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Knowledge Exchange Seminar Series (KESS)

An exploration of the dynamics of suicide among women

Dr Sharon Mallon

Key Points

1. Research into gendered aspects of suicide have increased over the past decade.
2. Female suicide is rarely discussed in isolation from male suicide. As a result, there remain significant gaps in our understanding of female-only issues and their connection to suicide.
3. The findings from this study show that the majority of women sought help from health services in the twelve months prior their death and many were engaged with mental health services.
4. By choosing to focus on female suicide it is possible to draw out particular social issues associated with female lives that can be linked to suicide. These include bereavement, motherhood and sexual assault.
5. Further qualitatively driven analyses are urgently needed that enhance our understanding of women's experiences of services and which narratively examine how women come to die by suicide.

Biography

Sharon Mallon is a Lecturer in Mental Health at the Open University. She has extensive experience of research in the areas of both suicide prevention and postvention. She has worked on a range of projects commissioned by national and local government, health trusts and voluntary organisations. Her work on suicide has been published and presented in both national and international settings. Sharon.mallon@open.ac.uk **Twitter @sharonmallonphd**

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1. Overview

This briefing focuses on suicide among women. We begin the paper with a brief summary of the current position in the literature on the issue of gender and suicide (Section 2.1). We then explore how the literature shapes our understanding of suicide among women (Section 2.2). We highlight how in direct contrast to male suicide there are a lack of studies that explore female suicide and suggest those female only studies that do exist limit our understanding of this issue among women by focusing only on physiology and mental illness (Section 2.3). Then, by examining primary data from the Understanding Suicide study we provide an overview of suicide among women in Northern Ireland (Section 3). By choosing to focus on female suicide in isolation from male suicide, we demonstrate it is possible to draw out particular issues associated with female lives that can be linked their deaths. We end by questioning whether the current ways of researching suicide allows sufficient possibility for the exploration of the social issues facing women and use our findings to make a practical, policy-driven contribution to the issue of suicide among women in Northern Ireland (section 4).

2. Context of Suicide among Women

2.1 Gendered approaches to researching suicide

Over the past two decades there have been a series of advances in our understanding of how gender impacts upon suicide related behaviour, with some authors suggesting that the suicidality of men and women may be manifestly different (Scourfield 2005). However, over the past decade there has been a particular focus on, and widespread concern about, the 'alarming' and 'dramatic' rises in the number of male suicides. This has caused an additional shift in our thinking about gender and suicide toward an increased interest in the nature of suicidal behaviour among men. Over recent years this has resulted in a number of studies of male only suicide and the development of theories in relation to suicide among this group (Jordan et al 2010, Pitman 2012, Scourfield 2005) In addition, policy documents have highlighted the reduction of male suicide rates as a specific focus of suicide prevention strategies (Department of Health 2012).

2.2 The invisibility of female suicide

By direct contrast to the studies on male only suicide, a specific focus on issues related to women's suicide is almost absent from the recent literature. It appears that the topic is been hampered by issues of visibility. As an example, it should be noted that between 1999 and 2012 the percentage rise in the suicide rate among women in Northern Ireland was slightly higher than that experienced among men (Tomlinson 2013), yet their deaths received very little attention. This is consistent with other countries as research suggests that male suicide remains proportionately over-represented in the media even when the higher male suicide rate for men is taken into account (Weinmann and Fishman 1995, Michel et al. 1995). As female suicides are rarely encountered in the media, it encourages the view that only men are at risk and die from suicide. More worryingly women also tend to be overlooked in policies on suicide prevention (Rugkhla 2011). We were also unable to identify any significant large-scale reports in the grey literature exploring issues that relate to female-only suicide. Studies of female-only cohorts are also harder to identify in the peer-reviewed literature. As a clear example, the psychological autopsy method is well regarded in suicide research and is widely applied to studies of suicide; however, we were able to identify a single female-only study using this method (Asgard 1990). Qualitative and sociologically driven studies of women's death by suicide are particularly rare.

Neuringer and Lettieri (1982) called the lack of women-only studies an 'unintentional slighting' and suggested various 'non-anti-feminist' explanations, in particular, the smaller numbers involved (p. 94). However,

Jaworski's (2014) subsequent critique of the role of masculine forms of knowledge in suicide research, argues there is a more deliberate bias involved in the lack of female-only studies. In order to consider this, in the final section of the review we review the publications we were able to identify in which the primary focus of investigation is suicide among women.

2.3 Suicide among women: what do we know?

As reported in the previous section, studies of female-only suicide are relatively rare. There are a number of notable individual case studies such as *Katie's Diary* (Lester 2004) and *Savage God* (Alvarez 2002). A valuable contribution has also been made by writers from a psychoanalytic perspective (Gerisch 1993, Kaplan and Klein 1990). Lester's (1988) cross-disciplinary edited collection, *Why Women Kill Themselves*, is one of the most comprehensive and contains a number of insightful chapters on the cognitive processes associated with female suicide and the psychological characteristics evident in the suicide notes of women. However, the collection is also problematic because it reflects the broad tendency for researchers to study women's suicide in connection to their physiology, in particular their reproductive cycle. Although some studies have demonstrated lower than expected rates of suicide among pregnant and perinatal women (Appleby 1991, Gissler et al. 1996, Marzuk et al. 1997, Robinson 1998), the relationship between menstruation and suicide remains inconclusive. It has been suggested that any relationship between physiology and suicide is likely to be complicated and affected by 'social roles' (Neuringer and Lettieri 1982). However, this remains under-explored and recent methodologically innovative and sociologically driven approaches have remained focused on men.

Those comprehensive, cohort studies of female-only death that we were able to identify are now dated and have tended to examine specific groups of women who are considered to be particularly vulnerable (see Iga et al. 1975, Johnson 1979). Concern about levels of suicide among female prisoners has led to research in this area (Liebling 1994). Overall, the studies on female only suicide tend to reflect the stereotyping in which female behaviour is linked to aspects of a woman's nature rather than her social conditions (Gerisch 1996). Occasional studies have examined how women have been prepared for victimhood because of their interpersonal histories (Counts 1987, Stephens 1988) but broader feminine issues are not afforded independent investigation in the way that male-only studies claim to allow us to understand 'the diversity of suicidal masculinities' (Scourfield 2005:14 18). This gap means we have a limited understanding of the diversity of suicidal femininities, both globally and within the UK. In the next section we present data from a two year cohort of female suicide deaths in Northern Ireland in an attempt to address this gap in our understanding.

3. Methods and Results

3.1 Data collection

The data analysed here are part of a larger retrospective cohort study of every death in Northern Ireland (NI) determined to be suicide by the NI Coroner Service (NICS) between 2007 and 2009 (325 men and 78 women). In this paper, we focus on the deaths of the 78 women. We were able to access all Coroner's records, the GP records of 70 of these 78 women and undertook interviews with 15 of their relatives. We present data from both our quantitative and qualitative analysis simultaneously, using qualitative data to illustrate pertinent points.

3.2 Findings

The women were aged between 14 and 82 years, with an average age of 39 years. Coroner's records indicated that 69 per cent (n = 54/78) of cases had been diagnosed as having a mental illness. 63 of the 70 (90%) women for whom GP records were available had attended the GP in the twelve months preceding their death, 52 (82.5%) of these women had done so in relation to an issue related to mental health. It was also noted that in 50 cases the women were receiving attention for these mental health issues at the time of their death, 30 (42.9%) were under psychiatric care, 9 (12.9%) were being managed by their GP, 3 (4.3%) were awaiting assessment and 3 (4.3%) women had refused psychiatric treatment.

Further analysis revealed that the levels and patterns of help-seeking in the year prior to the suicide varied according to age. 90.6% (48/53) of women aged over 25 had attended their GP in relation to emotional distress in the year preceding their death. We were able to identify ten women who had never sought help for emotional distress from their GP, accounting for 13% of the female cohort. This group were distinctly younger than the cohort as a whole (ranging from 14-22 years, mean age 17.5 years). It is hard to speculate on the reasons they did not attend. However, one father reported:

When we were going through her stuff after the death we had found a confirmation form from school that she had made an appointment with the school counsellor...But she hadn't actually made it to the appointment. The appointment was for the next day or later on that week. That was all. At that age I don't think she would have known where else to go for help. I don't think she would have understood her own feelings, maybe...or maybe known to come to ask us because she probably didn't understand why she was feeling the way she was feeling.

Father

Factors associated with women's emotional distress

A primary objective for us was to go beyond diagnostic labels to examine the social context of these suicides. Therefore, our primary analytic approach to the data presented here was influenced by the sociological autopsy method developed by Scourfield et al. (2012). This method focuses on sociological aspects of data in order to bring insights to our understanding of the social causes of suicide. Therefore, in the remainder of this section, the foci of our study are the broader social issues facing these women.

Three overarching themes were identified in the data; bereavement, motherhood and sexual assault. There were also two minor themes; family/relationship issues and deteriorating physical health. As space is limited we focus here only on the dominant themes. It is worth noting that in all cases, even those with severe and enduring mental health problems, the interviewees were keen to stress the complexity of the events that led to the death of their relative. One typical example is concisely summed up in the following quote:

But there was that big a combination of events at that time. My wife was being bullied at work, her father had died, we had been broken into and burgled and she had lost her wedding ring and her mother's wedding ring, she was going through the change of life. I had a whole catalogue of explanations for the doctors and none of them probably was the right one.

Husband

It is also worth noting that we did not set out to focus on characteristically female issues in our analysis; instead we found that as we undertook our systematic analysis of the available data, these gendered factors naturally

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dominated our coding schemes. An illustration showing the overall spread of these issues across the life span can be seen in Table 1. It should be noted that the categories are not mutually exclusive and a detailed description of these factors follows.

	<25 n=17	25-44 n=34	45-64 n=20	>65 n=7	Grand Total
Bereavement	1 (6%)	4 (12%)	7 (35%)	1 (14%)	13 (17%)
Death by suicide	4 (24%)	6 (18%)	2 (10%)	1 (14%)	13 (17%)
Sexual Assault	4 (24%)	9 (26%)	7 (35%)	-	20 (26%)
Issues with Motherhood	4 (24%)	16 (47%)	3 (15%)	2 (29%)	25 (32%)

Table 1: Types of issue identified as contributing to the suicide presented by age groups (n, %)

Bereavement including bereavement by suicide

In 34 per cent ($n = 26$) of cases, bereavement was identified as a partial trigger for the mental distress. In these bereaved cases, half ($n = 14$) were the result of a death by suicide, and 10 of these deaths were of an immediate family member. In most cases ($n = 9$) this appeared to be a direct and fast-acting form of suicide ‘contagion’, that is, the time from the preceding suicide to the death in all these cases was typically short, varying from 2 days to just over a year. In four cases the data supported the notion that the loss created a long-term predisposition towards suicide, in that when faced with emotional distress suicide appeared to become an option (Lester 2004). Similarly almost half ($n = 6$) of suicides that occurred after a bereavement from natural causes were events that occurred shortly after the death took place.

Motherhood

Motherhood or maternal issues were linked to 32 per cent ($n = 25$) of deaths and in nine of these cases, they were noted to be a long-term trigger to enduring mental health problems. In the remaining 16 cases, the time between the onset of psychological distress and death was brief and thus, had a more spontaneous appearance. Problems with motherhood (including, but not exclusively, infertility and loss of custody) mapped closely onto the reproductive life course, with a peak among those aged 25–44 ($n = 16$). In those aged over 65, the suicide took place shortly after the women were reported to have lost caring responsibilities for their grandchildren ($n = 2$). The following quote sums the view of one husband:

I can't think of anything. Unless that ... you see, she looked after her grandchildren and then they got bigger and she sort of didn't have to look after them and she kind of thought I suppose that she wasn't needed.

Husband

Failed fertility was noted in five cases, two of these being women had undergone *in vitro* fertilisation treatment. In a further three cases the women had experienced several miscarriages. Notably, no help-seeking had been undertaken for the emotional consequences of the failed attempts at motherhood but from the records we noted that the suicides took place shortly after a final failed fertility event. In one case the death of the woman could be related to an unplanned pregnancy.

A diagnosis of postnatal depression was recorded in four cases. In each of these, the involvement of services permitted us to track some of the events that occurred prior to the death. Two women had experienced post-

partum depression, apparently unrelated to their social circumstances. Family members were fully involved in referring the women for treatment and encouraging their engagement with services. In two other cases, postnatal depression formed part of a more complicated picture in which alcohol and drugs problems had resulted in social services intervention in the child's welfare. According to relatives, this created in them a state of hopelessness. The loss of custody of children was prominent in an additional five cases. The following quote illustrates one such complex situation in which the loss formed part of a narrative in which the women was also experiencing addiction problems and issues relating to family conflict:

He (her partner) tried to take control of her and didn't want me or any of the other sisters around and at that stage then, because her drinking had got so much worse and all, she had lost access to seeing the children again. So it just went sort of...

Sister 01

Sexual abuse and sexual assault

It was recorded that 26 per cent ($n = 20$) of women had experienced some form of sexual violence; for 13 of these women the abuse had taken place in childhood. In all but one of the cases of childhood sexual abuse, the perpetrator was reported to be a family member, typically a father, uncle or brother. In most cases the abuse was revealed after many years and in three cases there was a strong correspondence between the death of the perpetrator and a first attendance of the woman at the GP in relation to emotional issues. Typically, at the point of consultation the woman presented with bereavement issues and it was only later that the full significance of the death was revealed.

In just over half of such cases ($n = 11$) the sexual abuse was not reported to the coroner at the time of their suicide. Instead these women were noted by the coroner to be suffering only from severe mental health problems. However, upon reviewing the GP records it was apparent that all these women became engaged with services predominantly in relation to the sexual assault. In some cases records documented high numbers of attendances at the GP and high numbers of overdoses as well as alcohol and drug abuse. The sexual assault could thus be considered to act as a trigger for enduring problems that achieved no lasting recovery. The following quote sums up the position of one woman as it was described by her husband:

It came out that she had been sexually abused, which I knew nothing about when we got married...and I spoke to her family about it and her family said that this didn't happen, it was supposed to be by another member of her family, and that she had made it up. So there was a lot of issues going on there. She probably, I would say, attempted suicide on six or seven occasions before it (the death) actually happened.

Husband 01

Qualitative data:

In this section we report more extensively on the findings from the qualitative analysis in relation to the deaths of 15 of the women. Family opinion of the role of mental illness in the deaths varied however there were some clear areas of consensus around the treatment offered. The first was around the reluctance to take medication and disappointment with the lack of alternatives offered as these two quotes illustrate:

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I don't think giving all these drugs helps, you know. I thought with the psychiatrist, they have to come and talk to you and try and sort out what the problem was. But they come and they talk to you and we'll give you this medication, we'll give you that medication, another drug and we'll give you another one and another one. she was on about four or five different medications....Like I said, I'm not educated, I thought if you could talk to people more. Like every time we went to see the psychiatrist we had fifteen minutes, that's all you got.

Husband 01

There was no therapy or none of that. It was an appointment every six months. To me, it was pitiful. The hard work that I had and her GP had getting her to go and see a psychiatrist.

Husband 02

In some cases family members felt that previous negative experiences ultimately prevented their relative from seeking assistance in the time leading up to their death:

We knew that she was feeling suicidal; she had said that. ... I asked her about going to the GP and getting medical help and all that, she didn't want that and I didn't push it, because I guess, having visited her years back in (...) and (...), they're not nice places and she had no faith in the medical profession, which is quite driven by medical intervention, clinical, they put you on tablets. I do believe that's still the case, even working in the health service. She didn't want that...

Sister 02

It was clear that many participants relied upon the GP to fill in the gaps they perceived were left in the services provided by mental health. As this daughter suggests:

But I do think that there should have been maybe more feedback for my mum, even to the GP. The GP could have then maybe organised something obviously with my mum thinking it was useless, it wasn't going anywhere, it wasn't doing her no good, maybe if the GP was made aware of that or asked outright then maybe something else could have been arranged.

Daughter

Summary and recommendations

During the two years (2007-2009) examined here, there were 78 female suicides recorded in Northern Ireland. During the decade running up to this time, the rate of suicide among women demonstrated a similar percentage rise to that shown among men (Tomlinson, 2013), yet by virtue of their comparatively small numbers, in terms of public policy the impact of these female deaths appears diminished, especially in comparison to that given to male suicides. In particular they received little attention either within the wider public arena or the academic literature. Although this mirrors the situation globally, we remain concerned about the lack of visibility of female suicide within the Northern Ireland context. It is particularly concerning and potentially discriminatory to the female gender that their deaths have not been explicitly responded to within a policy context.

Our data draws attention to a number of key issues associated with female suicide. Firstly, within Northern Ireland much of the current focus around death by suicide has been on the broad changes in the rate of suicide and issues associated with the male gender. There has been a longstanding neglect of suicide among women.

This is particularly disconcerting given the high levels of help seeking among this group and our prior publication which demonstrated that 60% of these women had previously attempted suicide (Mallon et al, 2014). Given their engagement with mental health services, data associated with the deaths of women are likely to have already been captured by the Confidential Inquiry and it may be possible to perform a secondary analysis of this data to shed further light on how gender contributes to the deaths of these women. However, given the data presented here, it is also imperative that we qualitatively explore the experiences of vulnerable women and their families when using mental health services, especially around the time of a suicide attempt, to examine what services or support mechanisms may be useful in preventing further suicides. We also remain concerned about the link between bereavement, including bereavement by suicide and subsequent death by suicide. As we previously reported in our KESS seminar of 2014 we believe the evidence supports the notion that bereavement is a major challenge for the people of Northern Ireland and urge the government to prioritise access to support services for all those affected by these issues (Mallon & Galway, 2014).

Finally, we are concerned that while male death by suicide is often seen as an indication that masculinity is in crisis, female suicide remains a consequence of mental ill health. Our study supports the supposition that mental illness is a key factor in these suicides but also demonstrates that current methods for investigating suicide (including the sole use of Coroner's data) leave women vulnerable to having their deaths solely accounted for by an increased propensity towards mental illness, with little regard paid either to social factors of their lives and how they might be related to their gender (Jaworski 2014). By using data from GP records, we have demonstrated how social factors, life events, and issues of feminine identity may be associated with the deaths of women who died by suicide. We suggest that analysing the lives of women who die by suicide using methods that focus only on mental ill health and which exclude the social nature of their distress is potentially unhelpful to practitioners and policy makers. It is our opinion that analytic approaches, such as those critiqued by Hjelmeland and Knizek (2010), should be avoided when examining the suicides of women because they fail to take into account the social nature of the trauma that may trigger their mental ill health.

We further propose that simplistic explanations, such as those currently offered for female suicide, cannot be maintained if we are to understand the lives of these women in a way that will help to further reduce the rate of suicide in this group. Data from family members suggests that the social sequelae of the life events which contribute to mental illness were being inadequately addressed by current services. For example, our findings are supportive of previous studies that suggest female suicide sometimes takes place in the context of serious neglect or abuse by the significant male figures in their lives (Canetto and Lester 1998, Stephens 1988) and provide further evidence that such trauma needs specific and early intervention. Taking such an approach would model current best practice that suggest alterations in social factors are particularly suited to the prevention of male suicide (Shiner *et al.* 2009). We conclude by echoing Petersen (1997) and Fullagar and Gattuso's (2002) call for a broader range of analytic approaches to counter the ways in which women's experiences are made invisible in public health policy. Further qualitatively driven analyses are urgently needed that enhance our understanding of how women come to die by suicide. A move towards enhanced, narrative understandings of female suicide will help support and develop the translation of such findings into innovative policy and practice.

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