

**UNDERSTANDING SUICIDE:  
Conversations with the bereaved**

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**This thesis is submitted to Cardiff University in fulfilment for the degree of**

**DOCTOR OF PHILOSOPHY**

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*For Joe*

*with love*

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# ABSTRACT

This thesis presents a sociological inquiry into the meanings that families bereaved by suicide attach to the suicide of a young man. Through in-depth interviews and an email based focus group, this study explores families' attempts to understand how and why their loved one chose to end his life. Whilst interviews and focus group discussions were centred on the life and death of the young man, it became clear that the narratives of the bereaved were as much tales of themselves as they were tales of the deceased. The narratives of the life and death of the young man are only ever reconstructions from the relative's perspective. Therefore the research developed a broadly dual focus. It begins by exploring the families' constructions of the young man's life and death before moving on to look the experiences of the bereaved and their (re)constructions of themselves and their families.

A social constructionist approach was adopted in order to explore the most significant discourses in helping families make sense of their loved one's death. This thesis shows how the discourse of medical-psychiatry was especially salient in their attempts to reach an understanding of their young man's suicide. In particular, families either resisted, or appealed to its dominant construction of suicide as showing signs of mental illness. In addition, the meanings and understandings attached to the young man's death were highly sophisticated attempts to negotiate blame; to establish who was responsible for their loved one's death. Importantly – whether families appealed to or resisted the dominant medical-psychiatric discourse – the salient point in all the families' constructions was the need to place responsibility *outside* the family. Moreover, suicide is a devastating death, often leaving families feeling isolated and stigmatised. As such, this thesis also chronicles the families' experiences of being bereaved by suicide; their attempts to manage such a profound disruption in their own lives.

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# PREFACE

On the 30<sup>th</sup> October 1999, my younger brother fatally hung himself at the age of sixteen. Before that day suicide was simply a word to me, a rather abstract word that hovered on the outskirts of my mind. It named something that happened to other people, other families. It certainly didn't happen in my family. But when my brother killed himself, a reality that had previously been safely remote was suddenly propelled into my life. The meanings that I had attached to the world were shattered. On that October day, suicide changed my world forever, taking up a permanent place in my life.

This PhD is a culmination of my search for new meaning in my life, representing my journey towards a new life which could place suicide comfortably in it. Whilst not an explicit autoethnography, my relationship to the topic of research and my own experiences of learning to live with the suicide of my younger brother means that my own identity is integral to this thesis. Indeed it is the sole reason behind my decision to work towards a PhD. My identity as a sister bereaved by suicide cannot be divorced from my research – it has been present at every stage of my journey, from inception to writing up. As a result far from ignoring my place within the research process, I feel it is vital to be upfront about my experiences and my relationship with suicide. Therefore before beginning to chart the journey of my research, I feel it is important to start with my own story, positioning myself within the research as a whole.

## JOE'S STORY

I can remember being woken by the ringing of a phone. I looked at the time – it was five thirty in the morning. Never being one to wake early, I put a pillow over my head and tried to ignore it. But it did not stop, and a few minutes later my flat-mate knocked on my door and told me that my dad was on the phone and needed to speak to me. An early morning phone call did not seem to raise any warning signs to me. I grudgingly got out of bed and went to the phone. The first words that my dad

said to me were, “Nina, there’s been a hanging”. Even at this point I didn’t comprehend that something serious had happened. ‘Why was my dad phoning me so early in the morning to give me a jumbled message?’ I thought to myself. “What do you mean dad?” I asked him. He then asked me if anyone was sitting with me. It was then that I realised that this was not just an ordinary call. “Dad, tell me what’s happened”, I demanded. “It’s Joe”, he replied, “he’s hung himself”.

Every suicide is a shock. No one can ever prepare themselves to hear those words that will devastate their lives. I have spoken with other survivors, who have lost someone to suicide after the third or fourth attempt, and in one case after their twelfth attempt. Yet they still speak of the shock that thundered through their lives. And Joe’s suicide was an absolute shock.

It was the first half term of the school year, and the last remnants of the glorious summer we had were hanging on. Joe, his girlfriend and four friends wanted to go away to a caravan in West Wales, so they could enjoy the last traces of summer. My mum agonised over this. Joe was sixteen, and in her opinion far too young to go away by himself. After numerous long conversations between us, I managed to convince her to allow him to go for two nights – a compromise. After all, Joe was responsible, I told her, and a couple were going with them who were a few years older; they would make sure everything would be okay. “He will be fine”, I said to my mum.

The details about what actually happened the night that Joe died will always be vague. His friends had been in a caravan, drinking, when an argument between Joe and his girlfriend broke out. At some point during the argument, Joe stormed out of the caravan. There was a tree next to the caravan that everyone had been staying in. Joe took the cord from his jogging bottoms, climbed the tree and hung himself. Did he mean to kill himself is a question that I will never truly know the answer to. I was not with him at the time of his death. I do not know how angry or upset he was. However I do know my brother and I believe that he did not want to die that day.

Joe’s choice of method is almost certainly the reason for his death. A violent means, hanging rarely spares its victims. It is merciless in its speed of death. Joe was found

five minutes after he had hung himself. The tree where he was hanging was the first thing his friends saw when they came out to look for him. Had they been five minutes earlier, then Joe would still be alive. Joe had wanted to be found. I am sure of that. A method that is so often faultlessly seen as unequivocal in a person's desire to be dead was I believe, Joe's 'cry for help'. Yet so much of the literature on suicide tells me that Joe was firm in his decision to die. He had hung himself so therefore he had wanted to die.

Joe was a happy person. He would go out of his way to bring a smile to other people's faces, to make people laugh. No one will ever make me laugh as much as my brother. He was happy with his life. A new job, a new school, a baby sister, good family relations – we all just got on – Joe was enjoying his life. I had moved to Bristol to begin my undergraduate degree and would look forward to the times that Joe and I would meet up. I saw him the weekend before he died, and we had a conversation about how good things were going for the whole family. And particularly for Joe, who seemed to love the new stage that his life was entering. These understandings and my knowledge of my brother all added to the senselessness of his suicide.

After Joe died I was hungry for information and reassurance. I wanted to know what suicide was and what it was for my brother. I was searching for some way of making sense of the incomprehensible thing that he had done. I combed the literature on suicide, trying to find something that spoke to me about my brother. But nothing really helped me in my search for understanding. The picture that was painted of the suicidal person was someone who was depressed, withdrawn and with no hope for the future. Yet Joe was none of these things. In the months following his death, a real fear gripped me that people would make the wrong assumption about my brother, that they would assume that because he killed himself he must have been depressed or suffering from a mental illness.

This fear was advanced by my experience of the Coroner's court. During the hearing, my family were desperate to paint an accurate picture of the person that Joe was. However the positive aspects of his life were considered to be 'irrelevant' – the Coroner actually said this to us. My brother's recent relationship breakdown and the

manner of his death were what were considered important. By focussing on just these two aspects, the Coroner was able to construct his death as a suicide.

## REFLECTIONS

A year after Joe killed himself, I began a sociology degree, where I became particularly interested in medical sociology and the positioning of biomedicine as a discursive system. I began to see that for many sociologists and medical anthropologists, biomedicine appears as dominating, excluding and partial. Specifically biomedical knowledge practices are seen as reductive and essentialising. These understandings were integral in my own search to create meaning out of my brother's death.

During my years as an undergraduate I grappled with the idea that suicide was a socially constructed event, one that is constructed within the medico-psychiatric discourse. I began to see that the medico-psychiatric discourse is dominant in the contemporary construction of suicide, notably its connection between mental illness and suicide. However it is also partial and doesn't tell the whole story behind suicide. When Joe first died I refused to accept his death was a suicide. Because he was not depressed or mentally ill, I found it difficult to construct his death as a suicide. Indeed I would tell people that his death was 'an accident that went wrong'. I now think the reason for this was because I understood his suicide from the psychiatric discourse and was therefore guided by its understanding of suicide. However I began to see that there was nothing inevitable about this relationship and Joe did not have to be mentally ill or depressed to kill himself. In the years following Joe's suicide, I was able to move towards an understanding that made sense of his death *for me*. Through this process, I became increasingly interested in how others bereaved by suicide, attempt to explain what is often inexplicable. It is at this point where my research journey starts.

# Chapter One:

## INTRODUCTION

This thesis is concerned with exploring the meanings that families attach to the suicide of their young man. Using both qualitative in-depth interviews and online focus groups, the thesis maps how the discourse of medical-psychiatry constructs the life and death of their young man and shapes the lived experiences of the families as a group bereaved by suicide.

The suicide of young men has been represented as a concern in all Western nations. Within the British media, their suicide has been constructed as a 'nationwide phenomenon' and one that we should be 'desperately concerned about' (Batty 2008). It has been taken to signal the position that men find themselves in, 'having to cope with losing their role in society' (Browne 2001). Numerous studies have been conducted to try and understand what drives apparently healthy young men to suicide. These studies have isolated a wide range of factors that are considered to contribute to young men's suicide including employment (Hawton 2000; Platt and Hawton 2000; Albizu-Garciaa *et al.* 2001), relationship breakdown (Stack 1998; Cantor 2000) and sexual orientation (Remafedi *et al.* 1998; D'Augelli *et al.* 2001; Morrison and L'Heureux 2001). However, in reviewing this literature, Beautrais (2000) concludes that whilst a wide range of social conditions, life events and individual personality factors make up the complex event of young men's suicide, psychopathology plays the major role. This leads her to suggest that clinical detection and the subsequent treatment and management of mental illness represents the most beneficial preventative strategy.

Within the wider policy arena of health and illness, the connection between mental health/illness and suicide is well established. For example, the 1999 white paper 'Saving Lives: Our healthier nation' (Department of Health 1999) sets out a target to improve the mental health of the population of the U.K. The means to measure this

rests on the suicide rate. As is stated in the document, suicide continues to be 'a proxy target to cover the whole of the mental health priority area' (Department of Health 1999: 8.2). If we look more specifically at suicide prevention strategies, the relationship between mental illness and suicide is also firmly established, with suicide invariably viewed as the result of mental illness. As yet, there is no national suicide prevention strategy for Wales. However recent deaths from suicide in young people in South Wales have drawn attention to this absence and there is presently a 'Suicide Prevention Plan for Wales' in consultation (Hart 2008). Currently, the National Public Health Service for Wales' published report on suicide prevention largely presides over guidelines in this area (Price 2007). And once again we see the centrality of mental health/illness governing its approach, particularly in relation to primary prevention.

The relative dominance of psychiatric antecedents in both understanding young men's suicide and the subsequent response is partially due to a method heavily relied upon in suicide research. Known as the *psychological autopsy study*, the method was developed in the 1950s at the Los Angeles Suicide Prevention Center (see e.g. Curphey 1967; Shneidman 1981; Hawton *et al.* 1998) and sought to generate a detailed picture of the deceased person's life. Face-to-face interviews with family members are invariably the source most relied upon, although information can come from other places such as medical and Coroner's records, personal documents and police records. The priority for the researcher is to reconstruct the individual's psychological life, paying particular attention to their thoughts, feelings and behaviours in the days and weeks preceding the suicide. As a result, the usual quantitative data gathered tends to focus on psychological causes behind the person's suicide. Implicit in this focus is the assumption that psychological factors play a key role in a person's suicide. As Gavin and Rogers (2006:137) point out, the psychological autopsy suggests that the causes of suicide are 'located in the psychological states of the deceased person'. It could certainly be argued that studies adopting this method support the presumed relationship between mental illness and suicide. For example, in Cavanagh and colleagues' (2003) systematic review of 76 psychological autopsy studies, they found that 91 per cent of people dying by suicide had suffered from some kind of mental illness. This leads the authors to conclude that in order to be effective, suicide prevention strategies need to focus on the



treatment of mental illness. This percentage is by no means a coincidence. Indeed psychological autopsies have established that more than 90 per cent of 'completed' suicides had suffered from some form of mental illness (Isometsä 2001).

## THE SOCIOLOGY OF SUICIDE

Despite the relative dominance of suicide research by the psychological and medical disciplines, there have been attempts to examine the phenomenon sociologically. Durkheim's classic *Suicide* (1952, first published in 1897) has firmly established suicide as a topic of interest to sociologists. His study is invariably used to illustrate how even the most seemingly individual and personal of acts could be seen to be governed by the forces of social integration and social regulation. That is, that the causes of suicide are fundamentally *social* rather than *psychological*.

Durkheim's classic text was explicitly presented as the first 'manifesto' to 'demonstrate the possibility of sociology' (Durkheim 1952: 37; Tiryakian 1978: 188). Durkheim used the study of suicide to establish sociology as the science of society under the banner of positivism. Arguably, this contention set the terms of the debate primarily as a matter of methodology. On these terms, seventy years after the publication of Durkheim's work, Jack D. Douglas (1967) responded with *The Social Meanings of Suicide*, an interactionist proposal that contested the usefulness of positivist principles<sup>1</sup>. These two works, specifically the dispute between them, can be used to map out the characteristic sociological approaches to suicide.

The differences between Durkheim and Douglas' theories of suicide are arguably rooted in their contrasting methodologies. Durkheim's is based on positivist commitments made clear in his famous exhortation to 'treat the facts of moral life according to the methods of the positive sciences' (1952: xxv). Durkheimian

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<sup>1</sup> Durkheim's position is further elaborated in *The Division of Labour in Society* (1984, first published in 1893) and *The Rules of Sociological Method* (1982, first published in 1895). Douglas' position is further outlined in *Deviance and Respectability: The social construction of moral meanings* (1970a) and *Understanding Everyday Life: Towards the reconstruction of sociological knowledge* (1970b).

sociology studies the workings of a social order that exists over and above individual activity, focusing on the traces of these workings that are evident as 'social facts'. These facts are social phenomena that exist beyond the level of personal comprehension; they are 'realities external to the individual' (Durkheim 1952: 37). Suicide rates then, are not subjective meanings held by the individual but rather convey key moments at the level of the social structure.

The theory of suicide advanced by Douglas is very different from that of Durkheim. Douglas' understanding of suicide is driven by an interpretative methodology that draws explicitly on Weber's link between meaning and action. For Douglas, suicide is of sociological interest not as a statistical rate but as an intentional act. Suicide occurs when an already present subjective orientation towards suicidal thoughts, overrides any alternative interpretations that could mitigate against such an act (Douglas 1967: 330). Moreover, the social context contains many ambiguous meanings about suicide. These meanings are ultimately available to a motivated and consistent interpretation that supports an individual's already held intention to kill themselves.

Ultimately, Durkheim eschews the subjective realm as irrelevant, whilst Douglas rejects the external, positive dimension. As such, these differences are organised by a classical methodological dualism. More recent work on the sociology of suicide reveals largely the same polarity of positivism versus interpretivism. For example, Stack's (2000) review of research since 1985 concentrates solely on summarising studies that adopt positivistic methods, a tradition that he himself works within (Stack 2000). Interpretivist studies, although rarer, continue to be produced. The works of Szasz (1999) and Klug (1996) typify this tradition (see chapter two for a more detailed discussion).

## Development of the Focus and Significance of the Study

The interpretivist approach, exemplified by Douglas, has often been held up as a response to the many criticisms levied at the positivist tradition and specifically Durkheim's uncritical use of official statistics. Following Douglas, Atkinson (1978) proposed that it is how some deaths get categorised as suicide that should be the focus, rather than the suicide rate itself. That is, it is the *meanings* and common sense judgements that Coroners (and others) draw upon that are important. Whilst this was an important development in suicide research, much of the interpretivist literature has tended to overlook the way in which the meanings of suicide are formed and reproduced and the significance of power and resistance in the investment of different understandings of suicide. Consequently this thesis engages with recent poststructuralist accounts within the field of (mental) health and illness. Central here is the work of Foucault and also an awareness of the importance of narrative. My approach focuses on people's subjective experience of suicide and how they make sense of such a disruptive death, whilst at the same time emphasising the discursive construction of suicide, the centrality of power and the subordination of the more 'silent' subjugated knowledges and understandings of the act.

Suicide is a particularly difficult subject to research, one that is fraught with ethical, epistemological and practical challenges (Scourfield 2005). Broadly, much of the work concentrates on researching either people who have survived a suicide attempt or families who have been bereaved by suicide. Because of my own experience of losing my brother to suicide, I was particularly interested in their understanding of the act. As I lived this experience, my sociological training guided me to explore bereaved families' interpretation of 'our' situation. The difficulty that I had in making sense of my own brother's death led me to focus on the meaning making that bereaved families engaged in, how they understand it and importantly the knowledge that they draw upon in reaching this understanding. By talking to those close to suicide – in my case, the families of the deceased – we can potentially reveal not only the individual meanings behind suicide but how suicide is understood and responded to culturally. That is, they potentially shed light on the *discursive context* of suicide. A number of research questions emerged from this approach that came to form and reform the parameters of the study;

1. How do families make sense of their young man's death?
  - Which discourses inform different understandings of suicide?
  - Are there spaces for negotiation, avoidance and resistance in making sense of suicide?
  - Is there coherence between understandings of the young man's life and the young man's death?
2. How have families experienced suicide?

## **Intentions and Omissions: The purpose of the study**

What this thesis sets out to explore, through theoretical and empirical interpretations, is how families bereaved by suicide come to identify with and invest in understandings of their loved one's life and death. I focus on how families reconstruct their loved one's death through narrative. To this end, suicide is examined as a socially constructed event. That is to say, suicide is not simply an event where there are concrete causes and meanings, but rather the causes and meanings are constructed by discourse. It is these socially constructed understandings that I want to explore.

The understandings of bereaved families are integral to this thesis. Their centrality to my research means that their own experiences can not go ignored. Indeed whilst I am focussing on their constructions of the young man's death, I will also be finding out about their identity, their life and their path through grief. As such, this thesis will also focus on their *experiences* of being bereaved by suicide.

By foregrounding the families' experiences of suicide, the study can be criticised on two counts. Firstly, by focussing on the understandings of the bereaved, any interview is as much a narrative of the self for the family member as a narrative of the young man. As Scourfield (2005) has said, interviews with surviving relatives can provide more insight into the families themselves than the people who have killed themselves. Secondly, the study can be criticised on the grounds of solely focussing on young men. With regards to the former, it can be argued that family understandings are part of the social and cultural context of young men's suicide.

That is, that their understandings and explanations of their loved one's death will be shaped by, and therefore potentially reveal, wider discourses of suicide. The sole focus on young men is less easily overcome. Indeed by only limiting my research to families that have lost a young man to suicide, I am at risk of contributing to the current construction of young men's suicide as a 'nationwide phenomenon' (Batty 2008). However, my limited focus on young men represents my own research journey; one that I have to acknowledge, accept that I could have carried out differently, but one that I have ultimately learnt from. Moreover, within the research interview itself, I was able to ask questions which explored discourses about gender and distress. This means that I did not take the 'maleness' of suicidal men for granted, but rather interrogated the way they were understood by families as men in light of pervasive ideas about the crisis of masculinity.

## **Structure of the Thesis**

The thesis is organised to reflect the ways in which the research questions were developed, posited and answered by this qualitative inquiry. The next chapter provides a context within which the study is situated. I begin by locating the research in its theoretical context by examining debates surrounding social constructionism and how these relate to the study of suicide. I then move on to chart the various attempts that have been made to explain young men's suicide. The chapter concludes by highlighting the importance of narrative in understanding suicide.

Chapter three sets out the methodological framework of the study. It provides a detailed and reflexive account of the methods that were used. In this chapter, I explore some of the emotional and personal dangers involved in studying a topic which is so close to one's personal experience. In particular I develop the idea of emotion(al) work for both the researcher and the researched. In addition, I consider the research as a site for 'common connections' between families discussing shared experiences. The chapter closes with my reflections on my research journey and the impact that my identity as a sister bereaved by suicide had on the research process.

The chapters that follow present the data that were collected and discusses the emergent themes in relation to the sociological literature. Chapter four broadly looks at family constructions of the young man's life whilst chapter five focuses on how they make sense of his death. Both chapters consider the way the medico-psychiatric discourse worked to inform their understandings. Chapter six looks at the stories the families tell of the actual event of suicide. Whereas the focus in the previous two chapters is on *what* the families say – the content – the focus in this chapter is much more on *how* they say it. Through narrative analysis, chapter six shows the way families make sense of suicide and at the same time creates who they are in their search for meaning. Chapter seven focuses more explicitly on the families themselves. I look at their experiences of living with the suicide of a loved one and how they attempt to navigate through the path of grief, shame and stigma.

The findings from the data are brought together in the conclusion to the thesis (chapter eight). Here I reflect on theoretical, methodological and empirical findings highlighted in the previous chapters. Where possible, links are made to the wider policy arena. Further recommendations for research complete the thesis.

## Chapter Two:

# LITERATURE REVIEW

### INTRODUCTION

The reported increase in suicide in young men during the last quarter of the twentieth century has received considerable attention from both academia and the wider media. Despite more recent figures reporting an apparent decline in the numbers of young men killing themselves (Biddle *et al.* 2008), their suicide is often used as an example of the crisis that young men find themselves in. In this social understanding, young men are represented as having 'lost' their way in life. With no life-long job to depend upon for an identity, or religion to act as a moral guide, young men are popularly represented as being particularly vulnerable to the hazards of everyday life. And the ultimate hazard to modern day living is seen as their suicide.

Towards the end of the twentieth century, suicide became the biggest killer of young men under thirty-five (Department of Health 2002). And understandably there was a rush to understand 'why'. Moreover, because of the reported statistic that anywhere between half (Gunnell 1994; Vassilas 1994) and three-quarters (Barraclough *et al.* 1974; Evans 1994) of young men who killed themselves not only had no formal diagnosis of mental illness, but also had no contact with the mental health services at all, then clearly alternative explanations away from the popular (and dominant) psychiatric understanding were needed. After all, if young men were not in contact with the mental health services, then how could they be helped?

However, despite apparently more social understandings of suicide coming to the fore, psychiatry and its 'knowledge' of suicide still arguably frames the debate. Reviewing the numerous studies that have attempted to find out reasons behind

young men's suicide, Beautrais (2000) concluded that whilst social conditions play a part, psychopathology plays the major role in their suicide. Within suicide prevention strategies for example, mental illness continues to play a key part. As Gavin and Rogers (2006) point out, beginning with the Department of Health's white paper 'Health of the Nation', published in 1986, suicide is seen by policy makers as a direct manifestation of mental illness. All subsequent policy efforts to tackle suicide have reinforced its connection with mental illness. Indeed the suicide *rate* is invariably seen as the marker of the mental health of the nation. This would seem inevitable, after all it is difficult to think about suicide 'away' from mental illness. However, I hope to show that this relationship is by no means inevitable. Although I have raised the possibility of the social causes of suicide in the introduction to this thesis, in writing this review I am not concerned with arguing for the recognition that various social and cultural aspects of Western societies contribute to young men's suicide. Rather, my central thesis is that the dominant psychiatric understandings of suicide – as showing signs of an underlying mental health problem – are socially constructed through discourse.

The purpose of this review will be to both situate the thesis theoretically and also consider some of the main approaches to studying suicide in young men. I begin by outlining some of the key ideas within social constructionism, specifically how they relate to suicide. Such debates position suicide as a product of social reasoning and practice. With this in mind, I will discuss the various attempts that have been made to 'explain' young men's suicide. Starting with psychiatry and medical explanations, I explore how such understandings position suicide, and what this means for those attempting to study the phenomena. In particular, I consider how the discourse of medical-psychiatry limits what questions can be asked. I then move on to look at the more social understandings that have attempted to contribute to the debate. Here I focus explicitly on some of the main social reasons that have been put forward to help explain young men's suicide; for example, their unwillingness to seek help, their poor use of health care and unemployment. As well as being highly gendered, these social explanations also form part of a wider debate on the 'crisis' in masculinity. However, far from viewing social and medical-psychiatric understandings as separate, I go on to argue that there is a degree of overlap between social explanations and 'scientific' approaches. Firstly, I suggest that both continue to place the emphasis on



causation, a result of the continued search to answer 'why'. Secondly, both approaches place the focus firmly on the individual's mental and/or emotional state. Therefore, following Douglas (1967), I propose a re-focus on the *meanings* behind young men's suicide, in particular how families interpret their suicide. I extend Douglas' contention, arguing that if we want to discover how suicide is understood, *that is* how it is *socially constructed*, we need to attend to the way in which these meanings are culturally relevant.

The easiest way to *see* the socially constructed nature of a phenomenon is by charting its history. There have been numerous examples of this, starting with Foucault's history of madness (1965) disease (1973), and punishment (1977) through to alcoholism (Valverde 1998), incest (Bell 1993) and single motherhood (Little 1998). So before I begin to consider how suicide is a socially constructed event, I first turn to chart the journey that suicide, and its attendant understandings and responses, has taken throughout history.

## HISTORY OF SUICIDE

The history of suicide reveals its social and cultural basis. Indeed Western society's attitude to suicide throughout the ages has been, as Williams (1997: 1) illustrates, 'at best confused, swinging between punitive severity and tolerant advocacy'. Although it might seem reasonable to assume that our current understanding of suicide leans towards the 'tolerant advocacy', it should be remembered that it was only in the early 1960s that attempting to take one's life ceased to be a criminal offence. Up until this time, suicide was framed as a crime to be punished. More recently, suicide has been characterised by 'pathologisation' – here suicide is constructed as a form of mental illness amenable to medical treatment and cure.

## Attitudes across the Ages

It is often thought that in Greek and Roman times there was a tolerance for suicide, particularly if there were worthy reasons, such as to avoid the shame of dishonour. Philosophical writings during this time also seem to reveal a relatively liberal attitude towards suicide. Stoic and Epicurean philosophers believed that suicide could be the right course of action in some circumstances, for example if a person was suffering from a terminal illness or unremitting pain. There is also evidence to suggest that under certain circumstances, suicide might be an act of nobility, especially when it was seen as an expression of political rights or values (Williams 1997).

In the fifth and sixth centuries, attitudes to suicide gradually shifted away from the more permissive ideals of the Romans, towards a more punitive stance. Heavily influenced by ideas from Matthew, suicide increasingly became constructed as a crime against God. Indeed St Augustine thought the Roman philosophical support of suicide abhorrent. The basis of the early Matthew attitude to suicide was that it was against the natural law. Since God's will was expressed in natural laws, suicide was a sin. Appealing to the commandment 'Thou shalt not kill' similarly allowed suicide to be seen as sinful. Adding weight to the early church fathers' rejection of suicide was the popular belief in the 'demonic origin of self-killing' (Williams 1997: 3). The existence of super-natural activity in the natural world was considered to be a relatively frequent occurrence – people who committed suicide were thought to show signs that they had been possessed by devils. Such a conception of suicide therefore made it relatively easy for St Augustine to condemn suicide and in A.D. 553, the Council of Orleans outlawed suicide, denying funeral rites to those who took their own lives (Peters 2002).

The crime of self-murder then became a crime against God, against the King and against nature. A Coroner's jury tried those who were suspected of killing themselves after their death. If they were convicted of murdering themselves, all their goods, including household items, money and debts owed to them were surrendered to the Crown. Interestingly, the only mitigating circumstance during the trial of self-murder was if the person was thought to be insane. If someone killed

themselves when they were mad or mentally incompetent in some way, then they were not convicted (Williams 1997). However, despite popular feelings about suicide being a crime, during the Middle Ages very few juries actually brought in the verdict of suicide.

During the sixteenth century approaches to suicide began to change. As Williams (1997) points out, since the Crown stood to benefit from a verdict of self-murder, it had a great deal of interest in ensuring that the verdicts were given and the penalties exacted. As a result a number of changes to the English law on suicide occurred during this time, with the government controlling more aspects of the trial. The results of all the government changes were reflected in what appears to be a dramatic increase in the number of suicides (Williams 1997).

The reforms passed by the government were reinforced by the attitude of the church, which continued to emphasise their belief that self-murder was an expression of despair brought about by the devil. Williams (1997) draws attention to the many stories told during these times, where Satan was portrayed as playing on a man's guilt, ultimately luring him to his death. In such a culture, suicide was popularly understood as a lost battle or struggle with the devil. As Williams (1997: 7) explains:

The religious thinking of the time, combined with the popular belief that melancholy was a sign that the devil had taken over a person's soul, meant that society found it difficult to shake itself free from the conviction that suicide was the outcome of diabolical possession.

By the end of the 1700s, the Coroner's jury became increasingly reluctant to enforce penalties for self-murder. An increasing resistance to a law which seemed too draconian certainly assisted this reluctance, although arguably the increasing willingness to see suicide as the product of an unbalanced mind was at the forefront of the changes in attitudes. Supporting the trend towards viewing suicide as the result of a mental illness was the rejection of religious understandings of the world. The intellectual elite, during the Enlightenment, came to reject the belief in supernatural intervention in the natural world. This gave way, in the case of suicide, to a medical interpretation of the event. As Williams (1997: 11) makes clear, 'now, evidence of melancholy, previously evidence that the person had given in to the devil, was found sufficient proof that a person's balance of mind was disturbed'. And while

suicide remained a crime until 1961, increasingly the suicide itself was not judged to be the crime. Rather the Coroner began to judge the rest of the person's life, not the act of suicide.

Ultimately, what the history of suicide shows us is that how the act is understood and responded to, will greatly depend on prevailing cultural and social ideas of the time. Indeed our ways of understanding are always historically and culturally relative. They are specific to cultures, periods of history and are products of that culture and history, dependent upon the particular social and economic arrangements prevailing in that culture at that time (Burr 2003). With this in mind, the history of suicide does not involve the gradual unfolding of the 'truth' about its causes and potential solutions, but that these categories are contingent on their social, cultural and historical context. In other words they are socially constructed.

What does this mean for the study of suicide? How can suicide be seen as something socially constructed? Whilst it may be relatively straightforward to accept the socially constructed nature of mental illness, for example, with its associated aspects of social control, suicide ends in a real tangible event – a death. In order to consider these questions, I will take a closer look at the debates within social constructionism and consider the direction that it can take the study of suicide.

## **SOCIAL CONSTRUCTIONISM**

Wright and Treacher (1982: 9) argue that 'social constructionists begin by taking as problematic the very issues which appeared self-evident and uninteresting to earlier writers'. Whilst the study of suicide could hardly be described as uninteresting – indeed Prior (1989) notes the relative dominance of suicide in studies of death, disease and the body – problematising it certainly poses some challenges to researchers.

Social constructionism insists that we take a critical stance towards our taken for granted ways of understanding the world, including ourselves (Burr 2003). It invites us to be critical of the idea that our observations of the world unproblematically

reveal its nature to us. As Nettleton (1995: 20) makes clear, social constructionism above all calls for the 'problematization of reality'. For the purpose of my own research, this would mean that suicide is not simply a real, unquestionable event, but is the product of social reasoning and social practice. Suicide then, is not a discreet event that exists independently of social context, but rather is an event defined by society in a given time and place. This is not to say that suicides do not happen, but the interpretation of what constitutes such a death will vary between time and place. For instance, if we look at the apparent nature of suicidal behaviour, suicide attempts seem to be far more common among women than men. Young female suicide attempters are presented as outnumbering their male counterparts (Kerkhof 2000). This means however, that if we combine completions and attempts, 'there is not now, nor has there ever been so far as anyone can demonstrate, any gender specific difference in suicide' (Kushner 1985: 546). It has also been speculated that a man's death suspected of being a suicide is more likely to receive such a verdict from the Coroner than a woman's death (Atkinson 1978). Bury (1986: 137) observes that constructionists contend 'the objects of medical science are not what they appear to be: the stable realities of the human body and disease are in fact fabrications or inventions rather than discoveries'. Whilst 'discovery' would imply that the disease entity existed all along, just waiting to be detected, to talk of fabrications, in contrast, implies that the disease was established through various forms of negotiation.

Returning to suicide, the vast majority of debates presuppose that it is obvious what constitutes suicide. This unquestioning acceptance of what a suicide is leads many researchers to focus on how suicide should be explained. But as Douglas (1967) made clear in the late 1960s, suicide is an inherently complex event. Despite this, many suicide researchers, whilst acknowledging that there may be a degree of negotiation involved in the creation of the suicide rate, do take such official statistics as an indication of the nature of suicide. After all, to argue that because the suicide rate is constructed, all research is impossible could potentially mean ignoring the plight of many potentially at risk groups. Many choose to work with suicide rates as the best available quantitative data, rather than allow such epistemological problems to paralyse research activity. But suicides are not all the same, and when we try to unpack the term we are left with a mix of very different actions and meanings.

## A Stable Suicide?

Problematizing official statistics has a long history. The rejection of official rates of deviant behaviour is a position most commonly associated with both phenomenology and ethnomethodology. Briefly these approaches developed their critique of official statistics as part of a wider attack on what they variously described as 'orthodox', 'conventional' or 'traditional' sociology. Developments within these traditions, particularly ethnomethodology, owe a lot to Alfred Schutz, who many regard as the starting point for the study of ethnomethodology (Cuff *et al.* 1998). For Schutz (1967) the locus *classicus* of the problem of the social sciences was the methodological writing of Weber. Schutz (1967: 7-8) approved of Weber's attempts to base sociology upon the subjective meanings that individuals assign to their actions, but argues that Weber had not gone far enough in this direction:

[Weber] breaks off his analysis of the social world when he arrives at what he assumes to be the basic and irreducible elements of social phenomena. But he is wrong in this assumption. His concept of the meaningful act of the individual – the key idea of interpretive sociology – by no means defines a primitive, as he thinks it does. It is, on the contrary, a mere label for a highly complex and ramified area that calls for further study.

The 'further study' should involve the attempt to analyse, rather than take for granted, the ways in which individuals accomplish social interaction. Therefore to accept suicide as a 'social fact', an objective condition that we can actually 'see' will ultimately determine what questions can be asked.

Such a treatment of suicide is of course most commonly linked with the work of Durkheim and his research on the 'facts' of suicide. Suicide for Durkheim is an objective category, a social fact that can be measured in an attempt to produce social laws of society. Moreover, he was drawn to the topic of suicide because he was interested in demonstrating how such a seemingly individual act such as suicide could be analysed sociologically. As he argued, 'by such concentration [on suicide] real laws are discoverable which demonstrate the possibility of sociology better than any other dialectical argument' (Durkheim 1952: 37).

It is surprising to find how many studies have mirrored Durkheim's classic study. Even with recent work, it has proved very difficult for those who have embarked on studies of suicide to come up with anything very different from the original (e.g. Beautrais 2000). A more detailed consideration about the kinds of questions that can be asked about suicide will be looked at in the next section; however it is likely that this results, in part, from the dominance of quantitative methodology in the field of suicide research (Scourfield 2005). To accept that suicide is a fact, and therefore that rates tell us something about its nature, ultimately limits what can be asked. Looking at those who have died by suicide in order to explain their behaviour will mean that the observer will end up simply looking for similarities (Loseke 2003). Or put another way, researchers will look for consistency when attempting to explain suicidal behaviours. The nature of this approach to the researcher dictates that differences between suicidal individuals are ignored. It could be the case that all those who set out to 'explain' suicide or search for its underlying reasons, assume suicide means the same thing to everyone involved, when this is clearly not the case. As Atkinson (1978: 23) has made clear:

Taken for granted in all this is that suicides are the sort of 'thing', which are sufficiently similar to us to be able to group them together and study them as if they were identical. Taken for granted also is the existence of laws which account for this 'thing'.

So if suicide is not a 'stable reality' but is rather a product of social reasoning and practice, how are ideas about it created? In the next section I will consider further how presumed stable realities are in fact realised through variable discursive contexts.

## **THE SOCIAL CONSTRUCTION OF SUICIDE**

Discourses involve practices that position people who have killed themselves in particular ways and in turn reproduce dominant ideas about the phenomenon. Specifically, different discourses coalesced during the nineteenth century to produce a set of statements and practices that later established medicine, psychiatry and psychology as having the capacity to both explain why people kill themselves and to intervene in specific ways to prevent people from taking their own lives.

Ultimately these discourses explain and justify the practice within the dominant disciplines; their understanding of suicide appears as taken for granted and 'natural'. Such a position owes a lot, and is heavily influenced by, the ideas of Michel Foucault. This approach, sometimes referred to as discourse analysis, claims that objects are created through the language and practices that surround them. The approach is neatly summarised by Prior (1989: 3) in his study of the discourses surrounding death:

Familiar objects of the social world (whether they be death, disease, madness, sexuality, sin or even mankind itself) are ... realized only in and through the discursive elements which surround the objects in question ... As the discourse changes, so too do the objects of attention. A discourse, moreover, is not merely a narrow set of linguistic practices which report on the world, but is composed of a whole assemblage of activities, events, objects, settings and epistemological precepts.

Prior (1989) goes on to explain that phenomena are made visible and palpable through the existence of discursive practices. This means then, that disease, death or suicide are not referents about which there are discourses, but objects constructed by discourse.

This notion of discourse was developed by Foucault (1976) in his study of medicine. He found that it was within the discursive practices of eighteenth century medicine in Paris that our contemporary notion of disease was developed. At this time teaching, research, treatment and observation all took place for the first time in the hospital. The body was the prime focus of these medical activities and came to be the main site of disease. Thus within the discourse of what came to be called pathological medicine, disease was constructed as a discrete phenomenon which was located in the human body; disease caused death and the causal sequence which linked the one to the other were made visible in human organs (Prior 1989). As Foucault (1973: 149) explains:

From the point of view of death, disease has a land, a mappable territory, a subterranean, but secure place where its kinships and consequences are formed.

In other words, death and disease were seen as imprisoned in the living bodies of individuals and therefore the search for a cause of death became the main concern.



The analysis of disease and death, then, was organised according to the canons of positivist science. The subsequent preoccupation with causal explanations is therefore hardly surprising. Any approach to understanding the world will dictate what questions can be asked. Consequently the emphasis was placed on discovering the laws that explain, amongst other things, the development of disease and the structure and functions of the human body.

The impact that positivist science has had on the field of suicide research cannot go understated. Indeed Prior (1989: 10) maintains that 'the study of suicide ... reflects above all an enduring and obsessive interest in causation'. Durkheim (1952: 37) himself makes clear in his preface to *Suicide* that his aim is to study a specific form of death according to the rigours of science, and that his study was constructed on the 'basic principle that social facts must be studied as things'. Not only is Durkheim's original work constructed in a framework of causality, but Simpson's introduction to the English translation is written entirely in causal terms, as Prior (1989) highlights, a point which is very evident from the title alone; 'The aetiology of suicide'. This preoccupation with the causes of suicide however did not finish with Durkheim's classic study. On the contrary, most research into suicide has been dominated by the search for a causal explanation. A point to which Prior (1989:11) draws attention; 'during most of this century, the study of death was the study of suicide, and that in turn was the study of social causation'.

It is clear then, that death, and suicide as a specific form of death, is an object of scientific discourse. Indeed it has been suggested that for a large part of the twentieth century, it has been visible only through an objective and scientific language which speaks of 'depression' 'illness' and 'causation', rather than one that speaks of 'attitudes', 'sentiments' and 'awareness' (Prior 1989). The centrality of 'why' which occupies deaths from suicide could certainly result from scientific discourse's search for causation. A question that seems so natural to ask when a person dies by suicide, is only natural when a death is understood from a scientific discourse. As Prior (1989) speculates, a death that is made visible through attitudes, sentiments and awareness is likely to raise very different questions when a person dies by suicide.

## **The Dominance of Psychiatry**

If psychiatry is the dominant discourse in structuring our understandings of suicide, why is this the case? To search for an answer to this question brings us into the realms of power. Discourses regulate our knowledge of the world, our common understandings of things and events. What is more, these shared understandings inform our social practices. With this in mind, it becomes clear that there is an intimate relationship between discourse, knowledge and power. Events, people, social phenomena and so on are subject to a variety of possible constructions or representations. Some constructions will have a greater tendency to be seen as 'common sense' or more truthful than others, as is the case with psychiatry and suicide, but this can vary greatly with the specific culture, its location in history and the structure of society. For example, in contemporary Western societies it is commonplace for versions of events, including suicide, provided by science and medicine to be given greater credence than those offered by religion, magic or superstition and to be given the stamp of truth.

This has not always been the case however, and is not true of all cultures in the world. As I outlined at the beginning of this review, suicidal behaviour which years ago would have been taken as evidence of possession by evil spirits is today thought of as showing signs of a mental illness (Williams 1997). Even when scientists are unable to put forward adequate explanations of phenomena such as mind reading and psychic connections, these things are often thought to have a rational explanation which science, in time, will explain (Burr 2003). For Foucault, knowledge, the particular common sense view of the world prevailing in any culture at any one time, is intimately bound up with power. Any version of an event brings with it the potential for social practices, for acting in one way rather than another, and for marginalising alternative ways of acting. What is possible for one person to do to another, under what rights and obligations, is given by the version of events currently taken as knowledge. This means that the evil spirits 'controlling' the suicidal person may be exorcised, but mental illness, which results in a person becoming suicidal, may require treatment in a mental hospital (Burr 2003).

What this means is that the power to act in particular ways, to claim resources, to control or be controlled depends upon the knowledges currently prevailing in a society. Thus, psychiatry can exercise power over the construction of suicide by drawing on scientific discourses which allow human behaviour to be represented in an acceptable light. Foucault therefore does not see power as some form of possession that some people have and others do not, but as an effect of discourse. So when we define or represent suicide as the result of a battle with a psychiatric illness, depression, being unhappy or whatever, we are producing a particular form of knowledge – which brings power with it. To construe the world in terms of those who are mad and those who are sane, thereby producing a particular form of knowledge, brings with it a power inequality between these groups.

Given that there are always a number of discourses surrounding an event, each offering an alternative view, each bringing with it different possibilities for action then it follows that the dominant or prevailing discourse, is continually subject to contestation and resistance. We can see this in the increasing use of the ‘crisis of masculinity’ discourse to explain suicide in young men. Indeed Scourfield (2006) has speculated that this could certainly be as popular in explaining young men’s suicide as the discourse of psychiatry, at least in recent years. It is clear however, that by the end of the last century, the vast majority of studies of suicide were keen to draw the link between suicide and mental illness. This is in spite of the fact that little ‘proof’ has been shown that psychiatric or medical intervention can affect so-called suicidal behaviour.

Ultimately then, many different discourses can surround a single object, in this case suicide, each striving to represent or construct it in a different way. Each discourse brings different aspects into focus, raises different issues for consideration and has different implications for what we should do. As Burr (2003) explains, discourse, through what is said, written or otherwise represented, serves to construct the phenomena of our world for us. Moreover, different discourses construct things in very different ways, each portraying the object as having a very different nature from the next. Each discourse claims to say what the object really is, that is claims to be the truth.

## THE GROWING DISSATISFACTION WITH PSYCHIATRY

In spite of the relative dominance of medical, psychiatric and psychological understandings of suicide, there have been more than a few attempts to explain the phenomenon away from this discourse. The social constructionist debate, which is now considered to form an important strand (Bury 1986), if not the most important strand (White 1991), within the sociology of health and illness, emerged in the context of an increasingly critical sociology of health, illness and medicine; in particular the diagnosis and treatment of mental illness came in for special attack. In addition to the social constructionist approach, Pilgrim and Rogers (1993) have distinguished between two further perspectives; the epidemiological tradition of social causation and the post 1960s labelling theory. With regards to the former perspective, Pilgrim and Rogers (1993) point out that whilst authors accept the factual reality of mental illness, they view social inequalities as having a profound impact on their aetiology. A debate began to emerge that argued that mental illness was intrinsically related to the *social* conditions of a person's life and the notion of an underlying disease causation was neither capable of being proven nor desirable in terms of developing treatments. In contrast, the labelling theory was broadly concerned with the 'societal reaction' to the person with a diagnosis of mental illness (Pilgrim and Rogers 1993: 16). Moreover, during the 1960s a growing number of theorists began to question the medical origins of mental illness. Broadly bracketed under the term 'anti-psychiatry', many writing from this position argued that much of what is considered to be a mental illness was simply a social construction created by psychiatrists, who acted as powerful agents of social control (Ingelby 1980). Whilst there were many streams of thought that contributed to the social turn in explaining mental illness, I will briefly summarise some of the key writers who have been associated with this critique of psychiatry and how they introduced social explanations. This summary provides a context for understanding how this social turn has been used to explain suicide in young men.

R.D. Laing was a key advocate for the social origins of schizophrenia. Laing co-authored with Esterson a book entitled *Sanity, Madness and the Family* (1970) which was the first major consideration of the family and the part it played in the development of psychological disturbance. In this book, the authors argued that

families, particularly parental relationships, created patterns of dysfunctional behaviours in family members through inconsistent and often conflicting expectations. Laing and Esterson interpreted what they observed in these families using a framework of existential philosophy. Recovery from schizophrenia here involved facilitating patients through an intricate passage of self-discovery.

Thomas Szasz (1971, 1972) writing a few years later, went further in his radical examination of psychiatry as a political ideology. Indeed whilst Laing and Esterson did not deny the existence of mental illness, for Szasz people diagnosed with mental illness have a 'fake disease'. He casts modern forms of psychiatric practices as camouflaging the moral dimensions of human behaviours. In his critical appraisals of psychiatry, there are numerous insights into the strategic effects of the political organisation of madness. Underlying these writings, is his quest to achieve recognition for the moral responsibility of individual actions and the need to make decisions based upon this premise rather than those circulated by psychiatry.

Erving Goffman's ethnographic analysis of total institutions, *Asylums*, first published in 1961, gives a compelling account of the lives of the inpatients of St Elizabeth's Psychiatric Hospital, Washington DC. Goffman described the processes that were part of the taken-for-granted world of the psychiatric staff during 1955-6, but which for the patients introduced a series of dehumanising and humiliating practices that depersonalised them and constructed their 'non-identities'. These processes served various functions for the psychiatrist and encouraged patient compliance with institutional regimes.

## **Extending the Sociology of Suicide**

The development and diversification of theories and understandings of psychiatry and mental illness in the 1960s, outlined briefly above, arguably paved the way for a more social critique of suicide research. The theory of suicide advanced by Jack D. Douglas is often seen as the most comprehensive attempt to create an interpretative alternative to the dominant, positivist Durkheimian approach to suicide. For Douglas, suicide was of interest not as an event with identifiable causes, but rather as

an intentional, meaningful act. Suicide, rather than simply being an end, is a means or a strategy, through which people seek to achieve particular ends. As Douglas (1967: 320) puts it, a particular individual commits suicide 'because of the specific construction [of meanings] which seems plausible to him and in some way fits his intentions'. Suicide is therefore an outcome of the way in which individuals who intend to take their own life interpret morally ambiguous meanings.

Douglas' theory of suicide is driven by an interpretative methodology that draws explicitly on Weber's link between meaning and action. Indeed Douglas focuses his attention solely on subjective meanings. In this account, the social world ultimately derives from individual intentions. Even apparently objective or external social phenomenon can only be understood with recourse to such intentions. Subjective interpretations, for example, motivate the suicidal act and hence lie behind any translation of these acts into statistical phenomena such as rates (Douglas 1967). Accordingly, Douglas (1967: 256) advocates not statistical abstraction but rather the study of 'what people say and do in the real-world situations'. Only studies can shed light on the world of subjective intentions. Instead of external facts, Douglas maintains that sociologists should investigate the 'uninformed and informed experience of everyday phenomena' revealed in such sources as professional reports, diaries, personal letters and newspaper reports (Douglas 1967: 269).

This emphasis on the interpretation of meaning produced two important studies of suicide by Harold Garfinkel (1967) and Maxwell Atkinson (1978). Garfinkel (1967) used conversation analysis to examine suicide certification practices. The study established that these practices relied on members' accounts of everyday activities, on the 'practical reasoning' that generates 'prescriptions for locating, identifying, analysing, classifying, making recognisable, finding one's way around in comparable occasions' (Garfinkel 1967: 177). Emphasising the significance of common sense understandings in the compilation of statistical records, Garfinkel's work showed that many sociologists believed that interpretative methods offered significant gains over positivistic approaches. Atkinson's (1978) *Discovering Suicide* further elaborated upon Garfinkel's findings. Atkinson also used conversation analysis to interpret official decisions made by Coroners that categorised certain people as suicides. And like Garfinkel, Atkinson (1978: 183) concluded that the ability to account for these

categorisations demonstrated the capacity of ethnomethodology to solve the fundamental problem of sociology, that is, how social order is accomplished.

## **Reporting and Classification of Youth Suicide**

These early critiques formed part of a wider debate about the use of official statistics in suicide research. For example, the gendered nature of suicidal behaviour, evident in the official suicide rate, has been reported in a fairly clear way. Indeed official statistics' ability to identify trends – such as the prominence of suicide among young men – have been seen as invaluable by many looking at the topic (e.g. McClure 2000). This value however, should not be overplayed; all statistics require careful handling and suicide statistics are no exception. Indeed as we have just seen, it is quite possible that biases in reporting and classifying deaths have contributed to perceptions of gender differences in suicidal behaviours. The psychologist Sylvia Sara Canetto for example, has suggested that female suicide is regarded as less culturally acceptable than male suicide. She speculates that stronger efforts may be made *not* to record a suicide verdict for female deaths, leading to an under-reporting of female suicides (Canetto 1992-1993, 1995, 1997). And Douglas, writing in the 1960s, noted that relatives may have more compelling reasons to hide a woman's suicide than a man's suicide, a result of suicide in women often being attributed to family problems. Kushner (1995: 27) points out that 'a woman killing herself is seen as a judgement on her husband; in contrast when a husband kills himself it is taken as a legitimate criticism of a particular social condition occurring outside the family'. These cultural attitudes may not only influence a family's tendency to gloss over a female suicide, they may also influence how those reporting the death view it. 'Coroners, physicians and others responsible for determining whether a particular death was a suicide are already tied to an ideology that differentiates women's motives from men's', argues Kushner (1995: 23).

These difficulties in establishing a suicide verdict are compounded in the case of children and adolescents, who are the least likely to receive a suicide verdict (McClure 1984). In part this reflects a scarcity of proof; young suicide victims leave fewer clues. Clear evidence of planning tends to be unusual and suicide notes rarer

than for adults. Neither can it be assumed that a child or adolescent had a reliable understanding of the relative dangers of different suicide methods. Coroners' verdicts show that self-inflicted deaths by what are commonly perceived as the most unequivocal methods of hanging and suffocation, are often regarded as ambiguous when the person is young (Hill 1995). Between 1982 and 1996, 43 per cent of young men aged 10 to 19 and 27 per cent of young women dying by this method were given a suicide verdict (Kelly and Bunting 1998). The lethality of the method was not equated with a clear intention to die, as would generally be the case for adults. Where the death is by overdose, the balance of misfortune and suicidal motivations is conceived as particularly immeasurable. Suicide verdicts were given for 43 per cent of young women aged 10 to 19 and just 12 per cent of young men. What is more, the gendered difference contained within these statistics is obvious. A woman dying as a result of a drug overdose is far more likely to receive a suicide verdict than a young man dying by the same means (Kelly and Bunting 1998). Similarly, a suicide verdict is much more likely to be given to a young man hanging himself than a young woman. These figures would seem to suggest that there are certain suicidal methods that are viewed as more acceptable for women while others are seen as more appropriate for men.

A focus on the suicide rate ignores the huge numbers of young people who risk their lives each year. As many as 44,000 young people under the age of 25 are admitted to hospital each year in the U.K. having deliberately taken overdoses or injured themselves (Hawton and Fagg 1992). However, a large number of non-fatal suicide acts never reach the attention of the medical community (Canetto 1995). The relationship between suicide and self injury is a complex one, and many have questioned the value of looking at them together. As a result, it needs to be acknowledged that not all self injury is intended to threaten life. Indeed there is a well rehearsed literature that sees self-harm as a coping technique focussed on survival rather than on ending life (see e.g. Spandler 1996; Babiker and Arnold 1997).

Attempted suicide is an elusive subject. No country in the world keeps national records of it so consequently what is known is usually pieced together from hospital records or hospital based studies. Data are similarly hampered by the variations in definition of non-fatal suicidal behaviours. As DeLeo and Diekstra (1990 in Canetto



1995: 294) note, 'suicide acts with a non-fatal outcome are labelled either suicide attempts, attempted suicides, parasuicides or acts of deliberate self harm depending upon the county of origin of the author or the 'school' of thought he or she adheres to'. Whatever label one chooses to apply, the harm done ranges from the potentially deadly through to relatively minor injuries, and the motives and impulses behind these crises are diverse (Hill 1995). Some young people want to die, some definitely do not and others are confused. Exacerbating this is the fact that a young person who is quite determined to end their life may, unexpectedly, survive. Similarly some acts of parasuicide do have a quite unintended fatal outcome. As a result, 'attempts to define suicidal or self harming behaviour will continue to raise difficulties because there will always be the possibility for an unintended victim to become a fatality and for a potential fatality to become a survivor' (Kerfoot 2000: 2).

Heightening the contrast with suicide itself, suicide attempts are far more common among women than men. This reversal of the gender difference seen in fatal suicide acts is most decisive among the under 25s. Kushner (1985) has suggested that women do in fact outnumber men in terms of suicidal behaviours because attempts are more frequent than fatal suicides. Yet as long as studies of suicide are limited to the official statistics of fatal suicides, then this fact will continue to be ignored. As Kushner (1985) maintains, the reliance on suicide statistics ensures that suicidal behaviours among women will be trivialised when compared with the self-destruction of men.

Ultimately, both the growing disenchantment with psychiatry that emerged in Europe and America during the mid-twentieth century and an increasing critique of the credulous use of official statistics in social research arguably opened up the debate to more social understandings. Scientific medical literature continued to dominate the explanation of suicide and the treatment of suicidal individuals through psychiatric practice, but social theorists began to introduce some different understandings about the phenomena. The much cited trend of young men being especially vulnerable to suicide, meant that a focus on gender in particular, and social differences generally, have increasingly come to the fore. The relative dominance of psychological autopsy studies of suicide and their inevitable focus on identifying the presence or absence of psychopathology (Gavin and Rogers 2006) have recently

been accompanied by the relatively new sociological autopsy study (e.g. Fincham *et al.* 2008; Langer *et al.* 2008). However, I argue that the apparently more social understandings of young men's suicide continue to support the dominant psychiatric approach. What I turn to now then is a brief look at the more social understandings of their suicide, before considering the proposal that far from offering an alternative to the medical, psychiatric and psychological approach, they do in fact maintain its dominance.

## **WHAT DO WE 'KNOW' ABOUT YOUNG MEN'S SUICIDE?**

### **Unhealthy Young Men: Their use of health-care**

Gender has consistently been put forward as one of the most important determinants of health behaviour. However, until relatively recently, where health disadvantage has been linked to gender, the focus had been on women rather than on men (Cameron and Bernardes 1998). This is beginning to change as the links between masculinity and health are beginning to emerge within the debate (Doyle 2001). Research has pointed to the fact that men engage in less health-promoting behaviour and have less healthy lifestyles than women. As Courtenay (1998) has stated, simply being male is linked to poor health behaviours and increased health risks. With this in mind, it is clear the relevance that such research can have on understanding young men's suicide.

It is now generally accepted that health behaviours and beliefs are a way of demonstrating gender. As Saltonstall (1993: 12) proposes, 'the doing of health is a form of doing gender'. To forge a connection with suicide in young men, others have argued that it is precisely the demonstration of gender that places young men at risk of suicide. By constructing and maintaining their masculinity, young men take health risks and reject healthy norms – it is by adopting these ideals that they attempt to demonstrate their gender. As Courtenay (2000: 1389) has argued, 'by dismissing their health-care needs, men are constructing their gender'. An example that is often used to support this proposition is young men's alcohol and substance misuse. Canetto and Sakinofsky (1998) maintain that in most societies, alcohol consumption

is associated with masculinity, which they state helps to explain the strong link between alcohol use and suicide in young men.

### **Unwillingness to Seek Help**

Closely linked to the idea of unhealthy behaviours is young men's unwillingness to seek help. Contact with health-care services has also been closely studied in suicide research. Findings are particularly relevant amongst young men where, once again, we see the impact of gender coming to the fore. The gender differences in use of health-care services are widely reported, with men less likely to consult than women. In relation to suicide, it has been argued that men are less likely to disclose suicidal thoughts than women, less likely to ask for help when they are emotionally distressed (Meltzer *et al.* 2002) and are more reluctant to talk about their emotional problems generally (Hawton 2000). Such findings then help to establish the notion that young men are in crisis. As Cohen (1999: 67) has outlined, for young men 'asking for help involves suffering, soul searching and a major emotional effort to overcome a wider range of social and psychological obstacles that may, in the end, preclude the articulation of the request and the subsequent receipt of assistance'.

### **Emotional Illiteracy**

It is clear from discussions surrounding gender and suicide that dominant discourses of masculinity do not sit easily with notions of emotional literacy and maturity. Ways of being a man and exhibiting masculinity are seen as intruding into a young man's experiences and displays of emotion, rendering it as something 'synthetic, strategic or to be avoided' (Whitehead 2002: 173). The suicidal young man, then, is constructed as someone who is constrained by a gendered emotional distance, potentially leaving them unable to cope with a range of challenges such as a relationship breakdown (Scourfield 2005). What is more, the protective effects of marriage on the health and well-being of young men is often put forward (Kelly and Bunting 1998). In particular widowed and divorced young men are reported as having higher rates of suicide than men who are married. Such reports have allowed researchers to

conclude that young men seem to benefit more than women from the protective effects of marriage (e.g. Ross *et al.* 1990; Stack 1998; Cantor 2000).

## **Mental Illness**

Inevitably mental illness has been isolated as a risk factor for young men's suicide; mentally ill young men are consistently put forward as being at the greatest risk of suicide. Amongst professionals dealing with those at risk from suicide, there has been more than a little effort to pathologise suicidality, either as a form of mental illness or to interpret it as something buried within the individual (Coles 2000). As a result professionals have linked suicide to depression, anxiety and more serious mental illnesses. Despite the dominance of psychiatric understandings about this association, the relationship has also been explored socially.

The gendered differences in the strength of the relationship between young men's suicide and mental illness are increasingly isolated. As Smalley and colleagues (2005) point out, it is the gendered experience of mental illness and the gendered response from the sufferer that is important when considering the relationship. The experience of mental illness is constructed as a deep disruption between masculinity and identity (Sixsmith and Boneham 2002). McQueen and Henwood (2002) argue that adolescence is a time when the accumulation of masculine identities is particularly salient. This leads them to suggest that the experience of emotional distress and mental illness may produce tensions between young men's lived experience and what are considered acceptable forms of masculine identity.

The association between suicide and mental illness has also been constructed in terms of gender differences in classification. Warren (1993) has suggested that early classification of mental illness generally, and depression in particular, focussed on women rather than men. This, she argues, has led to an emphasis on treating women for depression, resulting in the common (mis)conception of an immunity to depression among men. She goes on to suggest that men's apparent unwillingness to seek help further contributes to the social construction of their invulnerability to depression.

## Sexuality

Research has pointed to the fact that another socially at risk group are gay and bisexual young men. The concept of hegemonic masculinity has often been used when explaining why there seems to be higher levels of suicidal ideation in the gay and bisexual population than the heterosexual population (Remafedi *et al.* 1998; Fergusson *et al.* 1999). As Horrocks (1994: 25) explains, the concept of hegemonic masculinity urges men 'don't accept who you are. Conceal your weakness, your tears, your fear of death, your love for others'. For a heterosexual male then, any behaviour that does not conform to this may be actively resisted; but what does this mean for young gay men? Using the concept of hegemonic masculinity, research has proposed that the distance between hegemonic and gay or bisexual masculinities is great, and as a result may constitute a threat to mental health (Russell 2003).

## Employment and Unemployment

The connection between young men, suicide and unemployment has a long history. Being out of work is seen to be a major factor in their suicide. Indeed the systematic review by Platt and Hawton (2000) points fairly conclusively to a link between unemployment and suicide. Such findings have inevitably been understood in terms of young men's gender. Future job aspirations are arguably extremely important to a young person's developing identity. This appears to be particularly pertinent to young men, where it has been argued that they often conceive future hopes and aspirations in terms of perceived job prospects (Pritchard 1995). As Bradford and Urquhart (1998: 38) have made clear, 'the young male identity still appears to be entirely defined by work'. This has led others to argue that for those young men who are not in work, there is a risk of suffering not only the loss of social contact and financial independence, but an erosion of the male sense of self (Hill 1995). Such understandings have indicated a link between unemployment and young men's suicide. Indeed Pritchard (1995: 69) has argued that the social *and* psychological consequences of unemployment make their correlation to 'steep' rises in suicide amongst young men 'understandable'.

## Young Men's Need for Control

When control has been discussed in the literature, it has often referred to both men asserting control over their own lives and also the lives of others (Scourfield 2005). Here I discuss the former element of the debate. The idea of men's own self-control is arguably connected to hegemonic masculinity, and this could certainly impact on the construction of their suicide. Men's suicide is popularly described as showing signs of 'tragic courage and fierce independence' (Canetto 1992-93: 5). The idea that men's suicidal behaviour represents a fight against external difficulties has a long tradition in Western society. Whereas women's suicidal behaviour is commonly viewed as showing signs of weakness, men's is frequently interpreted as displaying strength and pride. As Canetto (1992-93) points out, men's suicide is likely to be constructed as part of their resistance against powerful, external forces, not as a sign of simply giving up.

The idea that suicide is a means for young men to assert control over their lives is closely connected to debates surrounding youth transitions. For example, the fact that traditional reference points of marriage and religious guidance have become increasingly unstable have been used to highlight the deep uncertainty that can fill young people's lives (Jones 2000). Such an understanding led Alvarez (1971: 111) to argue that declining religious authority has been replaced by what he refers to as 'an uneasy perilous freedom'. And as Bradford and Urquhart (1998: 31) speculate, such freedom 'casts young people out to uncharted waters on which many adults are themselves adrift'. It is this modern uncertainty that helps suicide researchers to explain young men's suicide. We can see this when Hill (1995) proposes that in such uncertain times, the ultimate form of control could be suicide; at times of crisis, if there is nothing else that a young man can control, he has the final say in whether to stay alive.

Consequently, the young man dying by suicide is constructed as having the ultimate control over his life. Indeed, connections have been made between the status of the 'live fast – die young' imagery that is prevalent in modern society and young men's suicide. This allows Gaines (1991: 248) to state that suicide has become 'hip, dangerous and the final resistance to adult authority, a last stand against conformity'.

Rock suicides, like those of Kurt Cobain and Ian Curtis seem to confirm this for him. As he goes on to state, the image of martyr as hero is deeply embedded in our culture – from religion to pop, in Christ and in contemporary rock legends. For some young men with unfulfilled aspirations this offers a seductive narrative whose imagery may resonate deeply with their own circumstances.

## **A Sociological Understanding?**

As I have highlighted, within a discursive approach, there can be more than one discourse attempting to construct and explain a phenomenon. Each discourse claims to reveal the realities of a phenomenon; that is, each discourse claims to be the truth. The discourse of psychiatry, with its allegiance to scientific understandings of death, is unquestionably dominant in constructing suicide. However, as we have just seen, when young men's suicide is isolated, there are arguably other, more social discourses coming to the fore. The above social explanations of young men's suicide form part of a wider debate on a 'crisis in masculinity'. Whilst the idea is a controversial one, the notion of a male crisis is particularly pervasive, informing many of the social, political and academic debates about men. Evidence of this perceived 'crisis' that men find themselves in comes from a variety of sources; rising levels of men's violence, disadvantage in education, changes in the structure of the labour market, family relations and the rising suicide rate in young men under 35 in the latter half of the twentieth century. Indeed men's suicide alone has been used as evidence for a crisis in masculinity (Jefferson 2002). The implication of such a crisis is that young men are not coping in contemporary society. Changes in the gender order, such as shifting patterns of work and relationships are therefore constructed as destabilising the traditional masculine order, placing men, especially young men at risk of suicide. This then leads the way for writers such as Jefferson (2002) to argue that what it means to be a man has become a real social problem for large numbers of men, and a pressing social problem for society in general.

The crisis of masculinity idea could certainly be held up as an alternative construction to the dominant discourse from the medical sciences, psychiatry and psychology, which emphasises the role of mental illness in causing suicide.

Competing discourses can and do run parallel to one other, each attempting to construct an event. However, discourses also operate across disciplines, linking beliefs, values and expectations. With this in mind, rather than running *parallel* to, I suggest that social understandings are *informed* by the discourses of medicine, psychiatry and psychology. Two main arguments stem from my contention regarding the overlap between social explanations and scientific approaches. Firstly, the search to answer ‘why’ young men kill themselves effectively serves to continue the emphasis on causation. And secondly, the overlap between the two means that the focus continues to be on the individual’s emotional/mental state.

Much of the research on the social and cultural dimensions of young men’s suicide has been brought within a scientific hegemony and made to ‘fit’ the model of scientific criteria for establishing the ‘truth’. Social explanations, whether they focus on unemployment, an unwillingness to seek help or whatever, are put forward as reasons to help explain the route of young men’s *emotional distress* and subsequent suicide. These social understandings ultimately support the scientific contention that a suicide shows signs of at the very least emotional distress, or more probably mental illness and as such, any person who attempts suicide comes under the scientific, psychiatric gaze.

As a result, far from asking different questions about their suicide, social approaches continue to ask the question asked by medical science and psychiatry – why? Whilst their understandings are inevitably social, they continue to support the dominant psychiatric discourse’s focus on causation by helping to explain *why* young men are killing themselves. I am not suggesting that to ask why young men kill themselves is a fruitless task. Indeed if we did not ask ‘why’ then strategies could not be put in place to prevent suicide. But whilst social understandings can offer reasons behind young men’s emotional distress and suicidal behaviour, how these are addressed within preventative and treatment practices continue to be the domain of medicine, psychiatry and psychology.



## THE MEANING OF SUICIDE

Despite the social patterns of young men's suicide being highlighted by research, it is also the case that no two suicides are exactly alike. Yet the focus on causation means that people invariably search for commonalities. Loseke (2003) has talked about the categorisations that we are all involved in making. As she explains, 'everyday we categorize conditions and this is important because it encourages us to react to these conditions in predictable ways' (Loseke 2003: 16). For researchers searching for an explanation behind young men's suicide, the appeal of making categorisations is clear. To identify *who* is at risk as well as searching for commonalities about the reasons *why* helps to explain what is a largely an inexplicable death and therefore react to it in 'predictable ways'. So drug abuse, a relationship breakdown or mental illness for example, are all understandable reasons why a person might want to end their own life. What is more, these at risk groups can be targeted within suicide prevention strategies. Suicide then is explained in terms of risk factors – both structural and individual – as well as a person's motivations.

However, despite identifying general trends, such approaches will never reach a final understanding on the causes of suicide. After all, there will be those people at risk who never attempt to end their lives and people who are not at risk who do. Moreover explanations which focus on general trends are inherently reductionist. As Redley (2003) points out in his research exploring drug overdosing by deliberate self harmers, once we take the 'explanatory route' of seeing material factors, social circumstances, or cognitive ability as determinate, there is the danger of simply confirming already existing understandings of suicide and of doing little more than discovering more risk factors. This approach ignores the fact that suicide is an inherently complex event. As Alvarez (1971) has said, suicide is such an ambiguous act, with such complex motives that no single theory could ever explain it.

Like Redley (2003), I am not suggesting that the social realities of people's lives are not important in their suicides. Equally, I am not denying the significance of mental illness on young men's suicide. What I am suggesting however, is that there could be much to be gained from focussing on the *meanings* behind young men's suicide, *how*

individuals interpret their circumstances and the emotional force behind these interpretations. After all it is the emotional response to many social happenings that is important, rather than the social event alone. Pilgrim and Rogers (1998) highlight a similar point. They have shown that within the area of lay health knowledge, individual understandings and meanings are crucial in exploring the reasons behind a person's actions. And writing explicitly about suicide, Gavin and Rogers (2006) speculate that there could be much to be gained from attending to a person's knowledge and experience and the role this plays in their subsequent (suicidal) behaviour. As they explain, 'in studying the ways in which people act in the light of their existing knowledge and experience, we are in a much better position from which to try and understand the interaction between life events and personal conduct (suicide or attempted suicide)' (Gavin and Rogers 2006: 141). With this in mind then, it is not just that a young man suffered a relationship breakdown but rather it is *how* he responded to it that is important. Crucially however, to simply attend to the meaning that individuals attach to a suicide is not enough. Indeed to focus solely on meanings without further interrogation would further support the dualism between positivism and interpretivism (as outlined in chapter one). Rather, if we want to discover how suicide is understood and responded to (both in society generally and the suicidal individual in particular) then we need to attend to the ways in which these meanings and understandings are culturally relevant.

### **Talking to Relatives: The importance of narrative**

Within the sociology of health and illness, there has been a growing interest in how people experience illness; how they understand its causation and manage its disruptive effects on their lives. There has been an increased recognition that for the person who is sick, their illness is not simply a physiological state but an 'essential part of the self' (Goode 1997: 116). As such, a focus on the individual's 'meaning-making' and 'identity work', expressed through narrative is central to this development (Holstein and Gubrium 1997; Hyden 1997; Owens *et al.* 2008). This literature owes a lot to, and is heavily influenced by both Bury's (1982) idea of biographical disruption and Williams' (1984) work on narrative reconstruction. In relation to suicide, the potential of narrative is clear. By talking to those close to

suicide – whether it be the friends and families left behind or those who have survived a suicide attempt – it is possible to get a glimpse into their understanding, their interpretation and their knowledge. However, it is important to note that the use of narrative can not claim an especially privileged insight (see chapter three). That said, I maintain that individual narratives of suicide can tell us something about the way suicide is understood and responded to culturally. That is, they shed light on the *discursive context* of suicide.

This study has attempted to find out some of the ways in which suicide in young men is socially constructed. By talking to friends and families who have lost a young man to suicide, we can begin to see the meanings that they attach to his death, how they understand it and *construct* his suicide into a story. To understand suicide from the perspective of those closest to the deceased is not only important in terms of what it tells us about their biographical reconstruction of their sons' deaths, but also what it tells us about the cultural assumptions that are made about suicide. That is, the discursive context of the relatives' accounts will tell us something about the broader context within which suicidal behaviour occurs.

Whilst it may be the case that the relatives' accounts are individually constructed, meaningful accounts of their loved one's death, they emerge only from the meaningful categories and vocabularies of the participants' social setting. As Rosenwald and Ochberg (1992: 5) suggest, 'explanations individuals offer of their lives are inevitably shaped by the prevailing norms of discourse within which they operate'. In other words, a participant's specific local culture will provide him or her with shared meanings and interpretive vocabularies that they use to construct the shape and content of their lives (Gubrium and Holstein 1995). For this study then, this means a focus on how families talk about their loved one's life and death, the stories that they choose to share with others. As Chase (1995) explains, culture marks, shapes and can sometimes constrain certain narratives. Through narrative analysis we can see that certain narratives are possible for certain groups of people, and therefore we learn about the cultural world that makes their particular narratives possible. This means that rather than being devoid of social context, narratives can reveal many things about social life. Indeed Rosenwald and Ochberg (1992: 7) have been so convinced of this that they have claimed that 'culture actually speaks itself

through each individual story'. Far from simply confirming known risk factors for young men's suicide, a focus on the narratives of surviving family members has the potential to uncover further insights into their suicide. Explanations that seem obvious may not feature in family understandings. As Owens and colleagues (2008) found in their research with parents whose sons had killed themselves, notions of agency and accountability had far more bearing on their understandings than factors such as mental illness or a relationship breakdown.

This thesis not only focuses on families' own understandings of their loved one's death, but it also explores how these meanings both contribute to, and potentially reveal, the socially constructed nature of suicide. This means that the families' narratives of their son are integral. At the same time, however, they are also narratives of the self. As Owens and colleagues (2008) discovered, although the focus of the interview is the suicide of their loved one and their understanding of his death, the family's own identity is intimately bound up in the narrative. Indeed these authors go on to explain that, 'for the bereaved parent, it is impossible to disentangle the events leading to the son's death from the impact of that death on their own life and on their identity as a parent' (Owens *et al.* 2008: 239). Ultimately then, the story of the death is told amidst the families' own reconstruction of their disrupted biographies.

## CONCLUSION

This chapter has located the theoretical and substantive frameworks that will best help me to conceptualise and understand the different ways in which bereaved families make sense of their loved one's death. My positioning of suicide as a discursive event, rather than simply an objective reality, necessitates an approach informed by social constructionism. Such an approach enables us to see the way in which dominant understandings of suicide are tied up with issues of power. Foucault's notion of power illuminates psychiatry as the dominant discourse in the contemporary construction of suicide. After signalling the way in which this dominant medico-psychiatric discourse constructs suicide – notably as showing signs of a mental illness – I then identify a number of alternative, social understandings.

However far from viewing these as resistance discourses, I go on to suggest a degree of overlap between the two. Specifically I focus on the way that both put emphasis on issues of causation and the drive to answer 'why people kill themselves'. In addition, social understandings are often put forward to help explain *why* young men were depressed in the first place.

Understanding suicide as discursive, that is, recognising that it is the subject of and subjected to discourse, is crucial to understanding how families position their young men, and themselves, in relation to the act. By examining meanings that bereaved families attach to the event, and importantly the way in which these meanings are culturally relevant, we can potentially reveal something about how it is understood and responded to in wider society. This possibility is explored in the last section to this chapter, paying particular attention to the narrative, which is understood as a vital part of the way people create meaning in their lives.

The following chapters will identify a number of different understandings of suicide and suicidal young men and how these are made available through discourse. These are explored in relation to the internalisation of and resistance to the 'psychiatric /therapeutic gaze' and the way understandings are structured through narrative. The next chapter, however, discusses how these data were collected.

## **Chapter Three:**

# **METHODOLOGY AND RESEARCH STRATEGY**

## **INTRODUCTION**

This chapter details the methods used in the study and provides a reflexive narrative of the research process. As outlined in the opening preface to this thesis, suicide is a subject that I chose because of my own life experiences. Whilst my PhD is not an explicit auto/biography – I am largely absent from the empirical chapters – I cannot ignore my identity and the role that it played in shaping and understanding the research. Consequently I begin the chapter by outlining the uses of autobiography in social science and what this means for my own approach, before moving on to look at the contributions from feminism, which help to inform my methodological approach. Following this brief consideration of the methodological motivations behind the study I turn to the methods of my own research – in-depth interviews and online focus groups. Firstly looking at the in-depth interviews, I discuss the nature of my research relationships with participants and the personal dangers involved in studying a topic which is so close to one's personal experience. In particular I develop the idea of research as emotional work for both the researcher and the researched. I then move on to consider the issues involved in researching a sensitive and emotive topic electronically – the practical issues raised as well as the benefits that it offers.

## **Approaching Auto/biographical Research: The need for reflexivity**

Until relatively recently, social research typically sought to exclude the self and researcher emotions. As Letherby (2000) observes, such information has been written out of the research process, rather than being placed as central to one's understanding of the topic. Weber (1949) was amongst the first to consider one's own involvement in research. He wrote about the values that are intrinsic to research – values that are based on the problems of a society. This led him to assert that social scientists need to be clear about their own values and ideals and how they would impact on their research. Wright Mills (1959: 204) similarly argued that 'the social scientist is not some autonomous being standing outside society. No one is outside society, the question is where he stands in it'.

Despite these relatively early observations, writing the self into research has been largely ignored. Oakley (1981) for example, noted that methodological textbooks traditionally advised that the following of certain rules was necessary when conducting research in order to ensure the researcher remained 'detached' and 'objective'. The interview then, was typically seen as a way of collecting objective, scientific data which could only be achieved if the researcher themselves acted in an objective, scientific manner.

Yet as many writers have pointed out, the self is present in every aspect of the research. A recognition of this makes issues surrounding reflexivity key. Indeed no part of the research process is immune to concerns about reflexivity. 'From the glimmerings of an idea ... to authorship and publication' (Stanley 1993: 44) the self is present whether acknowledged or not. If we consider the areas that researchers choose to focus on, personal factors will almost certainly be implicated. As Bochner (1997) points out, it is rare to find a scholar whose work is unconnected to his or her personal history. Few people choose to study racism, addiction, domestic violence or suicide accidentally.

Writing about personal experiences has certainly gained more credibility since the days where methodological thinking centred on the objective and detached researcher. Indeed Letherby (2003) suggests that writing from personal experience, rather than a

position of detached researcher is likely to give the writer certain credentials. As Katz-Rothman (1996: 50) writes:

In the circles I travel in now, if you see an article by a colleague on breast cancer, you write to see how she is, wonder when she was diagnosed. If you see an article on Alzheimer's you assume someone's got a parent or in-law to help. I can track my colleagues' progression through the life cycle, through crises and passages, by articles and book titles.

Arguably drawing on one's own personal experience can allow connections to be made and rapport to be developed during the research process. Reinharz (1992) makes this point, maintaining that whilst gender does enable a connection to be made with (female) respondents, it alone is not enough. Certainly within ethnographic and interview research that requires interaction, a shared experience can actually enhance empathy. Finch (1984: 79) suggests that during her study of clergymen's wives, the fact that she too was a clergyman's wife (at the time) meant that she was perceived as 'one of them' by respondents, which she argues both equalized the relationship and justified her interest in the issue. Katz-Rothman (1986) takes this one step further when she writes, 'I could not have understood it intellectually I don't think, if I had not experienced it emotionally'. Wilkins (1993) similarly writes that she would not have attempted her research on motherhood if she did not have personal experience to draw on.

Clearly there is an increasingly widespread acceptance of the fact that 'personal narratives offer uniquely privileged data of the social world' which has in many respects led to a 'celebration of the researcher's tale' (Atkinson *et al.* 2003: 53). Not only does a shared experience between the researcher and the researched open up the possibilities of respondents placing a great deal of trust in the researcher, possibly leading to them reveal private and personal aspects of their lives, but increasingly there has been a move towards the researcher's tale being *the* focus of social research. Such an approach centres on the explicit positioning of the self in the text. Broadly bracketed under autoethnography, this approach is highly critical of many traditional forms of research. Of particular concern is the tendency for research to separate the researcher from their experience of fieldwork. As Atkinson and colleagues (2003: 61) point out, such approaches 'serve to isolate rather than integrate, the self into the field. They attempt to establish a separateness and distance that is not really there'.



This has led many to be highly critical of research that effectively ignores the self. As Reinharz (1992: 263) makes clear, 'I have feminist distrust for research reports that include no statement about the researcher's experience. Reading such reports, I feel that the researcher is hiding from me or does not know how important personal experience is. Such reports seem woefully incomplete and even dishonest'.

Because of the explicit focus on the experience of the self in many autoethnographies, writers have fallen victim to charges of self-indulgence. As Reed-Danahay (2001) notes, the fact that autobiographical and reflexive approaches contradict the objective, standardised forms of research that are inherent in the positivist tradition, means that they are especially vulnerable to such attacks. Mykhalovskiy (1996) however questions the validity of such claims. To accuse reflexive, autobiographical work of self-indulgence is to make claims that the work is only about the self of the writer and nothing else. Similarly Stanley (1993) disputes the conventional distinction between biography and autobiography. This is because an autobiography rarely focuses on just one person. By confining the research to the self does not mean that we simply uncover the individual. To the contrary from one person we can 'recover social processes and social structure, networks, social change and so forth, for people are located in a social and cultural environment which constructs and shapes not only what we see, but also how we see it' (Stanley 1993: 45).

Whilst an explicit focus on the self will not be the case for my own research, my own story of my brother's death and my identity as a sister bereaved by suicide would be impossible for me to divorce from the research process. Indeed when beginning my research journey I felt that my personal involvement would have an impact on what I did. However the place that Joe's suicide played in the research did vary both between the online focus groups and in-depth interviews, as well as between individual interviews. In some of the interviews Joe's story played a relatively small part, apart from justifying my interest in the issue, as Finch (1984) found with some of her interviewees. But even then, Joe was not entirely absent. During my interview with Gayle for example, whilst we focussed solely on her experiences, at the end of our conversation she asked me:

I'm aware that I haven't asked you about your brother. I would love to, but I just didn't know if it was the right thing to do.

(Gayle, Kai's mother)  
(Face to face interview)

In other interviews there were times when Joe's story took a more central role within the conversation. Here we both engaged in a collaborative process of '*meaning-making work*' (Holstein and Gubrium 1997: 114) in an attempt to make sense of what happened, as we tried to understand their individual suicides:

Jane: By talking about Joe, you encourage other people to talk, um, I don't know what to call it, things that are on their mind. Through, um, by you willing to talk it not only helps you but it helps others.

Nina: Yes, yes. I can see that. I have definitely reached, um, a, a comfortable level of understanding about Joe.

Jane: Yes and that's why its really important that you talk about Joe. Rather than keeping everything in, it will help you to make sense of it all.

(Jane, Liam's mother)  
(Face to face interview)

There are of course problems with researching a topic so close to one's own personal biography. Issues surrounding exposure to emotional threat will be looked at in more detail later in this chapter. However, for now I wish to concentrate on a potential problem that surfaced relatively early in my research journey. When studying a topic that is so close to one's own experience, questions may be raised about the motivations behind the research – who is the research for? At the start of the research I certainly had many unanswered questions about my brother's death and I was concerned that I would fall victim to charges of 'mere navel gazing' and 'self-adoration' that have been levied at reflexive, autobiographical work; that my unanswered questions would come to dominate my research. A very practical way of overcoming this was simply to keep my research questions at the forefront of my mind at all times. However my research diary, which came to document both my journey through the research process and my journey through grief, proved invaluable. Here I continually reflected on my place in the research, how my own experiences could potentially impact on my thoughts about the research. Like Okley

(1992), I came to believe that 'self-adoration' is quite different from self-awareness and a critical scrutiny of the self.

A further problem is linked to questions of power. Even though I was interested in the biographies and experiences of others who had been bereaved by suicide (and how my own biography linked with the research) I was ultimately the person writing. As Iles (1992) argues, it is the researcher who decides who to research and determines what is included, what is left out and how the data is presented. What this ultimately means is that the need for reflexivity will be paramount. Indeed it is increasingly accepted that reflexivity should be an integral part of qualitative research. Broadly defined, reflexivity refers to 'a turning back on oneself' (Davies 1999: 4). To be reflexive is to continuously reflect on how the products of research are affected by the process of conducting research. It requires the 'constant (and intensive) scrutiny of what I know and how I know it' (Hertz 1997: viii). In its fullest sense then, reflexivity forces researchers to think through the consequences of every aspect of the research process (Okley 1992). And nowhere is this more important than in the research relationship and how my own identity would impact on the collection of data. It is to this issue that I now turn.

## **Rapport and Reflexivity in the Research Relationship:**

### **Contributions from feminism**

Developments in feminism (and post-modernism) have unquestionably contributed to the debate surrounding the place of the self in the research process. Within feminism, initial critiques about the absence of women from social research have developed into a much more fundamental set of challenges about the basis of such research (Davies 1999). More specifically they have argued that the basic theoretical perspectives that social research has been founded upon, while being treated as universally valid, are actually partial, presenting a male perspective as if it were objective truth (Davies 1999).

Historically, objectivity, rationality and value-freedom rather than involvement, subjectivity and emotion have been given academic status. However as Letherby

(2000) points out, even though such an approach to research is clearly historically gendered, the fact that it is, ultimately means that as a social construction it is open to choice and change. And as she goes on to illustrate, it is not just women who are concerned with the reflexive issue of the self (e.g. Hearn 1993; Mykhalovskiy 1996). These male researchers face similar issues, as Mykhalovskiy notes:

... the criteria of sociological orthodoxy as expressed by a masculine academic discourse or voice, itself propped up by forms of thinking, writing, *doing research* and so on. As sociologists, this is a voice with which many of us are familiar; which we listen to and often reproduce as part of our apprenticeship ... Autobiographical sociology gives offence to this voice.

(Mykhalovskiy 1996: 139 my emphasis)

It is the 'doing research' that I now turn to, specifically the research relationship.

The feminist critique of traditional approaches to research went on to mount the first critique against the ensuing research relationship. Feminist researchers were explicit in acknowledging the hierarchical power relations that were embedded in the traditional dichotomy between the researcher and the researched. They highlighted the potentially exploitative nature of such methods. In contrast they proposed an alternative approach, one based on trust, openness and empathy, with both the researcher and the researched sharing experiences and working towards a genuine egalitarian relationship (Oakley 1981). For Oakley (1981) the best way to find out about people's lives is through a non-hierarchical relationship, where the interviewer is prepared to invest their own identity in the research relationship, answering questions and sharing knowledge.

Central to developing a 'genuine egalitarian relationship' is the notion of rapport. The importance of rapport in any research relationship – but perhaps more so when the topic under discussion is likely to be distressing – cannot go understated. If the goal of interviewing is to understand the world from the participant's perspective (Fontana and Frey 1994), then this demands that that we gain 'empathic access' to the experiences they recount (Kvale 1996). A lack of rapport would mean that participants would find it difficult, if not impossible, to share and recount their memories of loved ones. Moreover, ideas about rapport and trust in the research relationship seemed particularly significant to the study of suicide, a sensitive and

painful issue, which is still relatively under researched qualitatively. I wanted to give a voice to the bereaved and felt it was important to try and understand their individual experiences. In order to try and do this, I endeavoured to reject any notion of hierarchy in the research relationship and focussed on authenticating their personal experiences as a valid form of knowledge.

Despite being extensively developed within the literature on feminist methodologies, Roberts (1981) argues that rapport and a commitment to taking other views seriously should not be seen as specific to feminist research. This is because the general principles of listening, empathising and supporting one's participants can be applied to any qualitative research. Indeed, I feel it was my identity as a sister bereaved by suicide, rather than as a woman, that allowed me to develop rapport in the research relationship. I found it easy to identify with many of the thoughts and feelings families were describing, whether face-to-face or electronically, and showed this by listening attentively, nodding, asking further questions and at times sharing some of my own experiences in both the interviews and focus groups. Generating such rapport helped to foster a mutually supportive environment and allowed me to reassure participants that what they were telling me was valued and of importance. As Rubin and Rubin (1995) explain, a 'conversational partnership' is important for the development of a successful research relationship. Moreover, the 'conversational partnership' should be based upon warm and authentic exchanges that allow for the expression of alternative viewpoints. This last point was crucial in my own approach to research. Despite our shared experience of suicide, I ensured that participants were aware that I did not 'know' their life-world. Rather I was seeking to understand their individual and different experiences of suicide, in the hope that we could uncover something about the complex event.

## **IN-DEPTH INTERVIEWS**

Thirteen in-depth interviews with families who had lost a young man to suicide formed one of my principle research methods. This method seemed the most appropriate for a number of reasons. Firstly, using more than one source of data collection has the potential of offering the methodological advantage of triangulation

(Denzin 1970), whereby the validity of the data can be checked and the weakness of some methods can be balanced out by the strengths of others. Secondly, I felt face-to-face conversations would complement, and perhaps offer different insights to the written narratives I hoped to collect online. Thirdly, I felt an overwhelming ethical concern to protect bereaved families' emotional wellbeing; suicide is unquestionably a sensitive issue and as we will see, produced particularly distressing and painful emotions. As a result I felt it was vital to choose a method that allowed me to spend enough time with participants, not only to build up rapport and understanding, but to ensure that their welfare was safeguarded. And lastly, I was keen to collect qualitative data because I wanted to provide an alternative way of looking at young men's suicide to that found in the psychological literature. Whilst there are a handful of researchers looking at the distinctly social nature of suicide, there is certainly an absence of qualitative research on suicide (Scourfield 2005). Rather than seeking to uncover psychological and environmental details of a young man's life and death, I wanted to explore what discourses families appealed to when making sense of their loved one's death – how they explain it to others and how they understand it themselves. As a result in-depth qualitative interviews seemed like the most obvious and natural choice.

The complex nature of individual suicides, and the different stories that were likely to be told, I felt necessitated an unstructured approach to interviewing. That is, rather than imposing a pre-determined schedule of questions upon passive 'subjects', the conversations were more informal, focusing on families' subjective meanings and understandings of suicide. The ultimate aim then, was to build an inductive theory from 'naturally occurring' data (Hammersley 1992). With this in mind, I would ask fairly general, open-ended questions that encouraged participants to talk at length about their loved one's life and death. Indeed my main priority was to understand their individual experiences, rather than to explain the phenomenon of suicide in young men (Fontana and Frey 1994). However the use of the terms 'structured' and 'unstructured' when describing interviews have been shown to be unhelpful. This is largely because in practice the different styles do overlap (Denscombe 1998). As Collins (1998) explains, even the most unstructured interview is structured in a number of subtle ways. Ultimately it is the interviewer who initiates the interview, and therefore, they have the control over the nature of the event. In reality, the

unstructured nature of my interviews did incorporate some elements of the semi-structured approach. Following both Fielding (1993) and Flick (1998), alongside the primary aim of exploring individual understandings of suicide, I would sometimes ask theory driven questions when families recounted experiences that related specifically to sociological ideas such as stigma, medicalisation and gender roles. In order to do this, I was guided by a schedule of possible questions to ask when potential themes were touched upon in the interview. What emerged, then, were interviews that were 'conversations with a purpose' (Burgess 1984: 102), enabling me to pursue specific ideas that related to my research agenda.

### **Negotiating Access and Sample Selection**

Identifying and gaining access to populations for research purposes is very often the first milestone to overcome and my research was no exception. My own involvement with a national support group for people bereaved by suicide seemed like the most obvious route. However this was not without its difficulties. For instance, should I speak to people that I have previously met or only to those survivors of suicide that I did not know? The relationship between the researcher and the researched has been the subject of a longstanding debate within qualitative research (Atkinson *et al.* 2003). Whilst recent developments within autoethnography have celebrated the personal dimension in research, qualitative method texts have always, as a matter of course, offered advice on maintaining a level of distance within the field to guard against the risks of over-familiarity (Atkinson *et al.* 2003). With this in mind then, I felt it was appropriate to only speak to families that I had not previously met. Nevertheless with this decision I encountered a further dilemma. By only talking to people who were in contact with a support group could mean that I would only be speaking to those who felt willing and able to share their stories anyway. What about those families who had no contacts with a support group? Would they represent a 'different' type of survivor, one who not only found it difficult to share their story but had reached a different level of understanding without the guidance and support of group leaders and other survivors? This dilemma was not initially overcome but was eventually resolved through the course

of my research (three survivors were recruited through word of mouth or opportunity sampling who were not in contact with a support group).

My first approach for gaining access to bereaved families was to phone a number of support group leaders from around Britain. I began the conversation by giving a brief summary of my research before asking if I could send them more information for them to circulate in the support group meetings (see appendix one for the initial letter sent to group leaders). Despite two group leaders agreeing, I was surprised by the level of hostility that I received. Indeed one group leader informed me that he was “fed up with *you* researchers and journalists trying to pry into our lives”. He validated his resentment by telling me that the BBC had contacted him only a few weeks previously. This certainly opens up the debate about over-researched subjects and populations. In terms of my own research, it was only when I disclosed my identity as a sister bereaved by suicide that access was opened up to me. The relationship between gatekeepers and researchers has been written about, specifically the importance of having a shared investment in the goals of the research (see e.g. Arcury and Quandt 1999). Whilst I am not suggesting that the group leaders shared a commitment to the research, my experience of suicide certainly justified my interest in the topic and helped to secure access to potential participants.

The letters given out within the group meetings (see appendix two) only resulted in three people contacting me to say that they were willing to take part in the research. The same support group however, also organises an annual conference aimed at both practitioners and survivors of suicide. After seeking permission from the overall leader, I used the conference as an opportunity to talk to people about my research. I had a stall publicising my study (see appendix three) and gave out an information pack for families to take home with them (see appendix four). This proved a more successful approach and resulted in a further seven people agreeing to take part. To obtain a more detailed description of the composition of the sample, please see appendix five.



## The Interview Procedure

Interviews were typically arranged over the phone, where I gave participants the choice of where to conduct it. The majority were happy to be interviewed at home, although three participants preferred the interview to take place away from their own environment. In these situations I contacted the local college or university in their town to book a room at their institution. The interviews varied greatly in time, lasting anything from two to five hours, although the longer interviews often involved us eating together. I was keen to create a relaxed and informal environment, whereby families felt able to share their painful experiences. At the same time however, I was aware that families may feel uncomfortable with sharing particular stories. Therefore I also made sure they knew that not only what they were telling me would be confidential, but they could retract things at a later stage, once they had reflected on the interview.

With this in mind, the questions were open ended, providing families with a general frame of reference rather than imposing constraints on the range of answers (see appendix six for the interview schedule). I opened the interview up by asking families to talk to me about who they had lost, for example who the young man was and what was important to him. There were a number of reasons for beginning the interview in this way. Firstly, I was aware that it may be difficult for families to start with the story of the death. Indeed to do so would have laid open the possibility for participants to simply give a 'stock response' – the story they have rehearsed to tell whenever confronted with the question 'what happened'. Rather I was keen to uncover a more reflexive account of the young man's suicide. In addition, to begin the interview by asking families to tell me about their loved one's life would help me to see if their descriptions of the young man's life 'fit' with their understandings of his death. This part of the interview was particularly successful, especially for the parents, with families appreciating the opportunity to talk at great length about their loved one's life.

In keeping with this approach, I drew upon the idea of 'active interviewing', proposed by Holstein and Gubrium (1995, 1997), where both the interviewer and

the interviewee jointly contribute in the process of ‘meaning-making work’. In order to work towards this collaborative understanding, I was aware of the need to recognise that bereaved families were not simply ‘vessels of answers’ (1997: 114 - 116) – their role is not to simply respond passively to an interviewer’s questions. On the contrary, they were active participants in the joint production of knowledge about suicide in young men. Thus, whenever possible I refrained from overly steering the conversation in a particular direction, instead allowing families to talk openly and freely about whatever they felt was important. I asked fairly open ended questions, giving families plenty of time to think and reflect on the memory of their loved one. Moreover it is important to note that silence can often be as effective a strategy as questioning in an interview (Fetterman1998), as it allows the participant to develop their own train of thought. This was especially true in my interviews with bereaved families, who often got ‘lost’ in the memory of their son or brother when recounting memories that had sometimes been suppressed for a long time. Anderson and Jack (1991) also emphasise the importance of listening when a researcher is interviewing women, as the majority of my participants were. In particular, they suggest that women give out multiple messages through both ‘dominant’ and ‘muted’ channels, and so it is important to attend to what is *not* said as much as to what is said. It is this need to pay attention to what is unspoken that I now turn to.

### **The ‘Joint’ Interview – Common connections between the bereaved**

The unstructured nature of these interviews also facilitated a further important aspect of my research. Losing a loved one to suicide shatters families’ previously held meanings about the world. It was their search for new meaning which could effectively position suicide within it that I was particularly interested in. Therefore, rather than uncovering families’ pre-existing information, the interviews were designed to allow us to explore ideas together through the negotiation of meaning (Kvale 1996). There is a long-standing recognition that every research interview is a unique encounter, and the knowledge produced will depend on the interactions between those involved at that time (Denzin 2001). With this in mind, perhaps the biggest decision that I had to make was whether to bring my identity as a sister bereaved by suicide in to the context of the interview. To make either decision – to

disclose or not – would unquestionably impact on the nature of the interview and the subsequent data produced. Indeed there is a large amount of writing that recognises the impact that disclosure can have on the research relationship (Ramazanoglu 1989; Letherby 2000). As I had previously justified my interest in the issue in my opening letter to participants by explaining that I had lost my younger brother, I felt to hide Joe from the interview would appear dishonest. Nevertheless, I would not openly volunteer information during the interview unless I was specifically asked. I did not see my own experiences as an essential ingredient of my approach to interviewing, although they did make a difference. This difference is important to consider practically, theoretically and politically, not least because sameness may distance ‘participants (researcher and researched) from a critical reflexive research process’ and may privilege ‘one point of view over another’ (Hurd and McIntyre 1996: 78). I will look at the reflexive work needed when undertaking research that is so close to my own personal biography and the research relationships that were created as a result in the next section. However for now I turn to how my identity impacted on the *data* itself, specifically what was left unsaid.

Losing a loved one to suicide throws family members in to a world full of secrecy, isolation and guilt (Alexander 1991). It also propels them into a world imbued with bureaucracy and suspicion. Following any suspected suicide, evidence is heard in a Coroner’s court, where the cause of death is then decided. It was when conversations centred upon families’ experiences of the Coroner’s court that things were often left unsaid, as is apparent in the following conversation:

Susan: It was horrible, just horrible. You know how it is, what it’s about.

Nina: Hmm, so tell me more about it.

Susan: It was just horrendous ... Oh I can’t really remember.  
(Susan, Zack’s mother)  
(Face to face interview)

As a family member who has been through the traumatic and clinical nature of the Coroner’s court, I did know all too well ‘what it’s about’. And it is precisely because of this that the conversation didn’t go any further. So although I had considered my place within the research my identity inevitably impacted on the research in

unforeseen ways. A potential consequence I had considered, although had no way of knowing the outcome, was exposure to emotional threat for both myself and my participants. This signals the constant self-examination and scrutiny needed when conducting research so close to one's personal biography and it is this that I now turn.

### **Making and Maintaining Relationships – The importance of reflexivity**

I did believe that my personal experience would make it easier, rather than harder, to do research on suicide. Not only did it justify my interest in the topic, but experiencing the pain and trauma of losing a loved one to suicide meant that we both lived in the same 'world'. Oakley (1981) has suggested that by investing their own personal identity, researchers can go some way to creating a non-hierarchical research relationship. Indeed for Oakley (1981) it is only by appealing to sisterhood can researchers equalise their relationship with their participants. And it hasn't only been gender that has been highlighted – during her research on clergymen's wives, Finch (1984: 79) found that revealing her own identity greatly improved her interviews. Once participants placed her as 'one of them', they were happy to talk. Similar findings came out of my research:

We won't discuss this anymore with anyone else, you know, we know we can trust you because you've been through it.

(Peter, Joel's father)  
(Face to face interview)

and;

It's so good to talk to someone who knows.

(Lisa, Aaron's sister)  
(Face to face interview)

Families would also often talk about the benefits they felt having spoken to me at length about their loved one. The following responses were typical:

I mean I think it's so helpful to talk about it. 'Cos you don't get the opportunity really. It is, it's cathartic.

(Jan, Gareth's mother)  
(Face to face interview)

Anyway, thank you very much for listening. This has meant a lot to me.  
(Jane, Liam's mother)  
(Face to face interview)

Nina, this has been good for my soul.  
(Susan, Zack's mother)  
(Face to face interview)

Such responses are undoubtedly the result of the 'silent world of suicide' that bereaved families often find themselves in (Alexander 1991: 3). Suicide is unquestionably a stigmatised death which families are all too aware of, and can often mean they are reluctant to voluntarily bring their son or brother in to a conversation (see chapter seven). However I am wary to expel the therapeutic benefits of the research interview as providing an opportunity for families to talk about their loved one. In terms of the power balance and risk to participants, there are potential problems with the trust that they placed in me. As Finch (1984) argues, research about private and personal issues, particularly those concerned with taboo or sensitive topics can make people vulnerable. I also suspect, as Letherby (2000) did in her research on the involuntary childless, that my close personal connection to suicide encouraged families to tell me intimate details of their lives that they may not otherwise have done. Indeed my continuing involvement with a national support group means that there are times when I come into contact with the people I have interviewed, and there have been occasions when participants asked if some details would not appear in the final thesis. However this occurred relatively early in the interview process and whilst I do not believe the interview should be a counselling session for researcher or researched, it did force me to think further about the research relationship. Like Collins (1998), I believe that the interview is a complex social construction within which roles and selves are jointly negotiated.

These early assumptions were borne out during the process of interviewing. Despite my initial hesitancy about how much to reveal about my own circumstances and my concern to only volunteer information when asked, many of the interviews did involve two way conversations. Sharing the similar painful experience of losing a loved one to suicide would often mean that families were interested in how I had

coped, how I had learnt to live with my brother's death. The following are just some of the many questions that I was asked during the interviews:

I'm scared that the memories that I have of him are it. I can only remember the same few memories and I'm scared that that's gonna be it. Is it the same for you?

(Lisa, Aaron's sister)  
(Face to face interview)

Jane: We'll never know everything because he was the only one who could ever tell us what all the missing pieces are.

Neil: Did you have the same experience?

(Neil and Jane, Liam's parents)  
(Face to face interview)

When something like this has happened to us, people tell you all sorts of things. You find out all sorts. Have you found that?

(Susan, Zacks mother)  
(Face to face interview)

So what was the, if you want to talk about it, what was the background to your brother? Had he, had he any previous attempts of suicide or...?

(Jack, Adam's father)  
(Face to face interview)

During my research I spoke to people whom I felt I shared something with in terms of experience. Suicide however is a complex event and I inevitably spoke to families whose experiences were very different to my own. As a result I do not share Katz Rothman's (1986: 50) view that 'I could not have understood it intellectually ... if I had not experienced it emotionally'. In fact where my experiences were very similar to the families that I was speaking to, I often found these interviews harder than with those families whose circumstances I had less in common with. The amount of emotional management and emotional work that was needed for these interviews was far greater, and I would often find myself reflecting on my brother's death for some time after the interview. However, I also spoke to families whose loved one had attempted suicide on a number of occasions, had been involved in the psychiatric system for many years or had a history of drug abuse, yet none of these

fit with my own experiences. So whilst I obviously identified with the feelings of pain and loss that the families were going through, everyone's experience was different. As Temple (1997: 5.2) had said, 'it is by listening and learning from other people's experiences that the researcher can learn that the 'truth' is not the same for everyone'.

## **Risk and Emotions**

A study that is based on a particularly sensitive subject such as suicide cannot ignore the issue of emotions, not only of the respondent but also for the researcher. Traditionally, social science research has been shaped by the belief that emotions need to be cut out of the research process (Tierney 2000). This detachment was considered to be the best way of achieving a key priority of research that is obtaining information from respondents. This is based on the assumption that the research encounter is a neutral means for eliciting information, and therefore has no effect on the people involved (Owens 1996). Developments within feminism, ethnography and the social sciences more generally have seriously begun to question the value of such an approach. As Ely and colleagues (1997) maintain, feelings of intimacy and warmth towards one's research participants are not only natural, but are in fact essential part of research. An idea that was arguably brought to the fore by feminists, the overall belief that research necessarily involves *emotion work* (Frith and Kitzinger 1998) is now widely accepted.

Many researchers feel strong emotions in the field, and this can be exacerbated if the researcher has been personally affected by the topic under discussion. This was certainly found by Letherby (2003) during her research with women who had suffered a miscarriage. She writes, 'In my doctoral research I found that listening to the accounts of my respondents was often very distressing, and this was compounded by the fact that what they were describing often resonated with my own feelings and experiences' (Letherby 2003: 111). My personal involvement to the research meant that a consideration of the emotional management and emotional work needed was vital before I began the process of interviewing. Despite this, I really had no way of knowing how I would react the first time a participant cried.

Although I never cried during the interviews, I would often have to work hard not to. DeMarras and Tisdale (2002) give practical responses that can be used if the person being interviewed becomes upset which include giving them a break from the interview or providing them with information regarding relevant support groups. Whenever my participants cried I always offered to stop the tape or end the interview and had provided a guide to support for them at the beginning of the interview (see appendix seven). Indeed as I have previously suggested, many families spoke about the benefits they felt by talking about their loved one. For example, at the end of our interview, Lisa told me what she had gained from the experience:

I didn't know what to expect but it has been okay. I don't really talk to mum or dad or anyone really. It has been really good to talk to someone that's not involved.

(Lisa, Aaron's sister)  
(Face to face interview)

But despite many similar sentiments, I found the times when participants were visibly upset particularly challenging. What I found most difficult was not being able to 'help', especially as I felt I had caused their distress. So whilst I was aware of the need to establish trust and rapport so that my participants perceived the expression of emotion as safe and confidential, whenever they became upset I was often left wondering if I had handled things in the right way. Indeed as McRobbie (1982: 55) notes, at times the researcher can feel as if she is 'holidaying on people's misery, leaving the participant to cope with the consequences once the researcher has got what she came for'.

My concerns about the emotional impact of the research on families, coupled with my own involvement to the research meant that there were times when the research was particularly challenging. I shall illustrate this with an example of one research experience. I first met Neil and Jane at the support group's annual conference and they were both really eager to take part in the research. When I arrived at their home, they greeted me with a very warm welcome and invited me to have food with them. Once we had eaten and the interview had been conducted, they were keen to show me their son's room, possessions that were important to him, books he had read, artwork he had drawn, even clothes he had worn. I found this very difficult but I could see that this was important to them. They wanted me to see what their son



was like, rather than simply hear stories about him. As a novice researcher however, I found it difficult to manage the situation and the emotion work needed for this particular interview left me feeling exhausted.

Attending to my own emotional responses to the research, working through ways of managing my feelings, like Ramsey (1993 in Letherby 2000) I feel placed me clearly within the research process. My emotional involvement with the research also meant that there were times when participants left their role of researched. My own experiences, coupled with my age meant that a lot of families showed concern for me. Several participants asked if there would be anyone at home for me and some expressed concern for my drive home. Others showed concern about my own well-being as a result of carrying out research so close to my own personal biography. One participant wrote to me saying that they really appreciated being a part of the research and asked if there was anything else they could do for me.

Whilst it is difficult to know if the families felt a connection to me, as well as the research itself, our shared experiences certainly fostered a mutually supportive relationship. However, like Oakley (1981) I feel that one sign that points to our joint investment in the research are the friendships I have gained as a result. Indeed two friends made during the research process have developed into extremely close friendships, built explicitly on our shared experience of suicide.

It was these shared experiences and my knowledge of often frank and open discussions among fellow survivors that motivated my decision to carry out research online. I was particularly interested in the reported benefits of a space away from the judgment of others and the potential that this had for conversations about suicide. In the next section then, I consider the practical issues involved in carrying out research online before taking a closer look at the resultant talk that ensued.

## USING THE INTERNET FOR RESEARCH

There are more than 102,000,000 users of the internet worldwide (Mann and Stewart 2000) as such, researching online is clearly a fruitful tool in accessing the hard to reach bereaved by suicide population. Through this electronic research method, I worked with nineteen people in a focus group format. Online environments are arguably established as cultural contexts in their own right, distinguishable from wider society. However, their use within social research has been approached somewhat tentatively, particularly as researchers are often anxious to acknowledge this underlying caveat (Williams 2003; Stewart and Williams 2005). But as Williams (2003) goes on to suggest, many of the methods used in offline research, can be modified and then applied to the online world. Indeed there has been a rise in the use of online methods in recent years. Sociologists are increasingly using computer-mediated communication (CMC) to access geographically dispersed populations and consider issues that people might find difficult to talk about face-to-face. Such topics have included the potentially stigmatising subjects of alcohol dependency (Denzin 1998) as well as people's experience of inflammatory bowel disease (Robson 1999) and young women's perceptions of health risks in China and Australia (Stewart *et al.* 1998).

The in-depth interviews revealed that families were able to talk at length about their experiences. However, this was conditional on the assurance of the presence of an understanding listener and comfortable setting. The online focus group was able to offer this reassurance, creating a space for participants to offer their stories and to respond empathetically to others. As I was particularly interested in the way that bereaved families spoke to one another, what they brought up in conversation and how they responded to others, a virtual focus seemed like a natural choice. Indeed I was specifically concerned with the ways in which people talked about suicide and their experiences of losing a loved one through CMC. More generally Selwyn and Robson (1998) emphasise the value of emails as a form of communication that combines the efficient exchange of knowledge, with a relaxed, informal style. This process is also thought to encourage honesty in respondents and here works to complement the approach I undertook in the unstructured interviews. The Internet,

then, may appeal to bereaved families as a place of sanctuary distanced from the 'real' world, all the more inviting given the stigma attached to suicide in contemporary society. As I discuss in chapter seven, the taboo surrounding suicide ultimately serves to silence it. Despite an arguably more sympathetic and understanding approach to suicide since the days of it being an illegal act, relatives still spoke of the shame attached to suicide. In her work on the stories of people left behind, Alexander (1991) notes that even when people's reactions are overwhelmingly sympathetic, relatives still spoke of an element of uneasy questioning; what went on in that family to drive a person to suicide?

In this respect the Internet offers the chance for families to talk freely about their loss, away from any expected (or unexpected) stigma. King (1995) has said that this is one of the greatest advantages of the Internet. In her research on suicide support groups, she argues that, the power of the Internet is that it provides a calming atmosphere for discussion of ideas, which if discussed face-to-face may arouse tempers and biases. Furthermore the medium itself might prove conducive to the expression of otherwise silenced opinions. King (1995) further states that she found participants reported feeling less inhibited online, particularly as there was a lack of visual cues. Similarly Markham (1998: 79) explains that the internet provides people with the potential to feel connected to the world, enabling them to 'be more like themselves because they can backspace and edit their words prior to uttering them'. This may be especially significant when the topic of discussion is sensitive. As Walther and Boyd (2002) found in their study of Usenet support groups, members would often speak positively about the reduced sense of negative evaluation by others. This in turn led them to find potentially stigmatising and embarrassing disclosures a less risky prospect than it might be face-to-face. Ultimately then, the relative anonymity of CMC together with its textual rather than physical embodied nature could prove an important factor in attracting those who have lost a young man to suicide.

## Approaches to Internet Research

The Internet encompasses a range of different approaches to CMC, each with their own unique characteristics making them more or less suitable to any given research project. At the basis of such communication lies a fundamental distinction between forms which are real time (synchronous) or not (asynchronous) (Stewart and Williams 2005). Broadly speaking communication that is synchronous tends to be more chaotic and 'messy' than asynchronous. The immediacy of such CMC can also make it resonant of offline communication. Indeed much of the synchronous 'talk' consists of utterances that are typical of speech, such as grr and hmmm. In contrast asynchronous communication allows people to send more considered and measured responses, and as a result they tend to be lengthier than that found in synchronous communication (Stewart and Williams 2005).

These very different forms of CMC had the potential to provide me with very different stories of suicide. The nature of synchronous CMC, specifically the fact that it occurs in real time, means that interactions are often quite fleeting and of limited content. In addition, such an approach to research is notoriously difficult to monitor (Williams 2003; Stewart and Williams 2005). Since my ultimate aim was to uncover detailed qualitative data, it seemed more valuable to use asynchronous CMC. Such an approach meant that families could not only choose when to reply, but they could take as much time in reflecting on their responses. Asynchronous CMC also allows large groups of people with similar interests and ideas to exchange information and ideas. It was this potential that I found appealing, particularly the opportunity for families to discuss hidden or silenced thoughts.

Asynchronous approaches to CMC are broadly made up of those that are accessible to all users of the Internet – such as a publicly accessible bulletin board – and techniques that restrict access to members who have subscribed to the group – such as a subscription based newsgroup. The sensitive and distressing subject of suicide, I felt made the latter approach the most sensible option as it can provide respondents greater protection by safeguarding their privacy. More specifically an email based distribution list seemed the most appropriate option, as it does not use Internet based

archives of messages. Rather there is a central email address to which all responses are sent, before being pooled and then sent back out to those subscribed to the list in a digest form (Stewart and Williams 2005). The advantages of using a digest email also means that the moderator can remove any identifying 'header' information and ask further questions. Moreover as Stewart and Williams (2005) observed, they are easy to organise and run, making them particularly suitable to the novice researcher. Not only did I choose to make the list a closed subscription, but I also opted to ensure the list was moderated. I felt that it was necessary to edit identifying names and places on the messages before they were distributed to the list in order to protect the privacy of those involved.

### **The 'Suicide-Research' Mailing List**

As a means of facilitating the recruitment of participants to the mailing list, I created a website in order to introduce my research to potential participants; this is represented in appendix eight. On this webpage I included a short introduction detailing what had brought me to the research, a description of the research itself, instructions on how the mailing list would work, and a hypertext link for potential participants to subscribe to it. This link included a number of conditions about how I would use their data which participants were asked to read through and agree to. Once I had their agreement participants were then asked a short series of questions about their loved one and to choose a pseudonym, which would be used for the mailing list. Once the website was set up I visited the home pages of two major Internet search engines – *Google* and *Yahoo!* – to request the URL address of my site be added to their index, which was achieved successfully. Clearly the aim here was to catch the attention of Internet users, browsing through the search engines with the key words 'suicide' and 'suicide research', who could then be directed towards my website.

Such an approach however would not guarantee recruiting the number of participants needed for a successful online focus group. Therefore I felt it was also important to recruit people more actively. I decided the best way of finding surviving relatives and friends was to target a purposive sample from existing online support groups and

bulletin boards. Indeed Williams and Robson (2004) maintain that this use of 'captive' populations is particularly successful for recruiting people diagnosed particular condition of mental or physical health (Williams and Robson 2004). Therefore I visited several online newsgroups (e.g. SOLOS-sibs@yahoo, Journey through Suicide Grief and When a Loved One Commits Suicide) and bulletin boards (e.g. Healing after Loss) and collected the email addresses of as many members as I could. On all of these sites, members choose whether to give out their email addresses and did so, only if they were willing to be contacted, so I hoped I would not be invading the privacy of others. To the 1200 addresses I obtained, I sent out an access letter by email, introducing myself and my research and inviting people to visit the website to find out more about it (see appendix nine). Initially I had concerns about angered responses to an invasion of privacy from those that had received the email, although this did not happen. However as Williams (2003) notes an email is more likely to be ignored than produce an angered response. And this could certainly have happened with my research; of the 800 people I contacted, seventeen people responded, a response rate of two per cent, which is not uncommon for this technique (Williams 2003). A further two people joined over the next few weeks, having found my website whilst surfing the internet. This made a total of nineteen members, although only ten participants contributed to the written narratives.

### **The Virtual Focus Group**

The Suicide-Research mailing list mirrored the method of a virtual focus group, outlined by Bloor and colleagues (2000). Through this forum, participants were encouraged to engage in a dialogue with other members, sharing experiences and thoughts with each other in a free and open conversation. As in an off-line focus group, this virtual discussion rested on the interaction between those bereaved by suicide as a way of exploring their individual understandings and beliefs about suicide. I was particularly interested in the way that families and friends communicated with each other about suicide, what they thought was important in their loved one's death and how they have coped with the loss. Because the communication was asynchronous, the discussion developed in ways which would not have happened in face-to-face interactions. Whilst participants sent personal responses to questions,

members would also respond to each others previous posting, edited into the original response as an interjection.

Just as with the in-depth interviews, I drew on the feminist model of interviewing with its associated emphasis on rapport, reciprocity and a commitment to building egalitarian research relationships (Oakley 1981; Finch 1984). However as Mann and Stewart (2000) observe, it can be difficult to translate these principles to the online environment because of the lack of visual cues that would otherwise convey empathic responses. Online researchers do not have environmental or contextual information available to them. As a result CMC is rife with the possibility for misinterpretation (Stern 2003). The nuance involved in face-to-face communication is lost. Tone, volume, facial expressions and gestures all provide cues for the interpretation of messages; these cues are missing in online communication. Put simply the researcher cannot 'see' a smile or a sigh. The lack of physicality means that the researcher needs to work hard to establish rapport and trust between individuals linked only by a computer (Illingworth 2001). Nevertheless, I did strive to build rapport with members through textual communication. I would thank participants for their contributions and reassure them that what they said was of interest by asking them further questions about their narratives. Whilst such gestures were delayed by the asynchronous nature of the email, as O'Connor and Madge (2001) argue, they can help to convey the idea that the researcher is listening non-judgmentally, emphasising the fact that the research is a collaborative experience.

The first email sent to participants was an introductory 'welcome' message, asking them to introduce themselves and explain what had brought them to the research. Similarly to the in-depth interviews, I also encouraged them to talk about who they had lost, for example, how they would describe him and what was important to him. The discussions then continued onto topics such as the actual story of their loved one's suicide, their experiences with others outside the immediate family and successful routes of support. I organised the group discussions into 'threads' of different topics, directing members to ongoing conversations. Whilst I initiated 'starter' conversations, there were times when participants would voluntarily bring up topics. These discussions included a number of members comparing their experiences. However, many of participants preferred to write personal narratives to

share with the group rather than engage in conversation with others. What resulted was a series of rich, detailed accounts of their experiences of losing a loved one to suicide.

As the mailing list developed, and members began to learn about each others circumstances, participants started to provide emotional support to each other as well as simply exchanging information. In some respects such sharing of thoughts, feelings and support seemed to develop into a shared sense of a virtual community (Rheingold 1993). Indeed Wellman and Gulia (1999) have argued that the continued growth of the Internet means that online 'worlds' have the potential to provide social networks that are no less integrated and cohesive than those found in the offline world. And this is only furthered when the reason for the creation of the online community is to discuss a 'silenced' death. Such supportive environments, then, have the opportunity to foster an empowering effect upon stigmatised or socially invisible groups. The largely deviant subject of suicide that participants had come together to talk about might normally pose a barrier to interaction, but the knowledge that others were a member of their 'own' and 'wise' groups (Goffman 1968) really opened up conversations. Free from the restraints of face-to-face conversations on what they can talk about, the narratives were often very graphic in their content. Interestingly participants self-monitored this talk by warning others that their narratives contained distressing information by inserting the word 'graphic' in the subject header of their email. This practice is common within the community of Internet suicide support groups, a practice they voluntarily brought with them to the Suicide-Research mailing list.

It was not only the graphic nature of the online narratives that marked a difference with the face-to-face narratives. Conversations were often very open and honest, centring on the participants own emotions and recovery. Indeed, it has been reported that families who have lost a loved one to suicide are themselves at an increased risk of suicide (Wertheimer 2001). And within the suicide-research mailing list, a number of the participants discussed their own suicidal feelings. In face-to-face interactions, many reported being unable to share thoughts of suicide with others for fear of the potential reaction. As Jess explains:



If I could take a pill then I would. If only I could close my eyes and never wake up. I agree it is something that I would never do but I could never say that to anyone.

(Jess, Daniel's partner)  
(Online focus group)

Within the context of 'knowing others', families often reflected on thoughts and feelings that would normally be hidden. The knowledge that they would only be sharing their story with others who had been bereaved by suicide really seemed to 'free up' the conversations. If we look at another example from Kim:

I'm dying inside. I feel like I'm existing not living. The guilt is sometimes too much and its then when the thoughts come. I said this to a friend once and she just looked and me like, how could you do that to Hannah?

(Kim, Sam's mother)  
(Online focus group)

The lack of visual cues as well as their shared experiences certainly seemed to foster an environment whereby participants felt safe to share difficult and challenging emotions. This of course raises some ethical issues. Whilst the reduced sense of social presence and the seemingly anonymous nature of CMC helped to create an environment where families felt disinhibited and deindividualised (Joinson 1998; Scott 2004) participants may have felt moved to share intimate details of their lives that they may later regret. Moreover whilst the talk about suicide was not explicit threats, thoughts of suicide were still expressed. In addition the lack of physicality meant that any action or response to such talk was not only delayed but also distant. When conversations did drift into talk about their own suicidal feelings, I would ask participants if they were feeling suicidal and to talk through their thoughts with someone they trust or a confidential helpline. Even though all participants assured me they were not feeling suicidal, I was still left wondering if I had handled things in the right way.

Despite my concerns, comments made by the participants showed they valued the opportunity to express feelings they previously felt they needed to hide. As Kim explains:

Everyone here \*knows\* There is no room for shock or holding things back

(Kim, Sam's mother)  
(Online focus group)

Similarly, Zeke explicitly stated that:

I am the most open about Paul in forums such as this. We are all anonymous and therefore I don't have to protect anyone

(Zeke, Paul's father)  
(Online focus group)

Moreover it was when conversations were about particularly difficult emotions that the supportive nature of the group was developed. To look at some of the responses to Kim's admission of having suicidal thoughts:

I applaud you for being honest about these feelings that we no doubt all have. Suicidal thoughts are taboo generally, but if you yourself have lost a son to suicide then they are absolutely not allowed! Which is ridiculous because we need to share them.

(Camille, Hugh's wife)  
(Online focus group)

I agree completely. If I was to ever tell someone I had those thoughts then people would think I was the most selfish person on earth! Its actually quite reassuring to know that its normal and that I'm not selfish. Always remember that there will be someone out there who understands on groups like this when you next feel down. Lets not hide these feelings away!

(Tanya, Oliver's mother)  
(Online focus group)

The shared experiences and feelings expressed by the members of the focus group ultimately created a supportive environment in which the participants encouraged each other to express their inner most thoughts.

## ETHICAL CONSIDERATIONS

Talking about suicide is understandably very upsetting. This fact is heightened when talking about a person who was very close. Therefore to assume that my research would not cause distress in participants was simply naïve. The inevitability of the pain and sadness that participants felt as a result of this research means that a strong adherence to the British Sociological Associations (BSA) (2002) codes of ethical standards was of utmost importance. Whilst it was relatively straightforward to apply the codes of ethical conduct to the design of the interviews, Internet research poses some unique and challenging ethical dilemmas. Indeed Williams (2003: 99) maintains that 'ethical considerations of online participation must temper the enthusiastic rush to have a go'. And whilst some attempts have been made to develop a set of ethical guidelines for Internet research (for example the work of organisations such as the Computer Professionals for Social Responsibility and the Association of Internet Researchers) as yet there is no overall agreement over which to adopt (Williams 2003).

First of all, it was important to inform participants of the extent to which they could be guaranteed anonymity and confidentiality. They were aware that each participant would be provided with a pseudonym and that any identifying information (such as the names of people or places) would be removed in order to protect them from any unwarranted scrutiny. With Internet research however, guarantees of anonymity and confidentiality are harder to provide. As Williams (2003: 102) goes on to comment, 'in computer-mediated communications, complete anonymity is almost impossible to guarantee, as information about the origins of a computer transmitted message is, for most users, almost impossible to remove'. The discussions were set up to take place through a group moderator, myself, who received the emails before I sent them back out to participants. This meant that identifying and 'header' information could be disguised. However the danger of 'deductive disclosure' still remained. Even though identifying information was removed there was still the possibility that participants were able to identify the author through the stories told or other distinguishable features, such as sentence structure, personal marks or repeated spelling mistakes (Williams 2003). This was particularly likely as members 'cross post' messages to

different, but related internet groups, as other people may be able to determine the offline identity of a poster through their distinguishing features.

It is important for all participants who take part in social research to do so voluntarily, and this research was no exception. It would seem however that you cannot have voluntary participation without informed consent. The BSA (2002: 3) suggests that authors need to, 'explain in appropriate detail, and in terms meaningful to participants, what the research is about', why it is being undertaken and how the data are to be used. The in-depth interviews provided me with the opportunity to discuss with participants what I hoped to achieve from the research and also to answer any questions that participants had prior to the interview. Seeking consent from participants recruited for the online part of the research was also relatively straightforward, in that a response necessarily implies consent (although as Williams (2003) questions, is virtual consent enough, with its absence of a signed and tangible agreement?). However, it was also important to ensure that this consent was informed. Therefore I emailed participants privately once initial consent had been given, detailing their rights and responsibilities, making it clear that the discussion would be part of an academic project and not a self-help or support group.

Protecting respondents from psychological or emotional harm was, of course, of great importance. Lee (1993: 4) explains that research can be viewed as harmful if it 'potentially poses a threat to those who are or have been involved in it', and this can happen in any number of ways. The BSA (2002: 4) guidelines state that participants are at risk of harm if they 'perceive apparent intrusions into their private and personal worlds, or where research gives rise to false hopes, uncalled for self-knowledge, or unnecessary anxiety'. All of these possibilities could result from my research and therefore it was essential that participants were aware that if they found any question inappropriate or distressing, they had the right not to answer it. This feature was complicated within the online focus group because of the numbers involved; it was no longer my own responsibility to avoid distressing participants as they could become upset by comments made by other members of the group. However in addition to the right to refuse to answer a question, I made it clear to respondents that they could retract anything they said and later regret, once the interviews and focus groups had taken place. Of course all participants were also made aware that

they had the right to withdraw from the study at any time. Finally it should be noted, that the majority of participants were recruited from various support groups for people bereaved by suicide. As a result participants were used to sharing their story of suicide. And whilst it is certainly the case that talking about suicide can be very upsetting, it has also been suggested that talking about suicide can actually help people with their grief. Indeed participants in previous similar studies have noted the beneficial effects of such research, valuing the opportunity to talk about their friend or relative who has died (Hawton *et al.* 1998).

## DATA ANALYSIS

Data analysis is not a separate, distinct stage of a research project, but rather is a continual process, informing data collection, writing and further data collection (Miles and Huberman 1994; Hammersley and Atkinson 1995; Coffey and Atkinson 1996; Kvale 1996). As Coffey and Atkinson (1996) maintain, data analysis should develop as an ongoing process, whereby we reflect upon the findings collected so far. However, if tentative analysis begins at the preliminary stages of data collection, then the substantial process of in-depth analysis began once all the interviews were transcribed and the online focus group had reached its end. It is to this process of analysis that I now turn.

My experience of data collection had a profound impact on my initial approach to analysis. During the interviews, families would often engage in a painful yet meaningful search for an understanding behind their loved one's suicide; that is, they seemed to undergo an intense process of 'meaning-making work' (Holstein and Gubrium 1995: 114). To break their talk into codes and categories, at first, seemed to run the risk of stripping their stories of meaning. This was especially true when looking at the families' accounts of their loved one's death. Moreover, because I was particularly interested in how families went about making sense of suicide, it seemed that I needed to keep their stories whole. Therefore the decision was made to keep their tales of the young man's death intact. To do this would not only preserve their accounts of his death, but also allow me to look at *how* they told their story.

I drew upon the ideas and method of narrative analysis, specifically the approach adopted by Riessman (1990a; 1993). Rather than looking solely at content, I paid close attention to narrative structure, form and organisation. Following Riessman, this involved focussing on how the story was organised, how the tale was developed and where and how the narrative ends. In addition to structure, Riessman also points to the importance of rhetorical devices that narrators use when telling their story. Therefore I also focussed on factors such as choice of words, tense and pauses in the narrative. Such close attention to families' *ways* of telling the story of their loved one's death ultimately has the potential to bear the complex, interpretive work that they undergo when making sense of suicide. The results of this narrative analysis are presented in chapter six, where I take a detailed look at four family members' narratives.

Whilst an explicit focus on *how* families told the story of their loved one's death formed an integral part of my approach, narrative analysis was not my sole focus. Following Atkinson (1997: 343) I was aware that whilst the narrative approach is important, 'it is one mode of representation'. Moreover, as Atkinson (1997: 343) maintains, in order to guard against 'stripping out the social', narratives need to be placed within the context they are told. Therefore narrative analysis was only a part of my investigation. Indeed my initial immersion in the data for the purpose of the narrative analysis, not only brought the conversations 'back to life', but emerging themes started to come to the fore. My approach to this phase of the analysis was largely based upon the model proposed by Strauss (1987). Taking the key principles of grounded theory (Glaser and Strauss 1967) and applying them to the practice of data analysis, Strauss (1987) suggested that this should involve successive stages of interpretation, moving from empirical data to abstract theory. This part of the analysis was largely carried out using traditional methods. Whilst I began coding using specialist software, personally I feel that it restricted my relationship with the data. What is more, I always put pen to paper when I write, so a traditional approach to analysis was essential for me. That said I did use Microsoft Word as an aid to this process. Accordingly, data were initially analysed by content for emerging themes (Weber 1990). Examples included reactions to suicide, experiences of the mental health services and coping with the death. From this I was able to identify a

number of theoretically informed concepts. Coffey and Atkinson (1996) expand upon this link between concepts and data. As they state:

Many analyses of qualitative data begin with the identification of key themes and patterns. This, in turn, often depends on the processes of coding data. The segmenting and coding of data are often taken-for-granted parts of the qualitative research process. All researchers need to be able to organize, manage, and retrieve the most meaningful bits of our data.

(Coffey and Atkinson 1996: 26)

An example of a meaningful aspect of the data was the role that psychiatric knowledge played in helping families make sense of their loved one's death. This reminded me of Foucault's notion of 'disciplinary power', and subsequently became one of my core analytical categories to which I attached various related themes such as surveillance, psychiatry's gaze and resistance. These concepts and indicators served as codes that I then applied to relevant sections of the data, identifying them as revealing particular themes. As I continued to read through the data, I made constant comparisons of the emerging themes, working out patterns of association, order and continuity between them.

A theoretical framework was therefore developed through an in-depth analysis of the data from both the interviews and the online focus groups. By immersing myself in the data, I reduced the great volume of text into a number of significant, theoretically relevant concepts, which could then be re-organised into a coherent theory on the bereaved's understanding of suicide that was grounded in the families' perspective

## CONCLUSION

In conclusion I return to my identity and the role that it played in the research process. As I have highlighted, the research relationship, particularly during the interviews, did involve a lot of two-way discussion. What is more, there were times when our shared experiences of suicide affected the data that was obtained. In some cases conversations were cut short because I too had experienced what they were explaining – participants did not feel the need to go over what they knew I knew. Yet at other times my identity, I feel, led them to share feelings with me that they may not

have shared otherwise. A lot of these conversations centred on their own suicidal thoughts.

My experience of suicide also impacted on the research process in more personal ways. First, it meant that there were times when the process was painful for me. It made me confront my own healing and my path through grief and also the coping strategies of my family. Indeed there were occasions when my view of my family as a successful unit was threatened – at times the research was without doubt dangerous emotionally for me. But the research was also liberating for me. This is evident in the change in focus that my research has taken. At the beginning of my research journey my main aim was to find out ‘why’ – why so many young men seemed to be killing themselves. This question was undoubtedly fuelled by my own unanswered questions surrounding my brother’s death. As my research developed however, and I became fascinated by ideas relating to social constructionism, this seemed to be the wrong question to be asking (I discuss this in more detail in chapter two). I also became interested in methodology, particularly auto/biography and its relationship to the biographies of research participants and the research process itself. Suddenly the participants became visible for their own stories, experiences and understandings rather than simply what they could tell me about who they had lost. Whilst the young men were of course still important, they now shared the stage with their families. In many ways this is where my own journey has reached. My focus is less on the brother that I have lost, but on the brother I had and what he brought to my family – we share the stage together rather than my brother dominating my thoughts.

Nevertheless, my involvement with the research and the personal gains I have made throughout my research journey, I feel did not disable my ability to carry out research. Even though the research did help me in relation to my own journey, I was clear from the outset that my research was not about dealing with my own problems. Like Stanley (1993) I believe that this involvement did not disempower me intellectually; I was still critical about the issue, just as my participants often were. Indeed as Letherby (2000) has made clear, being critical and analytical about my involvement as well as about the issue ultimately ends up in a fuller picture being revealed.



In the following four chapters, I present the main findings that emerged from my analysis of the data. I begin this journey in the next chapter, where I focus largely on family understandings of the young man's life. I then move on to consider their constructions of the young man's death, how these understandings are structured through narrative and lastly the families' experiences of being a relative bereaved by suicide.

## Chapter Four:

# THE THERAPEUTIC GAZE

### INTRODUCTION

The contemporary psychiatric mission is not just about the management of mental illness, although this is inevitably still a priority for the profession of psychiatry. Indeed psychiatry is an 'eclectic enterprise' (Pilgrim and Rogers 1993: 4), encompassing an increasing range of approaches. Given the longstanding criticism of the psychiatric model and increasing theorisation of social practices, it would be naive to assume there have not been developments in psychomedical practices. As Parker (1999) points out, psychiatry and psychology are not monolithic entities that do not change over time. However there are some dominant features in its approach. Psychiatry arguably continues to operate along the lines of the medical model. After all it is a specialty within medicine; as a result its practitioners are charged with identifying mental illness (diagnosis), reflecting on its possible causes (aetiology) and the potential route of the illness (prognosis) and the subsequent response by curing or ameliorating its symptoms (Pilgrim and Rogers 1993: 4).

For the purpose of this chapter however, I use the term psychiatry in a broad sense. I refer to the general 'psy' discourse and enterprise incorporating amongst others, psychiatry, psychology and psychoanalysis. Drawing upon ideas from the poststructuralist tradition, rather than talking about psychiatry as a profession simply charged with the diagnosis and subsequent treatment of mental illness, following Rose (1999) I use the term to incorporate the following understandings: ① psychiatry is a profession that is no longer confined within the walls of the hospital; ② its practices are no longer about social control and coercion but rather 'upon the real nature of humans as psychological subjects' (Rose 1999: viii); ③ the discourse of 'psy', operationalised by amongst others, psychiatrists, psychologists,

psychotherapists and counsellors<sup>2</sup>, has been internalised by large numbers of the population via popular culture so that they judge everyday experiences according to psychological and psychiatric understandings; ④ central to its operation is the idea of self-reflection, of ‘speaking out’ about, for example, one’s victimhood, survival or exclusion. Increasingly people seek out voluntary relationships with ‘psy’ professionals in order to discuss one’s identity, to put ‘the self into discourse’ (Rose 1999: 269). Ultimately then, I stress the importance of viewing psychiatry as a way of understanding the world – a discourse – rather than solely as a medical profession.

Recent times have seen a broadening of the psychiatric focus. Indeed it could be argued that we are witnessing a ‘psychiatric gaze’. Increasingly a wide range of behavioural characteristics, from insanity to everyday unhappiness, are being constituted and understood in accordance with explanations offered by psychiatry. This broadening of focus will be central to the discussion in this chapter. Whilst psychiatry was prominent in families’ understandings of their loved one’s death – the appeal or rejection of the psychiatric construction as displaying signs of mental illness is discussed in chapter five – psychiatric, ‘psy’ understandings also informed their understandings of the young man’s life. Indeed when talking about the life that their loved one had led, the person he was, his aspirations and dreams, these were all often judged in accordance with a medico-psychiatric discourse. What follows then is an attempt to examine ideas around this broadening of the psychiatric gaze and how it informed the family narratives. In order to do this, I will look at both the families own constructions of their loved one’s life and also the experiences and understandings of the young men themselves (albeit told from the family member’s perspective). We will look at the way psychiatry has filtered through to govern how the families interpreted the young man’s life – how their happiness is judged according to psychiatric knowledge and principles, what I have called, following Rose (1999), the psychiatrization of everyday life. In order to do this, the discussion will draw upon ideas about the failed or shamed self that is a life lost to suicide, a life that could not live up to the psychiatric and culturally inscribed expectation of rational self-management. The discussion will also consider techniques that both psychiatry and the young men themselves employed in an attempt to lead a

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<sup>2</sup> Rose (1999) calls these the ‘engineers of the human soul’.

successful, 'perfect' life and the ways that these are invariably gendered. I will extend the gendered dimension of the families' understandings in the final section, where I will look at the way in which coping and feelings of pride are often bound up with a cultural vocabulary of what it means to be a man.

It is important to note that although the psychiatric focus has been extended, its two objectives – ① the regulation of mental illness; ② the management of personal happiness and individual subjectivities for the promotion of mental health – do remain quite distinct. So whilst mental illness is still the irreducible foundation of psychiatry, it is now branching off towards the different behavioural dimensions of personal life. What this means is psychiatry is ultimately extending its reach beyond unreason and insanity to the *normal* population. Psychiatry viewed in this way becomes less a simple response to inexplicable and extravagant behaviours and more a complex system of interrelated theoretical ideas, therapeutic practices and institutional sites (Miller 1986). In this sense then, as Miller (1986) has argued, it is not an institution as such that can be traced back to a founding strategy, rather it operates within and through multiple and interlocking strategies of social regulation. So it's the psychiatric *understandings* that become important as opposed to psychiatry as an institution. One advantage of thinking about psychiatry in this way is that it becomes possible to identify the differing levels of psychiatry's functioning that we have just touched upon. The focus then should no longer be simply about different forms of mental illness and how they become constituted as a psychiatric concern. Whilst it is still important to look at the processes that come to define mental illness as a psychiatric problem, it is important to examine the ways in which human emotions, such as unhappiness and feelings of failure, have increasingly been constituted as something amenable to psychiatric treatment.

## THE PSYCHIATRIZATION OF EVERYDAY LIFE

Rose (1986: 43) maintains that 'psychiatry is an indispensable element of our modern society'. 'Psy' expertise has blossomed and no phase of life is immune from psychiatry and its ministrations. And this is certainly the case if we think specifically about suicide. Indeed when reflecting upon possible *causes* of their young man's

suicide the conversation often centred upon areas that have had a psychiatric interpretation levied towards them: childhood and adolescence at home and at school; sexual normality; family life, marriage and divorce; employment and unemployment; life crises and failure to achieve, and illness and bereavement. But perhaps most importantly for this part of the discussion, it is increasingly in psychiatric and psychological terms that we think about and talk about our personal unhappiness.

When we talk about the power of psychiatry, it is not just about the way we think about mental illness. Indeed as Miller (1986) points out, discipline operates most successfully when it becomes automatic for a person to regulate themselves according to its principles. He goes on to suggest that, 'from the moment psychiatry becomes a component integral to the individual's repertoire of self-evaluation and reflection the personal tends increasingly to be defined in terms of the psychiatric' (Miller 1986: 40). This means that a person will interpret his or her behaviour, thoughts and feelings in terms of psychiatric knowledge and principles. So the varied dimensions of human existence – our fears, worries, happiness and unhappiness – are increasingly judged and understood according to the interpretations offered to us by psychiatry. Psychiatry then provides us with the very terms in which our problems and subsequent unhappiness are constructed. Furthermore, its portrayal of the norms of a healthy mental life to which we are all expected to aspire enables individuals to identify what is unhealthy. This is clear in the following quote from Lisa as she speculates about the dominance of the ideal of happiness in our society:

Society is so much about being confident and happy all the time and you begin to feel that if you're not you're abnormal, whereas actually you're abnormal if you're happy all the time. But it's not, it's not instinct to be happy all the time, is it?

(Lisa, Aaron's sister)  
(Face to face interview)

We can see clearly here that happiness is set as the norm, a desirable state to which we are all expected to invest out time in reaching. Interestingly Lisa goes on to suggest that anyone who doesn't attain this standard or indeed put in place psychiatric strategies that will help them in the quest to achieve happiness is seen as

abnormal. It is accepted however, that not everyone will be happy all of the time. Indeed the discourse of medical-psychiatry relies on this fact. The point is that people who do not actively seek ways of overcoming their unhappiness using strategies and coping mechanisms that are offered to us by psychiatry are made to feel in some way inferior, deviant even. We can see this in the following quote from Tessa as she talks about Matthew:

He didn't want to work in the printing place forever 'cos he felt, God I don't want to commit myself to doing this ... And in his perception people were getting on and doing well, whereas he was riddled with this depression business that would occur, you know in the winter months and that would be a recurring thing in his life, he felt that. And I said to him, 'Well why don't you get some help?'. I got so angry with him 'cos he wouldn't do anything about it. I mean how would you expect to get better if you don't get help?

(Tessa, Matthew's mother)  
(Face to face interview)

Happiness is arguably elevated as the most desirable emotional state by the psychiatric system. So once we interpret our own happiness, pleasure and achievement according to the principles provided to us by psychiatry then it becomes possible to realise that, for example, infertility is not just a medical condition but a potentially damaging psychological problem, and in the case of Matthew, work is not just an economic obligation but a means to achieve personal fulfilment. Once Matthew began to understand his emotional state according to the values offered to him by psychiatry, in this case 'depression', then a sense of failure was more keenly felt.

Nonetheless, psychiatric labels do offer the benefit of relieving the individual of immediate responsibility (Seale 1996). As long as the sufferer adheres to the techniques offered to them by psychiatry, the individual is no longer directly accountable for his or her unhappiness. After all, their recovery is now in the hands of psychiatry. However in Matthew's case, his resistance to the psychiatric requisite that we must seek help subsequently constructs his behaviour as deviant. Indeed by aligning his emotional state with understandings offered by psychiatry, yet actively resisting their techniques of recovery Matthew's behaviour is unintelligible to Tessa.

Matthew's levels of happiness featured heavily in the way that Tessa talked about her son. At times accompanied by crippling feelings of guilt, Tessa spoke at great lengths about the unhappiness that Matthew felt in his life:

The fact that he was living at home, he felt that wasn't great. And I said, 'Look Matthew, you're 22, loads of people live at home', I said 'I work with loads of people who have got sons who are in their late twenties, thirties who are still at home'. But he felt again, you know, he shouldn't be doing that. He should be off because a lot of his friends were doing better things. Umm.. So, you know.. I don't think he was a, a very happy person ... and I would say to him, 'I think your teens and twenties are the most difficult time in your life really, personally'. I said, 'I found those years very, very difficult'. But then he'd say, 'Oh you had a partner' or 'You had this'. He was always trying to sort of sell, 'Well it was all right for you 'cos you had...'. You know, he thought his situation was so much worse.

(Tessa, Matthew's mother)  
(Face to face interview)

Happiness for Matthew is set as the ultimate ideal, albeit an ideal that he felt he could not reach. Tessa also alludes to the fact that Matthew was extending a psychiatric understanding into aspects of his personal and social life. This is more apparent when Tessa talks about Matthew comparing his life and his level of happiness with others around him. It could be argued that subjective happiness is impossible to measure and compare. After all it is subjective. However, psychiatric practices work by instrumentalising and elaborating our fantasies of happiness. This is achieved by promoting an ideal of what we might be and working in the space that is ultimately opened up between our wishes and our desires (Rose 1999). By drawing upon this understanding, Matthew was able to place aspects of his social life, his living arrangements and employment, as responsible for his current mental state. They have been constructed as a psychological problem, one that could therefore be managed and potentially remedied through 'psy' input. What we see here then are the difficulties inherent in living being transposed on to a psychological register (Rose 1996). So whilst living at home, not having a partner and not enjoying his job are not in themselves psychological problems, Matthew used these difficulties in living as explicable for his mental state. As Rose (1986: 87) has suggested, 'they become not intractable features of desire and frustration but malfunctions of the psychological apparatus that are remediable through the operation of particular (psychiatric) techniques'. But by judging their life, their happiness according to the principles

offered by psychiatry, this ultimately meant that a sense of failure was acutely felt by many of the young men. Indeed the idea of failure informed many of the families' narratives, an understanding that I now turn to.

## THE FAILED SELF – SUICIDE AS FAILURE

Making a success of one's life, to be happy and to avoid failure at all costs, is arguably a cultural expectation that all young people (and adults) are encouraged to subscribe to. This neo-liberal imperative and contemporary psychiatric mission positions life as an object that the 'entrepreneurial self' must work on in the pursuit of happiness and a successful life. In these terms, suicide represents the failed or shamed self – the life that did not live up to the expectation of rational autonomous self-management (Fullagar 2003).

Arguably a highly individualised explanation – it was the failure that the young men themselves felt that took centre stage in the families' search for understanding. Indeed a suicide explained in terms of people's failure, not being strong enough to cope with life's problems, is consistent with political and social traditions of individualism and self-responsibility in Western society. Moreover, this is arguably a detail that the contemporary psychiatric mission relies upon. Studies of lay beliefs have highlighted this understanding where people believe that individuals have responsibility to maintain one's health (Mullen 1994). It could be the case, then, that these everyday understandings have filtered through to the families' explanations. In the following passage Tessa talks about the person that Matthew was, Matthew's identity rather than his actual suicide:

But I think his personality, 'cos he was, he was quite a sensitive person and a gentle person and I think in order to succeed in life you've got to be a fairly, um, you've got to be quite tough and he didn't have those qualities ... I just don't think he was strong enough.

(Tessa, Matthew's mother)  
(Face to face interview)

By talking about Matthew's personality, Tessa immediately individualises her explanation. Personality has often been seen as something fixed and unchangeable.



A dominant idea in experimental psychology and traditional psychiatry, the personality approach sees people as having unique, distinctive characteristics that are stable over time (Eysenck 1952). Moreover there are signs that this idea has filtered through to lay understandings of personality (Furnham and Cheng 2000) and we can certainly see this in Tessa's explanation; Matthew's sensitivity and gentleness are something intrinsic to him. By using this understanding, Tessa positions Matthew as 'abnormal', in many ways doomed to failure as he would always be working in contradiction to the expectations of rational self-management.

In this passage we also see Tessa signalling a passive identity, where she draws upon cultural ideas about what it means to be a man. Although gender is not explicitly mentioned, traits and ideals are. The language she uses positions Matthew against the hegemonic ideal – rather than having the desirable masculine qualities of being “strong” and “tough”, he was “sensitive” and “gentle”. When talking about the person that Matthew was, Tessa draws upon the dominant representations in Western culture of the masculine-feminine tough-soft dualism. These gendered cultural ideals about what it is to be a man could be seen to inform her interpretation of Matthew as failing. By placing Matthew in a gendered position that is in opposition to the successful man, his suicide becomes intelligible to her.

The association between suicide and the culturally inscribed discourse of personal and professional success can be seen in the following quote:

And I think the older you get the more things start to fall into place and you, you start to realise, you start to cultivate better friendships and things would come. And I said, 'It would happen for you, just be patient'. But he wanted it now and it wasn't happening for him, I think that's what it was. And the comparison with these friends who were all having such a much better life than he was.

(Susan, Zack's mother)  
(Face to face interview)

Here we see Susan indicating Zack's frustration at not being able to reach his desired heights of success. Susan also communicates the immediacy of life that Zack invested in. Increasingly not only do people have a responsibility to make a success of one's life, to invest our time and energy to reach the desirable emotional state of happiness, there is a greater need to achieve this quickly. In the pursuit of a

coherent successful identity, there is the risk that young people may get left behind if they do not achieve independence along with their peers. Adolescence is regarded as a time when individuals strive to develop clear and stable identities and a sense of independence (Jones 2000). Conformity with peers is often used as a benchmark by young people to assess their success. The comparisons that Zack made with his friends only served to make his feelings of failure more acute. It seems his failure to reach the levels that his friends had achieved ultimately left Zack with a profound sense of shame. Moreover, a common assumption underlying youth suicide is the failure to construct a healthy identity (Portes *et al.* 2002). Ultimately Zack's failure in developing a healthy identity allowed Susan to move to Zack's suicide in a relatively unproblematic way.

Research has shown how shame is very much connected to a person's performance of identity in relation to cultural norms (Fullagar 2003). Feelings of shame bring with it feelings of self-hatred, disgust and loathing which are internalised as part of the self, as cognitions. But as we can see from the following quote, although Lorna expresses Simon's feelings of shame as inner thoughts, they are in fact deeply social:

I think he felt he was a failure, I really do. Cos he didnae have any self-belief. All his friends said that he was a hundred times better than any of them. He was, he was a really decent bloke. He was kind, he had all the right qualities, but he didnae believe in himself. An' whatever I told him, you know, he'd think, oh it's me mum telling me that. You know, so you don't believe it.

(Lorna, Simon's mother)  
(Face to face interview)

What we can see here, is that the pursuit of a coherent, successful identity is bound up with psychiatric ideals. Self-belief, arguably a desirable emotional state needed in the construction of a successful life, is also a state that is central to the new techniques embraced by psychiatry. As I will go on to discuss, individuals are increasingly expected to manage their own behaviour – and this, according to psychiatry is only possible if the person has 'self-control' (Rose 1999) and self-belief. What becomes clear from Lorna then is that Simon's feelings of shame stem directly from his perceived failure to achieve this ideal.

What is more, the institution that is ascribed the role of bringing people back from the despairs of shame and failure is in some respects responsible for these feelings in the first place. By individualising a person's feelings, by constructing them as inner cognitions, albeit feelings that are changeable, Simon became personally responsible for his emotional state. The emphasis on self-control and self-responsibility for emotional life thus becomes intensified through the attribution of 'failure' to identities that differ from established psychiatric norms. As Fullagar (2003) has shown, this intensifies the feelings of failure and self-blame that suicidal young people feel, effectively deflecting criticism away from cultural norms and expectations. For Simon then, his response to failure becomes 'there is something wrong with me, my body, my ability to live in relation' rather than there is something wrong with the relations of value through which I am judged/judge myself (Fullagar 2003: 300). However as Fullagar (2003) goes on to explain, rather than viewing these feelings of failure in terms of self-esteem, it could be more useful to consider how shame and failure are implicated in the process of identity formation within the normalising practices of everyday life.

It is not always the case however that 'psy' culture demands that we only focus upon unsuccessful behaviour. As we can see from Joel's parents, it can equally be the case that positive behaviour becomes translated into psychological terms:

Peter: I can't over-emphasise this enough really, but he was just a happy 18 year old, or 17 year old, who was just the most happy I've ever seen him, you know. Okay he had a break-up from a relationship, but, you know, he loved his skating, loved his concerts, loved his college, was getting distinctions, was up to date with his coursework – was ahead of his coursework.. Umm.. you know had all the I.T. stuff he wanted..

Rachel: He was really loved, I mean, he used to say "oh, you know, I love you mum" there's not many boys at that sort of age who would say "I love you, mum", he always did, didn't he Peter?, "Love you, mum, love you, dad" you know, and even with Ben, you know sometimes brothers fight but they had such a close relationship. There was just no rhyme or reason.

(Peter and Rachel, Joel's parents)  
(Face to face interview)

'Psy' culture has, at the very least, facilitated the view that life is to be measured in terms of personal fulfilment rather than, for example, community or moral

commitment. An individual's life is given purpose and therefore judged to be successful through the accumulation of choices and experiences, the accretion of personal pleasures and the triumphs of love and happiness. And as we can see, Rachel and Peter draw upon these psychological understandings of what constitutes a successful and fulfilling life. As a result, Joel's parents have great difficulty in understanding his death as a suicide. Joel's positive, successful behaviour does not fit with the unsuccessful and damaging behaviour that is associated with suicide.

Ultimately, the processes that individualise shame also participate in the medicalisation or psychiatrization of emotional distress. Psychiatry almost certainly facilitates the identification of human unhappiness. Moreover its survival depends upon us not only measuring the size of the problem, we also need to interpret it as remediable. Mental life is arguably now a domain that can be understood through and managed by psychiatry's scientific expertise. What this means is the self is effectively opened up. New opportunities are now available to be utilised by professionals who have the last say in the psyche, who are readily available to offer us an image of the fulfilled person, who we can all potentially be, with their assistance. It is to these relatively new techniques that psychiatry has incorporated that I now turn.

## **RESHAPING THE SELF**

So far I have written about the medico-psychiatric discourse and its regulation and management of our human emotions – our fears, worries, happiness and unhappiness and the feelings of failure that can stem from this. However given the proliferation of psychiatric techniques to more and more aspects of our everyday lives, it is perhaps inevitable a new approach was needed. After all if we are all potentially amenable to psychiatric intervention then it would be impossible for everyone to access it as the system would quite simply be over loaded! Increasingly what we are witnessing is a growing trend of behavioural techniques whereby the therapist teaches the 'client' the practices they need to put in place themselves. From giving up smoking to anger management, behavioural therapies are increasingly being used.

Indeed if a specific form of human behaviour can be identified and is desired, then behavioural techniques could be deployed.

Central to this focus on behavioural therapy and behaviour techniques is the idea of the modern self. In the post-industrial 'risk society' (Beck 1992), identity is far more fluid. No longer tied to the traditional structures of modernity, individuals are increasingly free to choose their lifestyles, their conduct and their life. According to Giddens (1991) our biographies are far more uncertain than they were even 50 years ago. Individuals construct narratives of self-identity that have to be continually revised. Giddens (1991: 109) calls these 'reflexive biographies' and argues that the universe of future events is open to be shaped by human intervention. However, constrained by external or internal factors, the modern self is increasingly required to construct a life, an identity, through the exercise of choice. As Rose (1999: 23) explains:

Every aspect of life, like every commodity is imbued with a self-referential meaning; every choice we make is an emblem of our identity, a mark of our individuality, each a message to ourselves and to others as to the sort of person we are, each casts a glow back, illuminating the self of he or she who consumes.

What is more, we are increasingly witnessing a self that is not merely able to choose, but obliged to choose. Individuals are expected to create a life on the basis of their choices and account for their lives in terms of the reasons for those choices. It is here where the new focus on behaviour comes in. Such techniques are intimately bound to the idea of self-hood and the apparent choices that follow it. Individuals now have the freedom to choose techniques in a market of expertise rather than being coerced into something against their will. As a result we are turning more and more to sources of expert knowledge on the 'psy' professions, drawing on therapeutic discourses to learn ways of managing the emotional self (Lupton 1998). The basis of behavioural therapies – incorporating the medico-psychiatric discourse – is to restore individuals to the thinking, choosing individual; 'selves unable to operate the imperative of choice are to be restored through therapy to the status of a choosing individual' (Rose 1999: 231).

These new techniques are implicated in the expansion and re-shaping of 'psy' and behaviour therapies, far beyond the psychiatry of mental illness, ultimately to provide and promote new ways for individuals to cope with the stresses of everyday life. Central to the underpinnings of these new techniques is the idea of self-control (Rose 1999). The individual is expected, once guided by the therapist, to manage his or her own behaviour. So whether it be stopping smoking, managing anger, overcoming grief or communicating effectively individuals are increasingly *expected* to manage their natural and social environment.

The therapist instructs the client in the rationale behind the technique, but, more importantly, educates him or her in the means of self-inspection to be used. For example, systematic self-monitoring and record keeping, showing the occasions on which desired and undesired behaviour occur and following the desired behaviour with rewards becomes central to this approach. Such practices are alluded to in the following extract:

Eventually we took him to a private therapist to help with his drinking, to help with the break-up. He would come away from her fairly up beat. She would set him these little tasks to do.. Oh I don't know, like focus on one thing this week and try not to think about anything else. Um, like being able to cope with the anger he felt whenever he met up with Angela. You know, only concentrate on doing that well and not to worry about anything else. And for a while it did seem to work for him.

(Jack, Adam's father)  
(Face to face interview)

Once again we see aspects of Adam's social life, namely the breakdown of a relationship, being transposed onto the psychological register, being held up as responsible for his mental state and ultimately amenable to 'psy' input, which in Adam's case appears to come in the form of a behavioural therapist. And through a behavioural therapist, Adam was taught techniques of self-analysis and self-help. Such 'therapies of normality' (Rose 1999) encourage us to cope with stress, anxiety and demanding situations in the path to self-assertion. What is important in these behaviour therapies is that they transform social behaviour, whether positive or negative, away from being an inner expression of the self, towards being seen as a learnt behaviour. And anything that is learnt can subsequently be re-learnt (Rose 1999). This can be seen when Jack talks about the advice that Adam received from

his behaviour therapist. By framing his social environment (Adam had a particularly difficult break-up and was denied access to his children) and his initial response to this (Adam had been drinking heavily in the last year of his life) not as inevitable but as something to be systematically managed, we can see how behavioural techniques support the idea of the modern, autonomous and responsible self. Through these ‘therapies of normality’, Adam is encouraged to monitor and modify his own emotions and behaviour through small and achievable goals, as we see here in the case of his interactions with his ex-partner. Nothing is inevitable; Adam’s social behaviour becomes re-framed not as something positive or negative but as successful or unsuccessful.

Such an approach does appear to be fairly progressive. So whilst the idea of ‘self-control’ in itself may sound like a repressive, monolithic moral duty, techniques of self-analysis, self-help and reflection seem receptive, open and progressive. Indeed in Adam’s case behavioural techniques did work for him for a time. If we continue on from the previous passage:

And for a while it did seem to work for him. He was calmer. I’m not saying it was like he was a new person or anything. I mean he would still have his dark days, but he could definitely control himself more ... He didn’t get so angry with everything. And the big difference was with Angela. He didn’t let her get to him in the same way.

(Jack, Adam’s father)  
(Face to face interview)

This seems to embody the new direction that such behavioural techniques are taking our understanding of *low-level* emotional distress. Symbolised by the self-help movement, the approach to everyday human problems is now much more about one of education and skills rather than disease and treatment. In this sense, Adam was taught how to overcome demanding situations, in his case contact with his ex-partner, in an attempt to behave in more successful ways. Moreover, this management of Adam’s reaction to social situations that he found difficult was met by rewards, as we can see when Jack went on to say that “Adam’s contact with the kids increased”.

Rose (1999: 262) has suggested that ‘life has become a skilled performance’. And it could certainly be argued that Adam was taught performance skills that would assist him to cope with everyday life. Indeed psychologists have devised many techniques

that people themselves can put into practice in an attempt to change their behaviour, as we can see in the following passage:

The school, um, about that time, about in his first year, within about the first year and a half, um, got in touch with us and said 'cause for concern'. And they'd been in touch with the doctor, who suggested Asperger's Syndrome. So we saw the doctor together ... And they suggested counselling. But Liam didn't respond very well to it. The counsellor said that they couldn't actually do anything for him, that he had to do more work, 'you've got to do something'.

(Jane, Liam's mother)  
(Face to face interview)

Again we see here Liam being taught the underlying principles of the technique, being instructed in the art of self-help and self-analysis. Liam, and not the therapist, was expected to "do more work", to carry out the means of self-inspection that is central to behavioural therapies. However in this case, Liam's parents did not share the same view about the positive impact that such behavioural techniques had on their son. They didn't invest any faith in what Liam was being taught:

But to us he was Liam ... He was just being Liam. Umm, he was different, yea different. But then we liked that. We liked the fact that they were different. I mean he was such a quiet person anyway. He enjoyed his own company. He didn't desperately want people to come round and play ... when he was younger he would happily sit playing with his toys, chatting away to himself. But it was never a problem. At least we all never thought it was a problem.

(Jane, Liam's mother)  
(Face to face interview)

For his parents then, it was only once Liam was taught to view life as a skilled performance, once he was encouraged to reflect on his own behaviour, did they see things as deteriorating for him:



He was never actually diagnosed with Asperger's Syndrome though. But he was left with all these questions in his mind. I'm sure that's when he was left with the feeling of not being normal ... I mean when he was at, um, um, when he was at school and he'd had the Asperger's assessment, he was very down at that point. And we thought.. It had actually got to the stage at that time, that we, we thought about actually leaving him in the house on his own because he seemed so down. We thought that he might do something to himself.

(Neil, Liam's father)  
(Face to face interview)

It becomes clear then that the process of self-analysis, of learning to modify one's behaviour in an attempt to produce successful outcomes, are not necessarily the route to self-assertion and self-control. Indeed for his parents, the very process of reflection was a pivotal factor in Liam's subsequent deterioration. However there were times when families saw their young men as investing significance in the ideals held by the 'psy' discourse. Often framed around their loved one's search for perfectionism, families seemed to construct the young men in line with the neo-liberal imperative of living a successful and coherent life. In the next section I will therefore look at the way this informed the families' talk, in particular how it related to gender.

## HIGH EXPECTATIONS AND SEEKING PERFECTION

The responsibility on young people to create an identity, a life based on the choices they make could have further implications. What became apparent in the narratives, were the lengths that families would often go to in order to construct the young men as having particularly high expectations, as seeking a perfect life. Increasingly judged by the choices we make, there was evidence that this expectation had filtered through to families' constructions of their young men:

It's like if he didn't think he was capable of doing it, he wouldn't even try. It's like he had to be good at it, he had to be really good or just forget it. It was all or nothing about a lot of things. So he gave up.

(Susan, Zack's mother)  
(Face to face interview)

Here we see Susan constructing Zack as a person who strove for perfection. If everything we do, every choice we make, is a message to others about the person we are (Rose 1999), then for Susan, Zack was someone who wanted to project a particular message that he had a successful, competent identity. The irony of course is that by investing so much significance in this ideal, by avoiding being even second best, Zack is seen to 'give up' anyway. The link between perfectionism and suicide is by no means new. Within the psychological literature there appears to be a growing consensus about the relationship between the two (see e.g. Hamilton and Schweitzer 2001; Flamenbaum and Holden 2007; O'Connor 2007). And the centrality of perfectionism in the majority of the families' understandings was striking. Not tied to any factors such as age or history of mental illness, the prominence of this understanding should not go understated. In the following conversation, Neil and Jane talk about the ideals that Liam had:

Neil: So he was sort of obsessive about detail. Not particularly artistic, but, you know, detail was very important, getting things absolutely accurate.

Jane: Yea, well perfection...

Neil: Perfection.

Jane: ...perfectionist. I mean we knew that from quite a young age. If he played the piano, um, he had to get it absolutely right. Liam had to be in control. I think it's, you know, it's the bigger picture isn't it? He couldn't see a way to reach what he wanted to reach, if he knew what he wanted to reach, that I don't know. But he couldn't get there. He was never good enough, never good enough.

(Neil and Jane, Liam's parents)  
(Face to face interview)

Once again we see perfectionism set as an unattainable ideal, an ideal that Liam never truly knew himself. Liam's suicide is constructed in line with Neil and Jane's understanding of the person that he was – his life lost to suicide lives in the shadow of his desire for success, striving for perfection and avoiding failure at all costs. By constructing Liam as a person who lived with such high expectations in some respects allows his parents to interpret his death as almost inevitable whilst at the same time allowing him to be constructed as a moral and worthy person, holding him up as a principled young man.

People's concern about success, health and happiness in Western society represents a perceived pre-requisite for autonomy and competence, which ultimately underpins achievement in capitalist society. But for Williams (1993) it is not necessarily health itself that is considered important but rather the pursuit of it. The display of a successful, healthy lifestyle reflects a self-disciplined and virtuous self. This understanding could certainly have informed Neil and Jane's interpretation. For them, their overwhelmingly emphasis was on Liam's drive for success and perfection – the person he was rather than his failure to live up to such standards. In the following passage Lisa makes a comparison between her father and her brother Aaron:

The way that I look at it, is that he shares a lot of characteristics with my dad, some of which I can see in myself, like independence and a very self-critical way of looking at himself. He was worried when things weren't perfect, it upset him.

(Lisa, Aaron's sister)  
(Face to face interview)

Although not explicitly mentioned in any of the extracts, the role of gender in the apparent relationship between perfectionism and suicide is notable by its absence. Bound up with ideas about what it means to be a man, to have high expectations and to seek perfection could arguably have informed families' understandings. The comparisons that Lisa makes between her father and Aaron are clearly gendered. She draws upon the traditional Western view of masculinity and its associated attributes of 'independence' and 'achievement'. However rather than holding this up as an ideal, her interpretation defines masculinity and the experience of being male as something problematic. Whilst gender was only alluded to when talking about perfectionism, there were times when it was far more explicit in the narratives. In the final section, I consider how families viewed the young men's feelings of failure as being bound up with asking for help. In particular coping and asking for help was often discussed in line with a cultural vocabulary of what it means to be a man.

## COPING AND FEELINGS OF PRIDE

Research has consistently highlighted a gender difference when it comes to asking for help. Men are generally less likely to disclose suicidal thoughts, less likely to ask for help when they have emotional problems (Meltzer *et al.* 2002) and are generally more reluctant to talk about their emotions with others (Hawton 2000). Whether we accept this as a factual reality of men's lives or, instead, as an indication of the socially constructed nature of the male stronger sex, such ideas clearly informed many of the families' narratives:

He was not very good at with coping with emotional things. Anything, like really, like close emotional ties, he'd find really difficult. He liked to sort of keep himself to himself. He would have to really trust you, you had to sort of prove yourself, he had to really trust you.

(Susan, Zack's mother)  
(Face to face interview)

Coping is not simply a case of being emotionally strong. Rather it is bound up with the cultural vocabulary of being a man, feelings of failure and the sanctions that prohibit the expression of emotional distress. And for Susan, Zack clearly operated along these lines. She describes Zack as a person who was extremely reluctant to open up to people. Whilst Susan does not explicitly discuss his feelings of failure, the fact that Zack is seen as a young man who found expressing emotion "really difficult", seems to point to a concern to conceal his pain and vulnerability. Traditional masculine norms certainly foster a degree of emotional illiteracy. Consequently, ways of being a man and exhibiting masculinity are positioned in a way that intruded into Zack's experience and displays of emotion, rendering it something synthetic, strategic and to be avoided. We can see something similar in the following passage:

But he just, you know, it was so difficult to get information out of him, and he was so proud and wouldn't, you know, just wouldn't tell you stuff. It was really difficult.

(Jane, Liam's mother)  
(Face to face interview)

Liam's feelings of pride are seemingly bound up with his fear of humiliation and failure if he spoke about himself. However Jane's use of words here are interesting – pride has long been associated with ideas about male suicide. Liam's concern at keeping a degree of emotional distance is certainly evident in Jane's narrative; however she could also be seen to be referencing the popular conception of men's suicide as a sign of 'tragic courage and fierce independence' (Canetto 1992-1993: 5). As I discussed in chapter two, the idea that suicide in men represents a fight against external difficulties has a long history in Western culture. This conception could certainly have filtered through to Jane's understanding of both who Liam was when he was alive and his death. Whereas women's suicidal behaviour is often viewed as showing signs of weakness, men's is frequently interpreted as displaying strength and *pride*. It would seem, then, that pride is wrapped up in a concern to maintain a degree of social distance, necessary for the display and enactment of hegemonic masculinity. But this clearly has problems as we can see in the following quote:

I think he felt too ashamed to ask for help, I really do. Not that we would have known. He had to keep up the bravado.

(Lorna, Simon's mother)  
(Face to face interview)

Here we see Lorna aligning Simon in accordance with the norms of hegemonic masculinity. For Lorna, it was her son's "bravado" that prevented him from seeking help. It was also the reason that the family were seemingly unaware of his feelings of failure and an inability to cope. Help seeking is not simply a case of knowing where to go, but has to do with culturally sanctioned ways of being a man. By not asking for help (and not knowing he needed help), Lorna is able to position Simon as demonstrating his gender. For Lorna, Simon demonstrates his emotional and physical control by appearing strong, denying any weakness or vulnerability and dismissing any need of help. Once again we also see the issue of shame coming to the fore. The apparently overt display of masculinity also works to both further and conceal feelings of shame. The pervasive influence of masculine norms in Simon's life would seem to suggest that shame is highly gendered. In particular, cultural practices arguably regulate emotional expression and help seeking in everyday life (Fullagar 2003). By adopting traditional ideas about manhood, Simon is seen to find it impossible to express his emotional distress without experiencing intense feelings



of shame and failure in his cultural understanding of what it means to be a man. In the following passage Amy talks about Andrew's coping strategies:

We found out afterwards that he had kept a lot from us. He didn't want anyone to know about ... He couldn't bring himself to tell anyone, he didn't want to let us down.

(Amy, Andrew's sister)  
(Online focus group)

Here we see Andrew's behaviour (and subsequent suicide) being interpreted as a failure to live up to socially and culturally prescribed goals. What is also apparent from this passage is the importance of the visibility of Andrew's failure. As Scourfield (2005) has maintained, it is not only the failure to succeed in hegemonic masculine terms that causes psychological pressure, but also being *seen* to fail. Asking for help could have potentially violated masculine norms of behaviour. However, discourses of masculinity and mental illness clearly work to individualise the effects of culture on the embodied self. So, Andrew's feelings of shame are nothing to do with the society in which he is judged, but rather are seen as something intrinsic to him. This understanding ultimately allows Amy to construct her brother as someone who saw himself as abnormal and failing – *he* didn't want to let *his* family down.

## CONCLUSION

In this chapter I have shown how the broad discourse of medical-psychiatry (one that encompasses a range of approaches) was central to the families' understandings of their young man's life. The 'psy' discourse positions happiness as a desired norm – one that we are all expected to reach, or put in place 'psy' techniques if we do not. Indeed there are examples whereby the young men were taught the principles of such techniques. However, once their life was considered amenable to 'psy' input, these so-called 'therapies of normality' ensured they continually scrutinised their behaviours and emotions according to its principles.

Families' accounts also revealed the way that difficulties in the young men's lives were being constructed as a psychological problem. By viewing difficulties in this way, the families (and the young men) effectively transposed their loved one's

happiness onto a psychological register. However, far from being something that is attainable, by judging their life and happiness according to the principles offered by psychiatry ultimately meant that a sense of failure was more keenly felt by the young men.

Despite failure informing families' understandings of their loved one's life, this was not always so readily accepted. The idea of a failed life has a particularly powerful imagery, one that could potentially impact on the families feelings of responsibility and duty of care for their loved one. As a result there were also times when the young men were positioned in relation to perfectionism. A popular finding within suicide research, families often constructed their loved ones as men with particularly high expectations, who strove for a perfect life, albeit one that they could not reach. There was also the sense that these understandings surrounding perfectionism were gendered, whereby the young man was constructed in terms of a cultural vocabulary of what it means to be a man.

Ultimately the colonisation of the emotional life world by the 'psy' industry reinforces the idea that we must depend upon professional experts to teach us how and what to feel; such denial of patients' autonomy and self knowledge in managing their health was identified by Illich (1976) as a central dimension of social iatrogenesis and medicalisation. Indeed the iatrogenic effects of psychiatric services will be discussed in the following chapter. In addition I will extend the debate on the medicalisation of suicide, arguing for a genetisation of suicide.

## Chapter Five:

# PSYCHIATRY AND SUICIDE

### INTRODUCTION

This chapter is about the families' construction of their loved one's death. In many respects this chapter stands in contrast to chapter four which was much more about their constructions of his life. Once again psychiatry takes centre stage. However whereas in chapter four, psychiatry was used in a relatively broad sense, denoting a wider 'psy' culture, the focus here is also on the institution itself. Indeed the operation of psychiatry as well as the medico-psychiatric discourse was prominent in the families' construction of their loved one's suicide. This is hardly surprising; after all many of the families had direct contact with psychiatric services as a result of the young man's diagnosis of a mental illness. Yet the discourse of medical-psychiatry also informed many of the families' understandings whose loved one had no contact with psychiatric services, let alone a diagnosis of mental illness. In this chapter then, I attempt to explore some of the reasons behind why the discourse of medical-psychiatry was so powerful in constructing the families' understandings of the young men's suicide.

As I have discussed in chapter two, biomedicine acts as the most (socially and institutionally) privileged knowledge of the body, health and illness. What we understand about disease, about health and about illness is invariably understood through the discourse of clinical medicine (Turner 1997). This is not to say that this is the only way of making sense of these issues, but that it is the most dominant. If we think more specifically about mental illness, what comes to be designated as a mental illness, how it is described and what is done about it is intrinsically linked with medicine. Indeed in our culture, mental illness is very much owned by disciplines such as psychology, psychiatry and psychoanalysis. These disciplines and



the institutions, discourses and practitioners associated with them have more or less the final say on mental illness. For example if someone's behaviour was being examined in a court of law, then the court would rely upon these disciplines (say in the form of an expert witness) to guide their decision. Such disciplines, then, are understood as speaking the 'truth' on mental illness. How this truth operates is to incorporate any understanding of mental illness that fits with its ideas and to edit out and condemn anything that doesn't fit with the discursive formation. So if a practitioner decides that schizophrenia, for instance, is the result of demonic possession, he or she would automatically disqualify themselves from any claims to be a legitimate member of that discipline.

It is important to remember however, when talking about the power that psychiatry and its related disciplines have, it is not in terms of a kind of monolithic and dictatorial presence. Power is simply not like that. Drawing upon a Foucauldian analysis of power, Miller and Rose (1986: 2) have skilfully shown that when talking about the power of psychiatry we need to analyse it in terms of what it makes '...thinkable and possible, the new objectives to which it allows us to aspire, the new types of problem it allows us to conceive, the new types of solution it inserts into our reality'. In this sense then, the way that people make sense of suicide will depend on the problems, objectives and solutions that are produced by psychiatry. If we concentrate solely on the problems what do medicine and psychiatry see as the major concern? Overwhelmingly psychiatry and medical research into emotional distress and suicide view the problem of suicide as mental illness. This would seem self evident and natural. After all psychiatry is, in the large part, in control over how we make sense of and understand suicide. However what emerged from my interviews with bereaved families was that the discourse of medical-psychiatry is not always accepted. What became apparent was that those families who had been involved with the mental health services overwhelmingly rejected the conceptualisation that psychiatry offered in explaining their loved one's death. Interestingly it was those families that had no contact with such services who would appeal to the medico-psychiatric discourse to help them make sense of their young man's death.

Using Foucault's conception of power and resistance, this chapter begins by looking at the way in which the discourse of medical-psychiatry structured many of the families' understandings of suicide. I first consider the ways in which families appealed to psychiatry, searching for a psychiatric label that would help them make sense of their loved one's death, before moving on to look at instances where they resisted it. Often informed by their experiences of the psychiatric services, particularly its surveillance and iatrogenic effects, many of the families did not accept the conceptualisation that their young men killed themselves simply because they were mentally ill.

Despite the hostility and seeming resistance to the medico-psychiatric discourse, the issue is not as clear cut as this. Indeed there were times when families did accept its principles, notably its imperative for individuals to monitor their own health (Lupton 1995). Drawing upon Foucault's notion of the clinical gaze, I attempt to show how the suicide of a loved one often meant that family members inspected and scrutinised each other for signs that they were developing similar behaviour patterns or thought processes to the young man.

In the final part of this chapter, I turn to the topic of genetics. In the past few decades, genetics has become a burgeoning area of research, fuelling interest in genetic issues by the lay public and the mass media. Genetics is an integral part of contemporary biomedicine, predicting great advances on our understanding of health and illness (Finkler *et al.* 2003). In this respect then, it is hardly surprising that when conversations centred upon mental illness and psychiatry, the topic of genetics often seeped in. Once again these narratives were invariably structured around either accepting or resisting a genetic understanding of suicide.

## APPEALING TO PSYCHIATRY:

### ‘WELL OBVIOUSLY HIS MIND WAS DISTURBED’

Psychiatry problematises individual behaviour. A central feature of mental illness is that the sufferer exhibits behaviour and features deemed to be abnormal by the medical profession. A person’s conduct is what is held up as being a sign of the existence of mental illness. So with depression the features viewed as abnormal are self-hatred, lack of energy and low self-worth. With schizophrenia there are hallucinations, delusions, paranoia, complex thought processes and withdrawal from social life. Within the medical profession it is generally accepted that there is a strong link between depression, schizophrenia and other psychiatric conditions such as alcohol and drug abuse and suicide (Kelly *et al.* 2002). It is hardly surprising therefore, that when trying to make sense of a suicide, families often attempted to construct their loved one’s death in line with psychiatric understandings. What this means then is the young man’s behaviour is problematised in line with knowledge produced by psychiatry and the medical profession.

Kai did not have a history of mental illness. He was neither diagnosed by the medical profession nor displayed behaviour that his family were *sufficiently* concerned about when he was alive. However, when thinking about possible reasons why Kai killed himself, Gayle told me:

I think, I’m sure there must have been some mental health things going on ... you know there are so many theories now, there always are when somebody dies. Perhaps he was manic-depressive; perhaps he was schizophrenic, probably, possibly, I don’t know.

(Gayle, Kai’s mother)  
(Face to face interview)

What we see here is Gayle actively pulling in psychiatric labels to help her make sense of Kai’s suicide. She is relying on the problems that the medical profession have outlined as causing suicide. So even though when Kai was alive his mental health was not conceived in a way that led Gayle to any real cause for concern, after his death Kai’s mental health is pulled sharply into focus, so much so that it is the

only way that his death becomes intelligible. We can see the same when Tessa talks about Matthew:

Well obviously his mind was disturbed. He was looking at things in a very distorted way. You know that's just my guess. I'm sure he must have been thinking ... um ... Well he must have been depressed or something. I mean my brother was bipolar so he could well have been too.

(Tessa, Matthew's mother)  
(Face to face interview)

As with Kai, Matthew had not been diagnosed with any sort of mental illness. Although Tessa did express some concern about Matthew when he was alive, these were by no means dominant and were often centred on her worries for his future – Matthew had left university before finishing his degree. Similarly to Gayle, we can see Tessa constructing her son's death in line with the understanding provided to her by the discourse of medical-psychiatry. What we also see in this passage is something about the role of the family and genetics. It seems as though Tessa is also drawing upon ideas offered to her by genetics – he killed himself because it was in the family. I will return to this in greater detail later in the chapter; however it is important to note at this stage that ideas around psychiatry and genetics are bound up with feelings of responsibility and guilt, as they so often are with suicide (see e.g. Coyle and MacWhannell 2002; Fullagar 2003). By drawing upon ideas offered by psychiatry, Tessa does not understand Matthew's death in such a way that makes her responsible. There seems to be something about psychiatric labels when people are *not* diagnosed with a mental illness that work to lessen some of the guilt and responsibility that families inevitably feel.

What I am not suggesting is that constructing suicide in line with the medico-psychiatric discourse will always be a negative thing. When talking about psychiatry and the hold that it has over the way that we think about mental illness and suicide, it is far too easy to focus upon issues such as social control. This ignores the fact that it can be a real source of comfort and reassurance to the families at a distressing and traumatic time. Here we see Beth talking about her brother Howell:

Beth: You know, I've had periods in the morning where I wake up in the morning and I just start crying. And there's no reason for it, you just don't feel like doing anything ... and that's what I imagine he was feeling.

Nina: So do you think he suffered with depression?

Beth: He was depressed enough not to think logically about what he was doing, not to realise that things could get better.

(Beth, Howell's sister)  
(Face to face interview)

Not only is Beth seeking reassurance in the definition of depression that Howell was not thinking logically, thus making his death intelligible, we can also see that the psychiatric category of depression is being used as a form of shelter. Psychiatric categories offer a source of explanation for suicide. So when Beth draws upon depression to explain Howell's death, even though there is no formal diagnosis, the category takes on responsibility for her brother's death, consequently absolving her. This is not to say that feelings of guilt and responsibility are not present when Beth talks about her brother, but the use of the category is a form of shelter, softening any potentially stigmatising reactions others may have towards her.

Despite the relative ease with which these family members invoked a psychiatric understanding of their loved one's death, it was not always accepted. The medico-psychiatric discourse is arguably dominant in the construction of suicide and being dominant means that it will inevitably incite resistance. Indeed Foucault has shown how the exercise of power inevitably produces resistance as the two are intrinsically linked. As he says in *The History of Sexuality*, 'where there is power, there is resistance' (Foucault 1990: 95). It is to the subject of resistance, specifically the families' resistance to psychiatry's construction of suicide that I now turn.

## RESISTING PSYCHIATRY:

### ‘HIS ILLNESS WASN’T A PROBLEM’

Foucault’s writings on resistance have received relatively less focus than those on power. While his academic writings dealt with the issue of power, the topic of resistance was left to his political writings (Bloor and McIntosh 1990). The idea of resistance, however, is central to Foucault’s understanding of power. Indeed, ‘power, Foucault remarked, provokes resistance’ (Bloor and McIntosh 1990: 94). This would seem to be inevitable. After all there is no one view on suicide but rather a number of competing discourses and groups which all seek to produce different versions of the event. For instance whilst the discourse of medical-psychiatry has the dominant position when constructing suicide, it is not the only way it is understood. As I outlined in chapter two, the medico-psychiatric discourse, broadly contributing to the positivist tradition, stands in stark contrast to the understandings put forward by those using an interpretative approach, with its emphasis on the importance of subjective meanings. In addition, when looking specifically at young men’s suicide, we can see alternative or ‘resistance’ understandings with the increasing use of the ‘crisis of masculinity’ discourse to explain their suicide.

The point is that because these categories and discourses are not natural, there will always be competing understandings attempting to structure the way that we think about suicide – they are part of the effects of power. And one of the reasons that people are able to resist the forces of power is precisely because people recognise that there are different versions of an event. So during a doctor/patient encounter, for example, the patient is able, to some extent, influence the treatment decision by attempting to deflect the conversation from the topics on symptoms and history to the topic of alternative treatment options (Bloor *et al.* 1997). (Although the extent to which this is achievable in psychiatrist/patient encounters is arguable). What this means is that without any final authority to make people believe, we are in a sense partly free to shop around for what we believe and resist what we do not accept. The point is that power and resistance cannot be separated. As Bloor and McIntosh (1990: 104 my emphasis) maintain ‘power provokes resistance, indeed there is a sense in which power *creates* resistance’. With this in mind, we would expect to

uncover instances of resistance amongst families' understandings of their young man's suicide. Moreover since power provokes resistance, we would expect techniques of resistance to be diverse in form, since they will be local reactions to local and diverse forms of power.

Jan's son Gareth was diagnosed with schizophrenia in his early twenties. He spent a lot of time in and out of hospital and had made a number of suicide attempts before he actually killed himself when he was 31. When answering my question about what happened leading up to Gareth's diagnosis Jan told me:

He just wanted someone to come and help him take over [his life]. We all just wanted something to happen and I really thought that they would help ... but they said that there was 'nothing wrong with Gareth. Gareth wants attention. He's attention seeking'. And Gareth had to get a lot worse before they took him into hospital. And it was, it was literally, it must have been six years before they said he was schizophrenic.

(Jan, Gareth's mother)  
(Face to face interview)

During her first encounter with the mental health services, far from rejecting the psychiatric model, Jan is actually appealing to it. Both Gareth and his family initially sought help through the apparent benefits they thought psychiatry could offer them, as we can see when Gareth is described as wanting "someone to come and help him". But these perceptions of the psychiatric services and the perceived benefits that they could offer dissipate once Gareth was contained within the system. What was left was a strong sense of resentment and antipathy not towards individual doctors and psychiatrists but at the values and standards of the institution of psychiatry as a whole. We can see this in another extract from Jan's interview:

They just didn't understand his needs – they kept getting him wrong. Like they told him he didn't have to go to the hearing voices group because they weren't a problem to him. But they were. I'm his mother and I know that his voices were a problem.

(Jan, Gareth's mother)  
(Face to face interview)

Interestingly despite Gareth's diagnosis and psychiatry's assertion of the link between schizophrenia and suicide (Kelly *et al.* 2002), Jan didn't think Gareth's illness had anything to do with his suicide. Instead she told me of a number of incidents that

had happened in the months leading up to his death that she thought had more bearing on his suicide, particularly an incident with the police. However, she went on to tell me that during the inquest, all that they had focussed on was his schizophrenia, as she said:

It was just the fact that he had a mental illness that was considered important.

(Jan, Gareth's mother)  
(Face to face interview)

This understanding ran through many of the families narratives. And interestingly it was often amongst those whose sons or brothers were diagnosed with a mental illness. For them their illnesses were not the sole *reason* they killed themselves. It was other social or situational factors – a relationship breakdown or unemployment were some of the reasons put forward.

Camille's husband Hugh was diagnosed with bipolar disorder. But when talking about the person that Hugh was this is what she told me:

My husband Hugh was an extraordinarily bright and educated man ... His illness really wasn't a problem in our lives. Our life was so incredibly wonderful and really very normal right up until he was made redundant.

(Camille, Hugh's wife)  
(Online focus group)

This emphasis on normality featured prominently in many of the resistance discourses. Willig (2000) suggests that looking at resistance to dominant discourses enables the examination of alternative subject positions as well as subversive practices. With this in mind, what became apparent from the resistance narratives was that families accessed a discourse of normality as a means of minimising their son or brother's difference to other people. This is certainly alluded to in the following extract from Lucy:

I only wish there had been signs. The night he died, he was good. I don't mean good, manic good, but normal. He, Jen and the kids came round in the afternoon. We had supper together. Jen said that he seemed fine that night. How could we have known?

(Lucy, Mike's sister)  
(Online focus group)



Significantly then, Lucy emphasises normality in her reflections on events leading up to Mike's suicide. By positioning Mike as normal, Lucy not only attempts to detract any negative social judgement but also attempts to absolve herself, or at least lessen any feelings of guilt or responsibility that she may feel.

## Psychiatry's Gaze

The resistance narratives were often bound up with resentment towards what families saw as the 'prying nature' of the mental health services generally, and psychiatry in particular. Issues relating to surveillance have been particularly seductive to health researchers since they were first introduced by Foucault (1977, 1990). He saw surveillance as one of the principle ways of disciplining and managing people and their bodies. Whilst initially seen within the (panoptic) prison in the eighteenth century, nowhere is this more apparent than in the field of health-care. Indeed Foucault discussed the ways in which medical and psychiatric patients have been subjected to an institutionally validated gaze that monitors their every move. Doctors and psychiatrists embody an institutional gaze as they carry out their work of evaluating their patients in terms of their bodies, behaviours and attitudes. From the routine questioning of patients about how they are feeling to the confession of counselling to the overt observation of patients behaviour within the walls of the psychiatric hospital, surveillance is central to the operation of psychiatry:

He absolutely hated it there. I still firmly believe that place made him worse, not better. The namby pamby, talk to me about your feelings didn't cut it for him. But then of course because he wasn't complying they started to observe him in more in direct ways. How is that good for someone who is already paranoid?

(Cindy, Mark's mother-in-law)  
(Online focus group)

Here we see Cindy referring to two criticisms that have traditionally been levied at the practice of psychiatry; its surveillance and its iatrogenic effects. In the 1970s Bergin (1971) highlighted the so-called 'deterioration effect' of 'psy' therapies, where symptoms get worse during the normal course of treatment. This is clearly evident in Cindy's narrative where she explicitly states that her son-in-law deteriorated during

his stay at a psychiatric hospital. The iatrogenic problems of psychiatric treatment are well established. Often attributed to the problems of psychotropic drugs (Smith and Henderson 2000; Nasrallah and Mulvihill 2001) there has also been research that has pointed to the iatrogenic effects of the psychotherapy approach to treatment. The following quote perhaps more clearly establishes the centrality of surveillance to the everyday operation of psychiatry within the walls of the hospital:

The one psych ward was awful. It also made him worse than he was. The nurses were fucking rude. Kept checking on him without actually doing anything!! Their charts were more important than he was!!!!

(Lynn, Trevor's partner)  
(Online focus group)

Once again we see the iatrogenic problems of psychiatric treatment coming to the fore. In Lynn's narrative, however, the iatrogenic problems resonate strongly with Foucault's (1977) notion of disciplinary power. She alludes to the use of a psychiatric assessment, a practice frequently used by health authorities in their initial stages of assessment (Hazell 2000). It is against this grid of perceptions (Foucault 1973) that a patient's needs and deficiencies can be established and their progress monitored. Furthermore, the very techniques used to administer this type of surveillance are evocative of the disciplinary regimes described by Foucault (1977) in his account of military and prison yard drills. The surveillance that Lynn describes, then, could well be a form of monitoring Trevor's behaviour for the purpose of promoting and sustaining behaviour change.

In addition both Cindy and Lynn allude to psychiatry's silencing of their loved one's voice. Pilgrim and Rogers (1993) have drawn attention to the assumptions that many mental health workers make about the inability of their patients to hold valid opinions. The disregard of the patient's opinions about their illness and treatment can be seen when Jan talks about Gareth's experience of attending a hearing voices group:

It was probably only six months before he died that there was actually a 'hearing voices group' at the place he went to. And um... That was when they finally accepted that Gareth did have voices. And not only did they accept that he had voices but now they start saying that Gareth has the worst kind of voices, the worst of the worst. And now I have to start getting Gareth to talk to me about them. But how could I get him to talk to me when he blamed me? He blamed me and often didn't want to speak to me. To me or to anyone.

(Jan, Gareth's mother)  
(Face to face interview)

Jan had been concerned about the fact that Gareth's voices had not been recognised by his mental health team. Indeed this was one of the main criticisms that she had about her son's treatment. In her case then, it was not only the patient's opinions that were ignored, but the family's as well.

Despite the open hostility and resistance that many of the families had towards both psychiatry's construction of suicide as well as its day to day operation, the issue was more complex than this. It could be argued that families were resisting the psychiatric management of mental illness, viewing it as an explicit form of social control. However, this does not automatically mean that there are a dominant group of psychiatric professionals who consciously exploit their vulnerable patients. Rather the notion of disciplinary power suggests a far more pervasive, impersonal and blameless form of powerful knowledge, operating within a network of cultural values. Instead, following on from the previous chapter, I want to argue that the principles upon which psychiatry and its associated disciplines of, amongst others, psychology and psychoanalysis, have become so embedded in the values of late modern society, that we have increasingly come to take them for granted as prerequisites of the healthy self. So whilst some families were resisting the treatment and management of the young man, critiquing the explicit surveillance of their loved one in the form of assessments and checklists, this does not mean they have not internalised the clinical, 'psy' discourse. Indeed, there were instances where families turned the gaze onto themselves. It is the family as a site of surveillance that I now want to consider.

## SURVEILLANCE

The continuing trend towards surveillance medicine (Armstrong 1995) that has developed in contemporary Western societies, ultimately directs the Foucauldian clinical gaze onto the spaces between bodies, encouraging us to monitor our own health (Hughes 2000). As a result, health is increasingly being constructed as a commodity, one that is constantly pursued but never fully reached by the 'worried well'. However, could the bereaved by suicide be described as the 'worried well'? After all, they are living with the pain and heartache of losing someone to suicide. What emerged from my data, is that the experience of loss and grief ultimately meant that the pursuit of emotional well being through surveillance featured prominently in the families' lives. Following the suicide of a loved one, those left behind seem to be inspected, compared and scrutinised for signs that they are developing similar behaviour patterns or thought processes to the son or brother. Searching for an understanding of suicide often had implications for surveillance and risk assessment. As a result the family narratives are suffused with implicit accounts of surveillance.

### Self-surveillance

What becomes apparent from the narratives when looking at the family as a site for self-surveillance is that rather than individuals surveying their own behaviour for signs of deteriorating mental health, the focus tended to be how their own actions and behaviour affected other family members. We get a sense of this in the following passage from Tessa:

I think everything I say to Gemma now, I'm thinking, don't say that to her cos that could have x implication. Don't say that 'cos she would think that.. You know, that's what I'm thinking all the time, be careful what you say to Chloe, she might, she might have depression later on. Just be so careful, don't shout at her, don't raise your voice, don't do this, don't do that. You know, you think of everything you say.

(Tessa, Matthew's mother)

(Face to face interview)

Tessa is clearly monitoring her own actions here out of fear for the well-being of her family. Interestingly despite earlier drawing a genetic understanding of her son's death, here we see the social environment seeping back in – it is the family environment and her parenting skills that are being monitored.

## Surveillance of Others

As well as scrutinizing their own behaviour, data also revealed the continual surveillance of other family members. Often combined with lengthy conversations about their fear over losing other family members, the suicide of their loved one provided families with reasons to survey, check and monitor family members behaviour:

I do worry about mum. Yeah she's my biggest worry. I phone her everyday, sometimes twice an' if there's any hint of something then I'm right up there.

(Nicola, Simon's sister)  
(Face to face interview)

Despite Nicola expressing worries for her mother, the surveillance of others was often expressed in terms of parental concerns for their remaining children, as we can see from Peter:

And I was worried Ben wasn't talking and what if he was going to do something because he wasn't talking. You know, does he need counselling, does he not need counselling, took him to a psychiatrist.

(Peter, Joel's father)  
(Face to face interview)

Here we see Peter scrutinising his son's behaviour out of fear that he is repeating his brother's behaviour. As he went on to tell me, "if there are any warning signs then I'm straight onto him". In the extract above, this action comes in the form of a psychiatrist. So even though Ben was described as mentally healthy – indeed the psychiatrist said "there's nothing we can really do" – the continual surveillance for signs of mental ill health was still very much a part of their lives.

Jane similarly expressed worries that led her to constantly check her sons' emotional health:

We worry about them, well maybe not James so much because he's got Steff, but Alex, yeah. I'm always um, not trying to be obvious, but checking, you know, checking he's okay, checking he's happy.

(Jane, Liam's mother)  
(Face to face interview)

The surveillance of their children by many of the parents could certainly be due to the nature of the relationship. Family relationships were an important structuring factor for many of the families' experiences, as we will see in the case of their experience of stigma in chapter seven. In relation to surveillance, it is hardly surprising that parents felt an overbearing need to monitor their remaining children. After all, as Owens and colleagues (2008) have speculated, a parent whose child decides that life is not worth living may well feel that they could be accused of failing in their responsibility to their child. In terms of their remaining children, it could well be the case that parents not only feel this responsibility more acutely, but simply want to protect their family (and themselves) from further pain and suffering.

The issue of familial responsibility is further complicated when the role of genetics is isolated. The new genetics is a vital and vibrant part of biomedicine, promising to add to our understanding of disease and illness (Finkler *et al.* 2003). 'Genetic responsibility' and 'genetic inheritance' are key to these understandings. Despite many uncertainties recognised by medical geneticists and genetic counsellors (Finkler *et al.* 2003), the notion of genetic inheritance has grasped the imagination of the mass media and the lay public. And conversations with bereaved families were no different, with many tentatively using genetics to help inform their understanding of suicide. Indeed when conversations centred upon psychiatry and mental illness the topic of genetics often seeped in. Furthermore, similarly to conversations about psychiatry and mental illness, the issues of responsibility, guilt and blame were often the motivating factor to the talk.

## GENETICS

Issues of familial responsibility in the management of health and illness are commonplace. But when genetics is isolated these issues become heightened, simply by the very nature of hereditary risk (Arribas-Ayllon *et al.* 2008). The place that genetics takes in issues relating to biomedical knowledge, kinship and personal identity is a burgeoning area of research, one which was also tentatively dealt with by the families. A feature of the so-called 'new genetics' is that responsibility for the management and prevention of risk is no longer simply an individual realisation but a family obligation (Lupton 1995). It could certainly be the case then that a genetic diagnosis in the family could generate responsibility through self-blame and guilt. Many studies have found that parents often report feelings of guilt and blame after their children have been tested positive for a genetic condition (Chapple *et al.* 1995). But how does this relate to families whose loved one has killed himself? Despite some preliminary steps, a suicide gene is undiscovered. But then with the discovery of genetic patterns associated with schizophrenia (Finkler *et al.* 2003) and arguments in favour of the hereditary risk of bi-polar disorder (Meiser *et al.* 2005), it could certainly be suggested from within psychiatry that genetic risk of suicide is conceivable. Indeed, in their review of medical studies, Roy and colleagues (2000) maintain that there is in fact a genetic component to suicidal behaviour. With regards to conversations with bereaved families, the recent debates surrounding such issues seemed to have filtered through to their understandings. In many of the narratives, families often wrestled with the idea that their loved one's suicide and suicidal behaviour may be connected in some way to a genetic component. But herein lies a contradiction. If parents use psychiatry and its attendant construction of suicide – either by appealing to or resisting its understanding – as a way of lessening some of the guilt and blame that they feel, then surely the issue of genetics would place responsibility firmly at their feet again? After all, it would be the parents who had potentially passed on the 'faulty gene'. However, interestingly my data revealed that this was often *not* the case. Sometimes explicitly and sometimes subtly, the inherited component of young men's suicide and suicidal behaviour often worked in order to lessen the responsibility that the *parents* felt.

## The Geneticization of Suicide

In the following extracts we see parents attempt to invoke a genetic understanding of their son's suicide. This first extract from Gayle followed a conversation about her pain at not realising the depths to which Kai had fallen:

I have been depressed on and off for many years. I mean not just, you know, I'm feeling a bit fed up depressed but I can't get out of bed today depressed. Umm.. My uncle was either a schizophrenic or a manic-depressive, more likely the latter ... Umm.. You know I've tried really hard to go down the route that says, you know, depression is learnt behaviour, you can change the way you think, you can change your life and actually I can't. So I'm now a paid up member of the medical brigade believing that it's an imbalance in your head and that's the end of it.

(Gayle, Kai's mother)  
(Face to face interview)

This account is interesting in that Gayle makes no mention of Kai. However, the role of the family, kinship and hereditary risk is clear. Initially Gayle told me about her own experiences of living with depression. In some respects this could be seen as a justification for her knowledge on the area, as someone who has lived with depression "on and off for many years". This could also serve as a further understanding, one that positions mental illness within the family. This becomes further established in the next sentence, where she states that her uncle was "either a schizophrenic or a manic depressive". No further explanation is given to this fact, although if we remind ourselves that Gayle speculated whether Kai was himself schizophrenic or manic depressive, then perhaps the significance becomes clearer. Without explicitly mentioning genetics, the talk of her own experiences of depression and the signalling of a family member who suffered from a serious mental illness certainly alludes to the possibility of hereditary risk. This inference is further established in the remainder of the extract where Gayle explicitly states her belief in the biological causes of mental illness. For Gayle, mental illness is due to bio-chemical disturbances in the brain – it is a neurological disorder. And although she does not specifically talk about Kai, the potential that this understanding has for her construction of his death is particularly powerful. His (undiagnosed) mental illness and subsequent suicide is not caused by bad parenting or the social environment but rather is the result of a genetic imbalance in the brain; a genetic imbalance that Gayle herself was not immune to. The potential



of this understanding is clear – if a mental illness is genetically based, then although Gayle may have passed on a ‘bad gene’, it cannot be attributed to bad parenting. What we can begin to see is the blame-reducing quality of genetic attributions (Phelan 2002). In the next extract, Zeke talks about his beliefs about the origins of his son Paul’s illness:

I feel that there is an inherited component from me that maybe made him very shy and one who wanted to run from his problems rather than face them squarely.

My wife feels he got a bad combination of genes from each of our families plus some bad behavior.

I think our survival as a family has been that we knew that Paul was very sick when he took his life.

(Zeke, Paul’s father)  
(Online focus group)

Zeke’s account of ‘bad’ genes is not just the focus of the family’s search for meaning and understanding, but is also associated with the transmission of other traits. Here we see Paul’s shyness and a tendency to “run from his problems” being constructed genetically by his father. These behaviour traits, which Zeke sees as significant in his understanding of Paul’s suicide are effectively reduced to a biological origin. But despite seemingly drawing a (genetic) resemblance between himself and Paul, Zeke manages to deflect any direct responsibility that he may feel for his son’s suicide. This is developed in the following sentence, where Zeke talks about the route of Paul’s ‘bad’ genes; it is the combination of Zeke and his wife’s genes and not simply his. So despite presumed genetic resemblance between father and son, by bringing in the contributory factor of his wife’s genes then Zeke attempts to manage his feelings of blame and guilt. So even though he adopts a genetic understanding of Paul’s suicide, to accept (genetic) responsibility would imply that he had children from a knowing position about the “bad combination of genes”, which clearly he did not. The following quote from Kim further develops this point:

He showed me no signs of depression, which is something I know a lot about because I have suffered with it all my life, it runs in my family. It's a family disease. He had none of these signs. He gave nothing away, nor did he ever talk about suicide. He was a very happy, upbeat and involved in all kinds of activities.

(Kim, Sam's mother)  
(Online focus group)

In this first extract from Kim, she talks about the hereditary nature of depression in her family. She is clear that there is a genetic basis to the depression that “runs in [her] family”. However, the genetic basis to mild depression has not been proved. Indeed even with major depressive illnesses such as bipolar disorder, despite several chromosomes being implicated, susceptibility genes have not yet been cloned (Sklar 2002). Even though such uncertainties are recognised by medical geneticists and genetic counsellors, the notion of genetic inheritance has grasped the imagination of those with a family history of numerous diseases such as depression. And this is clear in Kim's opening sentence. What is interesting in this passage is the suggestion that her son was not susceptible to the family history of depression. She talks about her surveillance of Sam – his behaviour is seemingly inspected, compared and scrutinised for signs that he has inherited or may be developing what she believes to be a family disease. She makes a comparison between herself, someone who has suffered with depression “all [her] life” and her son. And Sam's behaviour led her to no real cause for concern. Throughout all her responses to the focus group questions, Kim expressed no worry for her son prior to his suicide. And this is clear in the passage above where she talks about Sam being a “happy” and “upbeat” young man, displaying “no signs” of the “family disease”. However, if we look at her response to my question about what she felt was important in Sam's decision to end his life this is what she said:

I tribute his death to hormones/ genetics. He grew almost over night ... In our family we all have a high impulse reaction to stressful things. Most of us yell and scream, he took it a step further. As far as understanding it, I guess that is as close as I will ever get, I don't think any type of suicide is understandable.

(Kim, Sam's mother)  
(Online focus group)

The most striking point in this passage is that despite initially dismissing the possibility of Sam inheriting depressive characteristics from her or her family, she

goes on to attribute his suicide to genetic inheritance. She furthers this by talking about personality characteristics that the family share. But why would she reach this understanding, albeit cautiously, when she previously stated that Sam showed none of the family traits? As we will see in chapter six, there was a suggestion that Sam had been the perpetrator of sexual abuse (although this is never actually explicitly stated) and this discovery could certainly be a motivating factor behind his suicide. Yet this possibility is never raised by Kim – for her the reasons behind Sam’s suicide seem to be genetics. In some respects reaching this understanding absolves her of guilt in two ways. Firstly, she cannot be blamed for missing the “family disease” and therefore any susceptibility Sam may have had to suicide as he displayed “none of the signs”. The fact that she understands her son’s death genetically, like Zeke, means that his death cannot be attributed to bad parenting or weak character. And secondly, not only are Kim’s potential feelings of blame and guilt lessened but at the same time Sam is in some respects exonerated. His suicide is not a result of an immoral character but rather a genetic flaw.

In the following narrative, Jan talks about Gareth’s younger brother Jeremy. In an earlier part of the interview she told me that they had always had a “very close” relationship. Here Jan talks about Jeremy’s fears about his own mental health as well as her own worries for him:

Jan: I can’t get him to talk about him really. I mean, I know it frightens him ‘cos he would, he would only have been 18, nearly 18 when Gareth was first ill. And I know he walked in the kitchen, through the garage into the kitchen to me, um, because he was at his father’s and his father had brought him back here and said, ‘Is it gonna happen to me? Am I going to get like that?’ And I said, ‘No don’t be silly, of course you’re not’. But I, I worry about him as well.

Nina: Do you have the same worry for your daughter as well?

Jan: No, no. No she would just drive somebody else to suicide. No it’s, it’s funny isn’t it, no I don’t. It’s not funny, but no I don’t.

Nina: Is that because of who he is or...

Jan: The fact that he’s male, it’s usually the males who get it [schizophrenia] isn’t it?

(Jan, Gareth’s mother)  
(Face to face interview)

In this passage, we see Jan alluding to the issue of genetic responsibility, a topic that has received increasing attention within academia (Featherstone *et al.* 2006; Arribas-Ayllon *et al.* 2008) and the media more generally. From the position of the Western liberal tradition, parents have at least a right to ignore genetic information concerning themselves. As Vehmas (2001) has pointed out, the respect for people's autonomy ultimately means that we let them make decisions for themselves, no matter how foolish these decisions may be – particularly if these decisions do not inflict harm on other people. The issue of genetics, however, throws this into question. In Jan's case, although there is no genetic testing for schizophrenia (U.K. Genetic Testing Network 2008), and genetic risk is therefore still only speculative, she still alludes to the potential for her son to inherit the disease. We can see her drawing upon an understanding that men are at a heightened risk of suffering from the disease, which adds to her concerns over Jeremy. However, far from discussing this, when her younger son voices similar concerns, she jokingly dismisses them.

Literature regarding family communication on genetic risk has pointed to times when individuals limit the information that they give to relatives (see e.g. Hallowell *et al.* 2006; van der Nieuwenhoff *et al.* 2007). It has also been highlighted that communication and disclosure on genetic risk often rests on the person's risk of having the mutation and the family's general disease history (McGivern *et al.* 2004). In Jan's case however, the absence of an established genetic risk means that any discussion within the family will only ever be speculative. This could therefore be seen to limit family talk about genetic risk in a bid to curtail already heightened concerns.

## **Refuting Genetics**

Jan clearly alludes to the fear that her younger son has of developing a mental illness, specifically schizophrenia, owing to his family history. This would seem somewhat understandable, after all the genetic component to schizophrenia is regularly reported in the media. Indeed a gene called COMT (catecho-o-methyltransferase) has long been suspected of being involved in the disease (Egan *et al.* 2001). Despite this it has been suggested that relatives, particularly siblings significantly over-

estimate their own personal risk for becoming ill (Austin 2005). This could certainly be the case for Jeremy. However, when it came to making sense of their brother's death, genetics played a relatively minor part in many of the sibling's understandings. Indeed far from echoing the concern about genetics that many of the parents expressed, the role of genetics in their brother's death was often played down by many of the siblings. This becomes clear in the following conversation between Nicola and her mother Lorna:

Nicola: But you had aspects where you thought he was manic depressive.

Lorna: I've been trying to look for a reason.

Nicola: He wasnae schizophrenic, definitely not an' I don't think he was manic depressive. It was ... He wanted to make Lauren suffer.

(Lorna and Nicola, Simon's mother and sister)  
(Face to face interview)

In this passage we have differing understandings of Simon's death. Whilst not specifically about genetics, Lorna is clearly invoking a psychiatric understanding of her son's suicide. Interestingly Nicola does not accept this. For her it wasn't Simon's mental health but rather an outside environmental trigger (his ex-partner) that helped Nicola make sense of her brother's death. And while we can only really speculate about possible reasons for the difference, it could certainly be something to do with the difference in relationship between siblings and parents. As I go on to discuss in chapter seven, parents often feel the intense feelings of blame and guilt most acutely. Indeed, I have demonstrated earlier that invoking a genetic understanding of their son's suicide can go some way to lessen parent's feelings. Of course I am not saying that siblings do not feel guilt and blame. But what I am suggesting is that the difference in the relationship with the deceased could well account for its lack of importance in the siblings narrative.

So why does the guilt and blame reducing qualities of biological attributions and genetics have more significance in the parent's narratives? What became apparent from the data was that it was exactly the inherited, genetic basis of mental illness and suicide that the siblings were rejecting, and this was often rejected out of fear:

I'll never forget when I was 16 and my brother had just killed himself I was in Film class and there was this guy (he was a really sweet guy actually) talking about some new kid from Vegas and he said "I heard his dad killed himself. He must be really fucked up" ... He was almost laughing as well. For along time it bothered me because it seems if you have an association with suicide you must automatically be suicidal and screwed up or something.

(Christine, Jon's sister and Martin's daughter)  
(Online focus group)

Stigma has been discussed in much greater depth in chapter seven, although the concept also has relevance when talking about many of the sibling's rejection of genetic understandings of suicide. Christine, a mentally healthy young woman, shows some concern about being tainted via a genetic connection to her brother and father. Just as stigma can persist for years after the suicide of a loved one, genetic labelling could mean that stigma comes to pre-date any sign of problematic behaviour from other family members. This becomes clearer in the following passage from Christine:

My last boyfriend used to call me crazy if I so much as said a cross word to him. Its like people are waiting for me to screw up. I also worry about how future boyfriends will take it.

(Christine, Jon's sister and Martin's daughter)  
(Online focus group)

Phelan (2002) has usefully come up with the term 'anticipatory stigma' to refer to the fact that genetic advances have the potential to create whole new labels for family members – 'carrier' or 'at risk' for example – who are related to someone with a potentially genetic illness. This potential could be seen to have had ramifications for Christine in the sense of her fear of potential rejection for a future partner, as well as discrimination and bullying within the school, based solely on her family's history.

Ultimately then, what seemed to emerge from many of the siblings narratives is that when considering the genetic element of their brother's mental health and subsequent suicide, issues surrounding fear come to the fore – fear for their own mental health and fear of the assumptions that others will make about them.

## CONCLUSION

In this chapter I have shown how families struggle to make sense of the suicide of a loved one. The dominant discourse of medical-psychiatry is central in their understanding, presenting different challenges to the families but also offering them opportunities to lessen feelings of responsibility therefore restoring the family to a successful unit.

Somewhat surprisingly, since the literature continually establishes the link between suicide and mental illness (see e.g. Beautrais 2000), all families whose loved one had a diagnosis of a mental illness resisted drawing upon a medico-psychiatric discourse in order to account for their son or brother's death. The dominant discourse of medical-psychiatry only became relevant when the young man had no formal diagnosis of a mental illness. However, in their struggle to re-build their lives, all families – whether accepting or resisting the dominant discourse – attempted to create meaning in a way that lessened feelings of blame and responsibility.

Blaming is common following a suicide (Dunn and Morrish-Vidners 1987), with families often searching for a reason, someone or something to blame (Owens *et al.* 2008). For some families in this study, a psychiatric understanding of suicide takes on the responsibility for the death, therefore absolving the family; they blame the 'undiagnosed' mental illness for their loved one's suicide. However this was not the case when the young man had a diagnosis of mental illness. For these families it was an outside or environmental trigger that was to be blamed. Had these families drawn upon a medico-psychiatric discourse to account for their loved one's suicide, then it could be that they may be blamed for missing the signs of the young man's deterioration. Rather by emphasising his normality, their responsibility is lessened. Instead responsibility lies with unemployment or trouble with the police for example. Indeed the only time the discourse of medical-psychiatry comes to the fore is with the families' criticisms of the psychiatric services treatment of their loved ones.

The second half of the chapter explored the way genetics impacted on families' sense of blame and responsibility. Here we saw the blame reducing quality of medical/biological attributions coming into play. By drawing on a genetic

understanding of their loved one's (undiagnosed) mental illness, their suicide cannot be attributed to bad parenting or a weak character. Importantly, this understanding was only adopted by parents. Siblings on the other hand, had more difficulty in drawing upon a genetic understanding. This could certainly be due to the potential to inherit 'bad genes'. Whilst parents may have passed on the 'bad genes', the likelihood of them developing a mental illness late in their life is less likely than siblings. It could be the case, then, that siblings reject a genetic understanding out of a fear that they too will inherit a mental illness. In addition, we also explored the possibility of siblings resisting such understandings as a means of lessening any potential stigma that may be directed towards them.

It is important to point out that whilst the dominant medico-psychiatric discourse was important in the structuring of the families' understandings of their young man's *death*, I am not suggesting that these were concrete understandings. As we will see in chapter seven, families can invoke different interpretations depending on what they are explaining or justifying. Ultimately all families were attempting to make sense of the death in a way that helps them restore the past and reflect on the future. Therefore the *stories* that families tell about their loved one's death are crucial in helping to reveal their path through understanding. The potential that narrative can offer in helping to uncover the way families make sense of suicide will be explored in the following chapter.



## Chapter Six:

# SUICIDAL STORIES

### INTRODUCTION

The practice of telling stories about events that have happened is a universal human activity, one that is learnt early in childhood and then used and developed throughout a person's life (Riessman 1993). The range of stories that people tell is limitless – from a conversation about the day's work around the dinner table to reconstructing a painful event to a counsellor – we are all potential story tellers. As such the process of telling a story, the chronicling of what happened, who was involved, what was said and how the plot developed is often employed without much thought. Indeed social research often overlooks the process of telling a story, seeing the content of what was said as holding the key to unlocking people's understanding of an event. The content of people's talk is given primacy over how people tell a story. Narrative analysis turns this on its head. As Riessman (1990a) suggests, for narrative analysts *how* a person tells a story is important for understanding *what* is significant for the teller. To move away from what (is the story telling) to how (is the story told) enables us to move beyond the basic content of the story and towards an understanding of how individuals make sense and give coherence to their lives (Gubrium and Holstein 1998). We all attempt to make sense of disruptive events and painful experiences by attempting to put them into storied form. And suicide is no different. In this chapter, four longer excerpts from different suicide accounts are drawn upon to illustrate the different narrative forms that people draw upon. This begins to show how personal meaning and narrative form are related. That is, this chapter illustrates *how* the telling of the story is important for understanding what is significant for the teller.

A focus on narrative is integral to my overall approach. Like Riessman (1990b), I maintain that to see how individuals actually go about making sense of the suicide of a loved one, it is important to take language seriously, because in many ways, it is through language that we create our realities. As Riessman (1990a: 17) goes on to suggest, 'rather than bypassing the messy stuff of 'talk' it needs to come to the center of the analysis, so that we can examine what people mean by what they say'. Four excerpts, from longer narrative accounts, show how bereaved family members – Susan, Lisa, Jess and Kim – not only make sense of suicide, but also create who they are and their connection with their loved one's death through language and interaction. All of the narratives are the participant's accounts of their loved one's death – the story of their suicide. As will become clear, despite all four narratives being told in response to a question about 'what actually happened', this is where the similarities largely end. Whilst the accounts are the story of their young man's death, each participant constructs a very different understanding – four different ways of telling. In doing so, they select from a variety of different narrative genres and structures to make particular points and to create a context that allow the listener to enter into their experience. Significantly two of the narratives – Susan and Lisa – come from the face-to-face interviews, whilst Jess and Kim's narratives were told in the online focus groups. As such two of the narratives were *spoken* and two were *written*; therefore we would expect differences to emerge between them as a result of the different medium used. In addition Kim and Jess are from the United States whereas Susan and Lisa are British. Whilst a discussion on any cultural differences between the narratives from the U.K. and those from the U.S. is beyond the scope of this chapter, it is important to bear in mind that this could also have impacted on the differences in telling that emerge.

The first narrative is told by Susan, an artist who lives in a council owned house in a large British city. Zack was her eldest son when he killed himself at the age of seventeen. Her youngest son Scott was two years younger than Zack. Susan often found it difficult to talk about Zack's death, although the conversation flowed easily for her was when she was remembering Zack as a young child. The second excerpt comes from Lisa, a young woman working in finance, who lost her older brother Aaron to suicide a little over a year before the time when we spoke. Her contact with Aaron had lessened in the years before his death – she had only seen him twice

in the year before he died. Unlike Susan, Lisa tells a specific story about an incident immediately prior to her brother's death. Whereas Susan chooses to narrate about the general course of events following her son's suicide, as well as reflecting on the person that Zack was, Lisa pulls the listener into the hours before Aaron's suicide. Both narratives were told during the face-to-face interviews.

Jess is from the United States where she lived with her partner and his child in a single room in a shared house. They were due to move into a house together two weeks after Daniel shot himself. In all her narratives Jess rarely speaks about her partner, preferring to focus on her own healing process and the transition through her grief. The fourth narrative is from Kim, a housewife from a small mid-western town in the United States. She has two children and it was her eldest, Sam, who killed himself. Unlike Jess, in her various narratives Kim goes into great detail about the person that her son Sam was. What links these two women is that unlike Susan and Lisa, they both found the body of their loved ones and this inevitably has an impact on the story that they tell. In addition whereas the first two accounts were told to me during face-to-face narratives, both Jess and Kim's narratives come from the online focus groups.

The detailed method of transcription that I have used for the narrative analysis facilitates an analysis of the relationship between narrative form and meaning. In order to see how families actually construct their accounts of their loved one's death, 'cleaned up' speech would not be sufficient. Utterances such as 'hmm' and 'uh huh', therefore, are left in and pauses in the interview interaction are noted as 'p'. The online transcripts are unedited in terms of spelling. The lines are numbered for ease of reference in all four narratives and are loosely based on the start of a new theme. Before each narrative there is a brief synopsis of who the young man was. For the face-to-face interviews, I have paraphrased aspects that Susan and Lisa told me during the interview whereas the synopsis from Jess and Kim are in their own words.

## SUSAN: THE ABSENCE OF STORY

Zack was seventeen when he killed himself. He had been living away from home for a year, working and living in a hotel. Although he was a “bright boy” he got “really bored at school” and left before taking his GCSEs. When he found a job away from his hometown at the age of sixteen, in many ways “he’d achieved his life goal, which was to be independent”. Zack got involved with friends who smoked cannabis and took ecstasy and acid whilst living at home, although he appeared to stop taking drugs once he moved away. Zack hung himself in his bedroom but was not found for two days. He left a long, detailed note.

Susan answers my question about the events that surround Zack’s suicide as follows:

- 1 *Nina:* So what actually happened?
- 2 *Susan:* So.. You know obviously it’s that thing where you never really know why anybody decides to kill themselves...
- 3 *Nina:* No..
- 4 *Susan:* But... Umm.. I mean, to begin with, when it first happened
- 5 when it happened, or before,
- 6 because it was a couple of days until we got his note
- 7 because he did leave quite a long note.
- 8 But the police had that, and we just
- 9 at the time we went up there and not even (p)
- 10 Well you know, you’re just in such a state
- 11 having to go up and identify the body. (p)
- 12 We just drove up there, did that, and then just drove straight back, sort of thing, without thinking about anything. (p)
- 13 And then we had to go back a couple of days later to the hotel and get, (p) you know (p)
- 14 clear his room out and stuff (p)
- 15 and then we got the note then. (p)
- 16 So to begin with we were sort of thinking
- 17 I was just thinking, it’s about the drugs that he’d taken and being paranoid and, you know
- 18 I don’t really know why.
- 19 And I was just thinking, ‘Oh my God, he must have been really depressed, and I didn’t know
- 20 and I thought he was doing alright’ (p) You know
- 21 it’s like everyone thought that he sort of really like, you know, turned that corner
- 22 You know, really started sorting himself out
- 23 and everyone was like so amazed about what he’d done for himself.

24 And um.. You know like people were saying (p) you know he's doing really  
well.  
25 I mean I was still concerned about, certain things about him.  
26 Like we were saying, he's never like a really sort of happy, happy person.  
27 So it was sort of quite hard to tell  
28 because he puts up this front of sort of  
29 you know, 'Yea I'm alright, I'm fine'.  
30 And it's quite difficult to get information out of him about how he really is  
31 because he just finds it really uncomfortable.  
32 *Nina:* Hmm  
33 *Susan:* Yea, so you'd just sort of think, yea, great, that's good (p)  
34 You know, and you just sort of think, well yea (p) There's all these (p)  
35 When you're a teenager your head's all over the place  
36 everything is really, really dramatic  
37 everything is like the end of the world (p)  
38 Everything is so; your world is so sort of small, isn't it?  
39 It's just like, you're just thinking about yourself. ((laughs))  
40 Not about many other people.. And you know,  
41 like your friends and your girlfriend or whatever and that's your little world  
isn't it?  
42 And you don't, you don't know that you're gonna get over things and get  
through things and things will change (p)  
43 It's like, cos you haven't been alive long enough to know that have you?  
44 That things change dramatically.

Susan begins the narrative by saying that “you never really know why anybody decides to kill themselves”. This understanding of suicide is commonplace within the literature for support after a suicide. This literature in many ways encourages such a conception in an attempt to ‘limit’ the cycle of ‘why’ and ‘what if’ that many families can get locked into following a suicide (Carlson 2000; Robinson and Hart 2001). However for Susan, the significance of beginning her narrative with this statement also primes the listener for what to expect next – no clear reasons for Zack’s suicide. And indeed this is what follows – for Susan, there is no single incident, no isolated event that ‘contributed’ towards Zack’s suicide. And as a result Susan has no real story to tell about Zack’s death.

Susan orientates the listener to a time immediately after Zack’s death, drawing attention to the importance of his suicide note. Although she tells us that Zack left “quite a long note”, she doesn’t go into any more detail about it. Her choice of words is also important here. She begins by saying “his note” and “he did” when talking about what Zack did before his death. However Susan begins distancing herself from the event as soon as she starts talking about Zack’s suicide. Rather than

'his body', Zack becomes 'the body', 'his note' transforms into 'the note'. Changing pronouns in this way from the personal 'he' and 'his' to the general and impersonal 'the' to describe a distinctly emotional and personal trauma communicates her attempts to distance herself from the manner of Zack's death. Significantly, impersonal pronouns are only used when describing events directly related to the suicide. Once she moves away from talking about the event and begins reflecting on Zack's behaviour and possible reasons for his death, Susan reverts back to the personal – Zack becomes a person again.

So it could well be the case then, that it is just the act that she is distancing herself from. This practice could also be the reason why Susan never actually tells a story about Zack's death. The actual event is something that is managed by distancing herself from it. To put it into storied form would require a certain amount of emotional investment. Indeed Susan explicitly says that when Zack first died they did what was needed "without thinking about anything". What we get is a general description about her movements around the time of Zack's death, rather than the story that I invited. Habitually, Susan is able to recollect the events that happened in the days and weeks following Zack's suicide without actually communicating any of the pain and trauma that she must have gone through. This serves to indicate that she has great difficulty in talking about his suicide.

If we look at the passage from line 16 "I was just thinking..." to line 22 "and everyone was so amazed..", Susan moves away from the actual time of Zack's suicide and on to speculating on reasons behind his death, and as the content shifts, so does the narrative. Susan changes from a story to a habitual narrative<sup>3</sup> as she briefly recounts general events in the last few years of Zack's life that may have contributed to him ending his life. Once she enters this speculative habitual narrative, possible factors stumble out, although no conclusive explanation is reached. This is apparent when Susan states, "I don't really know why". Language in this passage is also revealing. Although Susan uses personal pronouns when speculating on reasons such as "it's about the drugs" and "he must have been really depressed", when she

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<sup>3</sup> According to Riessman (1990a) a habitual narrative is where the teller recounts the general course of events over time rather than telling a specific story.

starts reflecting on Zack's state of mind immediately before his suicide, she starts to talk about him in the present tense – “he's doing really well” and “he puts up this front”. Once Susan moves away from Zack's suicide it's as if he becomes a person again. Susan separates the two – *Zack* from his *suicide*. She also finds it much easier to talk about the person Zack was rather than his suicide. The beginning part of the narrative is littered with pauses and no actual story about the manner of Zack's death. However, she quickly tries to leave this part of the narrative to talk about the person that Zack was. And once she does the narrative flows easily for Susan.

Susan also constructs her narrative in a way that makes a broader 'moral' point about adolescence and the transition to adulthood. She draws upon an understanding of youth - a period between childhood and adolescence - which has been popularly characterised by transitional status, semi-(in)dependence and potentially a time for increased risk. Such risks are spelt out in Susan's narrative – the 'dramatic' events that can happen in a young person's life which can throw them off course in their journey to adulthood. Even though Susan doesn't talk specifically about Zack in this final part of the narrative, she alludes to factors that may have stalled his progress, specifically friendships and relationships.

## LISA: THE IMPORTANCE OF FAMILY

Aaron started smoking marijuana and drinking when he was fifteen although this only seemed to become a problem when he was at university. He was studying for a degree but left after his first year because he was unable to cope, mainly because his drinking had developed into something 'quite serious'. He admitted himself into a private hospital, specifically onto an addiction programme to help him overcome his alcohol abuse. This was relatively successful and once discharged he re-enrolled at university. However the alcohol abuse took over again and after three months he left university and moved back home. He made a serious suicide attempt shortly after being back home and was admitted back to hospital. For the next three years Aaron was in and out of hospital for alcoholism and depression, although always held down a job when he was not in hospital. Aaron killed himself by carbon monoxide poisoning when he was 24. It was his second serious attempt.

Below is the full narrative account that Lisa offered explaining the events leading up to her brother's suicide:

1        *Nina*: So what actually happened?  
2        I mean could you tell me a bit about his actual suicide?  
3        *Lisa*: He, he'd had an argument on the morning that he disappeared, with  
4        mum and dad  
5        because he'd got into a bit of debt again. I mean it wasn't (p)  
6        by the standards of his debts, it wasn't major or anything.  
7        The reason there was an argument was because dad was forever denying that  
8        he couldn't read.  
9        But he couldn't see anymore and he opened up the letter by mistake  
10       thinking it was addressed to him, and then realised (p)  
11       He completely blew up.. And um...  
12       And I think they'd spent the morning in stony silence  
13       and then sat down at lunch time and talked about it reasonably.  
14       Talked about um, you know, what he could do about it  
15       worked out a budget, that kind of thing.  
16       And after that mum said he seemed fine.  
17       It was a Friday.  
18       And dad had just bought an old car, a classic car  
19       and Aaron would help him work on it.  
20       So they spent two or three hours in the garage doing that.  
21       And mum said that she had thought that it had all, you know, just blown  
22       over.  
23       And um she went, I think when it started to get dark, she went to his room  
24       because she'd just assumed that he was in his room.  
25       And then they couldn't find him and they started panicking... Um..  
26       And he'd left a note again, but only a very short, sketchy one this time.  
27       Not nearly as detailed as the one he'd left the first time.  
28       So I don't know if that means that he was more spontaneous, I don't know.  
29       But he'd been planning it for a long time.  
30       He'd been planning it for about six months.  
31       He just didn't know when to do it.  
32       Because he'd been hoarding his antidepressants.  
33       One thing that mum said to me was that he'd been going to this group, it was  
34       a Mind group in a nearby village.  
35       Another problem is that mum and dad live in a village and it's very isolated.  
36       But anyway he'd been going to the Mind group, and um (p)  
37       she said that he'd told her about people who had told him (p)  
38       Like the standard conversation would be methods of suicide, and (p)  
39       I mean while you can't really control what people say, it just seems ridiculous  
40       that they,  
41       they were getting these people together for some kinda therapy.  
42       I mean he didn't go to all the groups; he went to the art one, because art was  
43       his big passion  
44       it's what got him through the last few months really (p)  
45       But anyway, I think he, I think just through talking about it at this group it  
46       had put it back into his mind, I really do.  
47       And while I think he was probably thinking about it anyway



41 talking about it with people just exacerbated it (p)  
42 Anyway so he'd been planning it for a while  
43 but I don't think he really knew when to do it.  
44 You know he'd been hoarding his antidepressants, and he'd even (p)  
45 he got a hose pipe and put it in the car.  
46 And he knew exactly what he was doing  
47 'cos he drove into the forest  
48 down a track where no-one was gonna find him....

Unlike Susan who refrains from telling any actual story about her son's death, Lisa begins the story of Aaron's suicide by immediately inviting the listener into the narrative world by orientating me to the place, time, situation and people involved. The way that Lisa structures this opening part of her narrative is significant. The first thing that Lisa tells me is that Aaron had an argument with her parents. The fact that it is the first thing Lisa says when answering the question about Aaron's suicide primes the listener to expect the argument to be of significance. However, despite beginning her narrative with a statement about an argument, Lisa is keen to paint a particular picture of the significance that it went on to play in the story of Aaron's death. In many ways it is as though she wants to back track from the initial emphasis given to the argument. The reason that Lisa gives for the argument is Aaron's debt, but then the scale of this is quickly dispelled. She immediately works to detract from the severity of Aaron's debt (and the possibility of it as a potential factor in his suicide) by stating that "it wasn't major or anything". This statement is then promptly followed with a new reason for the family argument – no longer about his debt, Lisa puts forward her father's failing eye sight as the reason. And even though Lisa briefly draws the listener into the somewhat cool and uncomfortable environment in the house, once again we see her working to lessen the impact that this plays in the narrative. As we can gather, she places far more emphasis on the resolution – things were reasonable, communicable and ultimately he "seemed fine". So despite there being an argument Lisa tries to persuade the listener that this was not of great importance in Aaron's suicide. In addition the resolution is then followed by normality, with Lisa setting the scene for normal family life. She describes an activity that Aaron and his father engaged in together for over two hours, an activity that she had said previously they both enjoyed. Talk of food, both lunch and dinner, also work to conjure up an image of a typical family day. The complicating factor – Aaron's disappearance – is introduced after Lisa has built up a brief picture of typical family life. Despite the argument there were no

concerns expressed about Aaron's emotional health, things had seemingly "blown over".

Having set the scene for a normal family life, Aaron's disappearance and his suicide note are introduced very quickly. This fairly rushed narration helps to convey the panic that swiftly engulfed the household. In many ways, it seems that Lisa's understanding of Aaron's suicide have not been firmly cemented, perhaps because Aaron's death was still relatively recent when we spoke (indeed she told me that she had only discussed Aaron's death with one close friend and her boyfriend). Maybe the narrative has not been told like this before, certainly it has not been rehearsed, as possible reasons stumble from one to the next. The length and nature of Aaron's suicide note, seemingly "short and sketchy", and its comparison with his last one almost force Lisa to make a snap judgment. A rushed note leads her to quickly make a decision that his death was spontaneous. Although as quickly as this judgment was made, it is then quashed. In the telling of the narrative, Lisa reflects on information she has since learned about her brother that simply will not support this possible explanation. In a very explicit manner, we see Lisa search for possible explanations and then discard them, initially the argument and now the spontaneity of Aaron's suicide.

Lines 26 to 29 are important. Up until now any reasons put forward in the narrative have been quickly dispelled. But here we see Lisa very succinctly give precise details about Aaron's intention. To communicate this, she leaves the story, suspending the immediate action about what happened on the day of Aaron's suicide to give a definitive statement concerning Aaron's purpose. She makes certain that the listener knows that Aaron had a suicide plan and that the events of the day had not been significant in his decision. Following this clear statement, another possible reason is then thrown into the mix, the isolated location of the family home, although this received no further reflection. If we consider the possible contributing factors that Lisa talks about, factors that may help her to understand Aaron's suicide, they both centre around the family. The argument and then the isolation of the family home could potentially serve to make them in some way to blame for Aaron's suicide. By dismissing these possible reasons, Lisa attempts to persuade the listener that the

family were not significant, relieving them of guilt and restoring them as an effective family unit.

At this moment in the narrative, after leaving the story world, Lisa begins a new story, one that is important in her account of Aaron's suicide. Throughout this part of the narrative Lisa attempts to qualify her statement about the planned nature of her brother's suicide, resolving any uncertainty that the listener may have in also reaching this assumption. At this point, Lisa departs from the family and the home and takes the listener into the world of Aaron's therapy group. The place of talk often takes centre stage in therapy and it is here where suicide talk is crucial for Lisa's understanding of her brother's death. Lay understandings of suicide popularly promote the seriousness of suicide talk – talking about suicide is often seen as a warning sign that someone will take their own life. Caught up in this popular understanding is the belief that talking about suicide will encourage someone feeling suicidal to take their own life. A prominent media representation, but one that has been heavily criticised in the 'support world', it is very clearly a discourse that Lisa heavily draws upon in her narrative. As we can see, she establishes a link between talk of suicide and Aaron's death – "I think just talking about it ... put it back in his mind". And just to emphasise the point further, she repeats the idea again in line 41 where she states that "talking about it with people just exacerbated it".

## **JESS: THE IMPORTANCE OF SELF**

How do you describe unwavering support and devotion? Or blue eyes that lit up every time I entered a room? Or a voice that made angels envious and fingers that could pluck amazing things out of a guitar? I guess I could say he was sweet, funny, kind, gentle, and the most tormented soul I've ever known. I now live not only with grief, but with guilt. A rational part of me knows that I had no control over his choices, but there is a much bigger part that feels if I had only stuck it out, he would still be alive. I live every day with the knowledge that I put my own wants and needs above his, and it hurts. Being alone is something I'll never get used to, and without him I'm always alone. I think that's the worse thing.

1 The night that Daniel died I was there.  
2 I was the one who went up to our bedroom  
3 and found him sitting on the couch...  
4 hole in his head...  
5 bleeding to death.  
6 I sat upstairs holding a bath towel on the hole in his head,  
7 watched all the blood pour from his body  
8 held him as he took his last breath.  
9 That whole night was crazy...  
10 it feels like a never-ending nightmare.  
11 The next day  
12 when all our friends had come up to the house to find out the news.  
13 Our room had been cleaned up by our neighbors.  
14 The couch was still upstairs...  
15 It's the first thing you see when you open the door...  
16 they had put sheets over the couch  
17 so I wouldn't see all the blood.  
18 I went upstairs,  
19 tore the sheets off the couch  
20 and just layed there on the blood soaked couch  
21 and layed my head on the dried blood,  
22 caressing the couch.  
23 Wishing that he was still here,  
24 wondering what his last thoughts were.  
25 I stayed up there for hours...  
26 all day to be exact.  
27 I just couldn't pry myself off the couch  
28 or to leave the room.  
29 I could feel him in the room with me.  
30 It was strange.  
31 I had moved back home with my family in PA  
32 and Daniel and I had lived together in DE.  
33 I remember for the next couple of months...  
34 I would go to our old house,  
35 go up into our room and sit there and drink all night  
36 just laying on the floor talking to him.  
37 I want to know what the hell he was thinking...  
38 what in the world was going through his mind...  
39 right at that moment?!?!  
40 On May 22nd it will be 1 year  
41 and I am already reliving that day as if it were yesterday.  
42 I can't remember for the life of me  
43 if when I found him if his eyes were open or closed...  
44 why that bothers me I have no idea.  
45 Well thanks for listening.

If we look at the structure of the narrative we see that in the first three lines Jess quickly orientates the listener to the specific episode of her partner Daniel's suicide. Crucially she places herself as a central character in the opening lines of the narrative;

the way she introduces the sequence of events conveys its overall message – that her role is paramount to the story. The narrative that she wants to tell is how *she* coped with the experience of such a traumatic event. In many ways by opening the narrative with such a vivid and horrific image of her partner's death she immediately draws the listener into her narrative world. Not only do we have a clear picture about events immediately following Daniel's suicide but we also get an idea of just what Jess has had to cope with. Although she describes the events in a relatively distant way – Jess literally gives a 'blow by blow' account of what she did without giving any details about how the horrific events impacted on her – she does not hold back from telling the listener what she saw that night. In many ways this helps to convey just what she has had to endure, the picture that will always remain with her. And if the listener has not grasped this already, Jess ends the opening part of her narrative by explicitly saying that her life now "seems like a never ending nightmare".

Significantly, Jess quickly moves away from the day that her partner killed himself. After briefly describing her actions following Daniel's suicide, this is all we hear about what happened on that day – she moves on to tell a specific story about the following day. Again we see Jess placing herself as a central character in the narrative – it is her actions and response to Daniel's suicide that take centre stage. She tells a particularly dramatic and powerful story, one that could be designed to shock others. However, told in the context of knowing others it opens the door to a previously hidden and 'silent' world of experience, illuminating a general awareness that survivors of suicide often experience and 'see' very traumatic deaths which are usually concealed from others.

Jess begins the story by providing the listener with the necessary information needed to follow it. Because the couch will feature prominently in the narrative, Jess introduces the prop, where it is and what it looks like, just as a novelist or poet will make the reader aware of a significant object to be used later in the story. But the couch is more than a prop; it is invested with emotional value. The couch, presumably one that had simply been a place for the couple to sit and relax has now become imbued with a new meaning – as the site for Daniel's death. Jess' neighbours however, had tried to hide this from her, covering the reminder with a clean sheet. Significantly the first thing that Jess did was to tear the sheets off the

couch. This could be viewed as symbolic of her fighting against the more general stigma surrounding suicide that still exists in society today. By not only revealing the site of Daniel's death, but also the explicit way she describes the distressing events, Jess attempts to uncover the reality of suicide rather than hide it.

Through her narrative the couch also takes on a further meaning – it becomes a physical reminder of her partner. Her detailed description of Daniel's blood on the couch is a particularly compelling part of the narrative. The image of blood is a powerful symbol – it is both a sign of life and its spilling is often indicative of death. Jess' choice of words, "caressing the couch", is interesting. A word usually associated with intimacy with another person, it conjures up an image of affection with her partner. It is as though the couch takes on a substitution for Daniel – it is her last physical connection with him.

The second part to the narrative begins, as did her first, with a plot summary; Jess says that after Daniel's death she moved back home (line 30). Whilst not telling a specific story, as in the first episode she orientates the reader to time and place – at night in the room they had shared together, lying on the floor. We also see Jess taking centre stage again – it is her movements that she describes. Although she moves away from the specific events surrounding Daniel's suicide, by telling the reader her personal reflections about the months following Daniel's death she reveals the devastation of losing a loved one to suicide. Indeed the dramatic image of a woman sprawled on the floor weeping is particularly vivid for the reader.

## KIM: THE IMPORTANCE OF MORALITY

Sam was my 1st born child, and my only boy, he was beautiful! By the age of 13 he grew to 5'9", and was taller than me. He loved to fish and hunt. His friends and him spent countless hours fishing in our towns lake. He loved scouting. He was a cub, webelos and boy scout, where he camped and propelled down walls. He loved animals; he had a cat who slept with him every night. When he was younger someone had told him that if you cut one side off a cat's whisker, they would walk sideways, and he did. (It didn't work). Threw the years we had cats, dogs, turtles, hermit crab, hamster's and fish. He also loved his family and friends. One of the things I miss the most is when he came home from school, he would mess up my hair by rubbing my head and asking how my day was. One of his friends broke up with his girl-friend, and the girl called him and talked to him about taking her own life, we went over to her house, I finally got a hold of her parents, and I left after they got home, Sam stayed there all night talking to her. Sam did not enjoy school academics at all. He was diagnosed with a learning disability in 2nd grade. School was very hard for him. He loved going to school to see his friends, (As a teenager, but hated it in grade school, he was made fun of a lot) but hated school work. He hated homework that I made him do every night. His ambitions were to be a physical /medical trainer for football. He also wanted to be a youth counsellor for his church; he even went to a week long seminar in Jan. before he died. This was my baby boy.

- 1 August 3, 1996 started out a normal day as the one before.
- 2 It was a Wednesday.
- 3 I always took my mom shopping for grocery's
- 4 and my 2 children, Sam(16)and Hannah(14) (my daughter) were going to
- Wednesday night Youth group at my son's church.
- 5 My family was raised Catholic,
- 6 Both of my children went to a Catholic School,
- 7 My son found this church threw his friends
- 8 and he loved it there,
- 9 so that's why I call it" his church".
- 10 My daughter was forced to go with him
- 11 because I had found out she had been smoking cigarette's two weeks
- before,
- 12 I felt it would do her good to go too.
- 13 Mom and I had gotten home just before they did.

14 Sam had come home with a friend who had brought over his fishin pole  
so they could go fishin early the next morning.  
15 (They were on Spring Break from school)  
16 The Boys were helping me unload the car,  
17 and Sam had asked if he could take his friend home, so I let him.  
18 My daughter was not happy with me making her go to church,  
19 she started telling me how Sam was acting up and his teacher had to get  
on him.  
20 About that same time Sam arrived home and heard what she had been  
saying  
21 and he informed me she was still smoking  
22 and they started to argue.  
23 Then my daughter told me a secret she had been keeping,  
24 that Sam had been coming into her room at night...  
25 (I can't write the rest)  
26 and she told me it had been going on for a long time,  
27 I went crazy and started to bawl and yell  
28 and I sent them both to their rooms  
29 so I could think what I was suppose to do,  
30 but all I could do was cry,  
31 my son came down twice to clam me down  
32 and I screamed some horrible things to him.  
33 He went back upstairs to his room and put a 22 in his mouth and pulled  
the trigger.  
34 My words killed him.  
35 I heard the pop and I thought it sounded like a gun,  
36 but then I thought , "no, he must have kicked the screen out of his  
window",  
37 then I heard my daughter scream that he had shot himself,  
38 I ran up stairs,  
39 his feet were sticking out from the side of his bed  
40 and I could see smoke and smelled gun powder,  
41 I was hysterically screaming call 911 call 911!  
42 My daughter ran across to my bedroom and dialed  
43 and I ran downstairs to dial,  
44 they were already on the phone when I picked up the receiver,  
45 911 asked me if he had a pulse,  
46 and that's when I realized he was probably going to die.  
47 I just kept screaming oh my God,  
48 my daughter was the one who ran across back into his room  
49 and checked fro his pulse  
50 and she told them "no Pulse",  
51 I threw the phone down and ran upstairs  
52 and and I opened his eyelid  
53 because I thought if he was dead, they would be rolled back into his head,  
54 they weren't he looked right at me,  
55 they didn't move,  
56 I started to give him CPR, but I couldn't get an airway,



57 so I began to scoop blood and teeth and brain matter from his mouth,  
58 but it wouldn't stop,  
59 my daughter also tried to get a free airway, but it wouldn't stop.  
60 I put my hands under his bleeding head and I shook him  
61 and cried and screamed "Oh my God, don't you know you are going to  
die?"  
62 "Don't you know that I love you?"  
63 I was holding his head on my knees  
64 hugging him when the paramedic's finally got there,  
65 they made us leave the room.  
66 My daughter and I had blood all over us,  
67 I called my mom,  
68 before she got there my sister and her father in law, (who was the fire  
chief) and her husband was there,  
69 he had heard it on the scanner.  
70 They drove me to hospital,  
71 they worked on him for 40 minutes,  
72 but he was dead.  
73 They asked us several times if they could quit,  
74 but we all yelled "No",  
75 finally a nurse who had lost a child,  
76 explained that they had done all they could do and I needed to let him go.  
77 I told them they could stop.  
78 My sister requested that I go in and tell him goodbye,  
79 which I didn't want to do cause I felt like I had already done that upstairs  
in his room,  
80 but I did.  
81 It was awful.  
82 His hands looked like they were touching the ground,  
83 his lips were blue  
84 and he had a tube in his throat,  
85 I laid my head on his chest  
86 and a low pitched scream came out of the tube.  
87 His eyes and that noise are what I see and hear in my nightmares.  
88 And yet I'm still here!  
89 I get up each day and I try to exist in the best way I know how.  
90 I had to do this for my daughter,  
91 I had no choice,  
92 but a part of me died with him that night,  
93 I am not the same.  
94 My life changed in one second.  
95 I had 2 lives.  
96 life before August 3, 1996 and life after.  
97 Writing about this is extremely difficult  
98 its been a while for me since I relived this night.  
99 But I also know its good for my soul to do this every once in a while.

The reason that Kim gives for her son's suicide is a family breakdown, an argument; as she puts it her "words killed him". Yet the point that she wants to make is that family life was inherently normal. Indeed in the opening line Kim says that the day began as a "normal day". If we take a closer look at the structure of the narrative, we see that in the first four lines Kim introduces the main characters of the drama that is about to unfold; Kim, Sam, Hannah and the social others, specifically in this instance the church, whose definitions of reality Kim will appeal to. Interestingly she tells about the importance that Catholicism play in their lives, particularly Sam's. The strong emphasis on the church in the opening part of her narrative is perhaps an attempt to encourage the reader to form a judgment about their moral character. She goes to great lengths to encourage a certain understanding of her son. He found the church, it was "his church" and "he loved it there". By communicating his moral attitude, one that is presumably heavily influenced by religion, Kim helps the reader to imagine a particular type of character. She convinces the reader (as well as herself, perhaps) that Sam was a good person, that he behaved correctly, and that a suicide would be completely out of character. By contrast, her daughter is in many ways depicted as the rebellious sibling, the difficult child. Far from immersing herself in a religious way of life as her brother had done, Hannah is forced to go to church because Kim had discovered that she had been smoking. Her statement "I thought it would do her good too", further cements the conception of her son as the good child, implying that going to church has been beneficial to him.

Kim then goes on to develop her account of her son – he has outside interests, he has friends and he is helpful. It is as though she is fighting against the popular (mis)conception of the isolated, suicidal individual. To illustrate this Kim moves into story form and begins telling a story about what happened on that day. And again it is her daughter who is painted as the troublesome sibling, the childish girl who begins a 'tit for tat' argument because she was not happy with being forced to go to church. Kim's story about events preceding Sam's suicide portrays expectations and disappointments – it is her daughter who retaliates against her mother's rules and her son who helps to appease things.

It is then that a family secret is revealed, a secret that is never actually disclosed in the narrative, but the reader is led to believe that Hannah has been the victim of

child abuse, that her brother has been sexually abusing her. And it is during Kim's telling of this story that we discover her understanding of Sam's suicide. Not the argument or the revelation from her daughter, rather the reason that Kim gives for Sam's suicide is her – *her* “words killed him”.

Having set out events that happened immediately before her son's suicide, Kim then draws the listener in more deeply, as she moves into an illustration, a re-presentation of what happened in the minutes and hours following Sam shooting himself. The reader is given a highly detailed and graphic story about what happened next. The beginning of this new story is signalled lexically by a narrative clause told in the simple past tense (“I heard the pop and I thought it sounded like a gun”). The picture she is portraying for the reader helps to convey exactly what happened. This ‘blow by blow’ form of telling, unlike a summation, pulls the reader into the specific moment. Kim does not hold back when describing what she saw – we get a very vivid and graphic portrayal of what she encountered. This is in stark contrast to the story Kim tells about the events that happened immediately before Sam shot himself. Abuse is insinuated but never actually told. Indeed Kim explicitly says that she “cannot write the rest”. Why then is she able to write such a descriptive and visual account of the events immediately after Sam's suicide yet barely mention what happened before? Perhaps she wants to protect her son and her family from the assumptions a reader might make about the person Sam was. The vast majority of the narrative is taken up with her description of Sam after he shot himself. In some ways this vivid reconstruction detracts from the events that happened before. And as with Jess' narrative, her story is also a shocking one. But told in a forum where others have also gone through a traumatic and painful experience, Kim is free to go in to as much detail as she feels necessary, free from the concern of upsetting others.

Following her vivid reconstruction of these events, Kim moves into a dialogue with her son. In lines 59 to 63 we see Kim have a conversation with her dying son. In her dialogue with Sam she expresses her love for him. Here we also see her describe physical affection towards her son; she was “hugging him when the paramedic finally got there”. Without leaving the story, Kim not only reconstructs the temporal sequence of events, but is able to invest these events with meaning. She is able to

communicate to the reader how much her son meant to her; that the alleged abuse had no bearing on her commitment to her son.

## **NARRATIVE: MAKING SENSE OF SUICIDE**

Ultimately then, what becomes apparent when reading the four narratives is the difference between them, particularly the online accounts and face-to-face interviews. Although each of the four accounts has a distinctive feature – with each narrator actively constructing their understanding of their loved one’s death by selecting both a variety of ways of telling and what to tell – the graphic and often difficult descriptions that make up the online narratives is striking. Consequently, in the remaining sections, I consider two reasons behind this. One reason behind the graphic nature of the online narratives could well be that both Jess and Kim discovered the bodies of their loved ones. However the explanation could also be found in the medium through which the narrators told their story. Indeed, the impact of method on narrative account cannot go ignored. Therefore before considering the significance of the visibility of the body, I first explore the way in which method impacted on the stories that were told.

## **NARRATIVE AND METHOD**

The construction of meaning is not an internal, individual process; it is socially accomplished. Narratives are told by someone, for someone in the hope of gaining understanding. It follows, then, that different audiences will produce different narratives. The differences between the online accounts and the face-to-face stories is clear. The graphic and at times disturbing content of the stories told by Jess and Kim is inescapable. Potentially due to a number of factors, for example the body or cultural issues, the difference in the medium for telling suicidal stories cannot be ignored. Good (1996) has argued that within the written text, communication suffers in terms of its social and emotional content as well as losing the spontaneity of face-to-face interaction. Worryingly he goes on to suggest that this reduces the prospects for negotiating meaning. However the richness of the two internet

narratives, as Jess and Kim search for an understanding of their loved one's suicide, reveals the process of meaning construction that they engage in. Far from being devoid of meaning (where Jess and Kim would simply report events that happened to them) these narratives in themselves are a means for the two women to actively interpret and make sense of what has happened to them.

What becomes possible in online communication is essentially limitless. Free from the responsibility of having to manage a relationship – where both the researcher and the researched enter the narrative – the virtual realm offers the possibility of a space free from the everyday sequestration of death, thus opening the door to a previously hidden and silent world of experience (Illingworth 2006). This highlights an increasing awareness that people may be more willing to interface with a computer screen than talk directly to another person. It seems that people may feel less inhibited by the evaluation of others and more aware of their private selves online. Indeed within my research, the differences between the face-to-face and online narratives were striking. Conversations online would often be very graphic, reflective and frank. This is not to say that the face-to-face narratives were not upsetting, difficult and painful, but that the level of 'soul searching' in the online narratives was simply not present in the same way in the face-to-face conversations. This could perhaps be a reflection of the method used. The online environment and the (virtual) presence of knowing others meant that families often discussed difficult emotions and shared distressing stories that in different situations might otherwise have been silenced.

What I am not suggesting is that computer-mediated communication should be elevated to the 'gold standard' of research. Rather as Markham (1998: 20) makes clear, 'the use of both oral and written communication reveals an alternative space where we can explore how we write what we think we know'. Whilst the method certainly had an effect on the type of narrative told, another possible factor that I want to draw attention to is the significance of the body. In both the online accounts, Jess and Kim found their loved ones; they were the first people to come into contact with Daniel and Sam's body after the young men had shot themselves. In contrast the body is absent from the face-to-face stories. Neither Susan nor Lisa saw their loved ones in the moments or hours following the suicides (indeed it is

significant that both Susan and Lisa chose *not* to view the body at all, with other family members formally identifying the young men instead). And it is this point that is significant in the way the suicidal stories are told.

## THE SUICIDAL BODY

Death has arguably become one of the last taboos of modern society. It is something to be controlled, managed and put off at all costs. As a result, death has become a difficult subject – aside from its almost glamorised portrayal in the mass media, contact with death is increasingly sanitised. As Wilmott (2000: 649) maintains, ‘an uneasiness surrounds death that is routinely smoothed and managed by a plethora of specialists ... employed to render death invisible or, at least, minimally disruptive of normal appearances’. What this implies, then, is that death directly challenges the meaning that people invest in their lives. According to Shilling (1993: 178-9 paraphrasing Berger 1967), death has the ability to ‘threaten the basic assumptions upon which society is organised ... it radically questions the taken-for-granted ‘business as usual’ attitude which is usually adopted in everyday life’.

Suicide is unquestionably a taboo subject in Western society, a society which both hides suffering from everyday view and sequesters death (Fincham *et al.* 2008). Indeed writers have drawn attention to the sequestration of death in modern society, asserting notably that it has become increasingly privatised and medicalised (Giddens 1991; Mellor 1993; Mellor and Shilling 1993; Wilmott 2000). As Shilling (1993: 189) suggests, ‘rather than being an open, communal event, death is now a relatively hidden, private experience’. And this has an impact on the place of the (dying) body in modern society.

The body is now arguably the object of medical practice. The medical profession has *control* over the destiny of our bodies, they decide between the boundaries of life and death. Crucially, this is achieved through closing up bodies to lay people, regulating bodies in an attempt to maintain this control (Turner 1992); the body and contemporary medical discourse have become inseparable. As Turner (1991: 268) insightfully states, ‘scientific medicine has transformed the body into a silent

machine'. Consequently the visibility of the diseased and dying body is increasingly hidden away, seen as the domain of the clinician and scientist. The secrets contained within the body have become the realm of the physician and scientist. Medical developments over the last two centuries – the stethoscope, the x-ray and the endoscope – have opened the body up to medicine in ever increasing ways whilst at the same time closing it off to everyone else. People's contact with the dying body then is ever more mediated by the medical profession. And this means that the inner body – the sole proprietor of biomedicine – is hidden. Friends and family for example, are prevented from seeing the body in surgery, opened up revealing its natural state. Instead what they are presented with is the 'clean body', the closed up body with only a scar as a physical reminder of what is hidden beneath the skin.

So what happens when families step into this unknown world, transgress the boundary between the inner and outer body? As becomes apparent in both Jess' and Kim's narrative, there is something deeply powerful about seeing their loved one's dying body, their blood and body matter escaping from it. Both their narratives centre on the vivid description of what happened to the *bodies* of Daniel and Sam. It is the physical manner of the young men's death that is prominent, rather than the emotional aspect that is seen in the face-to-face narratives. As we can see Kim explicitly states that "his eyes and that noise are what I see and hear in my nightmares". And for Jess we see her agonise over whether Daniel's "eyes were open or closed".

Townsend (1998) has argued that death and the dying body are located at and beyond the margins of society. Indeed when the dead body is made visible, there is the tendency to present the deceased in a lifelike manner, as though they were asleep. As a result the impact of viewing the 'real' dying body, rather than the imagined body is likely to have a lasting effect (Hallam *et al.* 1999). The distancing of the dead and dying body means that coming into contact with it is often an emotionally fraught event, particularly for friends and relatives. This can only be heightened in the case of suicide, often a particularly violent death, as is apparent in Jess and Kim's narrative.

## CONCLUSION

At the most basic level, the four narratives reveal how people impose an intelligible order on events by constructing stories about them. Out of the pain and trauma of losing a loved one to suicide, bereaved families begin a process of searching for understanding and constructing meaning out of life. Importantly these understandings and meanings are played out in their narrative accounts. Suicide is a particularly horrific death, leaving those left behind struggling to find any meaning in the death of a loved one. Narrative analysis can attempt to reveal the interpretive work and meaning-making that bereaved families undertake.

Suicide occurs not just to the body, with the ending of a person's life, but it also happens *in* life. It is not a physical act alone, but occurs in time, in place, in history and in people's lived experience of the social world. This is why narratives are central to understanding the experience of suicide, placing it in relation to other events and experiences in bereaved families' lives. What may seem understandable to a person outside the family, as a possible contributing factor in a person's suicide may not carry the same *meaning* for those more directly involved. It is only by looking at longer stretches of talk, rather than specific factors and incidents, that we can uncover how families give meaning to the traumatic events that have happened to them. As we discovered from Kim's narrative, for example, for her it is not the child abuse that lay behind Sam's suicide, but rather her reaction to the initial claims.

Narrative accounts, however, are not simply private, internal processes. Following Riessman (1990a), I suggest that narrative accounts are also a product of society; that is they are socially constructed. Narrators do not arbitrarily create meaning from a cultural vacuum. Rather they draw upon 'cultural discourses' and 'taken-for-granted knowledge' (Riessman 1990a: 119). For example, Susan built upon her understandings of young people and risk and Lisa draws on ideas relating to social cohesion and the family.

It is also the case that narrative accounts are moral tales that attempt to repair damage to their individual and family identities. We can see this in the significance that Kim places on her own actions, rather than on Sam's. By detracting attention



away from Sam's alleged abuse, Kim attempts to preserve both his morality and that of the family's. As Riessman (1990a: 119) has made clear, 'individuals narrate to achieve social ends, making a claim for a valid identity'. It could be the case then that families are attempting to restore the integrity of both themselves and their family – 'I am a good person/we are a good family despite suicide'. Such attempts could be a response to the relative value that suicide has in society and the stigma that could stem from this as a result. In the last empirical chapter, I will therefore look at the experiences families had as a result of being bereaved by suicide, particularly their encounters of stigma.

## Chapter Seven:

# THE STIGMA OF SUICIDE

### INTRODUCTION

The idea of suicide as a stigmatised death has a long history. As I indicated in chapter two, the stigma against suicide intensified in Europe during the middle ages, with it coming to be seen as a great sin, a source of shame and eventually a crime. Despite its decriminalisation in 1961, suicide is arguably one of society's most powerful taboos, threatening the very basis of society (McManus 2005) by throwing away 'the gift of life' (Fullagar 2003). In this sense then, suicide is a stark reminder of the challenges in the modern day pursuit for the successful, rational and responsible self.

This chapter looks at the impact that the stigma of suicide has on bereaved families. Indeed it is well established that stigma not only harms people with the stigmatised condition, but it also affects family members who are associated with those individuals. Goffman (1968) called this 'courtesy stigma', the prejudice and discrimination that is extended to people not because of the mark they manifest, but rather because they are somehow associated to the person with the stigmatised mark. As such, families bereaved by suicide could suffer a courtesy stigma as a result of their relationship to the person who has killed himself. I will consider to what extent this is the case before proposing an alternative understanding – one which positions the families themselves as the stigmatised group.

A familial element to the stigma was evident in the narratives. Shame and guilt was felt most acutely by the parents. Arguably linked to a parent's responsibility for the creation of a healthy, happy and well socialised child (Harden 2005), for those parents whose child has decided that life is not worth living, their feelings of shame

and guilt were often unbearable. Indeed such feelings were evident in all the parents' narratives. This chapter will therefore also consider the nature of the stigma experienced by families. In doing so I draw upon Scambler and Hopkins' (1986) conceptualisation of 'felt' and 'enacted' stigma.

This chapter also examines the various strategies that families employed to cope with stigmatised reactions. Birenbaum (1970: 199) argues that relatives of a stigmatised individual commonly maintain a 'normal appearing round of family life'. Whilst there were occasions when families adopted this strategy, there were also examples of families concealing their loved one's death and selecting who and when to disclose it to. However, there were also instances whereby families refused to become victims of stigmatisation – instead transforming the hurt and pain of suicide into something positive.

## **STIGMA AND SUICIDE**

Stigma, as a sociological concept, was developed by Goffman (1968) and has since been enthusiastically taken up by medical sociologists. The work on stigmatising illness conditions, for example, is vast and the range of research interests impressive. For example Schneider and Conrad (1980) and Scambler (1984; Scambler and Hopkins 1986) have focused on the problems of perceiving and coping with epilepsy, whilst Nijhof (1995) has done the same for Parkinson's disease. Bury (1998) has concentrated on people suffering from arthritis and Lawless and colleagues (1996) have looked at the implications of stigma for women living with HIV/AIDs. Goffman (1968: 3) himself used the term stigma to 'refer to an attribute that is deeply discrediting'. Those possessing such an attribute are seen as different in a way that is undesired and shameful. The stigmatised person is therefore devalued and seen as a less than whole person. The stigmatised person's identity is also at risk of being 'spoiled' and relations with the non-stigmatised must be carefully managed if undue tension and strain are to be avoided.

The term itself originates from ancient Greece, where it was used to refer to bodily signs such as cuts or burns to the body which were designed to indicate the bearer as

a slave, a criminal or social outcast, someone 'ritually polluted' and therefore to be avoided, especially in public places. Stigma in the modern sense is used much more widely, referring to any condition, attribute, trait or behaviour that symbolically marks the bearer off as 'culturally unacceptable' or 'inferior' and its subjective referent is the notion of shame or disgrace (Williams 1987). Goffman (1968) distinguishes three types of stigma; there are stigmas of the body (blemishes or deformities); of character (e.g. being mentally ill, homosexual or criminal) and of social collectives (racial or tribal). Importantly, these stigmas are historically and culturally dependent. Nowhere is this more evident than in the study of suicide. Suicide in the Western world is unquestionably stigmatised. If we look at suicide outside the Western world, however, we can see that it has not suffered the same level of stigmatisation. In India for example, a culture-related suicide, a *suttee* death, which refers to a type of self-cremation of a widow on her husband's pyre, has a mythological status. It was symbolically the sign of the superiority of the feminine principle in the cosmos and as a result does not suffer the same stigma as a similar death in the west (Cheng and Lee 2000). Similarly Japan is often regarded as a country in which suicide is permissible to some extent. It has been suggested that the Japanese regard suicide as an honourable way to take responsibility (Andriolo 1998). Takahashi (1997) has written about the 'shinju' suicide found in Japan. This cultural suicide, which literally means 'oneness of mind', was originally used to mean a lovers' suicide pact based on mutual agreement, but now it has been more widely used to refer to a murder-suicide complex where a mother, usually in her 20s or 30s, kills her small children and then kills herself. Interestingly, such a death is not in itself stigmatised. Japanese society, according to Takahashi (1997) is largely sympathetic to a mother who has been unable to find any other way of solving her problems, and therefore does not criticise her behaviour. Conversely, she notes that society may be distinctively unsympathetic towards a mother who kills only herself but leaves her children alone and alive. Such differences in the way that suicide is viewed in different societies ultimately point to the way in which stigma is culturally dependent.

Not only is the stigmatisation of suicide culturally dependent, its position as a stigmatised death has also varied over time. This is reflected in both the treatment of those who attempt suicide and the laws relating to it. As Cvinar (2005: 16) states,

'in our society there continues to be a stigma associated with suicide'. The value that suicide has in contemporary society was recognised, and in many cases accepted by many of the families. It has been suggested that for stigma to exist, individuals possessing such attributes of difference must also accept this devaluation. If this is the case, then we would expect those affected by suicide to acknowledge the negative connotations surrounding the act and to some extent this is evident in the following extract:

Oh it's all acceptable now. Cancer's quite acceptable now; it's quite fashionable almost. Even AIDS I think would go down better. Well I know it would.

(Jan, Gareth's mother)  
(Face to face interview)

By using the comparison of cancer and AIDS, arguably illnesses which carry with them varying degrees of stigma, Jan appears to accept the relative value that suicide has as the foremost form of stigmatised death. However, even though bereaved families appeared to accept the value that suicide has in society, this does not mean that they did so with ease:

The assumptions one makes about a person who kills themselves is unavoidable, and I am just as guilty as the next person about this. I have struggled with my view on suicide since my brother died. This has been made harder because I know people look down on what he did.

(Amy, Andrew's sister)  
(Online focus group)

## The Silence of Suicide

The silence of suicide has been well documented, a silence that arguably reflects the potential for negative and stigmatising reactions:

Its just so hush, hush. I mean death anyway is a bit of a taboo. People do find that quite hard anyway. But then if it's suicide, I mean he chose to do it, wow how d'you understand that? No let's not even go there.

(Gayle, Kai's mother)  
(Face to face interview)

In many ways families' experience of the silence surrounding suicide was often an effort of others to avoid the contamination of suicide:

But no people are just horrible really. They just don't want to know. I don't know if they think it's catching or what, I don't know.

(Jan, Gareth's mother)  
(Face to face interview)

When Zack died, his school were 'frightened' of even mentioning the word suicide, as Susan explains:

So we phoned the school again, and we said look this is what's happened and we've had advice about it, this is what we want you to say ... We said, we want you to tell them that Zack killed himself, that he hung himself. That's what we want you to say. And they wouldn't. They were absolutely terrified of it. They couldn't even say the word suicide.

(Susan, Zack's mother)  
(Face to face interview)

But as Sommer-Rotenberg (1998) maintains, such responses only serve to exacerbate the stigma of suicide.

The words that we use to describe suicide, particularly the phrase 'commit suicide' (marking it as a criminal act) can serve as powerful signals of the status that suicide has in society. For my participants it seemed unavoidable that suicide would be a 'dirty' word, something to be ashamed of, something that produces embarrassment in others. This can be seen in the excerpts below:

But sometimes I say it (committed suicide) without meaning to and it's just... Because I'm in a panic. I'm instantly in a panic because I've got to tell someone new.

(Tessa, Matthew's mother)  
(Face to face interview)

And I sort of panic about it and I said it the other day and I was like, 'Oh God, what did I say that for?' It's a dirty word isn't it?

(Kim, Sam's mother)  
(Online focus group)

Committed suicide, it's horrible, its horrible. Its like committed a sin.  
(Susan, Zack's mother)  
(Face to face interview)

The only acts that we commit are heinous ones; adultery, a felony, a crime. The German term *Selbstmord begehen* is similar, denoting an act of commission. By contrast the French *le suicide* and the Italian *uccidersi* are reflexive (Sommer-Rotenberg 1998). Indeed, families often held up the expression 'to commit suicide' as being morally imprecise. As Susan makes clear, its connotation of illegality and dishonour intensifies the stigma attached to the person who has died, as well as those who have been traumatised by the loss.

## WHAT STIGMA?

Most studies of stigma have focussed on the experiences of those with the stigmatising condition, with attention given to the strategies they use to protect their precarious identities. What Goffman (1968: 30) has termed 'courtesy stigma' has received considerably less attention. To expand on the definition outlined at the start of this chapter, Goffman (1968: 30) argued that there is a 'tendency for stigma to spread from the stigmatised individual to his close connections'. It is a stigma of affiliation whereby the wider society may then 'treat both individuals in some respects as one'. Goffman (1968: 30) puts forward examples such as the 'loyal spouse of the mental patient' and the 'daughter of the ex con', maintaining that people with a courtesy stigma 'are obliged to share some of the discredit of the stigmatised person to whom they are related'. More recent examples have looked at the experiences of courtesy stigma by family members of individuals diagnosed with Alzheimer's disease (MacRae 1999) and parents of children with high functioning autism (Gray 2002). In the case of families who have lost a young man to suicide, a courtesy stigma is attributed to them because they are members of the same family as the person who died by suicide. The courtesy stigma is applied on the basis that family members are somehow *tainted* by their association with the person who has killed himself.

In Goffman's original writings on courtesy stigma there was a degree of choice exercised by those affected by it, as his examples included straight bartenders in gay bars and the maids of high class prostitutes. In these examples, the courtesy stigma is presumably the result of the supposed 'moral' failings of these individuals because they *chose* to associate with the stigmatised groups. Family members, however, are different. They have relatively little choice in their association with the stigmatised group. The element of choice in the courtesy stigma raises questions over whether the bereaved by suicide suffer such a stigma. There were certainly times when families spoke about the stigma they felt was directed specifically at them. For instance for Tanya, her work life altered drastically; "when Oliver died, at work, I was treated like a leper".

So is it that families suffered from a courtesy stigma or were they themselves stigmatised? We will examine the possibility of the latter – that families bereaved by suicide are a stigmatised group. This will be addressed by focussing on the feelings of self-blame and guilt that families feel surrounding their young man's suicide and importantly, the separation that they believe this creates between themselves and those who have not experienced suicide – the 'normals'.

A stigmatised identity is one that acknowledges the incongruity between themselves and the 'normals' and as a result has the potential to be 'shamefaced' (Goffman 1968: 29). To be shamefaced is to feel self-blame and guilt for discreditation. People who are bereaved by suicide are themselves stigmatised; they feel self-blame and guilt, as is clear in the following excerpts:

I blame myself all the time. I could have done more, I should have done more. These thoughts keep going round and round. You're so mixed up with the... and there's the shame.

(Jack, Adam's father)  
(Face to face interview)



‘Have you had any particularly negative experiences with others?’

Camille: Not so much to my face, but people have told me that others reacted. ‘What did she do to make him do that?’ and other such reactions, blaming me. My mother-in-law blamed me – said I ‘used him up’. I feel so guilty about that. I have to live with it.

(Camille, Hugh’s wife)  
(Online focus group)

You try and look for reasons but there are none and so you end up blaming yourself.

(Tanya, Oliver’s mother)  
(Online focus group)

These accounts clearly acknowledge the stigma of suicide bereavement as guilt and blame. Grief through suicide becomes a synthesis of the loss of losing a loved one but also stigma in the sense of feeling blame for the loss. It is important to remember however, that given the psychological distress and difficult circumstances of most suicidal people, it is almost inevitable that there will be self-examination and even self-blame on the part of the surviving families. After all, even if suicide were not stigmatised it is unavoidable that bereaved families are bound to examine their own actions or inactions.

The feelings of intense blame and its attendant guilt were often regarded as unbearable by the people experiencing them. In the following extract, Rachel talks about her sense of losing control following the death of her son:

He had only been dead three weeks and I thought I’m slowly going round the twist here. ‘Cause I couldn’t remember anything, I couldn’t finish a sentence, I couldn’t stop crying.

(Rachel, Joel’s mother)  
(Face to face interview)

Interestingly, the intense feelings of blame and guilt were felt most acutely by the parents. The overwhelming sense of guilt and blame simply was not present to the same extent in other family members’ accounts. This is almost certainly because of the difference in the relationship between siblings, partners, and parent and child. Parents’ association with a child who has killed himself, and their consequent stigmatisation, is one that is encouraged by the social audience because of the

parents' responsibilities as child raisers and carers (Birenbaum 1970; Gray 2002). In this respect then a parent could be seen as 'failing' in their social and moral role. Indeed a sense of guilt was tangible in all the interviews with parents:

Not a day goes by without me thinking about it. Not a day. I'll be thinking why did I leave him? Why did I leave him? ... I'll just never forgive myself. And then I think, what did I do? ... And I just blame myself all the time. I should have listened to him.

(Tessa, Matthew's mother)  
(Face to face interview)

I have also heard things like, 'his parents must not have loved him very much for him to do what he did'. Or we should have seen the 'signs', which I can assure you there wasn't any. I just feel like I am somehow to blame.

(Kim, Sam's mother)  
(Online focus group)

I think it's worse for parents who lose a child to suicide, because parents are supposed to protect their children. Suicide tells the world that you didn't do your job!

(Tanya, Oliver's mother)  
(Online focus group)

Research on the stigma experienced by people with mental illnesses has found that the public frequently blame them for their symptoms (Corrigan *et al.* 2000). Similar research has also suggested that the public views family members as responsible for their relative's mental illness (Corrigan and Miller 2004). In relation to suicide it could be the case that the parents have internalised this public perception and turned it onto themselves. Whilst not explicitly about mental illness, the following passage does reveal Tessa's concern that others would blame her for her son's death:

But I shouldn't be worrying about what the neighbours think. But I do. I think they must think I'm an awful mother. And I feel so guilty about that. In amongst the awful grief of missing him and not seeing him there's the guilt and the shame.

(Tessa, Matthew's mother)  
(Face to face interview)

Tessa's sense of shame is immediately apparent here. However, other instances of guilt and shame were alluded to in nearly all of the parents' accounts. Words like 'embarrassed', 'awkward' and 'disgrace' were used to describe the sense of shame that they felt. Gayle for example speaks of the awkwardness she felt when Kai's death inadvertently came up in conversation:

Yea, I will tell new people just because I don't want them to say anything crass or stupid, which, you know, people sometimes have without knowing. I was in a car with some people in the first few months and the, the driver, I'd never met him before, he was giving us a lift to the airport with the other two people. And um, he started going on about losing a child and I could see the girl just shaking her head at him and he must have suddenly realised because he just stopped what he was saying. It was horrible, people were embarrassed, I could tell. It was such an awkward situation but now I just kick myself for not being upfront about it.

(Gayle, Kai's mother)  
(Face to face interview)

The awkwardness that Gayle speaks of may not be simply about moral judgement. As Scourfield (2008) has speculated, such reactions from the 'normals' may be about their own nervousness in not knowing how to talk about death and bereavement. This not only relates to the taboo surrounding death, but may well be about other people's awareness of the enormity of families' loss and therefore not wanting to upset them by bringing up the loss of a family member.

In other instances however, self-stigma was far more apparent. When it did occur it was often fused with feelings of guilt. When the parents spoke of the guilt they felt for the death of their son, they often *blamed* themselves for his suicide. For example:

But you've still got this, you know, this harsh judge of yourself. Always have been. Could have done better, haven't done enough. Guilty. It's always there. You should have done more to be a better parent.

(Tessa, Matthew's mother)  
(Face to face interview)

But where does this sense of guilt come from? As has been suggested, most of the parents' notion of blame may represent most parents' sense of responsibility and concern about everything that happens to their children. Harden (2005) draws attention to the modern understanding of parenting which positions the creation of a

healthy, happy and well-socialised child as the major project. The performance of the child and his or her journey to successful adulthood are the key measures of a successful parent. As Owen and colleagues (2008) have put forward, for those parents whose child decides that life is not worth living, they may well feel that they stand accused of not doing enough to ensure their child's happiness.

Adding to the potential for parents' feelings of self-blame and guilt, from the moment suicide enters a family's life, the bereaved enter a bureaucratic world that bestows suspicion. A possible suicide is automatically regarded as suspicious and the police and Coroner's court are duty bound to ascertain the cause of death. Such procedures establish the issue of responsibility as a central concern. With the need to establish responsibility comes the inflection of suspicion and blame:

The inquest was horrendous, absolutely horrendous. People had warned me as well. They had warned me that it's really horrible and that it's all clinical and it's, well you know, it's a court. That's it; it was like we were on trial. There's nothing nice about it.

(Beth, Howell's sister)  
(Face to face interview)

This early experience is only supported and amplified by everyday encounters that apportion blame. As has been highlighted, suicide continues to be a stigmatised death and there has been persuasive evidence to suggest that the general public hold parents responsible for their child's death, particularly if the child is still living at home (Cvinar 2005). Public attitudes towards suicide are crucial, for they are important aspects of the value climate that inhibits and sometimes legitimises suicidal behaviour (Bagley and Ramsey 1997). This is well illustrated in Boldt's (1982) study of attitudes towards suicide and death in parents and children. The study found that parents were much more likely than their children to view suicide as a morally reprehensible act, reflecting an individual's personal failure.

Such views are not limited to the lay population. Research has also alluded to the fact that health professionals have a similar view. Indeed Lefley (1989) has suggested that the public have learned about parental blame from mental health providers. Dominant models on the cause of serious mental illness during the first half of the 1900s focussed on parental weaknesses as causing the early developmental problems

of children. Yet despite reactions against such an approach, such theories remain and have arguably spread to public notions of parental blame.

Both institutional practices and the more everyday understandings of suicide only serve to confirm to families that their association with suicide is marked in a pejorative way. What is more, such messages are so powerful and insidious that it would be difficult for the parents not to appropriate them.

## **THE NATURE OF THE STIGMA**

Gray (2002) has usefully highlighted the tendency of previous research to over-emphasise the situational context of stigma in general, and a courtesy stigma in particular. Such research seems to suggest that the courtesy stigma is only activated when family members are with the stigmatised person in public places (Birenbaum 1970). As Gray (2002) makes clear, this focus on the situational context of a courtesy stigma over-emphasises the significance of face-to-face interaction, thereby playing down the broader biographical nature of the family member's relationship with the stigmatised individual. To some extent this is inevitable since Goffman (1968) emphasised the situational nature of the stigma in his own seminal work. But he also drew attention to the wider identity-related issues of stigma and how they stabilised or challenged an individual's sense of self and their social world. This gets to the heart of what and why something comes to be stigmatised; that a particular stigma is dependent upon particular definitions of what it is to be 'normal'. With regards to a courtesy stigma in particular, the key issue is the success or failure of the individual in maintaining a 'normal' identity (Gray 2002).

According to Gray (2002), it is the interactional context where the success or failure is ultimately determined, as the individual strives to cope with stigma by performing a 'normal' way of life. Yet stigma is not limited to the interactional context. Rather it runs across social contexts, producing a generalised but situationally dependent biography of the individual. A courtesy stigma then, is ordinarily a product of both the biographical and interactional context. However, in the case of parents and family members who have lost a young man to suicide, the interactional context of

the courtesy stigma is absent. A courtesy stigma, in the traditional understanding of the concept, would encompass instances of rejection towards family members when accompanying the stigmatised individual; this is simply not possible for family members who have lost a young man to suicide. Rather, families experience a courtesy stigma on the basis of their larger biographical relationship with the young man and their 'known about' identity as someone who has lost a loved one to suicide.

Whilst the stigma of suicide has a long history, considerably less is known about the stigma experienced by families who have lost a loved one to suicide. As a result I hope to address this by examining the nature of the stigma experienced by families bereaved by suicide. Particular attention will be paid to the distinction between felt and enacted stigma and the effect this has on different family members as well as looking at the coping strategies that they employ in overcoming stigma.

### **Felt V Enacted Stigma**

Before looking at the nature of the stigma suffered by the families, it will be helpful to introduce the distinction between felt and enacted stigma. First introduced by Scambler and Hopkins (1986) the concept of enacted stigma refers to instances of overt discrimination against stigmatised people. The idea of felt stigma is slightly more complex. It refers to both the fear of enacted stigma and also feelings of shame. This could encompass what I have previously called self-stigma and is unquestionably bound up with feelings of blame following the suicide of a loved one.

The interviews and online focus groups revealed that the families overwhelmingly experienced felt stigma. Many talked about how they believed that others considered them to be different because of their son or brother's suicide. Most commonly parents imagined that others were critical of their child raising abilities and more generally all family members talked about feeling that others were not accepting of them and made them feel uncomfortable. As Susan commented:

You like want to talk about them, but then sometimes when you talk about them with your friends, people get uncomfortable and stuff, you know, because they killed themselves. But it's like just because they're dead doesn't mean you can't talk about them.

(Susan, Zack's mother)

(Face to face interview)

One of the more problematic aspects of the distinction between felt and enacted stigma is that although they are analytically separate, they often merge in the parents' experience of stigma. For example, despite telling me that she sometimes felt uncomfortable discussing Zack's suicide with others, when asked about actual experiences of stigma Susan had difficulty in providing any concrete examples:

Actually no one has been funny about it at all. I mean, I think, you know, people find it difficult to talk about it ... And obviously the death of somebody's child is really difficult to talk about anyway. I think it's what you put on yourself.

(Susan, Zack's mother)

(Face to face interview)

Initially Susan talks about enacted stigma, albeit a relatively mild form, whereby she states that her friends become uncomfortable when talking about her son. However, when asked to discuss experiences of this stigma she reassesses what she says. Importantly she goes on to say that "it's what you put on yourself", essentially alluding to felt stigma. Even though Susan could not provide examples of stigmatising behaviour from her friends, her own feelings of perceived awkwardness were projected onto the thoughts of the social audience.

Feelings of felt stigma however were most commonly experienced in public situations, such as social outings and shopping. In the case of a courtesy stigma experienced by parents of a child with a disability for example, it is in such public situations where the family, particularly the parents' competence is most likely to be judged. Once again we see the significance for families bereaved by suicide of the absence of the stigmatised individual. This is when the 'known about' identity as someone who has lost a loved one to suicide becomes crucial. When the families' status as having lost someone to suicide is known it ultimately threatens the ability of relatives to affect a presentation of family normality. In such situations, other people's knowledge of the

young man's suicide has the potential to generate extreme feelings of shame and embarrassment for the families, as Tessa related:

Tessa: Our lives are ruined. Me and Robin feel that our lives have been ruined. I mean I feel that when I go to the supermarket, I feel everybody knows what's happened.

Nina: Do you feel that?

Tessa: Yea. I feel they're thinking oh there's that woman whose son did that. And I feel that they're making a judgment on me, rightly or wrongly I feel that. Because there is definitely a stigma about suicide.

(Tessa, Matthew's mother)  
(Face to face interview)

For Goffman (1968: 152), those that were suffering from the shame associated with stigma ultimately felt ashamed because they interpreted being stigmatised as an infringement against what he called 'norms of identity'. Scambler and Hopkins (1986) for example found that amongst individuals living with epilepsy, 'having seizures' was less salient than 'being' epileptic. As they put forward, individuals in their study had a deep sense of what they characterised as 'ontological (rather than moral) inferiority' (Scambler and Hopkins 1986: 33). In Tessa's case, her words above suggest that perhaps the perception of the moral judgement against her has become salient as an organising principle in her life.

Felt stigma however was not pervasive in the families' lives. Rather, a sense of shame and embarrassment was more prevalent when activated by situational stimuli – when others knew about their young man's suicide. In the following quote we see Zeke alluding to a direct instance of guilt and the embarrassment that ensued as a result of this:

There was one friend I saw every day whom would get the most horrible expression on her face if we discussed Paul. It would create an embarrassing awkwardness where I would end up feeling guilty for even mentioning him. I got to where I would avoid the subject to avoid the expression.

(Zeke, Paul's father)  
(Online focus group)



Families less commonly experienced unambiguously enacted stigma. When they did occur these reactions overwhelmingly took the form of avoidance:

Well reactions I've had is my next door neighbour has never spoken to me since. Not once. She goes in the house if she sees me which is so upsetting.

(Jan, Gareth's mother)  
(Face to face interview)

Once you tell people that your child committed suicide, they shut up and change the subject and try to steer clear of you after that. It's really hard to tell people because I know things will be different. People distance themselves from you.

(Kim, Sam's mother)  
(Online face group)

Such reactions were often disturbing for the parents, especially when they affected the social lives of other members of the family, particularly other children:

I mean although it's hurtful and it is really hard, in a way I can cope with it, but it's Scott that I really worry about. How he is going to cope with people whispering about his brother?

(Susan, Zack's mother)  
(Face to face interview)

Despite being upsetting, at least avoidance can to some extent be interpreted as relatively non-provocative. Thoughtless comments and accusations are much harder to ignore and would often leave family members feeling isolated and more prone to concealing the suicide:

It was just after Jon died and this bitch from school was like, "didn't your dad kill himself as well? God your family is more messed up than mine" and then she laughed, can you believe it? Now it takes me a long time to tell people. I can't handle people's reactions.

(Christine, Jon's brother and Martin's daughter)  
(Online focus group)

## COPING STRATEGIES

As has already been noted, stigma was not omnipresent in the families' lives. However, when it was activated they often drew on a number of coping strategies in an attempt to lessen the effects of the stigma (felt or enacted). The choice of strategy employed would often depend upon the 'knownaboutness' of the stigma. For instance, where others did not know about the young man's suicide, the first choice strategy was secrecy and concealment; whenever feasible they tried to pass as 'normal'. Families would also selectively disclose information to others, often depending on the person they were talking to. If the audience was already in the know, the families were predisposed to cover or divert attention away from the stigma often by avoiding difficult situations, although there were instances when they would be upfront and tackle the stigma head on. In the following section I will consider these strategies in more detail.

### Secrecy and Concealment

A distinctive aspect of stigmatisation in the case of suicide arises from the fact that unless known to others it is not evident to outsiders. As such it falls into Goffman's (1968) category of discreditable rather than discredited stigma. When the young man's suicide was unknown to others, families overwhelmingly operated a policy of secrecy and concealment:

I generally avoid telling people who don't already know. It's really painful to tell, so I don't.

(Camille, Hugh's wife)  
(Online focus group)

Despite the fact that the majority of the families had concealed their young man's suicide, when confronted by someone who did not know about their death this was not always achieved with ease. Many agonised over keeping their son or brother's death a secret:

I shouldn't be ashamed. I'm not ashamed of him, no way. But then I kick myself. I mean why couldn't I just tell her? It just makes you, oh I don't know, it's just so difficult.

(Rachel, Joel's mother)  
(Face to face interview)

Despite finding concealing the nature of Joel's death extremely difficult, Rachel went on to tell me that she had found alternative coping strategies even more traumatic, and therefore found herself operating a policy of concealment:

I couldn't believe she didn't know. I mean everyone knew, everyone. So then I had to tell her my eldest had died. And she just said, 'Oh I'm so sorry, how did he die?' It was awful, just awful. I found the courage from somewhere to say, 'he committed suicide', and she just looked at me, and then said 'I'm sorry'. I wanted to run away screaming.

(Rachel, Joel's mother)  
(Face to face interview)

Following this experience, Rachel would only selectively disclose Joel's suicide once she felt she could trust the person she was telling. As she makes clear:

That's why I'm very, sort of, selective now when I speak to people, what I tell them.

(Rachel, Joel's mother)  
(Face to face interview)

Zeke makes a similar point when answering my question 'how do you find talking about your loved one with others?':

What I do now after 15 years is sometimes I tell people about my son and sometimes I don't. It depends on whether the person I am talking to is a casual acquaintance or someone I am going to be around a lot.

(Zeke, Paul's father)  
(Online focus group)

For others a policy of secrecy and concealment was rationalised in terms of their own healing:

Nicola: Um, you are kind of protecting yourself, your own feelings as well though. Like yeah, there's no way in the world that I'm ever ashamed of Simon, not at all, but you know, not so much now cause I've got my coping strategies, but you know, some days, some times I don't tell new people. Its not about them, it's about you, isn't it?

Nina: It is.

Nicola: And you don't want to break down in front of other people.

(Nicola, Simon's sister)

(Face to face interview)

The feelings of guilt that would often ensue instances when families concealed the nature of their young man's death were somewhat lessened over time, as their social networks grew to include others who had been bereaved by suicide. In the early stages of their loved one's death, opportunities for socialising with other families bereaved by suicide were understandably somewhat limited. However, as opportunities for such socialising grew, this had the effect of lessening the guilt felt by the families that enact such secrecy:

I felt so alienated. I felt it was this big secret that I couldn't talk about. That's why (the support group) was so good. You find that it is normal to be secretive.

(Peter, Joel's father)

(Face to face interview)

The effect of using support groups will be discussed in more detail in the final chapter. However in the context of stigma, support groups helped the families by being in a safe space that would be free from potential stigma.

According to Jones and colleagues (1984), one variable that influences stigma is the degree of social distance between the stigmatised person and those making the judgment. As MacRae (1999) makes clear, social distance refers to both the degree of familiarity between those involved in the interaction and the level of personal involvement between them. People at a close relational distance are less likely to stigmatise. This might explain why some families explained to me that they had not suffered any direct enactments of stigma usually because they surrounded themselves with people who were 'in the know'. Close others, such as family and friends make up what Goffman (1968) refers to as the 'wise' – those who tend to be the main providers of emotional and instrumental support:

About the only ones who bring his name up are my wife and daughters and a few relatives.

(Zeke, Paul's father)  
(Online focus group)

Outside of the family, no one brings him up in conversation. It's like his death did not happen.

(Lucy, Mike's sister)  
(Online focus group)

The wise have insight into the experiences of people living with a stigma, forming a 'protective circle' around them.

## Covering

Despite the nature of suicide often being discreditable, there were times when the young man's death was known to others, thereby potentially becoming a discredited stigma. Many family members adopted a policy of 'covering', when interacting with others who knew about the suicide. This is most usefully illustrated through their experiences at work. A topic that resonated strongly for many of the families was absences from work. Lisa, for example, was extremely concerned about how she would be perceived if she took time off work:

I didn't take that much time off because I was scared. It seems stupid perhaps, but I just didn't want to give them the impression that I was taking advantage.

(Lisa, Aaron's sister)  
(Face to face interview)

What we see here is Lisa attempting to minimise the potential for stigma by carrying out her normal, everyday duties. By covering the death of her brother, Lisa tries to detract any undue attention away from herself. As she told me, she only took a total of one week off work, "a couple of days when he died and then two more days for the funeral".

According to Goffman (1968: 102), covering practices are employed when the stigma is known about but effort is made to prevent it from 'looming large'. So despite the

fact that Lisa didn't report any stigmatisation from her employers she made efforts to minimise its potential salience. Covering, then, involves situation management, so that the visibility of the stigma and the shame and embarrassment it may cause are kept to a minimum:

The association between suicide and people thinking you're crazy drives me crazy! I will go out of my way to appear happy just to stop it when really I'm dying.

(Kim, Sam's mother)  
(Online focus group)

So, the management of information was often used to cover families' true feelings about the death of their loved one:

I mean it's difficult to talk about because if you actually told some of your friends, or your partner how you actually felt, they wouldn't be able to deal with that because it's just, it's just too much. So I think that in itself makes it difficult to talk about suicide.

(Susan, Zack's mother)  
(Face to face interview)

Essentially Susan is managing the amount of information that she gives out in an attempt to control the reactions of others. Despite other people potentially being a source of support to Susan, she chooses to disguise her actual feelings as a way of pre-empting any possible negative or un-supporting reaction.

In some cases family members engaged in what Blum (1991: 268) has called 'preventative passing'. In effect this is when families tried to anticipate a potentially negative and stigmatising situation and prevent it from happening. For example as Gayle explained, she always made sure new people at her work knew about Kai:

I tend to tell them, or make sure they know. Because sometimes there's headlines in papers and people say stupid things, you know, and I don't want to ... I suppose I don't want to, I wouldn't like for it all to come out. I don't want to turn around one day and say, 'I hate you all. You've got no idea how this is'. I don't want to do that.

(Gayle, Kai's mother)  
(Face to face interview)

By telling people in work about Kai's suicide, Gayle is attempting to avoid potentially upsetting and awkward situations. She goes on to explain to me that her reason for doing this is because she "wouldn't like for it all to come out", indicating that like Susan, she is covering what she is truly feeling.

## CHALLENGING THE STIGMA

A small minority of families refused to become victims of stigmatisation. This was often achieved through the practice of what MacRae (1999: 60) has called a 'technique of naturalisation'. In essence this means framing any negative reaction to a stigmatising condition as the other person's problem. In her study of the courtesy stigma suffered by family members of persons with Alzheimer's disease, MacRae (1999: 65) found that families sometimes took the position that people who react negatively 'don't count' anyway. Similarly in my study, some family members attempted to manage the threat of stigma by being upfront and tackling the issue head on. When asked about how she coped with work following her son's serious, although not fatal, suicide attempt, Jan told me:

When I went back nobody mentioned it. And I said to them all then,  
'but you're acting like I should be ashamed because he's ill'.

(Jan, Gareth's mother)  
(Face to face interview)

Jan uses a technique of neutralisation by holding onto the belief that if others felt uncomfortable about Gareth's suicide attempt, then it was their problem. But interestingly, she also medicalises the problem. Jan refuses to cover up Gareth's suicide attempt or act ashamed because she believes him to have an illness. As we have seen in chapter five, when constructing her own understanding of Gareth's death Jan refutes the psychiatric explanation. However when confronted with a potentially stigmatising reaction she pulls this explanation back in. By holding onto a psychiatric definition of suicide, Jan attempts to absolve Gareth of responsibility and therefore render any subsequent stigma irrelevant. Similarly Beth when asked about people's reactions to Howell's suicide stated:

You realise who your friends are. Someone in work said that people who commit suicide are selfish. She just came right out and said it. People like that though, you have to just ignore them.

(Beth, Howell's sister)  
(Face to face interview)

Interestingly the majority of family members who believed stigma to be other people's problem were families where the young man had a history of mental illness. Whilst not appealing to psychiatric understandings of their loved one's death in their own search for understanding, when confronted with possible instances of stigma, felt or enacted, they often tackled them by medicalising suicide. Because others didn't understand the nature of their young man's suicide, their views did not matter.

Appeals to biomedicine in an effort to reject stigma were not the only way that families were upfront about their loved one's suicide. In the following extract Susan describes her disappointment at how Zack's school responded to his death:

And I said to the school, why don't you use Zack's death as a starting point to talk about suicide? But they're just so fucking scared of it and they're just terrified that if they talk about it somebody might want to do it. But it won't make anyone do it. I mean they're all thinking about it anyway, just as a concept though. They're not all thinking of doing it. But it's a concept though, isn't it? Because you think you're immortal, don't you?

(Susan, Zack's mother)  
(Face to face interview)

In this case Susan is not dismissing what others say as irrelevant but is looking to the school for a positive reaction towards Zack's death, "a starting point to talk about suicide". However, far from receiving the positive reaction she expected, the school's response was thoroughly unsupportive. Indeed they didn't even tell the students at the school that Zack's death was a suicide<sup>4</sup>. After this response, Susan adopted a technique of naturalisation, dismissing the school's view entirely; as she told me, "to hell with them".

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<sup>4</sup> There is limited research evidence that school-based programmes may have potentially harmful effects (see Shaffer and Gould 2000). There is also evidence that media blackouts are thought to potentially prevent suicide clusters (Gould 2001). With this in mind, there might be a sensible basis for Zack's school taking this line.



Willig (2000) suggests that looking at resistance to dominant discourses enables the examination of alternative subject positions as well as subversive practices. So as well as both challenging and ignoring others' understandings of suicide, family members accessed a discourse of normality as a means of minimising their young man's difference to other people. By drawing upon this discourse, families attempted to challenge people's construction of suicide as only something that happens to other people. In line with Bennett and colleagues (2003) who identified similar findings in their research on young people's perception of the connection between depression and suicidal behaviours, families' reliance on the normality discourse was constituted by an emphasis on the young man's non-suicidal behaviours. Zack killed himself after a 'normal' evening out with his friends:

He'd been out with people on the Saturday night. He'd been out with Lewis and some friends drinking. A typical, normal Saturday night. Nobody said that he seemed down or different.

(Susan, Zack's mother)  
(Face to face interview)

Susan emphasises the importance of normality in her reflection on events leading up to Zack's suicide. By positioning Zack as 'normal', Susan attempts to detract any negative social judgements. Similarly Peter positions Joel within the normality discourse to minimise the potential of any stigma and negative judgments about mental health:

Just to reiterate again we did go to all his friends, his family, his lecturers, 'did we miss something?' But not one person said they thought he was down, unhappy, thought he was capable of doing what he'd done. He was a normal, normal boy.

(Peter, Joel's father)  
(Face to face interview)

In Goffman's original analysis he suggests that the stigmatised person holds the same views as society as a whole. However there were a number of instances where families renounce dominant perspectives. As we can see in the following quote, Tanya places emphasis on her son's normal behaviour prior to his suicide:

He was the last person you'd expect to do it. He did not leave a note and no one really knows WHY he did it. The autopsy showed no drugs or alcohol. There was nothing unusual about him. He basically got up, walked out the back door and shot himself.

(Tanya, Oliver's mother)  
(Online focus group)

Whilst I have touched on times when families attempted to challenge stigma surrounding suicide, the analysis so far has accepted Goffman's (1968: 3) understanding that when bodily signs or a person's character depart from the 'ordinary and natural' they are deeply discrediting; the person is reduced in the eyes of others 'from a whole and usual person to a tainted discounted one'. And I have added to the profusion of research that suggests that when a condition is potentially stigmatising, individuals strategically manage information about themselves. In this case, bereaved families control what others know about them by selective disclosure, covering or concealing. However only five years after Goffman's seminal text, Gussow and Tracy (1968: 317) identified a problematic assumption in his theory; the original theory did not offer the 'possibility of any serious attempt by stigmatised individuals to de-stigmatise themselves'. Goffman's original theory then, did not allow for individuals to put forth their stigma as a difference rather than a failing. Rose (1999) has picked up on a somewhat similar point. He argues that increasingly an individual's hidden injury or stigmatised condition becomes the grounds for a claim of valued identity. Identity then, 'can be legitimately claimed without individual or collective guilt, only to the extent that it can be represented as denied, repressed, injured or excluded by others' (Rose 1999: 268). For the families, their identity as a survivor of suicide has the potential to become an organising principle in their lives, a ground for changing their lives for the better.

Guilt will always be a factor for families bereaved by suicide. As well as the pain of losing a loved one in a tragic and unexpected way, they also have to contend with the stigma that surrounds suicide. However, despite the enormous sense of guilt and shame that many families felt, there were times when they chose to transform their loved one's suicide into something positive:

Before my son's suicide, I think I was like most people and did not give it much thought ... it just went in one ear and out the other. Now I just wish I could do more to help others see the need and make them see it could happen to them. I run a suicide support group, have a website dedicated to research on suicide prevention and have written articles and appeared on the radio. The message needs to get out.

(Zeke, Paul's father)  
(Online focus group)

Brown (in Rose 1999: 269) has argued that a person's identity, particularly one's politicised identity, is often attached to its own exclusion. Rather than be labelled as a victim or someone that failed in their social role, individuals turn their victim hood into the grounds for change. Indeed the idea of not being a victim to suicide was something that resonated strongly from some of the families. To draw upon Brown (in Rose 1999: 269) again, she has suggested that 'identity is not only founded upon a claim to exclusion or injury, it is also attached to a technique for reversing the direction of suffering [and] reversing pain'. Since her brother's death, Lucy described how she had become a "changed person". Her approach to her life in general and her family life in particular had drastically changed after Mike's suicide:

I now go out of my way to make sure that my sons know that they don't have to 'earn' my love, but that I will love them fiercely. No matter what they do or get into, I will still love them. I don't want them going into the well of despair thinking that the world would be better of without them and their perceived constant mistakes.

(Lucy, Mike's sister)  
(Online focus group)

Rose (1999) has also drawn attention to the fact that stigmatised groups often articulate themselves in terms of their survival by forming an identity through the discovery of themselves to be a part of a group who are similarly stigmatised. Owing a large part to the method of recruitment to my research, being a part of a 'survivor network' was not uncommon for families bereaved by suicide. Not only were such networks a harbour from the threat of stigma, they were a place for families to find themselves and re-assert their identities as one which comfortably incorporated the suicide of their loved one:

People are very supportive and try to be understanding. But only those who have experienced it can truly understand. They (support group) have helped me through the wilderness, through the guilt, through the pain. They were my lifeline.

(Amy, Andrew's sister)  
(Online focus group)

I think people will always be judgmental and can't really understand unless they are in the same place as you. I have my family, but people from the group are family now as well.

(Christine, Jon's sister and Martin's daughter)  
(Online focus group)

(The support group) has been a godsend. We are really trying to push the issue of suicide, make it less taboo.

(Tanya, Oliver's mother)  
(Online focus group)

## CONCLUSION

This chapter has explored the stigma that families experience as a result of losing a loved one to suicide. To be bereaved by suicide is a devastating experience and one that unfortunately produces stigmatising reactions (Cvinar 2005). For the families in my study this was often experienced as a stigma directed explicitly against them, rather than as a result of their association with the deceased. Moreover, my findings reveal a familial element to the stigma, with parents reporting higher levels than other family members. This is almost certainly due to the nature of a parent's relationship with their child and was often linked to parent's intense feelings of blame and guilt. Indeed many of the parents in my study not only had to learn to live with the loss of a child, but also had to account for their own actions and explain how suicide could happen in their family to *their* child (Owens *et al.* 2008). Therefore it was the moral judgement – whether this was perceived or actual – directed *at them*, that parents were often reacting to.

Once suicide had entered the families' lives, they quickly learnt to perceive their status as a suicide survivor as socially undesirable. What is more, their identity as

someone bereaved by suicide often became an organising principle in their lives. Their arguably stigmatised identity impinges on their experiences, relationships and operation in the outside world. The families' past experiences of stigma, as well as the fear of potentially stigmatising reactions, ultimately structured the way they made sense of events – past, present and future – and aligned them with a particular identity, as a survivor of suicide.

## Chapter Eight:

# CONCLUSION

### INTRODUCTION

The purpose of this thesis has been to move towards a discursive understanding of suicide in young men. Drawing upon the narratives of people bereaved by suicide, I have explored their attempts to make sense of their young man's death. The main focus has been on the young man, albeit the families' descriptions and their respective stories and memories of their loved one. That is, the narratives of the life and death of the young men have formed the core of this project, while recognising that these are 'reconstructions' from the relatives' point of view. However, in their search for meaning, it became clear that it is impossible to disentangle the families' own identities from the process of telling. Moreover the stories told show the families struggling to understand how *they* failed their son or brother. As Owens and colleagues (2008: 239) found in their research with parents who had lost a son to suicide, these are stories told amidst a 'profoundly disrupted biography'. Indeed Owens and colleagues show that when attempting to make sense of his death, the parent's focus was as much 'why did it happen to me?' as 'why did it happen to him?'. This finding was echoed throughout my own research. The suicide of the young man shattered the families' lives, destroying all previously held sense of meaning and understanding of the world. As Williams (1984: 178) states, 'the orderly sequence of facts gets broken up. It cannot be sustained against the chaos'. In their search for reasons behind the young man's death, families also had to re-build their lives with suicide within it. In line with Williams' (1984: 197) understanding of 'narrative reconstruction', families 'attempt to reconstitute and repair ruptures between body, self, and world by linking-up and interpreting different aspects of biography in order to realign present and past with self and society'.

Consequently this thesis developed a dual focus. On the one hand it addressed the families' search for meaning in their loved one's decision to die. At the same time it chronicled the families' attempts to incorporate the young man's suicide into the biography of the family, in a way that attempts to restore the family as a successful unit. This dual focus guided the two main research questions asked at the outset of this study: ① How do families make sense of their young man's death? ② How have families experienced suicide? I draw upon these questions, and the dual focus, in this conclusion to this thesis – discussing the families' constructions of the young man's life and suicide before moving on to look at their own experiences and their (re)construction of themselves and their family. I also consider the relevance of these findings for the wider policy arena and indicate possible paths for future research.

## TALES OF THE YOUNG MEN

In chapter four we saw families' constructions of their young man's life. The initial purpose behind this was an attempt to see if there was a degree of coherence between families' understandings of the young man's life and his suicide; whether families could rationalise his death on account of the life that he had led. However it soon became clear that the picture was far more complex than this. Ultimately, the stories of the young man's past were always told in the present. All of the families' re-constructions of the young man when he was alive are informed by the knowledge that his life ends with suicide. There is the sense then that families need to make his life 'fit' with his death. As a result it was often difficult to separate the two – life and death seemed to merge. Memories of their loved one suddenly become imbued with new meaning; stories have to be re-cast in the light of suicide. This is where the 'psy' discourse became important in their constructions.

The discourse of medical-psychiatry increasingly interprets problems in everyday living as psychological problems, providing an explanation for personal unhappiness. With this in mind, it was the young man's failure to cope with the hazards of modern life – a relationship breakdown or unemployment for example – that became *responsible* for his mental state. However families' reliance on the 'psy' discourse did

not end here. Indeed, there was evidence of families constructing their loved one against the psychiatric ideal of a rational, coherent identity. Here, stories were told in light of cultural assumptions about what it means for a young person to become a 'successful' adult. Families made assumptions about the young man's responsibility for controlling and managing an ideal way of being. It was the young man's failure to achieve this ideal that was an important structuring factor in the families' understandings.

Suicide is a deviant death. It represents a 'failed' life, one that could not succeed in living. In chapter seven we saw how families were all too aware of the value that suicide has in society. Yet despite the young man's failure to achieve a successful identity being an important structuring factor in their constructions, it was not always easily accepted. Indeed families would often wrestle with this understanding, revisiting it during the course of the interviews. There were times when family members were keen to re-construct the young man in less deviant ways, re-forming him in a more socially acceptable light. As they constructed their accounts, families drew on a number of alternative cultural discourses and concepts. Here, for example, we saw the issue of gender coming to the fore. Rather than a self that had failed, the young men were represented as displaying hegemonic masculine ideals of strength, pride and perfectionism. These understandings were also associated with men's unwillingness to seek help, helping the families to construct their loved ones as the 'stronger sex' (Coutenay 2000). For instance we saw Simon's reluctance to ask for help being bound up with his need to "keep up the bravado". Indeed this could be taken as an example of how some 'masculinising practices damage bodies' (Connell 2000: 184).

Chapter six documented the families' painful search for meaning behind their son or brother's death. As became apparent, their understandings were wrapped up with intense feelings of blame, responsibility and guilt. What began to emerge were understandings that were constructed in line with their own need to displace guilt. The families' constructions of the young man's death then became transformed into their negotiation of blame – who was *responsible* for their loved one's death. It was in this negotiation that we saw a complex process of reasoning emerge – one that attempted to position the family away from direct responsibility. In chapter five, we



saw instances where the dominant medico-psychiatric discourse took on responsibility for the young man's death. During these times, the young man's 'undiagnosed' mental illness was held up as a possible reason for his suicide. There was the sense that had he been diagnosed then he may still be alive, as Gayle says:

If you get a diagnosis, then you look to treatment and then you look to hope.

(Gayle, Kai's mother)  
(Face to face interview)

However this matter was complicated in the case of those young men who had received a 'diagnosis'. Here families resisted the dominant medical-psychiatric understanding that positions mental illness as *causing* suicide. Instead a number of alternative explanations came to the fore. Importantly, these explanations were positioned within a discourse of normality. Had these families drawn upon a medico-psychiatric discourse to account for their loved one's suicide, then *they* could potentially be blamed for missing the signs of his deterioration. However by emphasising his normality, their responsibility is lessened. Instead, the finger of blame can be pointed outside the family, for example at the police or a relationship breakdown.

## TALES OF THE BEREAVED

As well as charting the families' attempts to make sense of their loved one's death, this thesis also represents the bereaved's attempts to create new meaning in their own lives. Particularly for parents, their own identity becomes bound up with their son's suicide. Suicide is not simply something that happened to their son, it happened to *them* as well. As we saw in chapter seven, parents often felt that they had to account for their own actions, as well as their son's. How could *they* have let something like this happen to their son? We get a glimpse into the intense feelings of blame and guilt at failing their child. As Tanya says, "suicide tells the world you didn't do your job". Added to this, parents also had to contend with the stigma that surrounds suicide. Chapter seven documents the stigma that many families felt was directed specifically at them. As such, families not only have to learn to live with the feelings of blame they feel themselves, but also the blame that others direct at them.

This ultimately means that their loved one's suicide became an organising principle in their lives.

All of this points to the fact that it is not only the young man's deviant status that families have to wrestle with, but also that of their own. Recognising their status as deviant, the bereaved made various attempts to manage the associated stigma, by accepting, covering, challenging and subverting the meaning of suicide. It was in these attempts to challenge and subvert the meaning of suicide that we saw the rather fluid nature of families' understandings of their loved one's suicide. Once again the centrality of 'psy' understandings of suicide came to the fore. For example, despite resisting such discourses when families were attempting to make sense of their mentally ill son or brother's suicide, when confronted with potential stigma, families would invariably appeal to such understandings.

In addition to revealing the fluidity of understanding, attempts to challenge the stigma surrounding suicide also presented opportunities for the bereaved to forge a new group identity, one that was operationalised in terms of survival rather than victimhood. Within both the U.K. and the U.S.A., there is a growing 'bereaved by suicide' support movement. Indeed, families would often go out of their way to highlight the necessity of talking to others who had been through a similar experience. Time and time again, the issue of suicide being a different death, producing different feelings of grief, was brought up by the families. Importantly these feelings and emotions were only ever truly expressed with 'knowing others' – those who had also experienced the pain of losing a loved one to suicide. It is within this context that families were able to mobilise their resistance to the stigma of suicide. Support groups also provided a space whereby families could re-assert their identity – one that positions them away from blame and guilt in a bid to exonerate them. As Susan stated:

Meeting other mothers who have been through a similar tragedy gives you immense strength. Their tragedy makes you feel normal again.

(Susan, Zack's mother)  
(Face to face interview)

It is here that the importance of narrative becomes clear. As we saw in chapter six, in the context of research, to focus on the stories *as stories*, we can begin to see how

the bereaved attempt to make sense of the suicide that disrupted their family. Moreover, as Owens and colleagues found (2008: 241), the stories of the young men were not simply factual descriptions of his life, but ‘highly sophisticated and selective reconstructions’ that were crucial in the relatives’ search for meaning. Ultimately then, these reconstructions highlight the importance of narrative in the families’ quest for a version of events that helps them make sense of the past and face the future.

## **Policy Implications and Directions for Future Research**

A number of conclusions and reflections have emerged from this research that could potentially have a bearing on policy. One finding, illustrated above, is the value of the narrative approach. The importance of using the narrative approach has also been highlighted by those working in the helping services (e.g. White 1995, 2000; Parton and O’Byrne 2000). In the context of this research, the family narratives were important not solely for what they told me about the young men, but rather how relatives achieved understanding. As Owens and colleagues (2008) maintain, the strength of this approach centres on revealing a person’s interpretation of suicide rather than on uncovering events leading up to the death. Consequently the value lies in the ability to inform postvention rather than prevention<sup>5</sup>.

It has been reported that those bereaved by suicide frequently consider taking their own lives. Indeed, many of the families in my study would openly discuss their suicidal feelings with me. Although this finding is often discussed within the support literature (Fine 1999; Wertheimer 2001; Lukas and Seiden 2007), it is relatively absent within suicide prevention strategies. Indeed the ‘National Suicide Prevention Strategy for England’ (Department of Health 2002) makes no mention of their apparent increased risk at all. The Scottish strategy, ‘Choose Life’ (Scottish Executive 2002) is perhaps unique in its approach to suicide prevention at the

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<sup>5</sup> Shneidman (1972; 1973) coined the term postvention to refer to the work of helping those affected by suicide in a bid to reduce its ‘psychological psychache’ and manage its social stigma. As he states, ‘its purpose is to help survivors live longer, more productively, and less stressfully than they are likely to otherwise’ (Shneidman 1995: 165).

national level (Mackenzie *et al.* 2007), incorporating the views of the bereaved by suicide as well as recognising them as an at risk group. Wales currently has no national suicide prevention strategy, although one is soon to be implemented and it is expected to be based largely upon the Scottish initiative (Hart 2008). Whilst it is beyond the scope of this thesis to propose what constitutes 'best practice', the issues derived from researching families' understandings of suicide could certainly be used within postvention strategies and health and social policy guidelines.

The importance of postvention and the need for a consistent approach was apparent from my research. The value of the 'Choose Life' postvention, and the difference that it made to families living in Scotland was immediately apparent during their interviews. Indeed families would often talk at length about the Scottish strategy when answering questions about their own ways of coping. In contrast, families in both England and Wales frequently spoke about the lack of support, with the impetus to seek out avenues of help being placed firmly with them. As Susan told me; "I had more support when my house was burgled".

Ultimately, the care of the bereaved by suicide should be central to any suicide prevention strategy. Whilst I am not suggesting that postvention is the same as prevention, the uniqueness of grief following a death by suicide, the intense and often conflicting emotions that result, the stigma that still surrounds it and the suicidal feelings that bereaved families themselves sometimes report necessitates an integrated and unified approach. In addition, this study also highlights the need to focus on the approach adopted by postvention strategies. Shneidman (1995: 29) drew attention to the fact that suicide is often a 'highly charged dyadic crisis', involving surviving relatives as well as the person who had died. The intense suffering and painful feelings of guilt and shame that families felt was evident during my research. Indeed, through their search for meaning and attempts to manage blame, there were times when families would end up punishing themselves. Consequently, in line with Shneidman (1972; 1973; 1995), my research points to the need to focus explicitly on these painful and often destructive emotions in the work of postvention.

Another important, policy relevant finding to emerge from this study, is the significance and value of support groups for the bereaved. What was particularly

striking is the ability of such environments to help families overcome the destructive feelings they so often feel. Whilst this may well be due, in part, to my recruitment techniques – the majority of participants had been in contact with a suicide support group – the significance that families placed on talking to other survivors cannot go ignored. The isolation and stigma (felt or otherwise) that families frequently discussed as resulting from a death from suicide would often result in their true feelings being suppressed. It was only within the context of such supportive environments, that families revealed their inner-most thoughts and therefore started along the path of healing. Importantly, such value was not limited to those families in contact with a support group; as discussed in chapter three, not all participants had contact with such groups. Yet the need to talk with those who ‘know’ what it is to experience loss through suicide was just as palpable during their interviews.

These policy-relevant findings also lend themselves to possibilities for future research. The value that families spoke about the Scottish approach to postvention certainly opens up the opportunity for a more systematic evaluation of the approach that is soon to be implemented in Wales. Further research then, could examine and evaluate the impact that a national postvention/prevention strategy plays in people’s lives. Away from policy, a number of more concrete, empirical issues arose from the data that point to the potential for future research. First of all, as I have focussed solely on family understandings of young *men’s* suicide, it would be important to examine the meanings attached to young *women’s* suicide. It has been found that male and female suicide and suicidal behaviour are understood and responded to differently by lay people and professionals alike (Scourfield *et al.* 2007). Importantly these understandings are structured according to gendered ‘cultural scripts’ (Canetto 1997). It would be interesting to see if this is the same for families and those close to the deceased individual. In addition, this study also pointed to the impact of *time* on family understandings of suicide. Whilst it is outside the realms of this thesis, there did appear to be differences in understanding over time. In particular, the significance of guilt and blame seemed to lessen with time. We might then conduct a longitudinal study, to follow more closely the ways in which families attempt to manage and assimilate feelings of guilt and blame in their everyday lives.

## ENDINGS

Hammersley and Atkinson (1995: 17) state that research is and must remain 'the production of knowledge'. This thesis has gone some way to produce new truths and challenge old certainties about suicide in young men. Its focus has centred on how the meanings and understandings behind a death by suicide are complex and often contradictory. Moreover what may seem immediately apparent, for example a young man killing himself as a result of a mental illness, may in fact need greater interrogation. Ultimately, it is only by working within the contradictions and gaps of the normalising and regulatory discourses identified throughout this thesis can we move towards a greater understanding of the complexity that surrounds a death from suicide.

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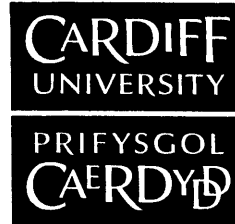
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# APPENDIX ONE

Cardiff School of Social Sciences  
Director Professor Huw Beynon

*Ysgol Gwyddorau Cymdeithasol Caerdydd*  
*Cyfarwyddwr Yr Athro Huw Beynon*



162 Treharris Street,  
Roath,  
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CF24 3HQ

JacobNK@cf.ac.uk

029 2019 8414

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*Prifysgol Caerdydd*  
*Adeilad Morgannwg*  
*Rhodfa Brenin Edward VII*  
*Caerdydd CF10 3WT*  
*Cymru Y Deyrnas Gyfunol*

Dear

As you know I lost my younger brother Joe to suicide six years ago. He was just 16 years old. His death was completely unexpected. At the time my family found it very difficult to accept that his death was a suicide. After all, Joe had never shown signs of behaving in a way that we then thought a suicidal person would. He was a cheerful and happy person, who would go out of his way to make others laugh. He was a popular member of his peer group and had just begun an art course that he had desperately wanted to do. Why then would he take his own life?

My background is in Sociology, and in an attempt to cope with my grief, I began reading the more academic texts on suicide. However far from helping me, such work merely served to frustrate me. The young men that they were describing were depressed, isolated and lonely people; the opposite of my brother.

It was around this time – eighteen months after my brother had died – that I attended my first SOBS annual conference in Birmingham. When I started to talk with others who had lost someone to suicide I realised that what I had experienced was not unique. Indeed it was inherently normal. Why then do so many academic texts insist on painting an incorrect picture of those who die by suicide?

This general frustration is what led me to begin my own research into suicide in young men. I have been fortunate enough to secure a grant from the Economics and Social Science Research Council that has enabled me to carry out this research. However far

from replicating many previous research projects on suicide, that tend to focus on the more psychological traits that are inherent in young men who die by suicide, I want to find out a complete a picture that is possible of their lives.

In order to achieve this however, I need to speak with survivors who are left behind after a young man's suicide. I would be eternally grateful if you would introduce my research to survivors in your group meeting. I have provided a letter along with an information sheet (which introduce myself and my research) that you could give to anyone who is interested. Please feel free to contact me if there is anything you would like to discuss with me. I can be contacted on the above phone number, as can Dr Jonathan Scourfield and Amanda Coffey, my PhD supervisors, who can both vouch for me.

Thank you again

Yours sincerely,

Nina Jacob

## **APPENDIX TWO**

Cardiff School of Social Sciences  
Director Professor Huw Beynon

*Ysgol Gwyddorau Cymdeithasol Caerdydd*  
*Cyfarwyddwr Yr Athro Huw Beynon*

162 Treharris Street  
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CF24 3HQ

JacobNK@cf.ac.uk

029 2019 8414

Date:

Dear

Thank you for showing an interest in my research. My name is Nina Jacob and I am a postgraduate researcher at Cardiff University. My background is in Sociology, so I am keen to explore the wider context of suicide in young men. Searching for a reason about why people take their lives is inevitable. However I am aware that the answer will never truly be known, since the information is no longer with us. All that we can hope to achieve is to reach a point where we our loved one's suicide makes sense to us. What I hope to achieve through my research is to build up a complete picture as is possible about young men who take their own lives, so that we may understand a bit more about their decision.

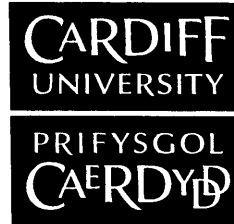
May I say at this point that my interest in suicide is not purely academic. I lost my younger brother Joe to suicide six years ago, when he was just 16 years old. As you know all too well, what a horrifying and life shattering experience this is. It is also life changing, and my life has certainly changed significantly in the six years since Joe died. I had never considered researching, however now it is the only thing that makes sense to me. In many ways I am doing this for him.

Suicide is still, at times, a taboo subject. People simply don't understand why anyone would not want to live. By carrying out research on suicide, I truly believe that we can educate the public and eradicate the stigma that still unfortunately surrounds suicide. With your help I hope that we can find out more about the reasons why so many young men are choosing to end their lives.

Thank you again for taking the time to read this letter, and I do hope that you'll consider helping me with my research. Please read the enclosed information sheet, which will hopefully answer any question that you may have. If you have any further questions or would like to know more about the research, please feel free to contact me at JacobNK@cf.ac.uk or on (029) 2019 8414. If you would like to help, please complete the enclosed form and return it in the pre-addressed envelope to me. In the meantime, I wish you all the very best, and hope to hear from you soon.

Best wishes,

Nina Jacob



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## **APPENDIX THREE**



# **Suicide in Young Men**

**Suicide is the commonest cause of death  
in young men under the age of 35**

My name is Nina Jacob, and I lost my  
younger brother Joe to suicide five years  
ago.

His death was a complete shock, yet I firmly believe  
that it could have been prevented. This belief has  
led me to research the topic of suicide as part of a  
higher degree at Cardiff University, in the hope  
that we can find out more about the reasons  
behind their deaths .

I am keen to talk with others who have lost  
a young male to suicide.

If you are interested in finding more about my  
research project, then please take an information  
pack that I have provided.

You can also contact me either by phone on:

029 2019 8414

Or by email at: [jacobnk@cf.ac.uk](mailto:jacobnk@cf.ac.uk)

## **APPENDIX FOUR**

# **The Social Context of Suicide in Young Men**

Information about the Interview (please keep this copy)

You are being invited to take part in an interview. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

## **What is the purpose of the study?**

My research project involves looking at a number of cases of suicide in young men. As you know, searching for a reason to explain why our loved ones chose to end their own lives is inevitable. Whilst the answer will never truly be known, with your help I hope to build up a picture of the young man's life (and death) so that we may understand more about their suicide. My research may even help with future suicide prevention/postvention strategies.

## **Why have I been chosen?**

To find the reason behind people's suicide can never be reached, since the only information is no longer with us. However by talking to families left behind, I hope to find out something about the way that we understand their death, how it makes sense to us.

## **Do I have to have to take part?**

Of course not! I understand that talking about our loved one's life can be extremely difficult. It is something that I still find tough now, particularly when I am having a bad day. If you do decide to take part, I would ask you to either contact me by phone or email or sign the enclosed consent form and send it back to me. If you do decide you are free to withdraw at any time, without giving a reason.

## **What will happen to me if I take part?**

I will make an appointment for an informal interview with you, to share with me stories of your loved one's life, and your feelings about their suicide. The interview will take place at a time to suit you (daytime or

evening), and at a location to suit you (e.g. your own home or at the support group meeting place). I will also request your permission for the interview to be audio-taped so that I can analyse the discussion after the interview has taken place.

**What are the possible disadvantages of taking part?**

Talking about suicide can also be very upsetting, and this is especially so if the person who died was very close. Please remember that I can be phoned on 029 2019 8414 or emailed at JacobNK@cf.ac.uk if you would like to talk to me about anything you said. If you would like to add comments to what you said or perhaps arrange to meet again and talk some more that would be fine.

**What are the possible benefits of taking part?**

Despite a more sympathetic and understanding approach to suicide, unfortunately a certain amount of taboo still surrounds it. The more we find out about why people choose to take their own lives, the more we can hope to change attitudes about suicide.

**Will my taking part in this study be kept confidential?**

All information collected during the course of the research will be kept strictly confidential. After the research is completed the audiotapes will be destroyed and data from the interview will be anonymised so that your name and other details cannot be identified.

It may be useful in my report to use direct quotations from the survivors who participated. Should this happen quotations will be anonymous and cannot be traced back to you.

**What will happen to the results of the research study?**

The results will be summarised in a booklet which will be available to all those who have taken part, as well as all members of SOBS and other support groups. The results will also be written up and submitted as part of my higher degree. You will not be named in any report or publication.

### **Who is organising and funding the research?**

The study is being organised at the School of Social Sciences at Cardiff University. I am lucky enough to have secured a grant from the Economics and Social Research Council.

### **Who has approved the study?**

My research has been approved by the School of Social Sciences Research Ethics Committee at Cardiff University

### **Contact for Further Information**

Nina Jacob

Cardiff University

School of Social Sciences

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Email: [JacobNK@cf.ac.uk](mailto:JacobNK@cf.ac.uk)

## **APPENDIX FIVE**

## LIST OF INTERVIEWEES

NAME	RELATIONSHIP	NAME OF YOUNG MAN
Beth	Sister	Howell
Gayle	Mother	Kai
Jack	Father	Adam
Jan	Mother	Gareth
Jane	Mother	Liam
Lisa	Sister	Aaron
Lorna	Mother	Simon
Neil	Father	Liam
Nicola	Sister	Simon
Peter	Father	Joel
Rachel	Mother	Joel
Susan	Mother	Zack
Tessa	Mother	Matthew

## MAIN ONLINE CONTRIBUTIONS

Amy	Sister	Andrew
Camille	Wife	Hugh
Christine	Sister (and father)	Jon (and Martin)
Cindy	Mother-in-law	Mark
Jess	Partner	Daniel
Kim	Mother	Sam
Lucy	Sister	Mike
Lynn	Partner	Trevor
Tanya	Mother	Oliver
Zeke	Father	Paul

## **APPENDIX SIX**



## **Interview Schedule**

Introduce myself: why I am interested in the topic and my personal experience of suicide.

### *Basic questions*

Who are we talking about here?  
When did they die?

### ***The young man's life***

“Let's not get into suicide now, let's just talk about their life for a while”

Allow the interviewee to talk as much about the young man's life as they want.

### **You might want to say a bit about**

What sort of person were they?  
How would you describe them?  
What did he spend his time doing?  
What was important to him?  
What did he bring to your family?  
What were his ambitions? – Were they achievable / achieved?  
Was he happy?

### **That kind of thing..**

What sort of child were they?  
Was he a happy child?  
Did he stay the same throughout his life – were there any changes?

### **Talk about his experiences of:**

- school
- work
- relationships
- friendships
- family life

### **Were there any difficulties in his life?**

How did he cope with them?

Did he ever talk about suicide?

Do you think his death was planned?

If you think back, do you think there were any warning signs?

## ***The young man's death***

"I'd now like to give you the opportunity to talk about what actually happened – to tell me about their suicide"

### ***The Coroner's court***

How did you find the experience of the coroner's court?

How was his death classified?

How did the verdict make you feel?

### ***The press***

Did you have any contact with the press?

How was his death reported?

Did you have any input into the reporting of his death?

### ***Own feelings***

Do you think that he wanted to die?

What do you think were the reasons for his suicide?

Do you think that his death could have been prevented?

e.g.

- role of the school
- mental health services
- crisis services, 'Samaritans'

## ***Experiences of suicide***

**“I think that being bereaved by suicide, places us in a unique position, whereby we are able to discover a bit about people’s general perceptions about suicide”**

How do you find talking about \_\_\_\_\_ with others?

Do people talk about \_\_\_\_\_ with you, voluntarily bring him up in conversation?

Do you notice any differences in how people are with you?

How do you find telling people for the first time?

If you are asked how many children / brothers and sisters – how do you cope?

Experiences in work – e.g. time off, reactions from colleagues

Experiences with friends and family

Have you had any particularly negative experiences with others?

Do you find people supportive? – Who is? Why are they?

Do you find people understanding? Again, who is and why are they?

## ***General questions about suicide***

Do you find suicide taboo?

What experiences have led you to think it is / is not?

Have you changed how you think about suicide since \_\_\_\_\_ died?

Why do you think that suicide in young men seems to be increasing?

There’s been a lot of concern in the media and sometimes from the government about suicide in young men, because until recently it was on the increase. Have you got any thoughts about this, about why there seems to have been a rise in suicides in young men?

## ***Endings***

I think that I have got what I need. Is there anything that you would like to say, add, ask me?

How are you feeling? Are you happy for us to end now?

## **APPENDIX SEVEN**

# The Social Context of Suicide in Young Men

## REFLECTIONS

...I don't know what to wonder, another day  
...I don't know what to wonder, another day  
...I don't know what to wonder, another day

My sense of wonder is of ... I heard their say  
It won't matter ... another day  
I did not need to ... so much talk  
It won't matter ... again

Despair and ...  
It won't matter ...  
If only I ...  
It won't matter ...



## Information for participants

## REFLECTION

Another day for you to wonder, another day for you to mourn  
It wasn't my intention to go before the coming dawn  
My pain was deep within my heart and troubled head  
It wasn't my intention to go without words said

My frame of mind seemed normal, or so I heard them say  
It wasn't my intention not to see another day  
I did not mean to make you suffer or cause you so much pain  
It wasn't my intention not to ever see you again

Despair and confusion left my aching mind unsure  
It wasn't my intention to suddenly close life's door  
If only I could give you reasons and brush your tears away  
It wasn't my intention to leave you and not stay

I did not mean for you to grieve, now left alone to cry  
It wasn't my intention to leave you, forever asking why  
As the burdens of life's worries slowly ebb from my heart  
It wasn't my intention to tear your soul apart.

Y. Docherty

## **Survival Guide**

---

**The survivor of a suicide bereavement faces a stark choice ... it is up to you to decide whether to be permanently hurt by the last act of a free individual or not ... this option is YOURS. (Luke 1984)**

- Know you can survive. You may not think so but you can.
- Struggle with 'why' it happened until you no longer need to know 'why' or until you are satisfied with partial answers.
- Know you may feel overwhelmed by the intensity of your feelings, but all these feelings are normal.
- Anger, guilt, confusion, denial, forgetfulness are common responses. You are not going crazy; you are in mourning. Be aware you may feel anger, appropriate anger, at the person, at the world, at friends, at God, at yourself; it is all right to express it.
- You may feel guilty for what you think you did or did not do. Remember the choice was not yours – one cannot be responsible for another's actions.
- Find a good listener; be open and honest with your feelings.
- Do not remain silent – about what has happened or about how you feel.
- You may feel suicidal, this is normal, it does not mean you will act on those thoughts.
- Do not be afraid to cry, tears are healing.
- Keeping an emotional diary is useful as well as healing. Record your thoughts, feelings and behaviour. Writing a letter to the deceased expressing your thoughts and feelings can also be part of the healing process.
- Give yourself time to heal.
- Expect setbacks. If emotions return like a tidal wave, you may be experiencing 'unfinished business'.
- Try to put off making any major decisions.

- Seek professional advice. Be aware of the pain of your family and friends.
- Be patient with yourself and others who may not understand.
- Set your own limits and learn to say no.
- Ask questions, work through the guilt, anger, bitterness and other feelings until you can let them go. Letting go does not mean forgetting.
- Keep in mind that each person grieves in his or her own way. Some people visit the cemetery weekly; others find it too painful to go at all.
- Each person also grieves at his or her own pace; there is no set rhythm or timeline for healing.
- It is common to experience physical symptoms in your grief, headaches, sleeplessness, loss of appetite etc.
- Be kind to yourself. When you feel ready, begin to go on with your life. Eventually starting to enjoy life again is not a betrayal of your loved one, but rather a sign that you've begun to heal.
- Know that you will never be the same again, **but you can survive and even go beyond just surviving.**

Taken from SOBs leaflet, 'Support after a Suicide'.



## Say 'Luke' to Me

Why wont you talk about my child?  
Why wont you say his name?  
Why wont you put your arms around me  
and understand my pain?  
Why wont you share the memories  
I have up in my head?  
Why wont you talk about him,  
now that he is dead?

The years have passed since the day he died.  
And for you it is over and done.  
But I need all the help that I can get –  
I'm still grieving for my son.  
I know that it all embarrasses you,  
I can see it in your face.  
But I wont let his name die,  
or sink without a trace.

Don't you know how much it hurts,  
When you turn your face away,  
every time I say his name  
or recall a special day?  
I don't want to make you miserable  
When I talk of what I had,  
I just need to know you loved him too,  
and to lose him made you sad.

So please just say 'Luke' to me  
Just every once in a while.  
It won't heal my broken heart,  
But I know it will make me smile.

The world's a very lonely place  
without my little boy.  
So please just say 'Luke' to me  
and give me back some joy.

Dany Sherlock

## **From Survivors**

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***Knowing that others share the same experience can bring hope and healing.***

"If telling my story can comfort another survivor, then I will continue to tell it. If I can get information into the hands of someone who can save a life, then I am doing something incredible. I may never know for sure that my work has saved a life. I can live with that; I don't want to live with the 'what if' questions of never having tried" (Laurell Reussow, survivor).

". . . There is a litany of feelings that all survivors of suicide know too well. The flippant use of 'I could just kill myself'; the incessant wondering of Why? Why? Why?; the anniversary of the death and its importance (no matter how long it has been); someone remembering that this is the day your world stopped and then started differently; the fear of memories yellowing and becoming harder to recall; and the instant connection that many survivors have with one another . . ." (Tinka, survivor).

". . . Since [my husband's] suicide, I felt increasingly isolated from my friends and family. They had no idea what I was going through, all their well-intentioned advice and words of comfort seeming ignorant at best and tinged with cruelty at worst . . . I thought about the singular bond suicide survivors share with one another. Even though each of our situations is unique, we all experience similar stages in our grieving. When we meet someone else who has been there, it makes our personal chaos and isolated secrecy -- seem a little less frightening." (Carla Fine 1996, 'No Time to Say Goodbye').

I don't know why.  
I'll never know why.  
I don't have to know why.  
I don't like it.  
What I do have to do is to make a choice about my living.  
The choice is mine.  
I can go on living, valuing every moment in a way u never did before,  
or I can be destroyed by it and, in turn, destroy others.  
I though I was immortal. That my family and children were also.  
That tragedy happened only to others.  
But I know now that life is tenuous and valuable.  
So I am choosing to go on living, making the most of the time I have,  
valuing my family and friends in a way never possible before.  
(Iris Bolton 1995, 'My Son ... My Son')

## **Online Resources**

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Email support groups and discussion boards:

[www.suicidediscussionboard.com](http://www.suicidediscussionboard.com)

A place for support and healing after a suicide.

[www.griefnet.org](http://www.griefnet.org).

Internet community of people dealing with death, and loss. Sponsors 47 email support groups, organized by type of loss (including suicide) and relationship.

[www.grohol.com/helpme.htm](http://www.grohol.com/helpme.htm).

Email support groups based on relationship (including groups for children, which are moderated by adults) and special interest. Also has links to other online resources.

[www.groww.org/Branches/sos.htm](http://www.groww.org/Branches/sos.htm).

Email support group.

[www.healingthehurt.com](http://www.healingthehurt.com).

Email support group.

[www.pbs.org/weblab/living](http://www.pbs.org/weblab/living).

Created by a survivor to provide a space for survivors to share their stories.

[www.compassionatefriends.org](http://www.compassionatefriends.org).

Sponsors on-line chat groups for those who've lost a child or sibling (not specific to suicide). Also has links to other online resources.

### **Other web sites of interest:**

[www.thegiftofkeith.org/info/main\\_navigation.html](http://www.thegiftofkeith.org/info/main_navigation.html)

Created by a survivor family that contains information and resources about surviving suicide loss.

[www.siblingsurvivors.com](http://www.siblingsurvivors.com)

Created by a survivor after she lost her sister to suicide.

[www.suicidememorialwall.com](http://www.suicidememorialwall.com)

Created to remember some of the names of those who died by suicide and to encourage survivors to better understand the causes of suicide.

[www.survivorsofsuicide.com](http://www.survivorsofsuicide.com)

Comprehensive web site for suicide survivors.

[www.suicidreferencelibrary](http://www.suicidreferencelibrary)

An extensive site with copies of articles and reports on suicide

## **Professional Organisations**

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[www.national-confidential-inquiry.ac.uk/nci/index.cfm](http://www.national-confidential-inquiry.ac.uk/nci/index.cfm)

Centre for Suicide Prevention at the University of Manchester brings together for the first time a number of projects, which will inform future policy and service planning.

<http://nimhe.csip.org.uk/home>

Suicide Programme focuses on implementing the National Suicide Prevention Strategy.

<http://cebmh.warne.ox.ac.uk/csr/profile.html>

The programme of work being conducted at the Centre for Suicide Research is aimed at increasing knowledge directly relevant to prevention of suicide and deliberate self harm.

[www.papyrus-uk.org/](http://www.papyrus-uk.org/)

PAPYRUS is a voluntary UK organisation committed to the prevention of young suicide and the promotion of mental health and emotional wellbeing.

[www.winstonswish.org.uk](http://www.winstonswish.org.uk)

Helps bereaved children and young people rebuild their lives after a family death.

## **Helpful Reading**

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### **Survivor Guides**

#### ***Suicide Survivors' Handbook -- Expanded Edition***

Trudy Carlson, Benline Press, 2000. Providing specific suggestions and practical advice from other survivors, the author addresses the questions: Why? What about shame and guilt? How long does the pain last? What helps? How do you deal with others?

#### ***Suicide and its Aftermath: Understanding and Counseling the Survivors***

Edward Dunne, John McIntosh, and Karen Dunne-Maxim (Eds.), W.W. Norton and Company, 1987. This compilation of articles and essays captures various dimensions of the many different aspects of the experience of surviving after a suicide loss. Although written by and for professional counsellors, it's very readable for the general public.

#### ***Lay My Burden Down: Unraveling Suicide and the Mental Health Crisis Among African-Americans***

Alvin F. Poussaint, M.D., and Amy Alexander. Beacon Press, 2001. One of the few books about suicide and mental health problems within the African-American community.

#### ***Survivors of Suicide***

Rita Robinson and Phyllis Hart. New Page Books, 2001. A compilation of advice and survivor stories.

#### ***After Suicide: A Ray of Hope for Those Left Behind***

Eleanora Betsy Ross et. al, Perseus Publishing, 2002. Emphasizes finding opportunities for personal growth after the tragedy of suicide loss.

#### ***Healing After the Suicide of a Loved One***

Ann Smolin and John Guinan, Simon and Schuster, 1993. So many survivors struggle with wondering, "why?" and "what if?" This book contains case studies together with advice, to help survivors begin to heal.

#### ***Suicide of a Child***

Adina Wroblewski, Centering Corp., 2002. A basic guide for early bereavement after your child's suicide. Comfortable, compassionate, easy-to-read observations and personal messages.

## **Survivor Stories**

### ***In the Wake of Suicide: Stories of the People Left Behind***

Victoria Alexander, Jossey-Bass, 1998. The author spent ten years collecting stories from fellow survivors, which she compiled into this well-organized collection.

### ***My Son...My Son: A Guide to Healing After Death, Loss or Suicide***

Iris Bolton and Curtis Mitchell, The Bolton Press, 1995. A mother's account of her progression through the grief process after the suicide of her 20-year old son.

### ***No Time to Say Goodbye: Surviving the Suicide of a Loved One***

Carla Fine, Doubleday, 1996. Following the suicide of her husband, the author interviewed over 100 suicide survivors. She weaves their experiences into her book, creating a story of loss, grief, and survival.

### ***The Empty Chair: The Journey of Grief After Suicide***

Beryl Glover, In Sight Books, 2000. The grief process as experienced by a variety of people dealing with different emotions following the suicide of a family member.

### ***Before Their Time: Adult Children's Experiences of Parental Suicide***

Mary and Maureen Stimming. Temple University Press, 1999. Presents adult children survivors' accounts of their loss, grief, and resolution following a parent's suicide. Separate sections offer perspectives on the deaths of mothers and fathers. Also includes the reflections of four siblings on the shared loss of their mother.

### ***A Special Scar: The Experience of People Bereaved by Suicide***

Alison Wertheimer, Routledge, 2001. The author (who lost her sister to suicide) presents interviews with 50 survivors, and covers a wide range of issues, including the press, stigma, guilt, anger and rejection.

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## **Suicide and Mental Illness**

### ***Understanding Depression: What We Know and What You Can Do About It***

Leslie Alan Horvitz, J Raymond Depaulo and John Hopkins 2002. The Psychiatrist-in-Chief of the John Hopkins Hospital presents a comprehensive, user-friendly guide to depression, including the latest research in brain chemistry, psychology and pharmacology.

### **Night Falls Fast: Understanding Suicide**

Kay Redfield Jamison, Ph.D., Alfred A. Knopf, 1999. Weaving together an in-depth psychological and scientific exploration of the subject, this book traces the network of reasons underlying suicide, including the factors that interact to cause suicide, and the evolving treatments available from modern medicine. Includes a particular focus on suicide by adolescents and young adults.

### **The Noonday Demon: An Atlas of Depression**

Andrew Solomon, Scribner, 2001. Winner of the American National Book award. A sufferer of chronic depression, Solomon shares his own story, while presenting the problem of depression in a broader social context.

### **Darkness Visible**

William Styron, Random House, 1990. A powerful and moving first-hand account of what depression feels like to the sufferer.

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## **Helping Children**

### **Someone I Love Died By Suicide: A Story for Child Survivors and Those Who Care for Them**

Doreen Cammarata, Grief Guidance, Inc., 2000. An illustrated book that explains depression and suicide in child-friendly language.

### **But I Didn't Say Goodbye: For Parents and Professionals Helping Child Suicide Survivors**

Barbara Rubel, Griefwork Center, Inc., 2000. Told from the point of view of a child, this book is intended for adults to read and then share with children.

### **Finding a Way Through When Someone Close has Died: What it Feels like and What You Can do to Help Yourself – A Workbook by Young People for Young People**

Pat Mood and Lesley Whittaker, 2001. Written by children for children, this unique workbook is both written and illustrated by children and teenagers who have experienced the death of someone close to them - a parent, grandparent, sibling or friend. They offer advice, based on their own experiences, on how to cope with the practical and emotional upheavals of bereavement.

## **For Adolescents and Teenagers**

### **After a Suicide: Young People Speak Up**

Susan Kuklin, Putnam Publishing Group, 1994. Nine personal accounts of survivors, many of whom are teens. Each account focuses on a specific topic, such as losing a parent, losing a sibling, seeking therapy, support groups.

### **No One Saw My Pain: Why Teens Kill Themselves**

Andrew Slaby and Lili Frank Garfinkle, W.W. Norton and Company, 1995. Written by an expert on suicide in young adults, this book looks at many examples of adolescent suicide and explores the complex factors that may contribute to it.

### **The Dougy Center**

[www.dougy.org](http://www.dougy.org) - publishes extensive resources for helping children and teens who are grieving the death of a parent, sibling or friend, including 'After suicide: A workbook for grieving kids'.



## **Final Note**

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I give heartfelt thanks for your valuable contribution to my research. Sharing the distress of suicide isn't easy. The books that I have listed in this information pack are all available at [amazon.co.uk](http://amazon.co.uk), and all the online resources that I have mentioned were up and running at the time of my writing.

In addition to these sources of support, I am happy to talk to you after the interview if there is anything that you would like to discuss with me. My phone number is 029 2019 8414, and my email address is [jacobnk@cf.ac.uk](mailto:jacobnk@cf.ac.uk)

# APPENDIX EIGHT

suicideresearch.co.uk - Microsoft Internet Explorer


File Edit View Favorites Tools Help

Address http://www.suicideresearch.co.uk/

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## THE SOCIAL CONTEXT OF SUICIDE IN YOUNG MEN

( Reflection ) ( Who Am I? ) ( Mailing List ) ( How do I subscribe )



**Who Am I?**

My name is Nina Jacob and I am a postgraduate student working for my PhD at Cardiff University in the UK. My background is in Sociology so I am keen to explore the wider social context of suicide in young men. For those of us who have been affected by suicide, searching for a reason about why people take their own lives is inevitable. However I am aware that the answer will never truly be known, since the information is no longer with us. All that we can hope to achieve is to reach a point where our loved one's suicide makes sense to us.

What's the project about? >>

Who Am I?

What's the project about?

What do you have to do?

If you have any technical problems or queries concerning the discussion list or any questions in general you can contact Nina Jacob (researcher) by emailing [jacobnk@cf.ac.uk](mailto:jacobnk@cf.ac.uk)

Local intranet

Start | suicideresearch.co.uk... | 20:52

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## THE SOCIAL CONTEXT OF SUICIDE IN YOUNG MEN

( Reflection ) ( Who Am I? ) ( Mailing List ) ( How do I subscribe )



**What is a mailing list and how does it work?**

A mailing list is a way of sharing and discussing ideas about a particular subject with other people through the medium of electronic communication. The messages you send are processed automatically by the majordomo program at Cardiff University, and then sent on to everybody else who has subscribed to the list. A digest post will operate ensuring that everyone involved receives one, maybe two (depending on volume) emails a week containing all the separate emails posted over seven days. The list is likely to run for about four weeks so all you will ever have to read is between four and eight emails, responding to the questions that I pose to the group with as much or as little as you want to write. At any point during the research you may withdraw your consent and can ask to be removed from the distribution list.

What kind of information should I send to the list? >>

What is a mailing list and how does it work?

What kind of information should I send to the mailing list?

Should I use my real name?

Who will be able to read the messages?

How do I subscribe to the mailing list?

If you have any technical problems or queries concerning the discussion list or any questions in general you can contact Nina Jacob (researcher) by emailing [jacobnk@cf.ac.uk](mailto:jacobnk@cf.ac.uk)

Local intranet

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## **APPENDIX NINE**

Hello,

Thank you for taking the time to read this message and I hope you don't mind receiving an email from a relative stranger! My name is Nina Jacob and I am a postgraduate researcher working for my PhD at Cardiff University in the UK. I found your name on a memorial website and wondered whether you might be willing to help with some research I am undertaking on suicide amongst men.

For those of us who have been affected by suicide, searching for an answer about why our loved one chose to end their life is inevitable. Whilst I understand that this can never truly be answered, I am hoping to collect survivor's stories and experiences of suicide so that we may understand a bit more about their decision.

As part of my research I have set up a website which contains a mailing list called **Suicide-Research-L** and I am inviting you to come and have a look and hopefully even join it. For more detailed information about the project and who I am please visit <http://www.suicideresearch.co.uk> where you can find out more about the mailing list and how to join.

May I say at this point that my interest in suicide is not purely academic. I lost my younger brother Joe to suicide six years ago, when he was just 16 years old. You know all too well, what a horrifying and life shattering experience this is. It is also life changing, and my life has certainly changed significantly in the six years since Joe died. I had never considered researching, however now it is the only thing that makes sense to me. In many ways I am doing this for him.

I know that there are a number of suicide support groups and mailing lists on the Internet, but the suicide-research list is unique in taking a wider view of suicide. My background is in sociology so I am keen to explore the wider social context of suicide in young men. The suicide-research list is also important because the more research we can undertake on suicide, the more we can understand it. Suicide is still, at times, a taboo subject. People simply don't understand why anyone would not want to live. By carrying out research on suicide, I truly believe that we can educate the public and eradicate the stigma that still unfortunately surrounds suicide.

Thank you again for taking the time to read this message and I do hope that you'll consider taking part in the discussions. If you have any questions or would like to know more about the research, please feel free to contact me at [JacobNJ@cf.ac.uk](mailto:JacobNJ@cf.ac.uk). In the meantime, I wish you all the very best and hope to hear from you soon.

Nina Jacob  
School of Social Sciences  
Cardiff University, UK

<http://www.suicideresearch.co.uk>

