# SUICIDE DISCOURSE IN CANADA:

# ANALYSIS AND IMPLICATIONS FOR PREVENTION

by

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*Knowledge of what is does not open the*
*door directly to what should be...*

*Albert Einstein*

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# Introduction

## Selection of Topic

According to the World Health Organization (WHO, 1999) someone in the world dies by suicide every forty seconds. The age group most likely to opt for suicide at this time is young adults, and among the 105 countries that provided data, suicide is now one of the three leading causes of death for young adults aged 15 to 35. This is a significant change, as it has historically been understood as a greater concern for the elderly population who, until the 1950s, died by suicide in greater numbers than any other age cohort. Among the industrialized countries that provide data to WHO, Canada has one of the highest rates of suicide in the world. The phenomenon of suicide has created controversy, debate, and interest that have resulted in copious amounts of literature being produced from a variety of disciplines. The phenomenon has been moralized, criminalized, and most recently medicalized in attempts to control a behaviour that is deemed unacceptable by 'civilized countries.' A Center for Suicide Prevention (SIEC), based in Calgary Alberta, has a database of over 100,000 documents on suicide that can be and are accessed at an average rate of 7,000 requests per month.

The subject of suicide has been a personal and professional interest of mine for over two decades. I have experienced loss by suicide and was a coordinator for a suicide prevention program in Alberta during the implementation of the Alberta Model that was established by the Boldt Task Force in the early 1980s. Since that time I have continued to provide training to the professional community. Additionally, I have been a member of several community suicide prevention networks, and I have written a program for those bereaved by suicide. I have always been intrigued by the apparent reluctance of the political community to commit itself to the amelioration of this phenomenon. The issue in question that continued to present itself was the reluctance for pursuing a more affirmative approach. The analysis that I chose was based on a decision to focus on what these political forces and professional communities are being told vis-à-vis the discourse, in an effort to offer an understanding as to why they respond as they do. The construction of knowledge which is promoted in federal government documents will be analyzed in an effort to expose potential influences and consequences.

Research, theories, and common knowledge consistently refer to suicide as a complex social issue. Circumstances that contribute to, or are perceived to contribute to, the phenomenon are in fact the creation of those who, for various reasons, have felt compelled to put in place systems to control this behaviour. Therefore, “complexity”, an adjective that is commonly applied to the phenomenon of suicide is constructed and defined by the discourse that is formulated to describe it. The potential of this complexity to create a barrier for the development of suicide prevention strategies will be examined and identified as a condition that exists in suicide discourse.

## The Aim of the Study

There exist divergent ideologies surrounding the issue of suicide, and consequently, there exist equally conflicting strategies for the amelioration of this problem. The way in which a country develops and implements policies in order to respond to social problems may be understood by examining how the meaning of an issue is perceived. However, this may only become implicit when the discourse that prevails is identified. Cultural relativism asserts that our reality is constructed through the prevailing discourse, and that this is how society’s basic notions, such as what is right/wrong, what is true, and what is morally correct are created. This process results in a reality that is not only perceived but is also experienced (Winch, 1964). An understanding of the choices that are made to address the issue of suicide will be presented through an explication of suicide discourse and the discourses and authorities that have influenced its production. The common thread that ties all the discourses together is social control, specifically efforts aimed at complicity with and commitment to the social values of the day. The means that have been deployed to promote social control have historically been coercive, through the enforcement of negative sanctions. These sanctions vary depending on the context from which suicide is defined.

In order to understand the prevailing discourse in Canada today, it is necessary to revisit the classical theories of suicide, review the contemporary research, and analyze documents that are regarded as exemplary representations of the current knowledge in Canada. The analysis of these documents on suicide will be conducted in order to determine the prevailing discourse and hence offer an explanation for the treatment of the suicidal in Canada today.

Health Canada documents have authority and influence on many issues, including suicide, and therefore they will be analyzed to determine the prevailing discourse and their potential to influence the way in which the issue of suicide is addressed. Foucault's theories relating to the construction of expert knowledge and other regulatory systems will provide the analytical framework for this analysis. The concept that is critical to this analysis is his belief that the way in which we talk about the world affects how we see the world.

## Implications for the Study

Institutions of power, such as Health Canada, have a covert and overt influence over the way in which social problems are both perceived and ameliorated. The documents that are produced by this institution have implicit authority and are often accessed by those in a position to directly impact the lived experience of individuals who are suicidal. If this knowledge is accepted as truth and policies are implemented based on this perceived truth they may become easily justified. The complexity of suicide that is consistently reinforced in the discourse may place those who are conscripted to care for the suicidal at a disadvantage and vulnerable to the suggestions supported by a respected authority. An analysis of suicide discourse that reveals the inconsistencies and challenges the way in which the knowledge has been produced can potentially provide the opportunity for reflection and ultimately create a space for new ideas. The reality is that the rates of suicide in Canada continue to increase, suggesting that the present methods implemented to address this issue are not working. This study will not offer new knowledge, but rather it will provide a critical look at the knowledge that exists and possible implications for those that are in need of assistance at a time when the option of death seems preferred over life.

## Plan of the Thesis

Chapter One provides a review of the classical theories on suicide and an introduction to contemporary literature. This review contributes to an understanding of the historical influences that persist, or have been displaced, in the discourse today. It is this history of ideas that is critical to a framework based on the work of Foucault.

In Chapter Two, a description of the analytical framework employed is discussed, and the concepts that pertain to this analysis will be explained. The method is influenced by the fact that Foucault does not emphasize traditional discourse analysis focusing on language and structure, but rather places emphasis on the historical context of the discourse. Also, he focuses on what has constrained and supported the production of discourse, and how it has emerged as a result of these influences. The criteria for the government documents chosen for the purposes of this study are briefly outlined.

Chapter Three provides a detailed analysis of the documents — each document is analyzed individually, and the nature of their interrelatedness is examined. The production of ideas and the authorities that influence this production are explored both external to and within the discourse. This chapter also includes a discussion of the findings, including the consequences for those who are suicidal, as a result of the power relations that have emerged. Chapter Four, the conclusion chapter, provides an overview of the findings, recommendations for future directions and research, and the implications of this study.

## General Findings

Suicide discourse in Canada has been created as a result of general conditions, as well as specific conditions and transformations that occurred within the discourse. The general conditions include the following: the identification of mortality and morbidity as indicators of overall health; prevention as a strategy for improvement of overall health; the recognition of science as the source of truth; the need to identify causes of ill health; the specialization and professionalization of fields of study; the increased involvement of the government in the health of Canadians; and the inclusion of risk as a determinant of health. A critical and specific condition that created space for suicide discourse in Canada was the decriminalization of attempted suicide, since it was at that time when the need to address the issue was imposed on the medical community.

Government documents that are perceived as having authority and credibility were analyzed, utilizing the concepts of discourse as presented by Foucault. The conditions that were identified above would both create a space for the discourse and constrain it. The discourse would support the need to control suicidal behaviour and in doing so would be limited by the need to locate, treat, and monitor suicide rates as a measure of success. Despite efforts to reduce the rates, the reality was that the rates continued to increase. The internal condition that would further limit the discourse was the position taken that the reason for limited success in preventing death by suicide was due to insufficient knowledge. The discourse would become focused on knowledge accumulation, and this would take precedence over the original goal of prevention. Despite professing the ideal of implementing a multidimensional approach to the understanding of suicide, there is an acknowledged reality in the discourse that this has been problematic. The result would be the development of what Foucault terms a *discursive subgroup* that would identify themselves as suicidologists. This group would create the science of suicide and would impose significantly on the discourse. Empirical studies based on good science would become the standard for knowledge related to suicide, and research related to factors, determinants, high-risk identification, and efficient treatment programs would be the focus. Fellowships, conferences, peer awards, peer-reviewed journals, and associations were the systems put in place to support this group. References to humanitarianism and the lived experience of the suicidal would fade from the discourse, as it became pragmatic and emotionally distanced from the experience of suicide. In 2003, the Canadian Institutes of Health Research (CIHR) would host a workshop with those identified as experts on suicide research, in order to determine the direction of research on suicide in Canada for the next ten years. As a topic of study, suicide was placed in the hands of the academic elite, solidifying scientific knowledge accumulation as a priority.

The suicidal would also be transformed until they became identified as mentally ill, irrational, and impulsive. Suicide was no longer an act; rather, it had become a symptom. The need for the suicidal to be saved and protected from themselves would support a paternalistic approach and a power dynamic that would place the suicidal in a disadvantaged position. Once the mentally ill correlation was accepted, the medico-psycho community was given the authority to treat without consent. This was based on a decision that individuals are at risk to themselves. Although the discourse recognizes that this mandated treatment may, in fact, not be in the best interest of the suicidal person, it continues to be supported rather than challenged.

Suicide discourse continues to be fraught with contradiction and uncertainty. With virtually no resistance, the attempt to rectify this is being deferred to the scientific community. The medical and psychological communities have dominated the discourse to date and are likely to continue, and there are obvious consequences for the suicidal. The preoccupation with knowledge accumulation reduces the emphasis on the lived experience of the suicidal. Despite their inadequacies, the present strategies are likely to continue as long as the discourse supports a reality that states we need more information before we can produce change.

# Chapter One – A Review of the Literature

## Introduction

The explication of the moral, illness, and social discourse of suicide will begin with a review of the literature. Prior to the 1970s, when the proliferation of research on this topic began, the literature was different. Research efforts since the 1970s to the present are focused on an attempt to locate causes and instruments of prediction to assist in the identification of those defined as at risk for suicide. The primary goal of this research has been on prevention through assessment, diagnosis, and treatment. Prior to this time the literature on suicide was primarily written by those who were interested in not only elucidating specifics about this phenomenon, but also in developing theories of explanation. For this reason it is necessary to include a review of these theories that are still referenced today, supported by some and challenged by others, before considering contemporary research. The review will begin with the history, development, and consequences of defining suicide as a moral problem.

## Moral Discourse

Viewing suicide in a moral context has a long and vivid history in Western society, connected implicitly to religion. Morality is best understood as a set of principles that are in place to guide and restrict actions that have been determined as sinful or detrimental to the well-being of all. It is essential to acknowledge that moral definitions have been created by individuals, based on their interpretations, and connected to a need to control specific behaviours deemed immoral. At the center of all debates that struggle to define social problems as moral — that is, right or wrong — is the dimension of free will. Pink (2004) describes the traditional moral theory as supporting the idea that individuals possess free will. Since they are responsible for their actions, they are responsible for the consequences of their actions. He concludes that common sense understands moral responsibility for actions because of the inherent belief that as human beings, we have the freedom to choose and should therefore logically be held accountable.

Philosophers, including Kant and Hume, have challenged the moral interpretation of suicide, not in regard to freedom of choice, but rather in regard to the interpretation of the choice as being wrong or right. Hume (1990) holds fast to the idea that humans are influenced by the same natural laws as all creatures are. Although he supported the reality of a Creator, he also believed that humans are placed in situations due to Providence, and that the decisions they make cannot defy the master plan. " If so, then neither does my death, however voluntary, happen without its consent; and whenever pain and sorrow overcome my patience, I may conclude that I have been recalled from my station in the clearest and most express terms" (p.42). Hume challenged the harsh condemnation of the church, by stating that remorse for actions against the Almighty are experienced internally through the human nature that human beings were instilled with. Specific to suicide he believed that when individuals kill themselves, they are not doing harm. In fact, if they are perceived as incapable of doing good for society, they are removing a burden by killing themselves. He suggests that these individuals are, in fact, innocent and should perhaps even be admired, "...and [their] voluntary death is equally advantageous to society, by ridding it of a pernicious member"(p.44). Hume believed that actions had nothing to do with morality, but that they were just symptomatic of what really mattered — that is, being a person of virtue (Pink, 2004, p.11).

Unlike Hume, Kant (1990) believed that humans, not natural laws or providence, determined their own actions. He also believed that self-preservation was a duty, and this duty superseded any and all justifications that have been argued in defense of suicide. "Humanity in one's own person is something inviolable; it is a holy trust; man is master of all else but he must not lay hands upon himself" (p.50). He argues that the freedom humanity claims to possess must not be used to remove them from life no matter how miserable or unhappy they may be. Like Hume, Kant uses the idea of purpose as given by the Creator. However, Kant still believes that to die by suicide is to deny one's purpose and therefore he or she loses face in the eyes of the Almighty. Death will come at a time of God's choosing, and humans must not interfere. Christianity interprets suicide as being forbidden by God, and Kant believed that God forbade it because it is wrong. However, Kant also believed that it is more important to live a moral and honourable life than to preserve life. The debates related to suicide and morality have been volleyed back and forth for centuries, but critical to these debates is the reality that they support. Regardless of the intellectual bantering, the act of suicide has been historically viewed as a behaviour that must be subdued.

The pervasive attempts by a society to deter specific behaviours are reflected in laws, religious sanctions, common knowledge, and the attitudes that are promoted as being embraced by the majority. Behaviours, that in reality can be defined and understood quite simply, became complicated by self-appointed overseers of morality. Under the auspices of protecting the general populace from the ills of constructed social problems, these overseers — most commonly accepted as the church and the state — were successful in constructing specific behaviours as right or wrong. The debates, which continue today in relation to same-sex marriage, abortion, and euthanasia, are glaring examples of how societies define, manipulate, and ascribe morality to specific issues. The consequences for those who are viewed as resisting the collective value system are all too familiar. However, in Canada, positive changes can be identified in relation to specific issues, albeit with continued resistance and reluctance by some. Many of these changes are a result of the Charter of Rights and Freedoms. Suicide, however, has a long history as a morally defined behaviour. This particular issue has produced a vigilant status quo and a society that seems compelled to control those who express a desire to die by their own hand. The sanctions, silence, and social control that are consequent to morally contextualizing suicide are critical considerations, because it is these consequences that impose on those who are experiencing suicidal feelings. Paradoxically, it is these consequences, resulting from the moral front against suicide, that may in fact contribute to many of the deaths that occur. The inclusion of moral discursive patterns in suicide discourse carries with it implicit consequences for the suicidal.

Alvarez (1990) provides an important historical context for suicide as a sin. There are no biblical references that explicitly ban suicide, and the Canon Law denouncing suicide did not exist until the sixth century A.D. It was the propensity of early Christians to sacrifice themselves that motivated the Church to take a stand against self-murder. St. Augustine placed suicide as a sin against God. He exalted life as a gift and claimed it breached the sixth commandment of “thou shalt not kill.” The original motivation may have been to *save* souls but the ultimate result was something very different. “Where martyrdom once served as a symbol of personal integrity, it was now seen as an act of rebellion against legitimate authority”(Lieberman, 2003, p.11). The sinfulness of this act has had devastating outcomes, including compromised burials, confiscation of assets, and the humiliation and ostracism of bereaved family members. This definition of suicide has successfully cloaked this behaviour in silence and shame, and it will be argued that in many regards it remains the same today.

The suicidal in Canada share a history of persecution with others around the world. Between 1946 and 1955 in England and Wales, 44,956 charges of attempted suicides were laid by the police. Of these 5,794 were tried and 347 convicted, with 308 receiving prison sentences. The Suicide Act was enacted in 1961, bringing to an end the criminalization of attempted suicide in this country, although it is still an offence to aid, abet, or counsel someone to complete suicide (Stengel, 1964, p.61). Canada would follow suit by decriminalizing the act a decade later, but in 1971 there were 460 convictions for attempted suicide — 21 were sentenced to prison, with the remainder being fined or placed on probation. Paradoxically, during this same period it was not a crime to die by suicide (Boldt, 1976). To this day the suicidal admitted to facilities for observation and/or treatment may find themselves stripped of their personal belongings and then placed in isolation with a security guard on watch. Life insurance policies have restrictions related to deaths by suicide, and less than a decade ago the funerals and burials of the suicidal were compromised because of the cause of death, including not being buried in consecrated ground if you were a follower of the Catholic faith. Obituaries rarely if ever identify suicide as a cause of death, and the cause is further denied as it may go unreported to protect the family from shame. Farberow (1991), who wrote about the experience of the families and friends of those who had died by suicide, recognized that until the 1990s, this population had virtually gone unnoticed, and even then the research and literature available on suicide bereavement was sparse at best. Those who are bereaved as a result of a death by suicide may feel marked as though the stigma society attaches to the suicidal is now attached to the entire family (Wertheimer, 2001). This is consistent with a general reluctance in our society to acknowledge the reality of suicide, and it becomes particularly distressing considering Canada boasts one of the highest rates of suicide in the industrialized world (WHO, 2002).

The perpetuation of a view that places suicide in a moral context also supports the persecution, punishment, and marginalization of those who express suicidal thoughts. These negative sanctions have been successful in silencing the suicidal for fear of consequences. Lieberman (2003), a cultural historian, discusses the dimensions of suicide. She firmly states her belief that the act of suicide is a meaningful gesture, essentially subversive, and that it is these very dimensions that have motivated the responses that have occurred over time (p. ix). Her review is a reminder of the long history of persecution that the suicidal have endured, as a direct result of society's need to control suicidal behaviour.

This perpetuation of a moral meaning creates an environment that supports the definition of populations as at risk for engaging in suicidal behaviour. These groups often include, but are not exclusive to, those 'born wrong' (i.e. sexual orientation, ethnicity, class, mentally ill), the 'lazy' (i.e. unemployed, homeless, poor) and 'sinners' (i.e. divorced, single mothers, pro-choice). Risk clearly becomes a concept, laden with meaning and purpose. Deborah Lupton (1997) concludes in her discussion on risk discourse that, although it is presented as scientific through the incorporation of epidemiological data and expert knowledge, the reality is that the defining of risk is often politically and morally motivated and used to blame the victim (p.77- 80). Lupton offers an interesting descriptive of a 'risk assessment' process. Her analogy is that of a religious confession. The individuals tells their 'sins' to the professional, a judgment is made, and "they are given appropriate 'penances' to perform to re-establish bodily, and moral, integrity" (p.82). The identification of the above groups is linked to the defining of behaviour as immoral and within the control of the individual. The double jeopardy, being marginalized and suicidal, that is experienced by these groups has become more prevalent in present day literature. Individuals who experience feelings of suicide often have their reality defined for them through the experience of being judged, and this response can only be connected to — conscious or not — the idea that suicide is fundamentally wrong. This meaning potentially constrains the individual and could ultimately increase their risk. This common belief rooted deeply in morality has resulted in suicide being described as an act that is selfish, irresponsible, and unnecessary. It is important to question where these ideas about suicide have come from, and what purpose they serve. Despite the formal removal of negative sanctions in Canada, the labeling of suicide as a sin and a crime has created a stigma that is firmly entrenched and can be witnessed in the discourse and the informal social sanctions that exist today. Stigma is a critical component of the suicide experience and Goffman offers insight into its function and creation.

Goffman (1963) explains the origin of stigma as a term used by Greeks to describe signs visible on the body that implied something negative about the moral status of an individual. The more modern definition is similar, except the focus is on the disgrace itself and not the bodily evidence. He explains the stigma of present day as creating a 'virtual social identity' and 'a spoiled identity,' imposed on individuals based on assumptions and stereotypes. He describes three types of stigma including physical deformities, inadequate character (where he places suicide), and the stigma connected to race, nation, and religion. The stigmatized person comes to accept the limitations placed on them by society, and this is realized through their experience of self-imposed isolation, self-degradation, and ultimately shame. The person becomes known as, and comes to believe, that they are a failure due to the reduced or non-existent respect and regard that they perceive to be afforded others by society. Goffman explains the challenges that are faced when a stigmatized person and another engage in conversation. The uneasiness that is experienced is a result of neither party clearly understanding what is expected of the other. He contributes the proliferation of self-help groups, clubs, and organizations as a result of the need for various stigmatized groups to feel connected and supported through the sharing of ideas and experiences (p.1-22). Once again, the suicidal person is effectively silenced by stigma due to the uncertainty of the consequences they may have to endure. It is essential to recognize that the shame often associated with suicide is a cognitive emotion that is a result of socially constructed stigma.

Discourses that support a moral context confirm shame and stigma as significant dimensions of the experience of either the suicidal or those bereaved by suicide. Research that promotes the suicidal as ultimately responsible for their actions implies that they are willingly engaging in suicidal behaviour and should therefore 'suffer' the consequences. Lieberman (2003) states that it is precisely the voluntary nature of suicide that places it in the realm of sin, because it implies that a person is deliberately doing wrong against the Almighty (p.12). Adjectives often used by mainstream society to describe suicidal people include irresponsible, weak, cowardly, unstable, irrational, and so on. The clear implication is that the suicidal person is making not only a choice, but a bad choice, and this implies morality. As Pritchard points out, “former attitudes still reverberate, creating confused and ambivalent echoes which continue to plague modern humanity” (1995. p. 9).

King (2004) has written a book on 20th century suicides and on the *black* cover, the title inscribed in *red* reads *Straight to Hell.* This is an example of the continued propensity to connect suicide with sin. The jacket describes the content as ripe with human carnage, a grim catalogue of the sudden brutal deaths that serve to remind us of our mortality. Twenty-three deaths by suicides are described and the morality infused in this collection becomes evident as the scenarios are examined.

With the exception of two women, the individuals featured in the book were all men. All of the individuals might easily be viewed by mainstream society as either deviant, morally corrupt, or cowardly for using suicide to avoid punishment for crimes they had committed. The issue of free will or choice is made apparent and the deaths could be classified as deserved and inevitable. There is only one reference to society as having failed them in some way and that was the case of Jonestown, where there were innocent children involved. The deaths of the women were presented differently as they were described more definitively as suffering from mental illness and depression, and therefore potentially less culpable. The suicides that were connected to religious cults were labeled as revolutionary, acts of defiance, an act of redemption, or an experience of an advanced level of being. The collection placed the act of suicide in the hands of the perpetrator as a deliberated choice that was planned and executed in deference to life.

Despite the fact that it attempted to be factual, the accounts of the cases supported the suicidal as morally inept and defiant. It is interesting that this book has not incorporated any of the science of suicide, but rather remains grid-locked in morality. This is perhaps a reflection of a reality that suggests the issue of suicide has not moved significantly from this position.

## Illness Discourse

The scientific community was spurred to seek alternative venues of understanding, as a result of society's inability to reconcile the morality of suicide and to reach a consensus on whether it is right or wrong. Deterministic theories that would appear to move away from the free will debate began to emerge. At a time when science was believed to be the only option where real truth could be found, suicide was one of many social phenomena that became a topic of study. The push was to empirically study suicide in an effort to redefine it, not as a moral problem, but as one that could only be understood as an illness, either biological or psychological. Causal determinism would focus attention away from moral responsibility to determinants and variables that were beyond the control of the individual, but still maintaining the suicidal person as the focus. Modern medicine, with its allopathic, mechanistic and individualistic ideologies, would further the effort to produce scientific explanations for suicidal behaviour. Kinsley (1996) defined this movement as the medicalization of culture. He plead a strong case for the existence of morality in medicine and pointed to the defining of social deviance as an 'illness' as being politically and morally motivated. One of the many examples he referenced from history included a mental illness created by a Southern United States physician that only afflicted slaves with the primary symptom being the urge to run away from their masters. Behaviours that were described as healthy were also described as desirable and good in a social and moral sense, thereby changing the language of sin and virtue, but not its reality (p.177-179). The move away from morality, inspired by a rational and secular exploration, did not (as shall be discussed later) offer immunity for the suicidal. A review of the empirical literature concludes that close to 90 percent of those who die by suicide have a diagnosable mental psychiatric disorder and lists five constructs that are consistently associated with suicide; impulsivity/aggression, depression, anxiety, hopelessness, and self-consciousness/social disengagement (Conner et al, 2001). The move to medicalize suicide gained momentum, as this community of thought not only studied suicide but was conscripted to care for the suicidal. As a result of this, the suicidal person now needs to be assessed, managed and treated, and during this process the need to locate a cause that is universal becomes paramount. The church and state are no longer identified as those best suited to control this behaviour. Scientific knowledge on the issue would provide society with new and more efficient, but not necessarily less punitive, strategies of control.

Freud presented a theory that would forever align suicide ideation and behaviour with mental illness. Litman (1970) wrote an essay on the evolution of Freud's theory of suicide. The review looks at the theme of suicide in Freud's writings from 1881-1939, recognizing that he never organized his views on suicide in one presentation. Most famous for his theory on *anger turned inward*, Freud also addresses suicide and guilt over death wishes for others. Identification with a suicidal parent, incapacity to renounce, suicide as revenge, as escape, as associated with masochism, and finally with the often challenged death instinct (p. 200). The psychoanalytical explanations are complex and beyond the scope of this discussion, but Freud is recognized as having developed concepts and theories that would make the potential for suicide real for everyone. The general features he described included the death instinct, the breaking down of the ego, and the social institutions that elicit guilt because of the compliance that is required by all. However, there also needed to be what Freud labeled as that which would create a breaking down of the ego such as loss, narcissistic injury, overwhelming rage, guilt, or anxiety, extreme ego splitting, or a suicide attitude, perhaps as a result of knowing someone who was suicidal. Finally, he believed that specific predisposing conditions that favour suicide needed to exist. For example, these included a tendency toward sadism or masochism, self-destructive living patterns, and a strong libido attachment to death or dead loved ones (p.214). Freud would firmly establish that the ability to comprehend suicide as best suited to the field of psychoanalysis.

Menninger (1956), a psychiatrist, claimed his interest in suicide emerged as he became aware of the taboo surrounding the subject. He was intrigued that an issue of such magnitude received no serious attention, and he felt that there existed a reluctance in society generally, and in the professional community specifically, to address it directly. He described his book as breaking through the taboo and was inspired to uncover the secret motives that bring someone to the point of suicide. He was amazed at not only the simplistic explanations given for suicide deaths to date, but of the willingness of others to accept them (p.15-16). Like Freud he also subscribed to the idea that suicide is the extreme example of the death instinct directed against self, and that an explication of the unconscious motives was necessary in order to understand suicide. He believed that these unconscious motives could only be understood through psychoanalytical studies. The constant struggle between the life and death instincts was believed to be the experience of all humans. Life is described as always in a state of compromise and the outcome would rest on an individual's ability to sustain a balance between these forces.

Menninger believed that suicide was a unique form of death as it involved three elements: the wish to kill, the wish to be killed, and the wish to die. He postulates that suicide is the result of a long process of outward and inward aggression, and death occurs when this aggression is combined with the wish to die. He suggests that this self-destruction can be detoured or neutralized at various stages of the destruction and construction phases. However, in order to understand this complex process, the conscious and unconscious motives must be examined. He believed that all three elements working together would result in death, adding that the wish to die was the critical, and not yet identified, element (p. 70-73).

Menninger also defined suicide as chronic, focal, or organic. Chronic suicide or chronic self-destruction is described as behaviours that contribute to a slow death. The examples include alcoholism, martyrdom, and psychosis. In contrast to chronic suicide that is more generalized, focal suicide is usually limited to specific parts of the body. In this category he includes self-mutilation, malingering, sexual impotence, polysurgery, and unconscious accidents. He concludes that the same motives exist as for true suicide except for the degree of the death instinct. The organic suicide places the act firmly in the realm of science. This type of suicide is not externally created but rather internally created through physiological mechanisms. "The traditional moralistic and legalistic methods of viewing behaviour are being gradually replaced by the scientific methodology of science" (p.310). The unconscious motivation for all three types of suicide is linked to guilt and self-punishment. He suggests that the commonly held beliefs around the connection between the mind and matter and body and spirit are the reasons for suicide not being recognized as a medical problem (p.309-310). Despite his desire to view suicide as a medical problem, he identified guilt and self-punishment as motivators for suicide, both of which are morally or socially defined.

Stengel (1969), a renowned and respected psychoanalyst, challenged and cautioned against the assumption that all who are suicidal are mentally ill. To connect mental illness to a specific behaviour could have far reaching implications, and he believed that other symptoms must be present. He believed that it was not necessary, and in fact not reasonable, to accept suicide alone as a criterion for mental illness, because this would remove the possibility that someone free of mental illness would be capable of killing themselves. When considering the same assumption in relation to homicide, it would imply that all those who committed this crime would be considered insane and therefore not culpable for their actions (p.49-50). In his study on suicide he acknowledged the importance of including external factors that have the potential to influence the individual. He promoted the work of Durkheim and described it as "...the most important sociological contribution to suicide" (p.41). In a brief discussion of Durkheim and Freud he proposed that they both share a deterministic view of suicide that implied that individuals are influenced, often unknowingly, by forces that are coercive and controlling. Durkheim identified these as external social facts and Freud identified them as the unconscious (p.48). Contemporary research still has not reached a consensus on the fundamental question regarding which force is most significant, resulting in a science of suicide that is fragmented.

In his discussion of motives, Stengel discussed what is referred to as the appeal effect of suicide. The appeal effect was described as a motivator for engaging in this behaviour and it implied that what the suicidal wants is recognition of their value to society, an acknowledgement that someone loves them. They engage in this risk taking behaviour as a way of disengaging and expressing dissatisfaction, but also with the expressed hope that someone would 'save' them. This elicited a varied response, including anger, from those connected to the suicidal, as many took the act personally and viewed it as manipulative, as it is clearly allied with self-preservation not death. This supports the punitive measures that have occurred over time in an attempt to reduce the appeal function of suicide. Stengel reminds us that punitive measures have proven unsuccessful and that the only thing that will reduce the power of the appeal effect would be to make the appeal unwarranted (p.105-109).

Freud, Menninger, and Stengel were all concerned with the motives of suicide. The motives described as both conscious and unconscious would become the foundation that would legitimate the right of the medical community to reduce the rights of the suicidal for their own good. The criminalization of mental illness (Laberge, Landreville, Morin, 2000) and the power imbedded in legislation that gives doctors the authority to hold an individual for up to 72 hours without their consent would place the suicidal at the mercy of a system that would virtually usurp their rights. The mental illness label tips the balance of power in favour of the professional and supports a take control strategy, reinforcing the idea that the suicidal are not capable of rational thought and must be protected from themselves. "It is well known that functional psychiatric disorders are one of the main causes of suicidal behaviour" (Moller, 2003). "For 25 years the medical profession has accepted that of every 100 individuals with major depressive disorder, 15 subjects will ultimately commit suicide" (Blair-West, Mellsop, Eyeson-Annan, 1997). "This new epidemiologic research adds to the evidence of an association between panic attacks and suicide attempts during middle years of adolescence" (Pilowsky, Wu, Anthony, 1999). The proliferation of research, that provides evidence of suicide as a symptom of a manageable illness, places the suicidal in a position to be judged once again. The difference is that they may not be judged for their suicidal intentions but rather for their unwillingness to manage their illness. The rhetoric that has been created to label this unwillingness includes noncompliant, uncooperative, and resistant to treatment. When these labels are combined with the labels of marginalized populations, the rates of suicide for constructed high-risk groups becomes meaningful. The deaths by suicide of those populations that have become accepted as having limited social value can potentially be rationalized, as they are viewed as contributing knowingly to their own demise, despite the efforts of the professional community.

In 1958 in California, the Los Angeles Suicide Prevention Center was established. Three men (Farberow, Litman, Shneidman), all educated in psychology, would partner at the center and become instrumental in changing the way in which suicide would be researched and invariably perceived, first in the United States, and then around the world. The center was to be a pilot project for other communities, with the goal of saving lives and doing research. There was a telephone service, emergency clinic, and a referral service that were all available 24 hours (Stengel, 1969, p.123). Although all three men became respected and prolific writers on various aspects of suicide, Edwin Shneidman stands out. He would become known as the father of suicidology, which is defined as the scientific study of suicide. Shneidman was a co-founder of the Los Angeles center and the founder (1968) of the American Association of Suicidolgy (AAS), which would publish a peer-reviewed journal titled *Suicide and Life-Threatening Behaviour.* This journal would provide a forum for a proliferation of academic literature on suicide. The majority of articles printed in the journal are quantitative, hence setting a standard for the way in which the science of suicide would be conducted and creating an abundance of empirical evidence related to various aspects of suicide. The mission of the AAS is to understand and prevent suicide through the promotion of research, public awareness and education, and training for professionals and volunteers. Suicide prevention/crisis centers and individuals can apply to be certified by an examiner of the AAS.

Canada has followed the Americans closely in an effort to prevent suicide, "...following Shneidman into the vault" (Leenaars, ed.,1997, p. 4). There exists a group of Canadians identified as 'experts' who are also predominantly trained in the field of psychology. In 1988, Leenaars resurrected the Canadian Association of Suicide Prevention (CASP) after an unsuccessful attempt by others to organize it in 1985. At this time and throughout his career, he states that his constant consultant has been Edwin Shneidman (p.19). The purpose of this Canadian association is to reduce, rather than prevent, suicide and to minimize its harmful effects. Rather than provide service, the Canadian association identifies its role as one of advocacy, facilitating, and advising. However, the establishment of the association can still be viewed as an effort to support the professionalization of the study of suicide. The focus of these efforts is promoted as prevention based on scientific conclusions that identify motives, causes, and ultimately effective treatment strategies. Certification is also available to Canadian crisis workers as the result of a partnership between the AAS and CASP. The evaluation and accreditation of individual crisis workers that is promoted by CASP is completed by and based on the criteria of the examiners of the American counterpart.

The AAS would support enduring alliances specifically between Litman, Shneidman, and Farberow, but this circle would expand to include others, as evidenced in the work that is coauthored and endorsed by this elite group. The science of suicide is purported as having begun in 1957 with a study on suicide notes that was completed by Shneidman and Farberow. The influence of the knowledge created by these associations should not be understated.

Shneidman, at the age of 85 and in consultation with his long time colleagues, continues to contribute to the bank of knowledge about suicide. His most recent book (2004) is a psychological autopsy of the death by suicide of a young man described as gifted. The concept for the psychological autopsy was developed at the LA Suicide Prevention Center by behavioural scientists to help answer the question of why people die by suicide. The 33 year old male, the subject of Shneidman's book, died by an overdose, and the book includes interviews with his family, friends, psychologist, and psychiatrist. The book also includes consultations with eight men described as renowned experts in the field of suicide, who, not surprisingly, have a connection with the LA Suicide Prevention Center, the AAS, or the peer-reviewed journal sponsored by AAS. They were invited to analyze the interviews as well as a lengthy suicide note left by the deceased. The contributors are respected as authorities on the subject of suicide, therefore making this book an important one in terms of its potential to direct and guide suicide discourse. The young man who is central to the discussion is described as having had a lifelong struggle with suicide and depression. They were all asked important questions: Why was he suicidal? Could this young man have been saved?

In response to the question of why this young person died by suicide, the experts offered several insights. Generally, there was a consensus that his biological depression was a critical factor. This was demonstrated by the following statements: "his illness prevented him from clearly thinking of alternatives" (p.18); "he was born with it" (p.53); "born with neurobiophysiological defects" (p.65); "his depression was a biological curse" (p.107, 147); "the biology of his illness prevented him from reaching out" (p.135); and "these cases are malignant" (p.148). Despite the emphasis on his illness as a major determinant in his death, the discussion of whether or not he could have been saved would now place much of the responsibility on the deceased himself or the social construction of suicide. Examples of this include comments like the following: "he saw depression as a reminder of his imperfection" (p.18); "he wanted to be saved but may have been too ashamed to ask for help" (p.20); "he chose to reject options" (p.20); "he was too smart for his own good" (p.21); "he was not willing to accept help" (p.20); "his fear of failure and fear of stigma prevented him from seeking help" (p.41); "he was his own worst enemy" (p.46); "anger and rage did there part to doom Arthur" (p.100); "he refused to be a patient" (p.107); and "his self-centered and shortsighted act" (p.161). The challenge of diagnosis seems less daunting than the challenge of preventing his death. The issue of responsibility for Arthur's death becomes a focal point, and the majority of interviewees agreed that Arthur's death was inevitable. Arthur's father stated, " I want to believe that his life could not be saved; that's easier for me" (p.42). It is reasonable to assume that this statement holds some truth for professionals as well, and accepting death by suicide as inevitable may offer absolution. The inevitability of his death (star-crossed) was evident in the following statements: "maybe Shneidman in his prime could have brought about a 5-10 year cure" (p.47); "his biology made suicide seem inevitable" (p.85); "everything was just prolonging the inevitable" (p.98); "I knew 100% that he would kill himself" (p.144); and "there is nothing that will save them, don't think he was savable" (p.148).

Arthur had been in receipt of professional therapies since early childhood. The autopsy also included a discussion related to what type of treatment may have altered the outcome. It was interesting to note that the expert consultants shared the view that better care may have helped, and they made specific recommendations. This is interesting given the claims that in fact it was his disease plus his resistance and unwillingness to accept help that was his demise. The recommendations ranged from working with his support network and maintaining contact indefinitely (p.55), to neurosurgery (p. 88) and electroshock therapy (p.149). The suggestions ranged from intrusive to supportive, but what was interesting was the tendency by some to want to resist hospitalization in order to avoid humiliating Arthur (p.148) — Arthur was a physician and a lawyer. As a conclusion to the book, Shneidman includes a letter he wrote to Arthur's mother. He explains to her the kind of therapy he would have provided to Arthur if he had been given the opportunity, after having stated that he believes he could save anyone if they were willing to engage with him (p.160). He does state that he would consult with others because "saving a life is a complicated mission" (p.162). The conclusion as described by Shneidman himself suggests that we are still left struggling to find the answers that will help make sense of deaths by suicide (p.163).

Wrobleski (1994) suggests that the proliferation of scientific knowledge has not diminished the taboo and stigma associated with suicide, but rather it has created an elite taboo. She implies that there is a perception that one must be an expert on the topic in order to speak on it. This interesting observation could at least partially explain the response by communities and organizations when deaths by suicide occur, that being to locate and parachute in the professionals. Hopelessness, helplessness, and despair are part of the common discourse around the experience of the suicidal person. The creation of experts in the field of suicide could be viewed as contributing to the sense of hopelessness as it presents suicide as complex, overwhelming, and in some instances inevitable. The systems that perpetuate and create this situation and a society that condones it may be best understood from a social perspective.

## Social Discourse

In his introduction to Durkheim's study of suicide (1951), Simpson suggests that the reason psychoanalytic psychiatry failed to place suicide in the social realm was because of the preoccupation with first locating a cure for mental illness and second an emphasis on the importance of the individual's ability to reconcile their unconscious motives. This preoccupation should not have precluded social factors from being causally involved, and he suggests that the causes may exist in the social history of the person (p.25). To examine suicide from a social perspective brings to light constructed meaning, the influence of social structures and systems, power, epistemology, and the importance of examining individual circumstances in the context of the world around them.

Henshel and Henshel (1983) define a social problem as one that first and foremost affects a significant number of individuals in society. They continue to describe three criteria that must be met. The first is it must be social in origin, which is related to social factors and determined to be social. The second criteria is that the problem must be social in definition and deemed undesirable. There must be a collective awareness, but more specifically society's power structure must acknowledge its existence and attempt to provide remedies to reduce the problem. The third and final component is that the problem must be social in treatment; that is, the problem must have the potential to be ameliorated by social change. Is suicide a social problem? There are many who would respond with a firm yes, but because of the success with which suicide has been labeled as a symptom of mental illness, the defining of suicide as a social problem provides a second body of knowledge, rather than an addition to the scientific knowledge that has been produced by the discipline of psychology. This has contributed to a fragmented, rather than cohesive, explanation of suicide. Not unlike psychology, however, sociology has put forward alternative and equally compelling theoretical explanations for this phenomenon.

Masaryk (1970, originally published in 1881) studied suicide as a social phenomenon and was interested in the connection between suicide and the condition of social life. He believed that the rate of suicide was a measure of the mood of a society. He concerned himself with society in transition and believed that the move away from religion as a moderating influence left people lacking a sense of stability and direction. His interpretation was based on the importance of the ability of religion to provide moral control. Masaryk believed that moral education was as critical as intellectual education, because he believed that the motives for suicide were predominately immoral. He clarifies his meaning of immoral to mean that a person who has moral weakness or a lack of moral principal is more likely to engage in suicidal behaviour. This, however, is explained as a consequence of the modernization of society and a move toward a secular world, where the individual must struggle to maintain moral courage in what he calls the moral vacuum that this new world has created (p.76-78). Although he acknowledges the importance of the physical environment, he places a stronger emphasis on the internal motivation of man and the irreligiosity of the modern world (p.85). Masaryk concludes with the idea that advances in civilization and irreligiosity must surely offer the best explanation for increases in the rates of suicide. During the Middle Ages, Catholicism offered a unified worldview that had the power to offer individuals a sense of peace. The transition from old world to new world brought with it Protestantism. "Besides its negative, disintegrating elements and where in specific circumstances it lost its positive elements, Protestantism evoked a great suicide tendency, which we must comprehend as the surest index of a great and powerful time of transition" (p.220). Although the ideas presented may seem harsh in their emphasis on the moral character of the suicidal, it was the social structures, and their ability to protect or compel the individual, that he blamed as contributing to suicide. His work would lay the foundation for future research into the social dimensions of this phenomenon.

Durkheim (1951,originally published in 1897) would follow with his work that is still touted as the most significant sociological study on suicide. He would bring attention to the concept of suicide as a non-material social fact (external to and coercive of the individual) and believed that it could only be understood in terms of the whole social system. Society, social institutions, and infrastructures were defined as material social facts that can affect, in this case, the rates of suicide. He did not support suicide as an individual phenomenon, but rather as an act that was constrained or motivated by larger social systems (p.149). The essential concepts that he used to support this were regulation (the degree that collective values are shared) and integration (the degree of external pressure on the individual), and he claimed that too much or too little of either would result in an increase in suicide. He correlated data (rates of suicide) with social institutions, such as marriage and the family (p.171-202) and religion (p.152-160) to prove his theory. He was very clear as to the purpose of his research, in that it was a study of the social suicide rate and the information that contributed to its form and variation (p.147), and he believed that motives were never the true causes (p.149).

In his examination of the relations between social institutions and the rates of suicide, the following represents a sample of his findings. It is no surprise that religion, which Durkheim believed was the ultimate non-material social fact, would be an object of study. First he compared the rates for death by suicide for the religious systems of Catholics and Protestants, and found that Protestants, in fact, had higher rates of suicide. He then sets out to offer an explanation by first looking at the similarities, such as severe negative sanctions toward suicide, the belief in an afterlife, and a divine authority. Despite these similarities, the reality is that there is disparity in the rates. He turns his attention to the concept of integration (and egoistic suicide) and determines that the Protestant church is less integrated, resulting in a weakening of collective faith that contributes to the higher rates of suicide — individual followers would experience a sense of meaninglessness (p.152-161). If the religious institution could be protective against suicide, he then considered other institutions, such as the family. His findings specific to marriage suggest that it is protective for men but not for women. The variable that changes this for both sexes is the introduction of children, and he therefore concludes that family is the essential factor in the immunity for married couples. He also considered widowhood and concluded that this state increased suicide for women rather than men and suggested that for women this would also mean financial difficulties and reduced status. Again, it is the aspect of a shared common life that serves to create a meaningful degree of integration that creates a safety net for the potentially suicidal (p.172-202).

His work was completed at a time when sociology was struggling to find its place as a legitimate science, and it was critical that his work be empirical and his methodology sound. Utilizing quantitative data he would systematically make the compelling argument that suicide is inextricably connected to social causes.

Durkheim includes a section in his study entitled practical consequences. He includes several interesting and thought-provoking conclusions. First, he says that the attitude that society holds in relation to suicide as normal or abnormal will influence the solutions that a society adopts (p.361). Second, despite the limited amount of data available, it is likely that suicide has always been an issue of relevance for law and morality. Thirdly, suicide is probably a part of the normal process of any social constitution, and the acceptability of suicide is connected to how life is valued. He discusses individualism and progress and suggests that, “suicide is the ransom-money for civilization” (p.397). All of these conclusions are related to his idea of the importance of understanding and identifying the social currents that exist in societies. He believed that the current of pessimism is where the ideas of suicide are rooted (p. 366). He believed that understanding and identifying social currents would help to explain the variations in suicide rates over time, and perhaps offer a predictive potential for a phenomenon that

Durkheim believed to be an otherwise normal part of the human condition. He based this conclusion on the fact that there has never been a time when suicide has not occurred.

The work of Douglas (1967) promoted the concept that suicidal actions are meaningful actions. He concerns himself with the contextual determination of meaning (p. 242), the construction of meanings, the importance of shared meanings (p.247-254), and common sense meaning (p.267). He believed that suicidal actions mean something both about the suicidal person and the situation of the person — each is seen as a cause of suicide (p.251). Douglas, in his critique of Durkheim's study, stated that he failed to see the significance of treating the meanings of suicide as problematic and urged future researchers not to make the same mistake.

Douglas believed that Durkheim fell victim to the ecological fallacy, "that social disorganization leads to personal disorganization" (p.99) and this leads to suicide. Douglas argued that individual and conflicting meanings of suicide could exist within a single system. Durkheim's focus on methodology and empirical study would result in weaknesses that were defined by Douglas. First, he suggests the data were faulty and made to fit the theory. He then identifies several erroneous assumptions that were made. The first assumption was that individual cases could not be included in a systemic theory. He also identified the assumptions of cultural homogeneity and the idea that social norms are homogeneous (p.155-158), and finally Douglas believed that the most important assumption was that meanings of suicidal actions were obvious (p.158). Douglas states that Durkhiem's most important contribution was the sociological perspective itself.

Douglas made the point that suicidal actions were a form of communication and must be understood in context. Throughout his work he insists that individuals, in their interactions with each other, construct local meanings. "It is such micro-cultural meanings that give (or give highly plausible) meaning to the communication of the individual committing suicide" (p.319). He explains that to consider the meaning of suicide only at the time of the act, rather than considering the act as the end result of a process, misses the opportunity to see the everyday meanings as important determinants of the phenomenon. He supports this by identifying the fact that many suicidal people articulate their intention prior to the act, indicating that suicide has meaning prior to the actual death (p.320-322). The construction of meaning for individuals is also culturally defined, and the medical specialist has been culturally accredited with the knowledge to do so (p.334). Douglas discusses the special context of meanings that are the result of a world that has become highly rationalized and complicated. For the suicidal the consequence of this context is mental heath, whereby regardless of suicidal ideations, there is an implicit link between the experience of mental illness and the potential of suicide. He suggests that it is not so much a part of the common understanding, but rather a shared meaning among professionals in the field (p.329-330). Douglas challenged the positivistic approach as effective in the development of an understanding of social phenomenon. He believed that unless researchers considered that, "social meanings are fundamentally problematic, both for the members of the society and for the scientists attempting to observe, describe, and explain their actions"(p339), the result is misleading. He cautions sociologists to consider meaning as problematic and to recognize the potential to impute meaning into statistics that would fit their own ideas of what the meaning should be. His conclusion is that social phenomenon cannot be understood through generalized abstracted meanings, but rather through the situated meanings that the person experiencing suicidal ideations is in (p.338-339).

Generally, sociologists have not heeded the warnings of Douglas, in that much of the present day research is quantitative. The empirical studies that are produced by the discipline are in line with the development of the study of suicide as a science or suicidology. Empirical studies have found statistical significance between suicide and unemployment, permanent sickness, family conflict, as well as economic troubles, serious illness (Pearson et al, 2002) lesbians, gays and bisexual behaviour (McBee-Strayer and Rogers, 2002), and homelessness (Eynan et al, 2002). Suicide has also been commonly connected with addictions, abuse issues, separation and divorce, isolation, and generally loss. Critics of the propensity for sociology to continue to view suicide as a topic of research claim that it denies suicide any serious meaning when it is reduced to statistics (Alvarez, 1990), and it transforms a meaningful statement into a type of social dysfunction (Lieberman, 2003). Detachment, often connected to science, real or otherwise, is played out, as once again, there is a compelling attempt to discover the reasons why individuals choose to die rather than an attempt to gain understanding that is related to the meaning of the act.

This goal of finding causes, correlations, and determinants has become the motivator for most research efforts. As a result, the production of research that connects suicide to social conditions continues to follow the aetiological and ecological traditions. However, the important contribution that the social discourse has provided is an alternative to the widely promoted and accepted mental illness factors as primary causes of suicide. Consideration of socio-economic factors, social construction of knowledge, power relations, and meaning would become issues for consideration. Although the contributions focus on social conditions, in the tradition of Durkheim, the data that grounds the research is most often statistical and rarely provides conclusive information. Like Durkheim the condition of the individual is not seen as significant as compared to the external factors that are protective or coercive. Marx (Plaut and Anderson, 1999), in a brief article, wrote on suicide and would agree that prevention of such deaths would only occur when there was "a total reform of the organization of our current society, [suggesting] all other attempts would be in vain" (p.50). The challenges for social discourse in relation to suicide prevention are the expansive strategies that would need to be implemented, in order to ameliorate the social conditions that are believed to contribute to a malaise that increases death by suicide. The following research represents examples of the efforts to challenge the view that suicide is an illness.

The research that challenges the generalizations that result from the label that defines certain population groups as high risk for suicide is reflecting a social examination of the phenomenon. There is much talk about the high rates of death by suicide of the First Nations people in Canada. Connors (Leenaars et al, 1998) describes the history of suicide among these nations. He describes suicide as being very rare. When it did occur, it was not a meaningless act of aggression, but rather it was an act of self-sacrifice that would result in a healthier and more viable, larger community. Individuals who chose suicide after being admonished for defying traditions were most often banished in order to retain harmony and balance in the community. Suicidal behaviour was believed to be ecocentric, not egocentric. To die after the loss of a loved one who died honourably, or an elder who decides it is time to go to the next life, is believed to be spiritually condoned because this is determined by the Creator. "In fact, suicide was both rational and adaptive when viewed in the context of survival of the tribe and maintaining equilibrium within all of creation" (p.6). Connor suggests that the meaning of suicide has changed since the acculturation and genocide of the tribal people, as the act now occurs in communities often devoid of values and beliefs. He proposes that the assimilation pressure by the dominant Canadian society is a major contributor to the increased rates of suicide (p. 4-7).

Chandler and Lalonde (1998) conducted research in British Columbia, and the results stand in direct contrast to the common knowledge that is promoted, implying a causal relationship between being Aboriginal and being at a higher risk for suicide. The researchers examined the following factors: community self-government, control over traditional land base, band-controlled schools, cultural facilities, and control over police and fire services. They discovered that communities with none of these factors had a suicide rate of 137.5 per 100.000, and those communities that had all of these factors had no suicides. Sociological studies such as these challenge the stereotypes and minimalist explanations and demand a more reflexive process to occur.

What unifies all of the discourses discussed (moral, illness and social) is that they are fundamentally motivated by the same goal, that being to reduce, prevent, and ultimately control the behaviour of suicide. Attempts to reconcile the morality of suicide and a focus on determining a cause, or a number of causes, that would explain this phenomenon has been the guiding post that has propelled suicide into the scientific arena. Despite these efforts and the implementation of various strategies of amelioration, suicide remains one of the primary causes of premature death in Canada.

# Chapter Two - Methodology

## Analytical Framework

Concepts and ideas espoused by Michael Foucault, will provide the analytical framework for this research. It is commonly agreed that he does not provide a clear method that can be embraced as a guide, yet he offers enticing alternatives to the way in which discourse has been traditionally analyzed.

Foucault challenged this traditional analysis of discourse (concerned with language and structure), believing that it was paramount to understand the history of ideas, and bodies of knowledge as "limited practical domains" (1972, p.50). He suggested that traditional discourse analysis serves a purpose, but also invited researchers to question where, how, and why the discourse has come to exist in the first place. He believed that in order for discourse to exist, a 'space' had to be created. Only through an exploration of the history of discourses could this 'space' be understood.

In *The Archaeology of Knowledge* (1972) he suggests that discourse can be identified vis-à-vis certain criteria. First he describes formation as the conditions that make it possible for the discourse to exist, or the formation of 'space'. Transformation is described as the limits or the rules that constrain discourse. Foucault believed that the transformations were not incidental to historical change but actually created it. Correlation is another important consideration, as he recognized the importance of the relationships that exist between discourses and the influence that they might have on each other. He was concerned with the dependencies that exist between and within discourses and the broader forms of socio-political change in which they arise. He was interested in the effects on society generally and sees discursive objects as a form of social practice (p.25).

Therefore, an analysis needs to accomplish several things. The transformations must be described with specificity to the discourse being considered. Foucault believed it was more important to explicate the discursive conditions or rules that support particular concepts and people, rather than focus on the structure of specific text and its content. The rules that exist can create unity of discourses around a particular phenomenon, even though the discourses can be isolated and often function quite separately. For example, sociology and psychology share a desire to determine the causes of suicide and potential strategies for amelioration, despite the fundamental differences in how this goal is achieved. He emphasizes this by stating, "Of course, discourses are composed of signs; but what they do is more than use these signs to designate things. It is this *more* that renders them irreducible to the language (*langue*) and to speech. It is this 'more' that we must reveal and describe" (p.49).

Foucault believes that discourse is historically formed. He developed the concept of the 'statement' not as a unit of discourse but as a functional (socio-historical rather than simply linguistic) unit that does things — it brings about effects; it is not just a representation of facts (p37). Statements must have "...a substance, a support, a place, and a date ...[and] a situated and dated uniqueness that is irreducible" (p.101). Statements are not just sentences, but they can be graphs, charts, lists, or pictures. He suggests that a group of statements can constrain and enable what we know, because they are a part of knowledge (p.82). When analyzing statements, the concern is not what is actually being said but rather Foucault "...questions them as to their mode of existence, what it means to them to have come into existence, to have left traces, and perhaps remain there…what it means to them to have appeared when and where they did, they and no others" (p.109). He describes 'fields of knowledge' as possessing statements that are distinct and unique both in reality and influence. The meaning of a statement is not simply what it contains, but what makes it different than other possible statements at certain points in time. Again, the challenge becomes one of determining the conditions that exist that support certain statements as accepted truths as parts of a field of knowledge.

Two errors that he describes as made often in analysis are the assumptions that fields of knowledge have an absolute center and are founded by one person (p.43).

This condition has the potential to determine the path that a discourse will take, conscious or not. He drives this point home by suggesting, "we are doomed historically to history…and to the task of hearing what has already been said" (2003, p.xvi). Foucault would expand on this thought by introducing the idea of 'discursive subgroups'. These subgroups are said to be produced when opposing concepts or elements are present and "… are usually believed to be of major importance" (1972, p.66). According to Foucault, these theoretical choices can only be understood through the identification of the authority on which these decisions are made, an authority that he characterizes first by what the discourse is expected to do in the non-discursive practice. This authority also involves "*the rules of and process of appropriation of* discourse" (1972, p.68). He further explains that the property of discourse – which includes the right to speak, ability to understand, to access present information, and to incorporate this discourse into practice — is usually confined to a specific group. This process is important in that it is not a result of the discourse but, in fact, is one of its formative elements (1972, p.68). When considering suicide discourse, it is essential to uncover the rules and the process of appropriation that have contributed to its formulation, for it is this that makes it possible to know what we know.

The presence of an authority in discourse leads us to another important consideration for Foucault, and that is knowledge and power. He believed it was essential to consider power historically and to recognize the "...essential link between power relations and their capacity to 'produce' the truths we live by" (McHoul and Grace, 1997, p.58). He was not concerned with power as an entity unto itself, but rather with how it is exercised and the effects it produced. His conception of power evolved to include the idea that power "...does [not] only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse" (1980, p.119). He believed that power relations could not be exercised or established without "...the production, accumulation, circulation, and functioning of a discourse" (1980 p.93). He further defines these discourses as ones of truth, and therefore possessing the authority to support power relations (1980 p.93). The knowledge or truths that produces discourses also affects self-knowledge, and it can therefore influence the way in which we define who we are. Foucault exemplified this in his research where he explores the idea of 'the subject' in medical discourse. This subject is the patient who came to be created and defined by the discourse, as a result of the power relations that the discourse supports.

Foucault provides a view of discourse that encourages the researcher to step outside of the more familiar structuralist perspective of language. It becomes possible to consider specific discourses, the influences that have both constrained and enabled its existence, and the power relations that the discourse supports. As Foucault himself suggests, it is only when we understand discourse in this way may room for new ideas be created.

## Method

Suicide is a subject that is not generally 'talked' about, but at the same time there is a recognized proliferation of written work. Suicide is associated with a shroud of silence that often precludes open dialogue, and it is commonly implied that it is the taboo or stigma that is responsible. Since the mode of understanding this phenomenon appears to be predominantly text, it is important to analyze the text that has been created through this communication medium. Strategies that are implemented in an effort to ameliorate social problems are not created in isolation. These strategies are influenced and often dependent on the knowledge and direction that is made available through a variety of sources. Funding for suicide prevention efforts are necessary and the federal government is identified as a primary source. Therefore, the suicide discourse that is contained in government documents has the potential to influence the direction of prevention efforts. In order to understand the strategies that are implemented to prevent suicide the discourse must be exposed. This will be accomplished through a descriptive analysis of the suicide discourse as presented in federal government publications and other literature identified by the criteria defined by the researcher. Incorporating Foucault's concept of discourse as bodies of knowledge rather than language, the analysis will include a discussion on how the 'space' for suicide discourse has been created and continues to be created. The reality that is created as a consequence of the present day discourse for those experiencing suicide will also be discussed. Rather than adding to the bank of knowledge that presently exists, this analysis will offer a description of the "official" government discourse that has guided and continues to guide the development of knowledge on suicide in Canada.

The method that will be used to accomplish this task will be qualitative, specifically a stream of discourse analysis in the tradition of Foucault, utilizing text as a data source. Text will be defined for this research as written material that meets the criteria as defined below. The goal of this research will be to uncover the discursive patterns in government documents that are produced to enhance, support, and create knowledge and strategies for the prevention of suicide. There will be a focus on the conditions of knowledge, why the discourse takes the form that it does, an examination of what is not being said, and who and what motivated the discourse. The data that is required to describe suicide discourse may best be explained as purposeful. Text that does not focus on suicide exclusively will also be considered, if suicide is a topic of interest within the document. The researcher will chronologically identify 'text events' specific to suicide that will guide the process, and the criteria defined below will then determine the final selection. Recognizing the arbitrary nature of the decision, the researcher will look at text (not conditions) that have been produced from the 1970s to the present.

## The Data Criteria

Several criteria will be used to determine how documents are chosen. The first criterion that must be met is that of official discourse. Not all written work is perceived or valued equally, and therefore, it is the legitimated text that will be the focus of this study. Legitimated text is that which has an established credibility through affiliation. Health Canada was chosen as the primary source of data, as it is identified as the state institution responsible for the overall health of all Canadians. The mission and vision are defined on the official Health Canada website. The mission states that Health Canada is the federal department that is responsible for helping the people of Canada maintain and improve their health. The vision asserts that Health Canada is committed to the following: improving the lives of all of Canada's people; to making this country's population among the healthiest in the world, as measured by longevity and lifestyle; and ensuring effective use of the public health care system.

Health Canada documents will be located through the official website and libraries. Other documents will be included if they are recognized as contributing to the understanding and perceptions of suicide in Canada. These documents have the potential to influence the production of Health Canada documents, either as references or through shared authors. These documents must also meet all additional criteria as defined for the Health Canada documents.

The second criterion is accessibility. It is important to include those documents that are readily accessible to the public at large and professional communities, with the assumption that this enhances the potential of these documents to influence the way in which suicide is understood. Therefore, all documents are available online, in most libraries, or for purchase. The issue of accessibility becomes relevant if the documents are viewed as providing facts that are then incorporated into policies (at government and organizational levels) that directly affect those who experience suicide in their lives.

Authoritative discourse and acceptability are included as the third and final criteria. There has been an historic proclivity to control suicidal behaviour in Canada. The strategies that have been implemented have met with limited success, yet the pursuit continues. Government initiatives began in Canada in the 1970s and were influenced to a large degree by the professionalization of suicidology in the United States. The creation of a core group of 'experts' has resulted in a reservoir of knowledge that has become accepted as truth. Government documents often incorporate the knowledge from this core group, thereby creating implicit authority for these texts. The content as described and the position of Health Canada as a respected source of information generates power within the discourse that is produced.

> It is when a particular fraction of a class is both claiming epistemological privilege *and* is in effect in control of the technical production of certain discourse in general and in explicit control of certain texts in particular (as in government publications) that it is most important, *in the interests of a politico-theoretical conception of science*, that a discursive deconstruction of those texts should be made.
> (Burton and Carlen, 1997, p.129)

## A 'Space' for Suicide Discourse

An analysis to determine the discursive practices incorporated in the documents will be critical in explaining the present day knowledge that is promoted on suicide. The historical relationship between discourses and within suicide discourse will therefore be explored in an attempt to elucidate how discourses can be supportive or detrimental to the development of ideas. In recognition of the commonly reiterated warning that history can be subjective, relationships will be identified through actual statements, memberships, and references. The researcher will employ a sequential procedure, thus incorporating documents over a period of time, with a primary focus on the actual text while paying heed to the external factors that have influenced the production of the text. Transformations defined by Foucault as 'rules' and limits will be examined. How these rules and limits have guided the production of suicide discourse will be explored. Correlations will be examined to determine the relationships between discourses and within suicide discourse and how these correlations have contributed to this 'field of knowledge'.

## Intentionality

Government documents are produced for a purpose. Van Dijk (1997) describes discourse as a communicative event. Despite the fact that text does not afford the opportunity for two-way communication, it does have a purpose and can be designed to solicit a reaction. Government documents are assumed to provide direction and are therefore significant in their ability to construct meaning and contextual understanding of social issues. Burton and Carlen (1997) describe official discourse as didactic, explaining that it presents both science and ideology, and the search for truth is sometimes obscured (p. 121-123). An exploration of intent would therefore assist in a more thorough understanding of the discursive patterns found in these documents.

## The Data

The following is a brief description of the data that will be analyzed and the researcher's rationale for the choice of documents. They are listed chronologically and meet the criteria previously outlined. The shared features include a Canadian focus, Health Canada affiliation, and with limited exception, collective authors.

a. *A New Perspective on the Health of Canadians*, 1974: Endorsed by Marc Lalonde, the Minister of National Health and Welfare at the time, this document is described as one of the founding documents in health promotion.

b. *Report of the Task Force on Suicides* ('The Boldt Report'), 1976: Although this document is from a provincial government (Alberta), it is included because the 'model' for the reduction of suicide that it promotes has been adopted in future documents. It is also the only effort that has been led by a sociologist who is recognized as having 'expert' status in the country, which earned him the Stengel Research Award from the International Association for Suicide Prevention.

c. *Suicide in Canada: Report on the National Task Force on Suicide in Canada*, 1987: This document is acknowledged as the first effort in Canada to recognize suicide and move toward the development of a strategy to reduce deaths by suicide. The Task Force was established after Canada hosted her first International Conference on Suicide in 1979.

d. *Suicide in Canada: Update of the Report of the Task Force on Suicide in Canada*, 1994: This document was the collaborative effort of a group of 'experts' in the field to update the previous report.

e. *The Canadian Guide to Clinical Preventative Health*, 1994: This document was chosen because it includes a chapter specifically on suicide.

f. *A Report on Mental Illness in Canada*, 2002: This document places the issue of suicide under the mental health umbrella, despite a recognized ongoing debate regarding the appropriateness of this choice. Therefore, its potential to influence the future direction of suicide discourse seems obvious.

g. *Report on the Workshop on Suicide- Related Research in Canada*, 2003: This is described as the first multi-disciplinary collaboration in Canada to address the issue of suicide. The document was the result of a workshop co-sponsored by Health Canada and the Canadian Institutes for Health Research (CIHR) and provides guidelines for research on suicide for the next ten years.

# Chapter Three - Analysis

## Introduction

Suicide was a crime in Canada as a result of the common laws that were imported from the United Kingdom during our status as a colony. The decriminalization of attempted suicide was a condition that was pivotal in creating a space for suicide discourse. The view of parliamentarians at the time was that a more humane alternative was warranted, and that the suicidal would be better served by the medical community. It is interesting to note that this change to the criminal code occurred following an investigation of the penal system. The system was being condemned for the number of suicides that were taking place among prisoners that were incarcerated. Whether motivated for truly humane reasons or as a measure to reduce suicides in the prison system, it was successful in having suicidal individuals removed from corrections and placed under the care of health professionals. Decriminalization only took place in 1972, and with this sanction removed, it became necessary to control this behaviour by other means. The cause/cure model of treatment so prevalent and recognized at this time would create an environment for suicide discourse that would seek empirical evidence supporting a treatment plan that was amenable to the medical model. This analysis will begin by focusing on the first five foundation documents that span two decades from 1974 to 1994.

### A New Perspective on the Health of Canadians, 1974

The first document, commonly known as 'The Lalonde Report,' endorsed in 1974 by the Minister of Health and Welfare, Marc Lalonde, is described as, "a cornerstone of

Canada's international reputation and a proud historical achievement in the health field" (www.phac-aspc.gc.ca).

The Lalonde Report was written at a time when the ability of public health and health care were being touted as having the capacity to alter the state of overall health of the population. A Scottish doctor, Thomas McKeown, would promote the idea that healthy behaviour and ones' social and physical environment had more influence than biological status or medical care. This was supported by the reality that the expenditures focused on public health and health care (curative medicine) were not having the positive impact on overall health that were anticipated. He began to look at other influences and the "Health Field Concept," which would later be integrated into the Lalonde Report (Glouberman, 2001, p.5). Glouberman would further explain that despite the success of the Medicare system in Canada, inflation in the mid 70s and the particular concern related to early deaths would create the motives for a new look at health. Hubert Laframboise, with the support of the Deputy Minister of Health at that time, would spearhead the effort. He would become the Director General of the Long-Range Health Planning Branch, and would then hire a team of policy planning consultants to think about how the future of health in Canada over the next twenty-five years may evolve. This team would also be asked to bring to light issues in the health field that had not yet been identified. McKeown's health concept was viewed as providing the opportunity to reduce the underlying causes of ill health that was regarded as the key to overall improvement. Versions of the concept would be tested in presentation and paper form, and with the incorporation of feedback received, the final product was produced. The tools that the final paper would support include legislation, persuasion, reorganization, and research. The Lalonde Report, is accepted by many as the one that began the public promotion movement (p.10-11). The concepts in this paper are presented as having been unanimously endorsed by the federal and provincial Ministers of Health at a meeting that was held in Ottawa in 1974. This clearly supports the ideas presented as having authority, power, and the potential to influence how health care would be modeled in the future, and that is precisely what it did. There are several general conditions and specific statements in relation to suicide that would guide future research and amelioration efforts of this phenomenon. Although not explicit in relation to suicide, the general conditions will be discussed, as well as statements that can be aligned more definitively to suicide discourse. It is also important to remember that the decriminalization of suicide occurred only two years prior to the publication of this paper. It can be anticipated that the need to 'deal' with the suicidal was becoming a reality for professionals, and more specifically, health care professionals.

The conditions, those ideas that influence and create a space for suicide discourse, that are present in the paper include the following: the weight placed on self-imposed risks; the defining of high-risk populations; mortality and morbidity as determinants of national health; the need for individuals to take more responsibility for their own health; the need for the government to take a more aggressive role in the health of Canadians "for whose health they are responsible." (p. 9); care versus cure; and science versus health promotion.

In the introduction it is made clear that health is a gift, and that generally Canadians are irresponsible and take unnecessary risks that are detrimental to their health, as they tend to look on "the sunny side of risk and probability" (p.8). The paper would begin to credit the idea of identifying causes of mortality and illness as critical to the pursuant development of strategies to improve the health conditions, and this condition remains primary in suicide discourse today.

The document starts with a discussion on the traditional view of health, and the limitations that this view supports. It describes the 'traditional or generally-accepted view' as having retained 'a dominant position,' resulting in the quality of the medical care system being synonymous with the level of health. The stage is being set for the argument that monies would be better spent on prevention and health promotion rather than the present situation where the lions' share of the expenditures are physician-centered (p.11-12). It is likely that the recognition of the escalating costs for health care could not be sustained at the present level, therefore viable alternatives needed to be both explored and rationalized.

In the chapter on the limitations of the traditional view, two alternatives for assessing the influence of various factors on illness are presented. The first is a historical approach, but it is the second that is developed, and that is the examination of the nature and underlying causes of mortality and morbidity. It is not suggested that mortality generally reflected adversely on the health of Canadians, but rather it was the early deaths that did so, and therefore it was these deaths that needed to be isolated and reduced. When early mortality became identified as a primary indicator of a nation's health, one of the most profound statements related to suicide was established. As a cause of early death, suicide would be on all tables and graphs as an issue that would remain in clear view, and one that would stand in the way of improved health status unless it could be reduced. After car accidents and other accidents, the report identified suicide as the third leading cause of death from age five to thirty-five. The brief explanation of these deaths has moral overtones and suggests that the individual is the primary factor in these deaths. "Since all these causes of death are mainly due to human factors, including carelessness, impaired driving, despair and self-imposed risks, it is evident that changes in these factors are needed if the rates of these deaths are to be lowered" (p.14). This would not be the only time that suicide is linked to the concept of "self-imposed" risks, suggesting that the suicidal are culpable for their own deaths. This concept would place suicide with other examples, such as cancer and smoking, and heart disease and obesity, giving the impression that the connection is obvious, and most importantly not only a choice that individuals make, but a bad choice directly linked to outcome.

The concept of self-imposed risks is expanded on, and a list is offered that is described as "a grisly litany of the more destructive lifestyle habits and their consequences" (p.16). It is notable that, despite the inference earlier that suicide belongs in this category, it is not in the grisly litany. What we do find are addictions, diet and exercise, careless driving, and promiscuity.

There is also a discussion of environmental issues "about which the individual can do little or nothing about" (p.17). The issues include water, air pollution, urbanization, and working conditions. The discourse digresses and, as is not uncommon in this document, moralizes this time about the social condition and "the crumbling of social values" (p.18). Once again there is a reminder that putting our own pleasures and needs first and sacrificing the common good can only lead to stresses that will be disastrous to health (p.18). The discussion concludes by affirming that it is these risks and not an inadequate health care system that provide the greatest risk to health, and it is here where efforts need to be focused.

Chapter three, which is titled "the major problem areas in the health field," expands on what is defined as the three main indicators of the health status of a population: life expectancy and mortality rates; causes of death; and morbidity. The importance placed on these determinants would have implications for the future of health discourse generally. There was a move away from acute illness to chronic illness and accidents, which supported the transformation from cure to care. The paper would identify heart disease, accidents, respiratory disease, and mental illness as the main 'causes' of hospitalization. The paper would also promote the need for ill-health to be measured through surveys and databases. Once the causes are understood and prioritized, programs could then be established to reduce the causes of early death. This would be taken one step further, and specific examples of the kinds of programs that are likely to result in a reduction of the prevalence of the causes of early death are suggested. Some examples of these programs included mandatory seat-belt use, stricter sanctions against impaired drivers, education campaigns against smoking, control and treatment of alcohol abuse, and promotion of physical fitness. Despite the fact that suicide is clearly identified as one of the leading causes of early death, no program recommendations were made specific to this cause. A paragraph that states that, "it is estimated that about half the burden of illness is psychological in origin," and that, "the social stigma attached to mental illness has contributed to the neglect of this area," does not make reference to suicide (p.25). It only appears in a list as follows "alcoholism and drug addiction, homicide and suicide, crime" (p.25).

The section on morbidity ends with a moral discourse, again focusing on the need for individuals to take responsibility for their health: "Individual blame must be accepted by many for the deleterious effect on health of their respective lifestyles"; "the many contributors for physical and mental illness for which the individual must accept responsibility and for which he must seek correction" (p.25). The medical research community is challenged to change its focus from the human biology to improving the knowledge on causes of illness that are related to the environment, lifestyle, and the health care sectors. It is argued that the monies being spent on treating existing illnesses needed to decrease, and more funding needed to be allocated for research and prevention, as this is where the future good health of Canadians rested (p.30).

In order to appreciate how this document transformed health discourse and the consequent influence it would have on suicide discourse, it is necessary to examine the Health Field Concept that it promoted. The rationale for the adoption of this model was that, in order to analyze and evaluate the health field, it was necessary to do the following: "break up the field into manageable segments"; "sufficiently simple to permit a quick location of almost any idea"; and "[create] a sort of map of the health environment" (p.31). The elements were developed based on the factors affecting the level of health in Canada. The first element, human biology, is defined as, "all those aspects of health, both physical and mental, which are developed in the human body as a consequence of the basic biology of man and the organic make-up of the individual" (p.31). The next is environment, defined as those things which are external to the individual and over which they have little or no control. The third is life-style and is described as the decisions that individuals make that affect their health, which "they more or less control" (p.32). The last element relates to the organization of health care, or the systemic issues related to the health care system. This concept is described as, "a powerful tool for analyzing health problems," "comprehensive," and it permits any question to be examined, and planners can focus on the most important contributing factors (p.33). One of the main problems identified in the challenge of improving health was that, "the essential power to do so is widely dispersed" (p.34). The fragmentation of responsibility was believed to be what led to certain issues having more importance than others, and this concept would create a "unified whole which permits everyone to see the importance of all factors, including those, which are the responsibility of others" (p.34).

The concept was developed with two goals in mind. The first was to increase the understanding of the causes of ill health and to identify what courses of action should be taken to improve health. It was acknowledged that rigid allocation of problems to one of the categories is not always possible, and that some issues may fall into one or more or all of the categories. The challenge of dividing external influences between those things that are in our control (lifestyle) and those things that are not (environment) was also presented. The long debated issue of free will was introduced, in reference to when this was no longer applicable to individual choice. It was concluded that the acceptance of the fact that environment affects lifestyle and personal habits are addictive, "requires a philosophical and moral response rather than a purely intellectual one" (p.36). "In short the deterministic view must be put aside in favour of a faith in the power of free will, hobbled as this power may be at times by environment and addiction" (p.36). This implies that despite the external challenges facing individuals, they still have the power to overcome and make the best choice, reinforcing again that ultimately the responsibility for improved health rests with the individual.

The document then addresses what is labeled, 'the ultimate philosophical issue raised by the concept,' and that is whether or not the government should get involved in the business of modifying behaviour. This document makes clear that the government has a duty to counteract negative influences on Canadians. The example of the television is described as being responsible for contributing to inactivity, and it is believed that this same media should be used to promote activity. "One must inevitably conclude that society, through government, owes it to itself to develop protective marketing techniques to counteract those abuses" (p.37). This was the beginning of an acceptance of the power of public education campaigns and a move to demand that good health become the personal responsibility of every Canadian.

Populations at risk are discussed at length. They are described as contributing adversely to the rates of ill health compared to the average person, therefore making it necessary to identify them, so they could be the focus of campaigns to reduce illnesses. Risk is defined as a statistical term expressed in percentages or odds, which helps to predict the likelihood of an event occurring in a particular group. The following criteria are given for the defining of a high-risk group: causes of mortality and morbidity; underlying reasons for this occurrence; and susceptible segments of the population. Once the population has been identified, the goal is then to reduce the contributing factors in the population at risk. "The identification of high-risk populations as targets for national risk-reduction programs depends on a number of factors including the gravity and incidence of various kinds of sickness and death, the availability of practical measures, and the costs" (p.40). It is here where the idea is introduced that care must become as important as cure, in order to meet the needs of these populations. The construction of risk discourse and the resultant categorizing of populations that has become familiar today in health discourse were established here as necessary to the improvement of overall health.

The call for more research is loud and clear. It is stated that health research is under-financed, and not enough money is allocated to clinical, socio-medical, and organizational aspects of health and health care. The challenge identified is that the science method is problematic because of the continuous existence of conflicting opinions, making agreement on factors and causes of illness difficult. It is concluded, however, that the health problems are sufficient to warrant that action be taken even if all the scientific evidence is not present (p.58).

The section on mental health begins with a statement related to the social stigma that, "generates such feelings of guilt that the subject is rarely talked about except in the abstract" (p.61). There are two references to suicide in this section: one refers to no one wanting to admit that a spouse had died by suicide; and the second in connection to criminal charges sometimes made against people who attempt suicide, as an example of the implications of mental illness (attempted suicide was no longer a crime at the time this was written). The two pages devoted to this topic focus on the need for changes in society's value system, the heavy burden of a diagnosis, and the need to dispel the shame before any programs will meet with success. "Measures to lift the cloud that obscures the subject of mental illness are an urgent prerequisite to action" (p.62) The goal of dispelling the stigma surrounding mental illness still continues to be a priority today — thirty years later.

The document finally moves to solutions and includes an extensive list (74 recommendations) of specific courses of action that could be taken. Hope is offered to professionals who are frustrated by the non-compliance of patients, specific to those who engage in lifestyle choices that are detrimental to their health and suggests that this paper offers “the opportunity to recruit powerful forces to their cause” (p.64). This promotes what can be described as a paternalistic attitude that gives the government and professionals the power and mandate to define priorities and design programs to alter those behaviours that are deemed detrimental to the good of all. Health promotion would take a front seat and would be aimed at “informing, influencing, and assisting both individuals and organizations so that they will accept more responsibility and be more active in matters affecting mental and physical health” (p.66). It also promoted the use of federal regulation powers, research, efficiency measures in the health care system, and the setting of specific goals. In recognition of the fact that funds are limited, it is emphasized that choices must be made. The paper ends with a ‘panorama of mortality in Canada’ in the form of a chart, which demonstrates the importance of lifestyle to mortality up to middle age. Suicide is included as a major cause of death up to the age of 49, at which time it disappears from the charts, “not due to a decrease in incidence but merely to a decrease in importance compared to other causes” (p.76).

The general conditions advanced in this document that would influence suicide discourse in the future include: the need to determine factors that contribute to the causes of death the need for empirical studies; the need for data that can be analyzed; prevention as a preferred strategy for reduction of early deaths; and the need for a multi-dimensional approach to the understanding of ill health issues.

**Summary of Discourse Themes**

This document includes one of the strongest statements related to suicide — that is, the charts and tables that clearly recognize suicide as a significant cause of early death. Despite this undeniable reality (given that risk is determined by numbers), it is unclear as to where the issue of suicide fits in the Health Concept Model, and this uncertainty continues to constrain suicide discourse today. Although never explicitly stated, the inference is made that suicide is a choice, as the connection to the Lifestyle sector is made most often. The document promotes the idea that those who continue to participate in self-imposed risks are being irresponsible and putting personal wants before the good of all. Suicide, when it is referenced, albeit isolated sentences, is connected to stigma, shame, and criminality. When this connection is made, the strategy promoted is primary prevention, and this remains a focus in suicide discourse. There is also an implication that individuals who make 'bad choices' need to be educated and influenced by awareness campaigns that support them in changing their behaviour. The prerequisite for such campaigns is the identification of those at risk so they can be targeted. This document has created conditions for health care provision in general. Risk discourse, public responsibility, primary prevention, scientific research, and decisions founded on the collection of data would impact suicide discourse. Since there are no recommendations specific to suicide and no attempt at explanations, despite the 'numbers,' the reader is left with the feeling that it is somehow not a priority or perhaps best left in the hands of the suicidal individuals. Suicide is identified, but is not acknowledged in any meaningful way that could potentially inspire the professional community or others to view it as a priority.

## Influences Outside our Borders

Prior to looking at further documents, it is important to discuss transformations within suicide discourse that were occurring outside of Canada that influenced the discourse within our borders. What happened within the discourse, particularly in the United States, would have a profound influence on the development of suicide discourse provincially and federally in Canada.

In 1958 in Los Angeles, California, a pilot project began with a mandate to save lives and conduct research in the area of suicide. Farberow, Litman, Shneidman, the three founders of the Suicide Prevention Center, would become revered as experts in the field. They were sought out as having both knowledge and experience that could assist the professional community in developing strategies that would prevent suicide. Shneidman would become known as the 'father of suicidology,' and in 1968 would establish the American Association of Suicidology. This Association soon produced a peer-reviewed journal that set the standard (quantitative) for how research would be conducted and what the priorities would be for research particular to suicide. These three men would become prolific writers (often published in the journal produced) and mentors who were in high demand as speakers, consultants, and endorsers of other efforts to prevent suicide. They promoted the idea that suicide could be prevented, and that empirical research would provide the answers needed to accomplish this. When the study of suicide became a *science*, this transformation within the discourse would first and foremost create the need for the space for the 'expert.' The credibility of these experts would rest on their education, their discipline, their publications, and the respect of their peers. Psychology predominated the discourse, placing limits on the introduction and recognition of alternate explanations. It was during this time that the 'Boldt Report' was written.

## The Boldt Report, 1976

Dr. Menno Boldt, a sociology professor at the University of Lethbridge, would chair a task force in Alberta to examine present knowledge on suicide, determine the localized problems, and develop recommendations. The Los Angeles Suicide Prevention Center is named in the acknowledgements as contributing both to the understanding of suicide and potential solutions for prevention. Although this is not a federal document, Boldt would carve a place for himself as an expert internationally, and the strategy for the reduction of suicide that was developed (The Alberta Model) would become recognized as a model of inspiration for communities worldwide.

"Suicide is a complex social phenomenon" (p.1). This statement is the first line in the document and is a profound statement about suicide. The continued reference to suicide as a complex issue would propel the discourse in the direction of *a need to acquire more knowledge* and in particular 'scientific' knowledge. Reminiscent of Lalonde Report's Health Field Concept, Boldt would support the need for social, psychological, and medical approaches in any plan to reduce suicide. Boldt agrees, "that the lack of definitive and fully specified answers to the problem of suicide must not be used to rationalize inaction or half-hearted action" (p.2). While this statement is a reminder that knowledge is insufficient, there is an urgency to move forward in the face of this in order to bring attention to this issue.

The urgency is compounded by the perpetuation of a belief that the suicidal do not want to die but rather these acts "are cries for help, and for the most part they go unanswered" (p.35). This is a familiar statement in suicide discourse, connected to a commonly held belief that, "more than two-thirds of completed suicides communicated suicidal ideas prior to committing the act" (p.44). The idea is confirmed when it is suggested that help needs to be made available "before they are driven to the extreme of threatening, or attempting to kill themselves in order to get someone to listen" (p.52). This discursive pattern carries with it an impression of the suicidal as desperate individuals and therefore solidifies the roles of victim and protector. The suicidal become a group to be saved, protected, managed, and rehabilitated.

Suicide discourse is fraught with conflicting statements. It is this conflict that presents itself as a powerful statement, in and of itself, that has determined the direction of the discourse. There are many examples of this conflicted reality in the Boldt Report. The one that is consistently visible is the persistent identification of the need to acquire more knowledge, despite the fact that it is commonly accepted that there exists a vast amount of literature on suicide. This conflict implies that, even though extensive efforts have been made, the solution to this 'complex' problem has yet to be found. The debate in relation to suicide as a mental illness is ongoing, and it is one that has gained and lost popularity through out time. Boldt repeatedly declares suicide as a social problem. "We know...that suicide results from a combination of one's social setting and one's psychological set" (p.19). Despite the affirmation of the social nature of suicide, later in the document in the same paragraph, he suggests that there are "several good reasons why suicide services should be placed under the mental health umbrella," and that, "not all potential suicides are mentally ill, but they are unhappy and disturbed" (p.91). This debate could be understood by the continued effort to make sense of an individual's decision to die rather than live — that is, to find a cause. There appears to be a general reluctance to view suicide as a meaningful act, and this becomes understandable because it stands in conflict with the development of strategies to reduce these deaths through programs that are focused on causes. If suicide can be unequivocally connected to mental illness, then prevention becomes possible through treatment modalities, and the continued need for the study of suicide is supported. Again, this affirms the necessity of determining causes as primary to prevention.

Another conflict that is illuminated in the Boldt document is directly related to the nature of suicide. "Suicides... typically occur during crisis situations and require immediate attention" (94) and "suicidal persons need help of a time-consuming and long-term nature" (p.103). This is conflicted because of the debate over whether suicide is an illness or situational, which is aligned with the philosophical debate of rationality. The debate over whether a suicidal person is rational at the time of death or not remains unresolved, and perpetuates the quandary over how best to 'deal' with the suicidal.

Despite the critical issues related to suicide, the approach that the task force purports is one that is defined under the general headings of prevention, intervention, and postvention. This statement implies that suicide is best dealt with by implementing this strategy, and its acceptance as fact would influence the direction of future discourse. It is interesting to consider these three categories as discipline-related (prevention - social) (intervention - medical) (postvention - psychological), and to reflect on whether this may in fact contribute to a divisiveness that has long beleaguered this discourse. The concepts of prevention, intervention, and postvention were developed and presented in a book edited by Shneidman, Farberow, and Litman (1970), but credit was not given to the source of this strategy in the Boldt Report. It is interesting to contemplate why credit was not given, in light of the fact that the Los Angeles Center established by these three men is acknowledged as a Center of excellence. The three concepts defined by Shneidman are as follows: (1970, p.147-154):

> **Prevention**: Those things that will prevent suicide from occurring, things that are done before and fall in line with public health and primary prevention strategies.
> **Tasks**: Research (specifically suicide and youth, biochemistry of, interpersonal relations, cognition, personality studies, terminal illness, environmental deprivation and stress, use of volunteers, psychological autopsies), special training for gatekeepers to enhance their detection skills, and massive public education (that must be developed, monitored, and studied by experts)
>
> **Intervention**: This is the place where things are done during the crisis, to reduce the stress and deter future crisis from occurring.
> **Tasks**: Research special groups that need special support (children, the Negro, American Indians, the aged, etc…), refinement of psychotherapy techniques, better cooperation and use of services available, development of a group of dedicated, trained professionals, creation of a fellowship in suicidology, and promotion of the use of volunteers as frontline workers.
>
> **Postvention**: These are things that need to be done to support those who attempt suicide and survive and those who are bereaved after a death by suicide has occurred.
> **Tasks**: The need to look at a new classification to improve record keeping and the statistics (inadequate at present) that would result in special programs (follow-up)

to support those who have attempted suicide and those who are bereaved as a result of a suicide.

It is not the intention of this study to analyze the information above, but rather to offer it as a reference point for the discourse that is present in the Boldt Report, and support the limitations that these conditions would place on the direction of suicide discourse in Canada. The Boldt Report would adopt the prevention, intervention, postvention framework as a foundation for the development of an approach to prevention. The Boldt Report would define the concepts as follows (p.21-28):

**Prevention**: The eradication of underlying causes that produce suicidal people.
**Tasks**: Emphasize and encourage improved family skills, advocate social change that would reduce those circumstances that support failure, rejection, and hopelessness.

**Intervention**: The treatment of those who attempt suicide.
**Tasks**: Efficacious treatment methods are needed, develop procedures for early detection, concentration on high-risk groups, be ready for immediate response.

**Postvention**: Reducing associated disability and preventing reoccurrence and counseling the bereaved of successful suicides, especially youth.
**Tasks**: Rehabilitate those who have attempted suicide and survived, offer long-term follow-up, and counseling as standard procedure for the bereaved.

When a comparison is made between the two presentations of these concepts there is one notable difference, the Boldt Report specific to the tasks takes a more practical and service-oriented approach reflected in the tasks. However, the adoption of this framework is limiting and would further influence the model as it too aligns with the general concepts defined.

The Task Force would set out to review present knowledge (what is known), do research if needed (what is not known), and provide recommendations (what should be done). The focus would be "on variables that lend themselves to manipulation" (p.5) and the promotion of "a new approach to social responsibility" (p.6) that supports total community involvement. In order to develop such a strategy there would be a reliance on epidemiology, current programs, and knowledge of other programs. The Task Force would solicit information from "the informed elite" (p.7) and would rely heavily on "the collective wisdom of these dedicated scholars" (p.8). Recognizing the vastness of the literature, there is a selection process that must occur to determine what knowledge will or will not be incorporated. "Our conceptualization of the problem and our approaches to it have been profoundly influenced by those who have created this impressive body of knowledge" (p.8). Constrained as they would be by the ideas and concepts of others, the Task Force would contribute to the discourse, not only by adding new ideas but more importantly by reinforcing others. The authority being acknowledged by the task force would continue to transform suicide discourse more and more as they became recognized as having the coveted answers to a long misunderstood phenomenon.

The 1960s and 1970s appeared to be exciting times for suicide discourse, in that there was a sense that progress was being made. Programs were springing up, monies were being invested, and a fraternity was growing. Foucault explored the idea that 'discursive subgroups' (1972.p.66) are produced when opposing concepts are present. Suicide discourse is riddled with risk, medical, moral, social, research, and legal discourses, making the challenge for determining an affective amelioration strategy extremely challenging. The need to prevent deaths by suicide, based on the belief that this was theoretically possible, was a strong statement that would mobilize individuals to solve this problem. The diffusion of explanations for this phenomenon is fertile ground for the production of a discursive subgroup and the birth of suicidology can easily be seen as just that. There is no clear track that can be determined as to how one becomes a suicidologist. They transcend all disciplines, although they were predominately in the psychology profession at this point in the discourse's history. It is the suicidologists who were believed to have the knowledge needed to prevent and/or reduce suicide, and they and would be sought after as a necessary ingredient for the success of any prevention plan. This fraternity would become identified as having privileged rights and virtually unchallenged authority to determine and direct the course of suicide discourse. 'Suicidologist' and 'expert in suicide' would become synonymous. The international and national conferences, associations, peer recognition, awards, and government initiatives were the systems that supported this group and would contribute to the creation of a collective optimism. Those perceived as being the leaders of this 'movement' were gaining status and power that would constitute a commanding formative element of suicide discourse.

The Boldt Report (1976) would embrace several statements related to suicide that were embedded in the discourse at the time. First and foremost is the statement that suicide can be prevented. When this fundamental belief is upheld, it hovers as the ultimate goal and a goal that can only be measured by numbers in the form of reduced rates. The statement that the goal of suicide prevention is to save lives furthers this goal and reinforces the belief that the success of suicide prevention efforts could only be measured by the number of lives saved. With this goal in view, it creates an urgency related to lives hanging in the balance. It also supports the need for 'us' to prevent 'them' from killing themselves. "We must also be ready to take immediate action" (p.24); "We have a humanitarian obligation" (p.41); "It is our responsibility to save lives, our task is the saving of lives" (p.68); "When forcible restraint is deemed absolutely necessary to prevent a person from killing himself, we do see a need for the provisions of this act...providing therapists with the necessary authority to protect those deemed an imminent threat" (p85). Within the discourse, these statements uphold a paternalistic approach that is used to support a power relationship. This approach to the prevention of suicide is unmistakably paternalistic when the following description of the role of a designated center related to intervention is presented: "Those working in the center must *find* the suicidal person, *manage* the suicidal crisis, and *assume immediate, full and on-going responsibility* for *treatment* and *rehabilitation* of all persons referred to them *until these suicidal function normally*, leave the jurisdiction, withdraw, or die" (p96) [italics added by researcher].

When the discourse assumes a position that the suicidal need to be protected and accepts this responsibility, the foundation is laid for the need for specialized knowledge, the accurate collection of statistics to confirm success, the identification of high-risks groups that present the greatest challenge to overall success, and the driving need to find a cause that can be managed. First is the need for specialized knowledge. This is reinforced by Boldt for the first time in the acknowledgement of the contributions of 'experts' to this document, and second in the recommendations for the necessity of advancing suicidology. "Suicidologists generally agree" (p.58); "professionals trained and specializing in the area of suicide" (p.64); "perhaps a program of fellowships in suicidology should be considered which might be taken up at centers of excellence such as The Los Angeles Suicide Prevention Center" (p.80); "the effectiveness of suicide and self-injury services is dependent on the development of a unique, scientifically based, and professional specialty" (p.92). This promotion would create a dependency on this elite group and discourage those who were 'less qualified' due to their lack of expertise and affiliation from contributing in a potentially meaningful way.

Based on the principle of detection, the collection of data is primary in all suicide discourse. "We can only treat those whom we can detect" (p.23). "If we can identify these people in advance we can literally save their lives"(p.20). The importance placed on detection creates a space for three important discursive patterns: the need for accurate data (statistics); the identification of groups at high risk for suicide; and the necessity of determining a cause of suicide. The ability to save lives was inextricably linked to the ability to locate and identify the suicidal. The accuracy of statistics on suicide is presented as an ongoing problem. "The data currently being collected relative to suicide is not useful...not valid, not reliable" (p.29); "Our costs estimates are based on official statistics which we know underestimate the true incidence of suicide by about 100%" (p.38); "with such data we might be able to ascertain rates for all kinds of suicidal behaviour" (p.87); "Accurate reporting of suicides is absolutely essential if society is to see the problem in its proper perspective as a public health problem" (p.130). When the need for valid reliable data that could be adequately analyzed was defined as a prerequisite to prevention, this supported the study of suicide as a science and enhanced the value of the expert. A primary goal connected to the need for data was to improve the ability of professionals to identify those at risk for suicide, in order that they are able to save lives. Accurate reporting was also deemed necessary to accomplish the task of identifying high-risk groups.

Risk discourse plays a critical role in suicide discourse and has resulted in profound statements specific to particular populations, and the resultant strategies for amelioration. This discourse strengthens the need to continue to pursue a paternalistic approach to prevention. This becomes obvious when the list of high-risk groups is identified. "While the tragic trend in youth suicides deserves special concern and attention, we dare not limit ourselves to that problem alone" (p.35). Boldt states that through analysis, other high-risk groups have been identified: previous attempters, those with a history of mental illness, those who have experienced family disruption (divorce, death, domestic conflict), chronic, debilitating or terminal illness, transients, unemployed, retired, in the case of housewives, the "empty nest" syndrome, and Native Indians. He states that the one thing they have in common is that, "society has defined them as undesirable, and has rejected them" (p.36). Further in the document, he adds drug abusers, alcoholics, the depressed, and the isolated elderly (p.52). There is an apology in the document related to the Indian population, in that this group was not addressed in depth. There is also a plea to the government to fund a study on Indians, and that this study must be given the highest priority (p.150).

With the identification of those at high risk of dying by suicide, the discourse is transformed in meaningful ways. First, there is the need to prioritize groups and decisions made as to which group demands the most attention and funding. A study as to how these decisions are made would be interesting, especially when one looks at how the determination of high-risk groups and the programs that have been implemented have changed over time. It is critical to not lose sight of the fact that these groups are identified through rates that are determined from data that is consistently described as inadequate.

In this document the following statement suggests the subjective nature that such decisions are vulnerable to. “We may feel we understand why older people, especially the lonely and unwell, kill themselves. Less intuitively understandable, however is the rising suicide rate among the young” (p.70). The latent message that is given space in the discourse, when such an emphasis is placed on particular groups, is that some are more worthy of saving than others. Second, programs are also designed to reach a target group that is deemed a priority, making the consequences of risk discourse not just theoretical but contributing to a lived reality for those not ‘chosen.’ The need to detect the suicidal would also contribute to the need to find a cause, or multiple causes, for suicide that would improve the ability to detect. The continued search for a cause places research as a priority beyond all others. “The more research that is conducted, the closer will we be to the goal of reducing the rates of suicide” (p.67). “If we do not improve on existing knowledge of the causes of suicide and non-accidental self-injury we will be wasting much valuable time and effort in continually intervening in suicidal cases without adequately dealing with the underlying causes of suicide” (p.66). Despite this recognition of the need for knowledge, there still remain in the discourse two dimensions described as a reality for suicide that are reflective of moral discourse — these are guilt and stigma.

A commonly held dimension of the experience of the bereaved by suicide is “intense feelings of guilt” (p.144). Suicide discourse supports the bereaved experience of guilt as shown by the following statements. The discourse describes the experience of suicide as “not supported”; “the outcome depends on how others react” (p.26); and “we know a person who attempts suicide is influenced by those around them” (p.26). The discourse also states that those who commit suicide broadcast their intentions, beg to be saved, and that it is the inability of others to respond that contributes to death as an outcome (p.21). The bereaved in an attempt to understand their loss will be confronted with facts that clearly imply they were remiss in some way, and that they could have altered the outcome. The explanation in the discourse for the apparent disregard of these "cries for help" is explained by another commonly held concept in suicide discourse — stigma.

It is virtually impossible to read anything on suicide that does not make reference to stigma and taboo, and this document is no exception. "Even if a member makes an attempt that does not result in death there is an oppressive burden of fear, stigma, and stress" (p.28). The task force was candid about the limited responses they received from organizations and agencies when they were asked to prepare briefs. The conclusion reached was that the limited response was a reflection of "the depth and extent of apathy and, indirectly, the stigma that attaches to suicide in our society"(p.8). Although "there is an increasing willingness to deal with it…it continues to carry a heavy stigma and is still a 'taboo' topic" (p.43). This has become an accepted statement in suicide discourse, not only as something that needs to be reduced, but it is also used to explain some of the conditions that exist relating to suicide. The under reporting of suicide deaths is one of the primary reasons given to support the inadequacy of available data, and stigma is seen as a reason. "The influence of religious and social taboos can be observed in concealment, at various levels, of the true cause of death" (p.31). "Because of the social stigma…certifying officials are under considerable moral and social pressure to give surviving family members the "benefit" of any doubt" (p.31). "The gathering of suicide statistics is a social process" and this will not change until "there is a significant change in the public attitude to suicide" (p.33). Stigma is also offered as the reason that the bereaved by suicide struggle, in that the death of a loved one by suicide "holds a special burden of shame, guilt, anger, and perplexity" (p.27). "No other kind of death produces such lasting emotional scars" (p.27). To protect the family, "well-meaning officials (police, doctors, coroners)" conceal the mode of death "to spare surviving family members" (p.31).

It is interesting to note that the reference to guilt, blame and stigma are stated as facts rather than offered as a dimension of the experience that is constructed external to the bereaved, and in doing so supports the existence of the very stigma that is condemned. The impact of stigma is also used to explain "the lack of an adequate response...which is deeply rooted in the pervasive taboo...and acts as an obstacle to early detection and effective treatment" (p.44). Stigma and taboo are presented as a reality that is connected to suicide and as having an immobilizing impact on all who are touched by this phenomenon.

### Summary of Discourse Themes

Connected to these statements, the statements that exist and the discursive patterns that emerge in the Boldt Report would provide a foundation for future discourse. There are several statements that have been identified. The first is the multiple tables and graphs (19 were included in this document) depicting the numbers and rates of suicide, as a constant reminder of the success and failure of efforts to reduce early deaths by suicide. The second is a combined pattern produced by the ever-present statements that suicide can be prevented and that the suicidal do not want to die. This is what mobilizes the efforts of amelioration and propels the discourse in a paternalistic direction. The urgency that is witnessed in the discourse and the acknowledgement of a moral obligation stem from this statement and the resulting need to determine what must be done to stop people from dying by suicide. Contributing to the urgency is the statement that identifies the increasing rates of deaths by suicide. Next is the statement that threads through the discourse and that is the idea of detection. In order to save the suicidal, they must be located. This would lead to an emphasis on epidemiology, statistics as critical to prevention, identification of high-risk populations, and the need to educate everyone about the clues and warning signs that the suicidal are said to give prior to a suicidal act. An additional statement that constrains and influences the discourse is the continued search for a cause. This is a reminder that, in the hierarchy of discourses that are intertwined in suicide discourse, illness discourse is number one — that is, find the cause, then find the cure, or at the very least find a reasonable explanation. This would profoundly transform the discourse. The task of determining the cause would require research and eventually specialists. Lastly, the statement that prevails is the connection between suicide and stigma. This connection is conveyed as an accepted reality in the discourse and a continued enemy of prevention. The Boldt Report has maintained its status as an important document in suicide discourse, as shall be witnessed in future documents.

## Suicide in Canada, The Task Force Report, 1987

Canada was the host of the 10th annual International Association for Suicide Prevention Congress in 1979. This is described as the first time that suicide in Canada was the focus of attention by the media, the health care community, and the public in general. As a result of this attention, Health and Welfare Canada established a National

Task Force to look at this problem. This Task Force would produce the third document that is analyzed in this study, titled *Suicide in Canada* and published in 1987.

In the forward the Lalonde Report (1974) was credited with identifying suicide as a major health problem and significant cause of early death, but it was also stated that, "beyond these facts, little had been learned about the fascinating, frightening, and complicated topic of suicide in Canada." The goal then became to investigate, better define, and consider strategies of response. The Task Force would meet six times, the first being in 1980, and although pleased with the diversity of their membership would warn the reader of the fact that, "consensus of opinion was sometimes impossible and therefore the potential for selective bias looms large." Despite these described "short comings," the chairperson believes the report will be "helpful, informative, and interesting" and worthwhile, simply because it represents the first effort at describing the Canadian experience of suicide. The members totaled fifteen, with ten clearly trained in psychiatry, with the other five representing corrections, clergy, employment services, social services, and the Mental Health Division of Health and Welfare Canada. It would be nine years after the publication of the Boldt Report that this report would be published. However, the statements rooted in the Boldt document would emerge again, and the format of this 'first' attempt describing the issue of suicide in Canada would look very familiar. The constraints that defined the Boldt Report would maintain their hold on this document.

The table of contents of the Task Force Report immediately reflects the statements that were identified in the Boldt Report. The headings include epidemiology (data), aetiology (causes), identification of high-risk populations, prevention, intervention, postvention, the law, and research. Closer examination of these sections will determine if the discourse has evolved or simply retained the statements of the past — in other words, finding out whether space has been created for new ideas, or whether the report is a reiteration of what is already known or not known, accepted or not accepted. The executive summary is the first opportunity to analyze the discourse.

"There are many unanswered questions about suicide and a multitude of conflicting theories"; " The questions are complex" (p.1) The idea that suicide is complex is not unfamiliar, and again it supports the need for extensive study in order to determine how to best address it. This group would begin where others have with "a comprehensive review of the state of current knowledge" (p.1), placing them in the position of having to 'select' discourse that they agree is relevant (in spite of the already warned potential for bias). It is also important to remember that the Task Force was created as a result of the International Conference, and it is reasonable to assume that the influence of the 'experts' in attendance was already established.

The conflicted nature of the discourse that has previously been identified is witnessed early by two statements: "Suicide is a low frequency event having a more limited societal impact than other pressing mental health issues"; this is followed in the next paragraph by "the breadth of the problem is immediately realized" (p.1) The issue of under reporting deaths by suicide, the necessity of a multi-dimensional approach despite the challenges, stigma as a reality, and the pressing need for more information in spite of a recognition of the breadth of research in the area are all referenced in the executive summary as important issues to be addressed. As the analysis of this document proceeds, it will be noted when the discourse retains statements previously identified and when aspects of the discourse have been altered. The first chapter concerns itself with statistics.

Science as truth is a condition that created in suicide discourse the necessity of empirical research to increase understanding and knowledge. This document is an example of the influence and limits of this condition. The first chapter, looking at epidemiology (although it is stated that this approach is limited by ecological fallacy), is laden with science discourse. Studies that are referenced include comparative, retrospective, case studies, ecological, cross-sectional, longitudinal, and methods of analysis used include regression and discriminant functional analysis. The discourse has clearly embraced 'hard science'. The findings are now being presented as truth, even though the studies included are selected by a limited number of individuals with a particular bias. The 'experts' (p.26) continue the promotion of science by presenting an equation designed to predict the probability of suicide.

$$S = \mathrm{f}\,\frac{(\mathrm{P/C,\ DEC,DIG,\ TS})}{(\mathrm{Su,\ HFT})}$$

Legend:

S = Probability of suicide; P/C = Personalities injured in their sense of competence; DEC = Demands for the exercising of competence; DIG = Demands for interpersonal giving; TS = Tolerance of suicide; Su = Availability of succor; HFT = Degree of hope in the future of the society (Farber, 1968).

The formula is described as the most recent, elaborate empirically-based interactional model of assessment of risk (p.26). This model reflects the continued influence of the medical model and the necessity of being able to predict or diagnose suicide in order to be able treat it. The goal remains to design a practical tool that would assure consistency in response, implying that all suicidal people are fundamentally the same. The science of suicide is also being used to determine causes — "the causes, as indicated by epidemiological studies, are complex and multifactorial" (p.9). The proclivity that encourages the need to find causes as a prerequisite to prevention is continued in the discourse.

A cause that is gaining recognition in the discourse is the connection to mental illness, despite the continued expression of uncertainty. "Suicide is not a disease although it may result from mental illness" (p.6). "Of major importance in many suicides is mental disorder" (p.1). "At the present time many health professionals regard suicidal behaviour as the result of irrational mental states induced by mental illness" (p.3). Although this debate is ongoing this document seems to be more supportive of this connection. "The theory that mental disorder is a major determinant of suicidal behaviour receives considerable support in extensive studies" (p.23). "Depressives had the highest suicide rate, while schizophrenics had the greatest absolute prevalence of suicide" (p.24). "Despite the ongoing debate regarding the nature of the relationship between mental disorder and suicide, the association cannot be ignored" (p.52). The strengthening of this correlation would guide the discourse toward viewing mental illness as a primary factor to consider in both the prediction of and the treatment of suicide.

A discussion on the issue of rationality connected to the quandary of mental illness surfaces again, and it is suggested that the solution to this controversy lies in "further research and in the broader philosophical debate between the soft and hard sciences" (p.3). In the next chapter devoted to aetiology, the study of causes and reasons, the importance of determining causes is evident

The discussion on causes begins with a connection to the study of suicide as "a reflection of broader trends in social attitudes toward suicide" and the "views which reflect the development and diversification of medical, social and psychological theory" (p.22). "Much of the contemporary debate over suicide reflects the tension which exists between these two "models" — the statistical social and the medico-psychiatric (p.22). The tension is connected to the long-standing debate over free will and determinism. The approach to understanding this debate and each side and "assessing their validity, is to examine the evidence"(p.22). The literal space given to the discussion of societal factors is half that of the medico-psychiatric, and the language that is used supports one over the other as providing answers that are supported by the preferred 'hard science'.

Social factors that are included are familial, job-related, ethnic, and social disorganization. The uncertainty of the validity of research related to social factors is reinforced by the discourse: "Research…suggests that"; "This may support"; "Job-related factors seem to play"; There appears to be considerable controversy"; "The effect…points to conflicting results"; " the nature of the association remains highly problematic" (p22-23). The only statement that is made definitively is related to ethnicity. "The high rate of suicide among Canadian Native peoples… points to ethnicity as being an important factor in the explanation of suicidal behaviour" (p.23). The need to study the high rates of death by suicide in the First Nation population that was deemed critical by Boldt is finding a space in the discourse here. The statement that ethnicity is an important factor for explaining suicide is an example of reductionism at its finest. It is questionable whether sociologists would have supported this idea in isolation as it was presented.

The medico-psychiatric model looks at physical illness, mental disorder, drug and alcohol abuse, stress, and certain biological conditions as primary factors in suicide. At this point, it is important to be reminded that ten of the fifteen members of the task force are from this discipline and therefore the probability of bias exists. These factors may also be recognized as lending themselves more readily to manipulation, treatment, and control, and providing opportunities to create recommendations that could be viewed has having the potential to affect some measurable change. The potential to manage the suicidal would become more feasible. The language that is used to describe these factors is more reassuring for the scientist, and in terms of the original goal of assessing validity, the medico-psychiatric would appear to be the victor: "Physical illness…as being of "pivotal importance"; "Considerable support in extensive studies" (p.23); "Had the greatest absolute prevalence"; "Has clearly established a strong link"; "A direct link between" (p.24-25). The persistent path in the discourse that supports illness in any form as primary in connection to suicide strengthens the paternalistic approach to prevention, because the suicidal are not only crying out for help, but they are 'sick'. However, the chapter concludes that, "the theories focusing exclusively on defining the suicidal personality have been no more successful in explaining the phenomenon of suicide than those focused on the sociology or biology of suicide" (p.26). The suggestion then becomes a familiar one and that is the need for a multi-dimensional approach and more research, as no conclusive answers have yet been found. The idea that something must be done anyway remains: "The professional and the policy-maker are inevitably forced to design approaches to deal with a problem, the root causes and mechanisms of which we only dimly know" (p.3). This continued condition in the discourse could contribute to the limited support that generally has occurred specific to the implementation of recommendations. At a time when efficacy, evaluation, best practice, and empirical evidence are viewed as necessary for policy change and funding, this admission of uncertainty may influence decision-makers.

Suicide discourse continues to be constrained by the belief that the identification and location of high-risk groups is critical to effective prevention. This document would not only embrace this idea but would further its validity by offering prevention, intervention, and postvention strategies that are specific to and separate from those developed for general population (p52). The populations that have retained high-risk status and believed to be "predisposed to suicide" (p.27) include youth, the elderly, alcoholics, Native peoples, persons-in-custody, individuals with mental disorders, and those bereaved as a result of a suicide. It becomes apparent that youth are viewed as the priority group. The discussion and recommendations that are the most comprehensive are for this group, and "extensive research in the area of youth suicide has identified several predisposing and precipitating factors that may serve as reliable indicators of suicide risk" (p.32). In light of the importance placed on detection in the discourse, and the fact that research claims to have provided an enhanced opportunity to do this effectively, an equal opportunity for success may be perceived. The overall goal to reduce suicide may be seen as attainable for youth, and this group may also have been recognized consciously or not as the most susceptible to the paternalistic approach that has been identified. The discourse had to this point identified these high-risk groups through rates, but this document would add research studies that would support the reality of their existence. “Investigations have established that the incidence of suicide is higher among individuals with mental disorders” (p.27). “Alcoholism has been found to be a significant factor in explaining suicide” (p.28). “Suicide among children and adolescents is clearly an escalating social and psychiatric phenomenon” (p.30). “Research shows that while the incidence of suicide among the elderly remains high, it has ceased to increase at the rate found in other age groups, such as those under 30 years of age” (p.32). “Native people are at high risk for suicide by virtue of the demonstrated high frequency of violent deaths in their society” (p.33). “There is evidence to support the notion that the overall rate of suicide in federal institutions is higher than in the general population, perhaps in the order of 3 to 1” (p36). The bereaved by suicide are supported as a high-risk population because “lack of both discussion and social support, which are essential in the process of bereavement, results in pathological grief, in which bereavement is inordinately intense and prolonged” (p.37).

Prevention, intervention, and postvention are retained in this document as a model for developing a strategy of amelioration, and these headings are credited to Boldt. Although the general headings remain the same, there are transformations that are evident. Shneidman, et al (1970) defined prevention as preventing suicide from occurring through increased research and education, while Boldt would focus attention on the amelioration of the underlying causes through social change and specifically, improved family skills. The present document defines prevention as reducing the prevalence and probability of suicide through the education of professionals, public education with specific reference to the use of the media (based on a concern regarding ‘the contagion effect'), and a reduction of lethal means. The transformation is one from academic to social, to more specific strategies that reflect public health. Intervention retains a focus on the actual act of suicide, from a focus on the crisis and deterring future crisis, to treatment for those who attempt, to managing the suicidal crisis. The divergence is seen, however, in the strategies recommended to attain this goal. Shneidman would suggest research specific to high-risk groups, service cooperation, volunteer involvement, and a fellowship in suicidology, while Boldt would emphasize improved treatment for high-risk populations and immediate response. The national task force would recommend specialized techniques in counseling and treatment and would retain the importance of immediacy. The differences in this section are subtle with all supporting the need for specialization in the treatment of the suicidal. Once again the discourse is supporting the role of the expert as necessary for the prevention and treatment of suicide.

Postvention is the section where the discourse makes a significant shift. There is consistent concern expressed for the bereaved by suicide and Shneidman and Boldt would both include the need to follow-up with those who had attempted suicide and survived. The present document, however, would not include those who had attempted, but would include the need for psychological autopsies to "provide researchers with valuable information" (p. 2). The focus now for postvention would include activities only related to actual deaths and how these deaths can be used to promote knowledge. There is no explanation offered as to why the decision to exclude those who attempted was made. It is interesting to note that the discourse has adopted the label of parasuicide (not quite suicide?) for those who attempt and survive, and there is a suggestion that those who do not die may be motivated differently from those who do. "Some studies have found a high incidence of mental disorder in parasuicidal patients, only 14% free of mental disorder, compared to 21% for completers"; "Certain characteristics have been shown to be more prevalent among parasuicidal individuals such as anxiety, introversion, lower intelligence, impulsivity, and neuroticism"(p.28). As well the bereaved are removed from postvention and would become part of the discourse as a clearly identified high-risk group.

Stigma and taboo were previously identified as an integral part of suicide discourse and a primary concern for effective amelioration. However, in this document this aspect has virtually disappeared, and is only referenced five times in very specific terms. A study of coroners determined that 33% were reluctant to certify a death as a suicide to avoid "stigmatization of the dead person" (p.39). In reference to the influence of the media on the experience of the bereaved, it was suggested that publicity could cause further grief by "perhaps maintaining the stigma" (p.40). Related to public education, "these programs could be directed toward reducing stigma attached to seeking treatment" (p.40). Specific to youth it is suggested that an education program could "reduce the taboos around the phenomenon so that the usual reactions of denial, embarrassment and shame do not prevent the distraught child from expressing his need for help" (p.52). Finally stigma is suggested as the reason for poor compliance of the suicidal who are referred to out-patient services. Again, the stigma is being connected to a psychiatric service generally. This could be interpreted as a positive change in the discourse, in that the stigma is not being perpetuated by its lessened value and is redirected to the experience of seeking and receiving assistance. However, the statement that now threads through the discourse, although subtle at this stage, is attitudes. Like stigma this can now be used to explain responses to the suicidal. Preferable to stigma or taboo discourse however, is the fact that attitudes are the responsibility of the holder (the caregiver) and less amenable to supporting the suicidal as a marginalized population. This lends itself, however, to a circular argument, as the attitudes of helpers are likely influenced by stigma. The Task Force is identified as being diverse, as well as having "different experiences and attitudes toward suicide," which contributed to the challenge of consensus (foreword). With regard to the under-reporting of suicide, it was stated that researchers agree that, "local attitudes may indeed influence the absolute accuracy of recording cases" (p.6). "The study and treatment of suicide have been a direct reflection of broader trends in social attitudes toward suicide" (p.22). "Changing social attitudes toward suicide" have supported a willingness to label child deaths as a suicide (p30). An offer of explanation for the high rates of suicide in males is "the reported negative attitude of health care workers to suicidal behaviour in males" (p30). "The last few years there has been a noticeable shift in attitudes toward suicide among elderly" (p.32). "With the decriminalization of suicide "there has been a change in the attitudes of the police toward the handling of suicidal individuals" (p.42). "Volunteers rated higher on exercising warmth, patience, and a less condescending attitude towards the client" (p.48). This diminished attention on stigma and increased attention on attitudes would create space for the development of education programs to modify attitudes toward suicide through the dissemination of knowledge.

The need for more knowledge has been retained in the discourse and is supported once again by a call for more research. "One of the greatest obstacles encountered by the Task Force in the preparation of this report was the lack of Canadian research on suicide" (p.57). "The requirement for increasing the research capability in Canada should be viewed as an essential prerequisite to the planning and delivering of appropriate programs and services, and in the evaluation of their effectiveness" (p.57). In connection with this need for more research is the need for data that "will need to be collected over many years before statistically reliable findings can be generated" (p.57). This limit that continues to be present in the discourse preserves the science of suicide rather than sustaining a concerted effort to prevent or reduce death.

The condition of the need to empirically study suicide in order to gain purposeful knowledge has produced discourse that is both factual and pragmatic, possessed of the sterility and emotional distance that is familiar to science discourse. This is acknowledged as deliberate on the part of the Task Force: "we tried to avoid existential debates and forays into the realms of philosophy and theology, we tried to keep close to the literature" (p.58). Gone from the discourse are references to humanitarianism, obligation, and the sense of urgency that prevailed, supporting the idea that something must be done despite inadequate knowledge.

### Summary of Discourse Themes

The discourse has not fundamentally changed; instead, certain ideas and concepts have been expanded, relocated, renamed, or diminished in value. The identification of high-risk groups, the connection between mental illness and suicide, the control of lethal means of suicide, anomie, prevention, intervention, and postvention as a strategy format, the need for empirical research, and collection of sound data have all been retained and expanded. Those who attempt suicide have been relabeled as parasuicidal (although this label is not used consistently), potentially as a result of the increased alliance with mental disorders, and they are no longer included in the strategies for postvention. Stigma has virtually disappeared in the discourse and has been replaced with a heightened interest in attitudes. Tables and charts as a statement depicting the reality of suicide continue to be presented with the number increasing from 19 in the Boldt Report to 63 in The National Task Force report. The recognition of expert knowledge as necessary for the enhancement of understanding is no longer something to strive toward, but has become a discursive condition that continues to support the science of suicide. The discourse continues to be constrained and limited by the conditions and transformations that have previously been identified in this study.

## Suicide in Canada, an Update, 1994

In 1994 an expert working group (including some members of the original task force) would publish an updated version of *Suicide in Canada*, and this will be the next document to be analyzed. "In 1991, following several discussions with a number of experts in suicidology in Canada, including members of the Canadian Association for Suicide Prevention, Health and Welfare Canada took the initiative to begin updating the Task Force Report of 1987" (p.xi). The mandate was to look at the original report and update the material to make it more relevant for the 1990s. There was concern expressed about maintaining the integrity of the original report, and the foreword in the 1994 report advises the reader "that the format has undergone a revision; some sections of the original report have been merged with other sections, or omitted, while others have been expanded" (p.xi). The analysis will focus on these revisions and how, or if, the discourse has changed.

A commonly understood condition that existed when this report was written includes a move to be politically correct. Many services would now include ethics as a important consideration in the provision of services. These same services were being challenged to become more efficient. These conditions were accepted as necessary considerations for special interest groups, if they were to be heard by those in power to implement policy changes. This is reflected in the changes in language (not the concern here), but more importantly, in the way in which the discourse would focus issues related to suicide. The format of this updated report is such that the general discourse has not changed significantly, but rather the way in which the information is presented has changed. The heading of epidemiology that previously focused on the prevalence of suicide has been expanded to include factors and high-risk populations. The approach using the general headings of prevention, intervention, and postvention is once again accepted as the preferred choice, albeit Shneidman was credited this time. Suicide and the law remains a concern and given space, as are the concerns related to under-reporting and the need for more research.

> As with the original Task Force, there was considerable diversity of perspectives and philosophies [not attitudes as stated in first report], reflecting a range of views in an expanding and sometimes controversial field of study. The intent has been to provide an overview of key issues and information, while avoiding categorical statements about matters that remain the subject of ongoing debate and research. Even so, the revised report, like its predecessor, reflects some tensions between different explanatory models of suicide. (xi)

This appears to be a condition that is internally driven in suicide discourse and has the potential to provide the most formidable obstacle to the creation of space for new and innovative ideas. The need to continue to be sensitive to and determine the importance of factors related to conflicting models restricts the opportunities for positive movement in the discourse. This continued limit placed on the discourse furthers the need for empirical research to determine which model will be most effective in supporting prevention and continues to constrain the implementation of a strategy that has universal consensus. As has been the case to date, minimal changes in the discourse are found only in the specifics related to general themes that are imbedded in the discourse. Examples are found in the discussions on prevalence, factors (not causes as before), high-risk populations, research, and recommended strategies for prevention, intervention, and postvention. This report essentially updates research findings and as stated, avoids any controversy that may in fact encourage the kinds of important questions relating to the phenomenon of suicide that still exist.

The discussion on prevalence in age cohorts has been divided to now include middle-aged adults suggesting that, "by age 55 there is a change in direction of the curve (down)" and an "increase beginning in the mid-seventies" (p.6). This report would also add two categories to the discussion on prevalence. One furthers the reference to the contagion effect in the earlier report, now expanded to a concern regarding suicide clusters: "There is evidence that there has been an increase in this type of suicide in recent years, and that it is more common among Aboriginal youth" (p.8); "The report suggests that true stories, especially repeated stories about celebrities, can be powerful inducers of imitation" (p.9); there is also reference to a study that implies that the "weakening of the societal taboo" (p.9) through media attention may enhance this phenomenon. The report goes on to state that these individuals were "found to have previous emotional problems" (p.9). However, the conclusions reached are familiar to this discourse — that the issue is still a topic of debate and more research would need to be done. Murder-suicide, "a particularly grisly variant of self-destructive behaviour …is fortunately uncommon" (p.9). The inclusion of these two controversial and uncommon issues in the discourse is perplexing. It could be a reflection of the continued move toward specialization within the discourse and the increased focus on specific aspects of suicidal behaviour, perhaps to create more manageability. A discussion in this section on methods of suicide would promote gun control as a prevention strategy, another example of a macro focus. "In many cases firearms suicides appear to be committed impulsively and without careful premeditation" (p.10). This statement alone implies that if the means were not available the death by suicide may have been averted. The discourse has become riddled with facts, supported by research that is admittedly conflicted. It becomes easier to read this information with little or no connection to death or the struggle that the suicidal individual may face. The discourse is becoming depersonalized by the condition of science as truth. Perhaps this was motivated by a desire to reduce the 'complexity' in an effort to make it more manageable. A condition that is not uncommon in the 21st century, that being a desensitization of the lived struggle of others, is recognizable in the discourse in this report.

The discourse on factors continues to present social, medical, and psychological explanations for suicide as distinct from one another. Durkheim's anomie, permissive social attitudes, the media attention to celebrity suicides, social isolation, suicide of role models and peers, and other factors are listed but not expanded on as sociological factors. More attention is paid to unemployment and income as two factors that have stood the test of time. As has become the expected however, the uncertainty of validation by virtue of a significant correlation is confirmed. “Although the literature supports the hypothesis of a link between unemployment and suicide and parasuicide, it is a controversial link” (p.12). There does not seem to be a straightforward and predictable link between income and suicide risk” (p.13). Although the discourse continues to describe suicide as “a process in which neurobiological, psychological, cultural and social variables contribute to produce the end result,” this report articulates the position that “factors carry unequal weight” (p.12). “Among the heterogeneity of causes, mental disorder can lay claim to a position in first rank of the matrix of causation. But the issue is complex, and multiple explanations may be operating simultaneously” (p.14). Suicide discourse has incorporated the advances in knowledge from the medico-psychiatric field, including more support for suicide as a symptom of, but not caused by, mental disorders, the effect of serotonin levels, and the importance of diagnosing and managing depression. The study of suicide has been dominated by ‘experts’ from the disciplines that would necessarily support this discourse as a determinant of how the phenomenon is perceived. This formative element would create a condition whereby strategies would be aimed not at suicide specifically, but rather at the determinants that became perceived as scientifically grounded. These determinants were viewed as the root causes of suicide, and therefore, if addressed, the result would be a reduction in the rates of suicide. This limit would contribute significantly to the fragmentation that has long been recognized. This can be seen in the discourse on youth suicide.

"Of major concern is the increase among young people" (p.4). The young despite the reality that, "the actual number of deaths is very small" would seem to elevate urgency and the paternalistic approach that has been previously identified. The need to protect is rationalized, "because of a dramatic upward trend in their rate over the past forty years" (p.21). The uncommitted nature of the discourse in relation to rationality and free will has vacillated over time. In the 1987 report the discussion on youth included as a reality "intentionality or at least planning" and suggested that the development of the child should be taken into consideration when this determination is made. The report goes on to identify 'warning signs' that may help to identify those at risk and support intervention (p.30-31). The 1994 report omits all reference to intentionality and suggests that, "Suicide in youth often occurs impulsively"(p.21). The factors that are attributed to the deaths are "availability of firearms, family dysfunction and parental arrests, adverse effects of publicizing suicide, presence of conduct or emotional disorder" (p.21), and suicide is said not to occur after a stressful event (58% had recently been involved in the breakup of a relationship) "unless they occurred in a chaotic or disturbed family context" (p.19). Another study that was referenced states that, "a poor relationship with parents is an important factor" (p.18). The discourse supports the external factors as primary for suicide among the young. The implication of this condition is that there are things that 'we' can do and must do to save 'them,' as they are somehow victims of circumstance and a great deal of the responsibility is shifting to the family. The discourse is becoming more fragmented as the high-risks groups receive more focused attention and prevention efforts become specialized to meet the needs of targeted groups. The identification of high-risk groups is not based on rates alone but rather on the conditions imposed by society on the populations that are viewed as needing or demanding recognition. Youth as a vulnerable group have maintained their status but there has been an increased interest and a reduced interest in other groups. This shift is evident in an increased interest in suicide and First Nation Peoples, the addition of gays and lesbians as a high-risk group (and AIDS as a factor), and the bereaved by suicide are still an interest group but not as a high-risk population. The high-risk groups are labeled in this report as "populations of special concern" (p.20), so one has to lament on the dynamics of how these choices to eliminate or add groups to this list are made, and the influence this may have on the suicidal and their families.

The issue of suicide for First Nations people was now focused more specifically on those living on reserves. "They concluded that the high suicide rate tended to be associated with various community characteristics, including a higher number of occupants per household, more single-parent families, fewer elders, lower than average income, and lower education" (p.23). "In high-suicide communities, suicide appears to be fostered by rampant anomie" (p.23). The condition that supports this increased interest is not related to data as the rates were identified as high in the Boldt Report, but rather in the First Nations communities taking back power and commanding the attention of all Canadian citizens, of whom the 'experts' belong. The addition of gays and lesbians can be explained in a similar way. They both represented marginalized groups that no longer remained invisible. The discourse as would be expected, is influenced externally by conditions that influence us all. This document, however, is a reminder that the overriding limits and transformations that were identified as guiding the Boldt Report in 1976 are still limiting the discourse. The need for data, charts and tables (there are 133 in this report, over double from the last report), knowledge as a result of empirical research, the controversy over factors, defining high-risk groups, the dependency on the 'expert,' and the preferred option of defining ameliorative strategies under the headings of prevention, intervention, and postvention still prevail and constrain the discourse. The discourse has been focused on knowledge accumulation and dissemination rather than design and implementation of programs to reduce and prevent suicide, which was the original goal of the organized efforts on this issue. This may help to explain why stigma, which many might argue is still a barrier to prevention, has virtually disappeared from the discourse as the discourse becomes reoriented to the science of suicide rather than the social condition.

The reference to stigma is retained in relation to the reluctance of coroners to certify deaths as suicide (p.98), as part of the explanation for the compromised experience of the bereaved by suicide (p.72-74), the reluctance of the suicidal to obtain assistance in times of crisis and the related goal of education programs to reduce this stigma (p.60). The only additional reference to stigma is in connection to the experience of gay men and the stigma that they experience as a result of their sexual orientation (p.25). The last report would turn to attitudes to explain the treatment of the suicidal that is often ineffective, but not so in this report. The discourse would transfer the responsibility to systemic issues and the suicidal: There are "only a few preliminary treatment protocols in existence and research in the area is practically non-existent" (p.68); "The patient is referred to outpatient services for follow-up" but "there is considerable evidence, however, of poor compliance" (p.69); "Preventing suicides in discharged psychiatric patients...may only be accomplished by having a mobile outreach team" (p.72); "Suicide prevention agencies should have a detailed code of ethics" (p.66). Perhaps the reason why the discourse has continually become more pragmatic is to avoid (as was stated) any controversy. Despite this, the report adds a discussion on euthanasia and assisted suicide (p.79 to 81), two issues which continue to spark controversy. This is another example of the discourse incorporating content based on the interests of society in general. This report was written during the time of the famous Rodriguez case (1993). Sue Rodriguez defended her right to die by assisted suicide and was denied this right by the Supreme Court of Canada.

**Summary of Discourse Themes**

The revised edition of *Suicide in Canada* can not therefore be said to have contributed to the evolution of new ideas in the discourse, but rather it has only offered additional information within the confines of all the constraints that have influenced the discourse for decades and the general conditions of society at the time. This becomes indisputable when it is acknowledged that all of the recommendations that were put forth in the first report remain in this report in their entirety and unaltered. The focus on the need for knowledge that cannot be disputed and knowledge that will be recognized as valid and reliable takes priority over the presentation of recommendations for prevention.

## The Canadian Task Force on Preventative Care, 1994

The next document is an example of how the discourse functions on a scientific level. This document, including the history, was retrieved from the Health Care Network at the Health Canada site on May 16, 2005. The history of the document (www.ctfphc.org/ctfphc&methods.htm) begins with the establishment of The Canadian Task Force on Preventive Care in 1976 by the Deputy Ministers of Health of all provinces, rather than those perceived as specializing in suicide. The Task Force spent two years developing a methodology, "weighing scientific evidence to make recommendations for or against including preventative maneuvers in the periodic health examination" (p.2). The chapter on suicide prevention would become part of a 1009-page document that "has become a standard reference tool for Canadian primary care clinicians" (p.2). The methodology developed is said to have been successfully used by others to evaluate the preventability of over 200 conditions. The membership of the task force included epidemiologists, health care researchers and clinicians (primary care and specialists), and was funded by Health Canada. The method adopted was developed in an effort to "provide a bridge between research findings and clinical preventative practice" (p.3). The Task Force would use "a standardized methodology, employing explicit analytical criteria" and "would place the greatest weight on the features of the study design and analysis that tend to eliminate or minimize biased results" (p.3). Both of the authors of the chapter on suicide were affiliated with the Department of Psychiatry at McMaster University and were not on the list of expert suicidologists that was beginning to be established, nor would these experts be referenced in the article. However, the general heading under which the chapter is placed, and the other subjects it is placed in context with, imply a connection to the Lalonde Report. The general heading is Prevention of Psychosocial Illness and Diseases of Lifestyle. The other [illegible]s that are included are depression, drinking, tobacco, motor vehicle accidents, physical activity counseling, unintended pregnancy, and sexually transmitted diseases. The connection being drawn again is that suicide is a behaviour that is to some degree in the control of the individual. The chapter is succinct, sterile, and devoid of any factors or ideologies that are controversial. In the true format of science, there is no moral or social discourse. This report would be constrained by the conditions of hard science, prevention as a strategy for improving overall health, and the quest to determine efficacious strategies for the reduction of deaths by suicide.

The article would begin with a reference to the 1989 Task Force Report on Suicide in Canada, indicating that the members had read it. "In 1989 the Task Force recommended that primary care physicians routinely evaluate suicide risk among patients in high-risk groups." Although this was the focus of this chapter, the authors would go on to challenge other recommendations of the 1989 report in the arena that suicide discourse has claimed as the only place where real answers could be found and that is hard science. The conflicted nature of suicide discourse that has been apparent in other documents would not be present here, but this report would contribute to this condition by contradicting the recommendations made by the 'experts'. The epidemiology would establish a "burden of suffering" (p.456-458) supporting the reality of deaths by suicide as an issue of concern. The report then turns to the task of determining what would be the most effective strategy for the reduction of these deaths based on evidence.

In the summary table (p.466-467) it states that there is insufficient evidence of reduced risk to support the referral of the suicidal to curriculum or school-based intervention/prevention or postvention programs, community-based prevention programs, crisis centers, general telephone help lines, or intensive psych-social follow-up. The evidence was also inadequate to establish reduced suicide whether the person was admitted to the hospital or discharged home for those who have previously attempted. There is poor evidence for routine evaluation of suicide risk for those identified as being in a high-risk population but it is still recommended for high-risk individuals based on the burden of proof. The two maneuvers (strategies) that showed fair evidence are the suicide education for physicians and medical treatment for suicidal ideation and depression. The role of the physician would be identified as critical to prevention and medical treatment as the most likely to support results (reduction of suicide), clearly supporting the inclusion of medical discourse as not only necessary, but essential.

The identification of high-risk groups is still retained in the discourse, but based on updated findings the high-risk groups would include, as the previous reports had, those who have attempted before, those with a history of psychiatric illness, a history of drug and alcohol abuse, Native people, people in specific age groups, and persons in custody. This report would bring back chronic and terminal illness and would add people with a family history of suicide, specifically Native youth in remote Northern communities, and new immigrants. They would not include gays and lesbians or youth, as identified by the Task Force who had published their updated version of the 1989 report in the same year. This would support the earlier suggestion that the identification of high-risk groups is influenced by something other than numbers.

The chapter concludes, "there is poor evidence (based on expert opinion alone) to include or exclude routine evaluation of suicide risk in the periodic health examination" (p.462). However, it is suggested that physicians remain alert to the possibility of suicide in high-risk populations, "particularly if there is evidence of psychiatric disorder, if the patient lives alone, has recently attempted, or a family has died by suicide and special attention should be paid to young Aboriginal males" (p.462).

**Summary of Discourse Themes**

This document reflects the value placed on empirical evidence and would tip the scale in favour of science as having the potential to provide answers, and the medico-psycho model as the best suited to conduct science. The correlation between suicide and mental disorders is not questioned or challenged but rather accepted as fact, and the discourse would continue to embrace this as a reality.

## A Report on Mental Illness in Canada, 2002

The next document, *A Report on Mental Illness in Canada*, 2002, would solidify the connection to mental illness and further support the macro specialization that has become a direction within suicide discourse. Suicide is being managed specific to identified high-risk groups and the 'proven' factors in isolation of each other. Prior to analyzing this document, it is important to comment on a 1998 publication, titled *Suicide in Canada,* that has inherent authority and is incorporated extensively in this document (6 of 10 references). No longer overtly constrained by the knowledge from experts in the United States and around the world, Canada has established her own experts who would now impose on the discourse.

Those who are interested in the 'field' of suicide will recognize at least some of the names of the editors of this publication as experts in suicidology. The preface describes this book as "uniquely Canadian," "addressing important topics that are principal areas in the field today in Canada," "a new pathway towards knowledge about suicide in Canada," and "concerns the current general state of the art of suicidology." The book also claims to be a "coming of age" book and a breaking away from the influence of the United States that was the historical foundation that the discourse was built on.

"Although there are great similarities [between the United States and Canada], there are enough differences to warrant Canada's own study of this issue." Rather than suicidologists the authors are labeled as "Canada's leading suicide preventionists, a diverse and talented group." The importance of co-opting experts, a multi-dimensional approach, and the inadequate federal support for much needed research, are highlighted. The claim that this is a truly Canadian compilation is a literal truth, but the discourse continues to follow a familiar path with a focus on youth and First Nations (the book is dedicated to First Nation and Inuit peoples, suggesting their status has surpassed youth) as priority high-risk groups as well as others. Epidemiology, reliable data as critical, the bereaved by suicide as a group of special concern, stigma, the need to locate the suicidal (detection), and the right to die debate are all present. The aspect of the discourse that perpetuates a paternalistic approach that is not found in the hard science efforts of explanation is present here: "most of all, we hope it (this book) will help to save lives." The document that utilizes this 'book' as a primary resource will be examined next.

The 2002 document is also the result of a workshop held in 1999, co-sponsored by Health Canada and the Canadian Alliance on Mental Illnesses and Mental Health, in response to the recommendations to collate the data and create a picture of mental illness in Canada. The document would look at mood, anxiety, personality, and eating disorders, schizophrenia, and suicidal behaviour. The conditions, transformations, and influences of other discourse can no longer be identified as constraints but rather as the reality that is the discourse. The chapter on suicide does not offer new ideas or concepts but is a simplified reiteration of the facts and controversy that has beset this discourse. The following are examples: "While it is not a mental illness, suicidal behaviour is highly correlated with mental illness and raises many similar issues" (p.92). There is a list of warning signs that are generalized and have become part of the common knowledge (p.92). The chapter highlights are a list of statistical facts related to numbers, constrained by the value placed on data. "The impulsiveness of youth and their lack of experience in dealing with stressful issues also contribute to the higher risks of suicide"(p.98). The high rates of suicide in the Aboriginal communities are connected to cultural instability and the associated increase in sexual abuse, family violence, and substance abuse (p.99). The impact of suicide is discussed only in relation to the bereaved and the challenges they face. The issue of stigma has returned and given more space again, but this could be related to the continued support of stigma as a barrier for those diagnosed with mental illness generally and is the topic focus for this report. "The stigma against suicide operates on two levels-social and personal. In either case, it acts as a major obstacle to frank discussion and emotional healing" (p.100). This idea that stigma is a reality is reinforced by the statement that, "in general, society does not condone suicide" (p.100). "The risk factors for suicidal behaviour are complex and mechanisms of their interaction are not well understood" (p.100). This complexity has become an accepted 'fact' related to suicide in the discourse and continues to be accepted. This report presents a "useful framework for categorizing factors" (p.100) and credits this framework to White (1998). The framework, however, was actually developed by Solomon and Boldt in 1977, as acknowledged in the 1987 Task Force report. Recommendations for prevention and treatment include those which have become predictable, including public awareness, decrease the stigma, address determinants, implement prevention program for youth, reduce access to lethal means, train and educate providers and educators, and conduct research and evaluation (p.102). It is commonly known that the research on suicide is prolific, and yet in 2002 the writers of this report make the claim that, "the existing data provide a very limited profile of suicidal behaviour in Canada" (p.103). The concern over this deficiency is directly related to a reduced ability "to monitor suicidal behaviour" (p.103), which is consistent with the limits that are associated with detection and location.

### Summary of Discourse Themes

This report is a reflection of how the power of conditions, transformations, and statements can constrain and smother a field of study to the extent that the creation of new ideas and concepts becomes virtually impossible. The urgency that was once identified with a need to save lives and prevent deaths was now identified with a need to acquire knowledge. Knowledge that is based on research conducted by experts in suicide and could provide unequivocal answers to how suicide can be prevented. This formative element of the discourse would culminate in the report that follows.

## Report on the Workshop on Suicide-Related Research in Canada, 2003

The history and the accomplishments of the Canadian Institutes of Health Research (CIHR-IRSC), formed in 2000 to replace the Medical Research Council of Canada and Health Canada's National Health and Research and Development Program, can be found on the CIHR-IRSC website (www.cihr-irsc.gc.ca). The legislated mandate of this institute is "to excel, according to internationally accepted standards of scientific excellence, in the creation of knowledge and its translation into improved health for Canadians, more effective health services and products and a strengthened Canadian health care system." This mandate has been expanded to include "all four pillars" of health research which are biomedical, clinical science, health services and systems research and social, cultural and environmental determinants of population heath.

In 2003, for the first time, Health Canada and CIHR co-sponsored a workshop, and over 45 of Canada's top suicide researchers were brought together to identify themes to guide research on suicide for the next ten years. This workshop is described as the first "multi-sectoral workshop on suicide related research in Canada." The hope was to identify cultural and demographic factors that underlie suicide to help researchers in their work, "especially in social and neurological approaches." This last statement upholds the dichotomy that has created a history of fragmentation within suicide discourse. One might view this statement positively, as a recognition of the importance of both; however, the reality is that the advisory board membership for the institute (Institute of Neurosciences, Mental Health, and Addictions) that has power to influence the discourse is overly representative of the hard sciences with only one sociologist on board. The key goal that is articulated on the website is "to ensure new research findings are applied to policy and made widely available to health practitioners across Canada." It is the report that was released on this workshop that will be the next document for analysis.

The specific objectives for the workshop starts where all reports have started, and that is to review the research that has been done to date. Next, it was to identify and establish themes to direct the research for the next ten years, and last to support a multi-disciplinary partnership in research and "knowledge translation" (p.1). In opening the workshop, Dr. Keough, the chief scientist for Health Canada, stated that their "interest in good science as a basis for its mandate of improving health" (p.1). When suicide became the focus of this powerful research body supported by the academic elite, it officially moved from a topic of concern to a topic of academic research.

The restrictions that exist in CIHR in relation to how, why, what, and, most significantly, who will conduct research is a condition that has the potential to profoundly shape the discourse in the future. The potential for funding alone is a condition that new and experienced researchers are likely to consider in their decisions about how they might contribute to the knowledge, and knowingly or not, to suicide discourse. It is not difficult to predict whether the subject of suicide may be of particular interest to researchers, but rather the challenge of research itself. In a discussion on the current situation in Canada, the first key point to emerge was that "Aboriginal suicide is a major concern" (p.3). It is also important to note that there was a determination to develop a research focus to find solutions for suicide as a leading cause of death for young Canadians. Once again, First Nation people and youth have retained and perhaps finally solidified their position of priority as high risk in suicide discourse. "What services need to be developed for disadvantaged groups, including adolescents, Aboriginals?" (p.10). The Aboriginal community would move to first place. "The situation that requires urgent implementation of this research agenda is that rates of suicide among aboriginal people are disproportional and at a crisis point"(p.25). A synopsis of the closing remarks by the scientific director quoted him as saying, "He emphasized that Aboriginal peoples are particularly important to CIHR" (p.36). The move in the discourse to choose particular high-risk populations over others has continued, despite an acknowledgement of the nature of this process. "There is something very political about priorities, e.g., it is easier to mobilize political support to protect younger people from suicide" (p.3). This statement not only recognizes this problem as a reality, but, reinforces the paternalism through the use of the word protect. The limits that have constrained the discourse persist and are witnessed in the design and deliberation of research themes by the experts at the workshop.

The research themes have been divided into six categories, the first being data systems. “An improvement and expansion of data systems depends on a strong classification system, reliability, and elimination of biases” “ The data base needs to link correlates and outcomes to individuals in order to establish strengths of association”(p.6). Data was identified as an issue of concern in the discourse in the 70’s in relation to the need to locate the suicidal, but as the importance of improving a knowledge base took precedence over detection the function of data changed. This transformation is apparent today. The database needs to be such “that researchers can use it as a tool”(p.7). “To have a scientific basis for indicators, four key concepts must be met: reliability, validity, specificity and sensitivity”(p.7). “A great deal of research needs to be done in the area related to mortality and morbidity… we need to know the reliability of suicide rates”(p.7) The coroners are still identified as key to this issue and it is suggested that “we could discuss standardization issues with them and ask for input on future directions”(p.8). The next theme identified is evidenced based practices.

The need to evaluate intervention strategies is not new to the discourse but has retained a presence. This group would choose to continue to perceive this as a priority. There is an expanded concern that calls for “studies of how suicide research and the development of evidence-based practices are influenced by current peer review and ethic review processes, and research into the nature of evaluation in this subject area, including its intent and utilization"(p.9). This is interesting and could be interpreted as one group of experts evaluating another and challenging the intervention efforts that have been implemented to date. In the brief discussion at the end of this section it states that, "the biomedical pillar should have the same weight as the others, if not we are excluding one important source of variation, and CIHR regards psychology as part of this pillars"(p.10). As is the nature of this discourse strategies are often generated as an expansion of the discourse or as a challenge to it. With predictability the group next turned to the issue of mental health promotion.

This theme includes "the development and dissemination of culturally and community-appropriate information"(p.11). Research topics that are consistent with patterns in the discourse include risk factors, shame and stigma and the perception of mental illness. Positive psychology and the effects of social supports and isolation should also be considered under this theme. Mental health promotion has been expanded to include "care for the caregiver", and resiliency, a concept that has gained popularity in biomedical discourse. The discussion specifically addresses the importance of helping the mental health workers in Nunavik. "Most are picked for their interest in mental health, some don't have their high school certificates but still have responsibility. We need to consult with them and provide support systems and a means of evaluation"(p.13). There is a sense that suicide discourse is moving in a continued direction of creating an elite group that will be positioned to best determine how suicide efforts will evolve. The power that this educated group has will be formidable in determining the future of suicide discourse despite the recognition in the next theme for the necessity of a multidimensional model for understanding suicide-related behaviour. This theme focuses on factors that include suicide and mental health, inter-regional variations, gender, and the implications of multidimensional models. It is suggested that the focus must be broader than suicide and include the spectrum of suicidal behaviour. Once again the need to understand suicide from all the ‘expert’ perspective of all disciplines aligns with the limit of complexity that has been retained in the discourse. Next there is a choice made to support previous discourse and consider those who have died by suicide and those who have attempted as separate and different as reflected in the next theme.

This theme accepts the shift in the discourse that has moved away from suicide as a whole and identifies a “spectrum of suicidal behaviour”(p.16). The issue of classifications and definitions is not new and “CIHR could consider a consensus meeting on the issue of terminology”(p.18). Although specific language is not the focus of this study the implications of an academic body determining the language that is fundamental to any discourse could have a long reaching impact on the suicidal. Research questions that focus on impulsivity, aggression, intention, repeat attempters, follow-up, range of wish to die, gender, the differences and similarities between suicide and euthanasia, facilitating and help-seeking are examples of how the discourse to date has influenced the future direction of research on suicide. The last theme is the social and cultural contexts of suicide.

“It is critical to develop new knowledge about how these, contextual factors have an impact on, not only the incidence of suicide, but on determining what constitutes best practice”(p.19). This theme is concerned with how values and practices influence stigma and attitudes toward suicide, and what cultural factors are responsible for a variance in rates. Suicide discourse has progressively distanced the individual from the act of suicide although it is recognized that "suicide affects individuals, factors and concepts extend beyond variables at the individual level"(p.20). Despite the acknowledgement that suicide is a personal experience, it is the variables that extend beyond and impose on the individual that are of primary interest. This choice in the discourse continues to reduce the value of the lived experience that is perhaps one of the most significant opportunities to truly enhance our understanding of this phenomenon.

### Summary of Discourse Themes

The struggle to make sense of suicide, to prevent death, and to mobilize communities and the country to come on board has undoubtedly taken a toll on those who have carried the torch. The reality is that the rates of suicide continue to increase and prevention programs are not consistently provided. The move away from prevention toward research would seem logical. If what we are doing isn't working then there must be some information we do not have. The fact that CIHR has taken up this challenge could provide a welcome relief and in fact may be viewed as long deserved recognition of the issue of suicide. This condition would make it possible for the following statement to not only be heard but to be listened to. "Many developed countries have national suicide prevention strategies. Given the jurisdictional issues, [this] may not be possible in Canada. A more appropriate focus would be a national research agenda on suicide and suicide-related behaviours"(p.30).

## Discussion

Suicide for centuries had presented a moral dilemma and was sanctioned heavily by religious institutions and the people who supported these institutions. The discourse has been influenced by the sinfulness of the act, the right/wrong debate, and the stigma and shame that resulted. Although the morality of suicide is now rarely articulated except as a historical reference the resultant stigma has been retained as a reality in the discourse. Philosophy discourse would provide fuel for the debates on free will, rationality, and the right to die as a choice. An acceptance of suicide as wrong and rational would support the move to criminalize the act. Religion and law were assigned the task of controlling this behaviour and it would not be until the 1970's that there was a realization in Canada that these sanctions were not successful.

The decriminalization of suicide is a critical condition in suicide discourse, because responsibility for controlling suicidal behaviour would be transferred to the medical community. The need now would be to offer explanation for this affliction and determine appropriate measures to treat and manage the suicidal. The discourse would continue to be constrained and limited by professionalization, hard science, data, the belief that knowledge is a prerequisite to prevention, and the need to locate, protect, and save the suicidal from themselves. There are always choices that are made within a discourse that gives more or less value to particular ideas and concepts. The debate related to rationality is a good example. Although this debate has never been resolved, the discourse 'acts' like it has. The correlation between mental illness and suicide confirms that the suicidal are not rational at the time of death and this has generally become accepted as fact. This appears to be a more comfortable position to take and the idea continues to gain strength as more science and research present "convincing" data to support this. It is interesting however that the debate about euthanasia and assisted suicide that is becoming part of suicide discourse suggests that life-ending decisions may in fact be rational, but these are explained by the desire to reduce or eliminate physical pain. Many who believe suicide is wrong will defend the right of those diagnosed with a terminal illness to choose death. The other interesting choice that has been made in the discourse is to separate those who survive an attempt by suicide from those who die.

The terminology that was popular in the 1980's and continues to surface today is parasuicide, implying that it is almost suicide but not quite. This would perpetuate the myth that if a person really wants to kill themselves they will, and that for others the act is a cry for help or an attempt to gain attention. Psychological autopsies were supported as being able to provide researchers with valuable information about suicide where as the focus for those who had attempted remained treatment and protection. What are the consequences for the discourse confined as it is by the conditions, transformations, and authorities that have influenced its production. The discourse appears more pragmatic, factual, and cold. The belief that only empirical research could provide the answers needed to ameliorate this phenomenon would create an elite group who would take the discourse on a quest for knowledge at the risk of placing prevention efforts as secondary to research. This professionalization and specialization would also limit who could participate in the production of knowledge and potentially reducing the production of new ideas into the discourse. There is an emotional distancing from the suicidal person; they are subjects of study, irrational, impulsive, and in need of protection. The discourse had been successful in creating an 'us' and 'them' dynamic that continues to have consequences for the suicidal today.

Foucault believed that discourse had function. He believed that relations of power could not be exercised or established without "the production, accumulation, circulation, and functioning of a discourse"(1980, p.93). Suicide discourse supports a power relation that is defined by the inability of the suicidal to manage the experience of suicide, and therefore they are subordinated to a position of being treated and managed in a way that is deemed suitable by others. The characteristics of a suicidal person as determined in the discourse would further diminish their power.

In the Lalonde report the suicidal are identified (as are others) with the lifestyle choices and that they "must accept some responsibility for and for which he should seek correction"(p.26). "When those risks result in illness and death, the victim's lifestyle can be said to have contributed to, or caused, his own illness or death"(p.26). Despite the blurred connection to mental illness the suicidal are implicated as being irresponsible. The Boldt report constrained by the urgent need to rescue and save the suicidal, and the perception of suicide as a problem, are statements about the condition of suicide that at once imply incapacity and would contribute to the defining of the suicidal as powerless. "Tragic suicides could have been prevented...could have been saved"(p.19). The suicidal are referred to as "victims"(p.31), "undesirables" and "rejected"(p.36), "with chronic problems"(p.48), and "susceptible to self-injury"(p.74). They are presented as a vulnerable population that is in need of protection. The first Task Force report would continue to characterize the suicidal in this way, describing them as suffering from mental illness (p.27), those who have attempted as more impulsive, unpredictable and immature (p.28), hopeless and helpless (p.28), in emergency settings often violent and severely disturbed (p.45), non-compliant (p45), and resistant (p.47). For the bereaved we are reminded that anniversary dates of deaths and holidays are particularly "dangerous times"(p.37), and the picture that is said to emerge for a First Nation individual is that of "an isolated, vulnerable individual within a fragmented, deprived and shattered culture" (p.35). The updated Task Force report would add to this litany of descriptives with "a diminished control of impulsivity and aggression" (p.17), "despair" (p.12, 22), and "depression, anhedonic, frantically anxious, and poor self-esteem" (p.20). The Report on Mental Illness in Canada would suggest "all people who consider suicide feel life to be unbearable" (p.92). The other statement that this document supports is a connection between mental illness and suicide by virtue of the fact that it is included in this report, despite an acknowledgement that it is not really a mental illness. This presentation of the suicidal establishes the justification needed for the paternalistic approach that the discourse embraces. They are 'obviously' not capable of managing such a crisis, and therefore need protection. The continued acceptance of the suicidal as mentally ill would recreate the opportunity for them to once again be sanctioned for their behaviour.

The "criminalization of mental illness" (Laberge, Landreville, Morin, 2000) and the power imbedded in Community Treatment Orders and Form One would place the suicidal at the mercy of a system that would virtually usurp their rights. The Form One legislation gives doctors the authority to hold an individual in the hospital for up to 72 hours without their consent for the purpose of completing a psychiatric assessment. The Form One can be instituted whether the individual is in the community or in the hospital. The only requirement is that the doctor must have seen the individual seven days prior to signing the form. The Form One remains in effect for seven days at which time an admission must become voluntary unless a second doctor concurs that an involuntary admission is in the best interest of the potentially suicidal person. A Community Treatment Order can also be enforced if it is believed that without continuing treatment an individual will cause serious bodily harm to their person. Informed consent from the individual is required by law, however, if consent is withdrawn by the person, the doctor then has the authority to institute a Form One. (www.ppao.gov.ca/inf-for, accessed 02/16/05). The mental illness label tips the balance of power in favour of the professional and supports a take control strategy, reinforcing the idea that the suicidal are not capable of rational thought and must be protected from them self. “It is well known that functional psychiatric disorders are one of the main causes of suicidal behaviour.” (Moller, 2003) The proliferation of research that provides evidence that suicide is a symptom of a manageable illness places the suicidal in a position to be judged once again. The difference is that they may not be judged for the criminality of their suicidal intentions or actions but rather for their unwillingness to manage their illness. The discourse that has been created to label this unwillingness includes noncompliant, uncooperative, and resistant to treatment. When these labels are combined with the labels of marginalized populations, the rates of suicide for constructed high-risk groups becomes meaningful. The deaths by suicide of those populations that have become recognized as having marginal value can potentially be rationalized, as they are viewed as contributing knowingly to their own demise despite the efforts of the professional community to save them.

The act of suicide has been transformed within the discourse from an act to symptom; a symptom of illness, a symptom of the social condition of the individual, or a symptom of the society within which the suicidal lives. What occurred as a result of this transformation was that the act of suicide became devoid of meaning. All efforts to reduce this behaviour are focused on the treatment or amelioration of the circumstance or illness that have become accepted as the cause(s) of suicide.

Suicide discourse continues to be constrained by this need to protect, manage, treat, save, and ultimately prevent suicide. The belief that the suicidal are not capable of managing this crisis and therefore need help continues to motivate the professional communities to keep looking for the most effective way to accomplish this task. The pursuit of the 'answer', the 'key' that will unlock the mystery of suicide has consumed the discourse and propelled it into the world of academic research with the hope that science will find the answers. In the interim the suicidal are faced with two options should they choose to disclose their suicidal thoughts and that is predetermined treatment or no treatment at all. Ironically the opportunity presented to the caregiver to offer understanding to the suicidal person is also an opportunity to gain understanding. The choice to focus the encounter on treatment rather than understanding perhaps misses the opportunity to gain truly meaningful knowledge.

# Chapter Four - Conclusion

## General Findings and Implications

The purpose of this study was not to explain suicide discourse but rather to expose it. The result has the potential to provide an opportunity to consider the implications of how the discourse has influenced what we know and the way in which strategies have been designed and implemented to prevent these deaths from occurring. Suicide discourse has been transformed both by the general conditions of Canadian society and the transformations and that have occurred within the discourse. The general conditions include, the identification of mortality and morbidity as indicators of overall health, prevention as a strategy for improvement of overall health, the recognition of science as the source of truth, the need to identify causes of ill health, the specialization and professionalization of fields of study, the increased involvement of the government in the health of Canadians, and the inclusion of risk as a determinant of health. The condition that would create space for suicide discourse in Canada would be the decriminalization of attempted suicide for it was then that the need to address the issue was imposed on the medical community. These conditions would serve to guide the direction of the discourse but it was the transformations that took place within the discourse that would create it.

The analyzed discourse began with a focus on the need to save lives. With this as the ultimate goal there was an acceptance of the expressed reality that despite inadequate knowledge there was a need to persevere for humanitarian reasons. The primary focus initially remained the prevention of deaths by suicide (control of the behaviour) and the work that was being done in an attempt to develop a strategy that would reduce death. The primary focus was on the provision of service that would treat suicidal individuals and counsel those bereaved by suicide. There has always been an acknowledgement of the copious amounts of literature on suicide. Despite this fact the discourse would assume the position of the general condition that the knowledge was not sufficient, primarily because it did not meet the standards set by the scientific community. There is a temptation to believe that scientific knowledge is like ordinary knowledge except better (Kitcher, 1993). The other factor that may have contributed to the choice to reline efforts with the pursuit of knowledge was the reality that the rates of suicide continued to rise despite isolated efforts to reduce them. The responsibility for the deaths of Canadians may have weighed heavy, particularly at a time when Health Care in Canada was being epitomized. When the complexity of suicide became accepted in the discourse and the demand for answers grew, one of the most significant transformations occurred in the discourse and that was the establishment of the science of suicide. This science of suicide, named suicidology, would lay the foundation for limits and constraints that would profoundly effect the direction of the discourse. Suicidology would create a stage for experts who would internally create and impose on the discourse. The controversy in relation to the nature of suicide that had become a familiar pattern in the discourse became viewed as problematic rather than an opportunity to continue the search for a broad spectrum of answers. The promise of understanding that would only come from a multidimensional approach, although retained in the discourse as an ideal, was losing momentum. Suicide was becoming a specialization and those who were seen as having authority and wisdom in this area were predominately supportive of the medico-psycho model. As the discourse progressed it would imbibe the power and assumed credibility of this elite, becoming continually more pragmatic and sterile. The suicidal person would appear to have become an object of study and with a focus placed on research and treatment. In order for the professional community to prevent suicide they had to be able to first find the suicidal person, to locate them. This idea would also transform the discourse.

The emphasis placed on detection and the importance of locating the suicidal required empirical evidence that could support the professional community's ability to do just that. The discourse would further become alienated from the suicidal person by focusing more attention on the community that was available to intervene. The suicidal became labeled as ill, irrational, impulsive, and ambivalent about dying, making the need to prepare others for the job of protection and rescue. Public awareness campaigns to teach warning signs, education of professionals, the determination of causes, valid and reliable data were all promoted as necessary prerequisites for prevention. Suicide was seen not as an act of choice but rather as a symptom, and amelioration then became possible by preventing or controlling the conditions that preceded the symptom. Soft science might have altered the discourse at this point, but the act of suicide would became devoid of meaning when it was established as a symptom by the hard sciences. The disciplines such as sociology and philosophy however deferred to the importance of science and became part of the discourse that supported this interpretation of the act. The discursive subgroup that was formed in the name of suicidology was a formidable influence that was positioned to control the direction of the discourse. The discourse would continue on the path of specialization and this was witnessed particularly in the risk discourse.

It is important to remember that the success of prevention efforts was supported in the discourse as determined by an actual reduction in the rates of suicide and therefore those who contribute to higher rates became of particular concern. High risk groups had the potential to stand in the way of success more than the average person. Despite the repeatedly confirmed inadequacy of the data substantiating suicide rates, this same data is used to identify these high-risk populations. Again it was the acceptance of the general condition that risk must be identified as a critical consideration for effective prevention that limited the discourse. High risk groups were stated as defined by rates however there are examples that challenge this criteria. The young for example have consistently maintained their status as a high risk group of special concern, despite the fact that they die at rates lower than other population groups. Men in the over eighty years of age cohort actually have higher rates of death by suicide. There is some suggestion in the discourse that the decision to designate high risk groups as priority is socially motivated, and yet it continues. This is interesting in that if the goal truly is to reduce suicide would it not be rational to target those groups that actually have the highest rates? The data tells us the suicide is the leading cause of death for men (mid twenties to mid forties) in Canada. The discourse would continue despite this reality to pursue certain groups as targets and today they remain youth and young adults and First Nation communities. The CIHR research goals reflect a support for these two groups as priority. Suicide would appear to no longer be viewed as a social phenomenon but rather as an affliction of particular groups. Research priorities and amelioration efforts would target these two populations and it is interesting to hypothesize as to why this choice has been made. Youth are likely to be viewed as more vulnerable and in need of protection and perhaps a sense of responsibility for the state of First Nation communities, particularly on reserve, is a motive for this choice. Both sets of reasons would suggest that it is the needs of the professional to protect and repent that contribute to these two groups as having priority. It might also be suggested that the paternalistic approach that has become so familiar in the discourse is most aligned with these two populations. This is not to imply that the rates of suicide, for some First Nation populations is not a reality or should not be a priority. However, it is important to recognize that this population has become a priority for research not prevention efforts.

The need to identify groups of special concern specifically and to protect the suicidal from themselves generally led to a discourse that supported a paternalistic approach to prevention and a power dynamic that would put the suicidal in a disadvantaged position. The suicidal are described in the discourse has being victims of illness or circumstance and despite their best efforts unable to seek assistance or accept it when offered. The institutions of power would determine what is best for the suicidal and the discourse would support this including hospitalization without consent for their own protection. The discourse, which would support such actions as protective and justified, may in fact contribute to the hopelessness and helplessness that the same discourse imputes as characteristic of the suicidal.

The discourse has evolved to create space for research on suicide and at the same time reduced the emphasis on prevention, other than as a distal objective. The conundrum for the scientific community however is that suicide does not lend itself to generalizations. The reality is that no factor or determinant can be identified that will provide definitive evidence for detection and predictability. And yet the pursuit continues. When suicide was denied a reality as an act with meaning in the discourse an opportunity to elicit a meaningful understanding of the act was derailed.

## Future Research

There seems an obvious need to balance the movement at present to promote and support hard science as the source of answers for the suicidal. The obvious choice then becomes qualitative research that would provide insight into the meaning of suicide not only for the suicidal but also for those who are involved in treating them. The experience of the suicidal must include individuals from all age cohorts, cultures, and geographic locations. As well, the researchers and suicidologists who have been established as authorities in the subject may offer interesting insights into what perpetuates this movement and how and why it is perceived as a preferred direction. Applying the unstructured interview technique would be a preferred method in an attempt to reduce as much as is possible the influence of the limits that the discourse has imposed on the way in which we have come to know suicide.

There is a continued recognition in suicide discourse of the importance of incorporating a multisectoral approach to research on the subject of suicide and yet at the same time the discourse has continually moved in the direction of the establishment of hard science as primary in determining the key to prevention. Research from disciplines other than medicine and psychology needs to be more assertively solicited to bring to fruition the goal of understanding suicide in its entirety. Sociology in particular, despite the prophetic warnings of Douglas, has become preoccupied with the empirical study of factors and determinants based on quantitative data in the fashion of Durkheim. The study of the social and personal meaning of suicide has been limited by this pursuit of scientific knowledge. Suicide as an act needs to be examined as a communicative event and this will only be understood through the lived experiences of the suicidal, and only if they are viewed as having the ability to rationally describe this experience. As Peter Berger reminds us "Unlike the puppets, we have the possibility of stopping in our movements, looking up and perceiving the machinery by which we have been moved. And in this same act we find conclusive justification of sociology as a humanistic discipline"(1963, p.176). This is not to imply that sociology is the only discipline that has the opportunity to redress the discourse and choose alternative research aims, however it does have a history of success in doing exactly that.

Research seems most concerned with populations that have high rates of suicide as is witnessed by the interest in First Nation communities, particularly on reserve, with a focus on what factors contribute to the high rates of death. There are communities in Canada that have low rates of suicide and perhaps a study of these communities would offer knowledge that would contribute to an understanding of factors that are protective. As well as a community profile, interviews with members of these communities may expose an attitude specific to suicide that has not been previously identified as having an ameliorating effect.

At what point do we become satisfied that we know enough, and that based on the knowledge available it is time to transfer that knowledge to action. The validity of the vast amounts of knowledge that exist on the topic of suicide will only truly be tested at that time. Perhaps that time has come.

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