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HABITUS, FIELD, AND SUICIDE: A BOURDIEUSIAN SYNTHESIS

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ABSTRACT

Suicidal behaviour invariably has a social connection. While Pierre Bourdieu did not directly study suicide or deviant behaviour, his dualistic theory can be used to describe it. Bourdieu attempts to synthesize individual agency with social structure—explaining the relationship between an individual's actions and the social context in which they occur—not through phenomenology or structuralism, but via a unit of typical social observation known as the theory of practice. This theoretical approach helps elucidate social reality by asserting that suicide is best comprehended as a dynamic interplay between agency and structure.

KEYWORDS : Suicide, Habitus, Bourdieu, Theorization, Criminology

1. INTRODUCTION

Suicide is a complex phenomenon, as numerous factors make precise scientific understanding challenging. Suicide is (i) a social fact, indicating that certain social groups exhibit higher rates of suicide than others; (ii) an interpersonal fact, where problematic relationships within families significantly contribute to suicidal ideation and behavior; (iii) a psychological or individual problem often associated with long-term depression or emotional disorders; and (iv) a psychiatric issue potentially stemming from physiological conditions leading to mental distress. Ironically, these observations present a complex connection: if a particular group demonstrates a higher prevalence of suicide, does this not suggest a social problem than one solely attributed to individual circumstances?

The core tenets of Bourdieu's theory [1] are articulated across his works, with Outline of a Theory of Practice considered foundational. This text explores the influences on human action, differing from structuralism, which posits that behavior is pre-structured in the mind, or phenomenology and ethnomethodology, which prioritize lived experience as the primary expression of social action. Bourdieu's theory of social action begins with several assumptions: (i) structure is universal and manifests as binary oppositions such as humans versus nature, modern versus traditional, dignified versus barbaric, among others; and (ii) agency refers to actors' capacity for independent action, unbound by structure or rules. To bridge the relationship between structure and independent action, Bourdieu introduced the concept of habitus.

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Action undertaken by agents occurs within a context Bourdieu terms a field—a competitive arena where individuals strive for power and influence through various forms of capital, including social capital (networks and relationships), cultural capital (broadly defined knowledge), symbolic capital (reputation, recognition, or authority conferred by the community), and economic capital. While Bourdieu [2] acknowledges the continued relevance of economic capital, he views it as only one element within the field. This field is relatively autonomous, wherein actors and institutions mobilize their capital to secure a distribution of resources characteristic of that arena. The status quo may be challenged by newcomers attempting to alter the field's characteristics, potentially shifting its criteria entirely [3].

Beyond the field, practice is another key concept in this theory. Practice refers to activity undertaken by agents within a field, across space and time, oriented toward chosen goals [4]. It represents the interplay between habitus, capital, and field—an interrelational entity that cannot be reduced to any single component [5]. Wacquant [6] defines practice as centered on the historicity of the agent (habitus), the world (social space and field), and analytical approaches (reflexivity). The theory aims to resolve dichotomies between material determinism and structural idealism, micro and macro levels of analysis, material and symbolic realms, empirical and theoretical approaches, public and private spheres, freedom and coercion—and ultimately reveal the logic underlying practice [7]. Bourdieu describes human life and activity as a dialectic between the internalization of external forces and the externalization of internal dispositions. These internal and external dimensions are not to be analyzed in isolation but rather integrated into the concept of habitus. In this sense, habitus is "society inscribed within the body" [8].

Habitus represents a system of dispositions—thought patterns, behaviors, and tastes—that connect social structure to practice. It arises from childhood experiences, particularly unconscious socialization by the family, and is modified over time. Members of different classes develop distinct socialization dispositions; each class possesses characteristic habitus, albeit with individual variations [9]. Habitus involves adopting a structurally organized system of activities based on specific conditions, or an order mediated through subjective expectations reflecting an individual's objective social position within a group or class [10].

However, habitus operates at a deeper level than this description suggests. It permeates both consciousness and unconsciousness, shaping individuals in profound ways, defining things beyond cognition and at the level of intuition. According to Bourdieu [1], education and distance from "minimal conditions" are crucial factors in the formation of habitus. An elementary school child receiving free lunch might reject fried chicken deemed too salty or oddly flavored, while a child unfamiliar with chicken would accept it as its authentic taste. Individuals distanced from "minimal conditions" may value basic sustenance, whereas those accustomed to abundance view food through an aesthetic lens, demonstrating divergent interests. These classes are not distinguished materially but rather embody class differences within the habitus; we are our class [11].

This process of socialization enables classes to reproduce themselves and generates typologies within populations. However, capital further complicates these dynamics. Capital is a resource (power) encompassing social activities both within and between classes. It is relational, always considered in relation to power dynamics within the social field, serving as a principle shaping the characteristics of social agents. This reflects the breadth of Bourdieu's analytical orientation compared to Marx, despite their shared focus on power. While economic capital remains significant, it is simultaneously symbolically mediated [12]. For example, while economic capital represents financial accumulation, social capital resides in collective organizations enabling its acquisition, and cultural capital manifests as educational credentials or skills. Consequently, society witnesses two forms of struggle: competition for the distribution of economic, social, and cultural resources among individuals, groups, strata, and classes; and symbolic struggles over the evaluation of these resources [2].

This logic of capital resembles a market or game. Similar to Weber's concept of stratification based on market position, Bourdieu's three forms of capital function as investments, as agents striving to manage them for survival and success within each respective "market." However, conditions vary across markets, historically and hierarchically. Over time, the prerequisites for achieving certain positions increase, leading to greater challenges and escalating inequality in specialized fields [13].

2. METHODS

This study is based on a literature review examining significant findings related to suicidal behaviour. It delves into the work of French sociologist and intellectual Pierre Bourdieu (1930–2002) and his theory of social structure, power dynamics, and cultural practices. The core concepts of Bourdieu's theory, namely habitus (socially rooted dispositions), capital (cultural, social, symbolic, and economic), and field (a structured social space where power struggles occur), explain the interplay between individual agency and structural constraints, reconciling structuralism with human agency. This study also draws on the insights of French sociologist Émile Durkheim (1858–1917) regarding the causes of suicide through his concepts of integration and regulation, as well as contemporary psychologist Thomas Joiner's [14] interpersonal perspective.

3. DISCUSSION

Suicide is a final decision in an individual's life, influenced by mental, physical, spiritual, emotional, and social conditions. It can be understood through three interconnected domains: macro (structural), meso (interpersonal), and micro (psychological). The macro level encompasses socio-economic conditions; the meso level includes social support and family relationships; and the micro level concerns the meaning of life and depressive patterns in individuals exhibiting suicidal behavior. To synthesize these perspectives, this study compiles a conceptual framework bridging micro and meso assumptions with Bourdieu's [1] theory of social practice, as illustrated in Figure I:

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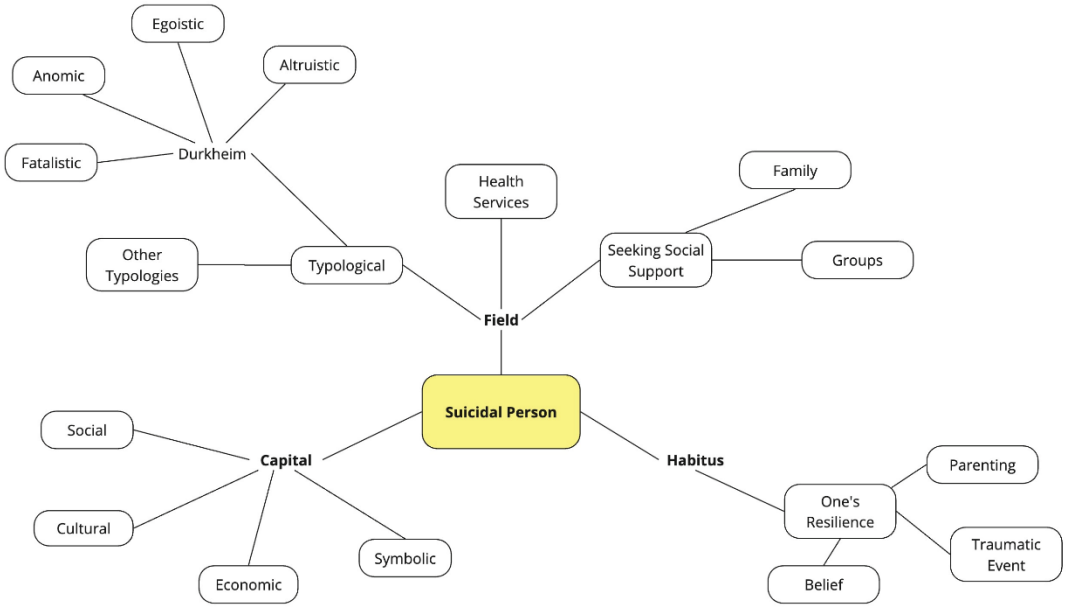

Figure 1: Habitus, Field, and Suicide

We begin by examining the field. The social and personal field of an individual who dies by suicide can be broadly categorized as follows: (i) Institutions or mental health services, representing state responsibility and sensitivity to individual experiences; (ii) Family, functioning either as a protective factor reducing burdens or as a stressor exacerbating them; and (iii) Groups or communities, potentially mitigating loneliness but also serving as sources of stress. Bourdieu's concept of the field extends beyond interactions between individuals within specific units, encompassing shared historical expressions and manifestations characterized by complexity that is not universal but rooted in culture, conflict, and context [15]-[16].

The health institution field in Indonesia is shaped by various historical and political factors. Traditionally, Indonesian society relied on indigenous institutions to address physical or mental health concerns, though not necessarily aligned with modern scientific developments. Traditional medicine often combines beliefs with care practices centered around herbal remedies, prana (energy), and influences from India. As Woodward [17] notes, citing Kleinman, traditional medicine is a system of symbolic meaning embedded in social institutions and interpersonal patterns, encompassing beliefs about illness causation, treatment modalities, social legitimacy, roles, and institutional contexts.

Gunungkidul Regency, Special Region of Yogyakarta, an area with high suicide rates in Indonesia, provides an example. A shortage of healthcare workers has sustained the practice of traditional healers, particularly those assisting with childbirth. According to data from the Central Statistics Agency in 2009, Semanu sub-district had only 6 doctors (24%), 8 midwives (32%), but 11 traditional healers (44%). Java boasts a diverse range of traditional healers—shamans, magicians, ritualists—including

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dukun bayi (childbirth assistants), *dukun pijet* (massage practitioners), *dukun sunat* (circumcision specialists), and others specializing in harvest rituals, marriage ceremonies, divination, or spiritual healing [18].

The field of traditional medicine defines the individual as a microcosmic figure, as part of the macro-cosmos identical to God, and interprets various disorders experienced by a person as disharmony resulting from past or present human actions, whether intentional or not. The cause of disease isn't attributed to microscopic pathogens (bacteria, viruses, amoebas, worms, or fungi) but to spirits; particularly, mental disorders are often seen as the influence of evil spirits or demons [17]. This perspective can bias individuals experiencing depression, which is a primary factor in suicide, and make appropriate intervention a challenge. However, the issue extends beyond structural characteristics. As an agent embedded within a cultural context, one will likely develop a habitus aligned with the system of ideas underpinning traditional practices, or the typology of traditional patients. These patients generally do not view depressive disorders as conditions requiring psychological or psychiatric therapy but instead, seek external causes for their distress and may respond with aggression or withdrawal from perceived disturbances.

From Bourdieu's perspective, an individual's decision to end his or her life represents agency—or a choice stemming from human free will—but one patterned by structural characteristics. This differs from the profile of suicide perpetrators in modern urban areas, although Joiner [14] notes that the underlying psychological factors remain consistent, as described in his interpersonal theory regarding perceived burdensomeness and loneliness. The response of traditional patients to depression may be more objectified than subjectified, necessitating a different approach to treatment. These patients choose suicide because their social environment permits it—as an ultimate solution within their established practices. This vulnerable environment is often found in specific locations, referred to as a suicide cluster, where the interaction between field and habitus for individuals with severe depression frequently leads to similar outcomes, presenting them with limited options. When these options fail to resolve the underlying issues, suicide may be perceived as the only recourse. Consequently, true vulnerability appears when an individual's agency is insufficient or other choices are unavailable.

Conversely, since the Dutch colonial era, the introduction of modern medicine to Indonesia has offered a new perspective, particularly in urban areas where access to education and engagement with modern culture are more prevalent. The availability of public health services, including those addressing physical and mental well-being, has influenced public perceptions of illness. Bourdieu [19] refers to this as *illusion*, a general perception that emerges among diverse groups, even those holding different positions within a given field, and serves as a guide for social action.

Unlike traditional medicine, modern medicine views individuals as physiological or materialistic entities, meaning that internal processes are governed by material laws and are unrelated to mysticism. As a result, diagnosis, treatment, and prevention are developed through empirical and measurable procedures. Similarly, patients, or "modern" patients, tend to interpret their symptoms as belonging to

the material or medical realm. Although they may still acknowledge supernatural forces, medical interventions are generally regarded as the primary course of action.

The development of psychology and psychiatry, alongside the integration of mental health services into general hospitals, has increased awareness of mental health issues and made their treatment more commonplace and accepted by the public. While historically understood as stemming from spiritual disturbances (within a shamanic framework), depression is now increasingly recognized as a condition linked to psychological factors and neurological processes. This shift in understanding extends beyond diagnosis; the general public is beginning to grasp the causes of, and methods for preventing depression. Modern treatments are being implemented, and at a societal level, new values regarding prevention and acceptance are emerging. The rise of movements like friendly schools (which advocate against physical punishment), the formal replacement of the stigmatizing term "Orang Gila" (crazy people) with “Orang dengan Gangguan Jiwa” (People with Mental Disorders), and the implementation of protective legislation for vulnerable groups all demonstrate a growing recognition of the complexities of depression.

Despite growing acceptance of mental illness within the medical field, individuals often exhibit limited agency regarding treatment options, fearing that seeking help will result in social stigmatization as “crazy.” Consequently, those intrinsically experiencing chronic mental disorders frequently avoid psychologists and psychiatrists. This disconnects between the potential for care offered by the medical field and the lived experiences (habitus) of individuals contributes to persistently high suicide rates in urban areas. From Bourdieu’s perspective, the medical field, intended to support vulnerable populations, can instead exert dominance and elicit resistance from those most in need of treatment.

This institutional dynamic results in an asymmetry between the habitus of urban dwellers with mental disorders and that of individuals experiencing physical illness. The fear of being perceived as “crazy” acts as a significant barrier to care, echoing traditional societal beliefs attributing depression to supernatural causes like black magic or spirit possession. Even with sufficient access to resources (“capital”) and knowledge regarding their condition, this stigma remains a formidable obstacle.

Beyond healthcare services, agency problems faced by vulnerable individuals are deeply intertwined with family dynamics. Socialization processes—including levels of familial conflict and broader collective characteristics—play a crucial role. Socialization encompasses not only how parents introduce children to societal norms but also the transmission of normative behaviors across generations facing diverse circumstances. Adverse parenting patterns in youth can perpetuate similar challenges for older adults, establishing cycles of tolerance for problematic actions and responses. If harsh statements or actions are normalized during socialization, they may be replicated later in life, potentially leading to neglect and symbolic violence experienced by elderly individuals.

In psychological studies, it is revealed that suicidal behavior is often considered by individuals experiencing severe depression [20]. This effort forms part of their internal struggle to alleviate their

distress. Although this option is understood as pathogenic, for someone contemplating suicide, it can represent a perceived respite from an overwhelming situation. From this perspective, there appears to be a discernible gap between suicidal ideation and the act itself—a critical period during which family intervention may be effective, particularly when symptoms are escalating. Intensive communication is key to restoring agency, as its absence can lead to a sense of entrapment.

Relating this understanding to Durkheim's [21] typology of suicide suggests that individuals experiencing depression and feeling cornered are often grappling with both a disruption from their normal life (anomic suicide) and a sense of disconnection or excessive integration (altruistic suicide). Similarly, other typologies may apply, such as imitation of a prominent figure's behavior or enactment of a social role, reminiscent of *The Sorrows of Young Werther*. This dynamic often manifests in vulnerable individuals within families, representing an adjustment to a new social environment with a corresponding shift in habitus, where suicide is considered one available option.

Another significant factor in cases of suicide is the individual's social network—spanning generations and cultural groups—which can range from close friends and interest groups to neighbors who regularly interact. Generally, stronger social connections correlate with reduced feelings of loneliness or depression. However, intensity without quality can lead to unhealthy relationships. These interactions involve bringing together different field and habitus characteristics, and in highly communal societies, this can intrude upon personal boundaries.

As Bourdieu & Wacquant [22] argue, within any given field, each actor possesses varying assets, resources, or forms of capital. The amount and distribution of these determine an individual's position within the field, as each strives to leverage available resources for their benefit. Profit is central to relationships within a social field; some are equitable, others unequal, and dominance in an unequal situation can make vulnerability worse, leading someone to feel trapped.

Habitus is crucial alongside field. While field defines the range of possibilities, habitus shapes how those choices are ultimately made. Although seemingly internal to the individual, habitus is fundamentally linked to social structure. Habitus is a reflection of the social structure within the personal field. It encompasses many factors, including identity formation. Identity extends beyond formal self-description; it represents the totality of one's self-image and actions within their social group. It arises from interactions with structural conditions, explaining why suicide rates may be higher in certain regions, potentially influencing future generations.

From this perspective, we can revisit Bourdieu's formulation of practice: [(habitus) (capital)] + field = practice [2]. Applying this to suicide, we might posit: [(depressive habitus) (limited capital)] + fatalistic field = suicide. Depressive habitus represents an individual's unique experience, even within a shared community. This can stem from various sources, such as traumatic events, upbringing, beliefs, psychiatric disorders, or economic hardship.

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Traumatic experiences are difficult to overcome due to their impact on the nervous system and their presence within the psychological field. Traumas can be profoundly destabilizing and fatal. For example, victims of sexual violence, racial conflict, or prisoners of war may experience lasting personality changes that clash with prevailing social norms, leading to desynchronization and increased vulnerability. Trauma survivors are often perceived as different, influencing their interactions with others; communication can become strained, and they may exhibit heightened emotional responses to situations others consider commonplace, fostering isolation and independence.

Beyond the influence of field, upbringing also shapes character and interactional patterns. In societies with strong cultural ties and strict regulations, individual characteristics tend to be more homogenous. This can encourage specific behaviors, including those related to suicide. In such contexts, values are paramount, and deviations from these norms may result in self-directed negative consequences. Fatalistic suicide, for example, can occur when an individual feels unable to meet community expectations. As Joiner [14] suggests, this is a tension between social deterrents and the pressures that can encourage suicidal behavior.

Individuals with physical or mental health disorders are vulnerable to acute depression, especially those from families characterized by low integration or weak symbolic ties. Society often uses terms like “egoistic” or “individualistic” to assess an individual’s level of engagement within their group, including their involvement in family challenges such as chronic illness or aging.

In Javanese culture, there is a tradition of sharing hardships, particularly in caring for elderly parents. This mutual support is integrated into the habitus of each member and transmitted through socialization from childhood. It is deeply embedded in their belief system regarding good and bad fortune. Those who neglect their parents are believed to face future misfortune. However, even with strong family support, individuals may feel like a burden, reflecting an internal conflict between beliefs and personal experience.

The feeling of *pakewuh* (acting out of a sense of obligation or discomfort) may represent a habitus that clashes with the strong cultural emphasis on caring for elderly parents. This can also manifest in a husband unable to provide for his family despite being healthy. Such habits are rooted in cultural codes and their inherent implications. Similarly, *gelo* (deep disappointment) can contribute to depression and vulnerability to suicide as a form of sublimation. *Gelo* is an emotionally charged state specific to certain cultures, arising from the unique composition of that society.

The third aspect is capital (an individual’s possession of various assets within their social field) which encompasses not only economic resources but also social, cultural, and symbolic capital. While economic factors are often highlighted in studies of suicide, it's a mistake to assume financial hardship is always the primary cause; suicide occurs across socioeconomic strata. The suicides of public figures underscore this point, prompting researchers to explore other significant variables.

Social capital is a concept developed by Putnam [23] from Bourdieu's initial ideas and is now understood as a more robust measure of agency and community quality. Despite varying developments, sociologists generally agree on three core components: social and institutional trust, norms of reciprocity, and social networks. Social capital demonstrably improves life opportunities and promotes better health outcomes within communities.

In the context of suicide, the role of social capital is large and is built up over a lifetime (chronological progression). This ultimately shapes an individual's resilience during difficult times. Those with extensive networks have greater opportunities to avoid factors that contribute to suicidal behavior. However, network size is less important than the quality of connections and the unwritten rules governing those relationships.

While often viewed in terms of resource ownership, the focus should be on how social patterns within a network shape individual character, influencing their ability to develop coping mechanisms compared to someone with limited connections. This applies to all circles with distinctive characteristics. The strength of friendships formed through shared interests can be as significant as bonds based on religion, profession, or business. Interest groups often foster greater collective intensity. This explains the pronounced militancy observed within punk subcultures and biker groups, a phenomenon extending beyond simply shared characteristics.

Likewise, cultural capital (ownership and involvement related to knowledge) expands an individual's range of choices and alternatives, fostering a sense of freedom. These choices are rooted in how individuals understand their lives and view solutions to problems. This aligns with various suicide typologies; those who end their lives often experience a perceived lack of viable options.

Symbolic capital is particularly relevant when connected to networks and social groups. Certain professions, such as doctors and nurses during the pandemic, are disproportionately vulnerable to suicide, reflecting the inherent burdens associated with those roles. Furthermore, a lack of symbolic capital can contribute to depression. Within social networks, an individual's symbols play a crucial role, bridging social class and habitus. However, on a personal level, symbolic capital can be a valuable tool for early detection—observing changes in behavior or the accumulation of objects related to inner turmoil, such as objects associated with depression, anger, despair, and life after death.

4. CONCLUSION

Bourdieu's work offers a flexible dualistic model for understanding deviant behaviors by examining the interplay between individual agency and structural forces. The universality of his concepts—capital, field, and habitus— allows for bridging micro-level experiences with broader social structures, revealing implicit or explicit dynamics within both individual action and cultural patterns. While Durkheim [21] and Bourdieu [1] provide valuable sociological insights into suicide, their approaches differ in focus, methodology, conceptualization of the individual, understanding of social influence, and analytical scope. Durkheim emphasizes statistical patterns and external social factors, while

Bourdieu highlights the complexity of individual experiences shaped by broader social structures. Thus, Bourdieusian practice theory provides a robust framework for analyzing criminogenic factors contributing to suicide.

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