Social Navigation Hypothesis of Depression and Suicide Prevention

Suicide seemingly is the most paradoxical behavior that evolutionary adaptationist hypotheses of depression must account for.

This essay provides ideas that I hope will encourage commentary and substantive testing of the social navigation or bargaining hypothesis of depression. I also hope it will further clarify the SNH for those interested in the hypothesis.

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Remarks Based On The Social Navigation Hypothesis of Depression
Concerning Scott Anderson's 6 July 2008 NYT Magazine Article On Suicide Prevention
by Dr. Paul J. Watson (posted 07/18/2008)

The July 6th 2008 issue of the New York Times Magazine carried an interesting article by Scott Anderson on innovative thinking amongst researchers concerning suicide prevention.

The article entitled, 'The Urge to End It All,' is available by clicking this link.

I found the article enormously thought provoking in relation to the

Social Navigation / Bargaining Hypothesis of Depression,

referred to below as the SNH.

The main thesis of Anderson�s article, which is based on empirical research concerning extrinsic or environmental factors that mitigate suicide risk, is that if you can find ways to make it even a little bit more difficult to commit suicide by any given means, you force a person who is contemplating an attempt to do more pre-planning and to take more time to execute the plan once it is set in motion. The added cognitive and logistical difficulty, data strongly show, reduces the probability that the person will ultimately carry out a successful suicide.

My first remark is that the article�s claim that many successful suicides are impulsive mistakes, which most of their victims would take back, if they only could, makes good evolutionary sense. Just consider that the mental mechanisms involved in suicidal ideation and action, like the rest of the human mind, evolved primarily in a stone age living environment. In this environment, while it certainly was easy to die in a thousand different ways, humans and their evolutionary ancestors had very strong instincts to avoid all or most of those ancient ways of death.

There had been ample time for such survival instincts to evolve since the dangers, and hence virtually all available suicidal means, had been stable for millennia. For example, the suicidal stone age person could opt to charge into a pack of lions alone, unarmed, naked. But there were strong fear instincts against being ripped to shreds that would tend to hold the person back. How about kissing a cobra. Not easy, there is a strong instinct about avoiding serpents. You could cut open an artery or two, with a stone tool. But ouch! We have strong instincts against pain and an aversion to seeing our own blood flow. It would be hard to come by a stone tool that would sink into flesh almost as easily as warm butter, quickly and irrevocably releasing a torrent of blood, the way many decent modern knives could do.

Even a good precipice to jump from usually would have been hard to come by in our prehistoric evolutionary environment. People seldom live close to them, even in mountainous country, due to instincts and other adaptations against falling, such as vertigo, as well as parental sorts of instincts for protecting offspring from accidental falls. So, a prospective jumper might have to walk a long way to get to a precipice. Then, once they�ve arrived in a general area where deadly falls are feasible, they would usually need to pick a spot. There are not going to be a lot of ready made long and clear free falls available, as are offered by modern structures like the Golden Gate bridge, a popular site for modern suicides. In nature, most dangerously high natural places are merely steep, not utterly sheer. The jumper would have to wander around to find a spot where he could be fairly sure he wouldn�t either be in for a lot of painful bouncing on his way down, or end up caught on a tree or rock, merely injured, and subsequently doomed to a slow death or crippled life.

Guns, odorless poison gases, concentrated pharmaceuticals (some that may actually make the death process feel good); against such modern conveniences we do not have strong avoidance instincts. So indeed, such modern conveniences should be expected to cause many tragic miscalculations, turning what were meant, often unconsciously, to merely be para-suicides into actual suicides.

My second point is more practical and important. It draws upon key observations from Anderson�s article and interprets them in light of the SNH of depression. These interpretations offer to add importantly to the methods that the concerned researchers and clinicians Anderson covers are developing to reduce the incidence of suicide.

A key premise of my first point is that even today�s impulsive suicides *are based on an intrapsychic calculation.* While it may flawed, it should not be assumed that a psychopathology is to blame, at least in the special, but epidemically common case of suicidal depressives.

The SNH proposes that all the explicitly and implicitly suicidal behaviors of depression serve a purpose in social bargaining. Under SNH reasoning, suicidal miscalculations therefore are attributed to the fact that we are saddled with mental adaptations for depression-related strategies of social navigation and fitness-enhancing goal fulfillment that simply are not tuned to the lethality and ease of modern means of deliberate self harm.

If permanent or temporary psychopathology were the main cause of the miscalculations that lead to so many impulsive suicides, then just about all we could do is put up more physical and temporal barriers, basically to slow down suicidal people and give their supposedly malfunctioning brains more time to consider what they are about to do. I�m not saying that the barriers are not useful, and I applaud the thinking reported in Anderson�s article. But, I say, there is much more that can be done. If the SNH is correct, then we can leverage the fact that specific kinds of systematic calculations are going on in depressives � if we harness and guide these in an informed manner, we can greatly lessen the risk of those calculations leading to impulsive suicidal mistakes.

Anderson�s article emphasizes that the more a person premeditates and plans a serious act of self harm, the less likely it ends up being a successful suicide. Well, according to the SNH the depressive state is all about formulating plans to overcome social constraints that stubbornly block one from moving forward with consciously or sub-consciously held fitness-enhancing goals. Under the SNH, these plans include relatively normal, albeit extraordinarily sober strategizing about interpersonal negotiations and/or abandonment of longstanding but maladaptive social alliances. Such planning represents working products of the more conscious, ruminative function of depression; these may be more distinct or prominent in episodes of relatively minor, perhaps sub-clinical depression.

However, under the SNH the social navigation and bargaining plans of depressives also include the sub-conscious or unconscious design of costly and therefore honest signals of need � the need for novel concerted social help and concessions so that fitness-enhancing goals are no longer blocked. These honest signals can include all manner of para-suicidal and apparently earnest explicit suicidal behavior.

Last but not least, plans for this kind of relatively desperate social bargaining also includes the designing of purely extortionary behaviors � ones that, in the name of persuasion, cause those who depend on the depressive to suffer costs that follow more or less directly from the dysfunction or injury that the depressive actually inflicts upon himself. The planning of extortionary maneuvers, under the SNH, is especially necessary when your �opponent� consists of a big resistant social group, or a few very powerful individuals, who are united in wanting to keep you in your maladaptive, goal-stopping, status quo social niche (Please refer to the papers and essay on my main depression page for more background and detail.) Again, consciously planned or not, the purpose of such �fitness extortion� is to be more powerfully persuasive. The self-harm that such extortion entails thus should not be patently lethal, although it might, for effect, be very risky and injurious.

So, the SNH suggests that the depressive mode is strikingly and inherently premeditative. To avoid successful suicide, perhaps the best thing to do, early in therapy, almost as first aid for depressives at risk of suicide, is to aggressively and creatively potentiate the depressive mind�s obsession with social planning. For depressives at risk of suicide, we should be using psychotherapeutic interventions that quickly move to explicit consideration of *socially strategic planning* to guide and accentuate just the deliberative cognitive states that apparently, according to the data discussed in Anderson�s article, reduce the incidence of impulsive suicides. Again, according to the SNH, the depressed mind typically *should be very receptive and responsive* to suggestions of such planning, assuming they are genuine and practical in relation to the patient�s actual social situation and their specific depression-causing fitness hindrances.

Perhaps, even the mere verbal suggestion from a trusted friend or therapist that a depressive�s whole God-awful mood state could be an evolved mechanism to help them successfully *deal strategically* with intractable social partners might energize the neural circuitry *that underpins social rumination*, and concomitantly diminish the circuitry that tends to drive desperate largely unplanned impulsive action. Suggesting to the patient that the real motive of suicidal ideation and behavior, like the rest of their depression, is to move their social partners toward more reasonable socioeconomic or political bargaining positions, may help draw the person into a much safer cognitive mode, one more concentrated on careful purposeful consideration of their next social move. Any residual urges in the direction of explicit physical self-harm would also become more subject to more deliberation, exactly as prescribed by the professionals in Anderson�s article.

Almost by definition, focusing on constructive social planning, entailing the identification of socially imposed limitations on the attainment of worthy livelihood and status-related goals, and the formulation of constructive obstacle-removing social moves, leads the person away from the un-analytic mind states that lead to successful impulsive suicides. A therapist that can promptly begin to offer practical hope of helping the patient develop negotiating strategies that do not involve or at least center on dangerous acts of self-harm may remove the urge for para-suicidal behavior altogether. By the way, young socially inexperienced people, who Anderson�s article points out are most prone to impulsive suicide, may need such help the most! By therapeutically intervening in a way that powerfully stimulates and encourages the social planning and goal-fulfillment functions of depression, suicidality risk often may plummet immediately, leaving the therapist and patient much more breathing room to work more deliberately with the underlying depression, using medication if necessary, and hopefully also, at least from the SNH point of view, practical, fitness-oriented, social-problem solving therapy.

At the time of this writing (7-17-2008), an easy-to-print version of Scott Anderson�s NYT article could be obtained at the following URL (make sure to paste the URL it into your browser as one line without spaces):

http://www.nytimes.com/2008/07/06/magazine/06suicide-t.html?
_r=1&ei=5087&em=&en=813f03627eee3d9f&ex=1215576000&oref=slogin&pagewanted=print

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