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LUCIE NALLETAMBY BSc Hons, MSc

The Discursive Construction of ‘Suicide’ and the Effects for Clinical Practice

Section A: Examining the discursive construction of suicide in discourse analytic research: A review of the empirical and theoretical literature
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Section B: The professional construction of ‘suicide’: A discourse analytic study exploring how language is used to construct suicide in professional accounts
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SALOMONS CENTRE FOR APPLIED PSYCHOLOGY
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DECLARATION FOR MAJOR RESEARCH PROJECT

Candidate name (PRINTED)

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

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Date

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended

Signed (candidate)

Date

Signed (supervisor)

Date

STATEMENT 2

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I would like to thank the clinicians who generously gave up their time to participate in this study. I am very grateful and really enjoyed our conversations!

I wish to thank my supervisors, Dr Ian Marsh, Ms Anne Cooke and Dr Rachel Bonel. I would also like to say thanks to Byron and my parents for all of their unwavering support in helping me get this point. Thank you so much.

This thesis examines the discursive construction of suicide and the effects for clinical practice.

Section A provides a critical overview of the theoretical and empirical literature examining the discursive construction of suicide. A critique of the theoretical and methodological limitations of the discourse analytic approach is provided.

Section B examines how suicide is constructed through dominant and subjugated discourses in the language of psychologists and psychiatrists. Suicide was dominantly constructed as the final act of an individual, unbalanced mind; however resistances to the dominant discourse opened up language to embed new meanings and other ways of 'knowing' about suicide.

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Section A

Examining the discursive construction of suicide in discourse analytic
literature: A review of the empirical and theoretical literature

Word count: 7975 (490)

Abstract

Background Suicide is often conceptualized through biomedical and psychological paradigms. However, these approaches are limited and have been criticized as reductionist and individualizing, respectively. The discursive paradigm assumes that language is not neutral or exact, but can “do” and achieve things and therefore asks different questions about suicide. *Aim* This narrative review draws on discursive and discourse analytic literature to explore how suicide is constructed in language and what the effects of this might be for clinical practice. *Method* Eleven electronic databases were searched. Twenty-three studies were identified, including seventeen empirical and eight theoretical papers. These were critically analysed and summarized. *Results* Nine broad discourses were identified. Suicide was constructed in contradictory ways, as; biomedical, individual, a failure, abnormal, shameful, taboo, masculine, normal and relational. *Conclusion* The dominant constructions of suicide could have negative effects for suicidal people by positioning them as worthless and exacerbating suffering, powerlessness, and isolation. However, a number of authors advocated a theoretical relational framework that could lead to richer conversation about suicide prevention, social justice, social fragmentation, and the historical and cultural context of suicide. A critique of the theoretical and methodological limitations of discourse analysis is provided, together with clinical and research implications.

Key words: Discourse analysis, discursive, suicide, construction, text

Examining the discursive construction of suicide in discourse analytic literature:

A review of the empirical and theoretical literature

Discourse is defined as *systems of meanings* that are related to the interactional and wider sociocultural context. They operate regardless of the speakers' intentions (Georgaca & Avdi, 2012). Discourse Analysis and Discursive Approaches are defined as the study of how talk and texts are used to perform actions (Potter, 2003). The terms 'discourse analytic approach' and 'discursive approach' are used interchangeably throughout.

The “Problem” of Suicide

Whilst the definition of suicide is the subject of much debate (Silverman, 2011), for the purpose of this review, it is defined as “a self-inflicted act resulting in death” (Goldney, 2008).

The World Health Organization proposes that an estimated 804 000 suicide deaths occurred worldwide in 2012. This represents an annual suicide rate of 11.4 per 100 000 population (WHO, 2014). There is little evidence to suggest that interventions can prevent suicide (Bertolote, 2014) and only one form of psychotherapy has been shown to reduce attempts, across multiple trials (Linehan, Comtois, Murray, Brown, Gallop, Heard, et al., 2006).

Suicide is difficult to study. Van Orden et al. (2010) suggests that research is problematic as: (1) large samples are needed to account for low base rates of suicide attempts in the population (Moscicki, 2001); (2) individuals at risk of suicide are often excluded from research for ethical and safety reasons (Rudd, Joiner, & Rajab., 2004) and; (3) those who complete suicide are, of course, unable to participant in

research (Owen, 2001). Some practitioners have advocated that a “lack of evidence” calls for more rigorous quantitative methodologies (Brown et al., 2012); however, there have also been appeals for more qualitative research to invite new questions about suicide (White & Morris, 2010).

Mainstream paradigms

The two dominant investigatory paradigms in understanding suicide can be broadly categorized as the biomedical and psychological approach. The introduction will briefly highlight some of the literature from these two paradigms, arguing that they are theoretically limited, before making the case for a “turn to language”: using a discursive approach to promote different understanding about suicide (Willig, 2008).

A Biomedical model: Genetic and Neurobiological Theories of Suicide

Biomedical theories explain suicidal behavior as a product of both an underlying biologically based condition and an activating psychosocial trigger (van Heeringen, 2012; Sarchiapone & D’Aulerio, 2014). These theories emphasize the role of genetic, neurochemical, and physiological components in understanding the aetiology of suicide. For example, Menke et al. (2008) have suggested that glutamate receptors may act as genetic markers for suicidal ideation. Neurochemical studies have identified low concentrations of serotonin metabolite, 5-hydroxyindoleacetic acid, in those who had attempted suicide (Mann, 2003). Furthermore, post-mortem studies on the brains of individuals who had completed suicide suggested changes in serotonergic function, specifically in the prefrontal cortex (Leonard, 2005). It is hypothesised that a deficit in serotonin could contribute to poor emotional and behavioural regulation and therefore may be associated with suicidal behaviour.

From Neurobiology to Motivations and Beliefs: Psychological Theories of Suicide

Critics have argued that biological theories of suicide are reductionist and de-personalize individuals with the aim of identifying a set of common factors that will identify those 'at risk' (Owens, Lambert, Lloyd, & Donovan, 2008). In contrast, psychological theories conceptualise suicidal behaviour as an act with meaning and purpose, as a product of internal (conscious or unconscious) motivations (Briggs, Lemma, & Crouch., 2009). Shneidman (1993) proposed that suicide occurs when mental pain becomes unbearable. He suggested that those who attempt suicide share commonalities including; frustration at unmet needs, ambivalence about dying, hopelessness about the future and self-destructive coping patterns (ibid).

Different schools of psychotherapy have led to competing understandings. For example, psychoanalytic theories variously suggest that suicidal urges may arise out of problematic attachment styles (Bowlby, 1973), unconscious compulsions (Menninger, 1938) or 'hostile or 'sadistic' introjects (Maltzberger & Buie, 1980). Whereas cognitive-behavioural traditions formulate suicide as associated with hopelessness (Collins & Cutcliffe, 2003), rumination and a negative thinking style (Kerkhof & van Spijker, 2011).

From Motivations and Beliefs to Language: Suicide and Discursive Approaches

Critics have pointed out a number of shortcomings in current theoretical approaches to suicide. Psychoanalytic theories have been criticized as largely speculative and based on constructed entities assumed to lie within the person's 'unconscious' (Wright, 2013). Whilst cognitive theories focus on beliefs and motivations that are typically isolated from their context, providing little understanding of *situated* attitudes (Hayes, Villatte, Levin, & Hildebrandt, 2011).

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In contrast, Potter (2012) has argued that all action, interaction and psychological phenomena start with discourse. Discourse analytic (DA) theory offers a way to explore how concepts are constructed in language. Previously, DA has examined the accounts of health professionals, policy, and legislation (Stevens & Harper, 2007; Griffiths & Hughes, 2000). DAs focus on the inherent variability of talk is useful in exploring how language is used to construct psychological concepts and justify mental health practices. For example, research has shown how use of rhetorical resources can construct service-users as violent, dangerous, and unwell, leading to practices of confinement (Moon, 2000), observation (Stevenson & Cutcliffe, 2006) and electro-convulsive therapy (Stevens & Harper, 2007).

Discourse analytic theory and suicide

The following section will outline the theoretical principles of DA to demonstrate why DA might constitute a useful approach for exploring suicide. Potter (2003) suggests that language is not natural or neutral but has the following key characteristics:

- Language is action. This means that it is able to “do” things. For example, talking about suicide as shameful is not simply a way of speaking but can have effects such as making the suicidal person feel ashamed.
- Language is variable. It can create different versions of the world. This means that talking about suicide in different ways can create different ‘versions’ of suicide. For example, a version in which people who complete suicide are seen as depressed.
- Language is functional. It functions to achieve things with others such as blame, persuade or justify. This means that talking about suicide in particular

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ways could be seen to have different functions. For example, describing people as “a danger to themselves” could persuade listeners that it is ok to deprive the person of their liberty.

Willig (2008) distinguishes between discursive psychology, critical DA and Foucauldian DA (see appendix A for additional information). This review will include studies that employ all variants.

Social constructionism. DA is broadly situated within a social constructionist framework (Harper, 1995). It differs from traditional positivist psychology in that it assumes that “our ways of understanding the world comes not from objective reality but other people, both past and present” (p.6, Burr, 2003). Gergen (1985) outlines four assumptions implicit in social constructionist work; (1) a radical doubt in the taken-for-granted world; (2) the viewing of knowledge as historically, socially and culturally specific; (3) the belief that knowledge is sustained by social processes and; (4) the view that language can never be entirely ‘neutral’ but serves to sustain certain knowledges and practices to the exclusion of others.

The author of the current paper has taken a social constructionist stance to the reviewed literature and topic of suicide. Rather than being ‘out there’ awaiting discovery, it is assumed that the meaning of ‘suicide’ is actively constituted through language, relationships, and other social practices. It is important to emphasize that this stance should not dismiss the painful reality of suicide but is intended to question the, arguably, mainstream ways of making sense of suicide as absolute, fixed and universal (White & Kouri, 2014).

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Rationale

In the context of the aforementioned criticisms, this paper will review the extant discursive literature in relation to suicide. This literature review will explore the merits of using a discursive approach and how DA can offer a critical insight into the understanding of suicide. A critique of methodological and theoretical issues in discursive research will be provided and the corresponding clinical and research implications will be discussed.

In summary, this narrative review aims to provide a critical overview of the DA literature that has examined the discourses in policy, spoken or written accounts of suicide. Specifically, the review will aim to answer the following question:

According to the discursive and discourse analytic literature, how is suicide constructed in language and what are the effects of this, in terms of understanding and practice?

Methodology

Literature Search

A review of the literature was conducted in which 11 electronic databases were searched for relevant studies: ScienceDirect, SAGE Journals, MedLine, Wiley Online Library, Pubmed Central, Google Scholar, PsychInfo, Taylor & Francis online, BioMed Central, and PsychSource. Key terms were applied to literature from 1970, since it was at that point that theorists began to critique mainstream psychological theory and a “turn to language” was identified in the literature (Willig, 2008).

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Various search terms relating to discursive psychology, discourse analysis and social constructionism were used, in combination with a variety of terms related to suicide (appendix C for search procedure).

To include a variety of perspectives, the review searched both empirical and theoretical papers provided they met the following criteria: (a) primarily related to suicide; (b) provided a social constructionist critique of the mainstream understanding of suicide or suicide prevention; (c) focused on discourse - a broad definition of DA was used to include methodologies based on discourse analytic, discursive, post-structuralist or social constructionist theory/method; (d) were published in English; (e) unpublished papers or papers in preparations were included where relevant. Papers were excluded if: (a) primarily related to physician-assisted suicide; (b) primarily related to suicide bombing and; (c) primarily related to murder-suicide.

In addition, Dr Ian Marsh, an expert in the field, was contacted for additional papers (see appendix D for flow chart of search strategy). The search yielded 23 relevant studies.

Quality criteria

The concepts of validity, reliability and replicability have traditionally been used to evaluate studies in the positivist tradition but are not appropriate for qualitative research informed by constructionist epistemology (Mays & Pope, 2000). Instead, qualitative research should be evaluated with criteria consistent with its epistemology (ibid), therefore the critique is drawn from criteria proposed by Georgaca and Avdi (2012) and Taylor (2001).

Results

The following section provides an overview of the studies identified.

Consistent with DA, the results are presented in the format of broad discourses to provide a summary of how suicide was constructed. Nine overarching discourses were identified. These included discourses that were identified by the authors as well as those also drawn on or advocated by the authors. Each discourse is described with examples of discursive strategies where relevant. (See appendix B for a list of analysis and guidelines used in the studies).

In brief, the dominant constructions of suicide are broadly presented through seven discourses: Suicide was commonly constructed as a **biomedical phenomenon** in which it was seen as a product of a pathological state of mind. The authors suggested that suicide was frequently constructed as an **individual issue**, with the cause and solution to suicidal thoughts seen as residing inside the person. Another dominant discourse constructed suicide as a **personal failing** or a selfish act, which was seen as unusual and **abnormal**. In addition, it was constructed as a **shameful** act, which became a **taboo subject** and difficult to talk about for both individuals and support staff. The authors highlighted that suicide was often **interpreted through the lens of gender** and therefore had different meanings for men and women.

In addition, the authors highlighted the emergence of two counter-discourses, which constructed suicidal thinking and the act of suicide as **normal and even creative**. Several of the theoretical papers advocated a discourse of suicide as a **relational phenomenon**. The authors drew on this discourse to challenge to the mainstream model of practice.

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Table one summarizes the main features of the 23 papers, providing the author, year, country, nature of the data and description of the paper.

Table 1: Main features of the reviewed studies

Authors	Year	Country	Nature of text/argument	Type of paper
Horsfall & Cleary	2000	Australia	Nursing policy in 'Nursing Services Manual'	Empirical paper
Bennett, Coggan & Adams	2003	New Zealand	Interviews with young people who had presented with self-harm	Empirical paper
Bourke	2003	Australia	Interviews with young people and adults from the general population	Empirical paper
Fullagar	2003	Australia	Interviews with young people, adults and service-providers from general population	Empirical paper
Fullagar	2005	Australia	Interviews with young people, adults and service-providers from the general population	Empirical paper
Gilchrist and Sullivan	2006	Australia	Interviews with young people, adults and service-providers from the general population	Empirical paper
Stevenson & Cutcliffe	2006	United Kingdom	Archeological and genealogical perspective on 'special observation' and practices	Empirical paper
Gilchrist, Howarth & Sullivan	2007	Australia	The construction of gender and youth suicide	Empirical paper
Fullagar, Gilchrist & Sullivan	2007	Australia	Interviews with young people, adults and service-providers	Empirical paper

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Roen, Scourfield & McDermott	2008	United Kingdom	Interviews and focus groups with young people	Empirical paper
Owens, Lambert, Lloyd, & Donovan	2008	United Kingdom	Interviews with parents of men who had died by suicide	Empirical paper
Jaworski	2010	Australia	The construction of suicide through gender	Theoretical paper
Robertson, Paterson, Lauder, Fenton & Gavin	2010	United Kingdom	Interviews with two nurses following a patient suicide	Empirical paper
White & Morris	2010	Canada	Naturally occurring class-room talk during a suicide prevention programme	Empirical paper
Shocolinsky -Dwyer	2011	United Kingdom	Governmental policy documents	Empirical paper - Unpublished thesis
Westerlund	2012	Sweden	A pro-suicide website	Empirical paper
Jaworski	2012	Australia	The construction of suicide as masculine	Theoretical paper
Mac an Ghail & Haywood	2012	United Kingdom	Interviews with children (9 – 13 yrs.) and 12 school staff	Empirical paper
White	2012	Canada	The construction of youth suicide	Theoretical paper
Westerlund	2013	Sweden	Online conversations about suicide	Empirical paper
Kouri & White	2014	Canada	The construction of youth suicide and prevention	Theoretical paper

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White & Kral	2014	Canada	Deconstruction of high profile suicides	Theoretical paper
Reynolds	2015	Canada	Suicide prevention and social justice	Theoretical paper

Dominant Discourses

Suicide as a biomedical phenomenon: People who kill themselves are mentally ill. Fourteen studies identified a biomedical discourse in which suicide was constructed a consequence of a mental health problem. The authors suggested this could have problematic effects for suicidal people, in terms of agency, identity, and restrictive mental health practices.

Suicide was constructed as an outcome of “depression” (Bennett, Coggan & Adams, 2003; White & Morris, 201 Bourke, 2003), “anxiety” (Westerlund, 2013) or “bipolar disorder” (White & Morris, 2010). In a DA of suicide-prevention literature, Shocolinsky-Dwyer (2011) highlighted how suicide was constructed as a medical issue, seen as related to ‘infected’ emotions and requiring ‘expert treatment’.

Bennett et al. (2003) identified that young people drew on an orthodox medicalised discourse to explain their suicidal behavior. Medical language served to normalize suicide as the end-point in the “heavy road of depression” (p. 4). The authors noted that using medical language enabled subjects to construct an alternative “depressed” identity, in which suicidal feelings could be attributed to ‘depression’ rather than their ‘true’ selves. In an online chatroom, Westerlund (2013) found that people employed discursive devices such as “anxiety” or “depression” to legitimize or justify a wish to die.

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However, Bennett et al. (2003) speculated that this could have problematic effects by reducing the person's sense of agency and legitimized a view that 'experts' are able to 'cure' suicidal thoughts/feelings by treating an underlying 'mental illness'. Westerlund (2012) claimed that this assumption could position suicidal individuals as powerless and constructed suicide as a tangible entity, for example; "I've had [suicidal thoughts] since I was about 12, and it's just grown and gotten stronger" (p.9). Fullagar (2003) highlighted that drawing on a biomedical discourse made the speaker appear authoritative but that this could lead to a process of subjectification in which individuals perceived themselves as pathological and abnormal, which could exacerbate, rather than relieve, suffering (ibid).

Several papers highlighted how a pathological 'patient' identity served to justify intrusive mainstream practices such as "special observation" in which professionals were able to "closely monitor" suicidal individuals (Stevenson & Cutcliffe, 2006; Horsfall & Cleary, 2000). Pathologising language served to reinforce traditional medical hierarchies of power with the effect of rendering the 'patient' worthless or impotent in making decisions (Horsfall & Cleary, 2000).

Suicide as an individual issue: The causes and solutions are within the person. Seventeen papers made reference to suicide as an "explicitly individual and private act" (Jaworski, 2012). This positioned the individual as both the cause and cure for suicidal feelings (Jaworski, 2010; Robertson et al., 2010). Participants drew on individualized discourses (White & Morris, 2010), which reflected wider societal discourses (White & Kral, 2014) and the ethos of treatment programmes (Fullagar, 2005).

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During a classroom-based suicide-prevention discussion, young people drew on individualised stress discourses in which difficulties were seen as building up inside the person, with suicide seen as the result of unreleased emotion (White & Morris, 2010). In semi-structured interviews about systemic contributions to suicide, young people struggled to describe suicide in relation to group, societal, or cultural factors and resorted to individualized explanations by referring to personality styles or emotions (Fullagar, 2005).

Several authors commented that a discourse of individualism stemmed from western, liberal humanist views of self, which typically value autonomy, independence and stability (White & Kral, 2014). Specifically, it was noted that language focused on diagnosis, personality traits and cognitive vulnerabilities reflected a westernized understanding that a self-determined and independent self lies ‘behind the act’ of suicide (ibid). Jaworski (2010) suggested that this discourse summons an individual as the sole author and therefore entirely responsible for the act of suicide.

This assumption implied that individuals were ultimately responsible for themselves and therefore had a duty to make changes, seek ‘expert’ help and feel better (Gilchrist, Howarth & Sullivan, 2007). In a review of treatment programmes, White and Morris (2010) and Fullagar (2005) emphasized a focus on the individual as the site of ‘illness’, irrational beliefs and/or overwhelming emotions, which were seen as the fundamental cause of suicide.

Suicide as a failing: People who kill themselves are selfish. Seven studies constructed suicide as indicative of deviance, sin, a lack of integrity and overall personal failure. The authors suggested that suicidal individuals (Bennett et al.,

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2003), parents (Owens et al., 2008) and lay people (Roen, Scourfield & McDermott., 2008; Gilchrist & Sullivan., 2006) drew on discursive devices to distance themselves from the effects of a discourse of failure.

Using a post-structural analysis, Fullagar (2003) argued that a neo-liberal discourse emphasizing individual personal responsibility and economic productivity meant that suicide came to be read as the actions of a “failed self” or a “waste”. Westerlund (2013), Bourke (2003), and Gilchrist and Sullivan (2006) identified that participants drew on discursive strategies labeling the person with a wish to die as “selfish”, an “egotist, who doesn’t care about anyone” and “totally wrong”. Bennett et al. (2003) highlighted that participants drew on a “two faces” analogy as a means of preserving a ‘good’ identity by enabling them to occupy both a “depressed [irresponsible]” face whilst maintaining a “true [moral]” face (p. 294).

Similarly, Owens et al. (2008) described that parents who had lost a child by suicide employed various discursive strategies to construct suicide as a “personal failing” in which their sons were positioned as “culpable agents of their own destruction” (p. 9). Gilchrist et al. (2007) suggested that lay people also constructed suicide as morally deviant and located in unacceptable out-groups such as “druggies”, “not nice” areas or public housing (p. 17). The authors suggested that such comments functioned to distance, or insulate the speaker and their group from the issue of suicide.

Suicide as abnormal: People who kill themselves are different from us.

The authors suggested that non-suicidal people constructed suicidal people as ‘other’ and vice versa, which served to maintain differences between the groups.

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Nine studies emphasized that accounts tended to categorise individuals who had died by suicide as ‘different’ in terms of class, (Bourke, 2003) values (Bennett et al., 2003) and gender (Jaworski, 2012). For example, Roen et al. (2008) suggested that, during interviews with young people, much discursive work was done to construct suicide and suicidal subjects as ‘other’. Fullagar et al. (2007) suggested that this emphasized a division between “us” (as “normal or average” and “don’t suicide”) and “them” (as “abnormal” and “did suicide”) (p. 9, *ibid*).

The authors argued that the effect of this discourse was to prevent people from discussing suicidal distress for fear of being ostracized and deemed ‘socially abnormal’. Roen et al. (2008) highlighted that this served to distance the non-suicidal participants from the threat of suicide. For instance, describing suicide as a ‘shock’ functioned to push suicide away, removing it to a safe distance and creating space from the reality of death.

In contrast, one paper also highlighted that non-suicidal people were constructed as ‘other’. Westerlund (2013) carried out a discourse analysis of online conversations containing ‘pro-suicide’ content (conversations encouraging suicide) and identified a discourse of “difference” as individuals spoke of “us” who share suicidal plans (insiders) and “you” who have no understanding of this (outsiders) (p. 10). The delineation of ‘insiders’ and ‘outsiders’ was also evident in the criticism of mental health professionals. Speakers constructed psychiatric services as ‘other’ and unknowing, for example: “I’ve learnt to fake it. Psychologists and doctors aren’t so smart” (p. 11). This discourse of professionals as outsiders who cannot ‘see’ offered a resistance against the dominant pathologised discourse that suicide *can* and *should* be ‘treated’ by professionals (Shocolinsky-Dwyer, 2011).

Suicide as stigmatised, shameful and blameworthy: People who want to kill themselves should be ashamed. Nine studies highlighted a discourse of shame, which positioned suicide as a stigmatized, shameful and blameworthy act. The authors suggested that this could have implications for suicidal individuals, families and professionals.

In a study that used a case vignette to explore how lay people make sense of suicide, Fullagar et al. (2007) concluded that suicidal persons were stigmatised through stereotyped depictions of weakness and a lack of resilience. They argued that stereotypes assigned personal responsibility to the individual, even when there were clear contextual and social circumstances that gave rise to suicide. They suggested that the language of suicide was dovetailed with stigmatized constructions of social difference (ibid).

Fullagar (2003) highlighted how a discourse of shame made it difficult for young people express suicidal feelings to others, which often left them disconnected and socially isolated. She highlighted that ‘shame’ meant that some people risked their lives (by remaining silent about suicide) rather than communicating with others about their feelings and experiences. The author suggested that young people internalized the discourse of shame as feelings of self-blame. Moreover, Reynolds (2015) critiqued that the very use of the word ‘suicide’ (as opposed to self-inflicted death etc.) acts to conceal the strength and resistance of the individual who has died by suicide and instead posits shame and blame for their actions.

A discourse of shame not only impacted on the individual but also had repercussions for the families of those who had died by suicide. Shocolinsky-Dwyer (2011) highlighted that there was risk of family members being seen as blameworthy.

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In a DA of governmental literature, she highlighted that shame was constructed as a legitimate, understandable and common reaction to suicide, which positioned family members as vulnerable to guilt and blame.

The authors also highlighted that a discourse of shame and blame could have implication for professionals. A study exploring nurses' accounts of working with an individual who died by suicide, suggested that nurses' drew on discursive devices to position themselves as separate from the suicide and protect themselves from criticism (Robertson, Paterson, Lauder, Fenton, & Gavin, 2010). This served to manage their accountability and negate potential inferences of blame (ibid).

Suicide as taboo: Talking about suicide is dangerous. Seven studies identified that suicide was constructed as an issue that was largely taboo and difficult to talk about for both individuals and service providers.

White and Morris (2010) and Bennett et al. (2003) argued that talking about suicide was framed as important but potentially dangerous. Bourke (2003) suggested that young people failed to acknowledge their own suicidal feelings to friends, family or supportive services and that their silence was based on a fear of rejection or being positioned as 'different' from the mainstream. This drew on a wider discourse of suicidal people as 'other' or as a 'personal failing'.

The discourse of taboo led to a particular dilemma for staff in suicide prevention services. For example, in an analysis of conversations with teachers and sports coaches, staff described feeling conflicted about how to "raise awareness" but not "normalize suicide by talking about it too much" (p.10, Fullagar, et al., 2007). The authors suggested that openly talking about suicide was seen as dangerous and that an effect of this could be to reinforce stigma; framing suicidal feelings as a

frightening and shameful experience. It was hypothesized that this may have implications for help seeking or providing support for someone distressed by suicide (ibid).

Horsfall & Cleary (2000) commented that collective social fear of talking or thinking about suicide has legitimized the rise of an authoritative position in law and psychiatry. This is evident in the UK, through the use of Mental Health Act, as professionals are able to forcibly attempt to control unacceptable behaviours (such as suicidality) despite the fact that it is not illegal (ibid).

Suicide as viewed through gender: Attempted by women but completed by men. Eight papers highlighted that the suicide was constructed through gender. Fullagar et al. (2007) highlighted that the act of suicide was often interpreted from a simplistic binary gendered discourse (e.g., active/passive method; serious/not serious intent) and typically rendered as masculine.

Jaworski (2010) highlighted that men were largely constructed as completers and women as attempters. She suggested that methods such as firearms were considered more physically violent and also constructed as more male, masculine and active. Conversely, methods such as drug overdoses were positioned as less violent and also as more female, reactive and passive.

Mac an Ghail and Haywood (2012) and Gilchrist and Sullivan (2006) described how notions of masculinity were also offered as *explanations* for suicide. For example, men's actions were seen through socially ascribed masculine codes, such as 'men don't talk about emotions'. Similarly, Jaworski (2012) highlighted that female suicides were constructed as a product of relationship breakdowns whereas male suicides were read as signals of courage and resistance against situations such as

physical illness or social isolation. She argued that is based on the assumption that men assert their independence and strength in crisis, whereas women internalize crises by becoming depressed, dependent and passive.

The authors highlighted that an effect of this construction was to position suicide as a male issue and under-acknowledge it as issue for women (Gilchrist et al., 2007). For example, Jaworski (2012) highlighted that both men and women completed suicide through hanging but that this was frequently framed as method used only by men (ibid).

Counter-discourses

Above, this review has argued that the literature has identified a number of dominant discourses. Suicide was constructed as a biomedical, individual, abnormal and masculine phenomenon. It was constructed as a personal failing and a shameful act. However, a number of the papers also sought to explore alternative theoretical frameworks in an effort to “think about the other side” of suicide (p. 191, Kouri & White, 2014). These perspectives are summarized as suicide as; (1) normal and even creative and; (2) a relational phenomenon.

Suicide as normal and even creative: Suicidal thoughts as part of life.

Three of the studies identified that participants drew upon a “normality” discourse as an alternative position to the biomedical or failure discourses (Bennett et al., 2003). Participants employed discursive devices such ‘common sense’ understandings and statistical data to position their wish to die as “everyday” and “something most people experience” (p. 23). The authors suggested that rehearsal of ‘common sense’ ideas could be seen as a counter-discourse to the dominant biomedical construction in which suicide was seen to require ‘expert’ detection and treatment (ibid). This served

to legitimise local, common sense knowledge as a useful ‘other’ way of knowing about suicide.

In a discussion with young people and service-providers, Bourke (2003) noted that whilst adults described suicide as “disturbing”, young people made reference to suicide as a “solution” rather than a problem. The author commented on the importance of embedding different perspectives into prevention programmes to foster creativity and understanding.

Similarly, Roen et al., (2008) highlighted an alternative reading in which, instead of being shocking or a sign of mental illness, participants constructed suicide as a struggle to find meaning in life. This construction positioned suicidal thinking as indicative of troubling times and almost ordinary. The authors suggested that this reading went some way towards normalising the experience of suicidal thoughts.

Moreover, in an analysis of a pro-suicide website, Westerlund (2012) suggested rather than being taboo, suppressed or prohibited, detailed descriptions of self-killing methods invited the reader to explore voluntary death as a reasonable option and a potentially “pure, artistic act” (p. 772). The author suggested that use of discursive devices such as “courage” and “strength” (re)presented suicide as heroic and honorable (p. 773). As a ‘pro-suicide’ website, this text explicitly positioned its perspective in contradiction to the dominant reading of suicide as a ‘personal failing’ and repositioned suicide as an “effective weapon in the struggle against society’s established morals and values” (p. 776, *ibid*).

Suicide as a relational: An individual manifestation of a problem. Five papers explored a counter-position of suicide as a relational phenomenon, in response to the dominant construction of suicide as an individual act (Kouri & White, 2014).

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One paper identified this discourse in the language of participants whilst the others proposed this position as a useful theoretical framework for thinking about “the other side of suicide” (p. 291, Kouri & White, 2014).

Roen et al. (2008) highlighted the presence of relational discourse in the language of participants. They noticed that participants, who had previously felt suicidal, attributed significant importance to their relationships and valued a sense of connectedness with other people. In this sense, suicidal persons were seen as in need of love, support and connection with others and these factors were seen as offering protection against suicide. Family relationships, in particular, were constructed as central to both the desire to live (not wanting to hurt loved ones) and the will to die (wanting to punish or escape from family members when relationships felt unbearable).

From a theoretical stance, Jaworski (2010) questioned suicide as an individual act when she argued that suicide could never be entirely individual because the act has a discursive history that has given it relational, societal and political meaning. She suggested that suicide must be recognized as occurring in relation to something else and that the act of deliberately taking one’s life placed suicide firmly within the social context. She suggested that an effect of re-conceptualizing suicide from a relational perspective could lead to asking important questions about agency, choice, deliberation and authorship.

Similarly, Reynolds (2015) and Kouri and White (2014) argued that it is ethically necessary to resist the individualization of suicide and highlighted some political aspects of the deaths that are described as suicides. In advocating for social justice and anti-oppression, Reynolds (2015) challenged the notion that people kill

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themselves and instead named “hate” as the cause of death. From this perspective, she argued that suicide could not be seen as an individual act, but rather as a response to oppression, discrimination, or other forms of injustice. On a personal note, she outlined that it is difficult for her to even say the word “suicide” because it is “constructed so individually” (p. 2). Kouri and White (2014) highlighted that, amongst indigenous Canadian youths, suicide could be re-conceptualized as a form of protest, for example against the “violent colonial logic of the ‘government era’ which led to intergenerational segregation, disruptions to traditional parenting, kinship and romantic affiliations” (p 194).

White (2012) advocated that a discourse of suicide as a relational act could lead to richer conversation about suicide prevention. She suggested that the focus for research and support should move from being located *inside* person (i.e. what is it about GLBTQ persons that makes them more likely to attempt suicide?) to the relational and socio-political context *between* people (i.e. What role is played by homophobia and societal expectations of gender?). The authors hoped that this would lead to different and fruitful conversations about suicide.

Discussion

The following section provides a discussion of the findings from the review. First, a brief overview of the findings, in the context of the wider literature, is provided. Following this, several key issues are addressed including (potentially) problematic effects for service-users and examples of resistance to the dominant discourse. A critique of the literature and theoretical issues in DA is provided. Finally the implications for clinical practice are reviewed together with the gaps in the literature for further research.

Overview of the Findings

This paper aimed to examine the discourses and discursive strategies identified in discourse analytic research as constructing 'suicide'. In reviewing the literature, the construction of suicide could be arranged into the following broad discourses: Suicide as; (1) a biomedical phenomenon; (2) an individual issue; (3) a personal failing; (4) a abnormal act; (5) a shameful act; (6) a taboo subject; (7) viewed through gender; (8) normal and even creative and; (9) a relational phenomenon.

The most dominant constructions of suicide appeared to be as an individual, abnormal and biomedical phenomenon; as a product of a pathological or disturbed state of mind. The authors highlighted that participants used discursive devices such as pathologised language (Westerlund, 2013), appeals to research findings (White & Morris, 2010), and references to statistics (Owens et al., 2008) to construct suicide as the, at times, "inevitable" consequence of an 'illness' such as depression (p. 7, Bennett et al., 2003). The suicidal person was dominantly constructed as a failure, as "selfish" (Westerlund, 2013) and "culpable" (Owens et al., 2008) for their actions. In line with previous research, this paper would argue that these constructions draw on a wider neo-liberal discourse in which all individuals are equally expected to be emotionally independent and successful, regardless of circumstance, class, race, gender, education, age, disabilities, and so forth (Gounari, 2006). Moreover, dominant discourses positioned suicide as shameful, abnormal and dangerous to talk about. Fullagar (2003) argued that a discourse of shame served to silence individuals from seeking help. This finding is consistent with the previous literature, which suggests that there professional and commonly held beliefs that talking about suicide

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may normalize it or make it appear more reasonable or appealing (e.g. Sudak, Maxim, & Carpenter, 2008).

With the rise of the “psy” disciplines, it is claimed that other forms of knowledge about suicide have been erased or subjugated (Kouri & White, 2014). However, this review has highlighted discursive constructions that challenged the dominant discourse and offered alternative ‘versions’ of suicide, such as suicidal thoughts as an ordinary experience (Bennett et al., 2003), a potential solution (Bourke, 2003), honorable (Westerlund, 2012), and as a relational or social issue (Reynolds, 2015).

This review has identified a number of dominant and counter-discourses in the literature. This paper argues that the dominant discourses could lead to problematic effects for service-users and that counter-discourse may provide opportunities for resistance. This is explored in the following sections.

Problematic effects for service-users. Taleff and Babcock (1998) suggest that dominant discourses define the parameters of a designated ‘problem’ and the direction of mainstream treatment. It is notable that a number of the authors argued from a position of “disenchantment” with services and, as such, were critical of mainstream prevention practices (p. 123, White, 2012). In line with Canetto and Lester (1998), this paper argues that the effects of the aforementioned constructions can be problematic as they were to frequently mobilized to achieve what Foucault (1974) referred to as a “regime of truth”. In clinical practice, there is little attention given to *how* such ‘truths’ come to be. However, dominant discourses (e.g. suicide as biomedical, suicide as a failing etc.) are often presented and treated as incontrovertible facts rather than as different theories. This has implications for

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service-users as these “truths” come to underlie contemporary prevention practices, leading to an overreliance on professional expertise, individual deficits and psychopathology (Marsh et al., in press).

A reading of the findings from the perspective of Positioning Theory (Harré & Langenhove, 1991) suggests that people use language to implicitly position themselves in relation to the topic discussed. For example, a dominant discourse of “suicide as biomedical” may position the speaker as a ‘responsible and accountable clinician’ in relation to the ‘dangerous and irresponsible patient’ (Marsh, 2010). Such constructions could have negative effects for suicidal people by positioning them as “worthless” (Horsfall, & Cleary, 2000) and exacerbating suffering (Fullagar, 2003), powerlessness (Bennett et al., 2003), and isolation (Fullagar, 2003).

A discourse of “suicide as shameful or taboo” served to construct suicidal people as different and socially deviant/unacceptable. The effect of which could be to isolate those affected by suicide from the community (Monk, 2000), increase social stigma (Cvinar, 2005) and internalized feelings of shame (Fullagar, 2003) and blame (Shocolinsky-Dwyer, 2011).

Resistance. Foucault argues that discourse can both maintain and resist the status quo (Foucault, 1974). The discourse of “suicide as normal and even creative” appeared to offer subject positions in which individuals could talk openly and honestly about suicidal feelings, albeit perhaps at risk of glamorizing suicide and positioning it as a desirable act. The discourse of “suicide as relational” was of particular interest as it provided a “theoretical resource for re-thinking suicide” (White & Kral, 2014). Reynolds (2015) and White (2012) argued that this could create new opportunities for interventions by asking different questions, perhaps

about social justice (Morrow & Weisser, 2012), social fragmentation (Rehkopf & Buka, 2006), and the historical and cultural context of suicide (Marsh, 2010). The extent to which the various discourses are seen as helpful is likely to depend on the reader's own perspective, ideological worldviews and values (Graham, 2011). However, this paper argues that alternative constructions offer the opportunity to question the 'truths' of suicide and provide a different, useful framework for understanding.

Critique

The following section will consider the methodological and theoretical limitations of the DA approach with references to specific examples from the studies reviewed. The methodological critique draws on criteria proposed by Georgaca and Avdi (2012) and Taylor (2001). These include evaluations in terms of: (1) discourse analysis methodology (2) situated analysis; (3) positional reflexivity; (4) usefulness and practical applicability and; (5) theoretical limitations

Discourse analysis methodology. It is commonly accepted that the discourse analytic process is difficult to describe (Harper, 1995). Phillips and Hardy (2002) suggested that a rigid approach risks limiting creativity, undermining the philosophies of DA and oversimplifying the complexity of accounts. However, analysts have provided general guidance, emphasizing the importance of flexibility (Potter & Wetherell, 1987; Willig, 2003; Parker, 1992). Overall, the studies varied in how explicitly they reported their procedures, either providing clear step-by-step accounts (Gilchrist et al., 2007), a broad overview (Mac an Ghail & Haywood, 2012) or directing the reader to specific principles elsewhere (Fullagar et al., 2007). However,

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a few studies made no reference to guidelines used (Owens et al., 2008; Fullagar, 2003).

Studies also varied in the type of DA used. Robertson et al. (2010) used a discursive action model drawing on Discursive Psychology (DP), which has been criticised for an over-emphasis on the minutia of language and failing to take broader contexts into account. Horsfall and Cleary (2000) described using a Critical Discourse Analysis (CDA) and combined two sets of guidelines in their approach. There is some criticism that combining multiple perspectives ignores different theoretical backgrounds. However, Potter and Wetherell (1987) have argued that the traditions of Foucauldian DA and discursive psychology are not incompatible. As such, CDA may provide a comprehensive approach exploring how language is performed in a specific context, whilst acknowledging the importance of wider societal discourses (ibid). Additionally, Fullagar et al. (2007) provided an under-analysis by simply offering a descriptive thematic analysis (rather than a DA), despite claims of exploring the dominant discourses of suicide (Antaki, Billig, Edwards, & Potter, 2003). Notably, this same sample was used by five of the reviewed papers (Fullagar, 2003; Fullagar, 2005; Fullagar et al., 2007; Gilchrist & Sullivan, 2006; Gilchrist, Howarth & Sullivan, 2007). However, these papers used different analytic methods and focused on different aspects of the suicide, for example shame (Fullagar, 2003) and community and rural identities (Fullagar et al., 2007) and so offered additional perspectives of interest. Much of literature focused on 'youth' suicide; whilst it may not be appropriate to critique the studies in term of "representativeness", it may that there are issues particular to youth culture that impact on suicide (Ryan, Coughlan, & Cronin, 2007). In addition, a number of authors published multiple

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papers, which may mean, even though they have explored different aspects of the topic, their perspectives are over-represented in the analysis, for example White, Fullagar and Jaworski.

Situated analysis. There is an ongoing dilemma in DA about how far the researcher should interpret beyond the data (Parker & Burman, 1993). However, situating an analysis within its socio-political and historical context can support the reader to draw their own conclusions regarding the data (Harper, 2003). Fullagar et al. (2007) located their data in two regional and suburban Australian settings in an attempt to highlight the fact that ideas about suicide are profoundly embedded within both the culture and structure of communities. In addition, several authors drew attention to the potential socio-cultural meanings of the neo-liberal socio-context of the data (Fullagar, 2005; Jaworski, 2010; Jaworski, 2012). This is merited as it supports the reader to draw their own conclusions based on the context and authors subsequent interpretation of the data. However, in selecting the location and text, the researcher always risks privileging a particular stance (Harper, 2003).

Positional reflexivity. Marshall and Raabe (1993) argue that there is a particularly difficulty with the stance of ‘letting discourses emerge’ in DA, as they are not simply ‘there’ waiting to be found but emerge through a process of engaging with the text. Lather and Ellsworth (1996) suggest that reflexivity can lead the analyst to deconstruct the dualities of power and resistance to describe how our representations of the world and people are positioned.

Harper (2008) suggests that it is important for the analyst to locate their position in the work, allowing the reader to speculate about how the author’s views or experiences may interact and result in their reading of the data. A number of authors

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clearly articulated their stance within the discourse by arguing from a place of “disenchantment” with mainstream prevention practices (White, 2014; White & Kral, 2014; White & Morris, 2010). However, other studies were less reflexive and offered no account for their position in relation to suicide (Mac an Ghail & Haywood, 2012).

Usefulness and practical application. Practical application refers to the degree to which the work invites new perspectives in informing everyday practice. The reviewed literature typically adopted a questioning perspective. As such, the papers offered a critique of mainstream practices as well as future alternatives. Whilst the majority of literature offered *some* interpretation of practical applications of their ideas, the papers varied in the degree to which they engaged with realistic, practical suggestions, which could be applied to the appropriate field.

White and Morris (2010) perhaps offered a good example; they described tracking the ongoing implications of their work through continued consultations with two participants from the study and formed a working group to encourage the development of youth prevention in education. Several authors also offered specific practical examples including, using narrative therapy approaches, reflective questions, enlisting young people (White & Kral, 2014), and de-stigmatisation campaigns (Bennett et al., 2003). However, others were vague suggesting the services need to be “reformed” (p. 7, Robertson et al., 2010) with little detail about how to implement changes.

Theoretical limitations. Parker (1998) argues that a particular theoretical limitation with DA is that it treats language as the most powerful and important aspect of human experience but that this may not always be the case. This risks privileging language at the expense of the materiality of power (Burman & Parker, 2003). Parker

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(1992) described that although power is (re)produced in discourse, it is also at work in the structural position of people when they are not speaking and endures when the text stops.

It is important to note that DA is arguably a political approach that frequently critiques powerful groups in society, for example, the discourses of right-wing politics (Wodak, KhosravNik & Mral, 2013), racism in the media (Teo, 2000) and implicit homophobia in the equal-marriage discourse (van der Bom, Coffey-Glover, Jones, Mills, & Paterson, 2015). However, Parker and Burman (1993) have argued that, like other “psy” research paradigms, DA affords a power to the analyst to impose their own meanings upon another text and that researchers construct their own image of the world when they seek to ‘reconstruct’ discourses. As such, it is important that researchers take some responsibility for how the analysis will function and acknowledge the ethical dilemmas in having ‘power and control over other people’s words’ (Stenner, 1993).

Implications

Due to word count restrictions the following section will be limited to implications for mental health professionals working in prevention settings as well as avenues for future research.

Clinical practice.

Language. This review has highlighted the importance how language is used to talk about suicide within prevention services. Kouri and White (2014) argue that a discourse of “suicide as biomedical” is stabilised and maintained by the very use of the word suicide. It is argued that clinical psychologists could mobilize alternative understandings by introducing alternative words with people who use services such as

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“self-accomplished death” or “cancelling life” (p. 191). This may help to de-stabilise the term suicide and open up possibilities for understanding distress and death in a different way.

In addition, White and Kral (2014) suggest that it would be useful for professionals to move beyond the dominant constructions of suicide by encouraging people to draw on their own experiences and questioning what is the most useful form of support for them. Bourke (2003) argues that it is important to reconsider practices based predominately on the assumption of suicidal people as ‘sick’ or ‘passive’. For example, rather than offering people ‘psycho-education’ based on a particular approach to suicide, services could be organised in a way that permit the exploration of local knowledges through mobilising communities, for example through peer support groups, critique and debate (Bourke, 2003).

Relational contexts. In addition, Reynolds (2015) argued that the ‘choice’ of suicide as a way of responding to distress is culturally conditioned and cannot be understood without reference to “relational embeddedness” (p. 3). This means that it is vital for clinical psychologists to attend to issues of gender, race, sexual orientation and age. White & Kral (2012) suggest that clinician could explore the ways in which these fluid and intersecting identity markers interact with institutional relations of power and broader societal contexts, such as sexual violence, racism, homophobia, and discrimination.

Embedding critique. Fullagar (2003) and Stevenson and Cutcliffe (2006) argue that taking a critical stance towards suicide prevention practices may improve ethical practice, empower people who use services and redress practices that may perpetuate oppression. McKenzie & Monk (1997) describe how they invite trainee

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therapists to practice identifying discourses and positions that they and their therapy clients adopt. This may enhance clinicians' curiosity about the conflicting demands made upon them; the different subject-positions they can adopt, be forced into and place others in; and the personal and social effects of different discourses. Service-users could also be invited to consider the role of dominant discourses in shaping ideas about what they consider a worthwhile and desirable life, and the potential costs of finding themselves positioned outside of the mainstream (White, 2012).

Research. This review argues that there is scope for future discourse analytic research to contribute to theoretical diversity as DA invites new and different questions about clinical practice, which can lead to a useful "rethinking" of suicide for the benefit of service-users and professionals. As such, future research could consider the accounts of professionals to explore how suicide is discursively constructed in mental health professionals' talk? What dominant and subjugated discourses do professionals draw on in talking about working with people who have a wish to die? This may be useful is understanding the assumptions that underlie clinical practice and questioning how might these discourses influence the actions and social positions available to professionals and service-users.

It would also be useful to explore survivor accounts of suicide and explore how survivors make sense of their experiences? What dominant and 'other' ways of knowing about suicide do they draw on? How do they describe how they have overcome feelings of despair and have re-engaged with life?

Finally, although this review has highlighted that there is some research examining the accounts of lay people, there is little exploration of how constructions are portrayed in the media. It would be useful to explore constructions of suicide in

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the public arena to examine how people are influenced by different descriptions of suicide? How does it shape their existing understanding?

Conclusion

This narrative review of the literature suggests that suicide was constructed in differing ways: most prominently as an individual, biomedical phenomenon or a shameful, selfish, personal failing. It was also constructed as abnormal and taboo. The effects of these discourses could be problematic for people who are suicidal by increasing stigma, blame, shame, isolation, dependency and powerlessness. There were also counter-discourses, which constructed suicidal thinking and suicide as a normal, creative and relational act. This provided different a way of thinking about suicide and highlighted the importance of considering language, relational perspectives and critical evaluations in clinical practice. Future research could usefully explore the accounts of policy-makers, professionals and survivors to examine the different ways in which these groups discursively construct suicide, and the effects of those constructions.

The implications for suicide prevention are considerable as the dominant discourse may serve to position suicide as an individual, shameful, consequence of 'mental illness'. People who have experienced suicidal thoughts may be negatively stereotyped and ostracized by the general population, leading to self-stigmatization, low self-esteem, feelings of shame and powerlessness (Wilbum & Smith, 2005). An internalisation of perceived public stigma has implications for social withdrawal and detachment, which may intensify feelings of loneliness, as well as an us/them dichotomy leading people to view themselves as 'unwell', 'less capable' or 'hopeless' (Cvinar, 2005). Previous research indicates that feelings of shame and isolation are

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often prominent in the dynamics leading up to suicidal thoughts and behaviors (Hastings, Northman & Tangney, 2002).

It is suggested that embedding critique within services opens up new opportunities for prevention (Taylor, 2001). This paper argues that embedding such practices enables both professionals and service-users to move away from a diagnostic framework to become more uncertain in their formulations of suicide. This would move conversations away from an expert dynamic; reducing the reliance on restrictive, pre-determined risk practices (Undrill, 2007) to become more curious and unknowing. The Samaritans is perhaps a good example of this approach. Such a stance may serve to redress power differentials, as it based on the assumption that SUs have as much to offer as professionals. Recent BPS guidelines suggest that prevention is improved when professionals focus on a genuine “shared understanding” and do not insist that service-users accept any one singular framework (BPS, 2015).

Embedding critique would also enable suicide to be seen primarily as an act in relation to a particular context or set of circumstances rather than as a direct consequence of an internal mental illness. This would empower SUs by positioning it within the ordinary range of human experience, thereby reducing the us/them dichotomy as well as the stigma, shame and exclusion associated with suicide. This could further aid prevention by enabling people to feel more hopeful, acceptable, and worthwhile and therefore more able to talk openly about suicidal feelings and seek support. This would also move the emphasis away from individual causality to a broader societal context in which factors such as racism, homophobia, and discrimination could be openly considered within services. This is important for

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ethical practice and safeguarding as individual discourse may risk sexual, emotional or physical abuse going unnoticed; all of which have implications for increased suicide risk (Fergusson, Woodward & Horwood, 2000).

In light of the potential link between discourse and suicide prevention, future research could explore questions such as:

1. What discourses do professionals draw on when talking about suicide prevention? What are the implications of such dominant and subjugated discourses for people who feel suicidal?
2. How have the survivors of suicide experienced conversations about suicide when talking to professionals?
3. How do survivor groups, exploring alternative narratives of suicide, impact on service-users feelings of self-worth and thoughts about suicide?

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Section B

The Professional Construction of Suicide: A Discourse Analysis Exploring How
Language is used to Construct Suicide in Professional Talk

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Abstract

In mainstream mental health services, the current approach to suicide prevention is often based on ‘risk’ management, the identification and treatment of mental health problems. Critics have argued that using this pathological/risk framework is inherently problematic; limiting the ways in which service-users and professionals are able to work together to understand suicide, contributing to service-user dissatisfaction and professional burnout. The current study aimed to critically examine the accounts of professionals, to explore how the concept of ‘suicide’ was constructed in language, together with the effects of those constructions for both thinking and practice. Semi-structured interviews were conducted with six clinical psychologists and four psychiatrists working in adult mental health services. Transcripts were studied using a method of Critical Discourse Analysis. Three dominant discourses; “not in your ‘right’ mind”, “blame” and “human-rights” and two subjugated discourses; “contextualising” and “fostering hope” were identified. Professional accounts drew on multiple, competing discourses. Suicide was dominantly constructed as the final act of an unbalanced mind, with the causes and solutions located within the individual and requiring ‘expert’ treatment; however resistances to the dominant discourse were also at work. Subjugated discourses opened up language to embed new meanings, legitimized different perspectives and explored other ways of ‘knowing’ about suicide. The study’s limitations are discussed, together with implications for clinical practice and future research.

Key words: Suicide, professional, language, discourse analysis, discursive construct

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Introduction

“I’m issuing a call to every part of the NHS to commit to a new ambition for zero suicides. We already know that this kind of approach can work in dramatically reducing suicides... suicide is preventable, it is not inevitable.” (Nick Clegg, Deputy Prime Minister in Meikle & Winton, 2015).

The prevention of ‘suicide’¹ is arguably an important political, national and international health priority (WHO, 2014). In recent years, the British government has published documents targeting organisations (DoH, 2010), professionals (HM Government, 2011) and families (NPSA, 2009) aimed at “saving lives” by preventing suicide (p. 1, DoH, 2010). Such guidance draws on the dominant paradigm of formulating suicide using a pathological/risk framework, which involves identifying ‘high risk’ individuals, offering strategies for reducing risk and improving detection and treatment of mental health problems (NPSA, 2009).

Critics have suggested that such guidance is based on taken-for-granted conjecture that suicide *can* and *should* be prevented (Shocolinsky-Dwyer, 2011) and locates suicide as a pathological, individual and medical phenomenon (Marsh, 2010).

¹ The definition of suicide is debated. Here suicide is defined as “a self-inflicted act related to death” (Goldney, 2007).

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These assumptions are drawn from positivist² literature associating suicide with; diagnosable psychiatric conditions (Beautrais et al., 2007); personality difficulties (Gvion & Apter, 2011); and/or substance use issues (Bertolote & Fleischmann, 2002). A reading of suicide through this risk framework positions clinicians as able to detect and predict which individuals may die by suicide (Fowler, 2012).

In the context of the “zero suicide” ambition, Mental Health Services (MHS) are seen as central to the prevention of death by suicide, with treatment including talking therapies (Thase, 2014), psychosocial support (Beautrais et al., 2007), medication (Isacson, Reutfors, Papadopoulos, Osby, & Ahlner., 2010), and detention (Stevenson & Cutcliffe, 2006). The evidence-base for the effectiveness of such ‘treatment’ is conflicted, with studies variously suggesting that interventions are effective (Fleischmann et al., 2008), slightly effective (Goldney, 2008) and even counterproductive (Perlis, 2011). One commentator, Professor Keith Hawton has expressed concern about the political emphasis given to the “zero suicide movement” and considers that it is; “causing concern to clinical staff in psychiatric services responsible for the care of people at risk of suicide. It is likely to encourage unhelpful defensive approaches to care” (Davies, 2015).

Professionals working with people at risk of suicide suggest that the prevention of suicide is difficult (Smith, et al., 2015). Service preoccupation with risk has been linked to professional anxiety and distress, feelings of inadequacy and a blame culture (O’Connor, Kotze, & Wright, 2011; Rossler, 2012). Critics argue that this has implications for staff burn-out (Rossler, 2012), defensive practice (Undrill,

²The positivist perspective regards our thoughts as more or less constructions of reality (Cruikshank, 2012).

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2007) and an over-reliance on evidence-based practice, in which complex decisions are made with reference to general agreements about “what works” (p. 11, White, Marsh, Kral, & Morris., 2015). White (2012) argues that suicide is a “wild” (rather than a “tame”) problem; in this sense meaning one associated with high levels of instability, uncertainty, unpredictability and complexity (p.42). As such, she suggests that suicide cannot be solved through an exclusive reliance on standardized interventions.

White and Stoneman (2012) have suggested that contemporary practice is inherently problematic and, at times, unhelpful. It has been argued that “technologies of prevention”, based on the assumption that all human behaviour can be predicted, may lead to a narrow focus on risk calculation, pre-emption and control (p. 181, Diprose, 2008). Kouri and White (2014) suggest that this reinforces a “false certainty” about the ‘scientific’ expertise of clinicians, which can marginalize other, potentially useful, ways of knowing (e.g., practical wisdom, local knowledge and experience) (p. 185). Moreover, research from a survivor perspective described clinical services as uncaring and assessments as superficial and rushed (Taylor, Hawton, Fortune, & Kapur, 2009).

Suicide has not always been understood within a pathological/risk framework. The meaning of suicide has varied over time and across cultures. Despite this, different definitions have been considered ‘true’ and beyond dispute within their own context (Bahr, 2013). A historical mapping of suicide demonstrates the contingent and political nature of knowledge and reminds us that things could have always been otherwise (Marsh, 2010).

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In ancient Rome and Greece, many terms were used to describe what we now homogenously term 'suicide' including "destroying oneself", "voluntary death", "to take the last measure" or to "strive after death" (van Hooff, 2000, p. 139). These subtle variations in vocabulary provided the linguistic resources necessary to construct suicide as a heterogeneous act with a range of meanings and rationales. For example, in early Rome, self-death was implausible without reference to honour, social status and the political system (Kouri & White, 2014).

From the 4th century, the meaning of suicide became gradually more singular as emerging Christian values of martyrdom began to influence attitudes and establish a moral climate that encouraged the prohibition of suicide (Marsh, 2013). Suicide became unequivocally condemned as *self-murder* and an insult to God. Funerals were denied to those who caused their own deaths and any honouring was only for those who had *lost* loved ones to suicide, not to those who had taken their life (ibid). Suicide as an insult to God gradually became interpreted as an insult to sovereign power (Bahr, 2013). Subsequently, in 673 AD the act was criminalized and the government became able to legally seize the property of 'perpetrators' (Szasz, 2002). Interestingly, the criminal legacy of suicide persists in our everyday talk of "*committing* suicide" (e.g. p.47, DoH, 2010).

The 18th century saw a shift from punishment to treatment as suicide became medicalized (Laragy, 2013). Juries began to classify suicide under "temporary insanity" (p. 9, ibid). This marked the beginning of suicide as a pathological phenomenon (p.4, Marsh, 2010). The suicidal person became labelled as unwell or imbalanced and therefore was deemed irresponsible for their actions. Simultaneously, a growing collective of experts began to take on increasing responsibility for

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preventing, what had come to be seen as, an “unnecessary, avoidable and preventable death” (p. 169, Kouri & White, 2014).

The end of the 19th century saw a rise of psychotherapy through which ‘suicide as pathology’ became relocated from the individual’s body to their internal psyche. Treatment evolved from physical confinement to “talking therapies” (confessions) as the new form of suicide ‘cure’ (Marsh, 2010). The psy-disciplines (psychologists and psychiatrists) became regarded as the “experts of the soul” encouraging monitoring, evaluation and reformation of the self (p. 211, Rose, 1990).

Rationale

Previous research has used interviews with professionals to explore assumptions and discursive strategies employed in discussions about different areas of clinical practice, including psychiatric medication (Harper, 1999), electro-convulsive therapy (Stevens & Harper, 2007) and diagnoses (Boyle, 2004).

Critics argue that contemporary approaches to suicide prevention are inherently problematic and may lead to professional burnout and service-user dissatisfaction (Taylor et al., 2009).

A critical stance acknowledges that there are a variety of stories to be told about suicide and prevention. However, the accounts of professionals are, arguably, more powerful than others (Harper, 1995). The current paper argues that how professionals think and act in relation to suicide is grounded in assumptions about what it is and how it should be studied, understood and responded to.

In this context, it would be of value to critically examine accounts of professionals working with people who are suicidal to explore the ways in which suicide is constructed, together with the effects of these constructions.

Research questions

1. How is 'suicide' discursively constructed in professionals talk?
2. What dominant and subjugated discourses do psychiatrists and psychologists draw on in describing their work with people who have a wish to die?
3. How do these discourses influence the actions and social positions available to professionals and service-users?

Method

Design³

Semi-structured interviews were conducted with clinical psychologists (CPs) and psychiatrists. It was hoped that interviews would encourage conversations in which professionals could undertake reflexive construction of their clinical practice. This is consistent with previous research (Stevens & Harper, 2007; Griffiths & Hughes, 2000). According to Parker (2005), semi-structured interviews offer a more in-depth opportunity to explore the individuals' accounts, compared with focus groups. The interviews were not regarded as a way of getting to 'the truth' of suicide but rather were seen as a space in which culturally available discourses and rhetorical strategies would be at work (Potter & Wetherell, 1998).

The data was interpreted using a method of Critical Discourse Analysis (CDA). CDA has emerged from Foucauldian discourse analysis (FDA) and discursive psychology (DP). Wetherell (1998) suggests that CDA is a hybrid methodology that

³A peer-review panel, Salomons Advisory Group of Experts by Experience (SAGE) and academic supervisors gave feedback on both the design and the interview schedules, which were incorporated as appropriate.

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allows the researcher to explore language at multiple levels; in terms of both discourse practices (FDA) and discursive resources (DP). In this case, the aim was to examine how professionals constructed the meaning of ‘suicide’ and the clinical practices related to it as well as how drawing on certain repertoires might achieve particular effects.

Coyle (2007) has outlined the three basic theoretical assumptions driving CDA. These are that discourse is; (1) functional (i.e. people choose their words based on what types of reality they wish to construct); (2) action-orientated (i.e. language is used to achieve something, such as blame, persuade, justify etc.) and; (3) socially constructed (i.e. it does not assume that language reflects an internal psychological truth).

DA is broadly situated within a social constructionist frame, which suggests that access to reality is through language (Burr, 2003). With language, people create representations of reality that are not simply reflections of a pre-existing reality but contribute to constructing a version of reality. DA does not deny the existence of a material reality. It suggests that meanings and representations are real. Physical objects also exist, but they gain meaning through discourse (Gergen, 2009).

Ethical considerations

Ethical approval was obtained from the CCCU Ethics committee (appendix F). The Research and Development consortiums (RDCs) of two NHS trusts provided permission for their staff to participate in this research (appendix G). A summary of the results was presented to applicable RDCs, sent to all participants (appendix I) and CCCU ethics panel (Appendix H). Ethical procedures included; obtaining informed consent, outlining confidentiality, appropriate storage and destruction of sensitive

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material and a debriefing conversation to explore any issues following the interview.

In addition, participants who had experienced either a personal or professional suicide within the last 6 months were excluded from the study.

Participants

Participants included six CPs and four psychiatrists, working in the adult Mental Health Services. The sample size was consistent with similar studies (Stevens & Harper, 2007). Participants were included if they had worked with at least one individual deemed at risk of suicide.

Participants made contact in response to an advertisement that was distributed through the “Psychosis and Complex Mental Health” Facility of the British Psychological Society Division of Clinical Psychology as well as through local NHS trusts (appendix J). Suitability to participate in the study was confirmed by email. Participants were provided with an information sheet (appendix K), consent form (appendix L) and interview schedule (appendix M). Participant characteristics are presented in aggregated form to protect anonymity (table 1).

Table 1: Participant demographics

Category	Characteristics
Gender	6 Women 4 Men
Ethnicity	9 White British 1 dual heritage (not specified)
Profession and Grade (i.e. Band 7)	2 CPs (Band 7) 3 Senior CPs (Band 8a and b) 1 Consultant CP (Band 8c) 4 Consultant Psychiatrists
Specialty	10 Adult Mental Health Services

Workplace	9 National Health Service 1 independent hospital
Years since qualifying	Range: 1 – 25 years

Procedure

Interviews ranged from 50 to 86 minutes. All were conducted in line with specified protocols approved by the Salomons ethics panel (appendix N). Initially, participants were invited to re-read the study information/interview prompts and discuss any queries. Written consent was obtained and participants were reminded of their right to withdraw at any time. The interviews were audio-recorded. Interview schedules were used as the basis for discussion, although participants were encouraged to discuss any relevant topics. Schedules were designed in collaboration with the author's academic supervisors and trialed in a pilot interview. Questions were formulated with respect to theoretical concerns and research aims. They were designed to be as open as possible to enable participants to draw on their own experience and language. Participants were offered the opportunity to debrief after the interview.

After each interview, brief notes were made reflecting on the process and initial ideas for themes were detailed in a reflexive journal (appendix O). These were returned to during analysis. The analysis involved an immersion in the data through a process of transcribing and careful re-readings of the text. Subsequently, "codings" were made on the text in an attempt to identify what was being talked about and how (see appendix P for annotated transcript). Codings were systematically expanded on using a coding book (appendix Q) to develop over-arching discourses (appendix R).

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The process of DA is difficult to describe (Harper, 2003) and there have been calls for clearer accounts (Coyle, 1995). It is noted that strict adherence to guidelines is inconsistent with a DA approach (Potter & Wetherell, 1998). To maximise the rigour and trustworthiness of the results, the analysis has drawn on guidance outlined by Willig (1999). She guides the researcher to consider six criteria for distinguishing discourses within the text: A discourse is: (1) about objects; (2) contains subjects; (3) action orientated; (4) creates and restricts subject positions; (5) legitimizes certain practices and behaviours; (6) has implications for individuals' subjective experiences (see appendix S for further information regarding each criterion).

Quality assurance

It is noted that the analysis represented a single interpretation of the text and that other readings are possible. Harper (2003) emphasizes the importance of developing a critical, reflexive position in DA. The author completed a reflective interview to explore her own place within the discourse. The author has worked as a trainee psychologist with people who are suicidal. In her experience, working with suicidal people raises strong, often contradictory feelings and can leave professionals feeling overwhelmed, uncertain and sometimes reliant on restrictive practices. She had found that suicide was sometimes difficult to talk about for both professionals and for the people using the services.

The study's credibility was pursued by following the guidelines recommended by Mays and Pope (2000); an academic supervisor, experienced in DA, periodically reviewed data coding; a research diary was written and an audit trail was completed (appendix T). For transparency and coherence extensive quotes from the transcripts are included allowing the reader to draw their own conclusions from the data, as the

meaning of the text is inherently unstable and open to multiple interpretations (Graham, 2011).

Results

The analysis focused on how the suicide was discursively constructed in professionals' talk and how these dominant and subjugated discourses offered certain subject positions to be taken up by the speaker. A critical discourse analysis identified five discourses; "not in your 'right' mind", "blame", "human rights", "contextualizing" and "fostering hope". While each of these discourses is presented separately, they are likely to be interconnected and the implications of each intertwined (Wetherell, 1998).

Not in your 'right' mind: Suicide as irrational, temporary and 'other'

A dominant discourse of suicide in the context of "not in your 'right' mind" was identified throughout the interviews. Within this discourse, suicide was presented as an irrational act ('irrationality'), an individual act ('individualism') and an act that could be identified using risk assessment ('objective and rationale risk assessment'). Suicidal people were positioned by labels such as "patient", "client", "service-user" or referred to through diagnostic categories, which served to create difference between the professional (as a provider of help) and people who use services (as receivers of help).

Irrationality. At times, feeling suicidal or having a wish to die was constructed as a temporary, irrational or regrettable state. A number of times, participants drew explicitly on suicide as a product of "mental illness" (Transcript 9,

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Lines 56) or related to a temporary state of mind such as “being intoxicated with alcohol” (Transcript 10, Line 72). This was seen as a way of making sense of complexity. For instance “I’ve always tended to think that there is reason... an irrational reason or that there has been a mental illness behind suicide, which has made life easy” (Transcript 6, Lines 87 – 92). The construction of suicide as a product of an irrational state of mind frames suicide as a problem of the inner psyche and subsequently legitimizes the “treatment” of the underlying mental health problem (Transcript 2, lines 453-454). In turn, this justified the need for mental health professionals by positioning them as a “knowing best” and having the expertise required to prevent suicide (Transcript 1, Line 55), for instance “As a service we *have to keep people safe* and make sure we *treat* them until that *passes*” (Transcript 10, line 132 – *emphasis added*). This comment positioned the individual as irrational and suicide as a threat to their *true* identity, which could legitimize practices that may over-ride the wishes of SUs, such as detention in hospital. In the following quotation, the participant used emotive language to separate the act of suicide from the wishes and identity of the individual:

“So he woke up, non-dead [after a suicide attempt] and he was *horrified* by what he did and it was a classic case of you know, this was someone who was in a *completely irrational* way and was very *pleased* that it didn’t actually work... It was completely *out of character* for him and it really *scared* him” (Transcript 6, Lines 360 – 366 – *emphasis added*).

Another participant spoke about how suicide as a symptom of an irrational mind provided a rationale for current practice but that simultaneously functioned to offer a reassurance to society that suicide could be understood and controlled;

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“I think that Mental Health Services have a unique position in our society of being able to detain people even when they haven’t done anything wrong and maybe there is something about the society, it's a kind of, we can take people and keep them safe and stop them doing things that we don't want them to do and if it wasn't a mental illness I guess how would society make sense of suicide, if it wasn't an individual illness or flaw?” (Transcript 7, Lines 262 – 268).

This implied that constructing suicide as “not in your ‘right’ mind” served a regulatory function through legitimizing the authority of services as able to sanction and control socially unacceptable behaviour such as suicide.

Individualism. The use of individual language constructed suicide as primarily an individual issue, whether aligned to biological: “an understandable symptom of mental illness” (Transcript 6, Lines 26 – 27), psychological: “her self criticism and negative thoughts” (Transcript 2, Lines 255-257) or social “what you were taught at school, messages you hear on TV” (Transcript 4, Lines 225-228) theories of causation. A construction of individuality served to position suicide as a private issue, located within the interiority of the human mind and originating from an internal psychic space. This assumption positioned suicide as a hidden issue requiring professional expertise to detect and treat symptoms of distress, through individualized talking therapies, medication and case management.

Objective and rational Risk Assessment. Throughout the interviews, there were multiple references to Risk Assessment (RA) as a means of detecting and scientifically identifying suicide. One participant constructed risk and suicide as something it is possible to identify and examine: “I think [RAs] are helpful in a number of ways [...] they are generally fairly *predictive*... so they are *accurate*. If

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someone has intent and active plans then they are *significantly more likely* to attempt suicide than if they don't so they have got some *face validity* and *predictive value* (Transcript 3, Lines 55 – 60). The tangibility of suicide and reality of risk were then seen to legitimize certain practices such as detention and observation. This served to position professionals as risk managers, with the task of detecting and preventing suicide.

Blame: Suicide as a threat to professional integrity

Clinicians described a culture of “blame” in which staff had “...*hideous* fantasies about what would happen to them [after a suicide], that they would be held *accountable* for that person's death” (Transcript 7, Lines 56 – 58). This discourse of “blame” positioned clinicians as responsible for the suicide prevention. As such, the act of suicide, suicide talk and suicidal people were seen as posing a threat to the clinician’s career and professional status. This discourse constructed the professional as responsible (‘The responsible professional) and as under constant observation (‘observation and visibility’). Risk was constructed as visible and talking about suicide was seen as dangerous (‘dangerous talk’). The “blame” discourse could be seen as a means of positioning the institution as a punitive authority figure relative to a victimised clinician: “if anything happened it would have been my fault and I would be in trouble for it... It would be on my hands... and I would have to explain myself to the inquest” (Transcript 4, Lines 365 – 367). Professionals drew on this discourse to explain defensive practices such as risk-aversion, ignoring distress/suicide talk and withholding information from colleagues.

The responsible professional. Clinicians constructed working with suicidal people as difficult and imposed expectations on themselves to actively change an

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individual's mind. For instance; "Just thinking perhaps you could have *done something* is not a comfortable thought and perhaps ties in with staff being *responsible* for clients and somehow we are *the professionals*, we *should know*, we *should have the answers* and *should know* how to *fix people*" (Transcript 4, Lines 76 – 87 – *emphasis added*).

This set up an expectation that clinicians have specialist 'expertise' that can stop people feeling suicidal, and drew on a wider discourse that suicide is preventable and should never happen in the NHS; "... there is a list of things that should never happen in the NHS, so suicide is on that, so it should never, ever happen" (Transcript 6, Lines 123 – 126).

A discourse of 'Blame' constructed suicide as a direct outcome of whether the professionals' work had been 'successful', for instance; "If I am honest with myself when somebody takes their own life or tries to [...] it is seen as a failure of the work that we have done... and I think that's our immediate reaction, that's how we feel. We should have prevented it. We didn't. What did we do wrong?" (Transcript 5, Lines 147 – 152).

Suicide became indicative of inadequacies within the team and the individual clinician, which may limit the ability to listen to the person. In addition, it created an expectancy of right and wrong ways of working with suicide, which circularly legitimized the perspective that somebody is at fault and should be held to blame. One participant described that "blame is apportioned out, they have words for it, like root cause analysis, all this sort of stuff, but that feels, whether its conscious or unconscious, like an attempt to apportion blame or responsibility... and I think that makes people become much more risk averse" (Transcript 2, line 191 – 194). This

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implied that individual clinicians are under threat of being openly blamed and that they have to protect their professional status in their practice.

Observation and visibility. The “blame” discourse created the position of an ever-present, observing and powerful institution (the managers, trust or NHS) in the consciousness of clinicians everyday talk and practices for instance; “...you can hear the corners court in that answer” (Transcript 1, Line 386). Professionals positioned themselves as under constant observation and valued being *seen* to be competent and judged as morally good by others. This was achieved through practices such as ensuring the notes were documented and “the right boxes are ticked” (Transcript 10, Line 146) or as one participant put it: “You would never want to be left with something that someone had told you and that you hadn’t done anything about it [...]. I always make sure I have done my notes before I leave and so if something happened...I’ve done what I needed to do” (Transcript 8, Lines 226 – 231).

This discourse positioned clinicians as risk managers and as hyper-vigilant to the perceived threat of a suicidal person. There was an underlying assumption that the suicidal person could not be trusted and should be “continually” checked and observed by professionals, for instance;

“It’s just that sort of feeling...we need to be continually checking, continuously making sure ermm because we had a situation before where consultants in particular were feeling that suicidal people are like time bombs waiting go off with my name on it, because the investigation which took place afterwards” (T9, Lines 282 – 286).

This quote suggested that there was tension between protecting oneself as a clinician and respecting the individual’s freedom or autonomy. It implied that

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continual “checking” would reduce risk status. This then served to legitimize observation and positioned risk as a tangible and material entity. This reinforced the visibility of risk. Clinicians were positioned as responsible through references to ‘duty of care’ but could absolve themselves from blame by systematically following guidance. As one participant put it;

“We have a duty of care and they [suicidal people] become our responsibility which is such a huge ask and somehow if we can focus...if we can show that we have ticked all the boxes, if we've got our eyes down, if we can do exactly what we are told to do then it's not our fault if something goes wrong” (T7 Lines 178 – 184).

Dangerous talk. Throughout the majority of interviews talking about suicide was constructed as dangerous, painful or taboo but also as something that should be talked about. Suicide was described as difficult to talk about with colleagues and often required specialist expertise, such as external supervision. Professionals also described fears about talking to clients who were suicidal. These fears included increasing the risk of suicide; becoming overwhelmed by others' distress, making others feel uncomfortable and being blamed: “it's difficult to have the conversations about what did you do... when there is a lot of blame flying around... maybe it's easier not to talk about it...” (Transcript 8, Lines 361 – 365) and shamed “we don't speak about helping families after death and I'm not quite sure why...maybe the team not really wanting it because it's a bit shameful that this person died...” (Transcript 10, Line 333 – 335).

Suicide was constructed as an issue that personally affects both professionals and service-users but was unacceptable to talk about as a professional; “We definitely

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don't talk about our own suicidal feelings [...] that's a no-go area. It's like suicide is its own little spectrum that is not ok to admit that you've been on that" (Transcript 7, Lines 197 – 201). The effect of this was to position suicidal people as a homogenous group, narrow the frame for understanding and encourage distance by promoting an 'us/them' dichotomy.

Human rights: Suicide as a rational choice

A competing liberal "human-rights" discourse constructed suicide as an understandable, reasoned choice like any other. Suicidal was not seen as 'irrational' but as an understandable, human and, at times, logical choice. The "human rights" discourse positioned free choice and individual human liberty as paramount, for instance, "I don't try and make a judgment about suicide with service users. I don't say "You know I think you're right, you know if I was in your situation that I probably would kill myself" but I also don't dismiss it, I just acknowledge that it's there as an option and that it ultimately is their choice to make as a person" (Transcript 1, lines 260 -263). Suicide was legitimized through constructing suicidal persons as being of "rational mind" (Transcript 10, Line 54) in the context of experiencing problematic life circumstances. Professionals spoke about a decision to die as a reasonable, understandable and logical process:

"I presume for the vast majority of people [suicide] is a pretty *rational* decision. You know working with people that have tried to do it, it makes so much *sense*. You look at how people are describing what their lives are *realistically* like and how much of a burden they are on people and how terrible they feel. It's a good *solution*... you know... so that feels very *rational*..." (T5, Lines 261 – 265 – *emphasis added*).

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The implication that suicidal people have the right to make their own choice about death positioned people as active, capable and competent. This could have been seen as a way of negotiating the complexity of blame by protecting the professional from engaging with talk about responsibility i.e. the choice to die is an individual decision to be made by solely by the individual using the service, provided they are professionally judged as able to do so. One participant commented:

“You know there’s the capacity issue and questions around is someone able to make that decision [...] but if they can then, you know, if people can refuse medical treatment for cancer, if they can make that decision to end their life, to take that control in their life, then why shouldn't someone do that, when it’s just a decision for other reasons. You know, who are we to decide what are the right reasons to live or die?” (Transcript 2, Line 127 – 133).

This constructed the rights of people who use services as dependent on whether professionals deemed them capable and responsible. This had implications for the agency of service-users as the construction of “capacity” served to legitimize either overriding consent or supporting an individuals’ choice. In addition, the participant took a moral stance by positioning mental health professionals as, at times, impeding on basic human rights by determining whether their choice to die was valid or not.

Participants cited particular circumstances in which suicide appeared logical and understandable, for example in response to chronic illness; “You know, people who take their own lives who have chronic illness, I can completely see why you would do that [...] why wouldn’t you in some cases?” (Transcript 10, Lines 82 – 83) and mental health diagnoses “You know to be quite honest I could see why she would [attempt suicide]. There is a high suicide rate after first episode psychosis and it’s not

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really surprising because it's a horrible illness, schizophrenia, or it can be" (Transcript 8, Lines 155 – 158).

This paper has positioned the aforementioned discourses as dominant. However, "...there are no relations of power without resistances" (p. 142, Foucault, 1978). Subjugated knowledges are defined as ways of knowing about suicide, which may be silenced by the dominant discourse but that continue to "inhabit the margins of the compulsory ontology" (p. 42, Kouri & White, 2014). The following discourses were examples of "subjugated" discourses that introduce contradictory accounts or "resistance" to the dominant discourse and move towards different understandings and subject positions.

Contextualizing suicide: Suicide as a relational, societal and even political issue

Throughout some interviews, a contrasting discourse emerged in which suicide was presented as a relational issue that could be understood in the context of the societal expectations and also as a political issue.

Relational. Suicide was constructed as a form of communication between relationships; "...suicide is important in that it allows people to give a message to partners or family that sometimes they are unhappy or want change in their relationships" (Transcript 5, lines 327 – 329). This description constructed suicide as a way of communicating a need within a relational network, impacting on significant others by inviting them to surround the person in support or otherwise alter the nature of their interpersonal interactions. In this sense, suicide was positioned as an invitation to others as illustrated in the following quote:

"An apparent wish to kill themselves is actually, for example, an angry communication to someone in the person's life, almost like the act becomes of

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way of punishing other people or conveying the distress. ‘You know, now you’ll see how bad it was, how badly you treated me...It can serve a communicative function with services as well’ (Transcript 1, Lines 409 – 413).

In the above extract suicide was viewed as a systemic issue, which re-positioned the ‘problem of suicide’ from a dominant discourse of individualism to a dynamic that exists in between relationships, contributed to by multiple parties, significant others and services. This created multiple subject positions in which service-users could occupy positions of distress as well as be purposeful and resourceful. Suicide was constructed as a solution to a relational problem. Subsequently professionals and services were positioned as actively contributing to the difficulties that could create the conditions for suicide (as a solution). This discourse legitimized the exploration of more contextual, subjective and relational factors in understanding suicide. It also questioned the professional contribution in maintaining distress. This was described by a participant in terms of becoming more “risk averse” (restrictive) in their practice; “After there has been a suicide in the team, you are automatically on higher alert and more risk averse and I think that can sometimes be unhelpful like you can sometimes feel changed by something that’s happened” (Transcript 3, Lines 371 – 378).

Societal and political. The mainstream language of suicide potentially obscures oppression and inequality by offering individualized and pathological reasons for death (Reynolds, 2015). However, there were some subjugated descriptions in which suicide was located as a response to being ‘othered’ and rejected from society as; “one of the most important things is to feel like you have a

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role in society [...] being accepted by others and feeling like you have what you feel like is a meaningful and fulfilling life” (Transcript 8, Lines 193 – 198). This implied that suicide may be an outcome of feeling marginalized and placed an emphasis on social inclusion and acceptance. One participant described that societal expectations could become internalized as individual feelings of shame: “It’s about where you are expected to be [...] I think that causes people a huge amount of shame, distress and discomfort, embarrassment, status issue... whether you fit into society” (Transcript 5, Lines 109 - 112). Similarly, in the following quotation, the clinician described that societal changes had created conditions for suicide:

“There has been a fundamental sort of change [...] government changed, rules have changed and men in those areas where there were mines and all sort of shipyard working, they used to be breadwinners but now there are high rates of unemployment [...] It is basically an issue of exclusion, shaming people from society and there is a vicious cycle where if you are poor, you can't afford to live...and then there are suicides” (T9, Lines 237 – 242).

This subjugated discourse constructed suicide as an outcome or response to unemployment, poverty and social exclusion. This drew attention to the historical and cultural conditions under which suicide might become a viable option.

Fostering hope: Suicide talk as engaging with life and human connection

A competing discourse about suicide talk as a form of engaging with life placed clinicians in a position of fostering hope and connecting with individual who use services on a “human level” as opposed to risk managers and suicide preventers (Transcript 10, Line 79). This constructed talking about suicide as potentially useful,

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as providing comfort, fostering hope and indicative of ordinary human relating and expression. One participant described that:

“In terms of talking about suicide with someone [...] it’s important building that reconnect so they don’t feel alone within that emotional exhaustion because if you are talking maybe it feels less awful than being alone with it, and connecting together with it, in just an ordinary human way can be a useful way of reconnecting with hope (Transcript 4, Lines 80 - 89).

This positioned the person as feeling isolated/disconnected and therefore talking about suicide as a useful way of connecting in an ordinary way. In this sense, suicide talk was constructed as providing comfort and alternative options for individuals in difficult situations, for instance; “I’ve worked with people where actually it’s a comfort to know that if things get bad they’ve got a way out, I’ve got a kind of way or dealing with life and holding onto hope” (Transcript 7, Line 32 – 34) and; “It can be a nice place to be and the planning is very comforting and its quite a nice experience and being in that bubble when you are going through in detail and nobody knows, is quite a nice experience” (Transcript 5, Lines, 69 – 77). Talking and thinking about suicide was constructed as a pleasurable experience that can signal an attempt to re-engage with life. It is positioned as a means of reassurance rather than simply the end of life. This positioned the person using services as resourceful, seeking ways to cope and feel connected with others. This legitimized talking about suicidal thoughts and plans as a helpful activity to be encouraged within services, therapeutic and other relationships.

Discussion

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The aim of this study was to critically examine how ‘suicide’ was constructed within clinicians’ talk about clinical practice. The findings suggested that suicide was dominantly constructed as symptom of an unbalanced mind, with the causes and solutions located within the individual. Professionals spoke about how, when risk of suicide was suspected, the focus of the conversation could shift from an open exploration of the issues affecting the client to one where organisational needs and priorities take over, leaving the client feeling not listened to. At times, suicide was constructed as a rational choice with a range of motivations. There were also examples of resistance to the dominant discourse when the meaning of suicide was constructed as complex, unstable and dependent on the (relational, societal and political) context. Participants described times when talking about suicide was seen as positive, representing hope and an attempt to re-engage with life.

In DA, language is not simply descriptive but is considered to achieve certain effects in the world. Foucault (1978) argued that discourses structure subject positions and relations of power. It is argued that each discourse worked to actively construct suicide and make available various subject positions from which particular practices were justified or legitimized.

A dominant discourse of “not in your ‘right’ mind” positioned feeling suicidal as a temporary, regrettable or irrational state (“irrational”) that was located inside the individual (“Individualism”) and could be accessed through rational, scientific risk assessment (“Objective and Rational Risk Assessment”). This is consistent with the reading offered by Marsh (2010) of suicide as a “compulsory ontology of pathology” (p.4). Furthermore, Shahtahmasebi (2013) argues that an emphasis on mental health problems as the cause of suicide means that suicide is often treated as a symptom of

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depression, which reinforces its taboo status and can lead people to take on a stigmatised identity (Corrigan & Wassel, 2008).

Western, liberal and humanist views of identity are typically linked to autonomy, independence and certainty (Sinclair, 2007). Such a view of selfhood may underlie the construction of suicidal feelings as a foreign entity, or attack on the person's *true* self. This construction created binary subject positions of an 'irrational' patient and 'knowing' professional, responsible for 'treating' people deemed unable to care for themselves ("The responsible professional"). It is argued that this worked to disempower the 'patient' by privileging the voice of the 'experts'. Althaus and Hegerl (2003) suggest that professionals are often positioned as 'instruments' of suicide prevention and able to obstruct attempts. In addition, suicidal persons were positioned as irresponsible and devious, needing continual checking and observation. Stevenson and Cutcliffe (2006) describe that special observation serves as a means of controlling risk in which the professional 'gaze' has a regulatory function in limiting socially unacceptable behaviour.

Suicide was constructed as a direct outcome of the professionals' worth/competence ("Blame") and therefore became a threat ("Dangerous Talk") to their sense of professional identity and career. Previous research has suggested that an over-emphasis on professional responsibility can lead to a blame culture, defensive practice and problematic experiences for staff (Douglas, 2013; Undrill, 2007; Alexander, Klein, Gray, Dewar, & Eagles., 2000). Professionals appeared to draw on discursive resources to position themselves as "good, competent professionals". The position as a *seen-to-be-good* clinician was maintained through practices such as

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“back-covering”, excessive paperwork, withholding information from colleagues and risk-aversion (“Observation and visibility”).

A competing discourse constructed suicide as a “rational choice” made by an individual with the “capacity” to make an informed decision (“rational mind”). This discourse drew on an essentialist, self-determined and independent construction of self and echoes the ideas of a “humanist” configuration, whereby individual human liberty is seen as sacrosanct, and its repression as impeding personal rights (Foucault, 1978). However, the position of a ‘capable, rational and responsible’ service-user was subject to the professional evaluation of “capacity”.

Professionals also drew on subjugated discourses that moved away from an individualized understanding. The discourse of “contextualizing” positioned suicide as inherently unstable and dependent on the context, for example, as a form of communication between others (“Relational”) or potentially obscuring oppression in wider society (“Societal and Political”). Reynolds (2015) argues that that language of suicide provides an decontextualized and depoliticized individual ‘cause’ for “stolen lives” by normalizing societal contexts of exclusion, stigma and hate in which deaths occur (p. 1). Research has suggested that action at a grassroots level can address social, community and individual parameters, which may be helpful in improving the societal conditions that foster suicide (Shahtahmasebi, 2013). Talking about suicide was seen as complex but also positive: an action aligned with coping, hope and human connection (“Fostering Hope”). This resonates with critical and narrative approaches to suicide prevention, which emphasize suicide as products of social negotiation and relational meaning making (Gergen, 2009a; Hosking, 2011).

Limitations

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As aforementioned, this paper offers one perspective on an issue where there are multiple possible interpretations. Moreover, Harper (2003) suggests that no DA can be situated outside discourse and that every account draws on rhetorical devices to privilege a particular stance.

Discourse theorists typically analyze naturally occurring data or documents that are available in the public sphere (Potter & Hepburn, 2005). Using interview data for DA has been criticised as the researcher actively co-constructs the interview by asking questions. As such, it is not discourse in its “purest form”, rather the data is shaped by factors including: the discourse that the interviewee normally acts in, research questions and the discursive situation created in the interview (p. 72, *ibid*).

In addition, the interview was a social context in which participants were invited to position their views in relation to suicide. Astrom (2006) suggests that a moralizing process is likely to be at work, in which participants may seek to manage contested issues by (re)presenting themselves as good, moral and competent clinicians. Professionals may have been reluctant to offer their private thoughts in the public sphere and been conscious of being judged or positioned by the interviewer and the dominant discourse (Cotton, 2001).

Participants were also interviewed by a trainee psychologist who, as a mental health professional, may be assumed to occupy a similar position to them. This may have influenced how participants spoke about suicide i.e. through the use of jargon, offered reassurance to a less experienced colleague etc.

Implications

There are epistemological challenges associated with applying findings from DA research (Willig, 2008). However, Stevens and Harper (2007) note that some

analysts seek to explicitly promote “subversive discursive practices and spaces of resistance” (p. 12, Willig, 1999). Here, the author will suggest some implications consistent with the analysis for clinical practice and research.

Clinical Practice. The findings of this study suggested that when a risk of suicide is suspected, the focus of the conversation can shift from open exploration of the issues affecting the client to one where organisational needs and priorities take over, leaving clients feeling not listened to. This has been highlighted by both service users (Spandler & Stickley, 2011; Webb, 2010) and clinicians (Smith et al., 2015). Rather than becoming restricted by a narrow risk model, clients could be supported to generate their own ideas for responding to suicidal despair, in ways that may not conform to services pre-determined ideas about ‘what works’ (Bourke, 2003).

By acknowledging that people who use services are active agents and authorities over their own lives, there can be more opportunity to privilege ‘other’ kinds of knowledge, such as local wisdom, experience etc. For example, enlisting suicide survivors as ‘knowledge consultants’ could offer a different way of ‘knowing’ about suicide from those who have successfully overcome despair. This may facilitate richer discussion amongst staff and service-users in which people are empowered to have different conversations, such as sharing strategies about overcoming adversity and “living through tough times” (Denborough, 2006). Previous research has suggested “preference-based approaches to suicide prevention” (p. 93, Klimes-Dougan, Klingbeil, & Meller., 2013) have led to an emphasis on choice, empowerment and engagement.

The findings suggest that clinicians are prone to imposing unattainable standards on themselves, which may limit the subject positions available to them. A

thoughtful approach is difficult to achieve if the system regards any death by suicide as a service failure. As such, it is argued that initiatives such as the “zero suicides” aspiration could adversely affect clinician behaviour by increasing the need for defensive practice and encouraging a ‘blame’ culture (Davies, 2015). Smith et al. (2015) suggest that a more realistic goal might be to aim for effective mitigation of suicide risk rather than the impossible task of eliminating risk altogether.

Chouliaraki and Fairclough (1999) suggested that the more stable discourses are, the less likely they will change. It is important that clinicians challenge the taken-for-granted ‘truths’ of suicide and question the individualising, pathological language that obscures issues of oppression and inequality. Other authors have suggested that social justice is served, at the micro-level, when clinical practice addresses issues of power, privilege and oppression (Jacobson, 2009).

It may be useful to draw on the current findings to develop training for professionals to explore how the language they use may embed particular meanings of suicide and create/limit subject positions. For example, a discourse of “fostering hope” constructed talking about suicide as fruitful and positioned service-users as resourceful, hopeful and seeking human connection.

Moreover, sharing a critical understanding with services-users could allow them to consider that there are multiple, flexible and politicized meanings of suicide and that no understanding is finite, natural or neutral (Kouri & White, 2014). Reflecting on different explanations could invite professionals and service-users take up different positions revealing different “solutions” and responses.

Research. DA can provide a useful way both of critically engaging with the assumptions implicit in policy, professional and survivor accounts and their effects.

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Future research examining survivor perspectives would be of interest in determining whether the constructions drawn on by professionals are also available in the language of service recipients. In addition, it would be of value to explore subjugated and alternative, localized knowledges to explore other ways of knowing about suicide. Further research studying the role of practitioners, service-users and families may be useful in understanding the role of larger economic, political and social structures and the interaction between language, power and institutions.

Conclusion

The suicidal person is both the cause and the casualty of harm, which brings challenges to the 'traditional sick role' for both professionals and SUs (Smith et al., 2015). Through a focus on language, this paper has questioned some of the taken-for-granted assumptions in prevention practices and suggested that the meaning of suicide is not natural, universal or fixed. The findings suggested that suicide was dominantly constructed as the final act of an unbalanced mind, with the causes and solutions located within the individual and requiring 'expert' treatment. The findings do not dismiss the painful reality of suicide or the expertise of professionals but do acknowledge that the dominant discourse risks disempowering clients and placing professionals in a position of inflated responsibility and false certainty. This is problematic as it risks encouraging defensive practices leading to service-user dissatisfaction and professional burnout. However, resistances were also at work. Subjugated discourses opened up language to embed new meanings, legitimize different perspectives and explore other ways of 'knowing' about suicide. Positioning suicidal people as active, authoritative agents may reduce the professional fear of being 'blamed'. It is hoped that can empower clients and professionals to engage in

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genuinely therapeutic encounters in which the meaning of suicide remains inherently uncertain but always open to exploration.

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Section C: Appendix of Supporting Material

Appendix A: Further Information Regarding Discourse Analysis Methodology

The review included literature that used various different types of discourse analysis. A brief description of each type is outlined below. This is intended as an exhaustive guide but is simply an outline for those who may be unfamiliar with discourse analysis. For a fuller account, the reader is directed to the listed references:

Discursive Psychology:

Potter and Wetherell (1987) described Discursive Psychology (DP) as an approach that constructs people as active sense-making agents who continually (re)create meaning through the tools afforded by language. Burr (2003) described DP as concerned with the role of language in social action. There is a particular focus on every day, local interactions and how people linguistically build accounts and make sense of events. DP tends to explore conversations and analysis is focused on the micro-level of interaction, such as what is said, by whom, how etc. (see Burr, 2003). DP has been criticized for neglecting broader social contexts such as social meanings (Parker, 1992).

Foucauldian Discourse Analysis:

Foucauldian discourse analysis FDA uses the historical and political tracking of documentation over time and the concept of power for interpretation. Analysis is particular focused at the macro-level, which enables FDA to critique taken-for-granted practices through exploring the overall relationship between language, power and institutions (see Willig, 2008). Foucault (1982) claimed that institutions hold power by producing particular discourses, which are then reproduced in interactions.

Critical Discourse Analysis:

Fairclough (2000) suggested that the basic premise of Critical Discourse Analysis (CDA) is that discourse is shaped by social groupings, culture and constructs and has the power to limit our knowledge and beliefs (see Fairclough, 2000).

Fairclough's (1989, 1995) model for CDA consists of analysis at multiple levels:

1. The micro – What is actually being talked about? What discursive devices are being used?
2. The meso – The processes by means of which the object is produced and received by human subjects. Who is talking? Who is the target audience?
3. The macro –The socio-historical conditions that govern these processes.

CDA has been criticised for combining multiple perspectives and ignoring different theoretical backgrounds. However, others argue that is simply has a different emphasis (Willig, 2001).

Appendix B: List of Analysis and Guidelines used in the Reviewed Papers

Table 2: Analysis and guidelines of the reviewed studies

Authors	Year	Type of Analysis	Guidelines/theoretical stance
Horsfall & Cleary	2000	Critical discourse analysis	Lupton (1992) Lupton & McLean (1998)
Bourke	2003	Discourse analysis	Healy & Mulholland (1998)
Fullagar	2003	Sociocultural, discursive analysis	Post-structuralism (specific guidelines not specified)
Roen, Scourfield & McDermott	2003	Critical discourse analysis	Garvey (1998) Holloway (1989) Parker (2005) Wetherell & Edley (1999) Wetherall, Taylor & Yates (2001)
Bennett, Coggan & Adams	2003	Discourse analysis	Potter & Wetherell (1987)
Fullagar	2005	Foucauldian/post-structuralist	Foucauldian literature on governmentality and risk theory
Gilchrist and Sullivan	2006	Social constructionist Grounded theory	Brown & Sullivan (1999)
Fullagar, Gilchrist & Sullivan	2007	Social constructionist Thematic analysis	Minichiello, Sullivan, Greenwood & Axford (1999)
Stevenson & Cutliffe	2007	Foucauldian discourse analysis	Foucault (1974)
Owens, Lambert, Lloyd, & Donovan	2008	Social constructionist thematic analysis	No guidelines specified
Jaworski	2010	Post-structuralist critique	Butler (1987)
Robertson, Paterson, Lauder, Fenton & Gavin	2010	Discursive action model	Edwards & Potter (2000)
White & Morris	2010	Critical constructionist discursive methodology	Hosking (2008)
Reynolds	2011	Social constructionist critique	Coats & Wade (2004)

Scholinsky-Dwyer	2011	Critical discursive approach	Wetherell, 1998
Westerlund	2011	Critical discourse analysis	Fairclough (1992)
Jaworski	2012	Post-structuralist, feminist critique	Bulter (1993) Hekman (1990)
Mac an Ghail & Haywood	2012	Foucauldian discourse analysis	Foucault (1981)
White	2012	Postmodernist/social constructionist critique	Gergen (2000)
Westerlund	2013	Critical discourse analysis	Fairclough (1992)
Kouri & White	2014	Critical social constructionist critique	Derrida (1967), Deleuze & Guattari (1972)
White & Kral	2014	Critical social constructionist critique	Gergen (2011)

Appendix C: Additional information for literature searches

A review of the literature was conducted. The study did not attempt to provide a systematic review of the literature but used the most relevant material for the study. The literature was searched on 3 occasions⁴ to ensure that the most relevant and up-to-date papers were included.

Initially a broad search was conducted to identify key terms for a specific literature search. Boolean search term 'AND' and 'OR' were used to identify papers specific to the review i.e. that considered both suicide 'AND' discourse 'OR' discursive.

A range of possible key terms were identified including:

[discourse analysis] or [discursive] or [narrative] or [language] or [social construction] or [conceptualization]

AND

[suicide] or [suicidal] or [death] or [self-murder] or [voluntary death] or [self-killing]

After refining the focus of the search, additional searches included the following terms:

[accounts] or [talk] or [critique]

AND

[self-harm]

⁴ Last searched 24/2/15

Appendix D: Flow Chart of Search Strategy

The searches resulted in 114 hits. All abstracts were read and full texts were sought if the abstract made reference to critique, language or construction and suicide (in line with inclusion criteria). Reference lists of all papers were hand-searched and relevant articles were included.

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Appendix E: Canterbury Christ Church Ethics Committee Approval

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Appendix F: Research and development consortium permission for research

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Appendix G: Letter Regarding Completion of Research and Summary Report

Runcie Court, David Salomons Estate
Broomhill Road
Tonbridge Wells
TN3 0FT
Email: ln95@canterbury.ac.uk

REC Reference:

Reference:

Dear Dr Pseudonym,

This letter is to inform you that the research project entitled: “The professional construction of suicide” has been completed. Many thanks once again for generously agreeing to participate in this study. This project has been written up in partial completion of a doctoral qualification in Clinical Psychology and has been submitted to the Salomons Centre for Applied Psychology at Canterbury Christ Church University for marking.

Please find attached a summary report of the findings from the research project. Should you have any queries about this project or its findings, feel free to contact me using the above details.

Many thanks,

Lucie Nalletamby
Trainee Clinical Psychologist
Salomons Centre for Applied Psychology

Research Summary Report

Research Project: **The professional construction of ‘suicide’**

Overview and aims

This research project was a qualitative discourse analysis study.

The study aimed to explore:

- How do professionals talk about the experience of working with people who are described as ‘suicidal’?
- What are the dominant and subjugated discourses that professionals draw on in talking about their work?
- How does this way of talking influence the actions and social positions available to professionals and people who use services?

The findings were analysed using a critical discourse analysis, using six-step guidance (Willig, 2008).

Participants

Participants were six clinical psychologists and four consultant psychiatrists working in adult mental health services. Discussions were audio recorded and transcribed by the author.

Summary of findings

Overall, five discourses were identified in the transcripts. These included three dominant discourses: ‘Not in your ‘right’ mind’, ‘blame’ and ‘human rights’. In addition, two (competing) subjugated discourses were identified: ‘contextualizing’ and ‘fostering hope’

A dominant discourse of “not in your ‘right’ mind” positioned feeling suicidal as a temporary, regrettable or irrational state that was located in the interiority of the individual mind or psyche. This was deemed to be accessible by using professional expertise and scientific tools, such as risk assessment. Suicidal feelings were positioned as a foreign entity, or attack on the person’s *true* self and served to legitimize “treatment” under a “duty of care”. The effect of this was to create binary subject positions, such as an “irrational”, passive patient and “rational”, knowing professional. This had implications for the agency of both professionals and service-users as professionals became responsible for ‘treating’ vulnerable people who are deemed unable to care for themselves. An effect of this could be to disempower the person positioned as ‘patient’ by privileging the voice of ‘experts’.

A dominant discourse of ‘blame’ constructed suicide as a direct outcome of the professionals’ worth/competence. This positioned suicide and therefore suicidal people as a threat to their sense of professional identity and competence. As such, professionals appeared to protect themselves by drawing on discursive resources to position themselves as “good, competent professionals”. The position as a *seen-to-*

be-good clinician was maintained through a range of practices such as “back-covering”, diligence, excessive paperwork, withholding information from colleagues and risk-aversion.

In contrast, a dominant discourse of “human rights” constructed suicide as a “rational choice” made by an individual with the “capacity” to make an informed decision. This discourse drew on an essentialist, self-determined and independent construction of self. This potentially created a tension for professionals by making the traditional role of the mental health professional unclear. However, this served to position service-users as capable and active in making decisions. However, this appeared to fluctuate depending on “capacity”.

There were some examples in which professionals drew on subjugated discourses that moved away from an individualized understanding.

A discourse of “contextualizing” positioned suicide as a form of communication potentially between significant others and services. This served to construct suicide as a solution to a social or relational problem, which may be contributed by others and/or maintained by professionals and mental health services. For example, suicide was constructed as an outcome of rejection from society and positive social contacts. This served to re-distribute focus away from the individual towards the relationships between people. In this sense, labeling the person as suicidal was seen as potentially obscuring oppression and inequality in wider society.

A discourse of “fostering hope” constructed talking about suicide as complex but also potentially positive: an action aligned with coping, hope and human connection. This constructed suicide talk as potentially useful, as providing comfort, fostering hope and indicative of ordinary human relating and expression. Thinking and talking about suicide was seen as a means of finding comfort and reassurance rather than simply the end of life. This positioned the person using services as resourceful, seeking ways to cope with adversity and feel connected with others. This legitimized talking about suicide as a useful and was seen as less threatening to professionals. Talking about suicide was constructed as a potentially helpful activity to be encouraged within services, therapeutic and other relationships.

Clinical and research implications

A number of implications are suggested including:

1. Clients should be supported to generate their own ideas for responding to suicidal despair, in ways that may not conform to services pre-determined ideas about ‘what works’. For example, preference-based approaches to suicide prevention have led to an emphasis on choice, empowerment and engagement.
2. Enlisting suicide survivors as ‘knowledge consultants’ in mental health services could offer a different way of ‘knowing’ about suicide from the perspective of people who have successfully overcome despair and mental health services.

3. Rather than working towards a goal of elimination of suicide within mental health services, a more realistic goal might be to aim for effective mitigation of suicide risk. An acknowledgment that neither professionals nor clients are likely to be wholly and individually responsible for a death by suicide may allow services to be able to focus on the client rather than becoming preoccupied with ‘blame’.
4. The findings suggest that individual language that may obscure oppression and inequality by offering individualized and pathological reasons for death. Exploring and addressing issues of power, privilege and oppression at the micro-level (in therapeutic interactions) may ensure that issues of social justice are made visible.
5. Teaching and training packages should be developed to help professionals become aware of how the language they use may embed particular meanings of suicide and create/limit subject positions.
6. Sharing a critical understanding with people who use services could allow them to consider that there are multiple, flexible and politicized meanings of suicide and that no understanding is finite, natural or neutral. Reflecting on different explanations could encourage professionals and service-users take up different positions, inviting different “solutions” and responses.
7. Future research examining survivor perspectives would be of interest in determining whether the constructions drawn on by professionals are also available in the language of service recipients. Further research would also be useful in studying the role of practitioners, service-users and families. Further qualitative research from a critical stance may help illuminate the larger economic, political and social structures of professional and healthcare institutions and the interaction between language, power and institutions.

Dissemination

It is intended that the author will disseminate the findings of the study through publication in The Journal of Mental Health.

Contact details

Researcher: Lucie Nalletamby (Canterbury Christ Church University)
Email: ln95@canterbury.ac.uk
Address: Salomons Centre for Applied Psychology
Canterbury Christ Church University
Runcie Court
Broomhill Road
Tunbridge Wells
TN3 0FT

Supervised by: Dr Ian Marsh (CCCU)
Ms Anne Cooke (CCCU)

Dr Rachel Bonel (Oxleas NHS Foundation Trust)

Appendix H: Feedback for Ethics Panel

Runcie Court, David Salomons Estate
Broomhill Road
Tonbridge Wells
TN3 0FT
Email: ln95@canterbury.ac.uk

Dear Canterbury Christ Church Ethics Panel

This letter is to inform you that the research project entitled: “The professional construction of suicide” has been completed and submitted for marking. Please find below a brief summary the findings from the research project.

Many thanks,

Lucie Nalletamby
Trainee Clinical Psychologist
Salomons Centre for Applied Psychology

Summary of Findings

The study aimed to critically examine the accounts of professionals, to explore how the concept of ‘suicide’ was constructed in language, together with the effects of those constructions for both thinking and practice. Semi-structured interviews were conducted with six clinical psychologists and four psychiatrists working in adult mental health services. Transcripts were studied using method of Critical Discourse Analysis. Three dominant discourses; “not in your ‘right’ mind”, “blame” and “human-rights” and two subjugated discourses; “contextualising” and “fostering hope” were identified. The findings suggested that suicide was dominantly constructed as symptom of an unbalanced mind, with the causes and solutions located within the individual. Professionals spoke about how, when risk of suicide was suspected, the focus of the conversation could shift from an open exploration of the issues affecting the client to one where organisational needs and priorities take over, leaving the client feeling not listened to. At times, suicide was constructed as a rational choice with a range of motivations. There were also examples of resistance to the dominant discourse when the meaning of suicide was constructed as complex, unstable and dependent on the (relational, societal and political) context. Participants described times when talking about suicide was seen as positive, representing hope and an attempt to re-engage with life. The findings do not dismiss the painful reality of suicide or expertise of professionals but do acknowledge that the dominant discourse risks disempowering clients and placing professionals in a position of inflated responsibility and false certainty. This is problematic as it risks encouraging defensive practices leading to service-user dissatisfaction and professional burnout. However, resistances offered an opportunity to open up language to embed new meanings, legitimize different perspectives and explore other ways of ‘knowing’

about suicide. Positioning suicidal people as active, authoritative agents may reduce the professional fear of being 'blamed'. It is hoped that the findings of the study can empower clients and professionals to engage in genuinely therapeutic encounters in which the meaning of suicide remains inherently uncertain but always open to exploration.

Appendix I: Advertisement for Recruitment

Runcie Court, David Salomons Estate
Broomhill Road
Tonbridge Wells
TN3 0FT
Email: ln95@canterbury.ac.uk

Dear colleagues,

I am a trainee clinical psychologist, conducting a research project exploring the ways in which mental health professionals (psychologists and psychiatrists) talk about, understand and work with suicide (and those labelled 'at risk of suicide'). This research is being completed as part of my doctoral training in clinical psychology at Canterbury Christ Church University (CCCU). I have attached an information sheet for full details.

I am hoping to recruit psychologists and psychiatrists who currently or have previously worked in the NHS, charities or private practice. Participants will be invited to meet with me to take part in an interview to explore their thoughts about suicide. It is anticipated that interviews will take approximately 1 hour to complete and can be conducted at your place of work or location of your choosing (or over the phone if preferred).

Please contact Lucie Nalletamby on 01227 782900 or email on ln95@canterbury.ac.uk <<mailto:ln95@canterbury.ac.uk>> if you are interested participating or would like any additional information.

I am very grateful for your interest and participation in this project. If you know of others who may be interested in this research or would like additional information, please forward these details onto them.

Many thanks,

Lucie Nalletamby
Trainee Clinical Psychologist,
Salomons Centre for Applied Psychology,
Canterbury Christ Church University

Appendix J: Research Information Sheet



Information Sheet

Research Project: The professional construction of suicide

I am a trainee clinical psychologist conducting a major research project in partial completion of a doctorate in clinical psychology at Salomons Centre for Applied Psychology, Canterbury Christ Church University. I hope you will consider participating in the following study. Before you decide whether you would like to take part or not please read the following information, which outlines the key issues in the study.

This research has been approved by Canterbury Christ Church University ethics panel.

Purpose of the study

Primarily, this study aims to explore professionals' experience of suicide. The study will consider how professionals talk about and understand their experience of suicide and working with individuals labelled 'at risk of suicide'. It is hoped that the study will increase our understanding of some of the discourses that are available to professionals and the impact of this for people who may use services. It is hoped that this research will be of benefit to individuals who work for and use services by questioning some of the taken-for-granted ways we talk about suicide. I would be very grateful for your participation in this study.

Who is invited to take part in the study?

I hope to interview 10 – 12 psychiatrists and psychologists who currently or have previously worked in the NHS with individuals who present with a 'risk of suicide'. Please note that participation in this study is on a voluntary basis. If you are happy to take part, you will be provided with this information sheet and asked to sign a consent form. However, you have the right to withdraw from the study at any point before or during the study, without giving a reason. Participation in this study will be kept confidential.

What happens if I decide to take part?

You will be asked to take part in an interview with me, which is expected to last between 45 minutes and an hour. The interview is interested in your perspective and experience of working with individuals who present with a wish to die. The interview will be audio-recorded for analysis.

The interview can take place at your work-base or an alternative location depending on your preference. Interviews can also take place over the phone.

Personal Issues

I appreciate that talking about professional experiences, particularly around suicide may be highly sensitive. I understand that many participants will have had experience of working with individuals who may have completed a suicide and that this is likely to raise difficult and uncomfortable feelings. If you have had a direct personal or professional experience of suicide within the last 6 months or believe that these feelings likely to be particularly distressing for you, you should not take part in the study.

For those who do wish to participate, please only answer the questions that you feel comfortable with. There will be an opportunity to debrief and discuss your experience of the interview after completion. Should you have other questions or if you would like more information on any aspect of the project, please leave a message for Lucie Nalletamby (trainee clinical psychologist) at 01227 782900 or email on ln95@canterbury.ac.uk.

Alternatively, please contact Dr Ian Marsh (Academic Supervisor), Ms Anne Cooke (Clinical Psychologist and academic tutor at Canterbury Christ Church University) or Dr Rachel Bonel (Clinical Psychologist at Oxleas NHS Foundation Trust) who are supervising the project.

Confidentiality and anonymity

If you choose to participate, please be aware that you have the right to withdraw at any time, without giving a reason. Transcripts of the recording will be typed up and stored in a locked filing cabinet. Audio recordings will be saved on a password-protected USB stick and also stored in a locked cabinet. Only myself, Dr Ian Marsh, Anne Cooke and Dr Rachel Bonel will have access to this information. This information will be kept for 5 years after the study is completed, after which point it will be destroyed.

After the work has been assessed you will be sent a copy of the write-up. It is hoped that the project will be written up for publication in an academic journal to contribute to the existing knowledge base. You will not be identified in either the report or publication; however, extracts from the transcripts may be quoted. All quotes would be anonymised and will contain no identifiable information.

Contact details

You are welcome to contact me (or the project supervisors) for further information or to discuss any aspect of this study:

Lucie Nalletamby (Researcher)

Address: Salomons Clinical Psychology Training Programme, Canterbury Christ Church University, Broomhill Road, Southborough, Tunbridge Wells.

Tel: 01227 782900

Email: ln95@canterbury.ac.uk

Appendix K: Research Consent Form



Participant Consent Form

Research Project: The professional construction of suicide

Thank you for agreeing to take part in this research project. Please read the following information carefully, print and sign below if you are happy to participate. By signing this form, you are agreeing to the following statements:

- I have been given an information sheet and fully understand the aims and nature of the study. I have been given the opportunity to ask any questions.
- I understand that the interview will be audio recorded. I understand that the audio recording will be stored in a locked cupboard on a password-protected USB stick, which will be destroyed after the work is assessed.
- I understand that the findings of this study may be written up for publication.
- I understand that all identifiable information will be treated with the strictest confidentiality and in accordance with the Data Protection Act (1998). I understand that no identifiable information will be available either in the final thesis and any subsequent publications.
- I agree to participate in this study and that the information I provide will be used for research purposes only. I understand that I have the right to withdraw before or during without giving a reason.

Participant's signature*

Date

Lucie Nalletamby
Trainee Clinical Psychologist (Researcher)

Date

**Participants wishing to preserve some degree of anonymity may use their initials (from the British Psychological Society Guidelines for Minimal Standards of Ethical Approval in Psychological Research)*

Appendix L: Interview Schedule

Interview Schedule

- Can you tell me a bit about why you agreed to participate? What's your relationship to the topics?
- What are your thoughts about why might people have a wish to die?
- How do you make sense of the link that is made between mental health problems and suicide?
- Are there instances in which suicide might be a justifiable/possible option?
- What are your thoughts about prevention?
- From your perspective, where does the responsibility lie when somebody completes suicide?
- Are there things that you find difficult about working with people who are suicidal?
- In your experience, are there things that don't get talked about in relation to suicide?
- Is there anything you find troublesome or problematic about suicide? or services response to suicide?

Appendix M: Study Protocol

Study Protocol

Measures

The following measures will be required for the procedure:

- Information sheet
- Consent form
- Interview schedule

Before the interview

- Participants will be guided through information sheet
- Participants will be guided though the interview prompts but are advised that it is hoped the interview will be an opportunity to have conversation about the matters they feel are relevant to the topic area.
- Participants will be asked to read and sign the consent form.
- Advised that interviews will be recorded (if consent is provided) or notes will be taken if preferred.
- Participants will be advised of the procedures related to confidentiality and their rights as a participants i.e. that they have the right to withdraw at any time etc.
- Participants will be advised that they will be debriefed at the end of the interview.
- Participants will be offered the opportunity to ask any questions

During the interview

- If participants consent to participation they will be invited to take part in the interview.
- It is anticipated that the interview will last 50 – 60 minutes.
- The researcher will use an interview schedule with open-ended questions and prompts to facilitate exploration of suicide.
- The researcher will also explore the participant's interest and motivation in participating in the research as appropriate.
- Participants will be encouraged to only answer questions they feel comfortable with.

After the interview

- There will be an opportunity to debrief and discuss the experience of the interview after completion to ensure that there are no lasting negative or unforeseen consequences of the study.
- Participants will be given the opportunity to ask any further questions
- Participants will be asked whether they would like to receive a summary of the findings once the project has been submitted for marking to Canterbury Christ Church University
- The researcher will ask whether the participant is still consenting to the material recorded and its use within the analysis and write-up will be sought.
- The researcher will explain next steps and offer advice about sources of on-going support (if required).

Appendix N: Abridged Reflective Journal

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Appendix O: Annotated Transcript

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Appendix P: Example Segment of Coding Book

Discursive constructs (stage 2) What is the subject/object constructed?	Action orientation/functions of the construct (stage 3) What is the language doing? (MICRO)	Subject positions (stage 4) How does this position clinician, client, external and me? (MESO)	Practices (stage 5) How does this impact clinical practice? (MACRO)	Ways of understanding (stage 6) made legitimate/illegitimate What wider perspectives/knowledge does this legitimize? (MACRO)	Example quotes (Transcript, Lines)
Suicide as going against human natural 'will' to live. Suicide as taboo.	Suggests that some humans live through immense pain and suffering and do not want to die, which suggests that someone wanting to die is unnatural, difficult to speak about?	Positions the clinician as understanding to me. Positions suicide as going against the human 'will to live' – positions the suicidal person as weak? Not strong? Different to others – against humanity? Not able to cope with adversity?	Perhaps legitimizes people who suicidal as different and understood in terms of mental health problems? Something to be understood? Drawing on a neo-liberal ideology.	In the context of a discourse of human rights! Wider societal philosophy of humanist value – every person should have rights and these should be held in upmost	"I mean, I suppose it's like doctor assisted suicide, I understand why people might want to do that and its something I couldn't do and there is such a strong will for people to live. You know people live in dreadful circumstances sometimes and yet they carry on living in all these warzones, how do people carry on living? There is just such a strong will to live that I suppose someone not wanting to live is taboo" (T8, Lines 150 – 154).
Suicide as understandable in the context of psychosis	Allows for understanding about the desire to die when associated with 'psychosis'. Medical terminology used as an explanation.	Positions the suicidal person as escaping from a chronic illness (parallels between physical and mental health). Limits the understanding of a desire to die to the impact of psychosis diagnosis - removes context. Positions individuals with psychosis as likely to want to die. Positions the clinician to me as understanding and having empathy.	Strengthens the association between 'psychosis' and a desire to die – emphasizes that the diagnosis may increase the risk of death. However, in some sense offers less clarity (see quote 2).	Legitimizes the understanding of suicide through a diagnostic frame – validates diagnostic categories. Draws on wider implications of suicide as a pathological – offers a way of making sense to protect the clinician and the person from responsibility but explains too.	"You know to be quite honest, with her, I can see why, I could see why see would do that, I could see why you would, you know, there is a high suicide rate after first episode psychosis and its not really surprising because it's a horrible illness schizophrenia or it can be" (T8, Lines 155 – 158). CONFLICT "I think also as well with the suicides, I've not had a really psychotic person kill themselves, you know with the girl who killed herself she was really depressed and that's more understandable, but the impression I get is when somebody who is psychotic kills themselves its really like because its so detached from reality, it is really difficult to understand... you know so I wonder if that you'd have different feelings...." (T8, Lines 280 – 284).
Suicide as contextual. Suicide as gendered.	The language allows for alternatives understandings of suicide (outside of MH). Suggests that suicides have a distinct cause and can be understood (partially) through a gender lens.	Reliance on statistics positions the clinician as scientific and knowing. Positions clinicians and clients as able to know what are the causes of suicide. Positions young men as more likely to die by suicide.	Illegitimises the use of a mental health frame – broadens scope for other ways of knowing? Limits the use of clinical practice.	Gendered discourse in which the act of self-inflicted death is a male phenomena.	"I think the statistics are, I can't remember off the top of my head but something like 50% of suicides are not anything to do with mental health and very few are. A very small proportion of people have seen a psychiatrist in the last year so most suicides are not to do with mental health but are to do with something else and you know... its young men and I can't remember the risk group for women... yeah, its not always mental health (T10, Lines 171 – 176).

<p>Suicide as a study of mind – internal and unseen (What was going on in their minds?)</p>	<p>The language functions to focus attention on the mind of the person who is suicidal – encourages looking inwards to the individual motivation.</p>	<p>Positions her as unsure to me – thinking and open as a thoughtful clinician – moral positioning.</p> <p>Positions understanding of suicide as by looking in the mind, interiority of the suicidal person.</p> <p>Positions the suicidal person as different? Silences the voice of the person?</p>	<p>Legitimizes study and assessment of suicidal mind – observation and objectification of person. Legitimises therapy and mental health professions to look into the mind.</p>	<p>Stops us looking outside of the person.</p> <p>Individualized perspective reduces the act to the interiority of the mind. Interesting in the context of neo-liberal society in which everyone is responsible for themselves! Can't see the 'cause' anywhere else. Protective?</p>	<p>"I think that most people try and establish that people weren't in the right, in a good frame of mind. I don't know do you have to be depressed to do it but I suppose it depends on your personality. I'm not sure (laughs) (T1, Lines, 177 – 179).</p>
<p>Clinicians are only allowed to feel sad when a client kill himself or herself – If they feel anything else it must not be communicated</p>	<p>There are a range of feelings that may come up for clinicians around suicide but only socially acceptable feelings should be expressed (must be "contained").</p>	<p>Positions clinicians (to me) as having a range of feelings towards suicide (humanizing and normalizing) but towards the client and family as professional, empathic and understanding.</p>	<p>Narrows the range of emotions that are socially acceptable for clinicians to express publically or think about with colleagues – protecting professional image as a 'kind and caring' professional.</p>	<p>Legitimizes that clinicians can only talk about their true feelings privately and that publically they remain empathic and caring.</p>	<p>"Ummm... I suppose you can always gets feelings of anger and frustration and you have to recognize those and contain them when you are with people... you know the one where the man fell on the train tracks [...] I ummm... I suppose I just felt like oh crikey not another you know it sounds horrible but he's just making my life more and more difficult this man and he was, he killed himself, and that's a horrible feeling to have ummm but it was a feeling that I had.....ermmmmm" (T8, Lines 254 – 268).</p> <p>"so rather than it, so the first one I could feel sorrow and sadness and those sorts of likes.... And here it was difficult cause I didn't really like him and that was more difficult actually because I didn't like the patient, I didn't like the family, you know, not that I behaved any differently to them but you know I think one I felt more angry than anything else that he done this thing and you know that is a horrible feeling to have because they lost a child..... which is really sad..... ermmmmm... so yeah" (T2, Lines 263 – 268)</p>
<p>Difficult feelings as a legitimate reaction to suicide.</p>	<p>Justifies that it is ok to experience difficult feelings – baked up by scientific explanation (psychoanalytic training - legitimate).</p>	<p>Positions the clinician as a good person despite having negative feelings towards the client.</p> <p>Clinician must remain competent and professional to others – maintains moral, professional position.</p>	<p>Hiding true feelings to family and others.</p>	<p>Legitimizes socially unacceptable feelings such as anger and rage towards the clients – but only within the private sphere or amongst professionals.</p>	<p>"... well like I've done some sort of psychoanalytic training and just the when someone is depressed the feeling that it arouses in themselves and you in anger... it often not sorrow, its frustration and angry and that's quite a common counter-transference. So I think helpful to know that and to..... Be able to contain that.... Yes... uncomfortable feelings...." (T4, Lines 271 – 275).</p>
<p>Risk as a subjective/dependent on external factors and tolerance of clinician.</p>	<p>Locates the way suicide is responded as dependent on resources, which have been reduced (by someone out there), which has a direct effect of how people with a wish to die are managed and how clinicians understand their risk of suicide.</p>	<p>Positions the clinician as powerless in offering treatments and managing competing demands – balancing lack of resources with patient safety.</p> <p>Treatments held by someone external (clinician as a middle manager).</p> <p>Positions the client as voiceless.</p>	<p>Legitimizes a particular pathway for treatment and why people who are suicidal may not be 'kept safe'.</p> <p>Positions the clinician as free from blame for not using the aforementioned pathway.</p>	<p>Risk as decide by the clinician</p>	<p>"And you know hospital admissions now are so short that they probably do keep people safe but the thresholds for everything are a lot higher, like the threshold to come and see me is a lot higher and the thresholds for me to refer to the CRT are a lot higher and to get someone into a bed is really, nearly impossible.... So I think that maybe that changes your tolerance of risk and I know I have spoken to people who work on the assessment ward and the consultant there was saying that they take you know, thought about risk but they take more risks than they would have done previously because you know that's the situation with the beds and generally I don't think that's impacted on suicide and so on" (T1, Lines 295 – 302).</p>

<p>Doctors as the experts of suicide – power knowledge – specialist knowledge.</p>	<p>This offers an explicit and implicit instruction about power and shows a risk to the team if they do not keep the doctor as the most powerful.</p>	<p>Publically positions clinicians as making decisions within a team. However, implicitly positions them as powerful and holders of knowledge about who is suicidal. Doctor as an expert – “experienced clinician” and able to read if a person is unwell.</p> <p>Positions the client as passive and to be examined by clinicians.</p> <p>Positions the team as passive to listen to the doctor.</p>	<p>Maintains the existing power structures and hierarchy – the doctors as the person who holds the truth about whether someone needs to be in hospital – knowledge power.</p>	<p>Doctors as the experts and holders of the truth about suicide – Hold the knowledge about suicide.</p>	<p>“you know cause I think in the old days it was about the doctors saying who goes in and out and that’s not in my power anymore and lots of people say ‘just cause you’re a doctor’ but actually I am quite an experienced clinician as well and if I think somebody is unwell it would be quite a big risk to not listen and I haven’t found that in this trust but I think that does go on...” (T5, Lines 310 – 314)</p>
<p>Completed suicide as leaving the network (families and clinicians) as ambivalent and lost.</p>	<p>Justifies a lack of communication with the family after suicide – cites the potential for the team to be held responsible for the death of the person and mixed feelings for the family.</p>	<p>Positions the family as in need of additional help and the team as expert but ambivalent about being able to help the family.</p> <p>Positions the clinician to me as helpful and concerned.</p> <p>Team as vulnerable to blame, guilty and ashamed – suggests that team have failed when there is a suicide.</p>	<p>Legitimizes not working with the family after suicide as they may have ambivalent feelings.</p>	<p>Legitimise avoiding talking about suicide. Questioning the taken-for-granted practice. People don’t talk but not sure why?</p>	<p>“There is a lot of experience within the team that could help and I don’t think that necessarily... It doesn’t always happen and I’m not quite sure why, whether it’s the family partly and the team not really wanting it because it’s a bit shameful that this person dies or it’s a bit difficult that this person died... and maybe that’s not the right people either because maybe if there is some blame there to go along... but yeah... I don’t know how much help people get after a suicide...” (T9, Lines 333 – 338).</p>
<p>Talking about uncertainty and distress about suicide is only ok amongst peers - Doctors should be seen to ‘know’ about suicide.</p> <p>Doctor as the container and person with the answers – stay strong.</p> <p>Constructs emotion about suicide as shameful and unprofessional and destabilising for colleagues.</p>	<p>Places importance on the need to talk about suicide and question practice but that this can be dangerous for the team so should be done with those who understand (i.e. doctors who have had the same experience).</p>	<p>Positions the doctor to me and other doctors as vulnerable, uncertain and questioning of her skills.</p> <p>However, positioned herself to the team as strong and unaffected by the suicide.</p> <p>Questions whether that is right or wrong to me – Positions me as knowledgeable about how one should deal with suicide – manages own identity about being a ‘good’ clinician – doing things the ‘right’ way.</p>	<p>Legitimizes peer support from other doctors and supports the practice of a strong and paternalistic doctor with the right answers.</p> <p>Makes becoming distressed with colleagues unacceptable.</p>	<p>Reinforces the power structures and hierarchy and the doctors as correct and certain. Societal perspectives about authority. “Technologies of authority” – who gets to say what is true!</p>	<p>A bit... I mean... a bit but its quite funny because I’ve sort of felt that I need to... [talk about suicide] you know... you can’t kind of break down in front of your team... you know not break down, but have the feeling difficult feelings about well am I blame, I didn’t want to do that in the team... I wanted to do that separately with other doctors who have experienced the same thing... so I didn’t ever do that with the team” (T6, Lines 342 – 349).</p> <p>“Well I suppose they are such strong emotions that get raised you think is that appropriate for work? Is that almost something that you have to do sort of separately caused its interesting the role of the consultant, you know, the training that we get is that you, even if you are struggling, you know, you are the container, the parent figure or whatever (laughs) that you do try and contain everything, contain the teams anxiety and help them to process things and do your own stuff separately I think that’s kind of what doctors do... I mean I don’t know whether that’s right or whether there should be sort of more shared responsibility for that I don’t know, I don’t know....” (T7, Lines 351 – 358).</p>

Appendix Q: Progression of theme development

Constructing suicide, illness and danger: Threat to the client and the professional self

- **Suicide as 'not in your right mind'**

Illness – a malfunctioning mind/ a product of mental health problems
Suicide as related to mental illness and personality disorder
Suicide as irrational
Suicide as an understandable symptom
Patients are not logical because they are unwell.
Suicide as an irrational or a complication or symptom of illness
Suicide as indicative of illness
Suicide as understood through disorder and mental health diagnosis – related to mental health
Suicide as 'not in your right mind' – not illness.
Suicidal people as unwell

Regrettable – a poor decision that one will later regret

Suicide as transient – something that could be regretted.
Feeling suicidal as a state that can be turned on or flipped into - disconnection and un-reality?
Suicide as likely to be regrettable/irrational (not the person's true identity)
Suicide as transient / regrettable

- **Suicide as unpredictable – IT CAN COME OUT OF NOWHERE!**

Suicide as unpredictable (uncertain) and scientific understanding as limited.
Suicide as unpredictable – professionals balancing what we know with what we don't know.
Suicide as unpredictable

- **Risk: observable and objective**

Suicide as visible – to be seen and examined by the clinician.
Sharing the knowledge reduces the responsibility – risk is shared.
Constructs suicide as a joint responsibility between clinician and client.
Clinicians as responsible for carrying and transmitting information re suicide
Risk as shared between client and professional but suicide as a choice
Constructs risk as a tangible entity that makes the clinician uncomfortable and is undesirable – sliced up amongst the team to tolerate it more.
Responsibility is negotiated.
Risk assessments as reducing anxiety – RA help to talk about suicide in the 'right' way.
The right way to manage risk.
Responsibility and risk as a tangible construct! Something to be taken and given and owned?
Risk as tangible – passed from patient to professional and along the professional hierarchy
Risk as something that can be collaboratively managed by the client and clinician.
Responsibility constructed as up for negotiation – something to be decided between client and clinician.

- **Risk as intangible and subjective**

Risk as a subjective/dependent on external factors and tolerance of clinician.
Risk [of suicide] as a something changeable
Professionals can never *truly* be certain about suicide.
Clinicians feelings as indicative of increased suicide risk.
Suicide as feelings to be read by clinicians.
Judgments about suicide as dependent on the clinician's beliefs and their view of the client.
Risk aversion = increase suicide talk
Dependent on values of the clinician
Risk as intangible

- **Talking about suicide as dangerous**

Understanding context can be dangerous.
There is a risk to the professional if they understand too much.
Professionals must not legitimize suicide.
Suicide talk as dangerous and painful

Suicide is difficult to talk about amongst staff – There is a risk that staff will not talk about it, which could make it more dangerous.
Suicide as difficult to talk about.
Suicide as difficult to discuss and raising painful feelings in the team – Easy to not talk about.
Suicide talk as dangerous/painful.
Suicide as evoking painful feelings.
Extended distress/suicide talk is difficult to tolerate.
Talking about suicide could increase the risk.
Suicide as a taboo subject
Positions suicide as something that is difficult to talk and needs expert training
Talking about it makes it worse/REAL. Talking about it means you have to take actions.

Negotiating responsibility

Seen to be responsible

Clinicians as callous if they don't feel responsible – Moral duty of clinicians.
Clinicians having clinical skills to prevent suicide.
Clinicians are only allowed to feel sad when a client kill himself or herself – If they feel anything else it must not be communicated.
Suicide is something that you can get wrong or right!
Doctors as the experts of suicide – power knowledge – specialist knowledge.
Talking about uncertainty and distress about suicide is only ok amongst peers - Doctors should be seen to 'know' about suicide.
Doctor as the container and person with the answers – stay strong.
Suicide raising uncomfortable feelings – specialist? Can only be tolerated by particular people?
Some staff are unable or can't work with suicide – Bad staff?
Most professionals do not have the skills to prevent suicide.
Suicide as a symptom to be detected by specialist doctors.
Suicide can be hidden and requires specialist detection and expertise.
Specialist knowledge needed for suicide – learn from experience or specialist tools.
Experts need to work with suicidal people – only they have the skills.
Suicide as raising anxiety in the professional – staff as responsible.
Doctors as responsible/liable for suicide.
Professionals as responsible for suicide – NEVER HAPPEN in the NHS (taboo)
Clinician as a specialist
The act may not preventable but clinicians can treat the underlying distress and cause.
INTERNALISATION OF RESPONSIBILITY.
Two heads are better than one – useful to work with other members of the team – reinforce 'expert' opinion "we both think the same".
Individuals as accountable but not responsible.
Professionals know what's best
DUTY OF CARE! We have to deprive people of their liberty
TAKING AWAY LIBERTY
Suicide risk as negated by communication between professionals.

Suicide as inevitable

Suicide as "a risk of the job" – Everyday.
Inevitable part of mental health services.
Suicide as inevitable
Suicide as an occupational hazard
Suicide as a random act/unpredictable
Suicide as inevitable.
Clinicians as unable to predict risk of suicide – discrepancy between assessment of risk and suicide.
Suicide as out of the blue (unpredictable).

Suicide as preventable

Suicide as preventable
Suicide as preventable – at a public health level.
Responsibility – negotiation. Suicide as preventable on a public health.
Suicide as a preventable? Public vs. personal
There is lots of complexity but the bottom line is the psychiatrist must prevent suicide.
Suicide can be prevented by minimizing human error.
Suicide as a technical fault.
Preventing suicide means placing responsibility with the clinician
Suicide as preventable

Suicide as a threat to professional integrity - Clinicians as blameworthy, scapegoated and persecuted

Competence

Suicide as an outcome of a professional's worth
BADGE OF HONOUR!
Risk to clinicians – risk of suicide and risk of blame/incompetence.
Suicide as evoking *feelings* of professional incompetence
Good and bad ways of working with suicide.
Shared responsibility as managing clinician's negative feelings of responsibility.
Suicide as indicative of 'competent' practice (counter - discourse? Reflects well on clinicians)
Outcome of professional worth – Prove their worth to justify power, money and status
Risk-tolerance as a poor practice? (APPROACH TO RISK AS INDICATIVE OF COMPETANCE)

Clinicians carry on after suicide because you heal with time and cannot continue to blame yourself
Documenting risk reduces risk and liability – "It's all been documented"
Constructs suicide as a risk to both the suicidal person (death) and risk to clinician (bad doctor - responsible).
Back covering - "Make sure it's documented!"
Suicide can make the professional become risk averse
Professional as responsible for detecting the suicide
Individual blame against clinicians from management
Professionals as responsible for suicide – SCAPEGOATED?
Suicidal people as a "ticking time bomb"
Clinicians as responsible - Doctors as liable for suicide (mistakes).
Suicide as a risk to the professional
Back-covering limiting practice and stopping colleagues from talking openly and honestly.
Suicide as a threat to professional status (clinicians as liable).
Risk assessment as a paper exercise – no meaning for the client
Documenting reduces risk of suicide
Services as risk-averse as a result of culture of blame towards the clinicians.
Staff need to feel supported by management to tolerate feelings of risk – Ensure that they will not be blamed.
Someone must be held accountable!!
Been seen to be in line with colleagues – avoiding blame and being seen as incompetent
Blame for responsibility for suicide coming from self as well as coming for the trust.
Good clinicians will not be blamed – ONLY poor clinicians are criticized
Discourse about whether the trust can be trusted?
Clinicians as persecuted
Risk assessments as protecting professionals

CONSEQUENCES OF BLAME

Stress leads to risk aversion – Clinicians needing support in managing risk.
Positive risk taking presented as a counter to mainstream MHS
Other professionals reacting in unhelpful ways.
Professionals ignoring suicide talk.
RISK AVERSION AS NEGATIVE AND UNHELPFUL

Privatization of suicide: An individual issue

- **Suicide as an individual issue – underlying psychological problem**

Suicide as a study of mind – internal and unseen - What was going on in their minds?
Suicide as a way out of ending an internal battle (individual, internal, unseen, distress).
Thinking about suicide as a dissociated state – including pleasant feelings but not real.
Suicide (A wish to die) as a dynamic internal entity that can be accessed by the individual (as if a physical ailment? Tracking a rash?) – Reported and mapped with the clinician
Suicide as an outcome of individual faulty thinking.
Suicide as an escape from internal intolerable pain
Intentionality?
Decision to end personal uncertainty.
Suicide as the end of a struggle.
Suicidal person as distressed and suffering – in need?

- **US and THEM - Suicide as shameful?**

Do not talk about our own experiences of suicide – US and THEM – **SUICIDE DOES NOT HAPPEN TO US!!**
Constructs emotion about suicide as shameful and unprofessional and destabilising for colleagues.

Suicide as engaging with life

- Suicide thoughts/planning as offering a nice experience
- Suicide as something positive?
- Suicide as a coping strategy
- Suicide as meaningful and something to be looked at rather than feared.
Fostering hope

Suicide as a relational, societal and even political issue

Relational

- Suicide talk as meaning different things and contextual.
- Suicide as a message to others – indicative of distress rather than an intention to die.
- Suicide as a non-verbal act to communicate distress.
- Suicide talk as a means of conveying distress and seeking protection
- Suicide as a communication to other people in a mental health population.
- What is the meaning of suicide? Real or message?
- Death of a family member as a relief

Societal

- Suicide as a response to stigma in society – not fitting into a expected role?
- Suicide as contextual.
- Suicide as gendered.

Political

- Who gets to decide what is risky? Power to speak about suicide!!!
- Suicide as related to societal/economic factors (suicide as political)
- Professionals vested interest in a medical model

Appendix R: Procedural Guidelines for the Discourse Analysis (Willig, 2008)

1. *Discursive constructions*: Highlight all instances (explicit and implicit) of the discursive objects⁵ (DO) in the transcripts (what the person is talking about). After repeated re-readings of the texts four DO were considered relevant; 'suicide', 'suicide talk', 'risk' and 'suicidal person'. The different ways in which these discursive objects were described was then explored.
2. *Discourses*: Once the different discursive objects had been highlighted, the difference between these objects were explored and located within wider discourses, which is useful for showing what might be taken-for-granted within a particular culture (Potter & Wetherall, 1987).
3. *Action*: Next the author explored the possible functions of these constructs and how these may relate to other constructs within the surrounding text and what these various constructions may be achieving (or limiting) within the text.
4. *Subject positions*: Following this the author explored what particular subject positions are offered or limited by the constructs?
5. *Institutional practices*: What practices are seen as legitimate behaviours or actions as a consequence of these positions and constructs?
6. *Subjectivity*: Explore what effects these subject positions have upon the speaker subjective experience i.e. what may be thought, felt and experienced. How does the subject position of a clinician or a service-user allow individuals to speak about suicide? How does this subject position offer a perspective from which to view reality and moral location?

⁵ 'Discursive objects' refers to the concepts that are the focus of the study. In this case, 'suicide' or 'risk' etc.

7.

Appendix S: Audit trail

Audit trails document the course of development of the completed analysis. *Lincoln & Guba (1985)* have suggested six elements that comprise an audit trail. These are outlined in the table below

Audit trail element	Location of 'evidence'
Raw data	<ul style="list-style-type: none"> • Interviews were conducted • Notes of interest were made during the interview • Notes were made in a reflexive journal (appendix N) immediately after the interview • All interviews were audio-recorded and stored on a password-protected USB stick. • Interviews were transcribed by the author. • Transcripts were carefully read.
Data reduction and analysis products	<ul style="list-style-type: none"> • Transcripts were re-read and initial annotations or "codings" were documented for initial thoughts. • Initial codings from two transcripts were reviewed with academic supervisor, experienced in DA. • Codings were expanded upon using a coding book (appendix P) • Sections of coding book were reviewed and discussed with academic supervisor.
Data reconstruction and synthesis products	<ul style="list-style-type: none"> • Similar codings were grouped together to form initial constructs/ objects of interest (appendix Q). • Initial 'mind map' of codes completed with both academic and field supervisors.
Process notes	<ul style="list-style-type: none"> • Reflective diary kept throughout the research process • Reflective interview completed with a colleague to explore the researchers own place within the discourse.
Materials relating to intentions and dispositions	<ul style="list-style-type: none"> • Reflective diary kept throughout the research process
Instrument development	<ul style="list-style-type: none"> • Pilot interview completed with psychologist to develop interview questions and procedure for the interview. • Interview questions discussed with Salmons Advisory Group of Experts (SAGE) by experience and feedback incorporated

Appendix T: Author guidelines for submissions to ‘Suicidology Online’

The empirical paper (Section B) will be submitted for publication to ‘Suicidology Online’, in line with the following guidelines.

Dear Author:

Please check for formatting errors when preparing your manuscript revision in APA, 5th edition.

Appearance and Presentation

- no bolding
- no font sizes other than 12-point
- no unacceptable font (e.g. a serif or compressed font)
- no single-spaced text
- no triple or quadruple-spaced text
- no full-justification – all right hand edges should be left “ragged”
- no margins of less than 1 inch on any side
- order of sections as follows: Title page; Abstract (separate page); text (starts on new page) with introduction, Method, Results, and Discussion; References (starts on a new page); Appendixes (new page); Author Notes (new page); Footnotes (new page); Tables (each on a new page); Figure Captions (list together, starting on a new page); Figures (each on a separate page, with figure number and ‘top’ indicated on reverse)

Cover Page

- page header and page number properly done, top of each page, flush right
- running head: ALL IN CAPITALS, flush left
- running head shouldn't exceed 50 characters
- Title, upper- and lower- case, centred
- author and affiliation, upper- and lower- case, centred
- if paper is to receive masked review, also place author note on title page, following bylines and affiliations
- nothing underlined on cover page

Abstract Page

- word “Abstract” top of page, centred
- only one paragraph
- paragraph not indented
- length of no more than 250 words

Body of Paper

- title as it appears on the cover page, centred, at top of page 3
- word “introduction” unneeded – this is assumed
- subheadings may be used in the introduction, but must be centered, italicized, uppercase and lowercase

Method Section – Specific Formatting

- immediately follows the end of the introduction (does not start on a new page)
- The section title “Method” is centred, upper- and lower- case
- Subsections (e.g. Participants, Materials, Procedures, or appropriate alternatives) are flush-left, upper- and lower- case, italicized. Text begins on next line.
- sub-subsections indented, upper- and lower- case, italicized, followed by a period, then text begins on same line.

Results Section- Specific Formatting

- Immediately follows method section (does not start on a new page)
- The section title “ Results” is centred, upper- and lower- case.
- Subheading structure, if present, follow same structure as method section.

Reference Section-specific Formatting

Note: because there are so many variations in publications and the way they are typed in the reference section, only the most common sorts of errors are listed here.

- References start on a new page
- Section heading “References” centred, upper- and lower- case
- First line of each reference is flush left, and subsequent lines indented
- References in proper alphabetical order
- Author(s) first name initials only
- Comma before ampersand, even for two-author articles
- Use of &, not the word “and” to join author names
- Only first word of title of book or article, or first word following a colon is capitalized
- All significant words in title of a journal are capitalized
- Title of journal or book is italicized
- Italicizing of journal title goes all the way to the volume number, except if issue number is included in parentheses
- There is no dash between the page number
- For books, location comes before publisher
- For edited volumes, the abbreviation for editor is Ed. or Eds.
- Only single space after periods in reference section

Appendix Section Formatting

- Section title “Appendix” centred, Upper- and lower- case
- If more than one appendix, they are identified with capital letters A, B, C. ... in the order that they are mentioned in the text
- If more than one appendix, each begins on a separate page

Author Note-specific Formatting

- Begins on a new page, with title “Author Note” centred, upper- and lower-case

Table Section-specific Formatting

- Table is mentioned in the text
- Word “Table” and the Arabic numeral for the table number is flush left at top of page
- Title of table is upper- and lower- case, flush left, and underlined
- Table structure follows prescribed APA form (see APA manual for specifics)
- If more than one table, they are in order that they are first mentioned in the text

Figure Captions-specific Formatting

- The title “Figure Captions” is centred, upper- and lower- case
- Each figure caption begins with the word “Figure” followed by the arabic numeral referring to the figure number, followed by a period. This whole expression is italicized, and then the caption is typed beside it

Figures

- Figures labelled in pencil, on back, with the word TOP, and the figure number
- In order that they are mentioned in the text number
- A border is rarely needed

References and Quotations Cited in The Text

- ampersand symbol (&) is used for citations that are enclosed in parentheses
- year of publication given
- for quoted material, page numbers provided with citation
- only first name initials are used if necessary to uniquely identify author
- every citation in the text must also appear in the reference section
- proper use of 'et al.' form of citation for multiple author citations
- multiple citations within a single set of parentheses must be in alphabetical order
- block quotations are not single spaced

Other

- paragraphs not indented
- no hyphenated words at the end of a line
- spacing error: statistics need spaces between elements: $r = -.35$, $p < .01$, NOT $r=-.35,p<.01$
- spacing error: double space following a period at the end of a sentence
- spacing error: double space following a colon or semi-colon

Reference

American Psychological Association (2001). *Publication Manual of the American Psychological Association, Fifth Edition*. American Psychological Association: Washington, DC.

APA 5th Internet Ressource:
<http://owl.english.purdue.edu/owl/resource/560/01/>