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Ethical and Political Implications of the Turn to Stories in Suicide Prevention

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Abstract The stories of suicide attempt survivors are gaining broader currency in suicide prevention where they have the potential to provide privileged insights into experiences of suicide, strengthen prevention and intervention measures, and reduce discrimination and stigmatization. Stories of suicide, however, have a double-edged power insofar as their benefits are counterweighted by a number of acknowledged harms. Drawing on the literatures and methods of narrative, and in particular, narrative approaches to bioethics, I contend that suicide prevention organizations make possible yet constrain the creation of personal stories of suicide, shaping the discursive meanings of public stories of suicide while setting limits on which stories are valued, legitimized, and rendered intelligible. Personal stories of suicide serve as important sites of meaning-making, power, and social identity, yet they also reproduce and normalize particular ways of thinking, acting, and communicating that reinforce the institutional logics of suicidology. These have ethical and political force as they help to frame the ways suicide is understood, the ways it is subjectively experienced, and the ways it is responded to.

Keywords Suicide, suicide attempt survivors, suicide prevention, narrative, bioethics, suicidology

One of the distinguishing features of the ‘narrative turn’ in bioethics has been the question of authorship. For bioethicists and clinicians worried about the distorting and diminishing effects of an increasingly objective, dualistic, and value-free medicine, narrative has played a leading role in establishing the importance of patients’ stories to the therapeutic endeavor while calling attention to the inadequacies of biomedicine (Arras, 1997; Brody, 1997).

Narrative is seen as a way of ceding patients the moral authority to tell their stories, while at the same time recognizing the value of patients’ stories to clinical practice. Because illness is an embodied and, therefore, deeply personal experience, stories enable persons to make sense of their lives in the midst of illness and suffering and help to make healing possible (Frank, 1995; Kleinman, 1988).

More recently, the field of suicidology—often defined as the scientific study of suicide and suicide prevention—has witnessed a similar shift in recognizing the importance of personal stories of suicide to its practice. Dominated for the most part by epidemiology, clinical psychiatry, and psychology, suicidology has been criticized by those bereaved by suicide for its objectivity, inaccessibility, use of inappropriate terminology, and for sanitizing the “‘raw’ reality of suicide” (Cutcliffe & Ball, 2009, p. 211). This places it in conflict with the anecdotal and subjective accounts of persons bereaved by suicide and poses a significant barrier to collaboration and care (Cutcliffe & Ball, 2009; Myers & Fine, 2007). Those who have struggled with ongoing suicidality or who have been hospitalized after a suicide attempt have also reported a degree of divergence between their experiences and the language of

experts that describe them (Webb, 2006). The dispassionate, detached, and objective reports of researchers, they argue, are ill-suited for capturing the chaos, ambiguity, and confusion of the suicidal crisis and the myriad challenges faced by persons after a suicide attempt. In response to these criticisms, organizations engaged in suicide research and prevention have argued for greater involvement of previously suicidal persons and those bereaved by suicide in suicide prevention initiatives, and for increased research and funding into the 'lived experience' of suicide (American Association of Suicidology, 2014; Suicide Prevention Australia, 2009). To this end, both the American Association of Suicidology and Suicide Prevention Australia have established formal suicide survivor/lived experience networks. For these organizations, the knowledge to be gained from those with lived experience is critical to modifying attitudes and to altering policies, programs, and practices, thus imparting personal narratives of suicide with a particular transformative power.

The epistemological value of narrative, therefore, is closely linked to its capacity to effect profound personal, social, and/or institutional change. One way that narrative contributes to what broadly might be referred to as the ethics of suicide, then, is as a form of moral education. The role of narrative in moral education has been the focus of works by Martha Nussbaum (1990) and Anthony Cunningham (2001), among others. These scholars acknowledge the importance of language, emotion, and reflection to the development of moral capacities. In the social realm, where the meaning of suicide and the experiences and interactions between suicidal persons, health professionals, community organizations, family members, and friends are morally significant, narrative directs and heightens our attention to morally salient features of human experience. Such issues are of primary concern to those engaged in the treatment and care of suicidal persons, and the work of Cutcliffe and others

(2002, 2007) is especially valuable for its attention to the stories of suicidal persons and a recognition of their importance for the provision of humane and effective care.

Although the virtues of narrative have been extolled as a way of morally enriching our understandings of suicide, there is an implicit danger in viewing stories, as is often the case, as essentially ‘soft’ or ‘benign’ and interested in enhancing our understanding of suicide only. Narratives are also exclusionary; they privilege and value certain kinds of reasoning and knowledge over others. They provide ways of seeing and representing suicide that have practical and ethical implications and, therefore, should not escape critical scrutiny. The transformative and healing power of narrative is well-documented in the illness narrative literature, however, the ethical value of stories of suicide—in particular, their role as a tool of moral edification—is less well-understood. Indeed, a strong body of research has demonstrated a correlation between fictional and nonfictional media representations of suicide and actual suicide, suggesting that stories of suicide may be morally harmful (Gould, Jamieson, & Romer, 2003; Hawton & Williams, 2001).

Concern about the potential danger of public stories of suicide has led to the development and implementation of best practice guidelines regarding the responsible reporting of suicide. These guidelines focus on such things as the need to take caution when reporting on the methods of suicide and of avoiding insensitive, gratuitous, or sensationalistic language, but they also emphasize particular story components. For example, stories that adopt a more permissive attitude toward suicide, that romanticize or politicize suicide, or that are critical of conventional treatments and interventions are discouraged in favor of those that more fully explore the risk factors for suicide, or those that stress its impacts on family,

friends, and the community, thus emphasizing the tragedy of suicide and encouraging people to seek help (Hunter Institute of Mental Health, 2014).

These divergent views on the role and value of stories of suicide in the public sphere suggest that stories of suicide have a double-edged power to both *heal* and *harm*. They also indicate that the formation and dissemination of stories of suicide in contemporary culture are deeply embedded within institutional structures that influence its content, style, modes of discourse, and, importantly, its erasures and silences (Saris, 1995). Storying suicide in contemporary suicidology, therefore, is not simply a matter of letting people tell their stories, but is “a form of social and political prioritizing; a particular way of telling stories that in its way privileges some story lines and silences others” (Goodson, 1995, p. 94).

Narrative theories and methods provide useful tools for thinking about personal stories of suicide and, in particular, about the narrative forms admissible within the bounds of suicidology and the political and moral interests they serve. In what follows, I present an overview of the context in which the call to stories in contemporary suicide prevention is grounded. Drawing on the literatures and methods of narrative, and in particular, narrative approaches to bioethics, I argue that although personal stories of suicide confer certain privileges and benefits on survivors of suicide attempts, they also manifest and normalize particular ways of thinking, acting, and communicating that have considerable ethical and political force in shaping the ways suicidal behavior is understood, the ways it is subjectively experienced, and the ways it is responded to. Finally, I discuss the implications of this for suicidal or recently suicidal persons, suicide research, and for public discourse.

A Bioethical Approach to Contemporary Stories of Suicide

Suicide, writes Margaret Higonnet “provokes narrative, both a narrative inscribed by the actor as subject, and those stories devised around the suicide as enigmatic object of interpretation” (2000, p. 230). For Higonnet, the proliferation of narrative is a necessary consequence of suicide as persons are compelled to interpret its meaning, and narrative, one of the primary ways this is done. Family members who have lost a relative to suicide invariably try to make sense of it through narrative (Owens, Lambert, Lloyd, & Donovan, 2008), as do coroners and researchers who use interviews and other biographical material to report their findings (Langer, Scourfield, & Fincham, 2008). Clinicians use narrative extensively in their work with patients and through the construction of case notes and studies (Hunter, 1991). Suicidal or recently suicidal persons also articulate their thoughts and feelings in everyday conversational narratives—with family, friends, or with counseling or other medical professionals—but also through diaries, online discussion forums, and suicide notes. However, not everyone has been accorded the same epistemic or moral authority when it comes to explaining suicide. Persons who have engaged in suicidal acts 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, with broad concerns expressed about the potential danger of public stories of suicide.

Recent and ongoing criticism of suicidology, particularly with regard to its epistemic conservatism (Hjelmeland & Knizek, 2011; White, 2012), the disjunction between scientific and experiential accounts (Cutcliffe & Ball, 2009; Webb, 2006), and limited advances in suicide prevention are, for an increasing number of scholars, symptoms of a broader crisis of

the biomedical paradigm of contemporary suicidology. Although suicidology retains a strong biomedical focus, it also encompasses a range of new institutional frameworks, strategies, and practices that include health promotion and education, peer involvement, intersectoral collaboration, and community and workplace-based initiatives.

These tensions and advancements are useful for understanding the emergence and endorsement of personal stories in contemporary suicidology, as is the widening influence of narrative in the human and social sciences. As Hyvärinen (2006) has argued, the emergent interest in narrative was not simply an extension of previous linguistic concerns in philosophy and critical theory; it also highlighted growing disillusionment with the abstract, objectivist approaches of existing human and social scientific research. The expansion of narrative research within the field of bioethics coincided with this upsurge in philosophical and methodological interest in the role and value of narrative, and with a more flexible and pragmatic notion of ethics.

Philosophers in the dominant Anglo-American (or analytic) tradition of moral philosophy have characteristically viewed the project of ‘doing ethics’ with the somewhat ambitious task of formulating moral rules about the rightness of human actions (Walker, 1998). In this view, ethics is primarily a task of thinking and judging clearly according to relevant norms, theories, and principles. In recent decades, this view has come under increasing criticism for its (mis)representation of morality as a compact, impersonal, and codifiable set of law-like propositions for guiding human conduct. For philosophers such as Margaret Urban Walker (1998) and Martha Nussbaum (1990), such approaches foster an abstract, intellectualist, and impersonal picture of morality and moral knowledge that is not an accurate reflection of human moral life. Narrative approaches, through their attention to

the rich and subtle nuances of human lives and action, are thus seen as a corrective to the impersonal, law-like approaches that have dominated moral theory (Arras, 1997).

As well as its normative dimension in acting as a guide to human conduct and action, Walker (1998) sees moral philosophy as the bearer of a descriptive and empirical responsibility toward the study of moral understandings and moral experience across a multitude of social orders and practices and involving a multitude of moral subjects. 'Doing bioethics' from a narrative perspective, therefore, means reflecting on the moral aspects of particular stories told within powerful social institutions (Nelson, 1997, p. xii). For what is needed in some cases is less a set of principles for resolving issues, but a form of dialogue that recognizes the different values, interests, and needs of those involved.

Like other illness narratives, personal stories of suicide offer a number of ethical, political, and therapeutic benefits. First, they allow suicidal or previously suicidal persons to be heard, garnering them both greater recognition and legitimation and helping to reduce discrimination and stigmatization. Not only do stories offer a more personalized interpretation of suicidal events that reflect the diversity of voices and perspectives that constitute experiences of suicide, they also privilege the situated, 'lived experience' of previously suicidal persons, recognizing them as important sources of 'expert' knowledge.

Second, stories may offer suicidal or previously suicidal persons a point of reflection for grappling with problematic life events in their bid to give shape and meaning to them. Stories provide interpretive frameworks for persons to explore and work through actual and unresolved life events and to communicate their experiences to others. Recent empirical research on recovery shows that meaning is crucial to the healing process and that it is closely tied to the need for persons to tell their own stories (Bracken & Thomas, 2005). Stories may,

in this way, be used to sort through the noise of everyday life and to gain an insight into events and experiences (Ochs & Capps, 2001). A third important function of personal stories of suicide is that they may provide guidance and hope to others who are experiencing similar difficulties. The stories of those with lived experience provide alternative viewpoints to those of experts and may be more responsive to survivors' needs (Bracken & Thomas, 2005).

Although these functions suggest a productive view of moral agency, recognition, and empowerment, stories may also manifest and normalize certain ways of thinking, acting, and communicating that are in keeping with the management and regulation of socially troublesome emotions and conduct in liberal democratic societies (Rose, 2007). Those advocating the greater use of personal stories in suicidology argue that it is only by empowering previously 'silenced' voices that the political and professional power imbalances of scientific suicidology will be redressed (Webb, 2006). In this view, the blindness of suicidology to personal, social, cultural, and political factors is a result of the prevailing biomedical focus of contemporary suicidology. The counterposing of subjective experience to an objective, impersonal, and value-free medicine is thus one of the primary justifications for the inclusion of personal stories in suicidology.¹ What this position overlooks, however, is how stories that empower those at the margins may also coincide with and serve the interests of clinical and public health professionals and other forms of institutional authority (Atkinson, 2009; Costa et al., 2012).

It is often presumed, for example, that narrative provides an especially authentic form of insight into human lives and experience. Narrative has been celebrated as a means by which persons are able to disclose their most personal and private thoughts and feelings and, in so doing, reveal their deepest, truest selves. Because of the marginalization of personal

stories of suicide in the past, the telling of these stories is viewed as an ethical good in itself, granting the storyteller recognition and empowering them to act upon their life. The story and its telling serve as both a form of identity politics as well an act of self-creation (Atkinson, 2009; Atkinson & Silverman, 1997). For Atkinson and Silverman (1997), however, this implicit appeal to the authenticity of narrative uncritically accepts the romantic view of isolated individuals and overlooks the broader social structures and relationships that contribute to biographical work. Stories might be thought of as private—revealing the feelings, experiences, and thoughts of speaking subjects—but they are never a fully accurate representation of them. This is not to suggest that these things do not exist or that we simply bring them into being by communicating them; rather, that narrative does more than represent something—it also helps to frame and interpret it (Webb, 2009). Hence, there is no way of separating personal stories from the beliefs, values, and expectations of the cultural narrative canon that give rise to them (Freeman, 2001).

The Recovery Narrative as Therapeutic Endeavor

In turning to actual stories of suicide in contemporary suicidology, a brief survey of published and online sources indicates the narrative most common to this domain is the recovery narrative. Told by persons who have made a previous suicide attempt, this story adheres to the following basic structure: Person experiences profound suffering, illness, trauma, or psychological pain; person attempts suicide; person survives; and person recovers through a gradual process of self-awareness, self-control, and personal and professional support. Invariably, recovery narratives not only recount a series of potentially tragic events that befall the story's main character before tracking toward a typically happy ending, they

also focus on the personal, often spiritual, growth of persons as they gradually reorient and reclaim a sense of self after the devastating effects of illness or trauma (Shapiro, 2011; Woods, 2011).

Such stories have been the staple of illness narratives—particularly cancer survivorship—where the capacity to tell one’s story is connected intimately to the project of restoring one’s sense of personal identity (Woods, 2011). If the illness experience is, to some degree at least, an epiphanic experience (Frank, 1993), then a suicide attempt may represent a distinct turning point in a person’s life. The point where a life is no longer considered worth living, together with the physical, emotional, and social ramifications that often follow a suicide attempt, provide conditions that are well suited to the forging of a new identity. Published works by Tina Zahn (2006) and Susan Blauner (2003), as well as a growing body of stories being told on social media, give some indication of the potentially transformative effects that a suicide attempt can have on lives.²

Survivors of suicide attempts, like users and survivors of psychiatry, have typically rejected a narrow framing of suicide as the outcome of mental illness, instead situating their illness within a broader personal life history. In *Why I Jumped* (2006), Tina Zahn recounts the story of her life leading up to her suicide attempt, detailing her history of sexual abuse, family problems, the experience of two terminated pregnancies, and, finally, her postpartum depression. Although Zahn is hospitalized and receives psychiatric treatment for her depression, she describes the partial curative effects provided by these treatments as she comes to the realization that recovery involves more than just clinical recovery, but is closely connected to the need to come to terms with her past.

I knew I wasn't cured. I had a long road of recovery ahead of me. We had the PPD [postpartum depression] under control, but I had years of abuse, denial, and repressed anger to wade through. All my life I'd tried to hide the pain. As a child I hid how much it hurt to be abused and rejected. As a teen I hid how much it hurt to be repeatedly betrayed. As a young woman, I hid the pain of two abortions. As a woman I hid the pain of back and arm injuries. I took medications to mask the pain and to keep on going, and I wore a mask to keep people from knowing the truth. But no matter how hard you try to outrun the past and the pain, it catches up with you. The harder you try to ignore it, the harder it will take you down. Now I had to learn to face the past, forgive people, accept who I was, and to learn to love myself. It wasn't going to be easy. (2006, pp. 164-165)

Like other writers of illness narratives, the self that emerges after her suicide attempt is not a radically new one (Frank, 1993). Instead, Zahn's recovery is piecemeal and defined by ongoing emotional and spiritual struggle. It involves her not only addressing the underlying causes of her pain, frustration, and disappointment through an ongoing process of self-examination and self-discovery, but of exercising honesty with herself and with others in order to locate the 'real' truth about herself so as to initiate personal growth (Rimke, 2000).

Zahn writes in the close of her book:

What I wanted more than anything in my life was to be accepted for who I was and loved unconditionally. But before I could believe that anyone loved me, I had to learn that I was worthy of love. I tried behaving in ways that I thought people wanted me to

behave. I tried to be compliant, submissive, obedient, and ‘good’. I didn’t speak up or speak out. I held onto secrets until they choked the life out of me. But all the while, I hated hiding behind a mask, knowing that I wasn’t letting anyone see the real me for fear of more rejection. The mask is off now. The secrets are out. (2006, p. 212)

As Zahn’s account suggests, reorienting and reclaiming a new sense of self after a suicide attempt requires not only examining one’s self privately, it also requires persons to tell their stories in order to publicly claim this new identity, making it both a social and rhetorical production (Bracken & Thomas, 2005; Frank, 1993).

Susan Blauner’s somewhat provocatively titled *How I stayed alive when my brain was trying to kill me* (2003) is a further example of a suicide attempt survivor narrative that situates suicidality within the context of an individual life history. Despite attempts to reduce the causes of suicide to the brain, Blauner’s story moves freely, if somewhat changeably, between different contributing factors—sexual abuse, loss, mental illness, relationship problems—revealing the complex set of compounding vulnerabilities that invariably contribute to suicidal events. Blauner’s recovery, like Zahn’s, is gradual, filled with struggle, and draws on a number of different psychological, emotional, neurological, and spiritual conceptualizations of suicide to explain her experiences and to aid in her recovery. And, like Zahn’s account, it too involves an ongoing process of self-examination as a means of effecting personal change. Blauner writes:

I had to go through what I went through in order to get where I am today, but I’m not sure my ratty road had to be quite so long. There were plenty of opportunities to

change my path, but I held on to self-destruction for as long as I could. When I finally began to let go, I started to find relief, though none of it was a straight line toward freedom. (2003, p. 25)

For Blauner, self-change requires not only honesty but self-discipline. Rather than languishing in the depths of her depression and self-destructiveness, she is forced to “take responsibility for her actions” to overcome her problems and achieve the sense of well-being and connectedness she so craves (2003, p. 21). To this end, she details in the final sections of her book the multitudinous therapeutic practices by which she comes to manage and control her emotions and combat her suicidal thoughts.

For Zahn and Blauner, recovery, although not a purely individual process insofar as it requires supportive environments to help realize it, is nevertheless person driven. It is holistic, but reliant on individual, familial, and community strengths and responsibility for its impetus. It is not a linear process and its stages are not clearly defined, yet active engagement, self-knowledge, and rational decision-making are all considered key to the achievement and preservation of mental well-being (National Action Alliance for Suicide Prevention, 2014; Teghtsoonian, 2009).

Narrative, Institutional Discourse, and the Rhetoric of Self-Change

The expansion of the personal confessional genre as a technique of self-formation and its valorization in contemporary Western culture reveals both the extent of our belief in psychology as the root cause of, and solution to, all human conflict, as well the public fascination with the personal and private self. It can be seen in the practice of psychotherapy,

which sees the elicitation of the patient's story as central to the therapeutic task, and it is also evident in the popular media with tell-all biographies, self-help books, and celebrity interviews acting as the medium and guarantor of truth (Atkinson and Silverman, 1997). In these contexts, the process of telling the truth about one's self is seen as integral to the process of self-actualization and the necessary first step in working through one's problems (Rimke, 2000).

Although the act of telling one's story seems to be an expression of personal truth, narratives are not entirely individual and personal but are shaped by sociolinguistic conventions embedded in established power relations that help determine their production, circulation, and interpretation (Shapiro, 2011). "Discourses exert a structuring influence on narrative accounts, at the same time as those accounts provide the broader parameters within which discursive meanings are negotiated and realized" (Day Sclater, 2000, p. 131). So although narratives may be constrained by discursive frameworks, they also offer the possibility for persons to negotiate, resist, and transform them.

This interrelation between narrative and discourse is conceptually important because it provides a means for examining the ways that individuals strategically deploy stories to serve certain functions, and in so doing, position themselves in relation to prevailing social norms (Day Sclater, 2000). Personal stories of suicide serve as a way for persons to resist the excesses of medicalization and the stripping away of personal experience from its human contexts. Although the view of suicide presented by survivors such as Zahn and Blauner emphasizes the psychological and social bases for suicide over a purely biomedical framing, their stories do not necessarily challenge the view that suicide is primarily individual in regards to its causes, treatment, and prevention. The view of personal stories of suicide as the

locus of self-knowledge, and the strengthening and deepening of psychological knowledge that makes it possible to understand and act upon oneself in terms of this knowledge, means that personal stories of suicide often reinforce the Western notion of the individualized, psychologized subject (Rose, 2007; Watson, 1993). We must consider, therefore, to what extent the medicalization of suicide persists within these stories, albeit within a sphere where medical power operates within a set of local and diffuse social practices (Turner, 1997).

The self-change rhetoric found within the suicide attempt survivor literature, I argue, both presupposes and enacts certain forms of self-relation that can be considered problematic. By structuring human action, experience, emotion, and identity as individual and internal rather than social and relational, suicide is presented as a primarily individual problem—one that given the right amount of personal insight, guidance, and determination can be overcome. It is not only biomedical approaches to suicide that lend themselves to these ways of acting and being. The conceptualization of suicide and survivorship offered by Zahn, Blauner, and others is the product of myriad overlapping and complementary discourses—psychology, religion, spiritualism, and ethics—that prescribe certain ways of acting and being over others (Rimke, 2000; Rowe, Tilbury, Rapley, & O’Ferrall, 2003). Rather than competing with, or for that matter refuting each other, these discourses can be seen as part of a larger project of regulating suicidal behavior and suicidal persons through practices of self-formation.

The congruence between suicide attempt survivor narratives and public and mental health policies and services that place greater accountability and responsibility on individuals to manage their own health and well-being raises pertinent questions about the reliability and authenticity of the stories of suicide attempt survivors. Although these stories provide an

important source of knowledge about suicide and recovery after a suicide attempt—rejecting a purely scientific understanding of suicide by drawing attention to aspects of human experience and suicide occluded by biomedical and epidemiological research—they do so, ostensibly, within the borders set by contemporary suicidology rather than outside them. Suicide continues to be represented as irrational, involuntary, and pathological, and, therefore, as requiring prevention and treatment. Although a discursive space for the discussion of the social determinants of suicide is created, an emphasis on personal stories as a mirror of individual experience divests these stories of systematic cultural and political analysis (Goodson, 1995). Suicidal persons seem to speak alone, by, about, and for themselves, rather than being seen as enacting their stories through socially shared forms or genres (Atkinson, 2009). In viewing personal stories of suicide as a vehicle for self-examination and self-development, the psychologized individual is celebrated and the therapeutic interests of suicide prevention maintained.

The framing of suicide within a primarily individualistic and psychological register has a number of ethical and political implications. First, it overlooks or downplays the socioeconomic and political forces that shape the social determinants of suicide and the political rationale that frames how these factors are understood as contributors of suicidal distress (Mills, 2014). Within the prevailing individualistic model of suicide, social inequities such as poverty, unemployment, and social disadvantage or discrimination are seen largely as indirect causes (or ‘triggers’) for predisposing biological or psychological factors, thereby reinforcing the view that suicide is best prevented or treated by improving mood and changing behavior rather than through social, political, and economic reform (Mills, 2014). The rendering of suicide in largely individualistic terms contrasts sharply with, for example, a

critical reading of suicide that might explain it reasonably in terms of social injustice, gender and sexual oppression, or inequitable socioeconomic environments. Such discussions, however, are conspicuously absent from personal stories of suicide where the individual and internal focus of most stories means that analysis rarely extends beyond a small circle of interpersonal relationships to consider the social and historical circumstances of human lives. Recent work in bioethics (Fitzpatrick, 2014), narrative therapy (Combs & Freedman, 2012), as well as activist work in this area (Harris, 2014; Webb, 2010) provide useful alternatives to the dominant individualized and pathologized constructions of suicide by paying attention to issues of individual and cultural diversity and social justice, and by working to expose, counter, and undermine the discourses and power relations inherent in research and therapeutic practices.

Although Zahn's work alludes to broader social justice issues (discrimination, ineffective medical treatments, and a lack of choice in services), it does little to disrupt these dominant practices, or to change the ways that suicide prevention and health services might be conceived. This orienting away from social and political action toward medical intervention and behavior change in personal stories of suicide is further evidence of the ways in which mental health systems are able to harness the democratic and progressive values of modern liberal societies to absorb oppositional accounts and enhance and solidify their own interests (Costa et al., 2012). As Costa and others have argued, the appropriation of the concept of personal recovery in the research and policy arenas and its resignification of language such as empowerment, resilience, and struggle has worked to depoliticize resistance accounts while at the same time using them to "further solidify hegemonic accounts of mental illness" (2012, p. 87).

Second, the entrepreneurial activity required to manage and improve the self places considerable demands and responsibilities upon persons. Talk of the self as a ‘project’ and associated notions of ‘responsibility,’ ‘authenticity,’ and ‘freedom’ have become part of our contemporary vernacular, transforming our normative frameworks so that the gauge by which persons now come to measure their lives is through a lens of personal initiative and the capacity to ‘become oneself’ (Ehrenberg, 2010). Those who do not conform to these norms and shared goals, or those who are incapable of developing the necessary skills required for such a task, may be subject to further material effects, including disadvantage, discrimination, and exclusion from telling their story. There are, after all, those whose experience of suicidality is neither meaningful nor transformative and whose struggle with despair, suffering, and failure presents no simple solutions (Fitzpatrick, 2014). The individualizing of suicide in terms of causality, risk, treatment, and prevention also overlooks the extent to which recovery is constrained (or enabled) by relations of gender, poverty, and class. We must consider, therefore, whether the confessional narrative genre serves as a therapeutic practice capable of truly enlightening and liberating persons or whether it merely produces a new level of subjection in which psychological and therapeutic introspection is valorized at the expense of other social interests and possibilities of expression (Bleakley, 2000).

Personal Stories of Suicide as Enabling or Restricting

Claims that the harnessing of personal stories of suicide by suicide prevention and health promotion organizations has resulted in their institutionalization, commodification, and homogenization raises difficult questions about the ‘truth’ and ‘authenticity’ of these accounts. The personal confessional genre and its contribution to the formation and

celebration of the self-determining, self-governing individual means that self-knowledge is not, as is often assumed, simply a matter of delving into one's own interior (Rimke, 2000). The meaning of an event, action, or experience does not 'speak for itself,' but is forged through processes of memory, reflection, interpretation, and imaginative telling. The constructed nature of stories and their imposition of order on the raw flux of human experience means that narrative provides not only a way of structuring experience, but of transforming or redescribing those experiences (Prince, 2000). The range of interpretive and discursive frameworks available for this task means that persons are able to represent their experiences in a number of possible ways and to serve a variety of interests, ends, or expectations.

However, because not all interpretations carry the same authority, the influence of institutional interests are important qualifications when assessing the value of personal stories of suicide and their capacity to enrich or constrain human lives. Not all first-person accounts are naïve or uncritical, yet the preference for stories told by those who have had time to recover and reflect on their experiences (American Association of Suicidology, 2014), and the importance of connecting one's lived experience to key suicide prevention messages (Suicide Prevention Australia, 2014), means that personal stories of suicide often reflect prevailing sociocultural and institutional norms and meanings.³ Thus, the overlapping and mutually reinforcing discourses of suicide prevention and suicide attempt survivor narratives play an important regulatory function through shaping the ways suicidal behavior is understood, the ways it is subjectively experienced, and the ways it is best responded to.

There is, I accept, a risk in seeing the personal stories of suicide attempt survivors as rigidly determined by institutional forces. Personal stories of suicide can act as sites of

conventional rhetoric, self-deception, and imitation, but they can also be sites of personal liberation (Shapiro, 2011). Writing on the trustworthiness of patient narratives in medicine, Johanna Shapiro implores readers to move beyond simplistic dichotomies of authentic/inauthentic, transgressive/conformist, and true/invalid to be responsive to the dynamic, multiple, and emergent meanings that illness and suffering might have for different people. For many, the telling of their story may simply be guided by a desire to make sense of their suffering and to find a way forward in their lives. The capacity of narrative to bestow meaning, power, and social identity makes it an important resource for those living in the face of trauma, illness, abuse, and personal tragedy, and the deployment of dominant cultural-normative understandings need not represent a less authentic or simplistic response to these human plights, nor make the self-change associated with them any less real.

One of the dangers of a critical reading of suicide attempt survivor stories is that, like the practices of psychiatry and psychology before them, the social sciences risk misappropriating the personal stories of suicide to serve particular sociopolitical interests. It is important, therefore, that such critical approaches occur within a respectful and compassionate context so as not to efface the voices of those who speak (Bracken & Thomas, 2005; Shapiro, 2011). However, we must also ask what the role of stories in suicide prevention is and whether it is enough to simply ‘listen to these stories.’ Although there is unquestionably a place for personal stories of suicide in suicidology, we should not forget that the impetus behind active user movements such as the Gay Rights and Mad Pride movements has been, and continues to be, the struggle against paternalism and those forms of morality that stifle and obliterate difference (Bracken & Thomas, 2005).

If personal stories mark a starting point for active collaboration with suicide prevention organizations, then we must acknowledge the institutional contexts and relations of power in which this collaborative enterprise takes place. If the promise of rebuilding a space for moral and political engagement in contemporary suicide prevention is to be realized through the practice of personal storytelling, then the interpretive and discursive practices through which suicidal subjectivities are constructed must become the subject of examination and critique. This means engaging in the close reading of personal stories of suicide to see how experiences of suicidal behavior are framed and what narrative resources are mobilized to do this. In particular, we need to consider how relations of responsibility are configured within these narratives (and in suicide prevention more broadly) and the ethical obligations that are made upon persons. For it may be the case that the institutionalization of personal stories of suicide results in the creating of a moral discourse that not only privileges certain ways of talking about suicide, but that confers legitimacy on those select few who are able to meet its strict demands. Rather than relinquishing power and challenging the homogeneity and orthodoxy of public discourse on suicide by opening up suicidology to previously excluded persons and groups, the institutionalization of personal stories of suicide may result in the legitimation and maintaining of existing power relations, the instrumentalization of personal stories of suicide, and the narrowing of the discussion on suicide and the ways it is understood, experienced, and responded to.

Notes

1. See Atkinson (2009) and Brody (1997).

2. For stories published online see: *American Association of Suicidology*: www.suicidology.org/suicide-survivors/suicide-attempt-survivors; *Suicide Awareness Voices of Education*: www.save.org/index.cfm.
3. For an example of more critical works see Laura Delano <http://recoveringfrompsychiatry.com/2014/02/reflecting-life-death-suicide/>; Leah Harris www.madinamerica.com/author/lharris/; and David Webb's *Thinking about suicide* (2010).

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