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Stories Worth Telling: Moral Experiences of Suicidal Behavior

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Abstract. Moral constructions of suicide are deliberately avoided in contemporary suicidology, yet morality persists, little or imperfectly acknowledged, in its practices and in the policies, discourses, and instruments that it underpins. This study used narrative methodologies to examine the normative force of suicidology and its implications for persons who had engaged in an act of nonfatal suicidal behavior. I interviewed a convenience sample of twelve persons from two inner-urban community mental health centers who were receiving crisis and case management services after a recent act of nonfatal suicidal behavior. Interviews focused on events leading up to and after participants' suicidal behavior; the responses their suicidal behavior generated in others, including family, friends, and the health professionals caring for them; and cultural views of suicide more broadly. Analysis of these interviews revealed that, although participants' narratives were broadly consistent with a number of recognizable, canonical story formats common to our cultural repertoire of stories of suicide, they also revealed important tensions, divisions, conflicts, and challenges to contemporary suicidological discourse and practice. Despite evidence to suggest that biomedical understandings of suicide provided some therapeutic benefit to participants, they did not address important social and moral dimensions of human life or explore their connection to suicidal behavior—aspects of the suicidal event that were critical to its causation and to its retelling and “resolution.” The results of this study provide important insights into the moral features of suicidal behavior, the moral and ethical implications of suicide research, and the limitations of moral and ethical discourse in suicidology.

Key Words. Ethics, moral experience, narrative, qualitative research, suicide, suicidology.

From the texts of ancient Greece and Rome through the theological writings of the Middle Ages up until the Enlightenment and beyond, philosophical reflection on the morality of suicide has been commonplace. Traditionally, this debate has involved theistic and secular arguments about the right to suicide, the sanctity of life, and the appropriate moral response to suicide (Donnelly, 1990; Pabst Battin, 1995). Although these moral issues continue to be the subject of philosophical and bioethical inquiry, modernist conceptualizations of suicide as largely nondeliberative and involuntary have led to a shift in moral discourse on suicide (Pabst Battin, 1995). Indeed, suicidology¹ has gone to great lengths to minimize the influence

¹ Suicidology is broadly conceived of as the scientific study of suicide and suicide prevention.

of moral judgments upon suicide, largely, in fact, with the laudable aim of expunging stigma from suicide as a corollary, but also as a way of transcending moral questions to focus on the determining causes of suicide. At the same time, medical and religious authorities have questioned whether suicide should be considered a moral dilemma or an illness (Rose, 1994; Weisman, 1971).

This does not mean that suicide is no longer considered a moral problem or that morality is completely excised from discourse on suicide. Morality persists in the epistemologies, health policies, discourses, and instruments (not to mention the concepts, experiences, and emotions of patients, their families, and the general public) that suicidology underpins. Moral issues are of primary concern to practitioners engaged in the treatment and care of suicidal persons where the role of competing moral frameworks for determining the norms and practice of care have been the subject of recent debate (Cutcliffe & Stevenson, 2007; Hewitt & Edwards, 2006; Pompili, 2010). Recognition of the importance of subjective experiences of suffering to the care of suicidal persons has been a feature of this research.

That suicide is irreducibly moral is in many ways self-evident. Numerous studies associate suicidal behavior with feelings of blame, guilt, shame, and stigma—not to mention those experiences that have deep moral significance and are also closely linked with suicidal behavior, such as illness, suffering, vulnerability, grief, and loss. But although many accept that suicide is a moral and ethical problem, and research continues to examine the norms and principles that underpin suicide prevention and the care of suicidal persons, little consideration has been given to the normative force of *suicidology* and the moral implications of its practices.

Discourse on suicide has always been especially diverse—including both academic and nonacademic writings on the social, medical, moral, historical, literary, and cultural dimensions of suicide and suicidal behavior. The formal *study* of suicide, what is now known as suicidology, is, however, a recent development. Contemporary suicidology is marked by a number of discontinuities with other, more traditional forms of thinking and knowing about suicide—privileging scientific medical approaches to understanding and preventing suicide (Cardinal, 2008; Goldblatt, Schechter, Maltsberger, & Ronningstam, 2012). This reconfiguring of suicide as a largely scientific and technical problem, as opposed to a philosophical or moral one, has meant that knowledge that involves metaphysical speculation, ethical values, or aesthetic judgments has become marginalized and diminished.

I suggest that narrative methodologies provide a way of enriching understanding of the moral realm by examining the normative practices that constitute contemporary understandings of suicide and their moral implications. For the way suicidal or previously suicidal persons understand and explain their suicidal behavior, the responses their behavior generates, and the processes they go through after their suicidal actions are all examples of the way the normative force of suicidology impacts upon lives. Narrative, therefore, as both a moral methodology and as a form of moral discourse (Murray, 1997) provides a method for reasoning about a variety of moral problems which emerge from personal narratives of suicidal behavior and which are linked to the social practice of suicidology. In this way, narrative provides an important means for expanding our moral conceptions of suicidal behavior, suicide research, and suicide prevention.

The idea that the moral life exists in everyday social contexts—as has been elaborated by Arthur Kleinman (2006), as well as writers such as Margaret Urban Walker (1998), Charles Taylor (1989), and Martha Nussbaum (1990)—substantially alters and enriches consideration of the ethics of suicide as it moves away from the idea that suicide is a contentious or vexing situation where options need to be evaluated and dilemmas resolved, to one where the idea of suicide is interwoven with an array of experiences to which persons ascribe moral significance. In using the term moral experience, I draw on the following conceptualization proposed by Hunt and Carnevale (2011, p. 659):

Moral experience encompasses a person's sense that values that he or she deems important are being realised or thwarted in everyday life. This includes a person's interpretations of a lived encounter, or a set of lived encounters, that fall on spectrums of right-wrong, good-bad or just-unjust.

In the social realm, where the meaning of suicide and the experiences and interactions between suicidal persons, family members, friends, and health care professionals are morally significant, narrative provides a means for delineating important aspects of moral experience. In addition, the capacity of narrative to illuminate the interrelationship between discourses, knowledges, and practices makes it a valuable tool for socio-political and ethical analysis and critique (Petersen & Lupton, 1996).

There is a tradition of viewing the stories of suicidal or previously suicidal persons with some suspicion regarding their veracity and scientific value. Persons who have engaged in suicidal behavior have been largely disqualified as sources of critical and potentially transformative knowledge. First, on epistemic grounds, which dismiss subjective self-reports because they do not accord with the standards of scientific method. And second, on moral grounds, because of a concern that the promulgation of subjective views on suicide may normalize, glorify, or romanticize suicidal behavior. Calls for suicidology to recognize the pivotal role of personal stories have grown more vocal in recent years, with concerns being raised about the disconnect between the linguistic, epistemological, and ontological frameworks through which suicidal behavior is understood by professionals and nonprofessionals (Cutcliffe & Ball, 2009; Myers & Fine, 2007; Webb, 2006). This disparity between authorial voices has been the focus of considerable work in bioethics (Chambers, 1999; Hunter, 1991; Nelson, 2001) and serves as a staging point for rethinking and transforming our moral understandings of suicide and suicidal behavior by recognizing the value of patients' stories. Despite the healing and transformative power of narrative being well-documented in the illness narrative literature, the value of stories of suicide is less well understood and raises serious ethical challenges, especially in cases where persons continue to express a desire to die, or for those who may have limited capacity.

The aim of this work, therefore, is twofold: First, to examine how persons who had engaged in a recent act of nonfatal suicidal behavior accounted for their actions through the construction and telling of stories, and second to consider the extent to which these narratives intersected with those of contemporary suicidology and the moral and ethical implications that follow.

Method

The study and analysis I present herein are part of a larger study of how persons who had engaged in a recent act of nonfatal suicidal behavior talked about their experiences. This research is informed by the work of narrative theorists such as Bamberg (2006) and Day Sclater (2000), who place analytic emphasis on the semantic and discursive properties that are intrinsic to the giving of an account. In this view, narratives are not entirely personal and individual but are determined by sociolinguistic conventions. They involve a dialectic between the individual and the social (Smith & Sparkes, 2008).

The fact that human beings do not have complete interpretive freedom over biographical events, but that narratives are structured according to discursive norms and conventions, means that both the structure and content of narratives are important, as are the personal, social, and discursive functions they serve. Therefore, although narratives are constrained by discursive frameworks, they also offer the possibilities for persons to negotiate, challenge, and transform them (Day Sclater, 2000). The strength of this approach is its sensitivity to the interrelation between narrative and discourse. It provides a method for examining the “individual” and “sociocultural” features of stories of suicide by considering the ways that individuals use stories to serve particular functions, and in so doing, position themselves in relation to moral norms which govern suicide and responses to it (Andrews, Day Sclater, Rustin, Squire, & Treacher, 2000; Day Sclater, 2000).

Research Setting and Participants

Recruitment of participants occurred at two inner-urban Community Mental Health Centres in Sydney, Australia, in liaison with the Acute Care Service (ACS). The ACS provides crisis management services for adults living in the community who experience a range of mental health issues. In the case of persons being admitted to the emergency department as a result of injuries sustained through an act of nonfatal suicidal behavior or self-harm, such persons are required by guidelines to be referred to mental health services for a complete mental health (including suicide risk) assessment and for support (New South Wales Department of Health, 2004). In the first instance, this falls under the provision of the ACS.

Persons who were receiving crisis support were identified by the ACS team who screened them to assess their suitability to participate in the study. Patients aged over 18 years who had engaged in an act of nonfatal suicidal behavior with or without injury within the past 6 months and who were receiving crisis support were considered eligible for the study. This included those patients who were referred to the ACS after hospitalization for injuries incurred as a result of their nonfatal suicidal behavior as well as those who had recently been discharged from inpatient mental health units. Those who did not speak English, were cognitively impaired, or were experiencing psychosis were excluded from the study.

Once participants were identified as being eligible for the study, they were contacted either in person or by phone by an ACS team member and asked whether they would consent

to being contacted by the researcher directly. Once consent was obtained, a telephone call was made by the researcher to eligible participants to introduce the study and to obtain further consent to send them a copy of the Participant Information Sheet. A follow-up telephone call approximately 7 days after the mailing of the Participant Information Sheet was then made to schedule an interview with those interested in taking part in the study.

In total, twelve interviews were conducted between February 2010 and June 2011. The participants' age range was 18 to 64 years. There were six females and six males. Of the twelve participants interviewed, ten of these were receiving crisis support from the ACS after discharge from the emergency department owing to injuries resulting from their suicidal behavior, and two, who had not sustained injuries, were receiving support after discharge from inpatient mental health units. Ethical approval of this study was granted by the research ethics committees of the area health service and the university concerned.

Data Collection

Face-to-face, semi-structured interviews were conducted with all twelve participants. The interviews lasted between 45 and 90 minutes and explored participants' stories of suicidal behavior. Interviews began with a broad, open-ended question asking participants to describe how they came to be in the ACS. This allowed participants to choose where to begin their story and was designed to act as an entry point into events and participants' experiences of them. To elicit narrative accounts on specific areas of research focus that allowed for follow-up and exploration of participants' responses, a loose structure of open-ended questions was used (Britten, 1995; Davidson, 2003). Participants were invited to respond to a set of questions on what life was like before and after their suicidal behavior; the responses their suicidal behavior generated in others, including family, friends, and the health professionals caring for them; and cultural views of suicide and suicidal behavior more broadly. Interviews were recorded on a digital voice recorder, transcribed verbatim, and de-identified. All participants were assigned a pseudonym. Narratives were analyzed iteratively and thematic saturation was achieved after twelve interviews.

Data Analysis

The interpretation of particular encounters by individuals (including the decision about what to tell, what not to tell, and how to tell it) alert us to the social and rhetorical function of narrative. When analyzing data initially the researcher was guided by the following questions: 1) How did participants position themselves in relation to the world and to others, and how did their talk reflect moral understandings and beliefs? 2) What social, cultural, and institutional discourses did participants use and how did their stories reproduce or challenge preexisting, dominant cultural understandings of suicidal behavior (Ewick & Silbey, 1995). This approach enabled a deep exploration of participants' narratives and allowed for emergent and novel themes to arise inductively. After this, a more focused analysis was carried out in which recurrent themes were coded using NVivo software and then grouped into a set of organizing concepts (Mason, 2002a) Transcripts were then re-read

to clarify these concepts, revisit any data that may have been missed or glossed over, and analyze them further in light of relevant theoretical frameworks.

The approach taken in this analysis was not to provide a representative sample, but to identify themes that were noteworthy and to build a convincing analytic narrative that expands and enriches our moral conceptions of suicidal behavior and suicidological discourse and practice (Mason, 2002b). Because the strength of this analysis lies in its sensitivity to context and language, I report analysis of the narratives of four of the twelve participants—Beth, Anita, Michael, and William—whose stories provided the most explicit and full account of how certain moral orders are reproduced and sustained by suicidological discourse and practice and their potential to be morally harmful.

Results

Structure and Content of Stories of Suicidal Behavior

Stories are told, but stories are also read, listened to, and viewed. We live in and among stories. Narrators and readers bring with them certain presuppositions about narratives that shape the ways they are told, interpreted, and evaluated (Abbott, 2009).² Another way of viewing these norms and conventions is through what narrative researchers term “canonical” formats. For example, Bordwell (1988) argues that the passage of cause and effect is the defining feature of canonical narratives and that character, setting, and action are largely subordinate to it. In contrast, Ewick and Sibley (1995) argue that content, which is governed by cultural norms and conventions, is of principle importance in canonical narratives (what they term *hegemonic tales*). A narrative’s intelligibility, therefore, is determined as much by its frames of reference as by its structure.

Not surprisingly then, when attempting to make sense of, justify, or explain their suicidal behavior, participants in this study produced narratives that adhered to certain principles of structure and content. William, for example, began his story with a particular date etched firmly in mind and an important event in his life—the death of his wife of 14 years.

My foray into the mental health world happened [when] my wife died in 1999 and shortly thereafter I tried to kill myself and I’ve tried three times since then. So I got released from jail in 2008 and I got referred here and I came a couple of times, every 3 months I suppose; and then January of this year I tried to kill myself again.

So began William’s recounting of the period leading up to his suicide attempt—a period of inconsolable grief, yet one marked equally by growing thoughts of suicide. William’s account of this period was marked by several telling events: His wife’s funeral, the meticulous planning of his suicide attempt(s), but above all, by his sense of grief and lost hope.

² I use the term ‘reader’ here in its broadest sense to refer to all texts whether written, oral, or visual.

I just miss my wife so much you know. She's the only person that I've ever really loved; the only person that I believe has ever loved me. It was just such a really strong relationship and when she died I just lost it. I just didn't want to know. There was nothing that could really convince me to live.

Beth's suicidal behavior was also placed within a narrative with a clearly defined beginning. Like that of William, it pointed toward a disruption in the fabric of daily life and of a life come "undone" by recent circumstances, albeit illness as opposed to the death of a loved one.

This stuff has only been going on for me for about 2 years now, prior to that I never had any mental health issues or any experience with them. What was happening is that I work in a fairly high stressed job and I always coped quite well with the stress, but I found myself being overloaded more and more. I found myself leaving work in the middle of the day and going home and just sitting on the bus on the way home and crying and having thoughts that I just wanted to jump off the balcony and die. I didn't really know what to do with these thoughts. I didn't know where they were coming from and I didn't know how to deal with them. So I just tried to pretend that everything was OK. That went on for about 3 months. And then one morning the guy who sat next to me at work asked me if I was OK and everything just fell to pieces.... He told my manager and they referred me to the employee assistance program. That really wasn't very helpful. It helped a little bit. What they did do that helped was send me to my GP. And that kind of got me started on antidepressants. They diagnosed me with depression. What happened then was I started self-harming, and that led to problems at work, and I got put on a contract at work saying that I wouldn't harm myself at work because it actually got to the stage where I was harming myself in the office and I tried to kill myself. I slashed my wrists and ended up in emergency.

Beth was hospitalized and, later, spent time in a private clinic. A period of calm followed and she took some time off with her partner to travel overseas. However, things "started going downhill" upon her return to work, culminating in another suicide attempt 3 weeks before our interview.

Anita was another who, when asked how she came to be in the ACS, recounted a narrative marked by a distinct beginning. In her case, an accident 3 years previously had drawn a line through her life, bringing life as she had previously known it to an end.

I'm just in constant pain. I broke my pelvis about 3 years ago and I have about nineteen screws at the back of me and the screws have gone loose, or something has gone loose inside.... I've got one foot shorter than the

other and I have to put an extra heel on my shoe. All these things. And I'm in agony. I keep waking up from my sleep in pain; just pain from here down and nobody can do anything about it.

Frustrated, ignored, mistreated, and in constant insufferable pain, Anita decided to try and end her own life.

Like William, Beth, and Anita, Michael also provided an organized, linear, and coherent explanation to explain his suicidal actions that accorded with certain narrative conventions regarding structure and content. Consider Michael's description of the events leading up to his suicidal behavior.

I was certainly becoming more withdrawn. A relationship ended at the start of the year. As it happened, we got back together a few months later and then it fell apart again. That was when the depression started to come on. I was finding it hard to get work, so then, obviously, financial stresses came and I was having trouble paying the rent which was causing conflict with my flatmate. I was becoming more withdrawn and wasn't talking to anyone, so that was sort of building up and building up and it was reaching a point where I didn't want to leave my room. I didn't want to see anyone or do anything. I still don't really, but that's ongoing. And things just got progressively worse and worse.

Michael employed a relatively conventional story format (at least as far as narratives of suicide are concerned) that rendered a tidy trail of cause and effect leading up to his suicide attempt. Events followed one another—both linearly and logically. A relationship breakup led to a state of depression, which resulted in a series of occupational, personal, and social problems that, in turn, got progressively worse, culminating in the suicidal act.

Suicidal Behavior as Individual, Internal, and Pathological

These coherent, well-formed, and believable stories about suicidal behavior both rely on and reproduce existing cultural norms with regards to their structure and content, in particular, those that view suicide as primarily individual, internal, and pathological (Marsh, 2010). Beth's account of her suicidal behavior is persuasive precisely because it draws on a number of culturally dominant metaphors and interpretive frameworks for understanding stress (Mulhall, 1996). Rather than attributing her suicidal and self-harming behavior to the pressures of her job, a lack of social support, and worries about her future, Beth contributed it to her emotions.

I find it hard to say no to people because I don't want to upset them. So I just take on more and more until something snaps. I just can't take anything else. Things fall to pieces.

Michael, by comparison, talked about the sense of irrational despair that overcame him before his suicidal behavior. Like, Beth, his description called forth an image of internal psychological processes.

It's these thoughts that are just sort of crowding around. This blackness, this sense of despair that I can recognize is irrational. Part of me can step back and go, you know things will not always be this way; situations will change; work will pick up.... It scares me that I could come that close to doing something irrevocable that I probably don't really want to do.

Michael presented two very distinct yet overlapping narratives. As well as the narrative of his depression and despair, he also presented a narrative of honor and agency. Suicide, he said, was a way of assuming control of the situation in which he was in. "I'm clearly depressed," he claimed. "I was very, very depressed a few weeks ago when I tried to kill myself, and yet, it seemed to be the honorable thing to do." The question of moral agency figured prominently in Michael's account.

What do you do when you don't have any choices? When you feel that there is no other choice you can make? When you are completely disempowered, the only way you can empower yourself is to take your own life.... The only thing that will solve all these problems at once is to kill myself, and it's the only thing I have the power to do.

Responsibility for participants' suicidal behavior, however, was for the most part, directed elsewhere and attributed to forces beyond their control. After their suicide attempts and through subsequent therapeutic interactions, participants were primarily led to understand their emotional distress and suicidal thoughts and actions in medical terms. Although not privy to the patient–client interaction, when questioned about this, participants' responses indicated that little was made of the social, cultural, and moral dimensions that may have contributed to their feelings of failure, or of being overwhelmed, isolated, or unable to cope. Even in those cases where diagnosis was disputed and moral agency most pronounced, such as in the suicidal actions of Anita and William, the reluctance to attribute their actions to anything other than an underlying pathology (whether behavioral or biological) was striking. As Anita said:

Nobody seems to do anything about it. I go the pain clinic and they ask me mental health questions thinking I'm mentally ill or something. But I'm saying I am in agony; that is why I am trying to get rid of my life.

William was also forced to face the contradictions inherent in our cultural narratives about care and social responsibility for suicidal persons and his experiences of indifference and disapproval that were sustained by them. Despite acknowledging the efforts of several of the mental health workers with whom he dealt, it was nevertheless telling that he felt staff were not interested in why he wanted to kill himself. As he remarked, "It's difficult for

people to understand where you're coming from. They're not really interested in why you are doing it. They are only interested in you not doing it." William's compliance with mental health services, therefore, was not so much owing to the fact that he felt them beneficial despite the support they did offer, but because of a fear of harsher measures being imposed upon him if he did not.

Practices of Moral Responsibility in Treatment and Recovery

The predominance of the medical frame in understanding suicide meant that participants often talked of a need to get "better," to change their beliefs, and/or to develop appropriate strategies for managing and controlling their emotions. This ethic of self-care was common to participants' accounts as they strived to name and control their emotions, to rid themselves of suicidal thoughts, and to generate new narratives as a replacement for other, more dysfunctional ones. As Michael said:

I hope that I can disable this narrative of failure which has become, as my psychologist said yesterday, more or less self-fulfilling. You know, I think there is no point trying any more [and] so I'm hoping I will be able to at least organize a few things and get control of that so that I do feel I can try.

The entrepreneurial activity required to manage and improve the self, however, demanded considerable work. For some, such as Beth, this created additional problems.

It's like I can't put words to the emotions because I've never, because it's not something I'm familiar with doing. So doing exercises with therapists and they are trying to get me to name my emotions, I find that really hard.

William's mocking of the prison counselling program he attended that required him to speak openly of his feelings further undermined the notion of narrative as disclosing something about our mental interior and the introspective practices that are considered essential to the therapeutic endeavor.

Every day, [it was] "How does that make you feel?" And the next day it would be, "How does that make you feel?" "I told you yesterday how that makes me feel." And the next week it's, "How does that make you feel?" "Fucking told you last week. It hasn't changed." They just think it's some sort of tap you can just switch off and it's all going to be good.

The view of narrative as providing access to the reputedly deeper (perhaps unspoken or unconscious) issues confronting suicidal persons and the resultant focus on individual-level variables and treatments meant that underlying sociocultural processes that shaped participants experiences of pain, sadness, depression, grief, isolation, failure, conflict, and injustice were less well understood. These issues were kept "at a distance" and suicidal

persons were forced to think and respond to their emotional distress and suicidal thoughts in ways that, arguably, led to an increasing sense of powerlessness, meaninglessness, and depression in some participants.

The Struggle for Alternative Stories

For Beth, the onset of mental illness resulted in her reevaluating her position in the world. Although her diagnosis afforded her some capacity to render her experiences intelligible, diminished the blame associated with her actions, and provided treatment for her that enabled her to continue working, they were also viewed with some ambivalence. The optimistic outcomes promised by the medical model were not always interpreted so, engendering in Beth a sense of apprehension about her future and the long-term consequences of medical diagnosis and treatment.

I would like to be not on medication and not to have to see a psychologist once a week and a psychiatrist once a month, and worrying about if I'm going to be hospitalized and that kind of thing. Not being worried about having time off work without pay, or worried about not letting anyone at work know that things aren't great because I'm worried how they'll react and stifle my career opportunities because they think that I'm not going to be able to cope, or they don't trust that I'm going to be able to do my job to its fullest extent.

Beth's narrative is important for the way it problematizes the connection between suicidal behavior and mental illnesses, such as depression and anxiety disorder. Although Beth's story is undoubtedly a story of illness, it is also one in which our understanding of mental illness cannot be separated from Beth's own experience of it. To fully grasp Beth's actions, we must recognize the value that she places on her work and that her fear and anxiety make sense only when explicated against a background of concern about losing her position, or having her career stymied as a result of her illness and behavior.

Anita, too, struggled with the disruption that her accident had brought to her life. The feeling that her life was in ruins and that she could no longer envisage a future permeated her story.

I can't even laugh anymore.... My life was beautiful before all of this happened. I was constantly meeting people and making friends. Now I don't feel like going anywhere. I don't feel like talking to anyone. I don't have many friends. Anytime I'm invited out I don't feel like it because I'm in pain. I can't meet anybody.... This accident has ruined me completely.

Every aspect of Anita's life up until the point of her accident—social, occupational, physical, and sexual—was gone. "It's like my life is finished," she said. "I'm alive, but dead." William also struggled to find a way of going on, of finding value, meaning, and purpose in his life.

I don't know if my story's particularly sad or anything, it's just basically the way I feel.... People say to me, "Why don't you get a hobby?" I don't want a hobby. I tried volunteer work and with medical illness and a criminal record people won't take you on as a volunteer. So I'm not going to go and start paper mâché. I'm not one of these people that's reinventing himself all the time.

The question for participants such as Anita, Beth, and others, then, was one of how to live—how to carry on when the rhythm of everyday life is ruptured; when the patterns of meaning which had previously sustained life lose their sense of interconnectedness, and when uncertainty and insecurity encroach (Caputo, 1993).

Narrative provides an occasion for persons to make legible these struggles. This may result in the deployment of certain canonical story formats as persons seek to construct coherent, recognizable narrative accounts of events; but equally, it may also result in persons grappling with unresolved life events, tracing out new itineraries for themselves, and exploring worlds of possibility and particularity beyond their present understanding(s) (Ricoeur, 1994). William explicitly explores the value and meaning of stories and story-telling and identifies both the possibilities and limits of narrative approaches.

It's difficult to try and explain to somebody how you're feeling or why you made the decision to do it. And there's really no simple answer. I don't know. I'm sure you must hear the same story day in day out.

William's words suggest that he is equally aware that narrative is constrained, plastic, rule-bound, and convention-bound. His repeated pronouncement that his story of grief, despair, and suicidal behavior was no different to the stories heard every day by clinicians and researchers attests to the conventionality of many stories of suicide. As to the question of why a particular tale is worth telling; perhaps the simple answer is that, as William suggests, there *is* no simple answer to the question of suicidal behavior. It is for this reason that stories need to be told.

Discussion

The proclivity of participants at various stages throughout their interviews to construct an overarching storyline capable of synthesizing events within a temporally and causally ordered whole suggests that personal narratives of suicidal behavior often reproduce existing cultural norms with regards to structure and content. The coherent, well-formed, and recognizable stories about suicide and suicidal behavior that circulate in the public sphere provide persons with templates for describing and explaining complex, uncertain, and often chaotic events which they may not yet fully grasp.

According to Ewick and Sibley (1995), canonical or hegemonic narratives can be distinguished by the way they reproduce preexisting cultural understandings without exposing the cultural, historical, and political relations that make these stories both possible and plausible. Understanding how a story might subvert a canonical or hegemonic narrative,

therefore, does not involve attending exclusively to its local and particular features. Subversive stories do not oppose or negate the general. Rather, they make visible the connection between the particular and the general and the organizing relations that exist between the two. In doing so, they locate particular persons and events within a larger complex of social relations. By making this connection visible and explicit, the dichotomy between the particular and general is challenged, as are the power relations that help to sustain it.

Following Ewick and Sibley (1995), I suggest that what makes the accounts of Beth, Anita, Michael, and William provocative and morally significant is the way they present subjective accounts of suicidal behavior within a larger complex of social relations and practices including, but not limited to, medicine. They challenge and enlighten precisely because they contrast the particular with the medical abstractions supposed to constrain them.

Although Beth's story is a story of illness and repeated suicidal and self-harming behavior, it is also a story about the construction of a distinction between public and private, between the normal and the abnormal (Fullagar & Gattuso, 2002). For instance, Beth described how she was referred to the employee assistance program after her emotional breakdown as a result of work-related stress and conflict. However, rather than acknowledging and attempting to resolve these issues in the workplace, her emotional distress was considered inappropriate and abnormal, and she was referred to her general practitioner.

Beth's story is the story of a young woman overcome by emotional distress who is struggling to cope. But at the same time, it is also a story of gendered norms and neoliberal health policy. Feminist thinkers have long argued that a discourse on depression is, implicitly at least, also a discourse on emotion and gender (Fullagar & Gattuso, 2002; Lutz, 1996). Emotion, like the realm of the feminine, has been viewed historically and culturally as irrational, chaotic, dangerous, and in stark contrast with the masculine spheres of reason, order, and control (Lutz, 1996). The constitution of Beth's emotional experience as a mental health disorder, therefore, needs to be understood in the context of these gendered norms, as does its management and treatment which encompassed culturally dominant practices of self-governance (Fullagar & Gattuso, 2002).

Similarly, although Beth's story is a story of despair, hopelessness, and of diminished choices, it is also a story of the social construction of knowledge and the transfiguring of social, moral, and existential issues into purely technical concerns (Rose, 1996). The reliance on drug therapy and other technical means of managing and controlling the emotions that were part of Beth's treatment do not account for the degree to which other factors may be implicated in social-emotional ill health, including oppression, poverty, significant loss, and poorly perceived social supports (Brown & Harris, 1978; Fullagar & Gattuso, 2002; Murali & Oyebode, 2004; O'Sullivan, 2004). Beth's story, therefore, is a story of the "blindness" of medicine to the social determinants of health and also how medical knowledge has limited capacity to assist Beth in understanding her predicament and how she might overcome the distinct set of challenges life poses.

In similar ways, Anita's story is a story of pain, disruption, and hopelessness, but it is also a story about the intractability and authority of the paradigm of mental illness in the management and prevention of suicidal behavior. Anita's account of her failed operation, her

constant, debilitating physical pain, and the impact it has had on her life and sense of self was repeatedly disregarded by mental health professionals as reasons for her suicidal behavior, despite evidence that shows a strong correlation between physical illness and suicidal behavior (Hawgood, Spathonis, & De Leo, 2004). Anita's story, therefore, is a story of her frustration and sense of powerlessness within the health care system. And, on another level, it is also a story of medical power, the representation of suicidal persons as emotionally fragile, and subsequently, their disqualification, both as valuable people and as valuable sources of insight into suicidal behavior. Anita, like many other suicidal persons, was forced to confront the contradiction between the intellectual work of suicidologists and health professionals who compete for the right to "explain" suicide, and their apparent disinterest and exclusion of those who "attempt" suicide as creditable and valuable sources of knowledge of their actions and experiences.

Michael's story is a story of a failed relationship, ongoing housing and financial problems, depression, and social isolation, but it is also a story of the individualist tradition and the transforming of cultural-normative frameworks of depression and the self within modern liberal democracies (Ehrenberg, 2010). Michael's sense of personal failure and his bid to overcome it through a process of self-management reflects the modern view that persons are best thought of as atomistic and autonomous in the conduct of their lives and that depression is best perceived as individual pathology rather than as social and relational. The importance of social problems such as unemployment, poverty, and insecure housing in contributing to Michael's sense of failure gives his depression a deep sociopolitical meaning that is obscured by a focus on the private realm (Ehrenberg, 2010). Michael's story is a story of psychological struggle, but it is also a story of human need and the inadequacy of contemporary social and political thought to articulate these needs beyond the material to consider what is needed to truly flourish (Ignatieff, 1984).

William's story is undoubtedly a story of personal loss and grief. But equally, it is also a story of the personal-confessional genre and the celebration of stories as the means by which persons are able to reveal their most personal and the private thoughts and feelings (Atkinson & Silverman, 1997). William's story is indeed a story of love, death, loss, imprisonment, and repeated suicide attempts, but it is also a rejection of the confessional narrative genre as revelatory and teleological. It is a story of growth as stagnation, decay, and repetition. Introspection did not provide William with the means for revealing something of himself to himself therapeutically. William's story, then, is a story of the "authentic" as brute, inchoate, nonsensical, and mute. William's claim that his story was no different to the stories heard every day by clinicians and researchers, therefore, is a critique of the confessional narrative genre as a therapeutic practice capable of truly enlightening and liberating persons.

What, then, are the ethical implications of recognizing the power of participants' stories? And what happens if we refuse to make certain methodological reductions? If we give epistemological privilege to Anita, for example, do we then put ourselves in a position of having to agree that suicide is an ethically acceptable choice for her? There are lots of reasons why "we" (as a society, as health professionals, or as a biopolitically oriented public health) might recoil from such a suggestion—ranging from the valuing of human life through to advocating for greater social support and health care provision that she no does not feel that way.

Equally challenging is the question of how we should deal with the ethical (and practical) issues of how to think about the authenticity and ontological value of participants' accounts of those who may have limited capacity. For suicidal persons in the early stages of recovery, or for those who remain suicidal, medical explanations may provide them with a means of rendering their experiences intelligible and of avoiding disquieting psychological reflection (Kitanaka, 2008). For this reason, medical explanations may be considered an ethical and practical response to the issue of suicidal behavior.

Far from being incongruent with mental health approaches, the stories of participants in this study illustrate the extent to which narrative underpins recovery and the social and cultural processes that are involved in the negotiation and production of meaning (Barrett, 1996; Bracken & Thomas, 2005). Like moral or sociocultural understandings of suicidal behavior, medical explanations may open up or close down possibilities for truth and meaning that may either help or hinder recovery (Bracken & Thomas, 2005). Indeed, recent empirical research on recovery shows that meaning is crucial to the healing process and that interaction with others is equally important. As Bracken and Thomas (2005, p. 227) argue:

Recovery from illness (in the medical sense) is an individual process. Illnesses affect individuals. But if we recover something that is lost or taken away, the meaning of this expression is thrown into the social domain. The questions that must be asked are what is it that was lost or taken away and, if taken away, who took it? Recovery in this sense involves something recovered from or through others. There is a powerful moral sense to this meaning of recovery.

Following Bracken and Thomas, we might say that within the practice of suicidology what is being recovered and reclaimed is the right for suicidal persons to tell their own stories and for them to be heard. Conferring epistemological privilege on participants' accounts, therefore, places considerable moral demands on mental health professionals, researchers, family members, and friends to listen and engage with these stories without judgment and prejudice to enhance social relationships and to acknowledge the injustices and misfortunes that, for many, lie at the heart of recovery.

Conclusion

The complex, often subtle relationship between morality, suicidal behavior, and suicidological practice has been the focus of this work. Findings from this study showed how participants' understandings of their suicidal behavior interacted and overlapped with those of contemporary suicidology. Although participants' narratives were shaped by discursive norms and structures and the call to provide coherent, well-formed, and comprehensive stories of suicidal events, they also revealed important tensions and challenges to contemporary suicidological discourse and practice. Narrative methods add to the critical literature on suicide by showing how the practice of suicidology and its privileging of scientific medical approaches to understanding suicidal behavior has epistemic and normative force. The way participants understood and explained their suicidal behavior, the responses

their behavior generated, and the processes they went through after their suicidal actions are all examples of the way the normative force of suicidology impacted their lives. Despite evidence to suggest that biomedical understandings of suicide provided some therapeutic benefit to participants, they often did not address the social and moral dimensions of human life, or explore their connection to suicidal behavior—aspects of the suicidal event that were critical to its causation and, therefore, to its retelling and “resolution.”

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Table 1. Participant Details

Participant Pseudonym	Age	Sex	Contact With MHS Before Attempt	First Incidence of Suicidal Behavior	Diagnosis at Time of Interview
Daniel	48	Male	No	No	BPD
Amy	24	Female	Yes	No	Depression
Beth	34	Female	Yes	No	Depression
William	48	Male	Yes	No	Depression
Rachel	48	Female	Yes	Yes	Depression
Anita	64	Female	No	Yes	Depression
Megan	18	Female	Yes	Yes	None
Kieran	33	Male	No	No	None
Michael	38	Male	No	No	Depression
Ben	36	Male	No	Yes	Depression
Mark	51	Male	Yes	No	Depression

Michelle	26	Female	No	No	None
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BPD, borderline personality disorder; MHS, mental health services.