the present, and most strongly during my suicidal periods, is

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the feeling that I was invisible. Not physically invisible, but that the 'real me' that I sensed so clearly from the inside and was so important to me, seemed to be largely invisible to those around me. I think I just couldn't figure it out. And didn't have a clue what to do about it. This frustrating tension, and at times conflict, between the 'in-here' and 'out-there' – between subjective and objective realities – has always been there for me with no way to reconcile it or live happily with it. Until recently, that is.

The final personal characteristic that I believe played a big part in my suicidality was an intense curiosity, a quality that I do not think is at all peculiar to me. In fact, I might call it the naturally creative intelligence that we see in possibly all kids. This curiosity I now see in more adult terms, particularly in regard to suicidality, as a great yearning. This yearning to know, to understand, to search for genuinely satisfactory and meaningful answers to my questions, has also been with me always. With this burning curiosity and yearning there is also a passion. If I was truly interested in something then second best was rarely good enough for me. On the sporting field I was used to winning, though I didn't mind losing if I knew I was beaten by a better opponent and I knew I'd given it my best shot. I was also adventurous in my curiosity – I remember my motto in adolescence was "adventures to the adventurous". Another motto later in life was "live your life like a work of art". Yes, I've had my adventures, but made a bloody mess of the canvas in the process. There was always this yearning though, wanting to know and understand and make sense of this life I was trying to live – and the world in which I was trying to live it. I was always hungry for experiences rather than possessions. I was passionate, inquisitive, clever, sensitive, thoughtful and adventurous. But also a confused misfit, angry, shy and pretty inept socially.

These are the personal qualities that I recognise in myself and which resonate for me as relevant to my suicidal hopelessness. These are the characteristics that have the most salience for me in my efforts to understand the intimately personal feelings of meaning and purpose that my hopelessness was struggling with. These issues and questions that had been a lifelong struggle, a quest even, were the issues and questions that now overflowed into my consciousness when I was struck by the grief of a great love lost. Why was I such a misfit? Why did I find being me so damned difficult? With all the talent and good fortune with which I had been blessed, how come I couldn't appreciate this and just make the most of it? Sad and angry, my outer world had collapsed and held no interest for me at all. Sad and angry, my inner world was bewildered and overwhelmed. I didn't have a clue what to do – though in 1995 this wasn't altogether true.

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Unlike in 1979, I did call out for help. But what I found then, despite the very best intentions of (most of) those around me, was that I felt only more invisible, adding to my pain and my suicidality. My soul was dying and nobody could even see it, far less do anything about it. Myself included. The inevitable conclusion was that it had to be true – I was just a misfit, unable to live in either this world or this body. Hopeless, totally and utterly bloody hopeless. And it could never be otherwise. There was only one option left.

This description of my own search for explanations of my own suicidality is far from complete. I have chosen to highlight these fragments of my personal introspections for several reasons. First of all, and to emphasise the point again, some of this introspective self-enquiry invariably occurs *before* you reach the point where you look for professional help. This needs to be acknowledged and respected more than it currently is, both by ourselves as we struggle with these feelings, but also by the professionals when we do eventually meet them. Many people who contemplate and/or attempt suicide do manage to resolve their pain and despair by themselves, perhaps with the help of family and friends, without ever seeking professional help. It is typical, and quite appropriate, that we would prefer to deal with these difficulties ourselves, which many people obviously do. This is not to discourage anyone from seeking help. Knowing the right time to do this is important and sooner is probably better than later. But if we are to prevent or avoid these feelings escalating into potentially dangerous behaviour then it is important to acknowledge them honestly and give them the legitimacy they deserve. To honour them as real, genuine and significant feelings, rather than repress, suppress or hide from them as some shameful character flaw or embarrassing sickness. There is much we can do to heal our wounds ourselves – we do it all the time – but this requires that we respect our suffering. This also applies to any professional help that we might consider. If a therapist does not respect your ‘inner voice’, which unfortunately occurs far too often, then just leave.

A second reason for this choice of fragments from my story is to highlight the subjective nature of what we are dealing with here. This seems altogether too obvious, but it just makes it more surprising that the subjective experience is so regularly ignored or dismissed in the expert discussion on suicidality. The academic discipline of suicidology strives hard to be an objective science but in doing so renders itself virtually blind to what are in fact the most ‘substantial’ and important issues being faced by the suicidal person. To me, as someone who has lived with and recovered from suicidality, when I look at the academic discipline of

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suicidology, it feels as if the expert ‘suicidologists’ are looking at us through the wrong end of their telescope. Their remote, long-distance (objective, empirical) view of suicidality transforms the subjective reality and the *meaning* of the suicidal crisis of the self into almost invisible pinpricks in the far distance. Few suicidologists ask the question, “What is it like to be suicidal?” And the few innovative suicidologists who do challenge the prevailing dogma of suicidology still tend to interpret our experience through their particular theoretical lenses – e.g. psychological, psychoanalytical, sociological. But these innovators would agree, I think, that their interpretations are no substitute for the need to hear the first-person voice of suicidality in the words of those who have actually lived it. And besides, the dominant influence of modern psychiatry in suicidology marginalises these creative thinkers about suicide almost as much as it excludes the first-person voice.

The final reason for highlighting these aspects from my own story is that, after much careful reflection in the light of my recovery, I can now say with certainty that these were the issues central to both my suicidality and my recovery. When I look for those personality traits that were most significant to my suicidality, the ones that resonate most for me are my thoughtfulness, sensitivity and my ‘creative intelligence’. I also see my passionate curiosity and yearning, mixed with my willingness, indeed need, to explore the boundaries and to be adventurous. This is not the whole story, but I do see them as significant factors in my suicidality.

These personal characteristics, which would usually be regarded as not only perfectly ‘normal’ but even as quite worthy, are largely unexamined by suicidology with its emphasis on illness and pathology. As I now seek out other suicide stories, what I hear again and again is of a suicidal personality that is not so dissimilar to mine. Time and again I hear of gentleness and sensitivity, of a sharp, keen intelligence, and a passionate yearning in these suicidal stories. What is alarming is how little we hear of this in suicidology. With a few notable exceptions, suicidology has shown little interest in these very human and usually highly regarded personality traits in its search for ‘risk factors’ for suicidality. Suicidology today is preoccupied with medical, ‘mental illness’ models of suicidality that inevitably pathologises the individual in quite negative ways, with often harmful consequences.

I have tried in this chapter, in both the narrative and the commentary, to give some sense of what it is actually like to live and experience suicidal feelings. In academic terms this could be called the ‘phenomenology’ of suicidality, which can be stated more simply as the question, “What is it like

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to be suicidal?” As I have said before, I do not seek to derive any generalisations from my own, individual experience. But my reflections on this personal story since my recovery, and also my research into suicidology, tell me that insufficient attention has been given to this fundamental question in our efforts to understand and respond to suicidality. The subjective, lived experience of suicidality is currently barely on the radar of mainstream suicidology. We therefore find that what is often most significant to the person struggling with these feelings is overlooked, ignored or (even worse) deliberately denied and dismissed as either irrelevant or (even worse still) the symptoms of some supposed illness. Suicidality as a crisis of personal meaning – a crisis of the self – is not a topic of any major discussion by the experts. I wish to challenge this situation because I don’t see how we can begin to understand suicidality without giving serious consideration to what suicidality means to those who live it. Similarly, any efforts to respond to or ‘treat’ suicidality will inevitably be flawed without this first-person knowledge.

I am occasionally asked these days what I would say to someone who was actively suicidal. My answer is always the same. First and foremost, I urge my suicidal soul-mates to respect and honour their own feelings as meaningful, significant and perfectly legitimate human feelings. I am not a therapist or a counsellor so I never pretend to be one and always explicitly state this – which, interestingly, has so far always been met with a sigh of relief. But I do my best to truly honour their suicidality as a noble struggle of the self, with the self. Such encounters with suicidality can be quite frightening, and this too needs to be honoured and respected – my own fears as well as the fears that are invariably being felt by my suicidal soul-mates in these encounters. And how can I best honour this person and their struggle? For me, I say that I can listen to their story, share a little of my own and, if they are interested, tell them a bit about my current research into suicide and suicidology.

This brings us back to the theme introduced in the first chapter, and which we will meet again in later chapters – the theme of story-telling. To listen to someone else’s story without judgement and resisting the urge to offer advice is the first and perhaps most important gift you can give to honour their story, to honour their pain and struggle, to honour *them*. Sharing some of your own story also honours such an encounter, but not if it’s presented as advice – the dreaded ‘what worked for me will also work for you’ kind of advice. Few things are as comforting and reassuring – and potentially healing – as recognising your own story, or parts of it, in someone else’s story. You can feel not quite so alone in what is an awfully

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lonely space. You can feel that perhaps survival is a possibility. You might also find that you can say things and talk about things that it has been impossible to talk about with anyone else. This might even include some shocking black humour that would horrify anyone eavesdropping on this conversation. And to be able to laugh about suicidal thoughts and feelings can be a wonderful and truly liberating joy.

This story-telling connects directly with the topic of this chapter. Story-telling is the key to any enquiry into the question that this chapter asks: “What is it like to be suicidal?” Story-telling allows, respects and reveals the full depth and richness of subjective, lived experience like no other form of enquiry. Stories, of many different kinds, are how we explore, understand and communicate the mystery of life as we live it. These stories are found in conversation, writing, art, music, dance and theatre. Being willing to tell our stories and to listen to the stories of others is the foundation of all culture, and healthy societies recognise the need for safe spaces where this story-telling can occur. Sadly, safe spaces to tell your story of suicidality are very rare in the society in which we live. On the contrary, there are far more spaces where it is distinctly dangerous to share such special and tender feelings. Correcting this problem will require a greater respect for the suicidal experience, and for those who live it, than currently exists in our culture. Among the experts of suicidology, much more attention needs to be given to what suicidality means to those who live it, to the fundamental phenomenological question, “What is it like to be suicidal?” This in turn requires that the stories of those who have lived suicidality are heard, for there is no other method for reaching into the invisible, subjective, inner worlds of lived experience.

Later in this book a paradox surfaces that might seem to contradict my enthusiasm for story-telling. A time will come on the spiritual path when all stories must stop, if only for the briefest of moments. This moment was, for me, the end of my suicidality. The spiritual silence at the end of all stories was where I finally met myself for the first time and discovered peace and freedom, and my suicidality became absurd. But to reach this moment, our stories must be told, so before we get to this silence and my recovery some other, more difficult, stories need to be told.

Chapter 3

The Drug Addiction Detour

You can't heal it if you can't feel it.

([Alcoholics] Anonymous)

In reaching out to my sister for help, both my suicidality and heroin use became public knowledge. Prior to this, I think I had been pretty successful in concealing the depths to which I had sunk ... including from myself, perhaps. But there was no hiding from it now. I was a mess. Over the next few days and weeks more and more people would learn of this. Although those closest to me have always given me fantastic support and never damned me for my behaviour, it is still very uncomfortable to raise the white flag and admit that your life is out of control and that you don't know what to do about it.

Worse than this, the most visible action I'd taken to help with my pain was to take refuge in heroin, which was perceived as overwhelmingly stupid, creating massive problems of its own. I'm sure some people thought that it was weak or self-indulgent of me to retreat into the heroin, but this was never said directly to me. These good people all wanted to look for constructive ways forward rather than laying any guilt trips on me. Another popular view that I did hear later on, from a drug counsellor no less, was that it was 'just' my drug addiction resurfacing again, even after all these years. This is the old "once an addict, always an addict" theory. Along with other prejudices about my drug use, this theory was to become a big part of my life for the next four years.

The consensus of those I sought help from was that I first had to attend to my drug problem, that I was never going to be able to sort out the deeper issues if I was constantly escaping from them with heroin. This made a lot of sense, was obvious really, even to me. Except it would take four years for me to realise that I was *never* going to get past my drug problem if the deeper issues around my suicidality were not resolved.

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My first ever 'detox' was at a drug and alcohol unit in Geelong that was recommended by a friend of my sister who worked in the field. The word 'detox' here means a detoxification centre - I had, of course, 'detoxed' (i.e. gone through the heroin withdrawals) many times by myself. This unit had a ten day, live-in program, which is more than enough time for the physical withdrawal from heroin. It was a 'lock-up' centre in the sense that we weren't allowed out of the centre at all in these ten days for any reason, except for the daily, supervised walks. It was not a lock-up, however, in the sense that we could leave any time we wanted ... but we would not be allowed back in if we did.

It had a daily program that was carefully designed to help with the detox - routines for diet, exercise, sleep etc - as well as classes and group therapy sessions. It was a 'non-medicated' detox, meaning that no drugs are used at all to soften the withdrawal symptoms. No pain-killers, no sleeping pills, and certainly no use at all of our drugs of abuse for a 'step-by-step' withdrawal from them. It was a 'cold turkey' detox. For this reason, people with addictions to the benzos, such as Valium, were not accepted into this unit as these drugs require a gradual withdrawal to prevent the real risk of seizure if you try to withdraw cold-turkey.

The unit could accommodate about ten people at a time and was staffed around the clock. When you first arrive, you meet the others, some of whom are soon to leave and are looking pretty healthy and sharp. These 'old-timers' are important allies for the newcomers as they not only know the ropes but also typically take us newbies under their wing to help us through the first few, difficult days. A peer support culture is deliberately encouraged and is an integral, though mostly informal, part of the program. Many people who have been through detoxes speak of these relationships with other residents as the most valuable part of the whole detox process. After completing the ten days I felt 'clean' and healthy and positive again and that it was an excellent service that had been very useful for me. I remember this place fondly and was saddened to hear that it was closed down for lack of funds a couple of years later.

Although I walked out of there 'clean', healthy and positive, I still picked up the heroin again the day after I left. This probably seems

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complete madness to those unfamiliar with addiction therapies but it is an all too common story. This doesn't mean that the centre was a failure. Very few people give up their drugs forever after their first detox. When I first contacted the unit they assumed that, at age 40, I was an old hand at the detox circuit and were surprised that this would be my first institutionalised detox. Most people my age with a heroin problem also had a history of detox visits. This was recognised, understood and accepted. It seems that, like everything else, giving up drugs takes practice. And these centres do not judge you negatively for making (yet) another attempt to give the drugs away. On the contrary, you are welcomed and congratulated for having another try and, yes, we all hope this one might prove more lasting. This is a very realistic and sensible attitude.

It was at this first detox that I also had my first encounter with Alcoholics Anonymous (AA) and its 'sister' fellowship for drug addicts, Narcotics Anonymous (NA). This was a big eye opener for me. What struck me most of all at first was the scorching honesty of the stories that are told at these meetings. Extraordinary stories of struggle and recovery (though sometimes just struggle without much recovery) often told with an almost brutal frankness. Some folk 'share' their stories with a tremendous eloquence that could bring you to tears or, just as likely, make you holler with laughter at the most awful experiences. But to 'share' at a meeting is not about eloquence or telling a good story, even though these are appreciated. Equally if not more important are the many clumsy, confused, inarticulate mumbblings or ramblings of those still trying to find their own voice for their struggles with the drugs. So along with the extraordinary stories, what struck me was the incredibly genuine, attentive respect that was given to every 'share', no matter how inarticulate, angry, tear-soaked, confused or incomprehensible it might be. The feeling was very much that we were all in this together.

Over the next four years I found myself in numerous other drug and alcohol treatment places. These included short, intensive, medicated detoxes in several hospitals as well as a couple of longer term 'rehab's'. A distinction is made between detox centres, such as my first at Geelong, and longer-term rehabilitation centres. These

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'rehab' focus more on the larger issues around establishing a lasting recovery rather than just the initial physical detox from the drugs. For some people, just breaking the cycle of the physical addiction, perhaps supported by family, friends and/or local community services, might be sufficient to establish a strong recovery. But for many, a longer, more intensive rehabilitation is necessary. Most people with a drug addiction history will tell you that the physical addiction, strong though it might be, is actually relatively minor compared to the psychological addiction that keeps bringing us back to the drugs even after quite long periods of sobriety or staying 'clean'. The rehabs seek to address these deeper, psychological issues, which invariably takes much longer than the 'simple' physical detox. My old running coach when I was a lad used to tell me it takes as long to get fit as it took to get unfit. Getting 'straight' is a bit like this.

I went to two rehabs during my time on the drug addiction circuit. The first was a five week program at the Alcohol and Chemical Dependency Unit attached to the Seventh Day Adventist hospital in Warburton. The other was at The Buttery in rural New South Wales, which had a minimum three months program (though it often became six months for many). I lasted three weeks at 'Warbie' (as the unit at Warburton was affectionately known) and three days at The Buttery.

Warbie was a very posh rehab, very expensive and very intensive. The program included daily group therapy sessions, lectures, videos and seminars on a range of topics. There were about fifteen residents, again each at varying stages of the program and, again, the old-timers were a vital support for the newbies. We slept in beds in the hospital wards where there was round the clock nursing staff, a necessary measure as this program did include detox support for those who needed it. They also catered for those requiring a medicated detox from drugs such as Valium, though cold-turkey was the preferred, and mostly the enforced, approach for most drugs, including heroin. Diet and exercise were important parts of the program (fabulous vegetarian meals in the hospital dining room, but a very carnivorous BBQ at the unit on Sundays when family could visit). It was a strictly controlled environment, including not being allowed out of the hospital/unit unless supervised. It was the 'top shelf' of rehabs and I would not have been

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able to afford it without the private health insurance that I still had at the time.

I have many stories from the three, intensive weeks I spent at Warbie. You meet an extraordinary mixed bag of people in these places and, though tensions do arise in such close company, I mostly found these folk interesting and at times fascinating. One delightful young woman there, devoutly religious, had never taken an intoxicating drug in her life but found herself seriously addicted to Valium because of a negligent doctor. She taught me how to accept a genuine compliment of appreciation, which I'm still not very good at but better than I used to be. I had simply assisted her back to her room one day, as she was feeling wobbly on her feet. When she thanked me I dismissed it as nothing, no more than anyone would do. She demanded (commanded?) my attention and insisted that I accept her thanks, that I had gone the extra yard for her and she was very appreciative of it. She was almost cross at me for dismissing her thanks. Her insistence forced me to pause a moment and allow myself to truly feel her appreciation. It felt great.

I joined in fully with the program, working hard to get whatever I could out of it. But I was also confused and angry and very disappointed with myself that it had come to this. In the group therapy sessions, we talked about many things - our families and other significant relationships, our work and other activities, our anger, sadness, grief, loneliness etc, as well as more specific drug related issues. I shared my past history with the group, including that I'd been having suicidal feelings again recently, but I didn't think I dwelt on this particularly.

After one of these sessions I was called into the office of the head of the unit. Our group facilitator had obviously reported to him and he told me in no uncertain terms that I was to stop talking about suicide because "it was bullshit, just a cry for help, and it was freaking out the girls in the group". He told me to focus on my real problem, which was my drug addiction. I was dumbstruck by this. I thought I was doing what I was meant to be doing. I felt that I was being censored in what I could and couldn't talk about. When I told my sister about this on the phone that evening, she was clearly alarmed as she knew how I

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might react to this - i.e. that I might feel I needed to prove my suicidality by demonstrating it. She was relieved when I told her that I had decided to stick with the program and try and fit in with it as best I could because it was a good program and I felt it was helping.

I was to have another major conflict with the head of this unit. Part of the program is to look at our entire drug use, not just our preferred 'drug of choice'. This includes alcohol, tobacco, tea and coffee and also any prescribed medications. This guy was concerned about my alcohol drinking and the message was clear that I would have to give this up entirely too if I was to have any hope of giving up the heroin. I queried this as I had never been a very heavy drinker and if anything my alcohol consumption in the preceding ten years or so had reduced considerably. I very rarely got drunk, certainly never had blackouts or other major symptoms of alcoholism, and was quite capable of putting half a bottle of wine back in the fridge. I virtually never drank over lunch any more these days for the simple reason that I didn't like feeling 'groggy' in the afternoons. I really didn't see that my drinking was a significant problem.

But I listened to what these experts were trying to teach me and examined my drinking habits very carefully. My questioning of what I was being taught was seen as that great demon of recovery, denial. This demon of denial is the first and often the biggest obstacle to recovery and has to be confronted firmly. But there is a difference between being firm, or 'tough love', and being a bully. This guy was a bully, though I was not aware of it at first. He was basically demanding that I accept what he was saying even though it didn't make sense to me. I was being treated as a disobedient child who had to agree with what he said "or else". This meant, of course, that I could pretend to agree with what he said, which would have been easy for me to do and for him to believe, but I could not take part in such a lie, which seemed to me to contradict the whole therapy process. Finally he confronted me with his "or else" when he demanded that I kowtow to his authority or leave the unit. It was now an untenable situation for me so I had to leave.

This was very sad for me, indeed quite distressing, as I felt I was in many other ways making good progress with the program. I was

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consoled by my fellow residents who were concerned that leaving the unit under these circumstances would lead to me picking up the heroin again, which was exactly what happened. But I was not given much time for these consolations as these occasions when someone is evicted are known to sometimes upset the residents that remain and often someone who might be wavering in their commitment to the program will discharge themselves at times like this. I was frogmarched out of the unit immediately, not even allowed a phone call to find out where I might be able to stay that night. This 'boot camp' mentality is often found in detoxes and rehabs, and to some extent this is perhaps necessary given the difficult behaviours, especially around denial, that are frequent in such places. But it didn't work for me.

I didn't then, and don't now, disagree with the expertise of these addiction recovery experts about the need to look at all mood-altering drugs, not just your drug(s) of abuse, your 'drug of choice'. I have met too many people, mainly through AA/NA, for whom this abstinence from all such drugs is an essential plank of their staying sober/clean. It is very common, and makes a lot of sense, that while we may have our favourite drug(s), we often use other drugs in addictive ways, particularly if our preferred drug is unavailable or hard to get. But I could not see this in my use of alcohol, which was interpreted as denial. My response to the head of this unit today is to point out that I have been drinking alcohol, in moderation, since I last used heroin four years ago. And I have not been tempted at all to take up the heroin during this time, even when I found myself living next door to a heroin dealer!

I must briefly mention The Buttery, the other long-term rehab I went to a year or so after Warbie, but where I lasted only three days. The Buttery has an excellent and well-deserved reputation, as far as I can tell. It is very different to Warbie in many ways, not the least being that it is affordable for those unemployed or on a pension as I was by then. It was very difficult to get into, as the demand was much greater than they could meet. But I persisted and was eventually accepted. They did not have the facilities for the detox phase of withdrawals so they required medical proof that you were 'clean' before they would admit you. This makes good sense beyond just the extra resources that are required to supervise detoxes. The cultural

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environment created by people going through the physical and emotional intensity of detox is very different to the culture you want for the rehab phases of recovery. For instance, people who are still getting established in their recovery do not need people around them who are having major drug withdrawals with all the frustration, anger and doubts (denial) that often come with this. Being around people who are detoxing from recent drug use can also trigger the urge for a 'taste' of your old drug again.

The main reason that I fled The Buttery after just three days was that I was just so burned out and desperate that I just didn't feel I could do it. I fled to nearby Byron Bay with the intention of doing myself in. But there were a couple of incidents that occurred in those few days that were significant and relevant to my story here.

First, The Buttery sends newcomers to a local GP in the first day or so for a full medical. Very sensible. When I told this GP of my history of suicidality, including current thoughts about it, he recommended that I see a psychiatrist and, with my permission, he would notify The Buttery of this and arrange a referral. Again, very sensible, and I agreed to this. The Buttery, unlike the boss at Warbie, recognised that drug addiction might not be the sole issue that needed to be diagnosed and treated and called on other expertise as appropriate if need be. Big brownie points to The Buttery for this.

They lost these brownie points, however, when I met the worker who had been assigned as my counsellor. I don't know if it was Buttery policy or just an 'initiative' of this fellow but he urged, almost pleaded with me, that if I was going to kill myself would I please not do it while a resident of The Buttery. I can understand his concern. It would be a big problem for them if a resident died, especially by suicide. But it did little to make me feel welcome. I felt he was more concerned about his workplace than he was about me. I assured him that I would leave first.

Another event that made me feel unwelcome was that I was told when I arrived that I would be allowed no outside contact for the first six weeks. No phone calls, no letters either in or out - nothing. This was not altogether unexpected and I accepted it. These rules mostly make sense and The Buttery is really not of the 'boot camp' school of

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recovery in the way that some others are. But I was particularly hurt when I was told that I was not even allowed to post, far less finish, a half-written letter that I had in my bag. It was confiscated along with other personal belongings such as any music tapes and all my writing materials. It was not a good welcome. Although I'm sure The Buttery could have been an excellent place for me had I stayed, my suicidality was burning too hot inside me and I fled.

Both Warbie and The Buttery were advocates of the AA/NA program with residents attending local meetings as well as holding their own in-house meetings. Like these expert institutions, I also came to regard AA/NA as the most comprehensive and effective 'treatment' for drug addictions. It's a wonderful program and I'm constantly amazed at some of the criticisms people have about it, particularly by doctors and psychiatrists but also from others in the mental health community who I would normally consider more socially aware, sensitive and sensible.

Although best known for its 12-step program this is not the real foundation of AA/NA. The real heart and soul of AA/NA is the 'fellowship' that assembles for meetings. Before you have been introduced to the 12 steps and certainly before you embark on them, you will be introduced to the meetings. First, just to attend and, as best you can, to listen to the 'sharing' of others there. You may be invited to share at your first meeting, but maybe not, and you will never be pressured to share if you don't want to. The wisdom and healing power of this sharing is both simple and deeply mysterious. Among the many stories you will hear, some which might horrify you, others which might strike you as pathetic, you will be urged to look for the similarities with your own story, not the differences. It's easy to find differences and these can tempt you to think that your problems are not the same, or even that you are different to these people, that you don't really belong there. Ahhh, that old demon denial is always lurking.

The first time you share you will probably be, like me, shit scared. All these people looking at you, attending to your every word. And you're feeling lousy, confused and bewildered, not really wanting to be there and certainly not wanting to be standing before all these people

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wondering what the hell am I going to say? Your first 'share', and probably the next few times, is a big mountain to have to climb. But you learn pretty quickly that you can actually say any damn thing at all. It really doesn't matter. No matter how big a sweat you break into, no matter how stupid or incoherent you feel you sound, no matter how angry or sad you are feeling, whatever you say will be listened to respectfully. Here is a place where you can be yourself - with all your confusion and frustration, all your emotional dramas, all your crazy beliefs and uncertainties. Here is a place where all of you - all of you! - can be present and welcomed. The only 'rule' that is somehow just apparent (I never saw any 'enforcement' of it) is that any violence towards others is not OK.

There are actually a few rules for meetings, known as the 12 Traditions. The most important of these is implied in the name of the fellowship, which is the right to be anonymous and the obligation to respect the anonymity of others. This essential feature of AA/NA I see as one of several moments of genius by the founders of the fellowship. You could fully be yourself at meetings, but you could also create an entirely fictitious character for yourself if you wanted. Yes, this means that you could lie when you shared if you wanted to. And people often did. One of the most moving shares that I witnessed was when one fellow told the meeting that he had been lying to us all for the last few months, that he had in fact still been using when he was telling us that he wasn't. He was in tears as he told us this. But the response of the meeting was to hold this man even closer to their hearts. Sure, we had been deceived by him but now he had realised, as we all do eventually, that in doing so we are really only deceiving ourselves. This moment of confessional honesty was moving and potent and we all felt that it was potentially a vital moment for this fellow to take a very big step in his recovery. In the tea-and-bikkies afterwards he got many hugs. There was not a trace of any negative judgement for his past deceit. Judging others is not a part of the AA/NA culture.

In the early stages of the AA/NA program, you are encouraged to attend "30 meetings in 30 days". I never managed this despite a few attempts, though attending meetings regularly (several times a week)

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did become a big part of my life at times. I did make a start on the 12 Steps but pretty much never got past spinning my wheels on the first three. Which was fine, and I certainly got a lot from the time I spent with just these three steps. AA/NA is an unabashedly spiritual program and the word 'God' in the 12 Steps is an insurmountable hurdle for some people. I find this very understandable, having my own problems with this word, and preferred to talk in terms of the more acceptable 'Higher Power'. But there's an AA/NA joke that GOD stands for Gathering Of Drunks (or Druggies if it's NA) because it is the meetings of the fellowship that is the Higher Power that keeps us sober or clean. Another fellow declared his Higher Power to be a tram because a tram could go past a pub but he couldn't.

Irreverent and sometimes black humour is a feature of AA/NA. The scorching honesty of meetings, and also the brilliant humour, is what makes it all so 'real' and relevant. These are people who know my struggle because they have experienced it, or are experiencing it, themselves. Each meeting has a chairperson and perhaps someone to organise the tea-and-bikkies. These roles are rotated among the older (nothing to do with age), regular members and are seen as opportunities to give service to the fellowship. Like sharing, this is more of a privilege than an obligation. Each meeting passes the bowl around and is financially self-sufficient and independent. Anyone can attend, the only requirement being the desire to get sober/clean (note that you don't have to *be* sober/clean). Doctors, lawyers, priests and prime ministers are all welcome. But they leave all status and rank at the door. You are here as a fellow 'addict' (alcoholic, whatever) and there is no status in this community. In time, if you do get sober/clean, you learn that you only keep what you have by giving it away. It is an extraordinary, powerful and very healing community. I would like to see a Suicides Anonymous.

I stopped going to meetings not because I lost faith in the program but because it can, for some, become its own obstacle to recovery. Initially I didn't clearly see the reasons for this. I found that I was having problems with my sensitivity to others at the meetings. I would turn up, clean and in a good mood, only to find myself tuning into some of the anger or sadness that was present at the meeting. It was

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disconcerting to find myself walking away from these meetings feeling angry or upset. It was even more disconcerting when I found myself heading straight to a dealer after a meeting even though I'd been clean and without any habit for some time. This happened a couple of times and alarmed me. I learned that I had to choose the meetings I attended carefully. Each meeting has its own culture and 'personality' - some meetings seem to attract a pretty rough and angry crowd while others have a softer, more thoughtful mood. This cultural diversity, which is constantly shifting as members come and go, is a strength that reflects the broad community of the fellowship. But you need to learn which meetings can help you and which might press the wrong buttons for you and are best avoided.

But the final reason why I left and am no longer part of the AA/NA fellowship is that I found that I had never thought about drugs so much as when I was attending meetings regularly. Admittedly these were noble, hopeful, staying clean kind of thoughts rather than the desperate, craving thoughts that I have when I'm hungry for heroin. But my heroin use had always been pretty intermittent and when I wasn't using I was not really thinking about it that much. But to stay clean using the AA/NA program, I had to be thinking about my drug use virtually every day, which annoyed me. Again, like the total abstinence from all mood-altering drugs philosophy, I have complete respect for those for whom this approach works. Which it does for many. The AA/NA program is without doubt the most successful program for overcoming serious addiction problems, especially when you consider that many who come to AA/NA do not get there until other programs have failed - that is, the hard cases that others have given up on.

It was to be a year or more before I really understood why I had to leave AA/NA. And a gruesome year it was. This most awful part of my story - the 'mental illness' story - is the next chapter. But one aspect of this horrible year, the medical treatment I received for my heroin addiction, belongs here in this detour into drug abuse and addiction therapy.

I had detoxed a couple of times in a hospital setting which focused mainly on getting me past the immediate withdrawal period. To assist

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with this I was given various medications that softened the worst of these symptoms - mainly benzos (Valium) but also a peculiar drug called Clonidine. This drug, I was told, was primarily a drug for high blood pressure but it also had the effect (i.e. side-effect) of reducing the awful aches and pains in the muscles and joints that are part of opiate withdrawal. For this, though, you had to take the maximum dose that you could physically tolerate so my blood pressure was monitored closely and I wasn't given the drug if it was too low. It did ease the aches somewhat, I guess, but I also felt that I was constantly on the edge of fainting, which was unpleasant. One hospital allowed me to decline the drug if this was too unpleasant, but another hospital insisted that I take all scheduled doses "or else" (I would be discharged?). So I pretended to take them - the silly games we play. You can imagine my alarm, though, when I read in the paper years later that this drug was being tested on children (in Australia) for the 'treatment' of ADHD!

I had been invited to consider Methadone a couple of times before but had always declined it. I didn't really know much about it but the word 'on the street' was that it was an awful drug, as it is much more addictive than heroin and it also chains you to whoever dispenses your daily dose for you. Both of these are true. But finally, in mid-1998 after my first serious suicide attempt (since 1979, that is), I relented and decided to go on the Methadone. I was already on anti-depressants and another particularly foul psycho-drug (an 'anti-psychotic' called Zyprexa, which I'll talk about in the next chapter). I was utterly exhausted, totally lost in my helplessness and without a clue about what to do. I surrendered to the Methadone, clutching at this possibly last straw.

The Methadone experiment was a failure. But unlike my experience with the psycho-drugs, I feel no resentment whatsoever towards the doctor, a drug and alcohol specialist, who put me on the Methadone. This is because it clearly was an experiment and he explicitly said so. He went to great lengths to ensure that I was well informed about this drug and how the experiment was to unfold. At no stage did he deceive me or make unrealistic, unjustified or extravagant promises about this drug. The idea was to create some stability in my life by managing my

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heroin addiction with a supervised supply of another opiate, Methadone, while I sorted things out - a reasonable approach that does work for some people. I entered into this experiment with both eyes open, well informed about the options, the risks, my own obligations, as well as the possible benefits this drug treatment *might* offer me.

I took Methadone, along with my psycho-drug cocktail, for about eight months. I diligently went to the chemist each day for my daily dose, which was slowly increased to my 'blockade' dose. This was initially 100 ml a day but this made me too dopey, so I was finally stabilised on 80 ml. As an opiate like heroin, Methadone treatment simply substitutes one opiate addiction for another. But at these 'blockade' doses three things happen. First, you don't get 'high' from the Methadone itself. Some folk inject Methadone (there is a black market for it if there's a heroin drought) to get a bit of a high, but I never used it this way. Second, if you do take some heroin then it has little effect as you are already saturated with opiates. And third, it takes an awfully long time to come off (withdraw) from Methadone, meaning that you can't easily use Methadone to tide you over between fixes of heroin during a drought as it takes too long and is too painful to withdraw from the Methadone.

The eight months taking the three prescribed drugs became a nightmare, more because of the psycho-drugs than the Methadone. I dutifully took all these drugs and was soon chronically constipated (probably the Methadone), became a couch-potato with a craving for ice-cream (the Zyprexa), and had problems sleeping and was sexually inert (the anti-depressant). I didn't go out other than to get my Methadone and was dull and uninterested in pretty much everything and anything. And I put on about 20 kilos. Most everyone was pretty pleased with this 'result' as I was not taking heroin and not actively suicidal. But not me. After eight months of this I'd had enough.

This (prescribed) drug-induced nightmare came to an end with my last serious suicide attempt in mid-Feb 1999. This time I took an OD of the Methadone I'd been stashing away from the takeaway doses you're allowed once a week after you've been on the program a while. My case manager had told me about a person who had died taking triple their normal dose of Methadone. I had about fifteen doses in my stash

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so I thought it would be a sure thing. I added a bottle of scotch, all the prescription drugs I had, and yes, some heroin, to make sure. I woke up with the motel staff banging on my door, dazed but otherwise still very alive. Dammit!

What do you do when you wake up to a day you never expected to have? My previous serious attempts had all landed me in hospital unconscious, where I didn't have to do anything but be a patient. I drove around for a while until I eventually (sensibly?) phoned the drug and alcohol clinic. They anxiously called me in for a physical checkup. After the doctors gave me the physical OK, I was asked to see the shrink who, after a tricky interview, certified me and I was sent under guard to the Royal Park psychiatric lock-up - the details of this story are told in the next chapter.

After being discharged from Royal Park only a couple of days later, and finding and settling into somewhere new to live, I decided I was not going to take any more of these horrible drugs. I made an appointment to see my Methadone doctor, the doctor I most trusted and still have enormous respect for. Before I spoke he told me that they had reviewed my file and decided that my treatment plan was not working for me. I chuckled and agreed, and told him of my intention to get off all these drugs. To my relief this was fine with him and we put a plan in place. I most wanted to get off the psycho-drugs but was advised that I should go off them one at a time, and that Methadone should be the first. Reluctantly, I accepted this argument.

Detoxing off Methadone is no joke. Among heroin users the (half) joke is that nobody gets off Methadone without using heroin to help them through the Methadone withdrawals. I'm sure there are some exceptions to this street wisdom, but I was not one. The doctor put in a schedule with the chemist where I would taper off over three months. I later learned, from another doctor who was to supervise this detox, that this was in fact a fairly rapid schedule for the dose I was on. This new doctor actually thought it was too quick and altered it without telling me. When I became aware of this deception I was outraged and insisted that we return to the original schedule. I was keen to get off the Methadone so I could then get off the other, wretched psycho-drugs.

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As I worked through this detox schedule, which I was doing 'blind', meaning that I was not told when doses were reduced, the chemist asked me a few times whether I'd 'hit the wall' yet. He was referring to the full-blast of the withdrawal symptoms, which almost always came, though at unpredictable times in the process. I kept saying no ... until the very last week of the schedule. I staggered in there one day and told him the wall had come - aches, cold sweats, limp with fatigue, craving some sort of 'relief'. At these times it is recommended that you stop any further dose reductions, maybe even return to a higher dose, until you stabilise for a while and then resume the schedule. I was down to some tiny dose and due to have my last ever dose the next Friday. I decided, after speaking with the chemist and my doctor, that I would tough it out, pretend that I was sick with the flu or something for a while, and proceed to my final dose on the Friday.

The next six weeks were just awful. And I did take some heroin a couple of times. But I've not taken any heroin since then.

Without telling my doctors, I had already stopped taking the psycho-drugs by this time - at least, I'd stopped the Zyprexa. I may still have been occasionally 'remembering' to take the anti-depressants, but not for much longer. I found that I was regularly 'forgetting' to take them and I can clearly recall the time when I went to take a Zyprexa tablet and just couldn't bring myself to put it in my mouth. Never again.

The drug doctors, including the shrink at the drug and alcohol centre, had now pretty much washed their hands of me. But I still felt that my discontent, my suicidality, was with me and that I still needed help with this. I stopped taking these medications with an attitude that I was either going to sort this out or die but I was not prepared to live a zombie life. These and other stories of the treatments I received for my suicidality, as opposed to my drug addiction, are told in the next chapter.

Today, with the hindsight of what is now a robust recovery, I can see that I was never going to get over my addiction to heroin while my internal, suicidal despair was still brewing inside me. The focus on my 'drug problem' was a massive distraction that dominated my four years of madness. While I was being taught - and tried hard to believe -

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that I was an 'addict', everyone's attention, including mine, was not looking at the real issue(s). I still treasure my encounter with AA/NA, and learned much through my time with the fellowship, which I would readily recommend to anyone struggling with addictions. I must also acknowledge, along with the fellowship of AA/NA, the genuine efforts I received from some doctors in my struggle with heroin. But in the end these addiction therapies, like the drug abuse itself, were a detour from the path I would have to walk if I was ever going to recover from my suicidality.

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I include this chapter about my drug history with some reluctance and hesitation. Not because I'm ashamed or embarrassed about it – I'm not, or not much (though nor am I proud of it). Nor because it's such a complex and emotive issue with strong feelings on both sides of the 'drug debate'. I'm reluctant because it's a distraction from the suicidality and spiritual awakening that is the essential story of this book. Which is exactly what both my drug use and the 'treatment' I received for it were on my journey to recovery – a distraction from and a diversion around the real issues of my suicidal crisis of the self.

But I must include it because it was such a significant part of my struggle during these four years. With hindsight, I can acknowledge that it was a necessary detour as there was so much that I learned from it, and as stepping stones to my eventual recovery this history should not be denied or excluded. I just wish this detour hadn't taken four years. It is also relevant because the struggle with heroin points to some core issues around suicidality, mental health in general, and the self-enquiry and spirituality that are the major themes of this book. In particular, the genius of the founders of Alcoholics Anonymous contains vital insights into recovery (including the concept of recovery itself), insights that the mental health industry we meet in the next chapter is only just beginning to wake up to.

Like suicidality, any addiction (not only drug addiction) can often be seen as a crisis of the self. I have told how AA/NA ultimately did not work for me because it failed to address adequately my particular crisis of the self. Some of my NA friends pointed out that of course all of us 'addicts' had underlying personal issues that were the source of our addiction and obstacles to recovery. These good friends wanted me to persist with AA/NA, claiming that if I stuck with the program these issues would eventually surface and be dealt with. They were probably right, but that's not how it worked out for me. Later, after a year of ineffective and harmful medical 'treatments' for my so-called 'mental illness' (the next chapter), I could look back and see more clearly the wisdom of my friends. Perhaps my recovery would have been quicker and/or smoother if I had persisted with AA/NA or The Buttery. It was not to be. But before looking at the medical treatments of my madness, it is useful to identify some of the key features that underpin the success of the AA/NA approach.

The first and most important of these is the need to have *a safe space to tell your story*. The importance of this cannot be overstated. Equally, the lack of these healing, story-telling spaces in our culture and communities cannot be overstated. Any healing of such crises of the self begin with telling your story. Perhaps most important of all are the stories we tell

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ourselves, our self-talk stories. But these stories are also much of the problem that we are struggling with. They are often confused and wounded stories. These stories, such as memories of past pains and/or fears of uncertain futures, can be the source of our crises or at least what gives them life and energy as we struggle with them today. This self-talk is part of what we all do regularly to heal life's little, and not so little, injuries. But sometimes we need help with these stories.

This might be the help of a professional counsellor, which we will look at in the next chapter. But for now we just note that any counselling begins with the telling of your story and that much of the counselling process aims to 're-write' these stories so that they don't cause so much pain. Before we seek professional help, though, we will probably share our stories with family and friends. Again, we do this all the time, and much of the healing that is possible from this comes from just the sharing itself and not necessarily from the advice we might receive from these friends (or other 'counsellors'). What we do need when we share these stories is an attentive listener. This attentiveness, which I sometimes call 'honest listening', is a very special skill. Although we all have the capacity for this, it is a subtle and in some ways a mysterious skill that we can always get better at. Women are typically better at this than men. Some people are particularly gifted and are naturally talented counsellors. We can learn and practise and develop this skill, though I suspect the most gifted are born with it rather than learn it. It is a very special gift.

One of the essential features of this 'honest listening' is to first accept the person *as they are*. None of us can ever truly know the reality of any other. To accept a person as they are, without judgement, is to respect their reality, no matter how chaotic, confused or incomprehensible that may seem. Sometimes parts of the other's stories may resonate with us and we experience an immediate *empathy* with them. At other times this resonant empathy will be absent and we are face to face with the mystery of another person's reality. Skilful, honest listeners will recognise the differences between these occasions and will not feign an empathy when none exists. This is so important, as few things are more frustrating – and less therapeutic – than false empathy. And when we are going through an intense, highly charged personal crisis, we often become very sensitive to artificial empathy even though we might seem to the observer to not be in touch with our feelings at all. There is a bit of a joke among the mad that "just because I'm mad doesn't mean I'm stupid". To feign empathy is as harmful or worse than that other well recognised obstacle to meaningful dialogue, phoney sympathy (false pity).

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This honest listening is vital not only for empathy. It allows ‘all of me’ to be present in any conversation or dialogue. This all-of-me, even if I am not in touch with it particularly well myself at the time (often the case in therapy), is the very me, the self that is in crisis. A huge part of my feelings of suicidality was a peculiar feeling of invisibility. Little did I realise that it was actually my invisibility to myself that was at the core of this. But so often I also felt invisible, or only partially visible, when I sought treatment. That is, I felt that only certain parts or aspects of me were visible to the counsellor/therapist. Sometimes this was not so serious, perhaps even necessary in order to focus on specific issues, but at other times the very narrow perceptions of the therapist were harmful, even abusive. We will meet examples of this in the next chapter. Of all the professional counsellors, doctors, psychologists and other therapists that I encountered during my four years of madness, there was only one, a woman called Nicky, with whom I truly felt that all-of-me was always allowed to be fully present. This is not to say that Nicky saw and empathised fully with all of me – for that to be true she would probably need to be suicidal herself. Nicky simply allowed all of me to be present in all its confusion and mystery. What she couldn’t see or couldn’t comprehend was still invited into our sessions together. Whatever arose could be discussed, debated, even contradicted and argued against. But never banished. Another way of saying it is to say that no part of me was denied a presence with Nicky. This was truly great ‘honest listening’.

In order to tell our stories, with all of me fully present, we need a space that is *safe*. If we are in crisis then we are unlikely to be forthcoming with our stories unless we feel it is safe to do so. With suicidality this is particularly acute because of the feelings of helplessness and hopelessness. This is exacerbated by the shame, fear and ignorance – the taboo – around suicide, which we know will likely be present in any conversation we might attempt about our suicidal feelings. All of me cannot be present when the biggest issue on my mind at the time, my suicidality, is being denied or avoided. If we feel this happening, then we will probably retreat further into the ‘closed world’ of our suicidality, remain silent and the crisis deepens. There are very few safe spaces where we can talk about our suicidality. One particular safety concern is the hazards around the one-on-one, behind-closed-doors space that is typically the therapeutic space adopted by many counsellors. In this space, another individual, who we do not know at all, enters our private and often secret worlds at a time when we are particularly vulnerable. This is an inherently risky space. We would like to trust the professional qualifications of these people and believe that it

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is safe to tell them our stories. But if all of me is not allowed into this space by the therapist – who owns control of the space in this unequal relationship – then this secretive, closed space can be very dangerous indeed (as we will see in the next chapter).

This *safe space to tell your story* is the very foundation of AA/NA. It exists in the meetings of the fellowship. The genius of its founders recognised that ‘sharing’ was in itself healing and that anonymity helps to create a safe space where all of you – all of me and all of us – can be present. The culture of these meetings is that we do not judge or advise others after they have shared; we just listen. Honest listening. We learn to listen with an honest ear. Empathy naturally arises in this space, but there is also no room in this space for false empathy. Along with the sensitivity that comes from recognising mutually shared problems comes a ruthless honesty that does not allow for artificial pretences for very long. Finally, this space also has the safety of numbers. There are no closed-door, secret, one-on-one relationships with all the hazards of the ‘transference’ and ‘counter-transference’ that counsellors are so wary of. The many heads and hearts at an AA/NA meeting, however, bring a richness of culture that is impossible in a private consultation between two individuals. A group of your peers also acknowledges your struggle as you recognise that you are not altogether alone, that others have been here in this space before you and are with you now. As well as a safe space, it is also an inherently destigmatising environment. You learn that you do not have to suffer in solitude – unless you choose to – and toxic loneliness becomes a little less toxic.

The other main feature of AA/NA is its 12-Step program. The main aspect of this that I wish to focus on here is that it is an unabashedly spiritual program. For some reason this triggers much confusion and prejudice about AA/NA, especially among its critics. The essence of this spirituality is to acknowledge some Higher Power and to look to this for guidance in your struggle against addiction. We do this by recognising and accepting that we have demonstrably failed in our own attempts to overcome our addictions. This is all the spirituality that the program speaks of. They do use the word ‘God’, which can be an obstacle for many, including myself, but as we saw in the narrative this notion of God, or Higher Power, can be whatever you want it to be, such as the fellowship itself or even a tram. The key to this Higher Power is to recognise some power, strength or force in the universe that is larger than your individual self and which has the capacity, the power, to beat our addictions. Some people see this power as a religious God, others see it as Mother Nature, still

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others relate to this notion best as some form of Higher Self. There are many ways of approaching this Higher Power or Spirit.

Entering into relationship with this Higher Power, and humbly acknowledging our own failures, we are invited to 'surrender' to this power. This surrender is definitely not the 'giving up' that would probably lead us back to our drugs (or suicidality). Nor is it a blind-faith belief in some supernatural father figure. It is an opening up to the deeper mystery of life. It is to let go of and transcend our attachment to the self-centred ego of the mind and all the battles we have with this ego. It is an invitation to allow into our lives a power and an experience that comes from beyond the individual self. If we dare to accept this invitation then many of us find ourselves in the embrace of a mysterious, loving and healing universe or spirit – a universe from which we all arose and of which we are all part. This is the Spirit of this Higher Power (or God) that breathes life into us all and can, if we allow it, lead us to recovery. From our addictions. And from suicidality.

One other acknowledgement I would like to make to the founders of AA/NA is that they pioneered the notion of 'recovery' from addiction, and that recovery is possible for everyone. Recovery is not seen solely in terms of physical health or the absence of illness. Recovery considers the whole person – body, mind and spirit – and also our relationships with family, friends and community. Recovery is more holistic, being concerned with the whole of our being and our personal sense of wellbeing. It does not assume that healing is necessarily about eradicating disease and is not as 'treatment' oriented as the medical approach. Recovery can mean becoming intimate with your suffering and learning from it, growing into a greater fullness, a more complete sense of wholeness and a deeper experience of life. Recovery emphasises personal growth rather than illness.

I am constantly amazed at the criticisms made of Alcoholics Anonymous. The most common one is that it replaces one addiction with another. The people who make this criticism usually call this other addiction an addiction to religion. They use this term to suggest that it is a blind faith belief in some artificial, false, supernatural deity. First of all, this is far from the spirituality of AA/NA (or this book). But even if this were so, I am stunned that these critics put such an addiction in the same class as drug addiction. Even if it is such a simplistic spiritual addiction as we are being accused of, is this not vastly superior to the drug addictions that brought us to AA/NA? At meetings you will hear many stories of sickness, crime, cheating on friends and families for drugs, poverty and waking up in

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the gutter in a pile of your own vomit. You will also hear many stories of people who, having embraced the 'addiction' to their Higher Power, have restored their physical health, repaired broken relationships, have resumed work or studies and now have hope and possibilities in their future. And yet the critics somehow regard these 'addictions' as comparable.

I have heard this criticism of AA/NA mainly from doctors. I see this as their denial of the effectiveness of the program, which seems particularly unfair in the face of their own poor record in treating addictions. This is highlighted by the fact that many who come to AA/NA only do so after the doctors have given them up as hopeless cases – or 'treatment resistant', to use the medical jargon. It is true that AA/NA is not the only path to recovery and that it is not suited to everyone. My own story speaks of this. But the principles behind the program do work for many and they work for very good reasons, some of which I have highlighted here. Fortunately, these criticisms from ignorant doctors are a source of much mirth at meetings, for AA/NA is deliberately and diligently independent of any of the professions. Each meeting is its own, autonomous, financially independent *peer support* group, another strength of the fellowship that makes it impervious to the prejudices of the medical profession.

There are other criticisms about AA/NA, such as the use of the 'disease model of addiction' that you will often find talked about at meetings. I share this criticism and I will explain why in a moment, but my understanding is that this 'disease model' was not in fact part of the original AA program, though I'm not sure how it seeped into the AA/NA discourse over the years. This model says that addiction is a disease, in particular a disease of the brain, and a progressive and incurable disease at that. There is also a strong implication that this disease is genetic, or at least largely so. If you have this genetic disease, the logic of this argument continues, then after it's triggered (by taking drugs or alcohol), you will have the disease for life. Moreover, this disease says that you are an 'addict' so that you will always behave addictively to any mood-altering drug. Once an addict, always an addict. I was taught this model of addiction at some of the detoxes and rehabs I went to, most notably the one at Warbuton, and tried hard to accept that it was true and that I had this disease. But in the end I simply couldn't, which the same model then interpreted as denial. This model explains the bullying behaviour of the boss of the Warburton unit. My 'real problem', in his view, was this disease, not my suicidal crisis of the self (which I was unable to articulate well at the time), and my inability to find addictive behaviour in my drinking was merely a symptom of my denial of this disease.

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I hesitate to completely damn this model for a couple of reasons. The first is that there is no doubt that there are some biological factors in a person's *susceptibility* to addiction. Some people seem to drink and drug heavily for years without falling into serious addiction problems, while others seem to fall into it almost from the very beginning of their drinking and drugging career. There are indications that this susceptibility is to some extent inherited and that maybe some ethnic groups are perhaps more sensitive to alcohol and/or drugs. But this is not sufficient to call it solely a biological disease. We will meet this again when we look at 'mental illness', but the obsession with looking only to biology as the sole source of various behaviours fails to consider our psychological, social and spiritual needs. There is a saying that if the only tool you have is a hammer then everything looks like a nail. I once translated this for my doctor, who sees psychology in mainly biochemical terms, saying that if the only knowledge you have is biochemistry then everything looks biochemical. The narrow, shallow and simplistic ignorance of the full depth of the psyche, in all its mystery and subtlety, has become an arrogant and harmful pathologising in modern psychiatry.

Another reason I hesitate is that I have met many people who have taken great comfort from learning that their addictions were a biological disease. This might seem odd at first, to be grateful to learn that you have a progressive, incurable disease, but for many it truly is a great relief. Again, there are many parallels here with 'mental illness'. For those of us who struggle with these difficulties – either addiction or 'mental illness' problems – we can easily feel that it is because we have some terrible character flaw or that we are in some way 'bad' people. The pain we suffer and the troubles we get into undermine our sense of self and we can easily feel a deep sense of failure. It can be reassuring, therefore, to learn that you have a disease, and that all your suffering comes from some biological malfunction. That is, it's not *your* fault. This can help us let go of our self-blame, shame, and deep sense of personal failure and, from there, we can often proceed with recovery.

So it is with some hesitation, and even some sadness, that I have to say that the comfort we get from this 'diagnosis' is in fact based on a false belief. The path to recovery for so many people has commenced with this false belief, so it seems unfair, almost cruel, to challenge it and undermine this seemingly therapeutic false belief. My 'bottom line' criterion for any therapy is whether it works, so if people are liberated from their suffering by false beliefs then that's fine with me. Up to a point. These false beliefs, unlike the truth, can also be harmful. When the boss at Warburton denied

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my suicidality and insisted that I believe what I was unable to (because it wasn't true), this was abuse, and a potentially dangerous abuse. Similar abuses based on false beliefs are now widespread in modern psychiatry, which has become dominated by the false and illegitimate belief of biological psychiatry that all 'mental illness' is a disease of the brain.

It seems almost ironic to be accusing the doctors of false beliefs when I am arguing for spiritual beliefs which are so often challenged as illusory (i.e. false beliefs) by many doctors, scientists, rationalists and other sceptics. It can seem that there is an unbridgeable gulf between these apparently fundamental, opposing views. But the gap must be bridged and, I believe, it can be. This urgent question is examined in later chapters.

Another criticism of AA/NA that I hear is that it is coercive, tantamount to a form of brainwashing, as people are 'seduced' into a new addiction to spiritual belief. This was not my experience of AA/NA. I suspect this criticism has arisen alongside the emergence of the broader 12-Step 'recovery' movement, which has become fashionable to the point of faddishness in some quarters. Some of these programs seem to be more commercially motivated – recovery programs can be very lucrative business. This is totally contrary to all the principles of AA/NA. But when the marketplace latches on to a good idea and sees business opportunities, then slick marketing and coercion are likely to appear. This modern day commercialisation of spirituality by the market parallels the institutionalisation of spirituality by religions. With similar consequences. Spirit is lost when the greed for personal wealth (commerce) or social power (religion) takes over as the primary motivation. It is right that these criticisms are made of the unethical appropriation of 12-Step programs, but in my experience they do not apply to the AA/NA that I know, neither in their principles nor in their practice.

Another criticism, more of spirituality in general rather than AA/NA specifically, is that it is escapism. This has some parallels with the 'substitute addiction' criticism, but is an intriguing perspective to explore for the questions it raises about our sense of self. Drug use itself can be seen as a form of escape, sometimes called 'self-medicating', which was certainly true in my use of heroin. I used it to escape the pain of being me. Such escapism is commonly seen in fairly derogatory terms, but we all 'escape' from our lives regularly, in many different ways. We 'escape' when we take a holiday or go to the movies or perhaps through adventure sports or other pastimes. We 'escape' through a whole variety of drugs, some of which are legally and/or culturally endorsed. We 'escape' through sexual activity, sometimes addictively. We 'escape' into a different reality

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through the great spiritual contemplative traditions of prayer or meditation. And each night, we 'escape' into sleep, another consciousness, another reality, but unquestionably a necessary escape. Some psychologists see such escapes as essential to a healthy sense of self and something that we must all do regularly to sustain a healthy self. These essential escapes can become harmful (pathological) if indulged excessively (addictively), but they are not automatically or necessarily so. Indeed, it is argued that a life without these regular escapes will become pathological in other ways. This is an interesting and useful line of enquiry, but I won't pursue it further here other than to pose the intriguing questions of what is it we are escaping *from* and/or what is it we are escaping *to*?

As this book now moves away from the drug story and in the direction of mental health, it is useful to look at the curious relationship between these two areas. In recent years we have seen the emergence of what is called 'dual-diagnosis'. This is the terminology now being used to refer to those who have both mental health and substance abuse problems, which is being recognised as more and more common. It is almost a joke – a sick joke – among users of addiction and/or mental health services that you will be rejected from the addiction services if you have a mental health problem and rejected from mental health services if you have a drug problem. Each says that you need to go to the other service (first). Many people, particularly the young, are falling between the gaping cracks between these services. These cracks are there partly because each service recognises that it is not well equipped to deal with the other problem. But it also reflects a deeper rift between these services.

With hindsight, I find it curious how few psychiatrists I encountered during my journey through the drug rehabs. And when I did speak to psychiatrists about my 'depression' and suicidality it was striking how uninterested, and at times even scornful, they were about my addiction problems. Psychiatrists, it seems to me, don't really want to deal with addictions. And drug rehabs, the good ones, don't want psychiatrists drugging their clients. It is this cultural schism between the different types of services, rather than the so-called 'comorbidity' of two diagnoses in the one individual (who probably sees them as just the one problem or perhaps two faces of the same problem) that lies behind the inadequate response to dual-diagnosis.

My main concern as dual-diagnosis becomes more recognised by policy-makers, is that recovery-oriented drug and alcohol services are being taken over and colonised by medicine and psychiatry. This colonisation can be seen even in the term 'dual-diagnosis', which would medicalise addiction in

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the way that mental health has been colonised by medicine. This could well lead to the ridiculous situation of giving someone with a drug problem some other drug under the guise of 'treatment'. This would be a big step backwards in our response to drug and alcohol problems.

One of the features of most addiction recovery programs, with the exception perhaps of those in medical/hospital settings, is that many of the staff on these programs have themselves been through addiction recovery. In the case of AA/NA that includes everyone in the fellowships, but the usual notions of 'staff' do not apply here. At the Geelong detox, Warburton, The Buttery and many other detoxes and rehabs, many former alcoholics or drug users are on the staff, often in leadership positions. There are many benefits of having people on staff who know the addiction experience 'from the inside'. A greater awareness and understanding of the issues an individual is facing in their struggle for recovery seems to be effortlessly present. A natural empathy, if you like. But this empathy is never a false sympathy, for those with their own history of recovery are all too aware of the many games that clients can play to avoid confronting their addictions and other issues. They know because they have probably already played these games themselves. Such street-smart staff are very quick to spot these games and can be very firm, almost harsh sometimes, in bringing them to your attention. Equally, this recognition by clients of a shared experience with staff prevents most of these games arising in the first place and enables a more open and honest communication. It also goes a long way to overcoming the toxic feeling of being so alone in your pain and struggle. Others have been here before you, and you can see that recovery is possible because it is standing in front of you, talking to you. Without judgement, with respect, and with a genuine compassion and, indeed, love. This is a powerful culture for healing.

The extent of the drug problem over quite a few years now has led to much knowledge and experience in how to assist people towards recovery. It remains a tough challenge with no guarantees of success, but there are some very good programs, just not enough of them. Strong peer support is a characteristic of all the best programs – such as the AA/NA fellowship, the support of fellow clients in these programs, various kinds of support groups after leaving the program, or former users on the staff of services. In many ways the models for the 'treatment' of addictions are superior to the treatment models we find for other psychosocial health problems, such as the medical 'mental illness' model. They represent some of the best examples of the (bio)psychosocial approach in actual practice. I can't help

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but wonder whether it is the absence of psychiatry from these programs that is the difference? But this is the story for the next chapter ...

Chapter 4

The 'Mental Illness' Circus

There are some things in our social system to which I am proud to be maladjusted and to which I suggest that we ought to be maladjusted. The salvation of the world lies in the hands of the maladjusted.

(Martin Luther King Jr)

My first encounter with mental health services (as opposed to drug addiction treatments) was with a psychiatrist not long after I had called out to my sister for help back in late '95. He came highly recommended by someone whose opinion I trusted. I called to make an appointment and had the first of many difficult lessons in psychiatry.

The first time available to see him was something like three weeks away. But I was calling because I was scared that I might not survive the next day or so. I didn't mention this as it felt too melodramatic and pathetic and, I guess, too embarrassing to say over the phone. Full of uncertainty, I made the appointment anyway. My situation deteriorated and I was getting very frightened about my growing suicidality. I was thinking about little else. One night I was feeling so distraught and unable to sleep that I called some emergency number (I don't recall which) who contacted the Crisis Assessment and Treatment Team (CAT Team) on my behalf.

They must have been having a quiet day because, before too long, two CAT-people turned up, a guy and a woman. I was impressed with how skilfully they handled me. They talked me down from the fear I was feeling and we discussed a strategy to get through just the next 24 hours. When I said I had an appointment with a psychiatrist but it was still over a week away they said they would contact him. They left saying they'd be in touch the next day and I was calmed down sufficiently to be confident that I could wait until I heard from them. Which I did, the next day as promised, when they told me they had spoken to the psychiatrist and that I had an appointment for the

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following day. I never saw my CAT friends again and don't remember their names. But I'm grateful for their visit that night.

The psychiatrist worked from home and he first reassured himself that I wasn't manic and didn't need any heavy sedation - I think he mentioned Lithium. We talked about anti-depressants and after the second or third session I agreed to try Aurorix, my first psycho-medication. It didn't have any noticeable effect and we figured it was probably due to the fact that I was still using heroin pretty regularly. Another psychiatrist a year or so later referred to this drug as "lollies".

Nothing really happened during the 8-10 times that I saw this psychiatrist. Or nothing of any significance that I can recall. He seemed to be waiting for the Aurorix to kick in, but it never did. I do recall, though, that he answered his mobile phone at least two or three times in each session I had with him. At around \$120 per 45 minute session I thought this was a bit rich, but I was too polite to have a go at him about it. My first lesson in modern psychiatry.

It was probably not long after this that I started seeing Nicky. Nicky is a very special character in this story. She is neither a psychiatrist nor a psychologist but does professional development work in the corporate world that includes, I think, some individual counselling, plus she sees just a few private individual clients at home. As a friend of my sister, I had known Nicky for several years and it was with Nicky that I'd had some brief relationship counselling with my partner before it all fell apart. Nicky is special because, after my suicidality and heroin addiction finally passed in 1999, she was like the single thread of sanity woven through those four horrible years; of all the people I sought help from, it was only with Nicky that I never, not once, felt invisible. With Nicky, all of me was always allowed to be fully present. My broken heart, my suicidality, my heroin use, my fears and doubts and pain, and also my soul and my confused and chaotic spirituality at the time - all of me was always welcomed into the sessions with Nicky even when she found aspects of this bewildering to her. Nicky has many special gifts but none greater than her generous capacity to simply 'bear witness' and be with me in my madness and to hold and embrace its chaos with respect and without judgement.

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Nicky made it clear at the outset that neither drug addiction nor crisis counselling was her area of expertise. But she was willing to see me and support me as best she could while I looked for some other counselling which might be more specific to my needs. In the end, such a counsellor was never found and it was Nicky who was still there for me when freedom finally arrived nearly four years later. Despite this, Nicky would never say that she was my saviour, or that she rescued or cured me. Like me, she would see all these as silly ideas that get in the way of meaningful personal growth - call it therapy, if you must.

Apart from Nicky and that first encounter with psychiatry, the emphasis of the first year or so of 'treatment' was primarily the drug addiction detour of the previous chapter. My next encounter with psychiatry came after fleeing The Buttery, the drug rehab in northern New South Wales. After chickening out yet again on another plan to kill myself, I made my way to Port Macquarie Base Hospital, looking for a psychologist called Phil who had been recommended by a friend from nearby Wauchope. As a consulting psychologist to the hospital, Phil was not there all day every day, and to see him at the hospital I had first to go through the admission assessment process of the hospital's psych unit. I don't recall whether I was actually seeking to be admitted - maybe I was. I was certainly looking for some refuge from my lost world. Anyway, I was assessed and admitted, but before eventually getting to see Phil I was seen by the psychiatrist in charge of the psych unit.

This psychiatrist immediately diagnosed me with 'depression' and recommended an anti-depressant called Aropax - this was the guy who thought the Aurorix I'd previously taken were "lollies". This time I was reluctant to take anti-depressants, I think because I felt a sense of failure resorting to the drugs, which sounds pretty silly given the state I was in and the illegal drug that I was self-medicating with. I was not vehemently opposed to them on principle, I just wanted to try and work things out without them if possible. In particular, I wanted to at least try some counselling with Phil first. This psychiatrist was clearly scornful of Phil's 'talking therapy' and I guess I reacted a bit to his pressure to take his drugs. He was quite pushy and also a pretty smug and unpleasant person, which may have influenced me too. When I

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finally decided to not take his drugs he in turn decided to discharge me from 'his' psych unit. But by then I had made contact with Phil and I liked him.

The few days in this psych unit (less than a week, I think it was), together with the time with Phil, managed to calm me down some so that my suicidality was not burning hot within me like it was when I was admitted. After a short while with some local friends, I headed back to Melbourne, but I picked up the heroin again and it wasn't too long before I found myself doing another detox, this time in a posh private hospital. It was this detox where I first met the terrific doctor who on a later occasion put me on the Methadone. After this particular detox and with the assistance of another friend, I went to a yoga ashram in the country where I lived very happily (most of the time) and drug-free (most of the time) for the rest of that year. I'll tell some of this story in another chapter.

The story here resumes in late 1996 after I'd left the ashram to go to a spiritual retreat to hear a woman called Gangaji (who we'll meet again later in this story) in Murwillumbah. After six months in the ashram I thought I was fine, but in the couple of weeks it took me to get from the ashram to the retreat I was back on to the heroin again. It was hopeless. I was hopeless.

On the second night at this retreat, I woke up in the middle of the night silently screaming for no more of this wretched life, feeling overwhelmed with the necessity to die now, right now. I had neither a plan nor the means to kill myself, but I just wanted to die so much. All I could find in the tent with me that might possibly do the job was my razor. I had never deliberately cut myself before - this was brand new territory for me. Today I laugh at the comical side of this when I think of how unlikely it is to cut yourself to death with one of today's modern twin-blade razors. I did manage to make quite a mess of my arms, but I was never going to die this way.

When I woke up after finally collapsing from the physical and emotional exhaustion (and a little Valium), I sensibly figured that I should get some medical attention for my arms. When I showed them to the organisers of the retreat they recognised what had taken place and gently but urgently arranged for me to go to the hospital in nearby

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Lismore. While waiting for assessment by the psych staff, I took off. I headed for Nimbin, determined that *this* time I would finally do it properly.

It took no time at all in Nimbin to purchase a couple of hundred dollars worth of good, strong, cheap heroin. More than enough for the task at hand. I treated myself to just a regular dose as I made preparations to take the rest in one shot. It was not the first time that the relief of the heroin high gave me pause to think again about what I was about to do. I could possibly argue that this self-medication with heroin stopped me from going ahead with my suicidal intentions on numerous occasions. Although there is certainly some truth in this, it's also true that this was not the only reason for my ambivalence. And I'd rather not endorse or encourage the use of heroin as an anti-depressant - it truly does create far more problems than it solves.

But in this pause, I heard a voice, or perhaps I just recalled what this voice had said to me some time before. It was the voice of Phil, the psychologist from Port Macquarie. I can still vividly recall his words that came back to me in Nimbin while preparing my final hit. They were simply "if you find yourself thinking of having a go at yourself, please come and see me first".

It's funny what sticks in the mind or comes back to you at certain critical moments. Another similar remark was made some years later by my GP at another critical moment. He simply said, "Please don't die". Like Phil's request, I think the significance of these two requests comes from the trust and respect I had for the two guys who spoke them. I could actually feel their concern and their caring for me in these utterances, something I never felt with any of the psychiatrists that I saw. I also think that these heartfelt but simple requests indicated an acknowledgment by these two guys that they both knew that ultimately they were powerless to stop me from killing myself. They both wanted to help but they also knew that in the end it was my decision. There is an honesty and respect for me in this that I did not often get elsewhere and which was really precious for me, maybe even life-saving.

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When Phil's words came to me, and perhaps with the help of the heroin again, I hesitated. Before long my doubts were approaching life-saving proportions. I wondered how I might get to Port Macquarie. Would I be able to find Phil? What would happen if I went and was there any point to making such an effort? And then I realised that I couldn't go through with my suicide plan, that while there was this doubt I had to give it a chance. Aware of the finality of suicide, part of me felt that it was probably important to exhaust all possibilities before taking that final step. So, fortified with heroin, I took a cab then a bus then a train to Wauchope and then the local school bus to the Port Macquarie hospital.

I was dazed, very stoned and exhausted when I approached the psych unit and asked for Phil. The staff at the desk said that Phil was not there until later in the day, and that I would again have to be assessed by the medical staff first. It was early in the day and I was asked to wait, so I went outside to the courtyard to have a smoke. I sat there for some time, unknowingly getting quite sunburnt in my stoned daze. After a while some staff came out and started setting up the barbecue for a staff lunch. I sat there watching. Finally one of these women asked me what I was doing and I said waiting to be assessed for admission. Her face dropped as she realised they had forgotten about me.

The assessment was pretty straightforward as I was clearly in a bad way (and now sunburnt as well). Except it was pointed out to me that I would first have to do a detox in the hospital ward before going into the psych unit. This was the detox mentioned in the last chapter where I was required to take more Clonidine than I could handle and had to pretend to take it. It was also the occasion for another of my clumsy, half-hearted and embarrassing suicide attempts, when I tried to hang myself on the shower hose in the hospital bathroom.

About a week later I was transferred to the psych unit and this time I surrendered to the urging of the psychiatrist to go on the anti-depressant medication. I say surrendered here quite deliberately as the first reaction to this decision, well before any effect from the drug, was that I felt some relief to have finally abandoned my own efforts to save myself. I simply had to admit that I was bewildered

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and failing in my own attempts to sort things out, so I surrendered myself to the advice of the experts. In a peculiar way, admitting that I really was the complete misfit that I was afraid I was, actually turned out to be something of a relief. For a little while.

I spent about three weeks in the psych unit this time. This was to monitor me - i.e. keep me safe - while waiting for the Aropax to start taking effect, but also to watch for any side effects. There were no noticeable side-effects but there were no noticeable therapeutic effects either so the dose was increased. The psychiatrist told me one side-effect that people reported on this drug was that they sometimes found themselves not caring so much about some of the things they normally used to care about. I joked, "But doc, isn't that why I'm here in the first place?"

This was my longest stay in a psych unit and one of the biggest problems in these places is how unbelievably boring it is. This is recognised by the doctors and nursing staff but nobody does anything about it. Very occasionally one of the nurses would bring out a board game or some cards. Even less often, some pretty lame efforts were made to do activities that are supposedly therapeutic. But no-one is much interested in them, including the nursing staff. The 'library' was a tiny and tattered collection of things like Readers Digest abridged versions and frayed waiting-room magazines, of which I read as much as I could stomach. Meals, TV and the medication rounds were the highlights of the day. It felt much like a child-minding centre as we sat back and waited for the drugs to do their magic. The nursing staff were as disgruntled and bored as the patients. One of them complained to me that this unit had not yet been registered to take involuntary patients and it seemed to me that he was saying that 'real' psychiatric nursing required involuntary patients.

The psychiatrist did his round of the unit each day which meant that you had a few minutes with him where he'd maybe fine tune your medication. And, importantly for me, I had a session with Phil every couple of days. The psychiatrist was clearly still scornful of Phil and his counselling, but now that I was being obedient and taking the medications I was not asked to leave. After three weeks, though, it was time to go. I had calmed down considerably over this time, which

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the psychiatrist attributed to the anti-depressant. I didn't really feel any noticeable effect from the drug other than a slightly stoned dullness, but I attributed most of this to the intense boredom of the place. I was ready to leave.

I decided to go and live with my friends in the forest inland from Port Macquarie. I didn't want to live in a big city and I felt that I'd got all that I could from the ashram. I was ready to move on rather than return there. I also wanted to keep seeing Phil. So, after a trip back to Melbourne and the ashram to pack up a few of my things, I moved in to the rustic but for me quite idyllic life in the hills among the trees. I spent a year here, living healthy and getting strong again. I was taking the anti-depressant medication and seeing Phil once a week in Port Macquarie.

I wanted to see Phil because I knew that my inner discontent was still far from resolved. In the peace and tranquillity of my secluded, rustic lifestyle, I was not actively suicidal but I was aware - or at least semi-aware - that I was still hiding from a world that I did not want to be a part of. I'm sure that some people saw my apparent calming down as me finally coming to terms with my broken heart that had triggered this whole sorry saga in the first place - maybe I was simply growing out of it at last. I'm equally sure that some others, such as the psychiatrist who prescribed the anti-depressants, saw this apparent improvement as due to the medication. But I knew that I was still troubled and hoped that I could work through some of these aching questions with Phil.

The first and most important thing about Phil is that he was a very decent and caring man. His concern and compassion for me was evident and genuine. He was honest with me, including listening honestly without judgement, and not feigning any false empathy. A mutual trust and respect developed quite quickly between us, which remained throughout the year that I spent with him. He showed a genuine commitment to helping me, including adjusting his rates for me so that I could see him as frequently as I did. He did not pretend to have any magic wand that could cure me but energetically applied his professional skills to help me unravel whatever it was that seemed to

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be haunting me. I greatly appreciate his efforts and remember this year with him fondly.

It seems to me that it should be unnecessary to highlight these admirable qualities that I found in Phil. Surely it's reasonable to expect these from anyone we approach for help with mental, emotional and/or spiritual problems. But I do feel it necessary to draw attention to the compassion, sensitivity and honesty of Phil because of the extraordinary absence of these qualities among the psychiatrists that I sought help from.

I cannot say which particular school of psychology Phil practised. I now know that there are many different approaches to psychotherapy and I suspect Phil mixed together a blend of these according to what he felt might be most useful for me. Now that I'm familiar with cognitive behaviour therapy I can see that at times he was clearly working with these techniques, where we look for negative thinking patterns and try and nip them in the bud and cultivate other, more positive thoughts. This is effectively re-writing the scripts we use to respond to life's circumstances, which can be a very useful method for changing these patterns of negativity. At other times he was clearly practising some 'deep psychology' techniques, delving into the unconscious and subconscious motivations for my behaviour looking for the source of my pain. We also looked at my history of relationships - interpersonal therapy - with family, friends and workmates as well as past lovers. Much useful territory was explored.

An important feature of Phil's professionalism became apparent when I talked with him about spirituality. First of all, he was respectful of it and in principle endorsed the legitimacy and potential benefits of the spiritual quest. But he was explicit that he was a psychologist, not a spiritual guide. He listened attentively and supportively when I talked of yoga and meditation and other aspects of my spirituality, but he rarely responded to this and certainly never gave anything that you might call spiritual advice. He was very clear about what he saw as the boundaries of his expertise and what he was able to offer in this therapeutic relationship. I admire Phil enormously for this - both for his clarity about his role and for his honesty with me about that.

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But, after a year of weekly counselling sessions, we never got to the core of my despair. The last time I saw Phil must have been very sad for him. I had decided to return to Melbourne, but in just one short fortnight in Port before leaving the district I had already picked up the heroin again and my suicidality was again percolating away inside me not far from the surface. I was clearly a mess again and Phil would have seen this. I thanked him for all his help and, with my own sadness, bade him farewell. Despite this lack of 'success', I am unable to be critical of his genuine and compassionate efforts on my behalf.

The same cannot be said for my experiences with psychiatrists. We have already met two psychiatrists in this story so far - one who answered his phone during counselling sessions, the other who was disdainful of Phil's talking therapy. These are relatively minor abuses of the therapeutic relationship, but nevertheless indicative. In the final year of my journey to recovery (roughly mid-98 to mid-99), I was to have encounters with four more psychiatrists. Two of these were brief, but still need to be mentioned for what they reveal. The other two were significant abuses of the trust that I placed in these men when I sought their help. Of all the non-psychiatrist counsellors and therapists I sought help from - my GP and the Methadone doctor, Nicky and Phil, and numerous drug counsellors - the only one who responded with such abuse was the head of the drug and alcohol unit at Warbie who denied my suicidality as "bullshit". But all six of the psychiatrists I met over these four years were in some way abusive towards me. Sometimes in minor ways, as with the first two, but at other times in quite serious and dangerous ways.

But first, a little more of the journey that led me to these people.

It's now early 1998 and I've left the forests of NSW and the counselling with Phil. I wanted to be at my dad's 80th birthday but picked up a pretty full-on heroin habit on the slow road back to Melbourne. I managed to make it back in time for my dad's party and also managed to present a reasonably calm face at this wonderful celebration. But I knew I was in trouble, so a day or so after the party I sought out the drug and alcohol doctor that I knew and liked and trusted from previous detoxes. He again suggested the Methadone and again I declined, but I did yet another hospitalised detox.

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While still in hospital I saw the psychiatrist who would later certify me and send me to Royal Park after a suicide attempt. On this occasion we talked through the options and I agreed to go back on the anti-depressants again. I'd stopped taking the Aropax when I left NSW because I didn't think they were helping and I didn't like the side-effects, mainly the 'sexual dysfunction'. He may have thought that my falling into the heroin again was because of this but he was decent enough not to say so.

He suggested I try one of the newer drugs at the time, a drug called Efexor. Normally when you start on one of these drugs you begin with maybe half the recommended full dose to see if that's sufficient for you and also to see if you might have any side-effects. Given my history and my rather desperate state, this guy recommended that I start at the full adult dose, to which I agreed. After a couple of weeks there was no really noticeable therapeutic effect, but nor were there any significant side-effects. So we doubled the dose and there was an almost immediate effect. I could not sleep. After about ten days with a total of maybe ten hours sleep, I called the psychiatrist and insisted that I could not continue with this and had to see him.

We considered the possibilities. First, we could switch to another anti-depressant. It is well known that some people respond to some anti-depressants while others do not. Side-effects are also equally unpredictable. So 'shopping around' for either maximum benefit and/or minimum side-effects is a common practice. He was reluctant to do this though because there was a window of time between weaning off the current drug and the new drug kicking in, which he thought might be a risky time for me. The option he recommended was to add another chemical to my drug diet that he claimed would "augment the anti-depressant effect" of the Efexor. He described it as a catalyst that would boost the serotonin enhancing properties of the Efexor. This drug also had a sedative effect, which would hopefully help me to sleep. The drug was Zyprexa.

Zyprexa is an anti-psychotic drug that was developed for the treatment of psychosis and, in particular, schizophrenia. I asked the psychiatrist whether he thought I was 'psychotic' or 'schizophrenic'.

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He reassured me that I was not, and repeated why he felt this drug might help me - that it would augment the serotonin-boosting effect of the Efexor. When I said OK, I'll give it a go, he got on the phone for the authorisation required to claim this expensive drug on the Pharmaceutical Benefit Scheme (PBS). He gave them some details for the authorisation and then I heard him say "schizophrenia". After he hung up I asked what was that about? He said that the PBS expects this drug to be prescribed for schizophrenia and that it's easier to tell them what they want to hear. At the time we chuckled over this deception. But it's not so funny for me now.

I still wonder if there is a government database somewhere that has me recorded as having received treatment for schizophrenia. And if there is, what are the consequences that might possibly arise due to this wrong information? I still don't know. My GP tells me that access to the PBS database is very strictly controlled, but I'm not altogether reassured by this. I was once told that both the psychiatrist and I were guilty of defrauding the government through this deception. Maybe, but I do not accept much of the responsibility as I feel that I was deceived by the psychiatrist myself and far more seriously than just cheating the government of a few dollars.

This psychiatrist deliberately and knowingly deceived me in order to get me to take this brutal, brain-numbing drug. It is simply impossible that he was not aware of the broad effect and potency of Zyprexa or of his duty to inform me about this. To present it as just some 'catalytic serotonin booster' was a gross misrepresentation of this drug and a devious manipulation of my ignorance and vulnerability at the time. It is necessary to ask why he felt the need to resort to such a drug and such a deception? My answer is that he just didn't have a clue what to do with me, which became very clear nearly a year later when he certified me.

So he pulled out one of the big pharmaceutical guns to dull my brain and behaviour, the drug Zyprexa. Although the mind-numbing 'therapeutic' effect of Zyprexa was concealed from me, he did warn me of the most common side-effect of this drug. He said I "might develop a bit of a sweet tooth". This proved to be quite an understatement as I developed not so much a 'sweet tooth' but an addictive passion for

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ice-cream (which I usually ate only rarely) and in particular Cadbury's Top-Deck ice-cream topped with vanilla custard. As told in the previous chapter, the next eight months in this stay-at-home, switched-off, meaningless zombie half-life was seen as a good result by those around me, including the psychiatrist, rather than the build-up to my next suicide attempt that it actually was.

This deceptive coercion to take Zyprexa needs to be contrasted with the truly genuine informed consent that I gave when I went on the Methadone. My Methadone doctor was honest with me, gave me plenty of information about Methadone and the program that went with it. He answered all my questions carefully and thoughtfully, and was frank with me about the experimental nature of my going on it. Methadone did not work for me either, but I hold no grudges towards my Methadone doctor about that. Maybe the Zyprexa was worth a try as an experiment too, like the Methadone. But the fundamental legal obligation of genuine informed consent was not honoured. On the contrary, I was manipulated and deceived. One has to wonder, along with why I was deceived, whether I would have consented to the Zyprexa if I had been fully informed. Or are the answers to these two questions linked - that no-one would take such a drug if they knew the truth about it - and that psychiatrists know this.

To be fair to this psychiatrist, I should note that it was quite clear, and agreed to by me, that his role in my overall therapy program was never as an ongoing therapist or counsellor for my mental health issues. That is, the focus was still on my addiction problems and these medications were really secondary to and supportive of the primary goal of getting off the heroin. In discussing the psycho-drugs he prescribed for me (the Efexor and Zyprexa), he quite liked the metaphor I came up with that they were like the plaster cast you put over a broken bone to create a space in which the bone can heal. He never said anything as stupid as suggesting that these drugs fixed a chemical imbalance in my brain, as some psychiatrists do. He also knew that I was seeing Nicky for counselling, which he approved of and encouraged.

But I was not seeing Nicky very often by this time because I simply couldn't afford it. She had already been incredibly generous in

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adjusting her rates to accommodate me. I was on the pension by now, having blown almost all my accumulated wealth, mostly on heroin but also on seeking treatment and just living. Nicky was still of the view, and I didn't disagree, that I might benefit from some counselling with someone more skilled in crisis intervention and addiction than she was. Psychologists such as Phil were no longer an option as they could not be claimed on Medicare and I had already cancelled my private health insurance some time before. I had to look for a psychiatrist as the only affordable option and Nicky gave me the name of one she did not know personally but about whom she had heard good things.

I saw this guy just twice. At the second appointment he prodded into my history and pain, where he deftly stirred up the deep well of sadness in me. I started crying, he kept prodding, and it became a gasping sob. This was difficult for me because, like many blokes, crying in front of others does not come easily and is particularly uncomfortable when this becomes an uncontrollable, gagging sob. But I deliberately chose not to suppress it in this situation and allowed the tears to flow, wanting to believe that this emotional release was appropriate and even necessary for the 'therapy'. Then, quite suddenly, he looked at his watch, said OK, time's up, and got to his feet and left the room.

When he returned with his card swipe device for me to pay for the session I was still sobbing pretty uncontrollably. He looked at me and asked if I was angry with him. I was more preoccupied with my sobbing so I was rather surprised by this question. But it made me think that, yes, I was angry with him, and I said so. I swear I saw a glint in his eye that said he was pleased with this. As I went to leave, still sobbing, I saw my anger more clearly and turned back to him and said that I was not angry with him that he had brought on my tears. Rather, I was angry that he could provoke such tears and then finish the session so abruptly simply because time was up. He just smiled at me, said nothing and I walked out. As I drove away, I realised that it was too dangerous to be driving sobbing like this and pulled over until I calmed down sufficiently.

This psychiatrist had also told me during that session that he was retiring in a month (he didn't mention this in my first session with him

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the week before). He said he could see me once more, maybe twice, before then if I wanted. I do not understand psychiatrists.

My living situation was pretty chaotic during this period and I was hoping to move in with my sister. But this didn't work out, largely because of her understandable concerns about my drug use, so I thought about retreating to the ashram again. I headed off in that direction but delayed and spent a night in a country pub. I was back on the heroin (again) and the return of this whole horrible, all too familiar, pattern seemed pointless and I couldn't face fronting up to the ashram. Besides, an ashram is not a place to detox and I knew that. I returned to Melbourne with yet again the intention of killing myself.

I checked into a motel in Footscray and once more got myself a lethal dose of heroin and also a bottle of whisky to add to all my psycho-drugs. After nearly three years, this was to be the first properly planned and serious attempt that I went ahead with. I woke up in hospital a day or so later. I have no memory of what happened but apparently the motel staff let themselves into my room the next morning after the check-out time, saw me and called an ambulance. At the hospital my stomach was pumped with that awful charcoal stuff and other resuscitation measures were taken. Apparently there was a period when they were not sure whether I would come around or not and the doctors who revived me seemed almost as surprised as I was when I came to. They were not, however, as disappointed and furious about this as I was.

How awful for my family, who had been dreading for some years now that this day might eventually come. I heard later that most of them, as well as some of my friends, had had times when the phone rang and the caller started with something like "I'm calling about David". And they had all had the instant reaction of "Is this it? Is he dead?" My poor family and friends. The doctors also told my family (but not me) that they had some concern about possible brain damage from this suicide attempt. Not because of the heroin but because of the psycho-drugs I had also taken.

It was a horrible few days after I woke up. One doctor wanted me to promise her that I wouldn't do it again - the so-called 'suicide contract'. How absurd! I said to her that if I couldn't make that

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promise to my dear brother sitting beside my bed in tears, how the hell did she think I could make such a promise to her? Then, when I was back on my feet and being transferred to another ward I did a runner to get some heroin on the streets of nearby Footscray. My poor suffering brother came looking for me and begged me to come back to the hospital but I refused to go until I scored. I needed a hit ... more than I needed air. Mike reluctantly conceded this knowing that he could not make me go back and that, maybe, just maybe, I would go back to the hospital if I had the hit that I was demanding. He had no choice really. I went and scored my hit and, as agreed, went back to Mike and returned to the hospital with him. Needless to say, this caused no end of mayhem back at the hospital where they initially refused to re-admit me. I was out of it and didn't care. But my family did, and they managed to persuade the doctors to re-admit me with the plausible argument that I would likely be dead soon if they didn't.

It was after this, my first serious attempt (since 1979, that is), that I finally went on the Methadone. My uncertain living situation was solved by a friend who invited me to join her in house-sitting the home of some friends of hers while they went overseas. I settled into the Methadone routine, on top of the anti-depressant and the stinking Zyprexa, with Cadbury's Top-Deck ice-cream (with vanilla custard) and daytime TV for company ... and became a placid, flaccid, zombie blob.

My next (and my last) serious suicide attempt came about six months later when we had to move out of this house in early 1999. Although I had been seemingly 'stable' during this time - i.e. not actively suicidal nor using heroin - it was a far from satisfactory way of being. And although I was in a thick fog from all the prescription drugs, deep down I still felt that this was not a life worth living. When the time came that I had to look again for somewhere to live, I had neither the strength nor the wits to do anything constructive about it. I just plodded along, as I had for the last six months or so, into this waiting disaster.

All the while, everyone around me was reasonably content that I was apparently on the mend. I don't think I shared my private feelings about just how awful living this way was, largely because I was so unaware of it myself. I was just numb. But also, I was not seeing

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anyone for any regular counselling because I couldn't afford Nicky and was only making half-hearted attempts to find another psychiatrist. Like those around me, I also accepted this passive, meaningless life with some contentment. I should or could have realised that trouble was brewing because I started stashing a portion of my take-away doses of the Methadone. I don't recall deliberately doing this as some long-term suicide plan - I just started doing it and had secretly accumulated about 15 doses. This is a poor description or explanation of what was going on within me, I know, but it really was a blur at the time and my recollection today is also blurred. With hindsight, I was clearly accumulating a lethal dose of Methadone, though not consciously aware at the time that this was what I was doing.

The previous chapter told the story of this attempt to OD with Methadone - waking up to the motel staff banging on the door, then driving around in a daze for a while before phoning the drug and alcohol clinic who called me in for a check-up. We pick up that story here with the same psychiatrist who had deceived me into taking the Zyprexa some six months previously. I still naïvely thought he was a reasonable guy and a good doctor. Hah! After a few preliminary questions he asked me where I would be staying that night. I said I didn't know. He asked me whether I would have another go at myself if he let me go. I said I didn't know. We circled round a few other questions, most of which I answered "don't know", but he kept coming back to these two. My answers remained the same - it was the simple truth, I didn't have a clue. Finally, exasperated, he stood up and almost shouted at me, "Do you know what your problem is, David?" I shrugged and he said, "You just don't want to take responsibility for yourself!" I was stunned. I didn't say it to him at the time (though I wish I had) but I could only think that well, umm, yes doc, I did try to kill myself last night.

He was left with no choice. He had to certify me. He tried to get me to change my mind ... or rather, to answer his questions, yet again, in the way that he wanted so that I could just leave. But my honest answer was still "I don't know". Besides, the psych hospital was as good a 'motel' as any other as far as I was concerned. I didn't know and I didn't care. So after all the necessary paperwork, which I think infuriated this guy as it was getting late on a Friday afternoon, I found

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myself being escorted to Royal Park psychiatric hospital. Again, after nearly 20 years.

It was a very different place compared with 1979. First of all I was not in a lockup ward this time, even though I was an involuntary patient. There was a bit of a hassle organising the Methadone for me but otherwise it was a pretty quiet, laid back weekend as I waited to be assessed by the hospital psychiatrist on the Monday morning. I have since learned that the Mental Health Act requires that all involuntary psych patients must be assessed within 24 hours of admission. Having been admitted late on a Friday but not assessed until the Monday morning, I find the concept of 'next business day' an odd one for an involuntary psych ward.

This was to be my penultimate, and briefest, encounter with a psychiatrist. The 'assessment' was quite straightforward. After about a fifteen minute consultation, he pronounced that my condition was an 'existential depression' and that I didn't need to be in the hospital. I was to be discharged immediately. They asked if I had somewhere to go and when I said no, I was given the phone number of the Salvation Army emergency accommodation. And then pretty much told to get on my bike. Have I mentioned that I don't understand psychiatrists? Despite a serious suicide attempt the previous Thursday, and with my history, this psychiatrist makes a 'diagnosis' of 'existential depression' after knowing me for no more than fifteen minutes, and that I did not need whatever 'his' psychiatric hospital provided. I'm afraid I just don't get it.

I spent the next few nights staying with friends or family as we desperately looked for somewhere I could live. As my great good fortune would have it, I found a room in a rooming house in Fitzroy, which became my home for the next four years. Later I will be discussing at length the spiritual self-enquiry that was so critical to my recovery, but the significance of this safe, clean, affordable public housing cannot be overstated as an important contributing factor to my recovery and, indeed, my survival. It was a tiny space and some of my fellow residents might not be your first choice as neighbours. But it was home for four years and this sense of 'home', no matter how

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meagre it might be, is very important, possibly essential, if you are to ever find your 'self'.

We're getting close now to that magic time in June 1999 when freedom finally came. But before then I was to have one last 'therapeutic relationship' with a psychiatrist. This was also to be my last ever because, after this guy, I promised myself that I would never again put myself in the hands of a psychiatrist. This may sound harsh and is probably unfair to many good psychiatrists that presumably exist 'out there'. But this fellow was the sixth, and after finding a snake in the grass six out of six times, I'm no longer prepared to enter that territory again. I have promised myself that if I am ever required to see a psychiatrist again I will insist on witnesses, or will remain silent.

I had made attempts to see this very highly regarded psychiatrist before but he was so solidly booked out it had been impossible. When I moved into the rooming house after being discharged from Royal Park, I saw Nicky once or twice and she was still encouraging me to find some professional help that I could afford. We pulled all the strings we could to see this guy, including my dad phoning him and, virtually in tears (or so the psychiatrist told me later), pleading with him to help his son. Eventually I had an appointment. By this time I had also decided that I was going to get off all the crazy psycho-drugs and had started the slow process of weaning myself off the Methadone.

The ten or so sessions I had with this fellow is a difficult story to tell. It was not until several months after I had stopped seeing him that I finally came to see what was happening behind his closed doors. For the first few sessions he brought up - and kept coming back to - his notion of my "foxiness" and how my efforts to get better were always a "two-edged sword". For instance, on the one hand I would reach out for help but then, rather than allow myself to be rescued, I would prefer to pull my rescuer into the whirlpool with me. Or so he perceived it to be. Another observation he made, and the only one that I found useful, was that I had something of an addictive relationship to my suicidality - a suicide junkie, if you like. This was useful as it highlighted how suicide had always been for me the final 'back door'

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through which I could escape. And yes, I needed that back door - I was dependent on it.

The main feature of these sessions was that, from the outset, anything I said was twisted and turned around and used against me. He always found some sinister, dark interpretation of anything I said, which he then threw back at me with his double-edged sword theory. When I eventually challenged him about this, saying that I was beginning to feel that I couldn't say anything without him twisting what I said in ways that were contrary to both my words and their intended meaning, he then twisted this into 'evidence' of my foxiness. I felt like he was always trying to beat me over the head with my own words. At times it was almost like some intellectual jousting game. In the end I figured that he must have seen me as some wild brumby that had to be tamed or 'broken' before any meaningful therapy could begin. But we never got that far. Thank heavens. Because after 10 or so weeks of my thoughts and feelings constantly being denied by him, no real relationship had developed, so I got out of there. Thank heavens.

There were other problems too. Early on I had asked him whether I could talk with him about any suicidal *intentions* that I might be contemplating or planning. This was relevant because in the early days with him this was happening again. It was during this time that I had my last hit of heroin - hopefully forever - as I tried to soften the Methadone withdrawals. But I was also thinking a lot about suicide and twice went to a high place and tried to throw myself off, but couldn't do it. Like the last heroin hit, these have turned out to be my last two suicidal gestures - also hopefully forever.

I wanted to know, first of all, whether he would lock me up if I shared these private thoughts with him. I also wanted to find out whether this was something that I could talk with him about. It was in my thoughts and I felt it appropriate, perhaps necessary, for me to talk about this with him - or did I have to keep it secret as is so often required? I had to find out whether this topic was allowed on the agenda at all. His response was clear. He simply didn't answer my question. Instead, this was one of the early instances for him of my foxiness, a game he seemed to think I was playing with him.

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It was actually during the time with this psychiatrist that my blessed freedom arrived (a story to be told in later chapters). I didn't know it for sure myself and inevitably had doubts that it was just another fleeting 'high'. I tried to discuss this with him and described it as feeling on top of a wave and that I had to decide whether to ride this wave, which might crash me onto the rocks, or trust it and go wherever it took me. To him this was just more foxiness. I guess it was understandable that he was not optimistic about this wave - who would be with my history of 'relapses'? But what was not understandable was when he claimed the credit for this 'high' and its potential hope. I was stunned. One the one hand, he was dismissive of it, but then claimed the credit for it. Who was being 'foxy' this time? After only three or four sessions with him, and without any meaningful dialogue between us yet, he wanted to claim that this was his doing! Not only did I think this was ridiculous, I felt it was insulting to all those had struggled on my behalf (including myself) for four long and painful years.

He also let it slip in one conversation that he saw himself as my "saviour". One of my general 'rules-of-thumb' with therapy is do not trust those who would be your saviour. Sure, some people can help and even play a critical role in the recovery process at times, but all the better therapists I know reject, as I do, the notion of 'therapist as saviour' as a dangerous attitude. So I was surprised to hear him say this and queried him about it, asking him, "Did you just refer to yourself as my saviour?" He got quite sharp with me, waved his hand and dismissed my query with the retort, "Don't play word games". I let it drop, but felt this was a bit rich from a guy who was playing such word games with me.

The final fallout between us occurred over my wanting to go away from Melbourne for a few weeks to visit my friends in NSW, including an ex-lover who had just had her first baby that she and I were keen for me to meet. For me it was just a holiday, but for this psychiatrist it was a demonstration of my lack of commitment to therapy. We 'negotiated' quite hard on this and he was clearly trying to make a strong point. But I couldn't see it.

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By this time, I was beginning to have some doubts about this guy. But I didn't want to just throw in the towel and run away. If I were to leave, I wanted to make sure that I'd thought it through carefully and was sure it was for the right reasons. I talked it over with Nicky and my GP (who had written the referral for me to see this psychiatrist), two people that I did have meaningful therapeutic relationships with and who knew me pretty well. Both felt that if no real connection, communication or trust had been made after ten sessions then it probably wasn't working and nor was it likely to after this time. My GP did raise the relevant question whether my 'quitting' was possibly running away from therapy and, if so, maybe I needed to look at that as an issue. He concluded though, as I did too, that from his own experience with me he knew this was not an issue so he figured that I just wasn't 'clicking' with this particular psychiatrist.

I decided to stop seeing this psychiatrist. I called and left a message on his answering service. Over the next day or so I found that I felt a huge relief that I would not be seeing this man any more and I knew that I had made the right decision. I was still riding that wave of peace and freedom that had arrived and was becoming more and more confident that it wasn't taking me onto the rocks. But even so, I was surprised at the relief I felt from ending the battles I had been having with this guy.

He called me back a couple of days later and recommended that I continue seeing him. He urged me to see him at least once more to talk through my decision to stop therapy. I told him I would think about it and call him back. It was with some bemusement (and amusement) that I pondered how he had never believed anything I told him so why would I want to waste my time and money to tell him my reasons for ending therapy with him, which he presumably wouldn't believe either. I called the next day and left a message that I could not think of any reason why I might want to see him again and if he really wanted to learn why I was 'quitting' then he could contact my GP (whom he might believe).

This should have been the end of it and I would have simply proceeded with this delightful new peace and freedom that was really starting to flood through my life. Except some months later I went to see my GP (about something else) and he tells me that he had received

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a letter from this psychiatrist about me. It was supposedly one of those 'right and proper' professional letters that is sent to the referring doctor at times like this. I was curious, of course, and quizzed my GP about it. As he pulled it out of his file he casually remarked that his recollection was that this letter said mostly nice things about me. I was a bit surprised by this and asked to see the letter. My GP hesitated and said that he needed to read it again to check first. I said no, now that he had revealed that this letter existed, I wanted a copy of it. He chuckled at my assertiveness and agreed to hand it over, though he still read it again, just to check. He still felt that it mostly said nice things about me.

But this was not how I read it. What I saw on my first reading of this letter was that first and foremost this was a 'cover your ass' letter. The psychiatrist was getting on the record his interpretation of our time together. At one level this is quite appropriate and probably very sensible. If I did happen to suicide shortly after my time with him, then such a record written prior to the suicide would be useful protection for him and I don't see anything wrong with that. As long as the truth is being told in these letters. I pointed out to my GP that this reputation protection and ass-saving was what this letter was really about and not some courteous 'for your information' letter as it pretended to be. There were some glaring factual errors in this letter, but of more concern were the subtle but quite sinister misrepresentations and prejudices that presented a very distorted version of our time together.

I read this letter carefully several times over the following days and became more and more outraged when I saw what this man was doing. I felt obliged to write a response to it, which I asked my GP to keep in his files as a correction to the one he held from the psychiatrist. I'm actually very grateful for this letter for several reasons. First, it confirmed for me my worst fears about this psychiatrist so that I felt another surge of relief that I was free of him. Second, it gave me a valuable insight into the inner workings of his psychiatric double-speak and the prejudices with which he had bullied me. And finally, this letter prompted me to write a reply. Although I had always enjoyed writing, I had not written at all for at least a

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couple of years. My suicidality had frozen my writing hand and I had abandoned writing as just another pointless exercise. So I had to resurrect my writing skills to craft a careful response to this shocking letter. I've been writing regularly ever since and, with some irony, I'm grateful to this psychiatrist for this unintended therapeutic contribution to my life today.

In the interest of brevity, and also because I generally prefer not to personalise my criticisms of psychiatry, I will only mention a few of the most salient and illustrative issues arising from this correspondence. The most obvious flaws in his letter are some simple factual errors. He referred to hangups I had about my "working-class family", while noting, in this letter to my GP, that "his personal and family history is probably well known to you so I won't go into it". Well, yes, my GP was familiar with my family background so at least he knew that it was not at all working-class. My father was a pretty successful businessman, I went to a posh private school and we grew up in Camberwell - it doesn't get much more middle-class than that. This psychiatrist couldn't tell my GP any of this in this letter for the simple reason that, after more than ten hours with me, he had simply not enquired about my family background at all. This is odd enough by itself, but to then invent a fictitious working-class family for me is decidedly peculiar. There must be a reason for this. I have no doubt that this invention reveals the prejudices of this psychiatrist. And I suspect these prejudices are that he saw me as not of his own 'class'.

More sinister than these simple factual errors, but no less prejudiced, was his 'diagnosis' of my 'disorder'. He mentions, in this letter to my GP, "sado-masochism" and "personality disorder" though he admits that he didn't use this language with me (which is true) because "he doesn't find such language helpful". I was alarmed to see myself being described as sado-masochistic but was reassured by Nicky and my GP that the clinical meaning of this is very different to the Marquis de Sade fetishism that is commonly understood by this term. I thought long and hard about this, wanting to understand what this man was seeing in me that he chose to describe in this way. I talked with Nicky and my GP about it and in the end concluded, with them, that what he seemed to be seeing, and using this language to describe, was

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my passion and intensity. Nicky and my GP, along with my family and good friends, are familiar with this passionately intense side of my personality and also that this can be an aspect of my self-destructive behaviour when it emerges.

Back in 1999 I had no idea what 'personality disorder' meant. I have since learned that he was probably diagnosing me with 'borderline' personality disorder, which is one of the most disreputable and insidious of the diagnostic categories of modern psychiatry. But for now, and at the time of this letter, my main concern about these 'diagnoses' is how he kept them to himself.

When I saw his words to my GP I recognised in his "sado-masochism" the "foxiness" and "two-edged sword" that were so central to my time with him. Somehow he thought that these metaphors were more useful than a formal diagnosis, even though I had asked him explicitly what he thought was wrong with me. I find this very sneaky and again wonder why he felt he had to play these games with me. Isn't it negligence and unprofessional and unethical conduct for a doctor to deliberately withhold their diagnosis from a patient? Withholding a diagnosis disempowers us. Without this information I am unable to do my own research into my so-called illness, including getting a second opinion. It is manipulative, shows a gross disrespect for the patient, and is an abuse of the therapeutic relationship. I have subsequently learned that these diagnostic categories of psychiatry are highly speculative and regularly used in this manipulative, disrespectful and abusive way. These days, with hindsight, I'm not that surprised that he shared them with his fellow medico but not with me.

I could not let this misrepresentation of my time with this psychiatrist go unchallenged as the 'official record' of our time together, so I wrote a response to it. This response was addressed to my GP, firstly because the original letter was to him, but also because I knew that my words were wasted on this psychiatrist. I asked my GP to file my response alongside the original letter and gave him permission to forward it to the psychiatrist if he wanted to. I don't know if he ever did this though and I've never heard from this psychiatrist again.

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I also discussed my letter briefly with my GP, who could see the obvious factual errors in the psychiatrist's letter, such as the working class family he had invented for me. He could also see, when it was pointed out to him, the other, more subtle misrepresentations in this letter where the person being described - me - was not the person that he knew. He could also see why no meaningful relationship ever developed between me and this guy. Remember, I had consulted with my GP when trying to decide whether to stop seeing this psychiatrist, so he was aware of my frustration with the games the psychiatrist seemed to be playing with me, games that were now apparent in this letter. And he could also now see the 'foxiness' and 'two-edged' word games of this psychiatrist's manipulations, clearly indicated by the deliberate withholding of his diagnosis. The inappropriate and unprofessional conduct of this psychiatrist was evident in his letter to my GP, which my GP could now also see.

I had also talked with my GP (and Nicky too) about how this psychiatrist seemed to be trying to 'deconstruct' me so that he might then 'reconstruct' me - the wild brumby that had to be broken metaphor, or maybe he just saw me as a naughty child. This too was now evident. My relief at escaping his 'therapy' makes sense now too because I can only shudder at what this guy's reconstruction of me might have looked like. Thank god that I was not at my most fragile and vulnerable with him and got out before any real damage was done. Today it frightens the hell out of me that people like this psychiatrist are seen as leaders in our mental health system.

It was this psychiatrist, more than the one who deceived me into taking the Zyprexa, who finally put the fear of psychiatry in me forever. It's easy to be critical of psychiatrists who deceive you into taking dangerous, potent psycho-drugs. And rightly so. But it was actually my experience with this last psychiatrist, the sixth and worst of six bad experiences with psychiatry, which prompted my promise to myself to never put myself in the hands of a psychiatrist again. Although perhaps not so blatantly abusive as forced or coercive drug 'therapies', it is the arrogant prejudices and deceitful manipulations that I encountered with this man that most frighten me. I was now able to see these prejudices and deceptions in all the relationships that

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I'd had with psychiatrists. And I have since learned that this is not just a few 'rotten apples' in the psychiatric barrel but is endemic and intrinsic to the modern practice of psychiatry - that is, such prejudices and deceptions are the very foundation of the profession.

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The mental health services that were available to me did not serve me at all well. I was more disappointed than angry about this at the time – a disappointment that reinforced the helplessness of my suicidality. But during the subsequent ‘making sense’ of my suicidality and of my recovery, I became quite angry at some of the so-called ‘treatment’ I had received from those I’d sought help from. I was angry to learn that I had been deceived into taking a dangerous drug that turned me into a zombie. I was angry to see how I had been bullied by a psychiatrist who twisted my thoughts and feelings into symptoms of some fanciful diagnosis that he concealed from me. I was angry that I was ripped off, financially and emotionally, by ‘therapists’ who saw me as just another ‘customer’ and my despair (i.e. my life) only in terms of symptoms of some abnormality.

The personal anger towards these individuals has subsided over the years since my recovery. But in its place another anger has arisen towards a system of mental health services in which these abuses in the name of treatment are intrinsic and institutionalised. I came to see that my personal encounter with these services, as told in the narrative, was not simply bad luck – in fact I probably had better access to these services than most people do. And this anger is not unique to me. I write today as an active member of the mental health ‘Consumer’ community. There are many in this community who, like me, are angry at – and becoming more active about – the shortcomings in mental health services. These problems are not solely about lack of resources, critical though these are. The most intense anger is towards the denial of the Consumer experience and the abusive or at least negligent ‘treatment’ we receive. This anger is not a symptom of our ‘illness’ that it is so often and conveniently dismissed as. It is a legitimate and purposeful anger that seeks genuine change towards more human and more humane mental health services.

Another aside on the language of mental health is necessary here. The term ‘Consumer’ is the commonly used jargon in the mental health industry for people who have, or have had, mental health difficulties. Many of us find the term offensive. I prefer to identify as a ‘psychiatric survivor’, a term used more in the U.S. and Europe than Australia. But for this chapter on the mental health industry, I’ll stick to the more recognised terminology of Consumer, though with a capital ‘C’ to remind us that, like many sticky labels in psychiatry, it comes with a lot of unwanted baggage.

It is impossible to write this commentary on suicidality as a mental health issue without this anger being present. Some would argue that such emotion diminishes the argument presented here. But the persistent

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silencing of a critical, and often angry, Consumer voice is precisely one of our major concerns. The professional experts would deny us our anger, a denial that is illegitimate, inappropriate and part of the gulf that exists between the experts and the Consumer voice. It would therefore be inappropriate for me to censor my anger here. Encouraged by some of my fellow Consumers, my response is to 'maintain my rage' and seek a balance where I neither suppress nor indulge the anger. Although not the focus of this chapter (or this book), these passionate human rights and political issues will be fundamental to meaningful reform of mental health services. Having made explicit my Consumer perspective and the anger and political context of this chapter, this commentary now looks at suicidality as a mental health issue.

Suicide is typically seen as a mental health issue. Government policies and programs for suicide prevention are typically situated in the mental health divisions of government public health departments. The bureaucrats who formulate and administer these policies and programs take advice and guidance from a diverse community, which we can call the mental health 'industry'. The academic and professional discipline of suicidology is an important voice in this industry for it represents the 'collective wisdom' of our understanding of suicidality. Although many of the issues raised here apply equally to the broader mental health industry, the focus is primarily on the discipline of suicidology and the issues it seeks to address.

Suicidology has three 'parent disciplines' – sociology, psychiatry and psychology. The first major study into suicide was *Le Suicide* in 1897 by one of the great pioneers of sociology, Emile Durkheim. Although Durkheim's taxonomy of four different types of suicide is still of interest, his greatest legacy is the ubiquitous epidemiological study that still makes up a large part of the current literature of suicidology. One of the aims of the studies behind this literature is to look for 'risk factors' that might help us to predict suicide or the risk of suicide, but despite enormous work in this area, suicide remains difficult to pin down demographically. Although there are some significant indicators for an increased risk of *completed* suicide – such as young, rural males currently in Australia – actually predicting suicide for any particular demographic remains problematic. The strongest indicator for completed suicide is in fact a previous suicide attempt, but this is of limited help in predicting *suicidality*. We should not be surprised by the lack of predictability from these studies as (completed) suicide is still a relatively rare event in population terms, despite the alarming overall numbers. This also highlights that there are no sectors of the community that can be regarded as 'immune' from suicide. These studies are important,

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though they need to be broadened to look more at suicidality rather than just completed suicides, so that social policies are developed that include suicide prevention as part of the promotion of mental health and wellbeing.

Despite this early contribution from sociology, suicidology is dominated today by psychiatry and, to a lesser extent, psychology. As part of the making sense of my suicidality and recovery, I have also had to enquire into why psychiatry in particular, but also psychology, were unable to help me and at times made things worse. This research has given me a glimpse of how suicidality is perceived through the eyes of the experts of suicidology. And what I found was that their theories (and their narratives, meta-narratives and other 'stories') of suicidality often clashed, sometimes dramatically, with my lived experience of it. Furthermore, by seeing suicidality through the eyes of academic psychiatry and psychology, I was able to recognise the 'treatments' I had received and see the rationale behind them, which went some way towards explaining why they helped me so little. It also explained the abuses of the psychiatrists described in the narrative, and why my naïve disappointment became and remains a horrified anger.

Psychiatry is the senior partner in suicidology with its special status and influence as part of the medical profession. Within psychiatry, two major trends over recent decades now dominate. These are the use of the *Diagnostic and Statistical Manual for Mental Disorders* (DSM) for diagnostic and assessment purposes, and the shift towards *biological psychiatry* as the primary mode of intervention and treatment. Both these trends attract considerable controversy.

The DSM is the 'Bible' of modern psychiatry with more than 200 'psychiatric disorders' catalogued, along with their diagnostic criteria (i.e. symptoms). It is frequently criticised for revealing more about the prejudices and arbitrary judgments of the psychiatrists on the DSM Committee than it does about the science of mental illness that it claims to be. The clearest example of this is that homosexuality was classified as a personality disorder until as recently as 1980, when it was removed from DSM-III. But many similar prejudices remain in the current version of the manual, DSM-IV, first published in 1994. It has been accused by some as not so much discovering psychiatric disorders as inventing them, which the distinguished pioneer of suicidology, Professor Edwin S. Shneidman, describes as "too much specious accuracy built on a false epistemology". My main concern with the DSM is its emphasis on the 'abnormal' without defining normality. The them-and-us attitude of the DSM makes it one of the primary sources of the stigma around mental health. I have to agree

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with Mary O'Hagan, one of New Zealand's Mental Health Commissioners, when she describes the DSM as "the greatest book of insults of the 20th century".

In some ways there is more public awareness of the other pillar of modern psychiatry, biological psychiatry, than there is of the DSM because of the frequent controversies about pharmaceutical treatments for mental health difficulties. Biological psychiatry sees the brain as the organ of the mind and 'mental illness' as a biological malfunction of the brain. When mental health is reduced to this narrow view, medical 'treatment' is similarly reduced to manipulating the biology of the brain, in particular its internal chemistry. This is popularly known as the simplistic and misleading 'chemical imbalance of the brain' explanation for mental illness, or what some call the 'broken brain' school of psychiatry. There are many controversies around this topic such as: the extravagant claims made about our current knowledge of the brain; the even more extravagant claims about the efficacy and safety of psychiatric drugs; issues of genuine informed consent and involuntary treatment; the lucrative drug market and dubious marketing practices that are compromising the integrity of the psychiatric profession, to mention just a few. These controversies are beyond the scope of this book but they are all well documented elsewhere. Psychiatry as a profession, however, remains defensive about addressing these openly and there is growing discontent in the community about this, especially among Consumers.

Psychology, without the medical background of psychiatry, has a less biological perspective on mental health. The focus is on the mind rather than the brain. The language of psychology is about our thoughts and feelings – intentions, desires, love and grief, joy and sadness – that are so rich and full of meaning to us at the human level. Unfortunately, the trend in mainstream psychology is to accept without much question the diagnostic categories of the DSM and the psychiatric/medical language of 'mental illness'. Psychology does not, however, follow biological psychiatry's emphasis on drugs for treatment, for the simple reason that psychologists are not allowed to prescribe them, though this is changing in some states of the U.S.

Most psychological therapies employ some form of counselling or 'talking therapy'. Cognitive behaviour therapy (CBT), for instance, counsels us to recognise negative thought patterns and learn alternative, less (self-)destructive responses to them. Other similar approaches, such as interpersonal therapy, can be very effective in resolving the mental and emotional pain of difficult life circumstances. These therapies tend to be

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pragmatic and targeted to specific issues and aim for concrete outcomes in a relatively short time frame (typically 6-12 weeks of perhaps weekly sessions).

Another class of psychological therapies is sometimes referred to as *depth psychology*. These seek to delve deeper into the 'psyche' (literally 'soul') where the unconscious drives and motivations for our behaviour are explored. This may include dream analysis, hypnosis, recovering of repressed memories and other 'deep' techniques, as well as extensive exploration of your past, particularly 'family of origin' issues. These therapies can be effective for deep-seated emotional traumas that can haunt us later in life, such as childhood abuse. They often aim for a cathartic release from these traumas by reconnecting with them. This can be painful and requires a strong supportive environment (e.g. family, friends, therapeutic relationships etc.). These forms of therapy can be protracted and problematic, requiring many painstaking sessions over months or years, putting them out of reach financially for most people. Questions are also raised about the efficacy (and ethics) of these therapies as the beneficial outcomes can be uncertain and slow to emerge, despite the intensity of them. The psychoanalytic tradition within psychiatry, arising from the work of Freud, Jung and others, falls into this category. But then these influences are out of favour in modern psychiatry, having been largely purged from the DSM, and simply irrelevant to biological psychiatry.

This is just a brief survey and summary of the prevailing 'wisdom' of the two major schools of therapy that we might turn to if we are feeling suicidal. There are numerous variations and sub-schools within both psychiatry and psychology, including some that are critical of the mainstream thinking of their discipline – for instance, there are Critical Psychiatry professional groups and university schools of Critical Psychology. I am frequently asked, though, what is the difference between psychiatry and psychology, which is a very good question that should be raised more frequently. The simple answer is that psychiatrists are medical doctors, which gives them the authority to prescribe drugs. Their signatures are also vested with the power to 'certify' you for involuntary admission to a hospital or to force some involuntary treatment upon you 'for medical reasons' – a controversial human rights issue beyond the scope of this book. Consultations with psychiatrists can also be claimed on Medicare so there is significant public subsidy of the profession – likewise for the drugs they prescribe.

From the Consumer perspective the question is, "Who should I see, a psychiatrist or a psychologist?" Why are there two distinct professions for

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the one health issue? Biological psychiatrists might argue that their medical knowledge is essential to diagnose possible disturbances in the function of the brain, and I wouldn't disagree. Except we have neurologists who have this expertise and, like the specialist pathologists called upon in general practice, these experts in the brain could be referred to (by psychologists even) for the necessary tests for any brain pathology. But even psychiatrists only rarely perform any biological tests for the 'mental illnesses' they so frequently diagnose. The reason for this is that, despite the claims of 'chemical imbalances in the brain', such tests simply do not exist. The 'chemical imbalance' school *assumes* that it is faulty brain chemistry that is the *cause* of mental illness but in most cases offers only meagre evidence, and no pathology tests, to support this assumption. So the question remains – why do we have both psychiatry and psychology?

The only answer I can see is an historical one of how the two disciplines emerged separately and independently, each coming from a different perspective – the medical, biological roots of psychiatry and the more humanistic, existential origins of psychology. From the Consumer perspective, it would make sense for these two disciplines to converge so that Consumers (and the community in general) were not confronted with this artificial and inappropriate division when seeking advice on mental health issues. To some extent this already occurs with some psychiatrists practising psychological techniques and many psychologists becoming more familiar with the principles of psychiatry. There is even a move in the U.S. to grant psychologists the authority to prescribe certain drugs. Mainstream psychiatry is not happy about this, which suggests that much of the distinction between the two disciplines is more about a territorial dispute between the professions rather than about good public health policy. In Australia this is most evident with psychologists arguing to be eligible for Medicare rebates, which would seem an impossibility given the impact this would have on government health budgets. Instead, we are seeing GPs doing crash courses in the most popular psychology techniques, such as cognitive behaviour therapy, and the medical profession negotiating a special Medicare category for these doctors. This hardly thrills the psychologists. It's messy, confused and very political.

Some of this confusion is being resolved by a more multi-disciplinary approach to mental health. The *psychosocial rehabilitation* model is becoming a well-established discipline in its own right with its own schools of training, practitioners, publications, conferences and so on. Briefly, two key features distinguish this approach. First, it emphasises developing the skills and capabilities of the individual rather than focusing on and

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pathologising their difficulties. Second, it looks more closely at social and environmental circumstances as critical to our wellbeing. The language of this approach reflects this perspective, where the aim becomes rehabilitation or recovery, rather than 'treatment'. It is also more multi-disciplinary and holistic, calling upon a variety of skills and practitioners to assist with recovery, such as life skills training, goal-setting, self-help and peer support groups, art and music therapy and so on, as well as counselling and access to medical support if required. Currently we mostly find this approach being provided for people with fairly severe difficulties who might otherwise be hospitalised, either permanently or repeatedly – the so-called Serious Mental Illnesses (SMIs) or 'low prevalence disorders' such as those that have the diagnostic (DSM) labels of 'schizophrenia', 'bipolar disorder' or 'psychosis'. I did not personally encounter these services during my struggles, though this approach is found in some of the drug and alcohol services. In drug rehabilitation (and sometimes other fields) we are also hearing more of a *biopsychosocial* model, which is further recognition of the need for a comprehensive multi-disciplinary approach.

At the centre of all these therapeutic approaches is a person. This is often forgotten or somehow lost in the confused and confusing technical detail of the various – and sometimes conflicting – disciplinary points of view. Under the convenient but in some ways misleading heading of 'mental health', this person will be struggling with some mental, emotional, relational or spiritual difficulty or, more likely, some combination of these. But in this individual person these different ways of understanding 'mental health' converge into the one lived experience of someone suffering. Sometimes this suffering arises from a specific lingering wound, which, if it could be healed, would relieve the suffering. But often the suffering goes to the very core of our sense of self. A critical moment for me was when a friend was talking about my 'problem' and I realised that what she was really talking about was my life. Many 'mental health' problems are about our innermost sense of who we are – of what it means to me to be me.

These various points of view about mental health might then be seen as different ways of understanding or knowing the self. They can be seen as different windows into the lived experience of our sense of personal wellbeing – or otherwise. Although I seek to draw attention to the spiritual dimension of our sense of self, I do this because I feel this particular 'window into the psyche' is seriously overlooked and neglected. I do not deny or dismiss the importance and legitimacy of these other views. Rather, my concern arises when these views are presented as the *whole* picture and used to deny or exclude other useful and important ways into these issues.

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Even the DSM, which has little scientific validity in my view, has some merit as a descriptive metaphor of the kinds of mental, emotional and spiritual anguish that we might find. For instance, a friend found that the DSM description of the Narcissistic Personality gave her useful insights into the personality and difficult behaviour of a relative (she did not then make the mistake, however, of attributing this to some 'illness'). Similarly, the brain sciences have much to teach us about how the biology of the brain affects our moods and sense of wellbeing. But an approach to mental health that considers *only* the brain will always be partial, incomplete and inadequate. Likewise with psychology. Exploring our thoughts and feelings, healing our psychological wounds, and so on (whether with family, friends or a therapist), is vital to understanding our moods and behaviour and for the development of mental and emotional wellbeing. But it is not the entire picture. And again, it is naïve and wrong to only see some 'mental illness' in the individual while ignoring the social context in which the supposed illness develops and manifests.

To illustrate the various ways of viewing (i.e. ways of knowing and understanding) mental health problems, consider depression. Depression is seen as one of the most widespread 'mental illnesses' and is the diagnosis I received to explain my suicidality. In the DSM, Major Depressive Episode (there are other lesser 'depressions' in the DSM but Major Depression was my diagnosis) is defined using nine symptoms, of which at least five must be present for a period of at least two weeks for a diagnosis. With the possible exception of "recurrent suicidal ideation", each symptom by itself is a pretty common occurrence in most people's lives from time to time. Fatigue, sleeping difficulties, indecisiveness, weight gain or loss, loss of interest in your usual pleasures and "depressed mood" (whatever that is) are all regularly experienced by most people. That is, each of these symptoms is a common, natural and perfectly normal, even healthy, part of the human experience. A few extra qualifications are made in the DSM such as these symptoms must cause "clinically significant" (what's that?) distress or impairment in social, occupational or other aspects of our lives. And then a few specific exemptions are made for these symptoms being due to some physiological reason (e.g. hyperthyroidism, drugs) or "bereavement" (i.e. healthy grief).

The first thing I noticed about these diagnostic criteria is that they completely fail to capture any sense of the despair of 'major depression'. People who have lived this despair typically speak of the 'black hole' inside them or of profound feelings of emptiness. I also regularly hear, particularly in stories of suicidality, of an agonising yearning. The DSM

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tries to restrict itself to observable behaviour – e.g. “appears tearful” – although it does at times refer to “subjective report” – e.g. “feels sad or empty”. The next thing I noticed is that the DSM offers no explanation for the cause of these symptoms (although it does exempt just a couple of specific causes). When I then look at them overall, it is apparent that there are many possible reasons why someone might exhibit these symptoms. The most obvious of these is sleep deprivation, an all too common occurrence in our modern, hectic lifestyles.

The clustering of at least five of these symptoms over at least two weeks is sufficient for the DSM to declare this to be the psychiatric disorder of Major Depression. And with this declaration by the DSM committee, it takes on a life of its own as a ‘mental illness’ or ‘psychiatric disorder’ (modern psychiatry’s euphemism for abnormality). Whenever I get the opportunity, I like to ask psychiatrists what definition of ‘illness’ they are using when they talk of depression as a mental illness. I have not yet heard an answer that would not include sleep deprivation as a mental illness. Which is inevitable, because their own diagnostic criteria for depression are indistinguishable from the symptoms of sleep deprivation. Is sleep deprivation then a mental illness? Is it a chemical imbalance of the brain? And should we ‘treat’ sleep deprivation with invasive, potent and sometimes dangerous chemicals to ‘fix’ this chemical imbalance? Or should we perhaps simply get some sleep? Maybe we should declare the causes of sleep deprivation, such as overwork or parenting, to be mental illnesses? The arbitrary, pseudo-scientific diagnostic criteria of depression in the DSM fail, on the one hand, to capture the true despair of suicidal anguish such as mine. But on the other hand, they do capture others in their diagnostic net, such as many parents of young kids, who do not belong there.

Once this mental ‘illness’ has been declared with the full authority of the psychiatric profession, it becomes a convenient justification for many other questionable claims. Looking through their medically-tinted glasses, with their assumptions about the brain as the organ of the mind, biological psychiatrists see a malfunctioning brain. And we get the ‘chemical imbalance of the brain’ (broken brain) school of psychiatry. Despite the many marvellous breakthroughs in brain science in recent years, what we truly know and understand about the staggering complexity of the brain is still very much less than what we don’t yet know. This is regularly acknowledged by the genuine experts in the field. But we frequently hear extravagant claims about these breakthroughs and even more extravagant

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claims about our ability to 'fix' these (alleged) chemical imbalances with psychotropic medications.

With depression, the neurotransmitter serotonin has even become popularised as the 'mood chemical' of our brains, and anti-depressants that boost our serotonin levels are heavily promoted as the 'cure' for depression. This is dangerously misleading hype that comes largely from the pharmaceutical industry, supported by many in the psychiatric profession. Serotonin has many functions in the body (and not just in the brain) and even this much-studied neurotransmitter is still not well understood in all its complexity. It is known to play an important role in, amongst other things, sleep, appetite and sex. It is also known to be important in the brain mechanisms that inhibit our aggressive impulses, which might mean that it is a significant neurotransmitter for suicidal behaviour. And serotonin is just one of several hundred neurotransmitters, most of which are even less well understood than serotonin. But there are no biological tests for what my serotonin levels should be – i.e. there is no pathology test for 'depression' – because no-one knows what the healthy, normal levels are for any individual. Our brain chemistry is undoubtedly an important part of our experience of mind and I welcome and endorse the fascinating and exciting research into it. But let's not kid ourselves that we understand it more than we do.

And let's not kid ourselves about the drugs that supposedly 'fix' these alleged chemical imbalances. I once suggested to my GP that the promotion of depression as an illness in recent decades was really just pharmaceutical public relations because if depression is the 'illness' then, of course, the 'cure' would be an 'anti-depressant'. To my surprise he said that this was probably pretty close to the truth.

The current medical fashion in anti-depressants are the selective serotonin re-uptake inhibitors (SSRIs). These are actually no more effective in reducing the symptoms of depression than earlier generations of anti-depressants – the very dangerous MAOIs (MonoAmine-Oxidase-Inhibitors) and the almost as dangerous tricyclics. The main virtue of the SSRI drugs is that they tend to have less severe side-effects and are much less lethal in overdose. This latter property is important because in the past many people have suicided using the medications given to them by their doctors that were meant to treat their depression. The therapeutic benefits of the SSRI drugs are grossly overstated in the marketing hype of the drug companies. An individual's response to them tends to be idiosyncratic. That is, some people report some relief of their symptoms, others report no significant

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benefit, and others report that the unpleasant side-effects outweigh the benefits.

There are several varieties (i.e. brands) of SSRI drug and the variation among these is also idiosyncratic – if one brand doesn't work for you then you will probably be advised to try another brand. No-one has an explanation for these idiosyncrasies, far less any way of predicting which drugs might work for which people. It is very hit-and-miss. This is hardly surprising when we consider the subtle complexity of our brain's biology and the peculiar nature of these very potent chemicals. And the psychiatric profession, rather than fulfilling their social responsibility of informing us with some balance to counter the marketing hype of the drug companies, seems rather to be in partnership with them to promote these drugs. This is not surprising, however, as it is consistent with the profession's energetic promotion of depression as an illness. And even less surprising when you see how dependent the profession has become on the financial 'sponsorship' of the pharmaceutical industry.

Finally, it is important to note that the purpose of these drugs is to reduce the *symptoms* of depression. They cannot be said to treat the cause of these symptoms because, first, the biological causes of these symptoms are not well understood and, second, there are many different possible causes, both biological and psychological, for such a symptom profile. To state this more clearly, these drugs *suppress symptoms*. Sometimes.

If, like I did, you try a few different types of anti-depressant, perhaps pushing them to their maximum dose, but with little beneficial effect, you might find yourself labelled as 'treatment resistant'. The response of some psychiatrists will then be to up the ante and bring out the big guns such as the anti-psychotic drug that I was given. These are just more powerful suppressors of symptoms. Some psychiatrists who are critical of extreme biological psychiatry describe this as chemically 'switching off' parts of the brain in order to reduce symptoms. Unfortunately these big guns usually have more severe side-effects which sometimes include permanently altering brain function – i.e. the side-effects don't go away when you stop taking the drug. These critical psychiatrists argue that the only chemical imbalances in the brain are those induced by these drugs. To deceive people into taking such drugs should be a criminal offence, but the case for human rights in mental health is for another book. The point here is that great care is required in the use of these drugs, which may have a legitimate role in extreme cases – but only with *genuine* informed consent and only under adequate medical supervision.

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Another problem with the artificial construction of depression as an illness is that it creates an assumption that is then used to make other dubious assertions. One of the most disturbing of these is the claim that depression is the major cause of suicide. This misleading assertion has been so widely touted (by people who should know better) that it has become a widely accepted 'fact' in the general community. More knowledgeable experts such as Diego de Leo, who heads Australia's first university course in suicidology and is a psychiatrist himself, has stated that "it is a mistake to concentrate on depression" in our efforts to understand suicidality. Professor Edwin S. Shneidman, one of the great pioneers of suicidology, finds the DSM notion of depression so useless that he invented the term *psychache*, which he defines as psychological *pain*. Depression, like pain, is a symptom of some underlying problem. Indeed, depression is just a collective noun for a cluster of symptoms and nothing more than that, even according to the DSM. But we do not grant pain the status of an illness – we need some understanding and explanation of the cause of the pain for that. There are many different causes for physical pain and, similarly, there are many different causes for the psychological pain of depression or psychache. We need to understand the physical, mental, emotional, social and spiritual causes of this pain if we wish to understand the cause of depression, psychache and suicidality. Depression does not *cause* anything, it is the *consequence* of something. It is these other 'somethings' that we must turn our attention to, which we will not do effectively if we believe that depression is the cause.

I am reminded at this point of one of my favourite Sufi tales. It sums up modern psychiatry for me with delightful Sufi humour. Nasruddin is walking through his village when he sees a neighbour searching on the ground for something. He asks his neighbour what he has lost. "My keys", replies the neighbour. Nasruddin gets down and helps his neighbour search for his keys but after some time without any success he asks his neighbour where he last saw his keys. "In the house", replied the neighbour. "So why are you looking for them out here?", asks Nasruddin. "Because the light is much better out here" was the neighbour's answer. The very bright light of biological medicine can never fully reveal the subtle worlds of mind and spirit – or of depression, psychache or suicidality.

I joked in the previous chapter that if the only tool you have is a hammer then everything looks like a nail. Like the Sufi tale above, this sums up the treatment I received from some of the psychiatrists I saw. Trapped by their ignorance, all they had to offer me was what they knew – psychotropic drugs. These drugs were a sledge hammer that thrashed around in my

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psyche, smashing numerous treasures but failing to hit the nail of my particular 'depression' on the head. Perhaps they were worth a try given the severity of my suicidality, if only to create the time and space for some deeper healing. But it is a kind of blindness to see mental anguish solely in such narrow biological terms. It is also an abuse, a violation of body, mind and soul, to press these dangerous chemicals on someone without great caution and care – and a crime to inflict them without genuine consent.

Another window into the psyche – and into depression, psychache and suicidality – is through psychological enquiry. The emphasis of psychology is on the mind rather than the brain. The language of psychology is the language of thoughts and feelings, rather than of neurons and neurotransmitters. It therefore speaks to us in terms that we are more familiar with from everyday language. Psychology is concerned about the lived human experience of love and joy, anger and sorrow, intentions and desires. It seeks to explore and understand how and why we might feel the way that we do. It looks at how life events contribute to our sense of wellbeing and recognises that invisible wounds to the psyche are real wounds that can cause considerable pain and trauma. Psychology is necessary because it speaks to us in more human terms.

It concerns me greatly that university courses in psychology seem to be embracing the DSM categories and criteria for diagnostic purposes. With this comes the assumption that depression is an illness rather a natural, 'normal' and even healthy response to life events. Probably the best book I have read on depression is *The Wisdom of Depression* by Jonathan Zeuss, an Australian medical practitioner living in the US. His book covers the biological aspects of depression, which includes brain chemistry but also the important though much overlooked dietary needs of the brain. The title of his book reflects his psychological argument, that what he calls the "depressed response" is actually a natural, and very normal, response to some life events. He does not pathologise this but invites us to appreciate it, even welcome it, as an indication of some disharmony in our lives, and therefore an opportunity for personal growth. This is a truly wise response to the wisdom of depression.

Psychological treatments for depression include the 'talking therapies' such as the cognitive behavioural therapy (CBT) and interpersonal therapy mentioned earlier. These are specific, targeted techniques for addressing, for instance, the negative thought patterns or relationship issues that might be the source of our depression. The 'deep psychology' methods of psychoanalysis can also be of help for depression, particularly for deep-seated psychological wounds from the past such as childhood abuse. One of

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the most common calls from mental health Consumers, including those in psychiatric wards, is for greater access to psychological therapies.

My main, but not only, experience of psychological therapies was the year-long relationship with Phil, who I still regard as a (more than) competent psychologist. But his greatest strength as a therapist was also his greatest weakness for someone like myself. Psychologists work with the mind. Our thoughts, feelings and behaviour are seen as attributes and expressions of the mind. Furthermore, it is through the mind that we seek to comprehend our mental world(s) and, through this understanding, learn more constructive ways of working with our thoughts and feelings. This is all very true, legitimate and appropriate. But it is not the whole story. I now know that it was my spirit, my very soul, my innermost sense of self, that was in crisis. This self is not of the mind and so any therapies that address just the mind will only ever be a dance on the surface. Which is exactly what these psychological therapies felt like at the time – a dance on the surface of my being, never truly getting to the source of what I was struggling with. Psychology, which sees the mind as the essence of our sense of self, the source of consciousness and the experience of being, is unable to reach into the spirit that is at the core of our being. Phil knew the boundaries of his expertise and did not venture beyond them – for which I respect and admire him enormously. The following chapters will tell of my recovery through spiritual self-enquiry, which picks up from where the stories of the mind and of psychology cannot go.

In discussing psychology and suicidality, special mention must be made of Professor Shneidman. As mentioned earlier, he rejects the DSM as “too much specious accuracy built on a false epistemology” so he invented the term *psychache* to get away from the medicalised language of ‘mental illness’. Defining psychache as psychological pain arising from frustrated or thwarted psychological needs, he then uses a taxonomy of these based on the work of one of his mentors, Henry Murray. I won’t elaborate on these here as I have doubts about Murray’s taxonomy, but I agree with Shneidman’s general approach and also his regret that since his pioneering work nearly fifty years ago, suicidology seems to be going backwards under the influence of modern psychiatry. I also endorse Shneidman’s recommendation that the two questions we need to ask someone suffering from psychache are “Where does it hurt?” and “How can I help?” My main criticism of Shneidman is that I wish he would include frustrated or thwarted spiritual needs, along with psychological needs, in his definition of psychache.

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The psychiatric and/or psychological approaches to understanding mental health are what you will most likely encounter if you seek help for a mental health problem. Although the boundaries are sometimes blurred as some psychiatrists also practise psychology and psychologists often draw upon psychiatry (e.g. the DSM) in their practice, they are quite distinct ways of understanding mental health. What they do share is the tendency to focus on the individual and their illness, disorder, abnormality, psychache – or whatever label is given to their psychiatric/psychological ‘problem’. The recent trend towards a psychosocial response to these difficulties is a welcome one but, as noted, such a multi-disciplinary approach is not yet common. Psychotherapy is still largely seen as a one-on-one relationship with a therapist, a relationship inherited from medical practice, where you take your ‘problems’ to the therapist for ‘treatment’.

Suicidology’s third and original ‘parent discipline’, sociology, has less to say about the ‘treatment’ of suicidality. If you are feeling depressed or suicidal you don’t look up ‘sociologists’ in the yellow pages. Sociology looks for the societal factors that might contribute to our psychache. It might also contribute to identifying the social and cultural infrastructure that supports and facilitates treatment or recovery. But it is not usually seen as a therapy. The therapies of psychology, sometimes, and also psychiatry, less often, do include consideration of our personal social relationships to some extent. But the focus again is on the individual, with the broader social and cultural contexts in which the psychache arises outside the scope of the therapy. One effect of this is that it reinforces the feelings within us that there is something ‘wrong’ with us for which we need ‘treatment’. There is little recognition or capacity in such individualised therapies to address the social circumstances, which may in fact be the source of the difficulties and be in more need of ‘treatment’ than the individual.

These problems are recognised in drug rehabilitation. One of the biggest obstacles to long-term recovery from addictions is the social world you return to after leaving rehab. The drugs are everywhere, and often glorified and romanticised. And the misery and anger that tempted you into escaping your pain through drugs is probably also still around. Returning to work and finding somewhere to live can be almost impossible and often disheartening. Even with the best of intentions to stay clean after you leave rehab, the risk of relapse is much greater if you simply return to the old, familiar social settings that are part of your drug use in the first place. The psychosocial approach to drug rehabilitation recognises that making the necessary changes in social circumstances is often the most important – and difficult – task to ensure a long-term recovery. Effective drug rehabilitation

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programs include case managers, social workers, after-care support groups, residential support services and other social programs.

Our current drug rehabilitation programs are still far from adequate but at least there is the recognition that these social contexts are vital for lasting recovery from drug addictions. The same cannot be said for those who present for psychiatric help. Studies clearly show that one of the highest risk groups for suicide are people in the first month or so after discharge from a psychiatric hospital. The only assistance I was given when discharged from Royal Park Psychiatric Hospital was the phone number of the Salvation Army emergency accommodation. Although I had attempted suicide only a couple of days before this, after just a fifteen minute 'assessment' the psychiatrist there simply dismissed me and washed his hands of any further responsibility. By discharging me from the hospital I was now somebody else's problem. I was lucky and survived the next few days and weeks. But the suicide rate for those recently discharged is more than 20 times the rate in the general community. If we are serious about suicide prevention then close psychosocial follow-up and support would be mandatory for all people after discharge from psychiatric care. It is a national disgrace and shameful tragedy that this is not the case.

Sociology and related disciplines have some other important contributions to make to our understanding of suicidality and suicide prevention. But these are less to do with *intervention* (therapy) at the time of a suicidal crisis and more to do with *prevention* of suicidality arising in the first place. The two main areas where the social sciences have much to offer are with our concepts of the self and with community wellbeing and building (mentally) healthy communities. We need to recognise that communities, as well as individuals, can be suicidal and that our communities today are exhibiting many suicidal symptoms. We need to explore how suicidal communities lead to suicidal individuals. We need to examine our collective psychache and consider that perhaps the best suicide prevention is to address this. Pathologising and blaming the individual, making them victims, turns our attention away from our collective psychological pain and needs. This allows us to see it as a problem with 'them' and not with 'us'. What I most despise about the DSM is the institutionalised them-and-us stigma that runs through it. Our suicide rates are like the canaries in the coalmines, falling off the perch as we gasp for mental, emotional, social and spiritual air. It may be that the real task of suicide prevention is "Healer, heal thyself".

Interlude

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The previous chapters represent what we might call the Bad News of this story – the Bad News of feeling suicidal, but also of the fears and myths that surround it, the drug addiction detour and the ineffectual and sometimes harmful treatments of the ‘mental illness’ circus. Before moving onto the Good News of the following chapters, it is appropriate to pause and reflect on the story thus far.

Suicidality is a crisis of the self. If there is one idea that I want people to get from this book it is that suicidality is a crisis of the self. There are several reasons why this is a more useful way of framing our thinking about suicide than the current emphasis on it as a mental health problem. First, in some ways it is a statement of the obvious, but an obvious truth that has become lost in all the ‘mental illness’ noise. The self is the ‘sui’ in suicide, and both the victim and perpetrator of any suicidal act. There cannot be any more central concept for the study of suicidality than that of the self. Second, and even more important though equally neglected, thinking about suicide as a crisis of the self corresponds more closely to the lived experience of suicidality. To know suicidality ‘from the inside’ is to experience it as a crisis of the self. By far the most neglected aspect of suicide research is what feeling suicidal means to those who actually live it. While this neglect continues, we cannot hope to understand suicidality and our efforts to help those struggling with these feelings will continue to be shallow and fundamentally flawed. And third, if we re-conceptualise or re-frame our thinking about suicide as a crisis of the self then some important questions immediately arise that the current thinking about suicide overlooks or ignores. In particular it demands that we address the central concept of the self in our thinking about suicide – or as one suicidologist who dared to ask this question put it, “Who or what is killing whom?”¹

In this Interlude we take a brief pause in our thinking about suicide to look at some of the contemporary thinking about the self and subjectivity. We first re-visit suicidology’s three parent disciplines – psychiatry, psychology and sociology – to look at their current thinking about the self beyond just what they say about it as it relates to suicide (which is not much). This will lead to thinking about the nature of the self in what we might broadly call ‘postmodern’ philosophy, where the self and subjectivity

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have been lively topics for half a century or more. Finally, we look at the current thinking about the self and subjectivity in the multi-disciplinary field of Consciousness Studies.

It is impossible in this short interlude to survey the enormous variety of ideas and thinking about the self and subjectivity from such a wide range of perspectives, so the focus here is limited to three main issues. The first is that there are some core ideas about the self and subjectivity about which there is a general consensus now, but of which suicidology, and in particular psychiatry, do not seem to be aware. The second is that current academic thinking about the self is at something of an intellectual dead-end. And the third is that at precisely the moment this intellectual dead-end occurs, the ancient wisdom of spiritual traditions surfaces and offers valuable knowledge that can take us beyond the current impasse.

In arguing these three points, the discussion inevitably gets a little technical and academic at times. I have tried to keep the academic detail (with all the tedious footnotes and citations) to a minimum so that it may be of interest to the general reader. Some readers may prefer to skim, or skip altogether, this Interlude and pick up the story in the next chapter. For those curious for more detail, some recommendations for further reading can be found at the end of the book.

To begin with the very simplest view of the self, modern biological psychiatry reduces us all to biochemical robots – selfless, soul-less, meaningless biochemical zombies (even before we take their drugs) whose subjective, lived experience is completely irrelevant. Before all you decent, well-intentioned psychiatrists howl in outrage at this seemingly simplistic assessment of psychiatry, I emphasise that I'm referring to the mainstream, dominant thinking in modern psychiatry. It is biological psychiatry that is simplistic, not the discussion here. Some schools of psychiatry, most notably the psychoanalytic tradition dating back to Freud, do dare to plumb the dark, interior depths of the subjective self – and sometimes even the soul (Jung, Hillman etc). But these have been progressively marginalised in recent decades as the diagnostic system of the DSM and the 'broken brain' thinking of biological psychiatry have become the dominant influence – and practice – of modern psychiatry. If you present yourself to a psychiatrist today experiencing a crisis of the self, then you will almost certainly get a diagnosis that assumes some pathology in your brain, which biological psychiatry will 'fix' with psychotropic medications.

The closest this dominant ideology in psychiatry comes to any consideration of the self is in its diagnostic categories of 'personality disorders', which are sometimes called disorders of the self. Here we find

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perhaps the most disreputable of psychiatry's diagnostic categories, in particular that of Borderline Personality Disorder (BPD). Some people peel back the prejudices of modern psychiatry's diagnostic system and see basically three major categories of disorder – the mad, the sad and the bad. The mad are the 'really' mad people, basically those who experience what psychiatry calls 'psychosis', the so-called Serious Mental Illness (or SMI), or sometimes the 'low-prevalence' disorders. In contrast, the 'high-prevalence' disorders, mainly depression and anxiety, are the sad, also sometimes referred to rather insultingly as the 'worried well'. And the bad are the personality disorders, especially BPD. BPD highlights modern psychiatry's inability to deal with a crisis of the self. Personality disorders (especially BPD) are sometimes dismissed as 'behavioural' – as opposed to psychiatric or medical – so that many psychiatrists will happily diagnose you with one (again, especially BPD), and then just as happily tell you that it is untreatable. It would be comical if it wasn't so tragic. People with the BPD diagnostic label are disproportionately represented in the suicide statistics. More sensitive psychiatrists are recognising that many people being caught in the BPD net have experienced significant trauma, such as childhood sexual abuse. But because these traumatised people often do not respond to drug therapies, psychiatrists then often judge them to be untreatable.

The fundamentally flawed understanding of the self by modern psychiatry arises directly from its position as a branch of medicine. The catchcry of medicine these days is the demand for 'evidence based' research and practice. The criteria for what constitutes valid evidence are carefully and strictly defined according to the established methods of traditional science – the experimental method based on objective, observable, measurable, testable, repeatable data. In medicine the 'gold standard' for this science is the double-blind, fully randomised control trial. These criteria for valid evidence are appropriate and necessary for testing surgical procedures on flesh and bone, and also for testing new drugs for their efficacy and safety.

I use the term 'traditional science' to refer to the science that we are all pretty familiar with. This is the science that has been so effective in fashioning rocks into spaceships that we can then land on the moon, for instance, as well as in the extraordinary achievements of modern, western medicine. But a science that depends solely on objective, observable, measurable (etc) data is not a good science for exploring and understanding subjective, invisible, unmeasurable *experiential* 'data'. From now on I'll mostly refer to these two kinds of data as either *third-person* data, for

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traditional scientific data, or *first-person* data for subjective, experiential data. The clearest example to highlight this distinction is love. Love simply does not register on the radar of traditional science – it is not objective, observable, measurable etc etc. In contrast, love is recognised as a significant feature of life by most people, despite its being totally subjective, invisible, unmeasurable etc etc. Love is not discussed at suicidology conferences.

The problem as I see it with modern psychiatry is not that the scientific method of medicine is wrong or invalid. The validity of the ‘traditional’ scientific method is clearly demonstrated by its fantastic achievements, perhaps nowhere more so than in medicine. The problem is that this scientific method is, by itself, inadequate for the questions psychiatry seeks to address. For a scientific enquiry into phenomena that include significant subjective, first-person data, the scientific methods of medicine – and its criteria for what constitutes valid evidence – are simply unsuitable and inappropriate. Medical science still has a vital role to play in exploring these questions but, *by itself*, it will never be able to comprehend subjectively lived experiences, such as suicidality.

The more fundamental and critical problem with modern psychiatry is that it clings to an outdated belief that the inadequate, traditional scientific method is the *only* legitimate form of scientific enquiry. Modern psychiatry works very hard to deliberately and systematically *exclude* the first-person data of subjective, lived experience. The discussion that follows shows that this is no longer a legitimate or tenable intellectual position for psychiatry to adopt – and that it hasn’t been for a long time. The deliberate exclusion of the first-person voice by modern psychiatry reveals an ideological commitment to one scientific approach and its associated criteria for what constitutes valid data or evidence. In the 21st century it can no longer be considered scientific or rational to exclude the important first-person data of subjective experience. Especially in a field such as psychiatry, which claims to study ‘disorders’ that must also be considered, probably always but at least sometimes, as crises of the self.

Turning to psychology, the second parent discipline of suicidology, we find that the self and subjectivity have been major themes throughout its history. A useful starting point is the American pioneer of psychology at the turn of the 20th century, William James, whose approach to exploring the self is still characteristic of psychology today. James proposed a tripartite model of the self: the material self (one’s body and possessions); the social self (the impressions one gives to others); and a spiritual self (one’s inner, subjective being).

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It is interesting that James recognised the spiritual dimension of our sense of self, which he explores in his famous lectures on *The Varieties of Religious Experience*. But the key point of James' approach that I wish to highlight here is his analysis that dissects the self into three component parts. For over a hundred years, psychology has been dissecting the self into various components but without, as yet, reaching any general agreement on the list of components that make up the self, nor on the important question of the relationships between the various components. For example, one recent psychological model of the self talks about the *individual, relational* and *collective selves*². Another dissects the self into: the self as *reflexive consciousness* (self-awareness); the self as *interpersonal being* (the social/relational self); and the self as *agent* or *executive function* (the ability to make choices, take action, exert control etc). On top of these and other taxonomies of the self, there seems to be an ever-growing list of properties of the self, such as self-knowledge, self-conceptions, self-presentation, self-regulation and the ubiquitous self-esteem, to mention just a few. The psychology of the self is a very busy domain of enquiry³.

The distinguishing characteristic of this approach to understanding the self is that it dissects the self into many parts and then studies each of those parts and, perhaps, how they relate to each other. All these attempts to analyse the self have probably contributed something useful to our understanding of what it is to be human. The problem is that in dissecting the self in this way the most important property of the lived experience of the self is often lost. That is, the unified, continuous wholeness or sense of *identity* that we feel as a self – as an individual person with a self – is lost by these taxonomies.

At this point it is appropriate to look at the psychoanalytical school of psychiatry, which by the standards of modern biological psychiatry is best understood as a psychological approach more concerned with the mind than the brain. Sigmund Freud, the founding father of psychoanalysis, distinguished between a conscious mind and an unconscious mind. This *divided self* has since permeated our thinking about the self to become Freud's most enduring legacy. Freud's heir apparent, Carl Jung, introduced the idea of a *collective unconscious*, expanding the self beyond the boundaries of just an individual self and hinting at his interest in spirituality, which Freud regarded as a neurosis and was central to his very public falling out with Jung. Once more, the key ideas here are about dissecting the self into its component parts. And once again, there is no general agreement on these components, nor which component is responsible for the

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critical subjective sense of a unified, continuous self or how they might work together to produce this.

These early days of psychology coincided with the decline in the influence of religion in western intellectual circles. At the turn of the 20th century, Nietzsche's declaration that 'God is dead' had rather more influence on the intellectual climate than did the churches. Prior to this, religious beliefs were central to our sense of self but now a new centre, a new 'home', for the self had to be found. The new site for the self became the mind, and psychology as the science of the mind also became the science of the self. It's interesting to note that some more recent psychiatrists in the psychoanalytic tradition have dared to revisit and reconsider the soul and spirituality as part of our sense of self. In particular, James Hillman and his book *Suicide and the Soul* needs to be mentioned, but also more recent works like *Thoughts Without a Thinker* by Mark Epstein are bringing spiritual ideas into modern psychoanalysis. We must remember, though, that these creative thinkers about the self are by and large marginalised by and on the fringe of mainstream, modern psychiatry.

The scientific endeavour to understand the self by dissecting it into its component parts, combined with relocating the self in the mind, brought into psychology the problem that has perplexed philosophers for centuries – the apparent *duality* of the self. Citing William James, Deborah Prentice describes this as:

Perhaps the most enduring of all questions about the self concerns its dual nature: How can we conceive of an entity that is, at once, both a known object and the knower of that object? This question has compelled and confounded philosophers and psychologists for hundreds of years. Most have approached the problem by distinguishing the knower from the known, the I from the me, in James' terms, and theorising about the two components of the self separately.⁴

Distinguishing between the subjective 'I' who knows and the objective 'me' that is known raises profound questions about the nature of knowledge, shifting our attention from various *objective* concepts of the self to the act or experience of 'knowing' the self as we subjectively live this knowledge. In order for any science of the mind, or of the self, to completely describe, understand and explain the self it must also take into account the *subjective* knowledge that we all have of the lived experience of the self. This first-person, subjective knowledge is a different kind of 'knowing' from the

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third-person, objective knowledge of traditional science, but an essential aspect of the self that psychology must address. Until very recently, mainstream psychology has largely heeded Allport's advice from the 1960s, as paraphrased by Prentice, that "psychologists should concern themselves only with the self as a known object and leave the self as knower to the philosophers".

Turning to suicidology's third parent discipline, sociology, again we find the division of the self. Some of the social aspects of our sense of self have already been mentioned above, such as concepts of the relational or social self. Indeed, social psychology is a distinct and significant sub-discipline within psychology. Many people see the self primarily in terms of our relationships with others so that the social, relational self is the primary component in these models of many selves, while others give primacy to the individual self. I do not take a side in this argument for I find the starting premise of a divided self as fundamentally flawed. A further weakness of the social or relational model of the self is that it sees the self in terms of relationship with some other self, which as well as being divided again is also a rather circular, even tautological, argument that doesn't seem to help us very much. It must be acknowledged again, though, that these models have given many useful insights that have enhanced our understanding of what it is to be human. It's just that they have inevitably proved rather limited for a full understanding of the subjective experience of a whole, unified, continuous self.

These criticisms of both sociology and psychology are general criticisms of current mainstream thinking in these disciplines. In fact these days we often hear of 'human sciences' and/or 'social sciences' as more appropriate terms to encompass the diverse and vast range of disciplines that might have once come under the umbrella of either psychology or sociology. These include education and learning, parenting, gender and cultural studies, anthropology, ethnography, linguistics and communications studies, to mention just a few. We also find 'critical voices' within the more established disciplines so that we now have university departments of Critical Psychology, for instance. And we must include in these critical voices the many schools of thought that have traditionally been viewed as 'the arts', such as literature and history. The boundaries between these disparate schools of thought are becoming increasingly blurred as new ideas emerge that no longer fit neatly under the old, traditional headings, so that intellectual enquiry today is becoming a truly multi-disciplinary endeavour. All of these intellectual disciplines, along with the continuing tradition of

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classical philosophy, have contributed to what is now often called a 'postmodern' view of the world.

Getting familiar with contemporary postmodern thinking, or just 'postmodernism', is a pretty daunting and often disheartening task. A useful starting point is to look at the modern era and what distinguishes it from the earlier pre-modern era and the postmodern era now upon us. For this, I am indebted to the American philosopher Ken Wilber who identifies the "great dignity" and the "great disaster" of modernity, which captures well the key aspects of these transitions.

The beginning of the modern era, sometimes called the Age of Reason or just 'modernity', is marked by the rise of rational, scientific thinking. The divine right to rule of inherited power and the authority of religion was challenged by the intellectual power of reason, of rational, scientific thinking and knowledge. With this came the great social advances of the era, such as democratic governments, the end of slavery, the emancipation of women, the separation of power between church and state, and so on. Although some of these projects are still unfinished, at least in some parts of the world, the rational principles behind them are now generally accepted. In what we now call mental health, the rise of modernity marked the shift from viewing madness as possession by the devil or the wages of sin to its being viewed as a health issue. Along with the great social changes mentioned above, and many others, this does indeed indicate the "great dignity of modernity".

The world, or at least the human world, was changed forever by this great dignity of modernity, a radical shift from pre-modern to modern ways of thinking. Using rational argument and systematic, objective methods of enquiry, science challenged, and by and large defeated, the dogmatic, ideological authority of church, dynasty and patriarchy. Along with its technological achievements, science and rational argument radically changed the social, cultural and political landscape. In the last half-century or so, though, another equally radical transition has commenced where the limits of the science of modernity that has served us so well in so many ways have now also been exposed. Science had become exalted so that rational, objective ways of knowing acquired supremacy as at least the best, if not the only, path to truth. Other ways of knowing – such as aesthetic, subjective, intersubjective, moral, spiritual and others – were marginalised, their validity and legitimacy challenged so that they were progressively excluded from scientific enquiry. Science became a scientific fundamentalism, or *scientism*, that invaded and colonised the domains of art and morals, reducing them to subjective non-scientific knowledge and

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therefore to be ignored. Wilber calls this the “great disaster of modernity”. Citing some of the greatest thinkers of our time he describes it as:

the great nightmare of scientific materialism was upon us (Whitehead), the nightmare of one-dimensional man (Marcuse), the disqualified universe (Mumford), the colonisation of art and morals by science (Habermas), the disenchantment of the world (Weber) – a nightmare I have also called flatland⁵

Modern psychiatry, dominated as it is by biological psychiatry, is a prime example of flatland science, and a prime example of the great disaster of modernity.

I was first drawn to the work of Wilber because spiritual ideas are central to his Integral Model, as he calls it. I had found that the few scholars who did attempt to bring spiritual ideas into psychology or the social sciences, for instance, were usually constrained by the need to bolt them on to the fringes of the established thinking of their disciplines. Wilber had no such constraints because he is not part of the ‘academy’ in the sense that he is not a university academic. Spirituality lies at the core of Wilber’s thinking and is one of the foundations of his philosophy and of the Integral Model. But Wilber’s philosophy is very much more than a modern, western interpretation of traditional spiritual wisdom, though it certainly includes this. He distils the core ideas of postmodern thinking into three very important truths: constructivism, contextualism, and pluralism.

constructivism means that the world we perceive is not simply given to us, it is partially constructed by us. Many – not all – of the things we thought were universal givens are really socially and historically constructed, and thus they vary from culture to culture. Contextualism points out that the meaning is context-dependent ... This gives interpretation a central place in our understanding of the world, because we do not simply perceive the world we interpret it. And pluralism means that, precisely because meaning and interpretation are context-dependent – and there are always multiple contexts – then we should privilege no single context in our quest for understanding.⁶

It’s difficult to pinpoint in time precisely when the established wisdom of modernity was superseded by the new truths of postmodernism. Some of the great philosophers of the late 19th and early 20th centuries, such as Nietzsche and Husserl, were clearly thinking along these lines. But

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postmodernism would usually be considered a post-war (WWII, that is) phenomenon and probably not really recognised and fully established until the tumultuous 1960s. Perhaps with the benefit of hindsight we can say that intellectually we have been in the postmodern era for at least fifty years. That is, the 'new' truths of this era, that have rendered the 'old' truths of modernity obsolete, are really not all that new.

It follows from the three key truths of postmodernism identified by Wilber – constructivism, contextualism and pluralism – that the central flaw of modernity was the myth that there is any such thing as 'pure' objective science. That is, human knowledge is *always* created (socially constructed) and interpreted by human experience. To put this another way, the way of an ancient spiritual truth, there is no knowing without a knower. No knowledge can ever be independent and free of subjectivity and a subjective knower. This is true even for the traditional 'hard' sciences of physics, chemistry and biology. It is especially true for the 'human sciences' where the object (or is it the subject?) of enquiry are conscious human beings that have their own subjective experiences – that is, where the subjectivity of both the researcher and the researched are part of the research.

This brings us back to the self and subjectivity as an essential element of any research today, especially in the human sciences that seek to understand what it is to be human. If we limit our enquiry to just the objective, third-person data then we will only ever achieve at best a partial understanding of whatever we might be studying. Wilber repeatedly points out that objective knowledge is not so much incorrect as incomplete. In the postmodern era the subjective dimensions of all knowledge must at all times be part of the research agenda.

This understanding has been grasped in the field of Consciousness Studies, to which I was drawn because of its relevance to concepts of self, but also because consciousness is often equated with spirit in some spiritual traditions. There has been a resurgence of interest in consciousness in the last decade or so that has brought together experts from a wide range of disciplines such as philosophy, neuroscience, psychology, cognitive science, computer science, cultural studies, and also the spiritual wisdom traditions. Although there is much that still remains mysterious about consciousness from a scientific standpoint, some of the conclusions thus far from these studies are relevant to the discussion here.

There is now a general acceptance in Consciousness Studies that the 'hard problem' of consciousness is that of *experience*, or the first-person, subjective, lived experience of any conscious phenomenon. The term 'hard problem' was coined by David Chalmers, an Australian philosopher at the

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forefront of Consciousness Studies. Chalmers identified the hard problem of experience to distinguish it from the 'easy' problem of a complete scientific understanding of the brain. The hugely complex and still largely unsolved problems of brain science are easy, in comparison, because at least "we have a clear idea of how we might go about explaining them", says Chalmers. That is, we can be confident that the traditional scientific method is capable of (eventually) explaining the biology of the brain. But Chalmers and others have shown that it will *never* be able to explain consciousness⁷.

The methods of traditional science – working with objective, observable, measurable, *third-person data* – will never fully explain consciousness because experience cannot be reduced to the third-person data required by these methods. The essential experiential data is subjective, invisible and unmeasurable *first-person data*, which cannot be reduced to third-person data without losing its most important properties, which are the subjective *value and meaning* of an experience to those who live it. The reductive, third-person methods of traditional science will simply not help us to understand, describe and explain the first-person, lived experience of consciousness.

The consensus now in Consciousness Studies is that the only way to approach the hard problem is to regard consciousness as an irreducible feature of the universe, like gravity or mass. Physics, for instance, does not attempt to dissect, analyse and reduce gravity to its component parts. Gravity is just a brute, irreducible fact of the universe, something that just *is*. Likewise with consciousness. A consequence of this is that if we wish to understand, describe and explain consciousness then this will only ever be achieved by studying the first-person data, which in turn requires *first-person methods* of enquiry.

Although largely spurned by traditional science, various first-person methods of research are available, such as phenomenology, heuristic and narrative enquiry methods, the fairly recent and exciting methods of autoethnography, and others. Of particular interest are the contemplative and meditative methods of the spiritual wisdom traditions, which can also be seen, through western scientific eyes, as first-person methods of enquiry. Chalmers points out, though, that "our methods for gathering first-person data are quite primitive, compared to our methods for gathering third-person data ... the former have not received nearly as much attention". If we wish to understand consciousness – and the lived experience of any phenomenon – then it is time to give attention to the first-person data and develop methods of sophistication comparable to current third-person methods.

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Consciousness Studies therefore reaches conclusions similar to the core ideas of contemporary postmodern thinking. Objective knowledge, by itself, is not sufficient for a complete understanding of *anything*. Nothing is ever known without a knower. Or to say this more precisely, nothing is known without the act of knowing – the subjective, lived experience of any knowledge. Subjective knowledge is *always* involved in any knowledge and must be taken into consideration. Any scientific enquiry that limits itself solely to the objective, third-person data must now be seen as partial and incomplete, and ideological rather than rational.

This ideological exclusion of the subjective, lived experience and the first-person data is the current status quo in mental health in general and suicidology in particular. As mentioned above, this is due to the excessive influence of a medical model of mental health. Chanting the mantra of ‘evidence based’ knowledge to cloak its ideological commitment to objective knowledge as the only valid knowledge, psychiatry systematically excludes subjective knowledge and the first-person data from mental health research and practice. At best, this can be seen as ignorance of contemporary thinking on the validity and importance of subjective knowledge. Given that the vital role of first-person data is old news in most other human sciences, and also that mental health touches our most intimate sense of self, it is hard to see how medicine – and psychiatry in particular – can remain deaf and blind to current thinking on these matters. It would seem that psychiatry is actually well aware of these ideas, but deliberately chooses to ignore them.

Indeed, rather than engaging with current thinking on the need to attend to the first-person data, modern psychiatry in recent decades has moved in the opposite direction. The psychoanalytic method of Freud and his heirs, which to some extent can be seen as a first-person method, has been progressively marginalised by modern psychiatry. The dominant influence in psychiatry today is biological psychiatry, which pathologises mental illness (based on a dubious, pseudo-scientific diagnostic system) as a biological malfunction of the brain. Biological psychiatry is totally unconcerned about the lived experience of what it calls ‘mental illness’. This represents an aggressive assertion of the supremacy of objective, third-person knowledge and an equally aggressive exclusion of subjective, first-person knowledge.

Although the importance of subjective experience – or first-person data – is now recognised and studied in most of the human and social sciences, concepts of the self remain confused and uncertain. David Chalmers, for instance, admits to not knowing what the self is and suggests that we “throw

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away talk of the self and let's just look at the experiences themselves"⁸. In psychology we have moved from the divided self of Freud and James to the thoroughly deconstructed postmodern 'fragmented self'. Amid the confusion of so many attempts at scientific theories and taxonomies of the self, some postmodern commentators conclude that there is no such thing as the self, that it is not a useful concept and, like Chalmers, suggest we should abandon our enquiry into it altogether. Although subjectivity is recognised, the self that subjectively experiences is nowhere to be found. At the turn of the 21st century we are hearing pronouncements of "The Death of the Self in a Postmodern World"⁹, an echo of Nietzsche's declaration of the death of God at the turn of the 20th century.

Nietzsche's personal response to the death of God a hundred years ago has been described as a 'radical nihilism'. During the course of the 20th century we have seen the widespread emergence of just such a nihilism, particularly in western cultures, and with it a profound sense of meaningless despair. The loss of God as the centre of our existence, and now the loss of the self, leaves us feeling as though "we seem to be losing our grip on something familiar", as the neuroscientist Francisco Varela put it¹⁰. The ground we stand on that seems so solid and familiar has been so thoroughly deconstructed that intellectually we have to doubt whether we exist at all. At the very least, without a self (or God) no meaning or purpose to life seems possible. Perhaps the biological psychiatrists are right – our sense of self is just an illusion, a side effect, created by a bunch of meaningless neurons in a sea of meaningless neurotransmitters. Against this, our sense of self not only persists but also remains important to us. How can we proceed past this intellectual impasse?

It is at precisely this moment in our enquiry into the self that we find the ancient spiritual wisdom traditions have much to say that is useful. One of the reasons I find the current debates in Consciousness Studies so exciting is that they are one of the very few academic disciplines that have genuinely opened their doors to spiritual wisdom and spiritual ways of knowing. This is very challenging for some of the neuroscientists and others from the traditional 'hard' sciences, but in the spirit of genuine open enquiry they have recognised that spiritual ideas probably have something to offer as they grapple with the hard problem of subjective experience. Commenting on the eastern meditative traditions, neuroscientist Francisco Varela observed that "it would be a great mistake of western chauvinism to deny such observations as data and their potential validity". Varela and his colleagues are therefore incorporating Buddhist mindfulness training into their research into human cognition. And David Chalmers, who is perhaps

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even more wary of any notion of spirit than he is of concepts of the self, recognises the potential value of spiritual ways of knowing:

I think the Buddhist traditions and other contemplative traditions have a lot to offer ... these guys have been studying subjective experience for many years from the inside, they've been gathering what we might call the first person data about the mind.¹¹

Chalmers' interest remains in how the first-person data of subjective experience can contribute to our understanding of consciousness. Although he has the intellectual honesty to recognise that the contemplative spiritual traditions have something to offer in this enquiry, he still sees consciousness, not spirit (or God), as the source or site of subjective experience. But we seem to be getting very close to something resembling our sense of self as we experience it. Which in turn bears a strong resemblance to the notion of spirit that we find in many spiritual traditions. Chalmers also clings steadfastly to the assumption – and it is an assumption – that consciousness arises from the mind, that consciousness is a phenomenon of the mind.

I find this intriguing as it was Chalmers who identified subjective experience as the 'hard problem' of consciousness precisely because it is so very different to all the other aspects of the mind that we study. I would argue with Chalmers that subjective experience, as the fundamental property of consciousness, is so unlike anything else that we think of as 'mental' that we need to at least entertain the possibility that it is not mental at all, that consciousness is not of the mind. Such a suggestion would clearly be provocative to many in Consciousness Studies, including Chalmers probably, because if it is not mental, and it's clearly not physical, then what could it be?

I don't want just to simply assert, like some dogmatic, religious ideologue, that the answer to this question is something we call 'spirit'. We need a better answer than that. I said that I was originally drawn to Consciousness Studies partly because consciousness is often equated with spirit in some spiritual traditions. I don't necessarily assume that spirit and consciousness are exactly equivalent, but it seems to me that consciousness as described by Chalmers and others is a lot closer to the notion of spirit in many spiritual traditions than it is to any notion of the mind. Consciousness, as a fundamental property of the universe, may be the 'something else' other than body and mind that spirituality speaks of and Consciousness Studies suggests. At the very least, I see contemporary

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thinking in Consciousness Studies playing a key role in bridging the current gap between the wisdom of (objective, third-person) modern science and the equally valuable wisdom of the (subjective, first-person) spiritual traditions.

The story of this book now resumes with the Good News of my recovery from suicidality through spiritual self-enquiry.

Endnotes

See the Further Reading section at the end of the book for more references to the topics of this Interlude. The specific references cited here are:

¹ Bell, David 2001, 'Who is killing what or whom? Some notes on the internal phenomenology of suicide', *Psychoanalytic Psychotherapy*, 15 (1) pp 21-37.

² Sedikides, Constantine & Marylin B. Brewer (Eds) 2001, *Individual Self, Relational Self, Collective Self*, Psychology Press, Philadelphia.

³ Baumeister, Roy. F. (Ed) 1999, *The Self in Social Psychology*, Psychology Press, Philadelphia.

⁴ Prentice in Sedikides et al above.

⁵ Wilber, Ken 2000, *Integral Psychology: Consciousness, spirit, psychology, therapy*, Shambhala, Boston, p 70.

⁶ Wilber, Ken 2000, *One Taste: Daily reflections on integral spirituality*. Shambala, Boston, p 152.

⁷ Chalmers, David 1995, 'Facing Up to the Problem of Consciousness', *Journal of Consciousness Studies*, 2 (3), p 201.

⁸ This quote from Chalmers comes from an ABC radio interview, transcript available on the ABC website:

<http://www.abc.net.au/rn/science/mind/s919229.htm>

Endnotes (cont'd)

⁹ The title of a chapter by Connie Zweig in *The Truth About the Truth: De-confusing and re-constructing the postmodern world*, Anderson, Walter Truett (Ed) 1995, Putnam Books, New York.

¹⁰ Varela, Francisco J., Evan Thompson & Eleanor Rosch 1993, *The Embodied Mind: Cognitive science and human experience*, MIT Press, Cambridge, Massachusetts, p 130.

¹¹ From the radio interview with Chalmers cited above.

Chapter 5

Spiritual Self-Enquiry

To all deep thinking minds, the enquiry about the 'I' and its nature has an irresistible fascination. Call it by any name, God, Self, the Heart or the seat of Consciousness, it is all the same. The point to be grasped is this: that Heart means the very core of one's being, the centre without which there is nothing whatever.

(Ramana Maharshi)

It was during one of my hospital detoxes that I woke up from a nap to find a grainy, black and white photo of this Indian-looking guy propped up beside my bed. I couldn't figure out who he was or how this photo had appeared by my bed. I eventually guessed that it must have been left by a visitor, and probably by my long-time yoga buddy Susan. But I still had no idea who this guy was. A nurse confirmed that Susan had visited, found me asleep, sat with me for a while and left. She had also left a small booklet that went some way towards explaining the photo.

This was my introduction to Ramana Maharshi. Although it occurred quite early on in my 'four years of madness' and well before any of the suicide attempts, I now regard this moment as the beginning of my recovery, though I had no sense of this at the time. Susan is one of my dearest friends and quite an Indiophile, visiting India regularly to nourish and maintain her spiritual equilibrium. We first met in the mid 1980s at a week-long yoga intensive that we had both decided to use as an occasion to give up smoking. At the front gate of the ashram (where smokers are banished to if they need to indulge their nasty habit) we met one day when Susan had run out of tobacco and I had run out of papers. An instant rapport was established and a beautiful friendship was born. Over the years I had become familiar with Susan bringing back her latest treasures from the spiritual supermarket that is India.

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These were not always my cup of tea but our sense of the spiritual was sufficiently similar that I usually found it worthwhile - and always great fun - to hear her latest stories of spiritual adventures and insights that she invariably came home with after each trip to India.

Bhagavan Sri Ramana Maharshi, to give him his full title (though I'll just call him Ramana from now), was the treasure Susan had brought home from her latest trip to India. This fellow, who died in 1950 (which explains the grainy photo), was my first introduction to a branch of yoga known as *gyan* yoga, or the yoga of self-enquiry. Although I had practised and studied yoga, irregularly and haphazardly, since the late 1970s and had probably heard mention of *gyan* yoga, I knew next to nothing about it. Today I translate it as 'spiritual self-enquiry', and it was this that set me free of my suicidality. But I'm getting ahead of my story ...

Initially, I was wary of this man in the photo. It looked too much like yet another *guru* from India and Susan knew very well that I was wary of the guru culture that surrounds much of yoga. My first serious encounter with yoga was when I was living in India in 1978 and I found that I loved the practices. Later, back in Melbourne after the Great Fire of London of 1979 and now a computer science student, I looked for a yoga school thinking I knew what I wanted. I found one which taught a comprehensive and fairly traditional style of yoga, and said to the swami (the orange-robed, shaven-head 'monks' of yoga) that I was looking for physical suppleness and relaxation. I can still see her lovely smile as she simply said think of it as a smorgasbord where I can sample the various practices and then take up whichever ones suited me. I might have even said that I didn't want any of the mystical crap and perhaps that is why she smiled so sweetly at me.

Over the next few years I was a pretty keen student of this school of yoga. And, bit by bit, through the breathing, deep relaxation and meditation practices, along with the physical postures, a spiritual awareness began to slowly awaken within me. This was not some devotional, worshipping kind of spirituality. I was raised as and had always been a firm atheist (which remains true today) and would have run a mile at any of the devotional spirituality such as that of the Hare Krishna folk. No, the spirituality that emerged for me through these

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practices began with developing an awareness of the subtle 'energies' at work in the body, breath and mind. The starting point for this yoga is the physical body and the postures or exercises known as *asanas*, which is what most people think of as yoga. We then add to this an awareness of the breath and the specific breathing practices known as *pranayama* to connect with the *prana* or subtle 'vital energy' (known as *chi* or *qi* in Chinese medicine). This yoga also had a deep relaxation practice known as *yoga nidra* or 'yogic sleep', and various meditation practices to develop a deeper awareness of the subtle aspects of the mind. This work with body, breath and mind was my doorway into spirituality.

I loved these practices and, being of an intellectual bent, I looked into the literature of yoga. This included not only the detailed explanations of the practices but also the philosophy of yoga, an ancient philosophy that has gone through many refinements over the centuries to give us the diverse and sophisticated schools and traditions that we have in yoga today. It was all extremely stimulating and rewarding so that over time I came to see myself as more of a spiritual being with a body, rather than the other way round. I can't put a date to this change in my thinking. It wasn't like some radical transformation - it happened very slowly, kind of organically, which was very nice. But I now lived in a richer, deeper world and spirituality was central to that. This came about primarily through the practices, but the philosophy of yoga also became a cornerstone of my own personal philosophy.

I was sufficiently enchanted by yoga and this deepening awareness of my spiritual being to consider becoming a swami. I felt that my atheistic origins had thrown out the spiritual baby with the religious bathwater and I had some catching up to do after thirty years of denial of my spirituality. The life of a swami was one where spiritual growth was constantly at the centre of every day, every activity, and for a while it was a very tempting possibility to consider.

I think there were two major reasons why I didn't follow the swami path. The first was that I was at the start of an exciting - and rewarding - career in the computer software industry. My life in the 'straight' world was really very good and I mostly liked it. And my

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attachments to this world included my social life - in particular the idea of celibacy that came with swami-hood did not appeal to me. This was probably sufficient to save me from renouncing this world, but I also had one other major obstacle to swami life. This was my wariness about the guru culture. To become a swami you effectively swear allegiance to the guru - a kind of surrender to the guru. I had always had big problems with this as it seemed so fraught with danger. I was told that these problems were just my ego getting in the way, which is probably true enough. Thank heavens for my ego.

I think I had already decided in favour of my career and social life rather than the life of a swami, but then an awful scandal exploded at this yoga school that made the decision certain. It turned out that the most senior swami in Australia, who was revered and 'worshipped' as a semi-guru, had a weakness for young girls. I don't know all the details and wouldn't want to go into them here if I did. But it culminated in this fellow going to jail for a while and apparently he died a pretty sad, miserable and lonely death a few years ago. This scandal rocked the yoga school and many swamis left - there were more than three hundred in Australia at its peak, I believe. And of course the young girls who lived at the ashram with this guy and had been abused by him were traumatically wounded, some permanently. The school almost collapsed and disappeared in Australia, only resurfacing in the late 1990s.

It's painful for me to remember this horror because I still have a great appreciation, even love, for the teachings of yoga. But this terrible scandal confirmed and reinforced all my doubts about the guru culture. Blind obedience to an all-powerful 'master' was just too dangerous, too susceptible to corruption and abuse. Bad as this individual's behaviour was, I also saw that it was the whole culture that contributed to it. I was horrified to learn, much later, that there were quite a few swamis who knew of this man's paedophilia but had remained silent. I even heard of one swami, who I knew quite well, who had reassured a fellow swami about the rumours that were going around before it exploded into a public scandal by saying "Don't worry, he won't get caught". For me, this is exactly equivalent to the scandals surfacing in the churches today and it's not due to a few rotten apples.

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It is systemic in such cultures. So I'm very glad that my ego stopped me from becoming a swami.

I'm also saddened by this scandal because I treasure ashram life as a place of spiritual refuge and sanctuary. At the start of my suicidal crisis I had talked with my sister about looking for some spiritual refuge where I might be able to attend to my despair. But I had lost touch with this yoga school and as far as I was aware all their ashrams had been closed down. No other spiritual refuges or sanctuaries came to mind at the time. Recall that for a long time, as told in the "Drug Detour" chapter, the advice I was receiving, and which I accepted, was to attend to my drug problem first - which brings us back to my hospital detox bed with this grainy photo of Ramana peering down at me.

When Susan next visited, I asked her to explain this photo - and I'll resume the story of Ramana shortly. But we also talked about what I might do after I got out of hospital. She told me that she'd heard that the ashram in the country not far from Melbourne that we used to go to had re-opened to the public and asked whether I might want to go there for a while after my detox. This was a scary thought. Neither Susan nor I had had anything to do with this school for nearly ten years and the whole sorry story was a horrible memory. But I'd had good times at this ashram years earlier - the occasional weekend and a few week-long courses - and remembered it as a sacred and special space. Susan offered to find out more about whether it was possible to go there and how the place was being run, etc. I didn't have anywhere to go after the detox, which would finish in just a few days. Despite my reservations, the thought of taking refuge at the ashram was pretty appealing. Susan clinched it for me when she offered to take me up there and stay with me for the first week - and bring me back if I couldn't handle it.

It was a weird feeling as we approached the ashram in the car some ten years after our last visit. It had hardly changed at all. Surrounded by state forest, it was a beautiful setting. Susan escorted me in and we were greeted warmly by the swamis who ran the place. After these initial formalities, I was keen to visit the *sadhana* (spiritual practice) room where classes and other yoga sessions were

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held. As soon as I stepped inside it felt so familiar. These rooms acquire a very special feeling or mood that I just love. The big picture on the wall of the guru made me shudder a bit though, and I wondered whether I could go through with this. But the air of peace and calm in this room, so familiar and comfortable, felt like just what I was looking for - and needed.

I lived in the ashram for the next six months. It was a bit tough at first, adjusting to the routine. Up before dawn for a quick shower (and a smoke at the front gate) before class at 6.00 a.m., followed by breakfast, then the daily cleaning chores, which are followed by more chores. This constant 'work' at an ashram, whether it's cleaning, cooking, gardening, building repairs or working in the office is called *karma yoga*. Karma yoga, or the yoga of action (karma), aims to bring spiritual awareness to every activity you undertake, no matter how mundane. It is the yoga of selfless service where no reward is sought other than the opportunity to do the task itself. No tasks are better or more important than any other - cleaning the toilets is no more or less of an opportunity to practise karma yoga than, say, teaching a yoga class. Living in an ashram is to practise yoga 24 hours of every day and karma yoga takes up most of these hours. Although to the outside observer it can appear to be free labour for the ashram, karma yoga is its own distinct form of yoga and a potent and effective one that can be fulfilling, rewarding and liberating.

Karma yoga is in fact one of the four major schools or traditions of yoga. The others are *bhakti yoga*, *raja yoga* and the *gyan yoga* already mentioned. Bhakti yoga is the yoga of devotion or worship. The simplest example of this is the Hare Krishna folk who worship the god Krishna, endlessly chanting his name. At this ashram we also practised bhakti yoga regularly, mainly through the chanting to music called *kirtan*. When I first encountered kirtan I was uneasy about it but once I accepted it as just another yoga practice rather than some worship of god or guru, I slowly learned to appreciate it as another of the delights of yoga. At the ashram I even learned to play the harmonium (a kind of musical squeeze-box with a piano-like keyboard), which was a big adventure for this musical klutz.

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Raja yoga includes the yoga that most of us think of when we hear the word yoga. Raja means 'king', so raja yoga is the yoga of kings - though I also translate this, with some Aussie irreverence perhaps, as the yoga that even a king can do. It includes the practices of asanas or postures, pranayama or breathing practices, pratyahara or deep relaxation, and the various 'meditation' practices. These we did mostly in the regular morning classes but we also had a daily deep relaxation before lunch and regular meditations in the evenings. And in between all these ... more karma yoga.

Gyan yoga did not, however, feature much in the teachings of this school or in the life of this ashram. Despite all my years of yoga I had hardly heard of it and knew next to nothing about it - until Susan gave me Ramana's photo and the little booklet. The booklet, *Nan Yar or Who Am I?*, is basically a dialogue between Ramana and a spiritual seeker who came to see him some time "about the year 1902". Maybe the reason gyan yoga is not often taught in yoga schools is that there are no real teachings. Gyan yoga works through dialogues that enquire into the nature of the self. In India these dialogues are known as *satsang*, which roughly translates into an assembly (sangha) to discuss truth or reality (sat). Another translation I like is 'to assemble in (the presence of) truth'.

When I first looked at this booklet while still in the hospital detox I'd assumed it would be pretty much more of the same sort of thing that I had read so much of over the last decade or so. But it seemed to have something more, or slightly different, and I found myself picking it up again and again during my time at the ashram. My copy is just fifteen pages so it was easy to read over and over. And each time I read it I seemed to find something more in it. Initially I didn't see it as the radical (non-)teaching that I do today. It was more like just another nuance on the vast literature of yoga that I was already reasonably familiar with. I picked it up in quiet moments in the busy routine of ashram life and I guess that, bit by bit, I incorporated some of the ideas from this tiny text into my meditations. And, remember, I was desperately seeking some way out of my pain that, despite the wonderful ashram life, was still very present deep within me.

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But the penny didn't drop, so to speak, while I was living at the ashram. I was too inculcated with the prevalent view that this peculiar thing called enlightenment or self-realisation was an impossible dream for ordinary folk such as myself. The teachings of yoga seemed quite clear on this. Enlightenment required many years of diligent and dedicated practice, the strict observance of a severe moral code, and also the blessing of an already enlightened guru who at some point might - just might - tap you on the shoulder and give you the much sought after 'transmission' of enlightenment. And all of this would take many lifetimes. In almost all the spiritual circles I have had some contact with, the message was always that it was presumptuous to expect or anticipate enlightenment in this life. So it was clearly not something that was on the agenda of someone like me who could not possibly follow such a strict and disciplined life. For me, this actually became an argument in favour of suicide. I had clearly messed up this life so why not just move on to the next one.

Although mostly dormant while at the ashram, my inner chaos quickly surfaced whenever I stepped out of this safe space. Towards the end of my time at the ashram I had a few visits to Melbourne, where I couldn't resist picking up the heroin again. It was bizarre. I was now very healthy and even cheerful and there was certainly no physical addiction to the heroin. But outside the safety and sanctuary of the ashram, I found the emptiness inside me was too hard to bear and I almost automatically took refuge in the heroin. I was only ever away for a day or so, so there was no time to run up any sort of serious habit. And as soon as I was back in the ashram the urge for heroin pretty much disappeared straight away and was not a problem.

During these visits to Melbourne I encountered the other spiritual teacher or guide who, along with Ramana, was to be so vital to my recovery - an American woman called Gangaji. Her American name is Antoinette Varner, but she was given the name Gangaji by her own teacher-guide, an Indian chap by the name of H.W.L. Poonja, but affectionately known as just Papaji. Papaji had spent time with and was a follower (I'm personally uncomfortable with the word devotee or disciple) of Ramana. He later carried on Ramana's tradition of satsang in Lucknow in north India, where my friend Susan met him and spent

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time in satsang with him on a couple of her visits to India. Papaji gave Antoinette the name Gangaji in 1990 and told her to take satsang to the West. She is now an eloquent, contemporary, Western voice of this lineage of satsang.

Towards the end of 1996, before finally leaving the ashram, I had heard a few of Susan's tapes of satsang with Gangaji, and I liked what I heard. I was still regularly dipping into *Nan Yar* and still finding new treasures each time I did. Gangaji helped me see more clearly what Ramana was saying and the radical nature of this teaching was starting to become apparent. Next thing I know, Gangaji was coming to Australia and Susan ropes me in to being a volunteer assistant at the satsang program that was being scheduled for her visit. I agreed and went to Melbourne, immediately started using heroin again and attended all of Gangaji's satsang, as a volunteer helper, rather stoned on heroin. I also signed up for the week-long retreat with Gangaji in Murwillumbah but my heroin use was out of control by the time I got there. This was the retreat where I made the pathetic, almost comical, attempt to cut myself with my twin-blade 'safety' razor. This retreat was not a big success for me.

I returned briefly to the ashram after yet another detox, now with my daily anti-depressants in my pocket. But I was ready to leave as I felt that I had got what I could out of the ashram and wanted to move on. Perhaps I should have stayed. Who can tell what might have happened if I had? I certainly felt safe and happy there, but I think I didn't want to feel that I was confined to this sanctuary for my safety. And the opportunity arose to go and live with some very dear friends in the hills inland from mid-coast New South Wales.

I spent all of 1997 in the hills with these friends. For me it was rather idyllic in a very rustic kind of way. My friends had just bought some land that they wanted to develop into a community and were happy for me to live there. Under one condition. No heroin. I agreed and for a year I didn't take any heroin at all. This was also my year on the Aropax anti-depressant with the regular counselling with Phil. I worked pretty hard, helping to make the run-down buildings habitable, establishing gardens and so on, but also taking many long walks in the beautiful forest on and around this property. But like at the ashram, I

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was still hiding from the world here - a beautiful, safe and healthy place to hide, but it was still hiding nevertheless. I didn't socialise much with others in the local village, and was happy just to continue my karma yoga practice, this time on the numerous chores at my friends' property.

It was while living here that I said to a friend I couldn't see any way out of my internal chaos without a change in consciousness, comparable to the change that occurs in puberty, that I was unable to imagine - prophetic words but not much consolation at the time. Instead, I tried to convince myself that this inner sadness and emptiness was just the human condition and that I had to accept this and get used to it. I tried - I feel I tried so very hard - to accept and adjust to this so that I might 'move on' and perhaps eventually find some joy and meaning again with this acceptance. But I never did. If I thought about it (which I tried not to) I hated it and just kept on hiding. Until the end of that year when I moved on out of this home in the forest and the worst year of my four years of madness began.

Previous chapters have told of this horrible year so I'll jump to early 1999, when I had just been discharged from the lockup at Royal Park after my last (and final) serious suicide attempt. I was about to start 'therapy' with the mad psychiatrist who wanted to bully me into submission with his undisclosed diagnoses of sado-masochism and personality disorder. After a week or so sleeping in spare beds in the homes of friends and family, I had found a space in the rooming house in North Fitzroy. It is impossible to overstate how important this meagre and not altogether convivial living space was to be for me. This tiny room, in a house with 11 other strangers each of whom had their own 'issues', was a godsend. My very own few square metres of space that I could call 'home'. I lived there for four years and am forever indebted to this tiny little patch of the planet that was a safe, clean, affordable and secure home for me.

During my year in NSW, I had continued to read and re-read my little booklet but I also now had a bigger book of Ramana's satsang, *The Teachings of Bhagavan Sri Ramana Maharshi in his own words*, edited by Arthur Osborne. This became a treasure trove and remains my favourite reference today. I had also, during the eight months in the

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zombie-land of the Methadone, Efexor and Zyprexa, attended the Gangaji video satsang that were being held in private homes in Melbourne. With Ramana as the source and Gangaji as a clear voice that spoke my language, the pieces of the jigsaw that were to save my life started coming together. Not that I noticed at the time though, except I guess I must have had some hope or I probably wouldn't have gone to these satsang.

The essence of these teachings - which Gangaji in particular emphasised as a 'non-teaching' - is that the fundamental spiritual question is "Who am I?" The second, and only other 'lesson' of this teaching is that the answer to this question is to be found in silence. That's it. That's all you need to know - there's nothing more to it. All the rest of any enquiry - and many other questions do get asked in satsang - will always return to these two basic 'truths' of self-enquiry. Even the tiny *Nan Yar* booklet was repetitive in constantly returning to these two fundamental truths.

These teachings are nothing that you can study and learn and practise, which is why Gangaji calls them a non-teaching (though she happens to be one of the most gifted 'teachers' I have ever listened to). That is, there is no 'method' to these teachings, nothing that you can do or practise. Chanting Who-am-I, Who-am-I, Who-am-I like some mantra will not help. All that is required is that this question "Who am I?" becomes the most important issue in your life. If fame or fortune or any other desire, such as the desire for that perfect lover, are more important for you then fine, pursue these first. But should the time come that this question arises for you as *the* critical issue in your life, then self-enquiry says attend to it - fully, earnestly, ruthlessly and without any compromise. I recognised this as exactly the crisis of the self that I had been struggling with in my suicidality.

Gangaji talks of these (non-)teachings as an invitation. For those for whom this question of "Who am I?" arises with urgency, self-enquiry is an invitation to 'wake up' and realise the Self, the spiritual self. It is the invitation Gangaji received from her teacher, Papaji, and that she is now simply passing on to anyone willing to receive it. But she also points out that this invitation comes from the Self. From your true Self within you that is inviting you into a deeper awareness and

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appreciation of your being. It is, to use Gangaji's simple eloquence, "your true self calling you home". These evocative words resonated powerfully for me. I recognised that I had always felt homeless within myself and here it was being suggested that there was a safe and peaceful 'home' already within my being that was waiting for me, waiting for me to come home. And my pain and yearning were a simple call to 'come home'.

But I couldn't just accept what Ramana and Gangaji were saying simply because these wonderful people were saying it. I was sceptical of all gurus and wary of the hype that you typically found around the idea of 'enlightenment'. My busy and 'clever' western intellectual mind searched hard for some flaw in their reasoning and the arguments they were making. But I was having trouble finding them. And, despite the elegant simplicity of what they were saying, I got bogged down on just *how* you might make the transition to this very simple awakening. That is, in one way it seemed all too easy and therefore not credible. But on the other hand, it was all too impossibly hard because *how* do you surrender to this silence of the Self? Clearly it was not some deliberate decision that you make like deciding to wash the car ... or kill yourself. I struggled with this for a couple of years before I finally 'understood' just how easy it really was to just be me. It was an ugly couple of years, but what a treasure there was waiting for me!

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Spirituality is almost as difficult a topic to have a meaningful conversation about as suicide. When I'm asked the question that many psychiatric survivors dread – "What do you do?" – I usually first say that I'm doing research into suicide. I often see a look of apprehension in people's eyes when I mention suicide, which I've come to recognise as the understandable fear most people have about this daunting topic. If I then say, "and spirituality", then the look in their eyes often changes from apprehension to suspicion as I see them step back in anticipation of some spiritual sales-pitch. Suicide is scary, but spiritual zealots can be even scarier.

Another problem in discussing spirituality for some people is that they see it as irrational and therefore unreal. For these people spirituality is a delusional belief in magic and so they easily dismiss it altogether as not 'scientific' and therefore beyond the possibility of any reasonable discussion. This is the ideological arrogance of the hardline scientist and the prevailing view in medicine, including psychiatry. Others, trying to be more tolerant and polite, regard spirituality as a 'belief system' and may even acknowledge some benefits for those who hold such spiritual beliefs. I have heard some psychiatrists talk of spirituality in this way but they too are in fact dismissing spirituality as a belief in the unreal. In order to accommodate this view into their scientific prejudices these psychiatrists are basically calling spiritual beliefs *benign* delusional beliefs, in contrast to their usual attitude that any belief in the 'unreal' is pathological.

Prejudices like these make discussion of spirituality very difficult. Although spiritual ways of knowing, almost by definition, take us beyond the simply rational mind, this does not automatically imply that they are delusional beliefs in the unreal. Similarly, it is quite possible – and very necessary – to have a sensible and rational discussion about spiritual ways of knowing, even as it takes us beyond the merely rational mind and into the spiritual self.

The narrative of this chapter tells some of my personal story on the spiritual path to recovery from suicidality, a story that continues in the narratives of the next two chapters. This commentary now begins an investigation, which also continues in the following chapters, of spirituality as a way of knowing the self and which was the key to my recovery. Spirituality is a vast topic so the focus here is the spiritual self-enquiry of Ramana Maharshi because this was the spiritual knowledge that appeared for me at a critical moment in my story. Although I am passionate about Ramana and his teachings, I do not want to be evangelical about either

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Ramana himself or his teachings. The spiritual wisdom of Ramana can be found in many other spiritual traditions, some of which we will touch on in this investigation. But I must acknowledge and honour the critical role of Ramana in my recovery. One way that I do this is through my attempt here to present his teachings, in my own voice, as best I can. For me, Ramana's teachings were a persuasive argument that helped me to a deeper, more peaceful sense of who I was. For me, it is a sound and rational argument, even as it takes us to a place beyond the limits of the merely rational mind.

One of the really attractive things about spiritual self-enquiry for me was that it was presented as an invitation. That is, spiritual self-enquiry is not an argument to persuade us to believe in some ideological dogma, such as the belief in a God, or the teachings of some guru. Rather, it is an invitation into an enquiry where you examine and test for yourself the arguments put forward by spiritual self-enquiry. This was the invitation that I received – an invitation that I now pass on here and in the next chapter as I attempt to present, as best I can, the spiritual self-enquiry I learned from Ramana Maharshi, Gangaji and others.

This chapter asks *what* is spiritual self-enquiry, which can perhaps be seen as the 'theory' of self-enquiry. The next chapter looks at the question many spiritual seekers find the most difficult, which is the *how* of self-enquiry – how to walk the spiritual path, how to awaken to the spiritual self – which we might call the 'method' of self-enquiry. The final chapter concludes with what arises or is revealed by spiritual self-enquiry, its 'outcomes' or consequences. For me, this conclusion is most of all a celebration of freedom from suicidality, but there is more to celebrate than just this.

A brief overview of self-enquiry as taught by Ramana begins with the fundamental question, "Who am I?" This is essentially the same question faced in the suicidal crisis of the self – "What does it mean to me that I exist?" Ramana explains how the answer to this question cannot be found in or by the mind. This represents a radical challenge to the prevailing orthodoxy of psychology that locates the self in the mind, so we will need to examine this challenge closely. Ramana then shows that the true nature of the self which, following Ramana, I will call the spiritual self, can only be revealed in the silence of a quiet mind. To intimately 'know' this silence is self-realisation or the ultimate goal of the spiritual quest. Except Ramana also explains that this silence is with us and within us already so that there is no goal to pursue or attain. This represents another radical challenge that we will need to examine closely, this time to the prevailing orthodoxy of

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many spiritual traditions that locate Spirit (or God) 'out there' and somehow separate from who we are *right now*.

We need to look closely at these two radical challenges because they expose two mistaken beliefs that are the biggest obstacles to realising the silent, spiritual self. The first and most critical of these is the mistaken psychological belief in the mind as the source of the self. I call this the Cartesian myth, where we incorrectly imagine that we are who we *think* we are. The second mistaken belief, which we must also let go of if we hold it, is the widespread belief in many spiritual circles that the spiritual self is something to be attained or acquired. I call this the enlightenment myth, where we incorrectly imagine that to know the spiritual self we must strive to become what we already are.

Letting go of these mistaken beliefs is all that is required to know the self. And it is the first of these that is the most important because to fully let go of the belief in the supremacy of the mind is to also let go of *all* beliefs, whether mistaken or otherwise. The second mistaken belief will therefore also collapse, but it still needs to be highlighted because it is perhaps the major obstacle encountered on the spiritual path. That is, it is perhaps the major obstacle for those seeking the spiritual source of the psyche. Or to say this another way, it is perhaps the major obstacle to letting go of the mistaken belief in the mind as self.

We need to let go of the mistaken belief that we are who we think we are because it is only in the silence of a quiet mind that the spiritual self is revealed. This silence is all that is left at the end of our search for the self. At the core of my being there is nothing other than this silence. Silence is the very source of my being, of who I am. Ramana urges us to turn our attention to this silence for in it we find the answer to the fundamental question, "Who am I?" Silence is where we find the answer, and silence is the answer. Silence is the deepest truth of who I am. To know this we need to surrender to this silence. This surrender is the 'letting go' of our attachment to the mind, the topic of the next chapter.

This is Ramana's entire teaching. First, ask "Who am I? Then, look for the answer in silence. This silence is nothing more than the silence of a truly quiet mind, which is always and already with us and within us. To know this silence is to know our deepest, spiritual self. And to know this we must let go of our attachment to the mind and surrender to this silence. That's it! The entire 'doctrine' of spiritual self-enquiry. There is nothing more that we need to know or learn or do. There is nothing more that I can tell you about spiritual self-enquiry. Except perhaps to repeat that in this

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silence I finally met myself for the very first time. And found peace and freedom.

Ramana himself, however, spoke of many other things in his dialogues, or *satsang*, with those who came to him seeking guidance. Although he always returned to the essential teachings just outlined, many other questions arose in these dialogues. Some of the more common questions were about the existence of God, the nature of the mind, truth and knowledge, what is enlightenment, what are the best spiritual practices, and so on. These and many other questions arise during spiritual self-enquiry and Ramana responded to them all, though always returning to the basic teachings as outlined above. In the rest of this chapter I look at some of the questions and issues that arose for me and also some that I judge as either the most frequent or the most tricky ones. Some of these are questions about God and religion, but these have never been major issues for me personally so I don't dwell on these too much. Others are about the nature of the mind or consciousness, which were my own questions and are still of much greater interest to me than God or religion. Many questions also arise about spiritual practice and the nagging 'how to' question, which are mostly left to the next chapter though we touch on them here.

The purpose of spending time with what is really my personal selection of the critical questions that arise during spiritual self-enquiry is to acknowledge these questions as part of the journey. That is, the 'doctrine' of Ramana's teachings can be set out quite easily and briefly, but the many questions that arise during our enquiry are a vital part of this enquiry. We will see that these questions are usually the mind struggling with thoughts, ideas and beliefs that Ramana would always urge us to simply let go of and give our attention to silence. But it is by attending to these questions, and all the thoughts, beliefs and stories that come with them, that we actually come to recognise the incessant chatter of the mind that obscures us from the silence in which mind arises. We'll see that this incessant chatter, the mind as a tree full of monkeys or thoughts, is not so easy to quieten. We need to attend to these questions for the simple reason that they so often demand our attention. The questions that arise for you, should you embark on the journey of spiritual self-enquiry, will be different from anyone else's, so they will be different from those that I've chosen to explore here. The personal selection that follows includes some of the main questions that are likely to arise but, more than this, I hope the discussion of them illustrates the need to attend to them respectfully and honestly. Because nothing is more valuable on the journey of self-enquiry than to respect your questions

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and a total commitment to an utterly ruthless, but simple, honesty as you grapple with them.

I have already mentioned the two major challenges that Ramana's teachings make to the prevailing orthodoxies of mainstream psychology and most spiritual traditions. We will get to these but first, to begin at the beginning, a short personal anecdote reinforces that the fundamental question for the spiritual journey is "Who am I?" I was talking with a friend who was curious about my claim that my spirituality was not at all religious. He wanted to insist that somewhere in my spirituality there must ultimately be some faith belief. It may not be a faith in God, he argued, but still, somewhere, some sort of faith – in something – was a necessary part of any spirituality. It was a good point and a challenging question. It forced me to look at my understanding of spirituality to see if I could find the faith belief he was insisting must be there somewhere.

Talking it through with him, my answer began with the observation that if we looked at religious faith, for instance, then faith in God is really just the most fundamental assumption of all systems of religion. That is, religious faith is the assumption that God exists even though this cannot be proved to our senses or explained rationally. This faith in God, the assumption that a God of some kind exists, is the bedrock on which all the other religious beliefs are then constructed. So I said to my frowning friend that although my sense of the spiritual does not assume the existence of any God, there was perhaps a similar sort of bedrock assumption to my understanding of spirituality. This is the assumption that I exist. Or at least, that I seem to exist, that is. If I think about it, this assumption that I exist – that 'I am' – is totally mysterious to me. I do not understand it at all. I don't understand how it has come about, nor what it means, if anything at all. But, as best as I can tell, I do seem to exist. Ramana describes this as:

Of all the thoughts that arise in the mind, the 'I' thought is the first. It is only after the rise of this that the other thoughts arise.

This mysterious 'first thought', which all other thoughts depend on, is what spiritual self-enquiry seeks to explore and comprehend. The 'I' thought is my one act of faith, the one assumption and the starting point of spiritual self-enquiry. The entire spiritual challenge is to know who or what this 'I' thought really means. And this spiritual challenge is contained entirely in the question, "Who am I?"

A whole host of questions immediately arise from this short story. Perhaps the first to consider in this delicate discussion on spirituality is to

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come up with some working definition of what we mean by 'spirituality'. For me, the first thing to say is that spirituality is very personal and very much of this world. That is, it is about my deepest sense of self as I experience it in the world in which I live, and nothing at all to do with faith in God or any 'other world' supernatural beliefs. In line with this view, one definition of spirituality is 'that which gives ultimate meaning and purpose to our lives'. I agree with this but some people will then attempt to explain this in psychological terms, which is never very successful. For others, spirituality is seen primarily in social terms, in our cultural relationships to each other, our history and ancestors, to the land and, perhaps, the relationship to God or Spirit(s). This too I have always found a rather incomplete, unsatisfactory and in the end inadequate definition of spirituality. What I'd like to propose as the distinguishing characteristic of spirituality, which I think encompasses all these variations, is simply that it is those aspects of the lived, human experience that are *neither physical nor mental*. There is a problem with this definition in that some people deny there is anything other than body and mind, so we will need to re-visit this definition later on, but for now this is the simplest and clearest definition for me of spirit or spirituality.

One question that invariably arises in discussion on spirituality, and has arisen for us already, is the distinction between religion and spirituality. At their best, religions can be seen as institutionalised and ritualised spirituality, which I compare with the political map of nations on planet earth. That is, they are cultural artefacts of human societies superimposed over our underlying natural spirituality in the way that nation states are superimposed over the underlying natural geography of earth. And spirituality does not require religion any more than geography requires nations. Similarly, as a nation without geography is a meaningless concept, so religion without spirituality is meaningless. At their best, religions give a social and cultural structure to the expression of our spirituality. They create spaces where our spirituality can be studied, taught, practised, shared and celebrated. And like the many different languages of nations, there are many different 'languages' for the religious expression of our spirituality. As humans, we all speak a language, though the specific language we speak is determined by the cultural environment we grow up in. Another similarity with the various different languages is that they are incomprehensible to each other, despite the underlying capacity for language that is common for all of us.

At their best, religions are the schools and sanctuaries of spiritual life. At their worst they have become political institutions that have lost contact

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with their spiritual origins and responsibilities. Sadly, the history of religions shows that the lust for social and political power has taken over most religions so that many people, myself included, have little respect for them as spiritual institutions. I cannot see any genuine spirituality in religions that claim their notion of god as the one true god and, what's more, are even prepared to kill anyone who thinks otherwise. For many of us, there are too many examples of religious abuses of power over too many years for the churches to have any credibility at all as spiritual institutions. Hand in hand with this abuse of power, religions have also not responded well to the challenges of science. When science began to demonstrate the folly of some core religious teachings, religions tried to respond by dogmatically asserting their authority rather than honestly engaging with this new knowledge. Religions plainly lost these debates and have been in decline ever since, at least in the western world. Most of what I see in religion today is a false spirituality, devoid of any real depth or compassion, and actually an obstacle to the spiritual development of both individuals and communities. I think the main point to keep in mind about the distinction between religion and spirituality is to recognise that it is possible to be religious without being at all spiritual, and that you can similarly be very spiritually oriented without being at all religious.

A related question that arose in the discussion with my friend is the question he put to me about faith as central to any spirituality. This is an intriguing question. The common understanding of faith in this context is as a belief in something that cannot be scientifically proven or rationally explained – the religious ‘act of faith’ in God, for instance. I have already explained that, for me, believing that I exist is in many ways a not dissimilar act of faith, though I think most people would not regard it as such. The distinction between faith and belief is a vital one as it lies at the heart of Ramana's first radical challenge to what most of us think of as the self. That is, the prevailing psychological view that we are who we *think* we are – Descartes' famous dictum, “I think therefore I am” – is shown to be a mistaken belief. Or to say this another way, it is an act of faith to believe in the mind as the source of who we are. Except, unlike a faith in a god that cannot be either proved or disproved, our faith in the supremacy of the mind can be shown to be mistaken – by spiritual self-enquiry.

The most important, the most frequent and the most difficult questions that arise in spiritual self-enquiry, then, are those around the nature of the mind. We have seen that Ramana identifies the ‘I’ thought as always the first thought on which all other thoughts depend. Following this line of

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thinking, he then argues that what we call ‘mind’ – or the experience of ‘having a mind’ – is nothing more than the presence of thoughts:

Apart from thoughts, there is no such thing as mind.

This is part of the radical challenge to modern psychology and how most of us think of the mind. We typically think of the mind as some sort of ‘thing’ that is always with us, always a part of us. But if we think carefully about it, Ramana is quite correct. What we call the mind is nothing other than our experience of ‘having thoughts’. When we are awake, these thoughts come and go in a seemingly constant stream so that it appears that the mind is always present. That is, most of us find it hard, if not impossible, to contemplate the total absence of any thoughts whatsoever. This difficulty, which is a very real difficulty, is actually the great obstacle that blinds us to those aspects of our self that are neither physical nor mental – what I call the spiritual self. The constant ‘chatter’ of the mind occupies, fills and overwhelms our consciousness so that the silent spiritual self within which we experience the mind remains obscured and hidden behind all this mental ‘noise’. It is this powerful presence of our thoughts, of the presence of mind, which leads us to believe that these thoughts, this mind, are all that there is. This belief (another kind of thought) has become a powerful belief in our culture since the collapse of supernatural religious beliefs. But this ‘mentalistic’ belief in the supremacy of the mind obscures the many silent moments between our thoughts as they come and go, so that we easily overlook these moments when the mind is briefly altogether absent.

People familiar with meditation practice will recognise these moments between the thoughts as the ‘space’ that we seek to spend time in during meditation. For this reason, Ramana encourages the practice of meditation, although more precisely he calls meditation any practice that helps to quieten the mind, as we’ll see in the next chapter. This space between the thoughts I sometimes call our ‘no-mind’ moments and they actually occur regularly for all of us throughout any day. I’ve heard the ecstasy of orgasm called the ‘gateway to paradise’ for precisely this reason. But my favourite – and more frequent – example of the ‘no-mind’ moment is hearty laughter. When laughter bursts out of us, the mind is quiet and, Ramana and I would argue, totally absent. Other times of intense emotion will also quieten the mind, perhaps the most obvious being when we cry. In these moments the self that exists in the absence of the mind is revealed. But we usually fail to notice it.

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The more typical example of 'no-mind', and one that Ramana frequently refers to, is deep sleep. During deep sleep we have extended periods of no thoughts at all. And some people describe advanced skills in meditation as deep sleep while still awake. The point is that in all these moments, no matter how brief, when thoughts are absent, so is mind. Mind is nothing other than the presence of thoughts.

The implications of this are obvious for our enquiry into the self, and form another part of the radical challenge to psychological notions of the self. If the mind comes and goes with our thoughts, then does the self also come and go with the mind? Or does it persist even when the mind is totally quiet or, as Ramana would say, when the mind is absent? The intuitive answer would seem to be yes, that the self persists. If this is the case then the self cannot reside in the mind. Recall that the self we are looking for is what the 'I' thought points to – the sense of self that 'I exist' as a whole, unified and continuous identity. Such a self cannot possibly reside in a transient mind. Furthermore, the self cannot be fully known by the mind because any thought we might have about the self can only ever be an approximation. Any thought of what the self is can only ever be at best a fleeting snapshot of some aspect of the self – a story *about* the self. No thought can ever capture the completeness and the fullness of the whole, unified, continuous self. That is, the self cannot be found either in or by the mind.

This also challenges one of the more popular notions or theories of the self that we hear about quite a bit in this postmodern era. This is the idea that the self is all the stories we tell ourselves about who or what we are, sometimes referred to as the 'narrative self'. I see story-telling as a vital part of any spiritual journey and the search to find out who or what we are. I also see story-telling as perhaps the most urgent but also the most neglected need for responding to a crisis of the self, such as suicidality. I'll say more about this in the next chapter, but at this point in the 'theory' of spiritual self-enquiry we have to say that these stories are also inadequate as a complete answer to our self-enquiry. Like any thought we have – and these stories are all just thoughts – no story, or collection of stories, can be any more than an approximation of what they describe. They are like the painting of Mona Lisa, which is not the person Mona Lisa. And any story requires a story-teller, so the question who or what is behind the creation and the telling of these stories remains. Again we find that we are not who we think we are and the question remains, "Who am I that tells these stories?"

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There are many questions, and perhaps many objections, which might arise at this stage in the argument. I'll look at just a few of these. First, some people will ask what about our feelings – the emotional mind? For many, the cognitive, rational, 'thinking' mind is privileged as superior to emotional feelings, which would be the prevailing view in western culture today. There are plenty of others, however, who regard our emotional feelings as at least as important, if not more so, than the cold, clinical thinking of the purely rational mind. Among these is the distinguished Australian biologist Charles Birch who, in his compelling book *Feelings*, argues that all thoughts are just particular kinds of feelings. That is, Birch privileges our more visceral, feeling, emotionally laden thoughts as more fundamental for the simple reason that it is these feelings that matter most to us. I am sympathetic to Birch's point of view, but Gangaji, the American woman we met briefly in the narrative and who teaches in the tradition of Ramana, sees it rather differently. I have heard her describe feelings as just particular kinds of thoughts. Whether we privilege feelings and say that thoughts are just particular kinds of feelings, or vice versa, is a moot point and irrelevant to the discussion here. The experience of mind is to experience mental activity, thoughts and feelings or, more accurately most of the time, some blend of these. With this in mind (no pun intended), I will generally follow Ramana and use the term 'thought' as the collective noun for all these different kinds of conscious mental activity.

Another question, or objection, might arise around the various notions of unconscious or subconscious minds. These theories state that there is mental activity that we are not consciously aware of and therefore imply that the mind persists and is a constant presence – i.e. 'exists' – even without any conscious awareness of it. I would call this understanding of the mind metaphorical as it uses our everyday, common sense understanding of what the mind is – i.e. thoughts and feelings – as a metaphor to help describe and understand the processes that lie behind our conscious thoughts. That is, it uses the language of thoughts and feelings to describe and explain the unseen influences on our conscious thoughts, feelings and behaviour. Like all good metaphors, it can be useful as a tool to express the invisible origins and motivations behind our conscious life in meaningful, human language – i.e. the language of thoughts and feelings. It is therefore a metaphor that is widely used, and often very effectively, in many forms of psychotherapy. But the metaphorical 'unconscious/subconscious mind' is not the mind that Ramana and I are exploring in spiritual self-enquiry, which is the conscious lived experience of the presence of thoughts and feelings.

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This raises further questions and, again, perhaps objections or disputes, around the fascinating topic of consciousness. There are many different meanings – and confusions – around the words ‘conscious’ and ‘consciousness’. First, when we talk of being conscious of something we really mean being *aware* of it. In a similar way, we often talk of consciousness when we mean ‘awake’. These are both psychological, that is mentalistic, notions of consciousness and being conscious. A more rigorous definition of consciousness emphasises its key characteristic, which is that consciousness is to *experience* something – that is, the *experience* of thoughts, feelings and perceptions, the *experience* of a self, the *experience* that you exist. This experiential aspect of consciousness needs to be distinguished from the psychological understanding of (conscious) awareness, which tells us little, if anything, about our experience of what we are aware of. And a biological or medical understanding of consciousness tells us precisely nothing about either the psychological or the experiential (not to mention the spiritual) dimensions of consciousness.

A further muddying of the terminology is found in some spiritual teachings where (psychological) awareness is not only equated with (experiential) consciousness but also with (spiritual) soul. Indeed Ramana himself, like many other spiritual teachers, frequently uses Self, Spirit and Consciousness (and sometimes God) as virtual synonyms. In contemporary studies into consciousness in the western academic tradition, consciousness is still predominantly seen as a feature or attribute of the mind. Many spiritual traditions see the reverse, where mind arises in consciousness rather than the other way round. My own view is the spiritual one where mind comes and goes within consciousness that is never absent. It remains to be seen whether the emerging understanding of consciousness in the western, intellectual, academic tradition is indeed exactly the same as the spiritual self or soul that many spiritual traditions speak of. My view is that this is quite likely the case. But it may be that the experiential dimension of consciousness, although very close to the spiritual self, may be just the doorway through which we will be intellectually able to approach the deeper spiritual self. Either way, the study of consciousness has a vital role in bridging the gap that currently exists between traditional spiritual wisdom and contemporary intellectual enquiry into the nature of the self.

Another way of approaching the limitations of the mind in the search for the self is summed up in yoga by the phrase *neti neti*, usually translated as ‘not this, not that’. It says that any *thought* that we may have about who or what I am is not – and cannot be – who or what I actually am. In yoga the

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process is to peel back what are called the ‘five sheaths’ of our being, each time asking ourselves, “Am I that?” The first of these sheaths is the physical body and most people, including most of us from the West, readily accept that “No, I am not my physical body”. The next sheath in yoga is the ‘pranic body’ representing the subtle, vital energy of *prana*, the *ch’i* or *qi* in Chinese medicine, and closely associated with the breath in yoga. This idea may seem foreign to many of us in the West, though ‘the breath of life’ and even ‘the breath of God’ are not uncommon phrases. In yoga, the pranic body is also associated with our emotional being but once again the answer to the question “Am I my vital, emotional self?” is *neti neti*. The three inner or ‘higher’ sheaths of our being are all to do with what we in the West would call the mind. The first of these (the third sheath) is our rational, thinking mind – am I that? Again, *neti neti*. The fourth sheath is the mind of knowledge and wisdom – am I that? Yet again, *neti neti*.

The final or fifth sheath is that of the awakened spiritual mind, which some people may feel is a candidate for the ‘true’ self. This brings us to Ramana’s second radical challenge, this time to the popular view in many spiritual traditions. Before we look at this, it’s useful to draw a parallel between this ancient yogic wisdom and current western thinking about the self. The many aspects of mind that we have looked at so far in our enquiry into the self – and there are many more that could also be mentioned – all come up wanting. In western psychological terms we could describe this as peeling back the many layers of the personality looking for our real, true or authentic self at the core of our being. These layers of our personality, like the onion rings of the five sheaths, can be seen as the many masks we wear as we present ourselves to the world, including the world of our own private thoughts. We might come up with a different set of ‘sheaths’ to what the ancient yogis identified. But my own enquiry has shown that the answer has always been the same as what the yogis found – *neti neti*, not this, not that. In the end we are left with nothing at all at the centre of all these layers or masks. In peeling them all back, however, we find ourselves surrounded by the debris of our enquiry, the many fragments of the self that we have examined and discarded as *neti neti*. These I now see as the wardrobe, the many cloaks we wear, of our personality. But even all these fragments in combination fail to add up to the sense of self that I know and recognise as the ‘I am’ experience, the feeling that I exist, the wearer of these cloaks, masks or sheaths, the teller of all my stories. Psychology, psychiatry, the other social and human sciences of western philosophical traditions, including current thinking on consciousness, all fail to come up

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with a satisfactory explanation for my burning curiosity about who or what it is to be me – *neti neti*.

In the western intellectual tradition of academia this pretty well leaves us at a dead-end. That is, if we can only conceptualise our sense of self in terms of body and/or mind then the history of traditional academia has left us with little more than a pile of postmodern fragments – the debris of our exhaustive analysis. After hundreds of years of rigorous scholarship, in many different academic disciplines, the unified experience of our identity, our sense of self or the feeling that I exist, that *I am*, continues to slip through our intellectual grasp. And furthermore, with no sign of how to proceed beyond this intellectual impasse.

At precisely this moment in our enquiry, when the intellectual tradition of western, academic thinking finds itself with nowhere to go, the spiritual wisdom traditions kick in with much to offer. Unrestrained by the limitation of only body and mind in which to find the self, spirituality can take us to the silent mystery at the core of our being where the mind cannot go. Spirituality introduces into our enquiry notions of spirit and soul (the real meaning of psyche), of God and enlightenment, of *nirvana*, *samadhi* and other similar terms, and of spiritual awakening and self-realisation. We need to proceed in our enquiry beyond the merely mental and psychological and look at this spiritual wisdom.

We might think that the fifth sheath of our *neti neti* exercise, which I called ‘spiritual mind’, is the goal of our enquiry, but Ramana is adamant that this too is *neti neti*. For Ramana, any mental notion of the self cannot be the true, spiritual self. This includes the spiritual mind of the fifth yogic sheath, which may well be the mental expression of knowing the spiritual self but is really just another psychological story about the self. *Neti neti*. To ‘know’ the spiritual self is an altogether different kind of knowing to any mental knowledge. Some would say that to know the spiritual self is to know God. I don’t disagree, except God is a term I usually choose to avoid because of its many confused and confusing meanings – and the tensions that are easily aroused in this confusion. Following Ramana, I prefer to say that to know the spiritual self is to ‘know’ the silence at the core of our being which, as the use of quotes here suggest, I would really prefer to call simply *being* this silence. There are many suggestive links that can be made with this language, such as knowing the spiritual self is to know God, which is to know the silence at the core of the self, which is to be that silence ... which is to be God. Ramana would not disagree with this logic, and neither would I, though it sometimes upsets some religious people who see it as a blasphemous vanity of the ego. But the spiritual self I am talking about has

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nothing at all to do with the ego. On the contrary it is the death of the ego, but we'll get to this later. The relevant question that arises at this point in our enquiry is what do we mean by terms such as spiritual self, spirit, soul, enlightenment, God and so on?

This brings us to Ramana's second radical challenge to another widespread mistaken belief. This time he challenges the prevailing orthodoxy of many spiritual teachings, which parallels his challenge to the psychology of the self. The orthodoxy he challenges is the belief – the mistaken belief – that the truth of who we really are is somehow something other than who we *already* are. Said like this, it does indeed sound absurd. But this absurd belief is implicit in most spiritual traditions as the belief that Spirit (or God or whatever) is somehow 'out there' and that there are things we must do to somehow 'get it'. That is, that what we are calling the spiritual self is somehow something separate and remote that has to be attained or acquired. Ramana explains that the spiritual self is nothing other than the truth of who we are right now – already and always – and therefore it is a folly to try and get, attain or acquire what you already are. For those steeped in spiritual or religious traditions that see God, Spirit, enlightenment, nirvana, self-realisation – or whatever you want to call it – as something 'out there' and separate from who we are right now, this is a radical challenge, perhaps even a blasphemous heresy. But it is another mistaken belief, similar to the mistaken belief in the mind and which, like the mind, is another obstacle on the spiritual path that has to be discarded.

The religious belief in an external God is perhaps the clearest example of the belief that Spirit is separate and remote from the self. As I've indicated, this notion of God is too supernatural for me and the religions that teach it do not speak to me, though one of the few religious teachings that has some appeal for me, and is often lacking in less religious spiritual traditions, is the 'omnipresence' of God. That is, most religions seem to recognise the 'always already' presence of God, that 'He' is always and already amongst us in our day to day lives. This, to me, is the presence of Spirit that Ramana points out is with and within us here and now.

It was with the less religious spiritual teachings, however, where Ramana's radical challenge to Spirit as separate and remote was particularly pertinent for me. Since I'm not at all religious, the challenge to a supernatural God was not a big deal at all. But Ramana's challenge to the yoga that I knew and loved, with its goal of enlightenment that can only be obtained through years of diligent spiritual practice, was a serious and disturbing one. It was also a serious challenge, it seemed to me, to the 'less religious' spirituality of Buddhism, which is perhaps hardly surprising given

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its close ties in history with yoga. These are the spiritual traditions that see the goal of the spiritual path as the attainment of enlightenment (which can be seen as the religious 'union with God' perhaps).

I now regard 'enlightenment' as a most unfortunate word that is problematic, misleading and downright unhelpful to the spiritual journey. With Ramana's help, I have come to recognise that the popular understanding of enlightenment, and our efforts to attain it, are major obstacles on the spiritual path. There are many words in yoga, Buddhism and other traditions, such as *samadhi*, *nirvana* or *satori*, with similar meanings, and similar problems, as 'enlightenment'. And that problem is that all these terms suggest that Spirit, which is the true nature of our existence – or of the spiritual self – is something 'over there' that can only be attained or acquired by disciplined spiritual practice. Ramana challenges this notion of enlightenment. Enlightenment, he says, is nothing other than the truth of who you are – who you already are – *right now*. And what's more, driving this message home, he points out that you cannot get what you already are.

Another term frequently heard as a synonym for enlightenment, and a much preferable one in my view, is self-realisation. To realise the self, says Ramana, nothing is required because we are already that:

Realisation already exists; no attempt need be made to attain it. For it is not anything external or new to be acquired. It is always and everywhere – here and now, too.

When I first encountered this profound wisdom it was a shock for me. And like Ramana's challenge to the supremacy of the mind, I struggled furiously against it with all the deeply entrenched prejudices of my years of yoga. This was heresy! A radical blasphemy!

But Ramana was adamant. Again, with the same rigour and clarity with which he exposes the false self of the mind, he exposes the folly of imagining that self-realisation (call it enlightenment, if you must) is anything other than to 'know' the spiritual self that you are, here, now and always:

No one is ever away from the Self and therefore everyone is in fact Self-realised; only – and this is the great mystery – people do not know this and want to realise the Self. Realisation consists only in getting rid of the false idea that one is not realised. It is not anything new to be acquired.

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This was indeed a radical challenge to the yoga that I knew and loved. The message I had taken from my years of study and practice of yoga was that self-realisation – enlightenment, *samadhi*, *nirvana*, whatever – was a state of consciousness (possibly a state of mind) that could only be achieved by dedicated spiritual practice, or *sadhana*. But even diligent dedication to *sadhana* (which I knew I was incapable of) would not be sufficient by itself, because enlightenment also required the ‘grace of guru’, the tap on the shoulder or ‘transmission’ (to use the Buddhist jargon) from the master to the student. Or so I had learned. This of course was a major problem for me as I had about as much faith in gurus as I did in the notion of God. And if that’s not enough, I had also learned that many lives would need to be lived to ‘attain’ this goal of enlightenment, the Holy Grail of the spiritual path, which even became an argument in favour of suicide for me. The message I learned was that it would clearly be presumptuous of me to imagine that enlightenment might be possible in this life.

You can imagine the shock for me then to hear Ramana’s radical challenge to the orthodoxy of these spiritual traditions. Here was this man, widely recognised as one of the great spiritual sages of the modern era, saying that this popular notion of the goal of spiritual practice was a false, mistaken belief, a lie. In some ways this was perhaps even more shocking than his equally radical challenge to the psychological, mental notion of the self.

This was tremendous news because it opened up the possibility for me of finding something beyond my persistent suicidality, perhaps the peace that I was yearning for like a drowning man yearns for air. It created a space in which my life might become something other than the utterly meaningless and constant pain of suicidal psychache. But I still did not ‘know’ the silence that Ramana spoke of. Although his arguments made very good sense to me, I still did not know the spiritual self that he was pointing me towards. It still felt ‘out there’ as something remote from who I was, something other than the daily pain of being me. Or so it seemed to me. Despite these very convincing arguments, in which I tried very hard to find some flaw but couldn’t, I still had the question of *how* do I realise and ‘know’ the silence that is the truth of who I really am.

This is the question we take up in the next chapter, but it is worth concluding this chapter by recapping the key ideas, or ‘theory’, of Ramana’s teaching. The two basic elements of spiritual self-enquiry are the question “Who am I?” and the answer: Silence. All the discussion around the nature of the mind or the nature of God is circumstantial and secondary to this key

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question and its very simple answer. All these secondary issues are important though, and I have spent time on some of them here, because of the tenacity with which we cling to the belief that the mind is the source or key to knowing who we are. That is, we need to see the limitations of the mind in order to overcome its hold on us and create the possibility, the space, where we can 'know' the silence at the core of our being. We need to let go of the mistaken belief that we are who we think we are. This is Ramana's radical challenge to modern psychology and the common understanding most of us have about the mind and the self.

What then is this silence that Ramana invites us into? It is simply the silence of a truly quiet mind. It is the silence of the self when no thoughts are present, when there is no mind. It is the silence in which thoughts arise and, with them, the mind. And it is the silence into which thoughts and mind subside – the silence before and after every thought, before and after every occasion of mind. It is the silence that is never absent but frequently overlooked. It is the silence at the very core of our being and beyond which the mind cannot proceed in our spiritual self-enquiry. This silence is who I am when all other candidates – all the *neti neti* – are peeled away. This silence is the spiritual self itself. It is who I am, the answer to "Who am I?" It is the utter, empty silence of my existence.

This silence is nothing other than the truth of who we are *right now*. It is the silence that is always present and can never not be present, for without it we simply cease to exist. It is already with us and within us. Always already, here and now. We can call it many names – spirit or the spiritual self, God, 'pure' consciousness, whatever – but it is always, it must always, be present here and now and always. And we can call 'knowing' this silence many names – self-realisation, enlightenment, *samadhi*, *satori*. But it is a mistake, a big mistake, to imagine that this silence (spirit, God, whatever) is anywhere other than right here, right now. And another big mistake to imagine that there is something we need to do in order to get, attain or acquire this 'knowledge'. All we need to do is to let go of our mistaken beliefs that there is something other than this silence at the core of our being. We already know this silence, we already *are* this silence. It is only the ignorance of our mistaken beliefs that are the obstacle to fully realising this. There is no 'enlightenment' to be strived for and acquired. We cannot become who we already are. This is Ramana's second radical challenge, this time to many spiritual traditions.

The only obstacles – the *only* obstacles – on the spiritual path are these mistaken beliefs that are the source of our ignorance and which, along with our noisy minds, cause us to overlook the silence that is already and always

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here. We now turn to the very real challenge of *how* do we let go of and discard these mistaken beliefs?

Chapter 6

The Willingness to Surrender

The time will come when you will have to stop with all stories
(Gangaji)

There is no greater mystery than this, that we keep seeking reality though in fact we are reality. We think that there is something hiding reality and that this must be destroyed before reality is gained. How ridiculous! A day will dawn when you will laugh at all your past efforts. That which will be on the day you laugh is also here and now.

(Ramana Maharshi)

I cannot point to a single day or moment when all the pieces of the self-enquiry jig-saw fell into place and peace and freedom arrived. But I can pinpoint it roughly to the first week of June, 1999. I shed my suicidality (and my heroin addiction) like a snake shedding a no-longer useful skin. I found that, instead of hiding from the world as I had for the previous four years, I now wanted to "walk in the world again". These were the actual words that I found myself saying to myself. And it was almost alarming. It was certainly disorienting and quite an alien feeling after years of trying to either escape (through drugs or suicide) or to just accept this endless sadness as the human condition that I simply had to get used to. And the key to this radical change was the realisation that at the core of my being was a bottomless, endless peace - a peace that I now also saw was what I had been yearning for all my life.

And in this peace there was a great freedom. Freedom is the other key word that characterises this liberation, this *moksha*. And peace and freedom have remained an ever-present part of my life since. The peace of the silent stillness is who I am, and the freedom is the freedom to be just me - nothing more and nothing less. Peace is the

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spiritual Emptiness (*sunyata* in Buddhism, *sunya* in yoga) that is without the constraints of the time and space of the material world. And freedom is my new relationship to the material, physical world around me that is still the world I live in and in which I continue to participate with my daily activities.

Another feature of this radical shift in consciousness is that it was very, very funny. Gangaji tells the story of a woman who described this liberation as being picked up and turned right side up after a lifetime of walking around on her hands. Her first reaction to this was an extraordinary sense of relief at how easy it was to get around now on her feet rather than on her hands. "So that's what these feet are for!", she exclaims. And then came the embarrassment of realising that she had had these feet all along. The delight of discovering her feet, though, was so much more than the embarrassment that all she could do was laugh at herself.

My version of this tale is that I now saw that, prior to June 1999, my inner 'home' had been one of sadness. Despite the many wonderful adventures of my life, the place that I always seemed to return to in the privacy of my inner self was a sad place. I was walking on my hands. Sometimes I was able to do this quite skilfully, at other times rather clumsily, and then sometimes I fell over. To realise the peace of the spiritual self as my new inner 'home' was to be put right side up. And how utterly easy it now became to walk in the world again. And how embarrassing it was to see how clumsily I had struggled all these years. I felt like a complete dope! But all I could do was laugh at the joy of it ... and I've been laughing joyously ever since.

In the same way that I can't pin down a date or particular moment, it's difficult to say what were the critical steps towards this 'recovery', this awakening. I had just started with the (foxy, two-edged) psychiatrist who had wanted to claim the credit for this radical change in me, which was an extraordinary vanity, especially since he didn't even believe it was real. Obviously I acknowledge the wisdom of Ramana and Gangaji as fundamental, but these teachings by themselves do not 'awaken' you to the Self. Waking up to the Self is not some cognitive decision that you take or something that you study in books and then sit an exam. It is a change of consciousness comparable, as I had

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unknowingly predicted years before, to the change that occurs during puberty. How does this happen? What can we do to help make it happen?

I can say that for me the key 'event' at this time was that I surrendered. Again, I cannot pin down some vital moment when this surrender took place. Nor can I say exactly what I mean by surrender. I can say that it was definitely not some decision that I deliberately and carefully took. In many ways it was simply a 'letting go' and the main obstacle to this was my clinging to something - it's hard to say exactly what. At the time it was certainly not clear what I was clinging to, nor what I needed to surrender to. Surrender was a step into the unknown and, I now believe (or, rather, I now 'know'), into the unknowable. And there was great resistance to this.

There were certain aspects of my circumstances at the time that I am sure were important for this surrender to occur. First, I was living in the rooming house in North Fitzroy, which gave me a physical, material 'home' that was clean and safe. As I have said, the importance of this cannot be overstated. Next, I had decided to get off the Methadone and all the crazy psycho-medications. I was quite clear in my mind that I was not prepared to live any longer in this drugged stupor, that I would rather die than continue like this. In other words, I made a very deliberate decision that I would get off these drugs or die. One or the other, it didn't matter to me which.

I'd gone to my Methadone doctor but before I could tell him of my decision, he'd announced that they had reviewed my file and decided that the treatment I was receiving wasn't working. I laughed as I told him that I had reached a similar decision. I mostly wanted to stop taking the beastly Zyprexa but his advice was that I should come off these drugs one by one and that Methadone should be the first. Reluctantly, I accepted the good sense of this advice even though I knew this would mean months, as described in the Drug Detour chapter, before I could stop taking the Zyprexa.

The word on the street is that no-one gets off Methadone without the help of a little heroin during these withdrawals. I was no exception, though as it turned out I didn't get seriously into it again. My GP, who supervised the latter stages of my methadone detox, had

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wanted me to leave town at this time. Get away, go bush and distance myself from the heroin scene. In drug circles this is called 'doing a geographical'. At the time, I didn't want to do this. I was content in my new home and, besides, there aren't many places where heroin is not readily available these days.

I persisted. I also found that, for some reason that I don't understand, I had the urge to start the day with a long walk. I've never been much of a walker for the sake of walking, but each day I was getting up at around dawn and walking around North Fitzroy for an hour or more. And I'm sure this was another ingredient of my detox and recovery. I was not up to more demanding physical exercise - remember, I was now twenty kilos overweight and basically a fat, lazy slug. But, for some peculiar reason, I just wanted to walk and walk these mornings.

Without telling any of my doctors, I had already stopped taking the Zyprexa. First I found that I was starting to forget the occasional dose. Then one day I went to put the pill in my mouth and I just couldn't do it. And I've never taken one since and never will again. When the Methadone withdrawals had finally passed, my doctor asked if I still wanted to go off the psycho-drugs. I had also stopped taking the anti-depressants by then and told him so. He was not too impressed because he knew, better than I did at the time, of the dangers of coming off these drugs unsupervised and 'cold-turkey' as I had done. But it was too late - I was finished with them all. Hooray!

This was another key moment leading up to my eventual surrender and recovery. One day not long after this I'd suddenly realised I was the most drug-free that I'd been in years. For more than two years I had been taking a pretty hefty dose of either the prescribed medications or heroin (or both) and now I had stopped and they had also finally washed out of my system. Drug free! What a radical thought - or so it seemed to me. And in this moment, this fleeting, unexpected thought, there was a feeling of being flung into some new space as though out of a slingshot. I can't say it any better than this, because this is how it felt and this was the language I used to describe it at the time. And it made me laugh. Not much later, when I knew that my 'recovery' was in place, this moment somehow seemed

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significant. Maybe this drug-free feeling was some clue to the freedom that might be possible. I don't know. By itself, it doesn't seem much. I had been totally drug-free for six months at the ashram so, by itself, I don't think it would have propelled me towards the recovery that was now imminent. But, somehow, it was important.

Another ingredient of this peculiar blend of influences at the time of my recovery was that I had effectively walked away from the doctors. I was finished with both addiction and 'depression' as the source of my suicidality. Neither made any sense to me now. And the various treatments I had received in some way confirmed this because they had not helped at all - in fact, they had made things worse. So I was finished with all the doctors who were only able to 'treat' me on the basis of these useless diagnoses. I still felt a need for some counselling, though, and was still seeing Nicky, but only very occasionally as I could no longer afford her. This led to my last (ever) relationship with a psychiatrist, but from the outset with him it was clear that I would not consider any medications or any other 'medical' treatments. As we have seen, this relationship never got off the ground - thankfully. I didn't realise it but I was slowly exhausting the possibilities, which was another significant ingredient in my ultimate recovery.

I think it was at my third session with this last psychiatrist that I'd said to him that I was feeling really - like, reeeeeeally - good. He was sceptical about this (though still able to congratulate himself for it), which was very understandable. I was sceptical too. And I knew others, family and friends, would be as well, so I didn't even mention it to them initially. One or two days of feeling 'high' does not constitute a recovery and we had all seen too many moments of hope shattered over the previous four years.

I'd talked with the psychiatrist about this 'high' being like on a wave. I knew that he, like everyone else (including me), could see this wave all too easily crashing me into the rocks on the shore. But somehow it felt more than that to me. Somehow I felt a glimmer, even among all my own doubts, that maybe there was something really significant in this 'wave'. And I was acutely aware, during the first few days of it, that I had the option to pull out of this wave if I chose to.

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That is, I could prevent the potential crash on the rocks if I pulled out now. Or I could stay on it and ride it ... to I don't know where. His view on this was quite clear. It was yet more 'double-edged' game-playing by me which I suspect he thought, for some peculiar reason, was a game I was playing to somehow trap him. I listened to his caution and tried to consider it carefully. I also listened to my own caution and tried to consider this as 'wisely' as I could. I may also have spoken with one or two of my closest friends too. Caution said pull out now - destruction, or at least danger, awaits. But my heart said ride this wave.

As best I can tell, this was my moment of surrender. I followed my heart, rather than the 'better judgement' of both my own mind and those I sought advice from. I was abandoning the doctors, ignoring my own mind and trusting my heart. I rode that wave. I'm so glad that I had not been a client of this psychiatrist for long, otherwise I might have been too enmeshed in the relationship and heeded his caution. But, as I've already said, we never managed to establish a meaningful trust between us and certainly not at that early stage. I was 'disobedient' and trusted this mysterious wave, which had now been rising steadily within me for maybe a week or so. I still didn't have a clue where it might be taking me, and I still felt that it was risky. And I still felt that I could pull out and avoid the 'crash' if I chose. But I trusted it and made a quite deliberate decision to let it take me. Even if that was to my death.

I emphasise that this is only my best guess of that moment of surrender. The fruits of this surrender were still not evident, or at least not in any reliable kind of way. It was too soon. It was only a few weeks since my last heroin. And I had even made my last (and final) suicide attempt of the not serious kind only a week or so before, when I had yet again tried to jump from a high place and found that I couldn't do it. Doubts persisted and I still felt a need for some counselling with this psychiatrist. Remember, it was only months later, long after I'd stopped seeing him, that I came to see his behaviour towards me - or 'treatment' of me - as simple bullying. My life was still a mess in many ways. I'd had four years of this madness and a few days or weeks of this wave was not going to convince even me, despite the confidence I felt in it, that everything was now hunky-dory.

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As it turned out, thus far at least, there have been no rocks. The wave took me to the peace and freedom that I enjoy today. But there was more - much more - to the circumstances surrounding and leading up to this moment.

Another essential ingredient to my surrender was that I was totally exhausted. Physically, mentally and emotionally, I was at a dead-end. I had struggled for four years to try and find a way to live with myself and had found nothing. Sure, I had done some clumsy and stupid things in the process, such as all the heroin I'd taken and the suicide attempts. But I really felt that, unlike in 1979, I had tried so very hard - again and again and again. And nothing had worked, or even come close. Drug rehab and AA/NA hadn't worked. All the efforts of the doctors, psychiatrists and psychologists hadn't achieved anything. Living at the ashram had been nice, but I left there as sad as I had arrived. Likewise with living with my friends in the bush in NSW. Family and friends, who had supported me so bravely, were also not enough. All my worst fears were being confirmed. I was just unable to live in this skin. It was too hard, too painful and nowhere near worth it. Four years of this had drained me of whatever strength I might have had. Or so it felt. It was more than just personal exhaustion. I also felt that I'd exhausted all possibilities of ever finding any sort of hope.

Another significant factor was the feeling that I was somehow not allowed to die. I don't want to overstate this as it has a connotation of some god or Higher Power that is calling the shots, and I don't feel that at all. It was more the case that I was such a misfit and a failure that I couldn't even kill myself. The overdose in mid-98 should have killed me, goddamit! It was a massive overdose, at least as big as the one of the Great Fire in 1979. But somehow my physical constitution, which has more than once been described as the proverbial 'brick shithouse', showed itself to be stronger than my efforts to snuff it out. Back in 1980 one of my sisters had said to me, "Dave, you've got more lives than a cat but I want you to slow down 'cos you're running out". Well, apparently not. There was a feeling that somewhere inside me, somehow, there was a life-force that did not want to go out. Or at least was not going to be extinguished that easily. I had even talked

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about this with Nicky, who pointed out that it was possible to override this life-force with will-power so I shouldn't assume that I was really not being allowed to die.

The work I'd done with Nicky was yet another important influence, which I've probably not said enough about. I particularly recall one session I had with her not too long before my recovery arrived. I think I had collapsed in tears and could not speak about anything much. My exhaustion was very apparent and all Nicky could do, I think, was to simply be with me, respectfully as always. Towards the end, she suggested that I could try saying to myself "I am willing". That was all. I asked her what I was willing for. She said it didn't matter, anything at all, or nothing at all. I shrugged, said OK, and we left it at that.

As usual, I then proceeded to forget Nicky's instructions for maybe a week or so. Then, one morning, I recalled her request to repeat "I am willing" to myself. I pondered this again, wondering what I might be willing for. First I felt that I was being asked to say to myself that I was willing to live. But this felt like a lie and I couldn't do it. Then I thought of some other things that I might be 'willing', such as maybe willing to not die, at least, or perhaps willing to persist with therapy. All sorts of things came to mind but none of them felt right and I was struggling with this "I am willing" request. Because of my huge respect for Nicky and trusting her intuitions even when they made little sense to me, I just sat with this "I am willing" thought for a while without trying to make any sense of it.

The next time I saw Nicky I told her that I'd had trouble with this "I am willing" request of hers. I told her that the best I'd been able to come up with was to say to myself that "I am willing to be willing ... to be willing ...". She guffawed with laughter and said "Excellent!" It didn't seem quite so 'excellent' to me but her delight was spontaneous and obviously genuine. She seemed almost thrilled that I'd come up with this. I had to laugh too, though I didn't know why.

Where this fits into the overall picture during these critical few months leading up to my recovery is very hard to say, impossible really. But it somehow seems significant - along with abandoning the medications and the doctors and the surprise at finding myself drug-free, plus the personal exhaustion and the apparent exhaustion of all

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possible options, as well as the feeling of not being allowed to die. I was not aware at the time of all these influences working together and still, today, it is impossible to tease out which might have been more important than others. But they all seem significant for what was about to happen.

My willingness became a willingness to surrender - though I didn't have this language for it at the time. But I did have a sense of what I was surrendering to. This I had through the teachings and the wisdom of Ramana and Gangaji. Their message was an invitation into silence. Silence, they said, again and again and again, is where to look for the answer to the "Who am I?" question. Silence is where the true Self can be found. And this silence was the silence of a truly quiet mind, if only for a second. A silence where there are no stories of the mind about the self. A silence that called for a stop to all stories, all mental notions, of who or what I am (or might be). A silence without any shape or form. A silence that was a huge, bottomless emptiness of absolutely nothing - no thing - at all.

It's possible that I may have glimpsed this void in the past. Possibly in meditation I had felt it and took it to be just a state of mind. Possibly this was the 'black hole' of meaningless emptiness that terrorised me, making it impossible to live with myself. It can be a fine line sometimes, I reckon, between 'death-terror' and spiritual insight. In many ways this Emptiness is a very scary place to contemplate. Surrendering to it is to dive into the Great Unknown, because it is to dive into the unknowable. The mind cannot go there. It is the 'space' in which mind arises. The 'space' before and after any thought or feeling. To dwell in this 'space' as your true Self is to surrender to the possibility that your life really is as utterly meaningless as you fear. It is to surrender to and into oblivion. It is to let go of the mind as the source of your being and dare to be willing to taste this oblivion as all that you are, ever have been, or ever will be. It is to let go of all illusions of the mind as in control. It is to risk going completely stark, raving mad. It is a willingness to be annihilated.

I doubt that I could ever muster this willingness to surrender out of deliberate choice. It is just too scary. In fact, I was prepared to kill my physical body rather than dive into this Emptiness that was (and

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is) 'me'. But circumstances conspired, it seems, to bring me to this point of surrender and my 'wave' came. If I'd had any other option at all I think I would have taken it. Or if I wasn't so completely exhausted after my four years of struggle with myself, then I may have fought it. And especially, if I didn't have the reassuring guidance of Ramana and Gangaji, I might have pulled out of this 'wave' or, indeed, ridden it clumsily into the rocks that everyone feared might be waiting for me. But there was simply nothing else I could do, nowhere else to go. That great, empty, black-hole of meaningless nothingness was calling me. And I had nowhere else to go.

But the willingness to die is so very different to wanting to die. And surrender is very different to giving up. Giving up had led me to heroin and suicide attempts. Surrendering to the silence at the core of my being, the very essence of who I am, has led me to a peace that I had never before experienced and was previously unimaginable. Within this silence all other aspects of the self arise. My body arises in this silence. My thoughts and feelings - that is, my mind - arise in this silence. This nameless silence - not my mind or any story of the mind - is the truth of who I am and where I found the peace I had been yearning for all my life and the freedom finally, at last, to just be me.

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At the end of the commentary in the previous chapter, which I tentatively referred to as the ‘theory’ of self-enquiry, we were left with silence as the only answer to the critical question of self-enquiry, “Who am I?” That is, silence is what is revealed as the answer to our enquiry. In this chapter, which might be called the ‘method’ chapter, we ask how to embrace this silence, which is a very real challenge and perhaps the most frustrating and frequent question of seekers on the spiritual path.

In the previous chapter we also saw that the main obstacles – indeed the only obstacles – to realising the self in silence are some mistaken beliefs we hold which, along with our ‘noisy’ minds, conceal this silence from us. The primary obstacle is the mistaken belief that we are who we think we are – the common but mistaken belief that the self can be found in or by the mind. This was Ramana’s radical challenge to the prevailing orthodoxy of modern psychology and the view most of us hold about the relationship between mind and self. The other mistaken belief that is a major obstacle in spiritual self-enquiry is the belief implicit in many spiritual traditions that spirit (or God, ‘enlightenment’, whatever) is somehow separate from who we are right now. Ramana’s teachings explain that the silence that is the truth of who we really are is with us and within us always and already, here and now, and therefore not something that needs to be attained or acquired. This was Ramana’s radical challenge to the prevailing orthodoxy of many spiritual traditions.

The last chapter also made it clear that to ‘know’ silence – to know the truth of who we really are – we must quieten the mind in order to let go of its mistaken beliefs. The question now becomes, how do we quieten the mind and let go of these mistaken but tenacious beliefs? The first of these is the easiest in some ways as there are many spiritual practices, such as meditation, that can help us quieten the mind. We will look briefly at some of these and see how they can all help but also see that none are actually necessary and that there are other paths to meeting this silence. We’ll also see that none of these spiritual practices is much help for finally embracing the silence, especially if we still cling to any of our mistaken beliefs. The real challenge of spiritual self-enquiry is letting go of our attachment to the mind and its mistaken beliefs, because to accept the invitation into silence is to surrender to it.

Surrender is what this chapter is really about. At almost the very end of our journey into self-enquiry, all we can find is a profound, unknowable silence. Spiritual self-enquiry is an invitation into this silence. And silence, when we meet it, is an invitation to surrender. Accepting the invitation to

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surrender into silence was my liberation from persistent suicidality. After years of prolonged and painful resistance where all other efforts had failed, including my suicide attempts, the bottomless peace at the silent core of my being was finally revealed. Silent peace, and with it the freedom to just be me, was the answer I found when I finally surrendered to silence as the truth of who I was. When we are ready and the time comes, surrender is effortless. But the path to this moment is often not easy.

Surrender is a beautiful and very special word for me these days, but it also sounds rather glib and not very helpful by itself, as it still begs the question of what surrender is and how we do it. Before saying more about surrender, it is worth looking at the various spiritual teachings and practices for what they can offer – and also what they cannot offer – those on the spiritual journey.

I find it helpful to consider the sometimes bewildering variety of spiritual practices using the four schools of yoga, briefly mentioned in the narrative of the previous chapter, as a taxonomy for the major types of spiritual practice. Raja yoga is the school or path of meditation with specific, systematic practices for quietening the mind, supported by physical postures (asana) and special breathing techniques (pranayama). Bhakti yoga is the path of faith, devotion and worship with the ultimate goal of union with God (or perhaps with your guru or Higher Power, or simply with Nature). Karma yoga is the path of altruistic, selfless service, of charity and compassion, which dissolves the individual, egoistic, personal self that separates us from Spirit, God or Nature. And gyan yoga is the path of intellectual enquiry into the nature of the self that reveals the spiritual self, Spirit or God, at the source of our being. We should note that gyan yoga includes the study of spiritual texts and scriptures as well as the Socratic-like dialogues of Ramana's teachings.

All four paths or 'methods' of spiritual practice – meditation, worship, selfless service and enquiry – are typically found in all spiritual teachings, including most religions. For instance, in Christianity there are the contemplative practices of prayer and meditation, the various devotional practices of worship, the strong tradition of Christian charity, compassion and selfless service, and also the study and discussion of the Bible and other religious texts. There is often much overlap between these practices and the boundaries between them blurred and not as clear-cut as suggested by the yogic taxonomy – for example, prayer is both meditative and devotional. We also find that most spiritual traditions and religions will emphasise one particular path or method of practice – for instance, faith and worship in Christianity, and meditation in most schools of Buddhism. This emphasis

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can sometimes be extreme so that its enthusiasts will claim their method (and maybe their notion of Spirit or God) as the only 'real' and legitimate path.

This brief overview of the various paths, practices or 'methods' of spirituality is useful for our enquiry here, because another radical claim in Ramana's teaching is that none of these practices is actually necessary to discover the truth of who you are and to realise the self. No postures, no special breathing, no meditation, no prayer, no worship, no selfless service – none of these practices is actually necessary for spiritual awakening, self-realisation, enlightenment ... or whatever you wish to call it. None at all!

This was not only another shock for me. It is an even bigger shock, indeed a radical heresy, for almost all other spiritual teachings with which I had any familiarity. It is clearly a heresy for religions with faith in God as their foundation. But it was also a radical challenge to the yoga that I understood where the sadhana of diligent practice was the foundation of spiritual growth. A similar commitment to meditation practice is also the foundation of most schools of Buddhism. To understand what seems yet another radical heresy by Ramana, it is necessary to see the real purpose of these spiritual practices, but also their limitations. Again, Ramana is very clear about their purpose:

the practice of breath-control, meditation on the forms of God, repetition of mantras, restriction on food, etc., are but aids for rendering the mind quiescent.

That is, all these practices can help us to quieten the mind, but none of them is in fact actually necessary. The critical moment in spiritual life is when we face this silent emptiness at the core of our being, which can only be found, is only revealed, by quietening the mind. Once we reach this moment, it is irrelevant how we got there. Furthermore, all our spiritual practices, all the teachings, all of our spiritual knowledge, are useless and again irrelevant for taking us beyond this critical moment. They can take us there and point to what lies beyond, but that is all. And they are not even necessary for that. They can perhaps comfort us at this time as we hesitate at what we face, maybe for years, and perhaps forever. But they can never take us to what they point to. This knife-edge moment is the common ground where all the spiritual traditions converge and meet, united in impotence, irrelevance and failure, simply unable to take us to what they point to.

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Please do not misunderstand this criticism. All these spiritual teachings and practices have enormous value and benefits, and not just for their ability to guide us and accompany us to this precious moment when the invitation into Spirit is offered. They can all, either by themselves or in combination, give significant physical, mental, emotional and/or social benefits. They can all aid our understanding of who and what we are and how to grow with life and live life more fully. And, as mentioned, they can be a great comfort, offering reassurance, encouragement and confidence, if and when the moment of silent invitation arises for you.

But it is a mistake to invest too much into these teachings and practices and believe they offer what they do not have to give. It is a mistake because this then becomes just another obstacle to both receiving and, perhaps more importantly, to accepting the invitation into silence. When spiritual seekers asked Ramana whether they should shave their heads, don the orange robes of the sadhu (the monks of yoga) and go into spiritual retreat in the forest or mountains, he invariably replied, “Why create another obstacle to self-realisation?” And in Zen there is the story of the master pointing to the moon, representing Spirit, but the student is totally absorbed in rapt adoration of the teacher’s finger and fails to see what it is pointing to. There are also many stories of spiritual aspirants obsessed with mastering the practices to the point of addiction, with many of the usual hazards of any addiction. All these practices, and all the teachings that go with them, can be useful, joyous and precious, but they can only ever take us so far and no further. To ask more of them than that is to create yet more obstacles out of them for those of us on the spiritual path.

It is here that a paradox emerges in the teachings of Ramana, as it does on all spiritual journeys. Ramana points out that the true nature of simply being – of Self, Spirit or Consciousness (or the presence of God, if you prefer) – is totally effortless, but that effort is required to realise this effortlessness. This effort is the journey we travel on the spiritual path leading up to the moment when we must finally let go of any effort. It is the effort of whatever spiritual teachings we might study and practice. It is also the effort of the mind, as we’ve discussed at length, to create and sustain the idea – the idea – of an individual, separate self that believes in the illusory self of the mind and is blind to the spiritual self in which mind arises. Effort is only required, Ramana would say, to create and sustain the illusion, the ignorance, of the mind. This ignorance, which is entirely of the mind, is the greatest obstacle to realising the spiritual self. And, paradoxically, effort is required to remove this ignorance. With this understanding, what appears a

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contradiction in Ramana's teachings is no longer contradictory, but paradoxical:

Effortless and choiceless awareness is our real nature. If we can attain that state and abide in it, that is all right. But one cannot reach it without effort, the effort of deliberate meditation ... That meditation can take whatever form most appeals to you. See what helps you to keep out all thoughts and adopt that for your meditation.

The “deliberate meditation” referred to here can be any of the spiritual practices we've discussed, but these must always be with the purpose, as Ramana reminds us here, of quietening the mind. Ramana would therefore endorse any practice that would help “to keep out all thoughts”. This paradoxical effort to quieten the mind to realise the effortless nature of being is akin to another paradox found on the spiritual path – the desire for desirelessness. The Buddha taught, as did Ramana, that desire is the source of all suffering. But this leaves the spiritual seeker with the conundrum of the desire for desirelessness – and the endless cycle of suffering resumes. This desire for desirelessness is another effort of the mind, yet another form or instance of our ignorance. And it is overcoming this ignorance, Ramana explains, that requires effort and is the real purpose of spiritual practice:

removal of ignorance is the aim of practice and not acquisition of Realisation.

To say this another way, to ‘know’ or realise the self is effortless, but effort is required to overcome the obstacles to this realisation. These are the obstacles of ignorance, of the mistaken beliefs of the mind, and it is letting go of these by quietening the mind where so much effort seems required. Ramana therefore endorses any effort, any practice, any ‘meditation’ that will assist with quietening of the mind. I once heard Gangaji capture the truth of this paradox, in rather more contemporary language:

happiness cannot be found through the pursuit of happiness, but we need to pursue happiness to learn this.

As a general rule of thumb, I personally like the suggestion that the best spiritual practice is the simplest one that works for you. But other than that, all paths are equal. As different paths to the moment of surrender – to the moment of invitation into silence – all are equally valid. The only

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meaningful distinction might be which one is the most appropriate for you, which would be determined by things like your personality, your social and cultural circumstances, and what practices are available and accessible to you. It is worth pointing out that Ramana himself did not claim that the spiritual self-enquiry he taught was the best path. He did claim it was the most direct means to realising the self, but he did not assume that this always meant it was the most appropriate means for everyone. Which is why he said “meditation can take whatever form most appeals to you” in our efforts to quieten the mind and remove the ignorance that is the only obstacle to self-realisation.

But there is another path to this moment of invitation that is not usually called a spiritual practice, though it regularly arises as a topic in many spiritual teachings. This is the path of suffering. Suffering, or *dukkha*, is a central theme in the teachings of the Buddha, who recognised it as a universal part of the human condition experienced by us all. Initially motivated by his concern for the suffering of others, it became his own suffering as he endured the trials and tribulations of his own spiritual journey. Through his own intense personal suffering, along with prolonged study and deep meditation, he eventually realised the nature of suffering and the nature of the self that suffers. I'm no Buddhist scholar (or practitioner or 'devotee'), but I see little difference between the central teachings of Buddhism and those of Ramana, other than the occasional confusion that can arise with some of the differences in terminology.

Although suffering is recognised in many spiritual teachings as a major motivating force for embarking on the spiritual journey, it is rarely recognised by itself as its own spiritual path, or 'method' of spiritual enquiry and practice. I guess this is understandable, but for me it is something of a moot point to distinguish between the motivation for the practice and the practice itself. That is, suffering by itself can take us to the same place, the same moment of invitation into silence, that all the 'official' spiritual practices can take us. To say this another way, I doubt whether any of the spiritual practices, regardless of how diligently they are practised, would take us very far at all in the absence of any suffering as central to our spiritual journey.

I don't want to glorify or romanticise suffering and call it a spiritual path or practice. Others have done this, which has led to some rather peculiar, and I would say silly, spiritual practices, such as deliberate self-mortification, self-flagellation, penances and other deliberately inflicted austerities. Rather, I wish to acknowledge suffering as a challenge that can confront and threaten our deepest sense of self. This suffering can arise in

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life in many ways. We can see the crisis of the self that often arises with life-threatening illnesses, such as cancer. It is also seen among those approaching a 'healthy' death by old age. Such occasions in a life will often lead people to seek solace from religious or spiritual traditions, which seems perfectly appropriate to me. Another example is the intense suffering felt at the death of a loved one, which can be especially intense if it is a premature death of, say, a child or spouse – or, indeed, a death by suicide. This is an interesting example because intense grief is not usually considered a 'mental illness', even though one of its key characteristics is often the same crisis of the self that is faced in suicidality. My own suicidality did indeed feel like an intense grieving, though I could never identify any loss that sufficiently explained its intensity, which I now think may have contributed to its potential lethality as suicidality. Elsewhere I have called this feeling an intense yearning, which today makes sense as the spiritual self that I was yearning for is the same 'lost' self that I was grieving for.

The point here is that any suffering that threatens our sense of self can and quite often does take us into new psychospiritual territory. This may occur alongside some 'formal' spiritual or religious teachings to hold our hand as we walk this difficult path. But it can also, all by itself, take us into profound enquiry into the nature of the self that is suffering. This in turn can take us – all by itself – to precisely the same moment that Ramana's self-enquiry and many other spiritual teachings point to. Suffering, by itself, can demand of us that we ask ourselves the critical spiritual question, "Who am I?"

For me these days, it is impossible and futile to try and tease out what contributed most to my particular journey along the spiritual path. I had the benefit of my years of yoga and, at the critical moment, the teachings of Ramana and the clear voice of Gangaji. These I acknowledge with much gratitude. But I also had the painful push (as opposed to the inviting 'pull' of Spirit perhaps) of feeling never satisfied with who I was. I now acknowledge this suffering, also with gratitude, including my suicidality, as central to my spiritual journey. It may sound bizarre to hear me appreciate my suicidality in this way, but I cannot imagine being where I am today without the struggle I had with suicidality. And I am so pleased to be where I am today. I am grateful for my suicidality as I am for all the spiritual teachings, and also my family and friends, which were all significant parts of my particular journey. For all these reasons, and more, I am quite adamant that suffering of all kinds – not only but definitely including suicidality – needs to be honoured and respected much more than is currently the case in Australian society. Suffering can be a great teacher

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that can lead us to spiritual treasures – but not if these treasures are denied as unreal, false, illusory or delusional ... or ‘mental illness’.

As I said, I do not want to elevate suffering to the status of a spiritual practice – and I particularly do not want to suggest suicidality as one. As Ramana says, all these ‘practices’ can help but none is necessary. I firmly believe – or want to believe – that there has to be a better way than life-threatening suicidality, because suicidality has a particularly hazardous risk associated with it. It can kill you. Far too many stumble off this noble path and die. There has to be a better way and there is. We can acknowledge the crisis of the self at the core of suicidality. We can respect and honour this self that is in crisis much more than we currently do. We can create spaces and possibilities, which by and large don’t currently exist (and certainly don’t in our mental health system), where we can engage with and explore our sense of self more meaningfully. That is, we can create spiritual spaces where we can embark on our spiritual journey, gently and in our own time, and receive guidance and companionship as we proceed, gently and in our own time. (Contrast this with today’s psychiatric wards for an illustration of what is not such a space.) These spaces, and the possibilities that can arise in them, would be a much more healing environment for those of us struggling with suicidality than what is currently available. What’s more, I believe that suicidality is much less likely to arise in a community that has these spaces where the spiritual self, and the struggles we might have with it, can be recognised, respected, honoured and treasured.

Suicidality is a particularly acute crisis of the self that confronts and threatens everything we have thought we are, have been, or might be. Many spiritual journeys will take us to a similar confrontation. If the spiritual path is walked with gentleness and guidance, then hopefully the confrontation with the self will not be as threatening as occurs with suicidality, though a spiritual path totally free of any suffering seems unlikely to me, if not impossible. But once we meet this moment, when the self we know is no longer adequate, it matters little how we got here. At this moment we are standing at the threshold of the great mystery of what it is to be human, of what it is and what it means to exist and to be conscious of our existence. In Ramana’s teachings this is the moment of invitation into the silence at the core of the self, the silent self that I have usually called the spiritual self. In other teachings, such as Buddhism, this threshold is to hover at the edge of the mysterious abyss of emptiness, the great Emptiness of sunyata. In other, more religious teachings, it might be called standing before God with the invitation into silence being an invitation into God’s embrace. Whatever language we might use for this critical moment matters little. Behind us lies

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a life story that has lost its meaning for us. Before us lies silent emptiness, the great unknowable mystery, or the arms of God. We cannot go back, but nor do we know how to proceed. This is the moment of surrender.

When this special moment of invitation into silence arises, it is worth pausing, as I think most people inevitably do. My story is just one of many testimonials that tells of the joy of stepping off the apparently solid threshold of the familiar and into the unfamiliar, unknowable emptiness of silence. But it is not an easy step to take. This step is the last and most difficult step on the spiritual path, and the most pressing moment of our question, "How?" How do I let go of my attachment to my mental, psychological self? How do I let go of my sense of Spirit (or God) that still feels 'out there' even as I stand before it? Surrendering to this silence is the smallest, most infinitesimally tiny step, but seems impossible. With the push of a meaningless life behind you and the pull of a glorious invitation before you, why does this last little step seem so impossibly difficult?

The first difficulty is that you cannot simply 'decide' to take this step. Surrender is not some cognitive, mental decision. Once more we learn that the mind cannot help us here. Ramana used to say that the final obstacle is doubt. This doubt is the final clinging of the mind. Surrender into silence asks you to suspend everything you have ever known or believed. One of the most shocking sentences for me in all of Ramana's teachings was:

There will come a time when one will have to forget all that one has learned.

This was perhaps the ultimate heresy of Ramana's teachings for someone like me and probably the one I struggled with the most, with my robust intellect and years of education that I valued so much. It didn't make any sense to me, how could this be so? The spiritual path seemed to be almost entirely about learning. Learning the teachings and the practices. Learning about yourself. Learning about spirit or God or whatever you called it. And here was this famous sage saying that we had to forget all we had learned. Not to mention how on earth you could ever possibly do this, even if you wanted to. I also once heard Gangaji say something similar, which also bothered me when I first heard it but it now makes so much sense to me:

In order to give up hopelessness you must also give up hope.

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In modern suicidology there is perhaps no greater heresy than this. Hopelessness is understood, quite correctly, as one of the primary feelings associated with suicidality. It is understandable then that cultivating hope is a major aim in 'treating' the suicidal. But what Gangaji is saying here, and Ramana before her, is that we need to forget or let go of the mind and all it thinks, believes, and hopes for, if we are to truly 'know' the self. And this 'letting go' is to surrender to silence.

It is important at this point, with suicidality mentioned again, to emphasise that the surrender I'm speaking of here is not 'giving up' or 'giving in'. That is, surrender must not be confused with giving up and choosing death, of giving in to the urge to escape your pain by killing yourself, or of giving in and indulging the desire to die. Surrender is the difference between wanting to die and being willing to die. This distinction is a critical one.

Gangaji's words were critical for me in recognising and appreciating this vital distinction. She urges us to neither suppress nor indulge our thoughts, feelings or desires. Rather, she encourages us to allow them to arise – which they inevitably will anyway – but then to not act on them, or at least to not act on them immediately. In spiritual terms this is sometimes known as cultivating detachment from the mind by developing the sense of being the witness to the activity of the mind. In some ways this is similar to Cognitive Behaviour Therapy (CBT) and even more so to CBT's more recent cousin, Dialectic Behaviour Therapy (DBT). The difference though is that CBT and DBT use this as a step towards controlling our thoughts whereas Gangaji is not at all concerned about this. On the contrary, she would encourage us to give up any fantasy of controlling our thoughts, another heresy in mental health and suicide prevention. Rather, she would urge us to spend time in the 'space' in which all thoughts arise. This is the 'space' of silence, the silent space within which all thoughts arise and into which they will all eventually subside. This is the silence that Ramana speaks of. This is the silence at the core of our being, the silence of the spiritual self. It is the space between indulging and suppressing, between wanting to die and being willing to die.

Another difficulty we might have accepting the invitation to surrender into silence are the fears that can arise at this time. We might feel the fear of death, a legitimate fear and indeed a kind of death does take place – and is required – to move beyond the world of mind. For some, an even greater terror might be the fear of madness, of completely losing your mind, another legitimate fear and, again, in a way this does happen – and is required. Another powerful fear is that if we step into this space then we might find

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that our lives really are as utterly meaningless as we sometimes suspect but dare not admit. And once more, there is some truth, some legitimacy, in this fear. It can be frightening to stand on this threshold with the invitation into total mystery and altogether understandable that we hesitate or retreat. Once again, I feel these legitimate fears need to be respected so that we spend whatever time with them that we need. Wise spiritual counsel would be valuable at these times too, but where do you find this in Australia today?

These fears are once again entirely of the mind. The three mentioned above – the fear of death, madness, or meaninglessness – are all fears of some anticipated possible future that we can easily imagine at this time. The other main kind of fear likely to arise is the memory of some past pain, such as grief at the loss of someone or something dear to us. This can include a strong fear about letting go of all our past history, of the stories we have about who and what we are, which has links with the fear that your life has been utterly meaningless. These are all powerful fears that should not be dismissed lightly so we should spend whatever time with them that we need. But to accept the invitation into silence it will become necessary to let go of them because they are all entirely of the mind and are in fact the mind clinging to these fearful stories as the truth of who and what we are.

I heard Gangaji speak in satsang about these kinds of fears when she was once asked, “Why do these demons keep coming back to haunt me?” The particular demons that were haunting the questioner were not specified, but Gangaji’s response was, for me, one of the most significant that I heard in all her satsang. “These fears keep coming back because the last time they visited they got fed”. These words came back to me again and again in the weeks that followed and I came to see how very true they were. The demons are our fearful stories that require our fear to sustain them. Gangaji pointed out that these fearful stories, like any story, are entirely of the mind and always about either some remembered past or some anticipated future. And the power of these stories also comes entirely from the mind, which will happily feed them with more fear. These fears have no power at all though, none whatsoever, in the silence of a quiet mind. Or to say this another way, in the silence of a quiet mind these demons are found to be phantoms – fictions of the mind that cannot touch the silent core of our being.

I tested this. When my fearful stories, or demons, arose on the horizon of my mind, I took Gangaji’s advice so that rather than trying to fight them, conquer or destroy them, or otherwise shoo them away and suppress them, I encouraged them and invited them in. I recall having an image at the time

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of sitting on a fence (I felt like the medieval village idiot I'd seen in old Monty Python sketches) as dark, familiar demons appear and start to approach. Instead of cowering in fear and trying to fend them off, which was my usual response and one that I knew was rarely very effective, I welcomed them and urged them on. I can recall saying to them, "Come on down, you bastards, come and do your darndest". I think a few times I even uttered this aloud, shouting at them and slapping the seat next to me, inviting them to join me (on my mad, medieval fence), urging them to come right on down next to me and take whatever it was they wanted. But this time I refused to feed them. I said to myself as I invited them in that they could come and do their worst, kill me even, but I was not going to feed them. I was not going to grant them the power of my mind and feed them the potent fears in my mind that they had come hunting for.

I found that Ganagji was absolutely correct. My fears had no power whatsoever other than the power I gave them. If I gave my attention to the silence at the core of my being at these times, even as the storm of fears raged in my mind, then it became like a movie. My demons were phantoms, fictions of my mind. And they couldn't touch the silence that was totally unmoved by this pathetic storm. What's more, I was able to see that all the fears were to do with either memories from the past or fantasies about the future. And in the immediate here and now of silence, where there is no time and no past or future, my demons were irrelevant. Again, the only power they had, or could ever have, was in the time and space of my mind. Without that, they could only rage and thrash about like furious wisps of smoke. And I had to laugh. Here I was getting beaten to death, almost literally, by these wisps of smoke.

Along with our fears, another likely cause for doubt and hesitation at the moment of silent invitation is any unfulfilled desires that might resurface, and possibly with great urgency. The invitation before us confronts us with the paradox of the desire for desirelessness, and any lingering desires of the mind – or the body – are likely to arise with some force at this time. Again, Gangaji speaks eloquently and compassionately of this. She says that if there is anything else you desire more than the truth of who you are, then you should pursue that desire. Truth, she says, is very patient. If you still have the desire for the bigger house, the next overseas holiday, or that promotion you've been working so hard for, then you should go for it. If you long for that perfect lover, that perfect sexual fantasy, or some as yet still unfulfilled adventure, then you should go for it and pursue these with the same commitment that is now being asked of you at this moment of truth. Because if any desires call to you more loudly than the desire to

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know the truth of who you really are, then truth will not compete with those desires. Truth, says Ganagji, is very silent, and very patient. And if satisfying these other desires gives you what you are looking for, well, that's fantastic. Mission accomplished. But if they fail to satisfy – or if the desire for them loses its allure – then waiting there for you, patiently in silence, is the truth of your spiritual self, ready to welcome and embrace you.

This is another way, and I think a particularly eloquent way for western minds, of re-stating Ramana's apparent contradiction or paradox that effort is required to discover the effortless truth of the spiritual self. It also highlights for me that I don't feel we should have too great a sense of urgency about striving for spiritual awakening. It seems to me that all these desires, from childhood, to adolescence, to early adulthood, mid-life and, indeed, throughout our entire lives, are all perfectly legitimate, valid and (mostly) healthy desires. While they continue to be important for us, it is appropriate and, dare I say, healthy for us to pursue them. For this reason, I don't really go along with urging the spiritual path on the young in any intense manner. And similarly, I worry about those who choose the ascetic life of prolonged spiritual retreat and intense spiritual practice which, it seems to me, is probably appropriate for only the very few. And I certainly don't appreciate those spiritual teachers who insist that such an ascetic life is necessary for spiritual growth.

It is certainly well worth pausing before accepting the invitation into silence. And besides, pause we must, for surrender is not a decision or choice that we can control. This feeling of no real control over our future is another fear and another reason for us to hesitate. Letting go of the need to control our lives is another heresy to modern psychology where most psychotherapies work to develop a greater sense of personal control. I'm not saying this is wrong, just that it is not appropriate at the unique and special moment of this invitation into silence. There is a strong parallel here with the struggle to resist and control death. This struggle can be a noble one, but for a peaceful death, the time comes when we must let go of our efforts to control what cannot be controlled. Like death, surrender cannot be controlled any more than it can be chosen.

We can sum up all these reasons for why we might pause before surrendering to silence by seeing them all as stories. The mistaken beliefs of the supremacy of the mind and of spirit as somehow separate from who we are right now are both stories of the mind that we choose to believe. Both hope and hopelessness are two other psychological stories. All our fears and the psychological demons that prey on our minds are more stories,

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entirely of the mind's creation. Likewise our desires, dreams and fantasies, including the desire to be in control. Indeed there are many who believe that the self – or our sense of self – consists solely and entirely of all these stories we tell ourselves about who and what we are. These stories include the various theories of the self, whether they're psychological, biological, or 'postmodern' theories about the social construction of the self and our sense of self. These latter theories of the self are particularly interesting as they often talk of 'self narratives' or the 'self as narrative', which I think is mostly quite correct and the most useful way for understanding the psychological self. We are the stories we tell ourselves about who or what we think we are.

Except these stories fall short in the end because they are all just stories. They are psychological stories. The rich narrative approach to understanding the psychological (mental) self, which embraces the full social and historical contexts of our stories, is certainly more sophisticated than the limited 'scientific' approach of most of mainstream psychology. And much more sophisticated than the mindless pseudo-science of modern psychiatry that reduces us all to biochemical robots. But even the rich, sophisticated and revealing narrative approach to exploring the self is ultimately inadequate because all these stories are stories of the mind. They are all psychological stories. They are all just stories. They are the noisy chatter of the mind that Ramana and Gangaji urge us to put aside – if only for the briefest of moments – in order to 'see' the silence in which all these stories come and go. In the end, all these stories tell us precisely nothing about the story-teller.

For me, Gangaji spoke with brilliant clarity about the limitations of these stories, and how recognising this can help us meet the challenge of surrender. These are the words I've chosen at the opening of this chapter, and they are worth repeating here at this point in my argument:

The time will come when you will have to stop with all the stories.

These words say that to accept the invitation into silence, to meet and 'know' silence – that is, to meet and know the Self – we must at some time let go of any and all stories we might have about who or what we are. All our desires, all our fears, all our beliefs (whether mistaken or otherwise), and all thoughts and feelings, must be abandoned, if only for a moment, if the depth of silence is to be revealed in all its fullness. This includes the radical heresy of Ramana that we must also let go of any notions, any teachings, any instructions, that we might have about what is Spirit (or God

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or enlightenment etc). Gangaji frequently repeated the one word that summed up the message of her own teacher, Papaji, which was just “Stop”. “Stop the search” is perhaps the phrase most frequently associated with Papaji’s teachings. For me, “Stop with all the stories” captures the essence of Gangaji’s teachings. And both these messages refer back to Ramana’s central message, which is to stop or quieten the mind. Just stop. If only for the very briefest of moments, because in that moment the silent stillness at the core of your being is revealed. And in that moment of silent surrender, I found peace.

Gangaji’s words also hint at another key contribution to my own surrender, but not one that I would wish on others. This was the point of sheer, utter exhaustion that I had reached in my struggle to stay alive. The silence waiting for us at the end of all our stories can be seen as the time when all our stories are exhausted and no longer have any meaning or power. Coinciding with this for me in mid-1999 was that I was physically, mentally, emotionally and socially exhausted. In some ways this parallels the discussion above on suffering as similar to the spiritual path. My life seemed meaningless and pointless so that I felt no energy for it. There was no imaginable future that I felt any desire for, nor any past history that I longed to return to. My many attempts to find some way out of this pain had all failed, and I could see no other options. Drugs, both legal and illegal, psychotherapy and counselling of various kinds, retreat to an ashram or the beautiful Australian bush – all had failed. I was physically, mentally, emotionally and socially utterly exhausted. But I also felt that I had exhausted all avenues, that there were no other options. I had even failed in trying to kill myself. I was beaten and beat. There was nowhere to go. I had no stories left. There was nowhere else for me to go. There was only the silence at the end of all my stories.

Finally, we come to the surrender. As we pause on the threshold of silence, letting go of all the stories and the mind’s need to control our destiny, something quite marvellous can happen. Quietly and softly, out of the silent stillness of emptiness, a gentle peace arises. We may pause and doubt again, which is fine. But if we sit with the unknowable without wanting or needing to know but just to be, then the peace will rise. As soon as we try to grasp and comprehend this silent, still peace then it will likely subside as the mind arises again. So we pause once more. Then if we ask again, “Who am I?”, and give our full attention to the silence that is the only answer to this question – peace is there. And as the peace rises, something extraordinary occurs. The peace is not rising in the silent emptiness beyond the threshold. No, it is rising within me. And as it rises, I cannot see any

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difference between the 'I' within which this peace is now beginning to flood and the 'out there' of the silent emptiness. I cannot discern any boundary between me and the silence, now full to overflowing with peace. I find that I have become this peace. That I am peace. And then, like some cosmic joke because you simply have to laugh at this, you see that you have always been this peace. Silent, still, beautiful peace is the very essence of who I am, have ever been or ever will be. Without this peace that is both who I am and the silence around me, I simply do not exist. Peace, eternal peace, always and already here, forever.

We struggle with this, of course. Or I certainly did as doubts continued to revisit my mind. This rising wave of silent, still, unknowable peace was the 'wave' I talked about in the 'madness' chapter. This was the wave that the psychiatrist I was seeing at the time doubted (and that I doubted too initially) while also claiming credit for it. But, unlike my psychiatrist, I chose to trust it. Whenever doubts arose, I turned to the silence for answers to these doubts and always – always – the answer was this peace. For me, after four years of suicidality, this was a quite peculiar and novel feeling. And it was almost exhilarating, except this seems an inappropriate word for the utter stillness, the total unmoving, unchanging silence of this peace that was really quite mundane and ever so dull. This was the 'bliss' of finally meeting myself for the very first time, but not at all orgasmic or intoxicating as the word bliss suggests. And as the doubts persisted and each time I knocked on the door of silence – there it was! Peace. Always and forever. And it could never be otherwise, because it had never been otherwise. And my suicidality became absurd.

This was my surrender. Without any 'decision' on my part, I could no longer regard my mind as the boss of who I was. Mind came and went in this silence and could never ever control it. My relationship to my mind shifted effortlessly from a domineering master to a faithful servant. Well, maybe not so faithful as it continued – and continues – to play its little tricks as it tries to regain control from time to time. I saw that these times invariably included suffering, which became my cue – blessed suffering – to knock on the door of silence again and remember who I was. And silence reminds me that my mind is a most wonderful and wondrous servant, but a shocking master. And I laugh. Again.

The next and final chapter celebrates this surrender to silence further and looks at some of the consequences of it. Before finishing here though, it is perhaps useful to ask how well we have answered the question of this chapter – of how we can accept the invitation into silence that we received in the last chapter?

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We have seen that this invitation into silence arises when we are confronted with our deepest sense of who we are, our deepest sense of self. We have seen that this confrontation can be a life-threatening crisis of the self, as it was for me with my suicidality. We have also seen that there are other paths to this moment of confrontation, or moment of invitation. These include the many forms of spiritual practice, which can also be a source of comfort, reassurance and encouragement at the critical moment of surrendering to this invitation. But we have also seen that all these paths and all these practices can only take us to the threshold of surrender and then point to what lies beyond. Suicidality cannot take us there, though it can kill us. Spiritual practices cannot take us there, though they can comfort and guide us as we hesitate. Only surrender can let go of what keeps us stuck to this threshold, stuck to the stories of bondage to the mind.

We have seen that the great obstacles on the spiritual journey, and especially at the moment of surrender at the end of the path, are the mistaken beliefs of the mind. The first and most difficult of these mistaken beliefs, especially in western culture, is the common psychological belief that there is only body and mind and that the mind represents who we are. This is the most tenacious and pernicious mistaken belief that Ramana Maharshi returns to again and again as the fundamental obstacle to realising the self in silence. The second mistaken belief is the common spiritual belief that Spirit (or God) is somehow 'out there' and separate from who we are right now. This mistaken belief takes us on an impossible treasure hunt as we try to attain or acquire what we already are. The rigorous spiritual self-enquiry of Ramana resoundingly debunks both of these mistaken beliefs and presents us with an invitation into the silence that is always already with us and within us. This is the invitation to surrender and let go of our attachment to these mistaken beliefs.

We have then seen that surrender is not as simple as it seems. It is impossible to simply decide to surrender. Nor is it possible to describe, explain, and far less offer any instruction in, how to surrender. That is, at the end of our enquiry, we are left with the frustrating but inevitable inability to fully answer the central question of this chapter – how do we accept this invitation to meet the self in silence? It is useful then to ask what can be done to assist us or facilitate this seemingly impossible task of surrender?

First and foremost, we can respect and honour the self far more than is currently the case. In particular we must respect and honour the self when it is in crisis. Not just the crisis of suicidality, but the many other occasions when we struggle with our feelings about who and what we are. Whether

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we call this a 'mental health' crisis or a spiritual crisis is irrelevant – we need to respect and honour this noble struggle more than we do. We need to respect and honour it when it arises in our own lives, and likewise when we see it in those around us. Of particular concern these days is that we must reverse the current trend to pathologise and medicalise this noble and very human and very common struggle that we so often have with our sense of self. As I said earlier, our current mental health system is a stunning illustration of how not to respect, honour and nurture the self. We cannot walk the path of discovering who we are if our struggles are dismissed as mere symptoms to be controlled, suppressed and eradicated. Furthermore, the urgent need to connect with our spiritual spirit and give abundant expression to all that we are is simply impossible if our culture denies not only the legitimacy but the very existence of spirit and the spiritual self. This is generally the case in Australian society today, with our current mental health system being a particularly extreme and cruel denial of spirit.

Many spiritual traditions and teachings have a much better appreciation and understanding of these struggles of, by and with the self, with much better ways of responding to them. We need the wisdom of these spiritual traditions, the wisdom of spirit, in our communities (not just in our mental health services). I have mentioned the comfort, reassurance and encouragement that the various spiritual practices can offer. I also mentioned the need to create spaces where spiritual possibilities can arise, safely and preferably with wise spiritual guidance and the company of other like-minded souls. Such safe spaces of spiritual possibilities are rare in today's Australia and especially so in our mental health system where they are most desperately needed.

A final, and I think useful, comment can be made on the question of how to walk the spiritual path and how to surrender. We cannot decide to surrender, but we can decide to be open to the possibility. This is willingness, which is now another beautiful and special word for me along with surrender. But willingness, unlike surrender, is an attitude of mind that we can cultivate, engage with, work with and put some deliberate, mental effort into moving to where we want to go. It is Ramana's paradox again, where we can make some useful effort towards discovering the effortless nature of simply being. It is an attitude that helps us sit with the paradox of the desire for desirelessness. Willingness for me is to be open to mystery. Willingness allows the possibility of the unimaginable. And a willingness to surrender can take us into the silence in ways that the greatest spiritual teachings, the most diligent spiritual practice, or the most rigorous intellectual arguments are simply incapable of doing.

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It's now time to celebrate the peace and freedom of surrender.

Chapter 7

This Is Enough

*A day will dawn when you will laugh at all your past efforts.
That which will be on the day you laugh is also here and now.*

(Ramana Maharshi)

For the first few months my feet hardly touched the ground. The wave that I had briefly hesitated to trust proved true. I had somehow let go of my mind as the source or essence of my being. I had learned that who I am is not who I *thought* I was. And I didn't collapse into a blithering madness. Instead, I was enchanted with the freedom that came with this inner peace. I didn't have to do anything - or, rather, anything I did, anything at all, was full of enchantment and wonder. It was, I guess, quite childlike in many ways. Life was like a brand new toy. After four years in the wilderness - which I now sometimes call the 'bewilderness' - it was now a novelty and delight to find myself actually *wanting* to be in the world.

These few months were such a treasure. And also very important. Each day that passed reinforced and consolidated the surrender that was taking place. As the days accumulated, the peace became more and more tangible, more and more constantly present. It became the ground that I stood on. It became the reality that underpinned all other reality. I call it 'peace' here, but I could equally call it silence, or stillness, or Self, or Spirit, or Emptiness, or 'sunya' (yoga) or 'sunyata' (Buddhism). It was the completely empty, meaningless, nothingness (no-thing-ness) that I had been so terrified of in my suicidality. It was death itself. And my suicidality, paradoxically, was the terror of death. And in this peace, this death, came freedom. Delightful, enchanting freedom. And I found that this simple peace and freedom was all that I had ever yearned for.

But doubts and uncertainties still arose in my mind - that busy, dratted mind again. It still felt possible that I could 'relapse' or 'regress' into the all too recent horrors that had dominated the last

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few years. I recall one occasion, walking in the city, when I became aware that I was getting uptight about something, that I was tightening up inside and that it was an unpleasant feeling. When I became aware of this - and this presence of mind is a very handy skill to cultivate - I realised that my mind was racing about something. I don't recall what, but I clearly recall the feeling of a busy mind that included some anger and frustration. I then recalled Gangaji's words of "Stop, just Stop!". Stop with all the stories. Stop with all the noisy activity of the mind. Stop, for just a moment, and ask who or what is experiencing this noise. Stop and meet the silent Self, *that* which you simply and effortlessly *are*.

By now I was familiar with connecting with the peace that is always there but which we usually overlook. So I stopped walking. I stopped the movement of the physical body to pause and witness this noise in my mind. I witnessed this noise from the vantage point of my recently discovered, recently revealed, spiritual Self, from the source of my consciousness and being. In doing so I reconnected with that source, with my Self. And there was the peace. Boundless, timeless peace. And I laughed. I laughed at the folly of my mind. I laughed that I had engaged with this mental noise to the extent that it was hurting me. I laughed at what a dope I was. I laughed at my great good fortune to be free of this attachment to my mind. And as I laughed, I celebrated and reinforced my new-found peace and freedom one more time. And again I found that *this that I am* was all I needed or had ever needed.

I may have got some peculiar, side-ways looks from passers-by as I stood in this busy street, chuckling away at myself. I may have appeared rather 'mad'. It didn't matter at all to me. This occasion is just one of many like it that I remember well, and they are all precious and important. The noise of the mind could rise up at any time - in the street, in a conversation, privately in bed - and it did regularly. I had definitely not 'lost' my mind. It remained very present and as active as ever. And old habits die hard so I also frequently engaged with the mind in ways that led to some discomfort. Typically for me this would be some anger or frustration, often tinged with impatience, but it could be sadness, disappointment, worry or some other thought or feeling. There's nothing wrong with all these different thoughts and feelings -

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on the contrary, they are all valid and valuable parts of the human experience. But I came to recognise when they were creating some tension or discomfort in me, which became a cue to just remember, pause, and reconnect with the silent Self.

And when I made this reconnection with the peace - which I now could whenever I had the presence of mind to do so - I learned that this inner peace was *always* there. Whenever I knocked on the door of the Self, there was this staggering, delightful peace. Always. And I was coming to recognise the truth of Ramana and Gangaji's teaching that this peace is always there because it is the deepest truth of who you are. This peace cannot *not* be there, for you simply cease to exist without it. But it's a good idea to 'practise' knocking on the door and checking regularly, especially if you are a sceptical, doubting person like me.

The next thing I learned from this 'practice' was that I had a choice whether to continue to engage with this mental noise. As the witness, the detached observer of my mind, I could weigh up what was going on here and make a decision (yes, with my mind) about whether I wanted to play with this or not. This 'play' could easily make me laugh as I did on that city street that day. I still regularly giggle at this 'lila', this play of *apparent* reality, that the mind engages in so energetically. But mostly I giggle at the madness I had indulged for so many years that this mental activity was so important. This is not to say that it is unimportant. I regularly choose to continue with these thoughts or feelings precisely because I do judge them to be important. But they were no longer the core of my sense of being. The mind was no longer the master. My sense of self was no longer tied to my mind, my mental world. My mind was now just one aspect of my Self, in a similar way to my body being another manifestation of my selfhood.

And I learned that the mind is a shocking master but a most wonderful servant. The mind can torment you. And there is no greater torment than the false belief that I am my thoughts, that I am who I *think* I am. Letting go of this false belief was, in fact, the surrender that set me free. In letting go of the mind as the boss, the Self that is the source of the mind is revealed. And that Self, when you dive

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into it, is boundless, not confined to the mental limitations of time and space. It is the Self that is always here, right now, and cannot be otherwise. Whether awake, dreaming or in deep dreamless sleep, this Self is present. The mind, which is only the presence of thoughts and feelings in consciousness, is not required for the Self to exist. But without the Self, without consciousness, there is no mind because you simply do not exist.

These and many other thoughts about my new sense of Self arose frequently. I constantly tested my understanding of this new relationship to myself - to my Self. When we move beyond the mind, and especially beyond the rational mind, we are likely to find ourselves confronted with many paradoxes. One of the first of these was around the traditional spiritual wisdom, which the Buddha spoke of frequently, that the source of all suffering is desire. This had led me to ponder, long before my recovery, of the tricky question of the desire for desirelessness. Such quizzical conundrums can truly make the mind spin - that dratted mind again, a tree full of monkeys running amok in my consciousness.

Another similar, paradoxical wisdom, and a particularly challenging one for someone contemplating suicide, was put before me in one of Gangaji's video satsang. She was asked about hopelessness - that key word of suicidality. And her answer was shocking. She said that you cannot get rid of hopelessness without also getting rid of hope. This one stumped me for quite a while. And I knew that such comments would be almost blasphemy to the psychologists who emphasise the need to cultivate hope and eliminate hopelessness in the suicidal. But Gangaji was absolutely correct. Hope and hopelessness go hand in hand. One does not - cannot - exist without the other. And both are attributes or qualities of the mind. The source of hopelessness, and the source of hope, is the mind. Although hopelessness is undoubtedly a fundamental feeling of suicidality, the 'cure' for the deep sense of meaninglessness that underlies it is not to be found, at least in my case, in the mind.

There are many of these paradoxes. But perhaps the greatest of these, at least for me, arose from the doubts that I was still harbouring about the 'reality' of this slight but significant shift in my

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thinking. I can recall reading Ramana saying that "doubt is the final obstacle", which is a phrase that has returned to me many times. I couldn't really understand this when I first heard it, but it seemed important. I have learned, though, that there is so much in this simple remark. First, doubt is, again, an attribute of mind. Doubt is likely to be the mind's last ditch effort to maintain control - to assert its primacy. But doubt is also the final hesitation before surrender. Surrender can never be complete if there is still some doubt. Letting go of doubt is to finally and fully meet the Self. And I have learned that, for me, letting go of doubt is not a one-off event. It is a constant presence, a constant 'letting go', a constant willingness to surrender, a constant willingness to be me, nothing more and nothing less. Daily I learn, through constant surrender to my beingness, that *this that I am*, is all I have ever needed or wanted.

I could go on with more of these little illustrations of surrender and doubt, blissful peace and the constant testing of it. But I found that whichever way I looked at it, it not only felt right, it made sense. This was important to me, with my sceptical mind. I have never been able to take something solely on faith. I doubt that I would have taken the plunge into surrender if I hadn't been suicidal. But when I did - because I had to, having nowhere else to go - I still had to test it, I still had to make sense of it. Which I did regularly, and I've told a little of this here. And I still do. Regularly, constantly, at least daily. Sure, I meditate, irregularly, haphazardly and not very adeptly. And sure, I do some yoga, even more irregularly. And I read the spiritual 'texts' of varying kinds from time to time. And I try to care for body, mind and soul as best I can - usually pretty clumsily. But my real spiritual practice today, and since June 1999, is really just to *be me*. Not to strive to *become* me, for not only can I never truly be me if I am always striving to become me, but also because *I am already that which I am*. Nor do I strive to be a *better* me, for there can be no 'better' me than to be *this that I am*, right now.

This spiritual practice, if I can call it that, then becomes simply to honour the Self, that which I am now, as best as I can. To some people this can sound like an indulgence to the ego, but nothing could be further from the truth. This Self is not the ego, which is best

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described for me as the 'individual self', or perhaps the 'separate self'. This 'egoic self' is the self that is of the mind. The self that sees the self - mentally imagines the self - as distinct and separate from others. It is the self that fears death but which must always die, the self of desires and aversions, the self of suffering. I do not deny the reality and legitimacy of this (limited) sense of self, for it is very much a part of our day-to-day human experience. But I learned, through self-enquiry, surrender and constant testing, that this individual, mental self arises from a deeper spiritual Self. This Self, which is not of the mental world of time and space and (other) thoughts, is the deepest and most complete sense of self that I have ever experienced. There may be even deeper experiences possible that are today unimaginable for me as this spiritual Self once was. I tend to doubt it, but I'm open to the possibility. But this Self is definitely not the egoic self of the mind. It is *that* which I am, now, already and always.

The bold trust with which I rode that original wave is no longer so bold now. I trust this Self enormously. It is now my trusted guide as well as my constant companion and comfort. When doubts arise, as they regularly do, and I am uncertain about what action or which path to take, I turn to this Self for guidance. The process is very simple. If I feel that this or that action or path would serve to honour that Self then I will follow that guidance. If it doesn't then I won't. It's often not as black and white as that and I have to look for clues in my doubts and make my best guess. But always the test is to look for whether I feel that I am doing my best to honour that Self that I trust. And I get it wrong - frequently. I still lose my temper about things, I make lousy choices and silly mistakes. But with the Self as my navigator, things seem to be mostly working just fine so far. Better than fine really. Not only has my suicidality disappeared, but the years since its passing have been the best of my life ... and looking better all the time.

Those first few months of giggling celebration were particularly special. Much of the 'bliss' and laughter at that time was about no longer feeling (or needing) my suicidality. The joke was on me and I enjoyed it enormously. Bliss is a word that is often associated with spiritual awakening, particularly with that misleading word

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'enlightenment'. But I find that bliss is also a misleading word as it suggests some sort of ecstatic 'high', like better than the best ever sex, or better than the best ever drug (though I'm perhaps projecting my own biases in these comparisons). The 'bliss' that I felt upon my recovery was really very mundane and dull. Sure, there was the thrill of the relief and release from my suicidality, which, as I said, was truly a big thrill. But the Self that emerged and is now the recognised source of who I am, is really very ordinary. One could say extraordinarily ordinary. There were no blinding lights or orgasmic altered states of consciousness. It was simply consciousness revealed in all its glorious ordinariness. It was to finally, and for the first time in my life, fully meet what had been so familiar all my life. It was to find a new 'home' in which my inner self could reside. Except this 'home' had always been there. It was to meet myself and to 'abide in the Self'. And it was dull, mundane and ordinary. And *this* was and is enough.

I later heard this described as the Zen wisdom of "before awakening, chop wood, carry water; after awakening, chop wood, carry water". A similar idea is seen in the title to Jack Kornfield's terrific book, *After the Ecstasy, the Laundry*. All the mundane, day-to-day activities are still there. I still wake up in the morning and shower, toilet and feed myself. I still have chores to do that I'd often rather not have to do - karma yoga reminds me, though, of the value of these chores. And I still have my disappointments, sorrows and still, all too frequently, I can get frustrated and angry. In the first few months each and every one of these was its own delight - the whole universe visible in a grain of sand. But it didn't take too long for it to actually get rather boring, or, more accurately, I started to find myself rather boring. I found I was occasionally feeling restless and the constant 'blissful' enchantment was not quite so constant.

It was around this time that I started crying. I can't even say why, but I just found that I had a need to cry, usually first thing in the morning. I've never been much good at crying, neither doing it very often nor very well. My mood at this time was to just let whatever needed to happen happen. So I cried. The first one or two times it was a bit scary, not only because I didn't know why I was crying, but

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also because I didn't know how to do it, how to 'be with' these tears. I had one crying session when I sobbed really hard and felt the fear (again) of just how much sadness I held within me. I feared that if I let go then these tears could become a flood and overwhelm me. But this time I dared to trust this moment and did let go and the tears did eventually stop. I then proceeded to get on with that day. Then I cried again the next morning after waking up, and the next, and the next. Sometimes it was just a brief sob with barely a tear. Other times it surged out of me and I had to grab a towel. I just let it happen and after a while I came to appreciate it and almost look forward to it after waking up. Thankfully, I was living very alone at the time so I could 'indulge' these tears however it suited me. I let them flow. And thankfully I was also not working - I could never have permitted these tears to flow if I had to get to work on time.

I was still seeing Nicky occasionally during this early period after my recovery. I also sought out yet another counsellor as I still felt there were 'issues' that needed to be addressed, even if I was now free of my suicidality. I found a doctor, a GP who practised his own variety of counselling therapy. He turned out to be terrific but after a month or so he/we agreed that whatever had changed for me, it had occurred before we'd first met. This was wonderful. Not only this man's humility and enthusiasm for my recovery, but it was also another confirmation that by then my recovery was emerging as robust and enduring. We joked about what the previous four years might have been like if I had met him at the start of the saga. We'll never know. There was one magic moment when we went to make our next appointment. Christmas was coming up and both he and I were planning some time out of town so our usual schedule didn't fit. As we looked into January, 2000, he asked if I felt I really needed another appointment. I wondered and said to him that if I didn't make one then it would be the first time in years that I didn't have some sort of 'therapy' appointment scheduled. His response was instant: "So let's not make one then". A joyous moment, a jolly good laugh, and further confirmation of my freedom.

But back to Nicky. I told Nicky about my crying which she was of course very reassuring about. She then suggested something that I

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found surprising. She suggested that when I cry, to cry not only for myself but for all who are suffering. As usual, I didn't really get what she was on about with this. And, as usual, I trusted her and said OK. And, also as usual, I immediately forgot about her instructions for a week or so. But then one morning, as I started my now familiar crying, I recalled her suggestion. And the quiet start to that morning's tears immediately went out of control. I gasped for breath at the enormity of the sadness that rushed out of me. It was actually scary and for the first time I reached for the brakes and held back my tears. It was too much, much too much. I couldn't do it. I regained a little composure and wondered whether to try again. I couldn't, it was too much. So I figured out a compromise. I decided to cry just for all those who were contemplating suicide at this very moment. This was big enough but it felt possibly more manageable. These invisible, anonymous folk 'out there', contemplating suicide as I cried, were my soul-mates, my kindred spirits. I somehow felt I could cry for them. So I cried and cried, a long and beautifully sad cry. This sadness too was now a jewel in my beingness.

Eventually this morning routine of crying stopped when I went on an interstate visit. And although I still occasionally cry, including for my many suicidal soul-mates who are still suffering, it is not with the regularity or intensity of this period. I'm still not altogether sure of the significance of it and don't really need to know. But I think that perhaps I released through these tears, some (if not all) of the sadness I had carried around for so long. I think that perhaps I also learned that my sadness was not all mine, or at least not entirely *for* me. I feel little sadness for myself these days but a great sadness is still within me for all who are suffering, and especially for all who are struggling with suicidality.

It was around this time, just a couple of months after my recovery, that another moment of extraordinary grace occurred. I would occasionally drop in for a coffee and a chat with some of my old computer buddies at the university where I used to teach. One or two of these people knew of my struggles and had been wonderful, stalwart friends whose support had helped me preserve some measure of sanity during the most difficult times. I decided to see if Elaine, who was not

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from the computer department, was still working there. I had attended some of Elaine's workshops on teaching and learning - a sort of internal 'train the trainers' program - during my time at the university. These were terrific workshops that helped me appreciate more fully the new profession of teaching that I was moving into at the time. I'd always liked Elaine, enjoying her wit and humour as well as her professional talents, so I thought it would be nice to see her again after all these years. I called and made an appointment for a perfectly innocent coffee with her.

As we walked to the café she asked me what I had been doing these last five years? "Trying to kill myself", I replied, "What about you?". "Having a bit of a battle with cancer", she said. It was an extraordinary moment. In some ways we were both quite 'ho hum' initially about each other's matter of fact answer. Like, "OK, but have you done anything *interesting*?" She was concerned, of course, to hear of my troubles, but not at all freaked out by it. And my reaction to her news was similar. The coffee break lasted nearly two hours. Along with genuine and sensitive concern for each other, we found that her efforts to live and my efforts to die had much in common.

These weekly coffee meetings went on for some time but we never seemed to find the end of this conversation. It was several months before either of us began to realise that maybe something more than a good conversation was happening between us. And several months more before this surfaced as what we now nostalgically call our unacknowledged 'courtship'. Slowly, slowly - oh, so slowly - a beautiful intimacy developed so that today we are partners in life and love. And still no sign of this conversation that we started back in late 1999 ever ending.

It seems almost ironic that this happened. I had spent a fair bit of my adult life single, which was often a source of considerable discontent for me. But now, for maybe the first time in my adult life, I was totally content to be single, unattached and not seeking intimate relationship. The joy of shedding my suicidality and the completely satisfying peace of just being me, of being *this that I am*, was a fullness that needed no 'other' to make it more full. Which is not to say that I had opted for the single, celibate life like some sort of monk

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or swami. As Joan Armatrading once sang, I was not in love but was open to persuasion. But I did not feel the *need* for it, nor was I actively seeking it, as I had done during most of the periods of my adult life when I was single. This was very clear to me and also to Elaine by the time our conversation, in hindsight, turned out to be a 'courtship'. Elaine too was not seeking a lover. Apart from the long but still unresolved separation from her husband, the trauma of the breast cancer had left her more or less accepting that love and intimacy with a man was in her past not her future. It's hard to know who was more surprised when we found ourselves falling in love.

This was quite important as it has given a great strength to our love and life together. I suspect that some people might think that my recovery is really due to meeting Elaine. These people might also worry that if it didn't work out with me and Elaine, then I might collapse into suicidality again, given that relationship failure had been the trigger for me in the past. This would be a terrible burden for Elaine, and me too, if she thought this. Fortunately, we are both very clear about this and know that my recovery was well in place before we met for that fateful coffee break. She sees, knows and understands where the real strength of my recovery lies. And it is no slight on her or our precious intimacy to say that my stability today does not depend on her love.

Elaine knows and understands this not only because she 'sees' me very clearly. She knows it because she recognises my surrender to the silent Self as essentially equivalent to her surrender, to her God, that was the key to her recovery from cancer. It's not for me to tell Elaine's story here, but when she said to me "a bit of a battle with cancer" it was something of an understatement. She had been through the full horrendous disaster of all the treatments but these had not been completely successful. In her exhaustion, so similar to my own, she had surrendered to her God and in her heart knew she would likely soon be saying goodbye to her greatest love, her children. When we met for that coffee her cancer had been in 'remission' for about a year and she was back at full-time work. Although the dark cloud of cancer still haunts her (us), in some ways more so than my suicidality haunts me (us), and there have been a few scares, she has been pretty well throughout these years we've been together.

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Unlike me and my suicidality, Elaine does not often talk about her cancer. It's not that it's a big secret, she's quite open about it. But she doesn't think it an interesting topic of conversation, and some of the details she chooses to keep very private. But she is quite clear in her own mind that her 'remission' did not come from the medical treatment, though she might have died without it and she respects the very fine efforts of her doctors to help her. These remissions from even quite late stage cancers remain perplexing to the medical profession. No-one really understands them, though everyone appreciates them when they occur - no explanations are needed. In her own mind, Elaine feels that surrender was a vital key to her remission, though she finds it as difficult as I do to say exactly what she (we) mean by 'surrender'. But we do know that we each recognise in the other this special moment of grace we call surrender.

Elaine is now, first and foremost, my partner in life and love. But she has also been an inspiration for the work I do today. It was also around the time of that first magical coffee conversation that I wrote the letter to my GP in response to the shocking letter he had received from that last psychiatrist. This letter was the first writing I had done for a couple of years, having deliberately stopped when I burned most of my journals and old letters in yet another attempt to purge myself of a life I didn't want. Writing, which I had always enjoyed as perhaps my most creative skill, had become another folly, another sick charade through which we try to find or create meaning when there is none. Since that letter to my GP, which had simply demanded a written reply, I have been writing ever since. And Elaine has been my 'first reader', guide and confidante, and inspiration to write more and more.

This writing, along with all the thinking and talking behind it, has eventually led to my current work as a PhD student at Victoria University. Elaine's influence has been vital in this journey into academia and I doubt if I'd be doing this without her encouragement. Although I have spent quite a few years at university as both a student and a lecturer, I am not as enamoured with academia as Elaine, for whom it is not only a career but also a passion. Elaine has tempered my cynicism towards academic emperors with no clothes masquerading as 'experts', and helped me see that maybe the work that I want to do

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could perhaps be pursued most effectively through the university. Initially I had my doubts about this but Elaine's wisdom has, so far, proved to be true.

But academia did not call me immediately. I considered returning to teaching computers, and even did a few semesters of part-time teaching at my old uni. But my heart was not really in computers, which had lost their interest for me. I was reading (and doing some writing) about suicidology and mental health and becoming more and more concerned with what I was learning. I saw the opportunity and the need to get more involved in what we might call the 'mental health consumer movement'. This remains true for me today and I really see my academic work in this context. But I also considered other ways that I might use my experiences to work in the mental health area.

In the drug and alcohol rehab field, it is common for people who recover from their addictions to then work in the field. This may be as a counsellor, social worker, advocate, community developer or numerous other roles that are possible. This high level of participation of ex-users is one of the reasons, I believe, that drug and alcohol programs are way ahead of most psychiatric services. So I looked at the range of activities, roles and opportunities in the mental health field where I might be able to contribute something. On a completely different tack I also considered making a career out of teaching yoga, and maybe a school of yoga that specialised in yoga for mental health. These were some of my thoughts before I had a look, with a few gentle nudges from Elaine, at academia.

In these deliberations it was necessary to do a pretty ruthless stocktake of what I may and may not have to offer in the area of mental health that I now knew I wanted work in. I knew that I didn't want to be a counsellor or therapist - for reasons which should be evident by now. Social work, advocacy, community development or similar work was perhaps closer to my skills and temperament. But still not quite.

I was on the pension, living happily in the rooming house, doing lots of reading and a little writing, and beginning to make some contacts with other survivors of the mental health system. This was my introduction to the mental health consumer movement, a human rights

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struggle against stigma, discrimination and abuse, and a fight for better treatment options and services, improved community awareness, and many other issues.

It's necessary to mention here that the term 'consumer' is the commonly accepted terminology in Australia for those of us who experience, or have experienced, a mental health 'issue' of some kind. Much of the language in mental health is just awful and one of the areas where there is a need for great change. For instance, I used the phrase 'mental health issues' because I simply cannot use the medical jargon of 'mental illness', which many consumers, myself included, see as one of the major sources and contributors to the stigma and discrimination against us. 'Consumers' is another problem word, which many of us - yes, me too - find offensive and stigmatising. Personally, I prefer the phrase 'psychiatric survivor', sometimes in its abbreviated form of just 'survivor'. Psychiatric survivors first coined this term to specifically identify themselves as having survived psychiatric treatment. But I also like it's double meaning that I am a survivor of a psychiatric crisis - in the original and noble meaning of 'psychiatry', which is to heal the psyche or soul - rather than having some mythical, medical mental illness.

Through my private study of 'suicidology', the formal academic discipline that seeks to understand suicide and suicidality, and also through my growing contacts with other psychiatric survivors, I became aware of the serious neglect of the first-person experience in our efforts to understand suicide and other kinds of madness. Yes, I also prefer the rich and meaningful language of madness to the sanitised and empty language of medicine and psychiatry. The denial of the lived experience of madness, of what it means to those who actually live it, was and still is a big problem in mental health. And I felt that nowhere was this more so than in suicidology, the 'collective wisdom' of the so-called experts on suicide, suicidality and suicide prevention. So I was beginning to think that maybe I could contribute something from my own experience to this collective wisdom.

Around this time there was an emerging awareness of 'depression' in the general community as an important public health issue, and in Australia the *beyondblue* National Initiative on Depression was

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launched. The full, sad story of this 'initiative' needs to be told elsewhere some time. But just briefly here, I offered my services to *beyondblue*, which were rejected, and then spent a fair bit of energy over the next year or so arguing with them for more consumer (sic) participation in what they were doing. In the end I had to conclude that it was in my best interest - for the sake of my own mental health, even - to stop banging my head against the *beyondblue* brick wall. With a budget approaching \$100 million of public money, that somehow miraculously appeared when all other mental health services were suffering severe cutbacks, *beyondblue* has shown itself to be part of the problem rather than part of any solution to 'depression' in the community. They pretend to welcome consumer participation but only, I found out, if we agree with their narrow perspective on the issues. They do not welcome, in fact they actively exclude, the many dissenting voices, such as mine, that challenge the medicalisation of depression. I regard this as breach of their social obligations and a serious misuse of this public money. Sadly, *beyondblue* is more about managing public opinion through public relations rather than the public enquiry into 'depression' that we really need.

I briefly mention *beyondblue* because I learned through my struggles with them that there is much deliberate misinformation being sold to us through campaigns like these that promote a simplistic approach to 'depression'. My efforts on this also showed me that I do have some capacity for wading through fairly large quantities of often quite complex information. Furthermore, my academic background and writing skills were sufficient to present an alternative argument to the *beyondblue* public relations exercise, an argument that many were already making but more voices were needed, especially more first-person voices of survivors. I particularly felt that more voices were needed to challenge the dominant discourse on suicidality where so few dissenting voices, and so few survivor voices, could be found. In short, my stocktake of what I most had to offer led me to conclude that it was to tell my story, as best I could - and through this, to make as strong an argument as I could for a more open, more honest and more comprehensive approach to understanding 'depression' and suicidality.

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And finally, arising directly from my own recovery, I needed in this argument to articulate, as best I could, the need for spirituality to be part of this discourse. It was apparent to me that all the arguments that needed to be made added up to a very big ask. I needed to make contact with others, both here and overseas, who were working on these arguments. I needed to do the research to make my own argument as strong as I could. But most of all I needed to find my own voice so that I might articulate this argument as clearly, as persuasively and as widely as I possibly could. This challenge has led me to academia, where I have been able to do the required research and to develop my writing skills so that I can give true voice to this argument. This is the work that I do today, and part of my ongoing recovery. And this book is for me the most important product of this work, even more so than the academic papers and other parts of my PhD thesis - of which this book is, by the way, a key component.

This work has proved more exciting, fascinating and rewarding than I could have dreamt. It has also proved to be *exactly* the best thing for me to be doing in order to be true to my spiritual need to honour the Self. This not only serves to make a contribution to the awareness and understanding of suicidality; it is also the best path for me to follow to ensure that suicidality does not return to my own life. For as long as I am guided in my actions by a sense of service to *this that I am*, then I am confident that the desire to destroy the small, egoic self of body and mind is less likely to arise.

This that I am is the source of my being. *This that I am*, revealed in silence, is what I now serve and honour to the best of my ability. *This* is the peace and freedom at the core of my being. *This* is my continuing journey of recovery from suicidality. *This* is the work that I do today. *This* is my daily spiritual practice that fills every moment and guides all that I do. *This* is everything and nothing, all meaning and all meaninglessness, all hope and all hopelessness. And *this* is enough.

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As we approach the end of the story of this book, I remember once more the words of Gangaji from the last chapter:

The time will come when you will have to stop with all the stories.

In the last chapter these words pointed to the spiritual silence beyond all stories where I finally fully met myself for the first time and discovered peace and freedom. But I think there is another valuable message to be found in these words: that in order to find what lies beyond our stories we must tell them. Or so it seems to me. It is through the telling of our stories that we can eventually get to the other side of them and meet the silent story-teller, the source of all our stories. To surrender to the silence of the spiritual self – the story-teller – it is necessary to let go of our stories and their hold on us, to release them and set them free. And to set these stories free, we need to tell them.

But story-telling is more than this liberating opportunity to meet the silent story-teller. Although the spiritual self can only be met in the silence of no mind and no stories, this intimate moment of self-realisation can be brief and fleeting. And then the stories resume. The mind arises again, with more stories of past memories and imagined futures. This may include fears and doubts, as discussed in the previous chapter, so that this fleeting encounter with the silent spiritual self is lost in the noisy ego of the mind. Indeed, this is typically what occurs many times every day for all of us. But if by some grace this brief moment of silence is recognised as the source of who we are and of all our stories, then this is the moment of self-realisation when all stories are forever changed. Realising the spiritual self, however, does not mean that the stories stop forever. Stories resume – and these stories also need to be told.

The main stories of this book have been of my struggle with, and recovery from, persistent suicidality. These stories have been told mainly in the narratives of each chapter as a personal history that is primarily descriptive. They are the stories that had to be told and exhausted before my own moment of silent grace could occur and reveal peace and freedom as the deepest truth of who I am. Of course, the narratives here are historical and not the story-telling, the stories that were told, as they were lived at the time. But they are my best effort to share this history and I regard these descriptive narratives as essential stories that need to be told and heard if we are to understand suicidality better.

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There are other stories in this book. These are the stories that have arisen since my freedom in mid-1999. These are the stories that resumed after I momentarily stopped with all stories and let go of them – and of my mind – as central to my sense of self. First among these is a story of liberation and celebration, and I hope the narrative of this chapter gives some sense of this. Then there are the stories of my life and work as they have continued in the years since my recovery. Again, the narrative of this chapter tells just a little of this. These stories include those that tell of my subsequent ‘making sense’ of the mainly descriptive stories of the narratives. These subsequent stories are more reflective than the narratives – informed by the benefit of hindsight, you could say. They are more interpretive than descriptive, being also informed by the study and research done in the years since my recovery. They are also less personal as they consider and comment upon the broader context of current thinking on suicide and suicidality. These subsequent ‘making sense’ stories are, by and large, the stories found in the commentaries of each chapter.

Two other stories need to be told in this final commentary, the two key stories of my ‘post-recovery’ life that are the context behind the commentaries of all the other chapters. The first is the story of my journey into the community of academia and PhD research. The second is the story of my journey into the embrace of another community, this time of Mad Culture that, like my academic work, is also current and continuing. Mad Culture is a growing worldwide social change and human rights political movement. But Mad Culture is more than just the politics of the ‘mad movement’, though this remains a key feature of it. In many ways, Mad Culture has become my spiritual home, a community of kindred spirits and soul-mates. As I celebrate my freedom from suicidality in this final commentary, I also celebrate Mad Culture.

The two stories of academia and Mad Culture have unfolded in parallel, side by side in a creative tension where each challenges and stimulates the other. For instance, my PhD supervisor was initially concerned that mad politics was interfering with my research – until he recognised that this was in fact the context of my research (rather than the other way round). Similarly, among my fellow mad mates, I think my research work sometimes seemed remote and ‘academic’ (i.e. irrelevant) compared to the immediate personal crises and human rights abuses that they were dealing with on a daily basis. I’m delighted to be able to say that these tensions have proved to be truly creative, with my academic research being informed by Mad Culture and vice versa.

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The results of my academic work can be seen elsewhere in this book, especially the commentary on the ‘mental illness’ circus of Chapter Four and in the ‘Who Am I?’ Interlude that follows it. But before celebrating Mad Culture, there are a few other stories from my journey into academia that are also worth celebrating.

The narrative of this chapter tells a little of how I stumbled into doing a PhD at Victoria University. The original motivation for this was to see if I could use my story in some way to help get spiritual ideas onto the agenda of suicidology. I was not at all optimistic that this would be possible but, with Elaine’s encouragement, I thought it was worth a try. The first major academic problems I encountered were the limitations of the traditional, ‘standard’ methods of research based as they were on first the collection of data, followed by analysis of the data and then reporting on the analysis. What would be the data of my research? If I tried to use just my own story, a sample size of one would be a major problem, especially given that the sample of one was myself. This was not – could not be – objective, scientific research, or so some would argue.

I considered following a standard research method of interviewing a ‘representative’ sample where I gathered stories (collected data) of others who had experienced suicidality. The analysis would then have been to look for spiritual themes in these stories. I still think this would be an excellent and valuable research project, but suicide is such a sensitive issue that it was made very clear to me at the outset that ethics approval would be difficult, if not impossible. It was pointed out that this would be the case even for a researcher with strong clinical and counselling skills. For someone with my history to seek out and interview research subjects with their own histories of suicidality was enough to make any ethics committee shudder in trepidation. While this is a reasonable ethical concern, it is also an instance of the suicide taboo at work. When I pointed out that I was already regularly talking with others who knew about suicidality ‘from the inside’, I was told that these conversations could not be used as data for my research. The university could not, of course, stop me from having these conversations as a private citizen, but as a researcher of the university they could prohibit their use as data for my research. This is a genuine ethical dilemma that seriously impedes useful research. I don’t know what the solution is, but fortunately another way forward appeared.

Before looking at this way forward, it is necessary to mention another problem that was apparent from the very outset of my research. Quite early in my research, I was invited to give a talk at a seminar on courageous research. In my opening remarks I acknowledged that many people felt it

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was quite courageous of me to speak publicly of my history of suicidality, but that I personally did not feel this to be the case – I needed to talk about it. I then quipped that perhaps some courage was required to try and talk about spirituality within the hallowed halls of academia. Spirituality, almost by definition, challenges the limitations of rational science that is the hallmark of academic cultures. Spirituality, again almost by definition, does not regard mental, intellectual knowledge as the sole legitimate or highest form of knowledge. I was wisely cautioned by one senior academic to be careful in my work not to be seen as too New Age and risk being sent to the bottom of the garden to play with the fairies. There are strong institutional prejudices in academic cultures against spiritual ways of knowing, which only added to my doubts about whether I could do the work I wanted to do in a university setting. Eventually a way forward was found that could combine the rigorous scholarship of good research without diluting or compromising the integrity of spiritual knowledge. But it was a bit tricky for a while.

To cut a long story short, I changed supervisors and departments, all quite amicably, and shifted to a form of PhD thesis that is commonly referred to as a ‘creative thesis’ – unfortunate terminology as it suggests there is such a thing as a non-creative PhD thesis. The concept was developed to bring the creative arts into scholarly research (and vice versa), a very noble enterprise. The ‘creative thesis’ typically consists of two parts. The first and major component is some creative work of the researcher, such as a novel, an art exhibition, or a dance or theatre performance. The second component of the thesis is usually called a ‘scholarly exegesis’, or academic commentary, that links the central ‘creative component’ to some relevant academic discipline.

The creative component of my thesis is the book you are reading now. Although not a novel, the ‘creative’ aspect of this work has been the challenge of finding and giving voice to my lived experience of suicidality. I therefore sometimes refer to this as a creative non-fiction book, though a fellow PhD student who is writing a novel as part of his own creative thesis suggested that I should perhaps call it a ‘literary’ non-fiction book. Whatever term we use, the intellectual challenge of first finding and then expressing the voice of my story – two distinct tasks – represents a major part of my research. It is this voice, primarily the voice of the narratives in this book, which is the vital ‘first-person data’ so most frequently missing but so urgently needed in our efforts to understand suicide and suicidality. It is only the first-person data that can reveal the invisible, innermost depths of any lived experience. It is only through the first-person voice that we

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will hear the significance of these experiences to those who live them – the value, meaning and purpose of the living of the experience. And it will take this first-person voice to challenge the ideological dogma of those who deny the significance of this data and try to exclude and silence those voices.

Although the first-person narratives of this book are, for me, the most important results of my research, other expressions of my research are important too (and not just because they are required to get a PhD). The commentaries in this book might be thought of as a ‘second-person’ voice, a voice mediated by research, as well as by reflection and hindsight. Although informed by my research, this voice is not the formal, academic voice that I use in my academic writing, such as in the ‘scholarly exegesis’ component of the PhD and the various academic papers written during the research. The less formal, but still informed, voice of the commentaries is important because a key argument of my research is that our efforts to understand suicidality (and mental health in general) cannot be left to just the so-called experts. Suicide prevention (and mental health) concerns the whole community, and the commentaries here are my attempt to communicate my research to as wide an audience as possible as my contribution to the broad community conversation that is required on these issues.

To complete the story of my journey into academia, the creative thesis proved to be the way forward around the ‘sample size of one’ problem. Not long after deciding to use the creative thesis as vehicle for my research methodology, my new supervisor made a casual observation that became a turning point in the research. He put it to me that my personal story of suicidality was not so much the data of my research but an ‘analytical tool’ that I was using to critique the discipline of suicidology. We played with this thought and quite quickly saw that we had stumbled on quite a powerful approach. We now state it more clearly by saying that the ‘data’ of my research is the accumulated knowledge of suicidology and my story then becomes the tool or ‘prism’ through which we examine that knowledge or data. That is, I look at the collective wisdom of suicidology through the lens of my personal story to see what this reveals. When we did this, some rather huge gaps in suicidology leapt out. The three main gaps were the absence of the first-person voice, the impoverished concepts of the self and, most obviously, the lack of spiritual values, needs or ideas.

I now sometimes express this powerful idea – and research method – through the metaphor of ground-truthing. I first heard of ground-truthing from a friend who was part of a team mapping the forests of East Gippsland using satellite images. He was involved in interpreting and translating the

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photos onto contoured maps showing the various forest types. Because of his local knowledge of the terrain being mapped, he was also part of the ground-truthing team. To verify the maps they were producing, small samples of the vast areas being surveyed were visited and walked over on foot to check whether what they had interpreted from the photos actually matched what was on the ground – ground-truthing. When there was a mismatch, it invariably meant some flaw in the original satellite image or, more usually, some error in the interpretation of them. The ‘real’ truth was what you found when you actually walked the terrain. I believe there are many useful research projects, especially (but not only) in mental health, where the established wisdom of the experts would benefit from some ground-truthing against the real, lived experience – the first-person data – of those who have actually been there.

Not long after this breakthrough, I completed my Candidature Proposal, upgrading my initial enrolment from a Masters to a PhD, and a month later won a scholarship so that I could convert to full-time study. After a chaotic and uncertain initial year, I now knew that there was a PhD in the work I wanted to do, that I had a supervisor and a method with which I could do this work, and that I had the support of my university. It’s been mostly pretty smooth sailing since then, though not without its challenges and frustrations. More importantly at the personal level, I came to see that this was precisely the right work for me to be doing. Not only was it the right work for my particular interests and talents at this time in my life, it was also the best way I could think of to live the vital spiritual truth I had learned, which was to just be me. I knew that my wellbeing these days rested entirely on being true to myself – to my spiritual self (which some call God) – to the best of my abilities. Life had become an expression of the spirit within me, which I was obliged to serve as honestly and truthfully as I possibly could. Or to say this another way, my best protection against suicidality returning to my life was to live this life truthfully, giving expression to it and telling its stories, as best I could. Research had now become a part of this and a vibrant and vital story within a story.

As mentioned, the substantive results of my research inform the commentaries, in particular, of the other chapters in this book. The personal story of my journey into academia is told here because it has been an exciting and fulfilling adventure, well worth celebrating in this final commentary. Research is not everyone’s cup of tea, but for me it has been just right – another illustration that being true to this that I am is enough and all I will ever need. It has also been a wonderful companion for my journey into Mad Culture.

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So the final story to be told here, and the final story of this book, is another personal journey that has occurred alongside my journey into academia. It began after my recovery when I first made contact with other mental health consumers, or psychiatric survivors, who were now working in the mental health field in various ways. The first thing to say about this community of the mad is that I have met many wonderful people. Some have become dear personal friends, others have become close and trusted colleagues, and others have become political comrades in the struggle for human rights in mental health. Then there are others I've met only occasionally, perhaps only once, in peer support groups or other similar encounters. Invariably, I recognise these people as kindred spirits, soul-mates with whom I share similar powerful experiences of pain and struggle. These may be experiences of psychache and suicidality that are so intimately familiar to me. But they may also be experiences with which I have no familiarity at all, such as hearing voices or what our mental health system calls psychosis. The sometimes significant differences in our experiences matter little in this community, where a mutual recognition of what we do share in common tends to occur automatically and effortlessly, along with an easy and genuine respect for each other. One experience that most of us share is that of a psychiatric diagnosis. And typically we have all been wounded by this experience in some way.

I now see the mental health consumer, psychiatric survivor, community as primarily a social change, human rights movement in the tradition of the civil rights movements of coloured and indigenous peoples, women's liberation, feminism and Gay Pride, as well as other disability rights movements. At the grassroots, there are many other issues, not just human rights, that this movement is also campaigning for, such as greater consumer-survivor participation in mental health services, policy development and research. Some consumer-survivors give their energy to creating much sought after services that are run by and for consumer-survivors, and there are some notable examples, despite minimal government support. Other consumer-survivors are making valuable contributions to existing mainstream services through advocacy, education or as consultants. A small but growing number of consumer-survivors, such as myself, are now also working to bring the consumer-survivor perspective into mental health research.

Grassroots groups and organisations of all kinds are appearing, some with government support, others entirely voluntary and self-funded. Some of these groups are primarily social, some are bringing together people who share a common diagnosis for peer support, while others have more political

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agendas. In some countries, consumer-survivor organisations are recognised as essential participants in the mental health system and are being funded (though usually inadequately). These people, groups and organisations make up the many diverse voices of a community that is now, with the help of the Internet, finding its voice at national and international as well as local levels. This community, like our predecessor social movements, is emerging as a distinct culture with its own unique discourse, which some call 'Mad Culture'.

It is necessary to mention the critical issue of language in this emerging culture and social movement. Some people, including some consumer-survivors, find the word 'madness' stigmatising and offensive. There are a growing number of people, however, including myself, who deliberately choose the language of madness in preference to the medical language of 'mental illness'. I first heard the term Mad Culture used by Mary O'Hagan, one of three Commissioners in New Zealand's Mental Health Commission. Mary is a pioneer of the psychiatric survivor movement, a movement that has its own distinct history, with its own literature, and many other pioneers and champions like Mary.

I choose the language of madness because it is a rich and meaningful language for my own experience of what the society I live in calls 'mental illness'. It is a language capable of expressing the emotional depth, the chaos and confusion, the mystery and spirit of being human, in ways that medical language simply cannot. For me, it is the medical language of mental illness that is stigmatising and offensive. Indeed, the medical language is the language of the colonisation of the human psyche by the shallow, narrow, 'flatland' science of medicine – and the pseudo-science of psychiatry. It is a colonisation that reduces the vast mystery of life to merely objective, third-person data and that denies me my lived experience. It is also a colonisation that is the primary source of most of the human rights abuses we find in mental health. The medical language of mental illness is the language of the coloniser, the language of those who would oppress us. And consistent with the language of imperialism, the medical colonisers of the psyche claim, and probably believe, that their interventions into our lives are in our own best interest.

Through the language of madness I reclaim my lived experience as legitimate, meaningful and significant. I also assert through this language the unique and distinct culture of psychiatric survivors who are proud to declare that we are glad to be mad. Mad Pride is another phrase of Mad Culture, and July 14 – Bastille day when they opened the lunatic asylums

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along with the prisons – has become the annual day of Mad Pride and of celebration of Mad Culture.

Although Mad Culture is the culture and language I choose, I do not seek to impose this on other mental health consumer-survivors. In the same way that I ask others to respect my language, I respect those who prefer the language of mental illness. I know many consumer-survivors for whom a medical diagnosis was a significant part of their journey of recovery and who therefore embrace the medical language. It would be inappropriate, and indeed offensive, for me to ask these friends to discard their language for my preferred language. But I do ask and expect that my language for my madness be similarly respected. The many voices, and many languages, in the discourse on mental health need to be seen as a healthy and vibrant part of a still emerging culture, as has occurred in all the other social movements mentioned.

As a social change movement, Mad Culture seeks to bring madness ‘out of the closet’ as a perfectly natural, and yes normal, aspect of all human societies. One of the major issues recognised by everyone in mental health is that of stigma, which needs to be seen as discrimination. Anti-stigma campaigns are a common (and expensive) part of most mental health awareness campaigns, but these campaigns have not been very effective and many consumer-survivors actually find them stigmatising with their attitude of patronising tolerance towards us. It would be far more effective to first make stigma – that is, discrimination – illegal in the same way that discrimination against women, blacks, gay people and the (physically) disabled is now illegal, at least in most western countries. And then, instead of TV ads with actors pretending to be mad, the anti-stigma campaign would be simply to get to know us as we take our rightful place in society, without shame or fear of abuse. The prejudices against the mad are essentially the same as those that in the past discriminated against women, blacks, gays and the disabled. And as with these social change movements, the fears that come from these prejudices will be exposed as baseless when we are openly embraced as part of our communities rather than shamefully hiding ourselves – or being hidden – out of sight and out of mind.

The difficulty with legislating against discrimination against the mad is that the primary source of this discrimination comes from the medical profession, in particular psychiatry. Which brings us to the human rights campaign of Mad Culture. Of all the many human rights issues in mental health, by far the most critical one, and the source of many others, is the use of force to try and control our behaviour. In no other walk of life, not even in the criminal justice system, are such extraordinary powers granted to

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deprive someone of their most fundamental human rights. First, we can be forcibly detained indefinitely on little more than the whim of a psychiatrist. But more than this, we can be forced to undergo violent interventions in the name of treatment that significantly change our personalities, sometimes permanently. In other circumstances, such as war crimes tribunals, these sorts of assaults are recognised as torture, which is precisely what many mad activists are now calling forced psychiatric ‘treatment’.

Forced psychiatric treatment needs to be exposed for the human rights violation that it is. All the arguments used to justify forced treatment boil down to it being “for their own good”. We have heard this argument before in Australia. The history of the white occupation of Australia has included, amongst other atrocities, Aboriginal children being forcibly taken from their parents and put into white foster care “for their own good”. Today these children are known as the Stolen Generation. It is precisely the same patronising argument that it is “for their own good” that is used to justify forced psychiatric treatment. It is an argument with the same weaknesses as the racism of the Stolen Generation, and with the same inevitable consequences of human rights abuses. It is not a sufficient argument to justify depriving people of fundamental liberties that most of us take for granted. It is not a sufficient argument for drugging people against their will in ways that radically change their personality. And it is a fundamentally flawed excuse for torture.

One red herring commonly heard as part of the “for their own good” argument is that force is required to protect a person from harming either themselves or someone else. I’ll deal with the latter of these first – the risk of harm to others – for this is the easiest and most straightforward. First, we have to expose the myth that the mad are any more dangerous to others than any other group of people in the community. Numerous studies have shown that, despite popular fears flamed by sensationalist hype, we are by and large very gentle folk and no more likely to harm others than any other group you might care to compare us with. In fact, if society was truly concerned about restraining those most likely to harm others, then the epidemiological data clearly shows that it is drunk men who would be routinely locked up, constrained and controlled. But we don’t do this because our legal system requires that a crime is committed before we can detain and incarcerate someone. And quite rightly so. Simply fitting a demographic category of people more likely to commit a crime – such as drunk men (but not mad people!) – is not sufficient grounds in our legal system for detaining them and locking them up. Except these basic human and legal rights are explicitly and deliberately denied – legally, in special

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mental health legislation – if a psychiatrist judges you as appearing to have a psychiatric disorder.

The argument that force is required to protect us from harm to ourselves is a little more tricky. First, it is no longer against the law to commit suicide. I have a legal right to kill myself, if that's what I want to do. But if a psychiatrist judges me to be mad, I can lose the right to kill myself and force can be used to stop me and, moreover, to detain me indefinitely and drug me into zombie-land, all against my will. Many people argue that this is a legitimate power for society to assert over the mad, even an obligation that society has to protect the mad from themselves. The wish behind this thinking – and it is wishful thinking – is to save lives, but the consequences of this denial of a fundamental human right can in fact have the opposite effect.

First, we need to consider the frequency with which people abscond from psychiatric 'care', whether they are voluntary or involuntary patients, specifically to go and kill themselves. No-one is asking what is happening in these places that is so awful that people literally escape in order to kill themselves. If you present yourself to a psychiatric ward seeking help but instead find yourself being physically and violently assaulted, then I think it hardly surprising that distressed people choose to escape and give up on what may have been their last grasp for life. Assaulting someone who is experiencing a serious crisis of the self cannot be seen as 'treatment'. On the contrary, such a response to suicidal despair is quite likely only going to make it worse. Many consumer-survivors speak of such experiences but the psychiatric profession steadfastly refuses to hear these complaints, dismissing them as the 'illness speaking'.

Second, even before we find ourselves in the psychiatric wards, the threat of force is contributing to the suicide toll. It is a cliché in suicide prevention that one of the great challenges is to encourage people to speak up and reach out if they are having suicidal feelings. But who is going to confess to these feelings if the person they confess them to will have them locked up and probably drugged into oblivion? The threat of force, along with the taboos and prejudices that feed feelings of shame, is one of many pressures that drive those thinking about suicide 'underground'. Again, the threat of assault is not helpful for someone who is having a serious crisis of the self.

There are consumer-survivors who will say that they would be dead if not for the forced 'treatment' they received. I always respect such first-person accounts, but then I ask two questions. First, do they think force sometimes drives people to suicide and, second, can they think of anything

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else that might have helped them as much (or more) than force. So far, the answer has always been yes to both questions. The few people – and they seem to be very few – who are possibly ‘saved’ by psychiatric force have to be weighed against those who are killed by the very same force. It’s very hard to know what the numbers are here, partly because it is so difficult to measure but also partly because it’s simply not investigated or researched. The supposedly life-saving benefits of psychiatric force is a largely unchallenged assumption in psychiatry, which as a profession, like the police, does not have a good track record of investigating abuses amongst their own.

Finally, the use of force and the threat of force has to be recognised as one of the key determinants of a culture of fear and intimidation that is the status quo in our public psychiatric wards. Such a culture is the exact opposite of what people experiencing extreme emotional distress require. Even among those who believe force is sometimes necessary, which does include some consumer-survivors, there are few who do not think that the current use of force is grossly excessive. The use of force is not justified in basic human rights terms. Force is not justified by the patronising and simplistic ‘for their own good’ argument. Force, and the threat of force, creates a culture of fear and intimidation that destroys the safe space that distressed people are desperately looking for. Force, and the threat of force, is the source of many other human rights abuses that are endemic in our mental health system. Force, and the threat of force, is the foundation and characteristic feature of most mental health systems. And force is almost certainly killing more people than it saves. Psychiatric force is the number one human rights issue of the political campaign of Mad Culture.

Mad Culture is mounting a growing international campaign to stop the use of force in psychiatry. We are certain that history will look back on the current use of force by psychiatry and see it as primitive and barbaric in the same way that we now look back on slavery. We also recognise that force and many of the other interventions of psychiatry are more about social control than they are about treatment. Force and the growing reliance on heavy drugs to control behaviour that others see as ‘difficult’ is more about the fears and prejudices of society than it is about compassion for the distressed and disturbed. The extensive and growing use of force and heavy drugs is a symptom of a sick society, rather than of sick individuals. The big challenge is to heal this social sickness more than controlling those who are different. The message of Mad Culture, a message that has appeared elsewhere in this book, is “healer, heal thyself”.

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This is a grim note on which to conclude this story, but it is indeed a grim fight. We are currently losing this fight. The use of force against the mad is increasing, along with massive increases in the use of heavy psychiatric drugging. Dubious psychiatric diagnoses are being used to explain all sorts of behaviours that our culture finds difficult, from depression and anxiety, to Social Anxiety Disorder (SAD or shyness) to Attention Deficit Hyperactivity Disorder (ADHD or wild childhood behaviour). In some communities in the U.S., psychiatry, the law and schools are colluding to refuse kids permission to attend school unless they take their psycho-drugs, regardless of the parents' – and the child's – wishes. Some pro-force lobbyists, supported by the pharmaceutical industry, are campaigning for compulsory pro-active and pre-emptive 'treatment' of not only people who have had a 'psychosis' but those who they deem to be at risk of psychotic behaviour, such as close relatives of the mad. Imagine being legally required to take potent, dangerous psycho-drugs because your first cousin, for instance, had once had a psychotic experience. This is psychiatric social control gone berserk.

There is a modern industry, sometimes called the Sickness Industry, that is promoting dubious psychiatric disorders in ways that is being recognised as 'disease mongering'. This is not just the so-called 'serious mental illnesses' that the pro-force lobby whips up a frenzy of fear about, portraying us as axe-wielding mass murderers. Perhaps the major example of psychiatric disease mongering is the current heavy promotion of the psychiatric disorders of depression and anxiety under the guise of mental health awareness campaigns. If we scratch the surface of these campaigns we see that they are more about getting people back to work than they are about care for the distressed. The real motivation for them, along with expanding the market of psychiatry and psycho-drugs, is social engineering to reduce the incidence of these so-called 'high prevalence' disorders that are beginning to impact on the economic system, with rising numbers of mad people either unable or refusing to work. And this model of mental health, a very western, very medical, very economically driven model, is now being heavily promoted in the developing world under the auspices of the World Health Organisation and the World Bank. It is indeed a grim picture.

But Mad Culture is much more than just this grim human rights struggle. It is also a community of people who have survived their madness, not by conquering and controlling it with heavy drugs but by embracing their madness as a significant, if at times difficult, part of their life story. Although we are sometimes portrayed as anti-drugs, this is not the case at

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all. We are anti-force and pro-choice, which includes for some the choice of using drugs as part of their personal management of their madness. But more than controlling the extremes of madness, Mad Culture is about living life as fully as we can, madness and all. We do not accept that we are cripples to be hidden away from a society that doesn't know how to accept us, either in institutions or by drugs that alter our personalities so that we become invisible. Often the more disabling aspects of madness are the prejudices of society, rather than the symptoms of our supposed mental illness. Sometimes we call our madness 'psychosocial disability', a much more accurate term than mental illness, and find that we have much in common with other disability movements that have had their own social revolution in recent decades. The deaf, the blind and the wheelchair-bound, for instance, are some of the strongest supporters of the mad movement for the simple reason that they understand the disabling discrimination against their so-called disabilities.

Mad Culture demands the right to full citizenship just like these other disability communities have demanded and largely achieved. Similarly, we choose to meet and embrace our so-called disability front-on as a part of our particular human adventure and as a part of human diversity. We refuse to cower and hide from a society that would discriminate against us, demanding that we destroy our unique personalities simply to 'fit in' to a culture than finds us ugly, disturbing and threatening. More than this, we recognise that our madness is not only at times a difficulty for us, but is also full of opportunity. Our madness is often lively, stimulating, creative, productive and entertaining, and frequently very funny. It can also be an extraordinarily rewarding challenge to discover new and deeper qualities within ourselves. Madness, such as my suicidality, can often be a path to profound personal growth and transformation where we move into some new psychospiritual territory. I have heard deeply moving stories from people who work with the mad and describe it as a kind of midwifery, which they experience as an extraordinary privilege as they participate in the birth of new life. These transformations, like all transitions, can be painful. Indeed, suffering of the mental anguish variety, or madness, is generally recognised as an inevitable part of any spiritual journey. Mad Culture embraces, celebrates and tenderly nurtures these precious and mysterious opportunities. Modern psychiatry suppresses, controls and tries to eliminate them, with force if necessary.

Mad Culture is so much more for me than just the critical and urgent human rights campaign that it champions. It is a community of people that celebrates the full diversity of being human, in all its wild and wonderful

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glory. No-one is excluded from Mad Culture. It embraces me as I now embrace it. Mad Culture understands, better than any community I know, the message from Al Alvarez that opened the first chapter:

*We must at all times remember,
That the decision to take your own life
Is as vast and complex and mysterious
As life itself.*

Although spirituality has been the key to my recovery from persistent suicidality, and a central theme of this book, I have to confess that I still do not feel connected with any particular spiritual community. There is certainly no church in which I have ever felt comfortable. And much as I love yoga and ashram life, I've always felt a bit of an outsider among the orange people. I treasure the times I have sat with Buddhist groups in sacred silence, but never quite felt at home there either. Even the community that exists around the satsang with Gangaji, whose teachings were so pivotal to my own spiritual awakening and recovery, is a community that I am socially uncomfortable in.

I think that I am beginning to recognise Mad Culture as my spiritual home. I feel comfortable in Mad Culture. I feel I can identify with this community, whose embrace is wide enough for me to feel that all of me is accepted here: my madness, my darkness as well as my light, my enquiring mind with its academic interests, my anger as well as my humour, my sadness as well as my joys, my passions, my irreverence, my social skills as well as my social ineptness, my talents as well as my mistakes, my spirit in all its silent mystery. All of me seems welcome and accepted in Mad Culture. In Mad Culture I feel the living expression of the wisdom I heard from Gangaji when she spoke of a perfection that is so perfect that it embraces all imperfections as well. I felt this perfection when I woke up to the silence that is who I am. I am beginning to feel this perfection in the community of my mad mates, in Mad Culture.

And *this* is enough.

So finally we come to the end of all the stories of this book, stories told and stories lived. Each and every one of us has similar stories. And these stories have to be told. Perhaps to reach the end of them and meet the silence that waits for all of us. But until that moment, they need to be told for these stories are the stories of life. Telling our stories is to live our lives,

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and living our lives is to tell our stories – to live our stories. If the moment of meeting silence comes, then we can celebrate and let go of all our stories, let go of our attachment to them and the agonising world of our petty, glorious minds that foolishly imagines that we are the story-teller. And then ... and then ... the stories resume. More stories to be lived and told.

And *this* is enough.

Om shanti.

Epilogue

Who Are We?

Thinking about suicide – that is, contemplating suicide for yourself – is an intimately personal, private and often secret feeling that many people struggle with. The story of this book tells something of this struggle for one individual. It tells of the pain of struggling to live in your own skin. It tells of the anguish of feeling an utter misfit in the world you find yourself living in. It tells of the agonising crisis of the self, where life as you experience it has lost all meaning and purpose. It tells of the dark, inner loneliness and isolation, the hopelessness and helplessness, of nowhere to go with these feelings. The story here also tells of attempts to overcome or perhaps deny these feelings, sometimes through a noble search to find meaning in life, at other times through the less noble escape into self-medication. It also tells of seeking help but only finding more hopelessness and helplessness. And at the end of this story, unlike many other similar stories, there is a happy ending, when peace was finally found where it was least expected but where it had been all along – in the silent, spiritual heart of my being.

The motivation to tell this story of one individual's thinking about suicide is to offer it as my contribution to our collective thinking about suicide – that is, our efforts to comprehend suicide so that we might help prevent it. Some people may think that we can learn little from one individual story, especially, according to one school of thought, when that story does not end in a 'completed' suicide. I obviously disagree with this view, although I do not attempt to make any generalisations from a single story, particularly when that story is my own. On the contrary, I regard suicide and suicidality as mysterious as life itself. But this does not mean that we cannot understand it much better than we currently do. Along with my personal story in the narratives of this book, which I regard as the most valuable contribution that I have to offer, I have also reflected on the various aspects of this story in the commentaries. The aim here is to encourage, stimulate and provoke critical thinking and discussion about these issues. But the emphasis throughout the book is on understanding the individual experience of suicidality. In this epilogue I feel obliged to consider and make some comment on how the stories in this book might help us find a way forward in our suicide prevention strategies and campaigns.

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My experience, and my subsequent research and ‘making sense’ of it, has shown me that the greatest flaw in our current thinking about suicide is that we don’t understand it at all well. In particular, current thinking about suicide prevention does not appreciate or give enough attention to what suicidal feelings mean to those who experience them. Enormous effort and expense are being made to identify risk and protective factors, medical explanations and treatments, and ways to encourage the suicidal to come forward and seek help. But remarkably little effort has been made to comprehend the actual lived experience of suicidality – the silent, invisible meaning of it to those who live it. On the contrary, there has been a distinct lack of attention to the subjective meaning of contemplating suicide, so much so that it seems like a determined effort to look the other way.

In the prologue I spoke to my suicidal soul-mates and urged them to first and foremost respect and honour their suicidal thoughts and feelings as real, legitimate and important. I now make the same call to the experts of suicidology, but also to all concerned about suicidality in our communities. Any attempt to reduce the incidence of suicide and other self-harming behaviour must include – and should be based on – an understanding of suicidal feelings and what they mean to those who live them. This cannot and does not happen while we continue to pathologise these feelings as symptoms of some (dubious) mental illness. It is these feelings that are central to understanding suicidality because it is our feelings, not some notional illness, that cause us to deliberately choose death. Current ‘expert’ thinking about suicide largely disregards subjective feelings as irrelevant to understanding suicidality. This arises partly from medical prejudices against subjective knowledge, but also from prejudices found in the wider community that see suicidal feelings as mad, bad or somehow ‘broken’ feelings for a person to have.

These prejudices tell us more about our fears around suicide than they do about the lived experience of feeling suicidal. Behind these prejudices we find two of our most potent fears, which come together in our fear of suicide – the fear of death and the fear of madness. As a society we still tend to have more fear of death than respect for it as a part of life. Our fear and denial of madness as also a part of life are perhaps even stronger. In some ways this is understandable, for death and madness can be painful or ugly to experience or witness, so that we want to look away and not see them. But they also go to the very heart of the mystery of what it is to be human. To deny death, or madness, is to deny life. We can, and indeed must, acknowledge our fears as part of respecting and engaging fully with life. But not to allow these fears, which become prejudices when we deny

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them, to poison our efforts to understand suicidal feelings. If we hope to make progress in suicide prevention, we must all recognise these fears but not allow them to become prejudices that deny the real, legitimate and important feelings of those contemplating suicide for themselves.

The denial by suicidal people themselves of the legitimacy of suicidal feelings only complicates and undermines their struggle to stay alive. So I urge my suicidal soul-mates to respect and honour these sacred feelings. Equally, the denial of the legitimacy of suicidal feelings by those we seek help from, and by the general community, complicates and undermines our efforts at suicide prevention. So I call upon the experts of suicidology, and the wider community of everyone concerned about suicide, to also respect and honour suicidal feelings as part of the sacred mystery of life. Without this the toxic taboo that surrounds suicide, fed by ignorance and shame, fear and prejudice, will continue to dominate and thwart our efforts at suicide prevention. The first and most important message that I hope might be taken from this book is the need to change our thinking about suicide from one of fear and denial of suicidal feelings to one of respect and honour for them. This applies equally to the expert thinking about suicide prevention as it does to the personal thinking about suicide of my suicidal soul-mates.

In the Interlude that asked 'Who Am I?', I argued for our thinking about suicide to shift from a medical, mental illness way of thinking to a more whole-of-person approach that sees it as a crisis of the self. I argued that reconceptualising suicidality as a crisis of the self raises important and useful questions, in particular around the lived experience of suicidality and the personal, subjective meaning of suicidal feelings to those who live them. This would by itself go a long way towards promoting a healthier, more respectful attitude to suicidal feelings – and to those who have them. Thinking about suicidality as a crisis of the self also prompts useful questions about the *social* self, or the relationship between self and community. This important aspect of our sense of self for many people has not been emphasised in the stories in this book because my particular journey into and out of suicidality was very much a private, personal and spiritual journey. This is not the case for everyone though (another reason why I do not try to make generalisations from my own story). When we look at the current, expert collective thinking about suicide we find that the social aspects of our sense of self are almost as neglected as our personal, subjective feelings. Once again it can be seen that this exclusion of the social self is due to the excessive influence of medical ways of thinking.

Some experts in suicidology would argue that this is unfair of me. They would say that suicidology, reflecting its roots in sociology, is much more

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aware of the social dimension of suicide than is found in the broader mental health field. While I would agree with this, I would interpret this as a sad reflection on our approach to mental health rather than something for suicidology to be too boastful about. I have said throughout this book that suicidology, under the dominant influence of psychiatry and the medical 'treatment' of suicidality, still sees suicidality very much in terms of a medical pathology that is located within the individual. There is some competition between psychiatry and psychology whether this pathology is located in the mind or the brain, but little serious discussion about the possible social origins of suicidality. With these underlying medical assumptions, most of the social analysis that suicidology does pursue is primarily the ubiquitous epidemiological study that searches for risk and/or protective factors for preventing or alleviating this pathology. The sociology of suicidology is largely the demographic analysis of sub-populations. It gives almost as little attention to the social self and our sense of social wellbeing as it does to our individual sense of subjective wellbeing.

In the broader mental health field, there is also some competition between the medical model of mental illness and what is sometimes called a 'social model' of mental health. The *psychosocial* approach of this model gives more consideration to a person's social environment and emphasises recovery and rehabilitation rather than the 'diagnose and treat' approach of the medical model. Although there is quite a bit of talk of integrating these various models into a *biopsychosocial* approach, the reality is that the 'bio' of the medical model continues to dominate, consuming the vast bulk of limited resources available for mental health. I strongly support the move towards a genuine biopsychosocial approach, but even this does not really address the 'social self' that I am referring to.

The critical weakness of many of the more social approaches to suicidology (and mental health) is the same weakness that we find in the models that focus on the individual. As they strive for the same scientific credibility that psychiatry and psychology claim for themselves, they use essentially similar, and equally flawed, criteria for their notion of 'evidence based' practice and research, with similar consequences. The invisible, subjective, lived experience of the social self fails to register on their objective, scientific radars that see only visible, third-person 'data'. And just like the subjective, individual self that the medical model fails to see so that it ignores, dismisses or denies it, social models that work only with third-person perspectives will be similarly blind to the vital *intersubjective* lived experience of the self as a social being.

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The term 'intersubjective' is not a familiar one for many people (it's only appeared for me as a result of my research), so it is worth being clear and careful with our language here. As with the excursion into postmodern thinking in the Interlude, I am particularly indebted to the American philosopher Ken Wilber for his clarity on this topic and, in general, follow his terminology. We are all familiar with the notion of the personal, subjective, invisible world of our own inner lived experience, which has been the emphasis in this book. Sometimes this is called the first-person perspective of *felt experience*, as opposed to the third-person perspective of *observable behaviour*. As social creatures, we also have *mutually shared* subjective – that is, intersubjective – experiences. Our intersubjective world is every bit as important as our subjective world, and is similarly neglected by objective science, including much of the social sciences.

Let's make this clear with an example or two. In the Interlude I used the example of love as a significant and meaningful subjective experience that a strictly third-person science simply fails to detect at all. Love is an equally good example of a mutually shared intersubjective experience. Along with the *individual* subjective feeling of love, which can occur with or without the loved one present, there are also those precious moments when we feel a sense of mutually shared union, or communion, with a loved one – the intersubjective experience of love. Anyone who has experienced this knows that love exists, is real and that it is often shared. And just like the individual, personal feeling of love, these shared moments are of enormous meaning and significance to those who experience them. And in exactly the same way that the subjective experience of love is invisible to medical science, so too is the intersubjective experience of it.

Love is perhaps a particularly powerful example, but there are many more everyday, intersubjective experiences. The individual, subjective experience is sometimes described as that 'Ah-hah' moment when we recognise something to be true – when we *live* the truth of that moment. Intersubjective experience is then sometimes called a collective 'Ah-hah' moment when we experience and live a mutually shared recognition of the truth of that moment. A common example of such collective 'Ah-hah' moments is humour or comedy when laughter spontaneously rises up within us as we collectively recognise and delight in the wit and humour of a good joke or a funny moment. There are also those times when we bear witness to someone's pain and suffering and recognise it as our own, whether through some similar experience we've had or because of a natural empathy for the other. This can occur between two people or in groups of thousands

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– indeed ‘mob hysteria’ is another example of shared, intersubjective experience, this time of fear.

Intersubjectivity refers to collective, first-person experiences, in the same way that subjectivity refers to individual, first-person ones. Ken Wilber highlights this by describing the language of subjectivity as ‘I’ language while the language of intersubjectivity is ‘We’ language, or the first-person plural – in contrast to the ‘It’ language of third-person, objective knowledge. The significance of the first-person domains of knowledge (both the singular ‘I’ and the plural ‘We’) is that they are the domains of *value* and *meaning*. Wilber calls the singular, subjective ‘I’ knowledge *aesthetic* knowledge, which is characterised by values of sincerity, integrity and truthfulness. Collective, intersubjective ‘We’ knowledge, is *cultural* knowledge characterised by a sense of morality based on shared values. Objective, third-person knowledge, on the other hand, is almost by definition value neutral. A clear example of this is that the science of the brain is totally value-neutral – knowledge about the brain’s neurotransmitters, for instance, tells us nothing about the value and meaning of what we experience.

Yet what is most significant and important in any human experience is the value and meaning of that experience to those who live it *as it is lived*. And value and meaning can only ever be found in the first-person knowledge of subjective and intersubjective lived experience. Put another way, value and meaning can never be found in objective, third-person knowledge. Despite this, the traditional sciences of third-person, objective knowledge have become privileged above first-person, subjective and intersubjective knowledge. Moreover, the ideology of the traditional ‘hard’ sciences is *exclusively* third-person so that first-person knowledge is deliberately and systematically excluded by its criteria for what constitutes valid evidence that can only be met by third-person forms of knowledge. Nowhere is this more evident than in mental health where we see the medical colonisation of what it is to be human by the narrow and shallow evidence criteria of biological psychiatry.

Returning to suicide, suicidality and mental health in general, we can see that collective, intersubjective, first-person knowledge is every bit as neglected as individual, subjective, first-person knowledge. An immediate consequence of this is the widespread individual and collective failure to recognise and appreciate suicidal feelings as real, legitimate and important. But there are other, equally significant consequences. The first of these, as discussed elsewhere in this book, is that excluding vital first-person knowledge and expertise inevitably leads to an impoverished understanding

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of suicide and suicidality (and mental health in general). We see the most extreme expression of this in modern psychiatry with its almost total denial of first-person knowledge and experience in the pseudo-science of the DSM and the meaningless, value-neutral science of biological psychiatry.

Despite frequent claims by all branches of mental health that ‘consumer participation’ is now a priority, the reality remains that the unique expertise of those who know about suicidality ‘from the inside’ is still largely excluded. Engaging meaningfully with the first-person expertise of mental health consumers is impossible under the constraints of exclusively third-person science. Even with the best of intentions, the current collective thinking about mental health is intellectually crippled by its ideological commitment to an obsolete notion of what is good science, as discussed in the Interlude.

There are other reasons why the first-person data, knowledge and expertise, and in particular the collective, intersubjective kind, are necessary for suicide prevention (and mental health promotion). The stories of this book have focussed mainly on the individual, subjective experience of suicidality. I have only touched on some other stories where the collective meaning-making of shared, intersubjective experiences have been part of this larger story, such as family and friends, my time with AA and NA, and the spiritual community of the ashram. I could have acknowledged these more than I have, but my own sense remains that my own spiritual journey was very personal, very individual and also very lonely. This is not at all a complaint, and may be a reflection of my personality as perhaps a bit of a ‘loner’. Besides, today I feel very fortunate and one of the lucky ones, not only because I have survived but also because I am very happy to be where (and who) I am today, which includes being grateful for all of my history, including my suicidality. Despite this, despite my own ‘solo’ journey of recovery, I am quite certain that the real hope for preventing suicide lies in a collective, intersubjective response to it.

When discussing suicide prevention it is necessary to distinguish between preventing suicidality and preventing ‘completed’ suicides. I repeat again that the emphasis of suicide prevention needs to shift to preventing suicidality, not just ‘completed’ suicides. But before looking at the importance of the collective, intersubjective response to preventing suicide, I want to return to another major theme of this book.

Story-telling is essentially an intersubjective experience where we tell our stories and hear the stories of others. We humans have been described as ‘meaning-making’ creatures and story-telling is such a central feature of this that we could call ourselves story-telling creatures. It is through our

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stories that we not only come to know others but also come to know ourselves. And the stories that contribute most to this meaning-making are those that resonate for us where something in someone else's story 'connects' with something in our own lives in a significant way. Sometimes this might be a private, personal 'Ah-hah' moment when we recognise a truth that we hadn't seen previously – and we learn and grow with this new, first-person knowledge. At other times, story-telling triggers a collective, shared 'Ah-hah' moment and we feel intimately connected with some others. Again, we learn and grow from this. We are all familiar with these occasions and we all recognise them as significant – *and they are all first-person, subjective or intersubjective, occasions.*

Story-telling is the primary means we humans use to find and create meaning in our lives and also to connect with others. Touch is also very important – both touching and being touched – as is doing things, the various tasks and activities where we learn through the doing, both by ourselves and with others. But it is mainly through story-telling that we make sense of our lives, of others, and of the world we live in. In this sense we might think of the theories of science as stories we humans tell ourselves to help make sense of our world. We also tell our stories through art, dance and theatre – there are many ways that we tell our stories. And always, what gives any story its significance is the *value* we find in it and the *meaning* we are able to create from it. This is equally true for the theories or stories of science as it is for the stories of Shakespeare. And *always*, these significant, value-laden, meaning-making occasions are subjective or intersubjective experiences, sometimes both. First-person knowledge is the knowledge of lived experience and the source of all our meaning-making and all that we value.

We need to resurrect story-telling as vital for both suicidality prevention and suicide prevention. We need to do this to restore subjective and intersubjective values to our suicide prevention efforts. First of all we need to hear the stories of those who know suicidality from the inside in order to understand it much better than we currently do. This individual, subjective knowledge is vital but will only become available if we are able to enter into meaningful, intersubjective engagement with those who have the first-person expertise. We need to create spaces where, first of all, these stories can be told, but then we also need to be able to be in these spaces so that they can be heard.

This is perhaps the most critical and urgent need in mental health today. For people struggling with mental health difficulties, whether suicidality or any other expression of mental, emotional, social or spiritual distress, what

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we most need is *a safe space to tell our stories*. Telling your story is the beginning of any healing or therapeutic encounter. Indeed, by itself, or perhaps together with hearing the stories of others, the telling of your story may be all the healing or ‘therapy’ that you need. But this can only occur if we feel safe. The calamity of mental health today is that in our current mental health system we have the exact opposite of a safe space where we can tell our stories.

Returning to suicide prevention, a safe space to tell your story is necessary if we are to overcome the biggest obstacle to helping the suicidal. How often do we hear that the first and most urgent task of suicide prevention is to encourage people to seek help – to come forward and tell their story? But psychiatric wards and the psychiatrist’s office are not safe spaces to tell stories of suicidal feelings. Nor, in many cases, is your doctor’s office. It is also probably difficult, if not impossible, to share your story with family or friends. For a whole host of reasons, not the least of which is the fear and taboo that surrounds suicide making almost anywhere in the community difficult, often impossible, and sometimes dangerous to tell your story. Once upon a time we might have ‘confessed’ our story to the priest, but this is also out of bounds for many people today. No, there are very few safe spaces to tell a story about feeling suicidal. This reflects very poorly on the so-called experts in mental health, but it also reflects poorly on all of us. As a society, we have lost the capacity to create spaces – intersubjective spaces – where these distressing stories can safely be told.

But these safe, intersubjective spaces are needed for more than just helping us to first come forward with our stories. The opportunity to tell your story, and to have it heard respectfully, can by itself be very healing. The intersubjective experience of sharing stories – telling yours and hearing those of others – can make a vital, life-saving, contribution to your own making sense of your struggles, which in turn can lead to a pathway out of and beyond them. By sharing our stories, we learn that we are not quite as alone and unique in our despair as we usually feel when we are suicidal. We also learn from those who have been there before us and can find comfort and solidarity among those who, like us, might still be struggling. We might also learn to our surprise that our story becomes part of the precious gift of healing to others who struggle alongside us. Sharing your story, in a safe space, alongside your peers, can at least make a vital contribution to your recovery, and may even be all that you need to move beyond your current story of pain.

In my story, the outstanding example of just such a safe space for story-telling is Alcoholics Anonymous (and related ‘fellowships’ like NA). As

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pointed out in an earlier chapter, the foundation of AA is not the 12-Step program that many people first think of when AA is mentioned. The foundation of AA is the regular meetings where you are invited to 'share' your story among a group of your peers, fellow alcoholics, and to hear their stories. And what makes AA a safe space for this sharing is first that you are among your peers so that your own struggles will be respected as real, legitimate and important, without negative judgement. And second, there is the cardinal rule of AA that enshrines anonymity as both permitted and protected, one of the key ingredients of the safe space created by AA for sharing what are often shameful and difficult stories.

In mental health and other health and disability fields, groups similar to AA are typically called 'peer support' groups. They are greatly valued by participants or 'consumers' and some groups do it very well. But they all have a lot to learn, I believe, from the 'experts' in peer support, the drunks of AA. And as a society we also have a lot to learn from these drunks about how to support each other when we experience times of difficulty in our lives. And governments and health departments have a great deal to learn about the healing power of such communities that are so much more effective, and also cost-effective, than the current expensive medicalising of human difficulties and distress.

This brings us to how these safe, intersubjective, story-telling spaces are vital for the even bigger task of preventing suicidality – that is, of preventing suicidality from arising in the first place. I am sceptical whether we can achieve significant reductions in the suicide toll if we just focus on trying to prevent the already suicidal from killing themselves. It seems to me that surviving suicidality is often a matter of grim determination by the individual, combined with a fair bit of pot luck, as in my own story. First there is the problem already mentioned that we tend to go underground and can be very hard to reach. Then there is the luck or otherwise, it seems, of whether you survive your initial attempts to kill yourself. Next is how problematic it can be, should you reach out for help, to find someone who you can safely talk to and who can maybe help. Although we still need to do all we can to help the actively suicidal, it all seems a very perilous journey. The real hope for suicide prevention is preventing suicidality.

For me, the key to preventing suicidality is to promote and create healthy communities. This is a slow process and a long-term goal but one that will be more effective (including cost-effective) in the long run. Suicidality is just one of many symptoms in our society of not only high levels of distress in the community but of our collective failure as a society to prevent and respond to this distress. We need to include with suicidality

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things like our widespread drug abuse and drug addiction (especially with alcohol and prescribed drugs), the high levels of crime and homelessness, and I would include other public health issues such as obesity, asthma and diabetes. And most of all, and often not unrelated to these other issues, we need to re-think what we mean by mental health. We need to ask what would a mentally healthy *community* look like and how might we proceed towards creating that?

I think a few critical issues leap to our attention when we ask these questions. First, despite our material abundance, we are not a particularly healthy society. We are overweight, the incidence of asthma and diabetes seem to be rising, and we are seriously drug-addicted (of all kinds – alcohol, coffee and especially prescription drugs). We are also not a very happy or contented society with widespread anger, sadness, social stress and emotional distress, and massive consumption of anti-depressant medications. Despite these widespread difficult personal and social issues, and despite our material abundance, economic and material values still dominate our thinking and the political agenda. We are not very generous or compassionate to our neighbours, whether they are within or outside our national borders. We are in fact not very compassionate to ourselves. Everyone seems to be working harder just to stay where they are, with stress and distress a constant feature of most people's lives. Many people are dropping out of the rat-race, either by deliberately choosing less affluent but more peaceful lifestyles, or by escaping into drugs, madness and suicide. As one wit observed, the real problem with the rat-race is that even when you win you're still a rat.

Instead of responding to this as a medical epidemic of 'depression' and getting people back to work with the help of their 'happy pills', we need to re-focus on creating and promoting wellbeing. We have the material wealth these days to make wellbeing and *quality* of life a national priority, if we choose. If we choose this rather than the current self-destructive madness, then we would find that what we need is not that dissimilar to what the suicidal, the mad, the addicted, and other 'drop-outs' so desperately need. We need to connect or re-connect with what is most important to us. We need to discover or rediscover what really gives life value and meaning. We need to listen to our pain and suffering, and to the pain and suffering of others. We need to care – truly and deeply care – for ourselves and for each other. For this we need to tell our stories, and to hear the stories of others.

We need safe spaces where we can tell our stories. In families, in the schools, in local neighbourhood community centres, in the workplace, in sporting clubs, in churches, mosques and temples. We need to discover

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how to trust each other again. We need to create time simply to be with each other, as well as time for quiet, private solitude where we can reflect on and tell ourselves our own most intimate stories. We need to ask the same question that I discovered was behind my suicidality: “What does it mean to me that I exist?”

You might find it odd that I’ve not mentioned spirituality in this epilogue, given that it is so central to the story of this book. But I believe that the challenge we face as a society that wishes to reduce the suicide toll is exactly the same challenge I faced when I was struggling with my suicidal feelings. At the core of suicidality is a crisis of the self and the key to my recovery was a deep, personal enquiry into who or what I was and am. For me, this led me into spiritual territory and, frankly, I don’t see how it could ever be otherwise. But I might be wrong. For others, self-enquiry might take them into reconnecting with family and community, or to a new relationship with their working life. Others might turn to the creative arts to give expression to a renewed, reinvigorated and re-enchanted sense of self. All of these possibilities, and others such as joining a church, are for me full of spiritual value and spiritual wisdom. If we attend to what is *really* most important and re-connect with what our souls are really crying out for, then it seems to me that suicidal feelings and many other forms of madness are much less likely to arise. And as social creatures, to do this we need to touch and feel and hear each other. We need to share and communicate who we are and what we need to live life fully. And to do this ... we need safe spaces where we can tell our stories.

Having painted this somewhat optimistic and thoroughly idyllic dream of the future, it is necessary to remind ourselves that suffering and madness are probably always going to be part of our lives and our communities. The challenge then is still much the same. We need to respect and honour suffering and madness as a rich and vital, if difficult, part of life’s mystery. Suffering and madness have so much to teach us about what it is to be human. We need to hear these stories so that we can learn from them. Again, to do this ... we need safe spaces where we can tell our stories.

The final, perhaps obvious, observation that needs to be made as we look at the broader issues around suicide prevention is that societies and communities can also be suicidal. Once more we find that the emphasis on suicide as a pathology of the individual distracts us from our collective suicidality, which may indeed be a major contributing factor in individual suicidality. Even if we take a simplistic symptomatic approach to suicidality, as psychiatry does, then we can see many symptoms in our societies that could be called suicidal symptoms. Some have been

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mentioned above – crime, drugs, the madness ‘epidemic’. We can add to these the environmental crisis where we are destroying the biosphere on which we depend. This is surely collective suicidality. We demonise and lash out against the ‘other’, failing to recognise that in doing so we are harming ourselves, and the current globalisation of economics as almost the sole measure of our wellbeing diminishes us and will perhaps destroy us. And spirituality, which lies at the heart of the mystery of our being, has been reduced to a fashion statement as another optional lifestyle choice.

If we are serious about reducing the suicide toll then we must also get serious about our collective sense of self. In the same way that my personal suicidality forced me to confront the fundamental spiritual question of “Who am I?”, our collective suicidality obliges us to ask an equally spiritual question – “Who are we?”

Acknowledgements

There are too many people who have been part of the journey of this book to acknowledge them all fully. But a few must be named.

Along with Susan, who introduced me to Ramana, Janty and Steve in particular sustained me during my 'four years of madness' with their food, wine and other hospitality. But mostly with their constant strength, humour and love. Margie likewise was always there to share a tear with at any time of day or night, sometimes hers, sometimes mine. And Daryl, once a colleague but now an enduring friend, has been an inspiring 'fellow traveller' on the PhD adventure, which I'm pleased to say he has completed before me. Then there's Susi and Greg who gave me precious refuge, support and much love in the beautiful Australian bush where they live. And warm thanks and blessings to Atma and all those I shared the sacred sanctuary of ashram life, especially my dear companion Surya.

More recently, new colleagues and friends in the mental health 'industry' in which I now work have contributed to this book. In particular, I thank my many fellow psychiatric survivors, my new 'mad mates', who have motivated and guided me to an ever deeper appreciation of what madness can teach us all. There are too many to name (you know who you are), but the membership and staff of the Victorian Mental Illness Awareness Council (VMIAC) have given more to me, and this book, than can adequately be acknowledged here. I especially thank Merinda and Cath for teaching me about Mad Pride and that Batty Is Beautiful, the motto of *insane australia*. And special thanks also to David and Susan who, along with Cath, were three 'critical friends' who generously read and gave comments on the final draft of the book. I acknowledge now also the critical eye of my PhD supervisors, Ron and Mark, but do so more fully in the academic exegesis that accompanies this book.

A key event during my research for this book was to attend the congress of the World Network of Users and Survivors of Psychiatry (WNUSP) in Denmark in 2004, which introduced me to mad colleagues from around the world. Again, there are too many to name, but I particularly wish to acknowledge Peter from Berlin who opened the door to this magnificent world for me – world where I met Mary and Chris (New Zealand), Iris (Berlin again), Mary (UK), Gabor (Hungary), Tina, Sylvia and David (US), Bhargavi (India), Mari (Japan), and Mousa (South Africa). Not only my work but also myself personally have been inspired by your collective efforts fighting for the rights of people who know madness 'from the

Acknowledgments

inside', which you do with such great determination but also such great humour. Nothing About Us Without Us, my comrades!

More close to home is the new 'family' that has surfaced in my life since I stopped wanting to kill myself. It is impossible to describe how Elaine has been my first reader, my keenest critic, and my closest companion on this journey and now, it seems, in life. Leo and Helen have warmly and generously welcomed this stranger into their mother's life, and contributed their valuable, youthful wisdom to my work.

But most of all, I acknowledge my immediate family who have endured my most difficult madness but never not been there for me. My mother Sonya, sadly but peacefully, died last year so will miss the party to celebrate this book that she would have enjoyed so much. Her partner of 56 years, my father Bob, has been perhaps the most enthusiastic supporter of my work with his usual flair for asking the hard questions with a wit and humour that show no sign of wavering as he approaches 90. Twin brother Mike and sister Barb, who make brief appearances in this book, were often in the front-line of my madness when it was burning hot – perplexing, bewildering, frustrating, even infuriating. But never did their love waver, though at times it was the 'tough love' often required at these times, perhaps the toughest love of all to give. Sisters Megan and Sal were not quite so close to it being so far away geographically, but their love and support were always near. And Megan's own journey of recovery continues to be a joy and inspiration for us all. It's doubtful if I could have done a project such as this book, and the accompanying PhD, if anyone in my family, especially my mum or dad, had asked me not to, which many families might. But I have only ever received support and encouragement from this extraordinary family.

Needless to say, the responsibility for any arguments, errors, points of view or opinions expressed in this thesis rests entirely with me.

Further Reading

[Given that footnotes and endnotes have been deliberately avoided in *Thinking About Suicide* (with the exception of the Interlude) an annotated 'Further Reading' section would be required should the book proceed to commercial publication. For this thesis version of *Thinking About Suicide*, a full bibliography of the literature behind my thesis – and *Thinking About Suicide* – is found in the exegesis. The first reference in this Further Reading is therefore to a (currently) fictional website where an electronic version of the exegesis would be publicly available.]

Companion Volume to *Thinking About Suicide*

Thinking About Suicide was written as part of a PhD thesis at Victoria University, which has a companion volume known as an 'exegesis'. The exegesis presents the formal academic arguments of my PhD thesis and includes a comprehensive bibliography for readers curious for more detail on this. It is available on the Internet at:

'www.madbooks.org/webb/exegesis.pdf'

Suicidology

Comprehensive Textbook of Suicidology

Although generally regarded as a major reference in suicidology that comprehensively defines the scope of the discipline, my research argues that it is not as comprehensive as the title suggests.

Maris, Ronald W., Alan L. Berman & Morton M. Silverman (Eds) 2000, *Comprehensive Textbook of Suicidology*, Guilford Press, New York.

Professor Edwin S. Shneidman

One of the pioneers of suicidology back in the 1950s and the first President of the American Association of Suicidology (AAS) whose annual award for contributions to the field carries his name. A psychologist now in his mid-80s, he laments, as I do, the current trend in recent decades towards the increasing medicalisation of suicidality. *The Suicidal Mind* is perhaps his classic work, and *Comprehending Suicide* is included here because it is

Further Reading

Professor Shneidman's thoughtful selections from his choice of classics from the literature of suicidology.

Shneidman, Edwin S. 1996, *The Suicidal Mind*, Oxford University Press.

Shneidman, Edwin S. 2002, *Comprehending Suicide: Landmarks in 20th Century Suicidology*, American Psychological Association, Washington.

The Aeschi Group - <http://www.aeschiconference.unibe.ch/>

The Aeschi Group are about a dozen eminent and innovative suicidologists who meet every two years in the Swiss town of Aeschi. Mostly clinicians, their focus is on therapeutic responses for the suicidal, but from a perspective that challenges the prevailing mainstream ideas and practice in suicidology. In particular, they continue the legacy of Professor Shneidman in putting what the suicidal say about their suicidality in their own words at the centre of their practice. The best source for the group is their website shown above, which outlines their approach and includes references to published works of group members and other useful references. My personal assessment is that the Aeschi Group represents the hope for the future of suicidology. Strongly recommended.

First-person accounts of surviving suicidality

If I had to recommend one book on suicide then it would probably be *The Savage God* by Al Alvarez, a close friend of Sylvia Plath, which looks at the history of suicide through the eyes of a literary critic. Blauner's book is an important first-person account, and 'self-help' book, of surviving suicidality with lots of thoughtful advice – pity about the title. Jamison is a psychiatrist who also knows suicidality 'from the inside'. Her *Night Falls Fast* is a classic, as is Styron's small and gentle book. After surviving her own struggle with suicidality, as told in *Waking Up*, Terry Wise is now an active public speaker and suicide prevention campaigner. And special mention must be made of David Conroy as a pioneering first-person voice in his *Out of the Nightmare*, though it's a hard book to find in Australia. But I'm particularly fond of the selection of passages by great writers in *On Suicide*.

Alvarez, A. 1971, *The Savage God: A Study of Suicide*, Penguin, London.

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Blauner, Susan Rose 2002, *How I Stayed Alive When My Brain Was Trying to Kill Me: One Person's Guide to Suicide Prevention*, HarperCollins, New York.

Conroy, David L. 1991, *Out of the nightmare: recovery from depression and suicidal pain*, New Liberty Press, New York

Jamison, Kay Redfield 1999, *Night Falls Fast: Understanding Suicide*, Alfred A. Knopf, New York.

Miller, John (Ed) 1992, *On Suicide: Great Writers on the Ultimate Question*, Chronicle Books, San Francisco.

Styron, William 1992, *Darkness Visible*, Picador, London.

Wise, Terry L. 2003, *Waking Up: Climbing through the darkness*, Pathfinder, Los Angeles (see also www.terrywise.com)

Critiques of Psychiatry

Madness Explained

After soundly debunking the Kraepelinian assumptions of the DSM, the highly credentialled clinical psychologist, Richard Bentall, calls upon comprehensive and compelling research to show that madness is not a medical mental illness of the brain but a natural, normal and indeed very human psychological response to very human life events. He shows that the boundary between sanity and madness is very much in the eye of the beholder and that the greatest threat to the wellbeing of the mad is often the fear of madness.

Bentall, Richard B. 2004, *Madness Explained: Psychosis and Human Nature*, Penguin, London.

Making Us Crazy

A thorough and damning expose of the inner workings of the DSM committee of the American Psychiatric Association (APA). It shows how the pseudo-science and politics of this committee, backed by the enormous power of the APA, has produced this disgraceful 'manual' that is one of the

Further Reading

foundations of modern psychiatry. Along with the horrors, you can enjoy reading about the brilliant campaign by a few women psychiatrists to keep some blatantly sexist ‘disorders’, such as premenstrual tension, out of this catalogue of madness. This is the official manual of psychiatry that Professor Edwin S. Shneidman describes as “too much specious accuracy built on a false epistemology”.

Kutchins, Herb & Stuart A. Kirk 1997, *Making Us Crazy: DSM - the Psychiatric Bible and the Creation of Mental Disorders*, The Free Press, New York.

The Postmodern Self and Consciousness Studies

Along with the references on these topics in the endnotes of the Interlude, the following sources are recommended.

Journal of Consciousness Studies

An academic journal but with many readable papers from a wide range of authors, reflecting a multi-disciplinary and collaborative approach to the many questions in this exciting field. Of particular note is the special issue on ‘Models of the self’ that was also published separately in book form:

Gallagher, Shaun & Jonathan Shear (Eds) 1999, *Models of the Self*, Imprint Academic, Thoverton UK.

David Chalmers

As part of the Australian government’s Federation Fellow program to reverse the brain-drain of Australia’s leading academics to overseas university’s, Chalmers was recruited back from the University of Arizona in the U.S. to the Australia National University (ANU) in 2004. Although still relatively young, he is regarded as one of the leading thinkers in the field of Consciousness Studies. His main book is *The Conscious Mind*, which gets into some pretty solid academic philosophy at times, but he’s written many papers that are quite brilliant and beautifully written. Most of these are available at his extensive website at ANU where you will also find that even the most academic of philosophers can have a wicked sense of humour too.

Website: <http://consc.net./chalmers/>

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Francisco Varela and colleagues

Francisco J. Varela is a neuroscientist with a particular interest in the cognitive aspects of the mind and consciousness. With his colleagues, he has pioneered the idea of bringing spiritual wisdom into the study of the mind, in particular using Buddhist mindfulness training to reach more deeply into the subjective, first-person data of cognitive experience. His 1993 book with Evan Thompson and Eleanor Rosch, *The Embodied Mind*, is a landmark and still 'essential reading' in the field. Sadly, Varela died just prior to the publication of *On Becoming Aware*, which was a major reference for my own research.

Varela, Francisco J., Evan Thompson & Eleanor Rosch 1993, *The Embodied Mind: Cognitive Science and Human Experience*, MIT Press, Cambridge, Massachusetts.

Depraz, Natalie, Francisco J. Varela & Pierre Vermersch (Eds) 2002, *On Becoming Aware: A Pragmatics of Experiencing*, John Benjamins Publishing Company, Amsterdam/Philadelphia.

Ken Wilber

Although the 800+ pages of *Sex, Ecology and Spirituality* is Wilber's 'magnum opus' where his Integral Model is spelt out in detail, I would recommend either *The Marriage of Sense and Soul*, or my personal favourite, *The Eye of Spirit*, for an initial taste of his ideas. If your interest is specifically in psychology (or mental health) then *Integral Psychology* is succinct but comprehensive. For his personal reflections on spirituality then *One Taste* is a book you can dip into at random, or check out the delightful *Simple Feeling of Being*, an edited collection of his spiritual contemplations from his other books. Much spiritual wisdom will also be found in the moving story of his wife Treya's (and Wilber's) battle with breast cancer in *Grace and Grit*. Wilber's Integral Model is the framework used in my own research to propose a more comprehensive approach to suicide and suicidality, which I call Integral Suicidology.

Wilber, Ken 1991, *Grace and Grit: Spirituality and Healing in the Life and Death of Treya Killam Wilber*, Newleaf, Boston.

Further Reading

Wilber, Ken 1998, *The Marriage of Sense and Soul*, Hill of Content, Melbourne.

Wilber, Ken 2000a, *Integral Psychology: Consciousness, Spirit, Psychology, Therapy*, Shambhala, Boston.

Wilber, Ken 2000b, *One Taste: Daily Reflections on Integral Spirituality*, Shambhala, Boston.

Wilber, Ken 2000c, *Sex, Ecology, Spirituality: The Spirit of Evolution*, Shambhala, Boston.

Wilber, Ken 2004, *The Simple Feeling of Being: Embracing Your True Nature*, Shambhala, Boston.

Spiritual Teachings of Ramana Maharshi and Gangaji

Ramana's teachings are now more widely available in the west, though still not commonplace. The tiny booklet *Nan Yaar* remains my personal treasure of his teachings. It can be ordered (via the website below) under the title 'Who Am I?' from his ashram, Ramanasramam, in Tiruvannamalai, India – for the exorbitant price of \$US 1.00! David Godman's compilation of Ramana's teachings are also a treasure.

Godman, David (Ed) 1985, *Be as You Are: The Teachings of Sri Ramana Maharshi*, Penguin/Arkana, London.

Website: <http://www.ramana-maharshi.org/>

Gangaji's main means of sharing the teachings of her lineage is via satsang, including video recordings of public satsang she has held. You can find out about these at the website below, where you can also find details on several books published by the Gangaji Foundation. *The Diamond in Your Pocket* is her first, major release book.

Gangaji 2005, *The Diamond in Your Pocket*, Sounds True, Colorado.

Website: <http://www.gangaji.org/>

Thinking About Suicide

Mad Culture

Two books that I consider classics of Mad Culture are those by Mary O'Hagan and Judi Chamberlin, though there are others that you'll come across if you visit some of the following websites. These websites are recommended for those curious to learn more about Mad Culture as they are up to date and topical, as well as having references and links to other literature/websites. The *MindFreedom* website is perhaps the most comprehensive with many links to the rest of Mad Culture, as well as information on their current campaigns and also an extensive, ongoing oral history project. Sylvia Caras' *PeopleWho* website is terrific for those wanting to make Internet connections (bulletin boards, discussion lists, chatrooms etc) with mad comrades. The website of the World Network of Users and Survivors of Psychiatry (WNUSP) is mostly links to fairly technical documents on the organisation and its projects, mostly at the UN Convention on the Rights of People with Disabilities. But it's an important website because they're an important international voice for Mad Culture. Morrison's PhD dissertation has recently been commercially published and is an important analysis of Mad Culture, with an extensive bibliography (including websites), though mostly in the US.

Chamberlin, Judi 1978, *On Our Own: Patient-Controlled Alternatives to the Mental Health System*, Hawthorn Press, New York.

O'Hagan, Mary 1993, *Stopovers on My Way Home from Mars*, Survivors Speak Out, London.

Morrison, Linda Joy 2005, *Talking Back to Psychiatry: Resistant Identities in the Psychiatric Consumer/Survivor/Ex-Patient Movement*, Routledge, New York.

WNUSP: www.wnusp.org

MindFreedom: www.mindfreedom.org

PeopleWho: www.peoplewho.org