

LIFE AFTER DEATH

Suicide, Care, and Responsibility



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Abstract

This thesis focuses on suicide bereavement, particularly of those parents who have lost children to suicide while in care of the state. I argue that, for these parents, action taken following the suicide of their children is an extension of the care that was given throughout their child's lives. For parents of those suffering with mental health issues, care is fraught with confusion and tension. This is no more apparent than when they and their children are seeking professional care. Care is inextricably linked with responsibility, which as I will show, is a very important concept in understanding suicide prevention. Governance of regimes of care shapes bereavement through biopolitical responsibilisation. The conflict found within understandings of care lays the foundation for the conflated tensions that arise in suicide bereaved parents' search for recognition and accountability of and for their child's suicide. In this thesis I explore these actions to understand the motives and desires of these parents. In exploring these, meaning becomes a useful analytical lens, for meaning, care, and the projects that my participants undertake in search of answers were all intimately linked. Through understanding the actions of bereaved parents as an extension of the care for their children we can understand how these actions are shaped by the governance and regimes of care within New Zealand.

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Introduction

The social and academic value of research on suicide in New Zealand cannot be overstated. New Zealand has one of the highest rates of youth suicide – particularly among males and Māori. There is no anthropological literature, however, on suicide in this specific context. Suicide in New Zealand is a contentious issue. One does not need to look far to see the controversy that speaking about suicide can stir. In 2017, the television show, *13 Reasons Why* was aired on Netflix to the dismay of many parents and mental health advocates across the country. It is a drama about a young girl who kills herself leaving behind a series of cassette tapes explaining why she killed herself. The ‘13 Reasons Why’ are thirteen of her schoolmates that drove her to suicide. At the end of the show there are graphic images of the girl’s suicide. The public debate that ensued, including its censorship rating, however, was not new or unique in any way. However, it points to the moral panic that can be sparked by the thought of youth suicide. On one side of the argument, the show glorifies youth suicide and will encourage copycat behaviour. On the other side, speaking about suicide is healthy and necessary. This argument has cycled in and out of the public conversation for at least three decades (Weaver 2014). Outside of journalism and other such media, there is a lack of discussions and explorations of this topic in this context. It is clear that there is a great need for socio-cultural research into suicide and suicide prevention in New Zealand.

This thesis has evolved – at times seemingly of its own volition – over the months of research and fieldwork. However, one thing has remained throughout, my focus on the experiences of suicide prevention. I am not attempting to explain why people end their own lives, or even assess the state of suicide prevention measures in New Zealand, my aim is to understand the experiences of those who are the target of those measures. I realised early in my research that finding participants who have attempted to take their own lives had both practical and ethical concerns. Thus, and somewhat serendipitously, those who care for those who suicided – namely parents – became the focus of this thesis. What I wish to explore in this thesis is care, and its relation to suicide. As I argue throughout this thesis, care is a term intertwined with suicide and suicidality. For parents of those suffering with mental health issues, care is fraught with confusion and tension. This is no more apparent than when they and their children are seeking professional care – stories of which are riddled with uncertainty, anger, and distrust.

In relation to care and suicide, there are two main themes which I will explore: responsibility and meaning. Care is inextricably linked with responsibility, which as I will show, is a very important concept in understanding suicide prevention. By understanding the diversity and instability within regimes and forms of care, contradictions become visible; and when attending to responsibility within care all the more so. Governance of these regimes of care begins to shape bereavement through biopolitical responsibilisation and other forms of contemporary governmentality. Understandings of care are not always congruent, particularly between professionals and families. This latter point creates a great deal of tension and conflict when that life ends by suicide. The conflict found within these understandings of care lays the foundation for the conflated tensions that arise in suicide bereaved parents' search for recognition and accountability of and for their child's suicide. For parents of children and young adults that die by suicide, the care they give often extends beyond death. I argue that the action taken following the suicide of their children is an extension of the care that these parents enacted throughout their children's lives, and more specifically, in the times of mental and emotional affliction that lead up to their suicides. What I wish to achieve in this thesis, is to explore these actions, and to understand the motives and desires of these parents. In exploring these, meaning becomes a useful analytical lens, for meaning, care, and the projects that my participants undertake in search of answers were all intimately linked.

Finally, by focussing on the coroner's inquiries and other official inquests by state and independent agencies I show how contemporary neoliberal regimes of care, particularly in bureaucratic situations such as formal inquests, can, for those bereaved, feel cold, uncompassionate, and uncaring, as if the state were indifferent to the death. These suicide bereaved parents feel the oppressive force of silence on a daily basis. This silence was a force

which they vehemently fought against, and was one of their most symbolic battles. Although the silence is largely culturally shaped, in the ways that friends, co-workers, and strangers would avoid speaking about suicide and mental health, the fight also encapsulated their fight for recognition of their loss, and bereavement, by state agencies and officials. Through the lens of biopolitics, I will show how responsibility is understood and shapes the attitudes and actions of the state agencies in response to these parents' claims.

The resistance of these parents to what can feel like a cover-up of state neglect is not without ill-effect, however. Their activism against the current state of mental health services in New Zealand can fuel reluctance for themselves and others to engage with professional support. There is a possibility that the voices can influence people around the country to feel disillusioned with such services. As I will discuss, this could be problematic as engagement and trust are integral in the efficacy of mental health services. The tensions created in these interactions can be detrimental to regimes of mental health care in New Zealand.

Expectations of Care

The death of a loved one can often leave one with questions, confusion, or anger. A death by suicide all the more. It is a death that we struggle, as individuals, as families, and as a society, to understand. However, there are some suicides that elicit a stronger reaction, such as youth suicide. We try to explain suicide. However, questions always remain. Why did they no longer want to live? Could we have seen this coming? What more could we have done? There is an expectation that a suicide can be foreseen and thus be avoided. As suicide has increasingly come under the umbrella of mental illness, the biomedical model of health has allowed for a dominant cultural discourse of 'treating' suicidality, much like one would treat a chest infection or high blood pressure. Thus, if it can be treated, under New Zealand's public health care system it should be. There is thus a high expectation of care for those suffering from a mental or emotional affliction, including suicidality.

The biomedical model of suicidality is not just a professional one, but also has a hold on the wider cultural discourse of suicide. There is some shared understanding of suicide between both professionals and the public. As Karine Vanthuyne states (2003, 413), "people's narrativisation of their experience of mental illness is a socially situated, individualized version of a body of cultural knowledge, a knowledge that, in modern society, is particularly and increasingly impregnated by expert knowledge". However, what has become highly contested is how those who are suffering through suicidality should be treated once they are in the care of mental health services. These become visible through my participants' narratives of the care

that they and their child received. The language that they employ is that of humanistic care, whereby their loved ones are treated with the same kind of respect, compassion, and empathy that they would give them themselves. Their experiences are unique in that they consider the reason for their children's suicide to be neglect of those who have been charged with their care. The ways in which they speak about their expectations not being met illuminate the intersections and tensions that become apparent between families and professional institutions.

The tensions between these families and the state stem from biopolitical experiences; experiences of being treated as a name on paper; as a case number; as someone who the state must manage. These are diametrically opposed to being treated empathically or compassionately. When carrying serious complaints, biopolitical systems of care are keenly felt. They can often feel cold and uncompassionate much like their experiences of state care itself. In bereavement of the suicide they are faced with coroner's inquests into the death of their son; legal suppression, stipulating they cannot publicly speak of their son's suicide; and formal action they undertake against the District Health Board (DHB) that was charged with their son's care. These experiences can take a toll, particularly amidst grief and bereavement. Through interviews with professionals and families of those who feel failed by the state, and online fieldwork via Facebook pages to voice their complaints, I will explore what these bereaved parents face following the suicide of their child while in state care.

For my participants their complaints did not begin or end with the neglect that they argue cause their child's death. They trace back the times before they felt that their expectations of care were not met. They talk of the first time that they encountered a mental health professional, and how they were received with perceived disdain, or apathy. They told me that their concerns for their children were disregarded. These encounters have profound effects on the way that any further engagements with mental health services occur. In a profession where trust, rapport, and active engagement are paramount to the efficacy achieving positive outcomes, creating resistance and tension between families and mental health services can have profound consequences both during and after care.

Following suicide families often become active in their search for answers and accountability. This can happen in various ways. However, one very common theme among my participants is that they have all become vocal in their complaints. This is often cloaked in the mantra, "No Stigma, No Shame, No Silence"¹. The idea of silence is used to fight suppression, a stipulation under the Coroner's Act. They feel this as a way of muzzling them from vocalising their complaints, often to the point that they feel that their case is being covered-up. Some of my participants have chosen to ignore suppression orders as a form of resistance. Some have

¹ This 'mantra', I first heard from Tanya, however I later noticed it used fairly widely among online suicide bereaved groups on Facebook. This was also a sentiment that was apparent among all of my participants.

chosen to take to social media to voice their concerns, both specific to their case and also over the efficacy of mental health services more generally. Families in similar situations mobilise on social media groups, many of which are created and run by my participants. However, these groups are not simply to vocalise their complaints, they are therapeutic. They allow those bereaved to connect with others that can empathise with their grief and with their bereavement of a suicide. Vocalising complaints is seen as necessary in order to allow others around New Zealand to know that there are some serious issues surrounding mental health services in the country. However, this can reinforce the resistance of engaging with mental health services, and as I mentioned above, engagement, trust, and rapport are critical to effective treatment within mental health services. The conflicts that arise between ideas of intimate and public care are expanded and situated with the anthropological literature later in the introduction.

Suicide Prevention in New Zealand

In beginning this research I focussed on care and prevention of suicidality in New Zealand. I created in my mind a conceptual and categorical divide of preventative care into two distinct although intersecting areas; public care and intimate care. Public care included public policy and legislation. Such as the *Coroners Act 2006*, a unique legislation pertaining to the media suppression of reporting on suicide. This also included psychiatric and public health intervention, helplines, and advocacy groups. Intimate care focussed on care within the domestic sphere, from family, friends, and networks of those one shares in everyday life. Although I created a split between the two domains of care, these are not, in reality, discrete categories. An example of this is the *Mental Health Act 1992*, which gives health professionals the ability to hold those they deem to be a threat to either themselves or those around them in a psychiatric facility for as long as six months. It is legislation that has profound implications for the rights, and sovereignty, of those suffering from suicidality and other mental illnesses. It becomes clear that these intersections at which public and intimate meet and the tensions that they can produce shall be my focus. The questions that shaped this research and ultimately who I was to speak to regarding suicide in New Zealand are as follows:

- What is suicide prevention in New Zealand?
- What does this mean for those suffering with suicidality?
- How does this affect those involved in care?
- How does the type of care provided affect the conceptualization of suicide?
- How do these levels of care intersect?

The Ministry of Justice (2015) reported the number of suicides in New Zealand of the 2015/16 year as 579, 15 more than the previous year. Demographically there are a disproportionate number of males and Māori killing themselves each year. For the year 2015/16, 409 of the 579 New Zealanders that killed themselves were male, making up over 70 percent of total suicides. The Māori suicide total was 129, again seeing a disproportionate number of male suicides; 83 of those were male. The 'suicide rate', which is often talked about in suicide prevention is measured per 100,000, which gives a more comparative view of these statistics. In this same period, the suicide rate for New Zealand was 12.33, with a male rate of 17.71, and a female rate of 7.13. However, the Māori rate is 21.57. A discussion of the demographics of suicide in New Zealand raises the limitations of my field and sample. With the exception of one family, Jane and Dave, whose son identified as Māori, all other participants are New Zealand European, or Pākehā². Along with this, all of my participants' children who died by suicide were male, all between the ages of 16 and 26.

Appeals for suicide and mental health to hold a more prominent place in the national conversation are undoubtedly being heard, exemplified by a strong social media presence as well as various government initiatives. However, numbers of those killing themselves remain stubbornly high. Chief Coroner of New Zealand, Judge Deborah Marshall stated on release the provisional statistics from 2015 stated that, "over the last eight years I believe we've seen a shift in society's preparedness to have a more open conversation about suicide, but we are not seeing any movement in what is an unfortunate static annual figure" (Ministry of Justice 2015).

I must make clear that I do not wish to attempt to explain what motivates people to end their lives. There exists substantial work in psychology, psychiatry, and to a lesser extent the social sciences, that attempts to address these motives. Furthermore, of this endeavour Zoe Wool (2015a, 27) notes that this is "a doomed task". Within the social sciences, work from Emile Durkheim (1898) has created a perpetual legacy of explaining suicide through the lens of social inclusion and moral regulation. This lens is almost invariably employed even in contemporary studies, yet the statistics suggest that these insights have not led to significant inroads in prevention. Therefore, it is preventative care itself that shall receive my attention. In turn I hope to contribute to the efforts of those involved. In order to do this however, demographics of suicides must be acknowledged. One such resource to aid in this will be John C. Weaver's recent work (2009; 2013), in particular, 'Sorrows of a Century: Interpreting Suicide in New Zealand 1900-2000' (2013). This gives not only an in-depth and nuanced overview of suicide in New Zealand but will also allow me to situate current preventative measures historically. The

² Māori term meaning New Zealander of European or non- Māori descent.

Ministry of Health is also an invaluable resource, with all policy statements, legislation, statistics and government action plans pertaining to suicide publicly available.

Anthropological literature on suicide is relatively sparse, although in recent years there have been several significant contributions. This thesis is particularly influenced by the work of Lisa Stevenson (2012; 2014) and Zoe Wool (2015a; 2015b). Stevenson's work has guided me to strive for a historical, economic, and political, as well as cultural understanding of suicide prevention in New Zealand. Stevenson's 'Life Beside Itself: Imagining Care in the Canadian Arctic' (2014) takes a biopolitical approach to postcolonial care of the Canadian Inuit. Her emphasis is on preventative care rather than suicide itself. Zoe Wool's 'After War' (2015) is an ethnographic account of the lives of service-members that have returned home following harrowing injury such as loss of limbs or traumatic brain injuries. Wool situates their lives historically, politically, and morally so as to understand the implications of living with such injuries following their return home. What is of particular significance are the moral, political and subjective tensions that can arise for both those being cared for and those providing care, particularly when mediated by the state. Through ethnographic method, we can gain a better insight into the subjective experiences of the informant's suffering (Biehl, et al. 2007). In the following two sections I shall give an outline of the anthropological literature of suicide and care. Given the focus of this thesis and constraints of a Master's thesis, I shall not be touching on the vast literature on death within this review.

An Anthropology of Suicide

Although sporadic, suicide has garnered some attention within anthropology throughout the twentieth century – Bronislaw Malinowski (1949[1926]) and Paul Bohannon (1960) being the two most notable. Malinowski posited that suicide among the Trobriand Islanders was a social institution in itself rather than being measured against social integration and moral regulation as per Durkheim (Staples and Widger 2012, 192). He found that suicide was an act of social protest against insult or transgression. In Bohannon's 'Homicide and Suicide in Africa' (1960), and throughout the nineteenth and early-twentieth centuries, suicide and homicide were seen as different sides of the same coin. Bohannon's theory has been mirrored in the frustration-aggression hypothesis, an assumption which much of the research within suicidology has been based upon (Staples & Widger 2012, 189). Although "ethnographic, cross-cultural analyses of what lies behind people's attempts to take their own lives remain few in number" (Staples and Widger 2012, 190), several significant studies have been published in the past decade (see Chua 2012; 2014; Dabbagh 2005; 2012; Ozawa-de Silva 2008; 2010; Stevenson 2012; 2014).

Rob Whitley (2014) has noted that one of anthropology's goals when studying suicide or mental illness is to "provide a meaningful critique of practices, beliefs and movements within current psychiatry" (2014, 499). Junko Kitanaka's work (2008; 2012) has done just this, giving a comprehensive ethnographic, historical, cultural, and political account of the rising medicalization of suicide and depression in Japan. In Kitanaka's work (2008; 2012) psychiatric knowledge and practice has become the object of inquiry; she argues that the medicalization of suicide is "fraught with tensions, as psychiatrists are confronted with people who hold competing moral views on the nature of their distress" (Kitanaka 2008, 170). This contestation of ideas reveals the culturally dynamic notions of suicide that are apparent in Japanese society, where "suicide has long been depicted as an act of free will, even aestheticized in the cultural notion, suicide of resolve" (2008, 152). Psychiatry itself has been, and continues to be an important influence on the cultural logic, and consequently "the current medicalization of suicide is helping create an important conceptual shift in the way Japanese think about the normalcy and intentionality of those who take their own lives" (2008, 154). Approaches such as Kitanaka's (2008; 2010) are necessary as they not only give constructive critique, but also reveal social and cultural notions and logics.

Psychiatric and sociological models of, and approaches to, suicide have almost invariably seen suicide as an ending, a final act. However as Staples and Widger argue, "suicide should not simply be understood as a destructive act, but as a constitutive one as well" (2012, 186), a statement that I see as very pertinent to my research. As I will discuss throughout this thesis, communities are constructed around shared experiences of suicide bereavement, meaning is created through loss, and identities are also constituted. Of Japan, Mary Picone (2012) discusses the spiritual implications to family and friends of one that has taken their own life. Within this discussion she asserts that Buddhism does not permit self-destruction but rather "religious practitioners of all sorts have maintained that suicide creates unhappy, resentful spirits who harm the living" (2012, 391). John W. Traphagan, an anthropologist of Japanese religion, explores how suicide causes a substantial financial, social, and emotional burden on the family of the deceased and can also require special ritual treatment (2004, 321). Using self-destruction as a departure point, rather than simply an ending, can broaden insight into understandings of suicide, and has informed the ways I approach suicide bereavement.

Contemporary ethnographies of suicide primarily focus on Indigenous, non-Western, and minority populations. Jocelyn Lim Chua (2014) has written on suicide in South India in the context of globalization. Nadia Taysir Dabbagh (2005) published the first anthropological study of suicide in the Arab world, 'Suicide in Palestine: Narratives of Despair'. She posits Palestinian suicide against the effects of Israeli occupation and within the context of the Palestinian identity. Colin Tatz (2005) in 'Aboriginal Suicide is Different: A Portrait of Life and Self-Destruction', like

Stevenson, views Aboriginal suicide through a post-colonial lens, arguing that this epidemic of Indigenous deaths to suicide should be seen as a failure of the Australian nation. Lisa Stevenson (2012; 2014) in her work on the care of Inuit throughout the tuberculosis epidemic of the mid-twentieth century and the current youth suicide epidemic has illuminated the bureaucratic indifference to individual life even though aiming for benevolence and care.

Although not primarily focusing on suicide, Zoe Wool (2015a; 2015b), Kenneth MacLeish (2013a; 2013b) and others (Howell & Wool 2011; Wool & Messinger 2012) have discussed suicide within the context of the United States' military. As mentioned above, Wool approaches suicide through the lens of care; she asks, what are the implications for intimate partners of those suffering with suicidality? What are the implications for those suffering themselves? In 'Labors of Love' (2011) Wool and Seth Messinger introduce what they call grey zones of care. Through the non-medical attendant program at Walter Reed Army Medical Centre family members occupy both intimate roles of kin and also professional caregivers, a mediation of roles that can cause a great deal of stress.

Tensions and contradictions become visible within such contexts, whether they be contradictions within cultural logics of suicide and mental illness between psychiatrist and patient; or the tensions that arise from occupying the role of both professional and spouse. It is with these tensions in mind that I conducted ethnographic research of the intersections of preventative care in New Zealand.

An Anthropology of Care

Compared to suicide and suicidality, care is a concept that has garnered significant attention within anthropology in the past two decades, according to Elana Buch (2015, 279) "motivated in part by a turn from discussions of suffering to considerations of the social relations that sustain life in both mundane and dire moments". The concept of 'care' is complex and ambiguous; it is far from stable. As such, there are a wide variety of emphases within ethnographic explorations of care; "social and cultural, local and global embeddedness; the variety of human experiences and relationships of obligation, trust, loyalty and commitment to the wellbeing of others; and discourses of care" (Alber & Drotbohm 2012).

Arthur Kleinman (2009, 293) argues that more attention must be paid to the ways that care is a "defining moral practice... of empathic imagination, responsibility, witnessing and solidarity with those in great need", as it requires the recognition of 'need' and to be co-opted via some type of relationship. What becomes clear through these definitions, although few, is that 'care' involves social relations, includes moral ideals of responsibility and obligation, but

prior to this requires the recognition of those in need. This is why I argue throughout this thesis that the action taken through the journey of bereavement is an extension of the care projects prior to my informants' sons' suicides.

Susanna Trnka and Catherine Trundle (2014, 142) note that "care is enacted across various levels of relationality, manifested through intimate, face-to-face relationships (such as between parent and child) or in relationships between collectives (for example, teachers and students; citizens and the nation)". Relations of care can be enacted locally or globally, and with varying degrees of temporality. There is significant attention to global regimes of care throughout the anthropological literature, with particular attention paid to biopolitical distribution of care in humanitarian and global health development (Feldman & Ticktin 2010; Fassin 2011; Ticktin 2011). Much of the literature focuses on institutional care. For example, Kleinman (2008; 2009) and Mol (2008) focus on the "moral and ethical aspects of daily care practices to productively critique biomedicine's focus on autonomous choice" (Buch 2015, 279). Critics of modern forms of care assert, "By individualizing, anonymizing, or medicalizing responses to human suffering, these forms of care can foreclose structural or collective responses to injustice" (Buch 2015, 280). In a similar vein Paul Brodwin (2013) discusses the ethical decisions made daily by those working in community psychiatry and the tensions that arise between the moral dilemmas of giving adequate care and the constraints of the systems and institutions within which they work.

Relations of care, or what is often called "care work" (Alber & Drotbohm 2012), do not necessarily involve an enduring commitment, nor must they be steeped in discourses of intimacy or love. Barry Adam (2005) writes of HIV/AIDS and the sexual engagements of homosexual and bisexual men in Toronto. Adam notes that "while not requiring a long term commitment, [they] demand attentiveness and a willingness to respond" (Trnka & Trundle 2014, 145). Omri Elisha (2008) and Catherine Trundle (2014) both write of charity work through the Church, the former showing that "charity might be represented through the rhetoric of brotherly love", however the latter showing, like Adam (2005) that "such affects are not essential to those relationships" (Trnka & Trundle 2014, 143). The inverse may also be true. Stevenson (2012; 2014) discusses how Inuit of the Canadian Arctic experience the intentions of care and benevolence of the Canadian State as murderous or even genocidal. Although intentions are genuine and compassionate, the effect is not necessarily beneficial for those being cared for.

Care is caught up in a conflict between structure and agency, between professionalism and intimacy. It often involves contradictions between altruism and control, coercion and kindness. For Han (2012, 5) care "takes shape and is experienced through concrete relations inextricably woven into uneven social relations". Uneven relations can often lead to tensions as

the contradictions mentioned above become visible. These tensions that often lie at the intersections of care, between those that are giving care and those that are being cared for, are at the heart of what this research is focused on. In this thesis I explore the intersections of such care with suicidality and thus provide a bridge between these two fields of anthropological inquiry.

Methods

At the embryonic stage of this research I knew that I wanted to speak to those that had been affected in some way by suicide prevention in New Zealand. I did not originally set out to speak specifically to those who had lost their children to suicide. This can be seen in the early interviews that I did with others who had been affected by suicide in other ways, such as Christine, whose father had attempted suicide; or Katherine, who had attempted herself. Although they gave their time and emotional energy into speaking with me about such subjects, I painfully had to make the decision to omit their stories from this thesis to focus on the experiences of parents who had lost children to suicide. These are augmented with interviews with others working professionally within suicide prevention. However, that is not to say that their words and stories did not influence this thesis, for speaking with them brought reflection and insight into their experiences of suicide and suicide prevention.

I must note, all names of persons, places, groups, and organisations have been changed to protect the identities of those involved. Most importantly, pseudonyms have been used for all participants in this thesis. However, Jane Stevens and Dave McPherson wished to be named. As I demonstrate throughout this thesis, this is an active resistance to stigma, shame, or silence around suicide.

The lens through which I view my methodological approach is the *interaction perspective* as put forth by Pertti Alasuutari (1995) and others (Pool 1957; Mishler 1986). The interaction perspective sees the interview as “an occasion for purposefully animated participants to construct versions of reality interactionally rather than merely purvey data” (Holstein et al. 2003: 14). From this perspective the entire interaction between researcher and participant is an object of analysis. This includes reactions to questions, or my reaction to an interviewee’s reply (Alasuutari 1995, 86). This perspective is situated in opposition to a more factist perspective, whereby, “the qualitative interview and other methods of data collection are regarded as ways of generating information about the object of study” (Alasuutari 1995, 85). Mishler “recognizes that interviews are speech events, that interviews are jointly constructed by interviewers and respondents, that analysis and interpretation are based on a theory of

discourse and meaning, and that the meaning of questions and answers are contextually grounded" (Csordas, et al. 2010, 30).

Given their vehement desire to make heard their complaints of both how their sons' care was handled and, by extension, the state of mental health care in New Zealand, at times I was perhaps seen as a tool to expand my informants' audience. This is not to undermine the stories they told me, but to not make the mistake of treating them as objective fact. As I will discuss later in this section, memory and narrative, too, are important concepts to address. In a similar vein Holstein et al. (2003, 14) note that, "the subject behind the respondent not only holds the details of a life's experience but in the very process of offering them up to the interviewer, constructively shapes the information". To put this more simply, there is a "discourse between speakers", rather than simply from the interviewee. Therefore the interviewee and the interviewer are "equal partner[s] in the interview conversation" (Mishler 1986, 16).

The interview is an interaction that takes place within a specific context and social milieu. It is a social encounter "a site of, and occasion for, producing knowledge" (Holstein et al. 2003, 4). They go on to assert, "Meaning is not merely elicited by apt questioning, nor simply transported through respondent replies; it is actively and socially assembled in the interview encounter" (2003, 4). Mishler asserts that the social context of interactions "guide how individuals enter into situations, define and frame their sense of what is appropriate or inappropriate to say, and provide that basis for their understanding of what is said" (1986: 11). Csordas, et al. (2010, 30) writes:

Interviews must be understood as communicative events and that researchers must more closely examine the compatibility between different styles of interviews as a means of acquiring information and the ways in which their subjects typically convey information to one another (such as storytelling). Statements made during an interview should be considered in light of their performative context, not just as objective facts waiting for observation and the subsequent ascription of meaning by the investigators: not doing so blinds interviewers to potential errors in interpretation and to the limitations for the interview in acquiring data.

As a social encounter it is imperative to understand the relationship between the interviewer and interviewee. In this way, the salience of rapport is great. It affects the length and efficacy of the interview. In this same way it affects the data; there is no underlying truth that can be gained from an interview for it is always socially embedded and performative within this context. Along with this, power within social relations must too be understood and contextualised. As a researcher, I was perhaps seen as holding a privileged position in the construction and control of knowledge surrounding suicide and suicide prevention. The

relationships that were made with my participants were influenced by my being a young, male researcher working within a reputable University. Although it would be difficult for me to assert precisely how this shaped the relationships, anecdotally I could see that my being a similar age to their sons meant that there was almost a filial relationship between us. Many of the parents, particularly mothers, would note that I would be about their sons age now if he were still alive. Tanya particularly still checks in with me to make sure that I am coping with what can be a triggering topic.

When conducting interviews, memory and narrative are extremely important concepts, and are foundational to understanding the stories of my participants throughout this thesis. The interview is a social encounter, but it is also an act of memory and narrative. Michael Lambek and Paul Antze (1996, xxv) write:

Memory acts in the present to represent the past. Such representations... are extremely complex, no simple retelling but a work of interpretation. Moreover, to say "I remember..." is not to frame a mere description, but to signal a speech act. Memories are acts of commemoration, of testimony, of confession, of accusation. Memories do not merely describe the speaker's relation to the past but place her quite specifically in reference to it. As assertions and performances, they carry moral entailments of various sorts.

Commemoration and accusation are both apparent in all interviews. Not only this, but they are two of the main themes that this thesis is based upon. Memory is a practice between parties, and in the case of the interview, between myself and the bereaved parent. However, knowing my position in the academy, and perhaps seeking a wider audience, practices of memory and narrative can be focussed more on accusation. Of this Lambek writes, "the value of articulating a particular version of the past would be explicitly connected to its moral ends and consequences for relations in the present" (1996, 239). Finally, Lambek (1996, 239) argues, "such an approach treats memory not as a neutral representation, more or less accurate, of the past, but as a claim or set of claims, more or less firm, more or less justified, more or less appropriate, about it".

Memory and narrative are not only relevant in understanding interviews, but also for my online fieldwork, which involved viewing my participants' public Facebook groups. The Facebook groups were created following the suicide of their children, and are in the name of advocacy for the suicide bereaved and suicide prevention. Over the three months that I conducted my fieldwork I took note of the messages and stories that my participants were sharing on their public Facebook groups. The public nature of these pages can mean that parents' narratives of their experiences of care are shaped for a public audience, and are

“explicitly connected to its moral ends and consequences for relations in the present” (Lambek 1996, 239).

Throughout this thesis I have chosen to use the language of suicide that is preferred by my participants and the advocate community. There are certain terms that are explicitly absent when speaking about suicide. The term ‘commit suicide’ is one of these terms, and is not used by this community as it denotes some sort of illegality. Instead, they prefer terms such as ‘died by suicide’, or ‘killed themselves’. The term ‘bereaved’, a term that I use extensively throughout this thesis, is widely used by my participants, for example, to name their groups, ‘suicide bereaved networks’. To label themselves ‘suicide bereaved’ is to foreground their loss, and thus basing their identity on this experience. Language is extremely important to my participants, and to suicide prevention more generally, for it is often affiliated with silence, a symbolic target for the suicide bereaved.

Putting the Feelers Out

Knowing that one of the most pressing and variable aspects of fieldwork is contacting participants to share their experiences, I created a website³, a space for my thoughts and for my research. This proved to be an extremely helpful endeavour. Social media allowed me to put my feelers out to networks of suicide survivors and bereaved and their families across the country without the rigmarole of one-by-one emailing or calling each group or individual.

On Good Friday, the beginning of the Easter break, when I was taking the weekend off to visit my partner’s Mother in Taranaki, I received an email from a man named Grant. His brother had been murdered the previous year and his killer had just beat jail time by reason of insanity. I had followed this story in the news and was thus familiar with the case. Although not exactly relevant to my research it was interesting nonetheless. He told me about a network of those who were dissatisfied and angry with the DHBs around the country for their role in the deaths of friends and family. He felt that “DHB failures in these case[s] are the same as in cases of suicide of patients under mental health care”. He used the term “care” somewhat ironically it seems, saying later that he, “use[s] the term ‘care’ loosely”. This was the beginning of the day; a day in which I was welcomed into a large network of family, friends, survivors, and bereaved, all openly angry with the level of care that they, or their loved ones, were given by their respective DHBs and mental health services.

In the 24 hours following his email I received emails and messages from numerous others offering to share their experiences with suicidality, whether experienced within their

³ See www.facebook.com/theexistentiailelephant

family or personally, it became clear throughout this research that these are more often than not coexisting. Jane Stevens was the first, telling me in her email that Grant had contacted her. Jane's son had killed himself roughly a year prior and was still waiting for answers about why he had been able to die whilst in legal care of the Waikato DHB mental health services. Since his death, Jane and her family have been "working at a more strategic level to challenge the dysfunction of our mental health system". Like Grant, and what seems to be a theme among those I have talked to, they have connected with many people around the country who are experiencing similar tragedies. They are also active on Facebook with a page, "Nicky Autumn Stevens", set up for the reasons outlined above.

Messages came in from survivors across the country, from Hastings to Dunedin. Mental health advocate, Carol, who is the chair of a charitable trust aimed at suicide prevention, and whose son was a victim of suicide, contacted me. Seven others, all women, all with family, friends, or who have personally suffered through suicidality, expressed their willingness to be part of this research. It became clear very quickly that not only were there networks of people around the country that wished to speak with me regarding suicide and mental health services in New Zealand, but they also felt a need and desire for their voices to be heard. They reiterated to me the social merit of this research. What soon became clear was that those with the most desire to speak about their experiences with suicide were those who had lost children to suicide. Within only three weeks this theme emerged. As mentioned above, I had been contacted by Jane, Carol, and I had also been put in touch with Tanya, Terri, and Bill, all of whom had sons that suicided. Their experiences were to become the focus of this thesis.

Before I began this research, I had heard countless stories from others who struggled to gain access to their respective fields. They had waited for months before they found the right person, that one informant who opens up the world, the gatekeeper, as they are often spoken of. As mentioned above, for myself this was not the case. As these people let me into their lives, sharing their stories, laying bare their ultimate vulnerabilities, it started to dawn on me that their desire to speak of their tragedies is no coincidence. It is not simply the luck of the ethnographer. What became clear, very early on was that those who I spoke to were actively seeking to share their stories. Was this a therapeutic process? Was it so that others could avoid the same fate of their loved ones? Or rather, was it to voice the anger and dissatisfaction that they felt toward the services that had let them down? These became very important questions, and in the following chapters something that I wish to address.

The stories and lives of those who opened up to me, were unique, but not without similarities. They too were not without parallels to others throughout New Zealand. I must make clear that I do not wish to gloss over the distinctiveness of those of whom I write, however certain aspects of their understandings, complaints, and stories speak to many others in New

Zealand. I must not make the mistake of suggesting that their circumstances indicate wider cultural understandings of suicide and care, and I must not assume that the complaints of participants are apparent in all areas of care. In saying this, the complaints and understandings of my participants do reflect and illuminate certain views within the community that they are in; the socioscaples of those bereaved by suicide.

There was a varying degree to which my participants voiced their concerns with the mental health system and systems of care, including suicide prevention and postvention⁴. However, one thing that remained constant across the range of views held by my participants was that all believed that more could be done. It would be easy to assume that those involved in professional care would have the potential to defend accusations that systems of care in New Zealand were failing those for which they care. However, this was not the case. In fact, some of the views held by professionals were as vehement as those who had lost their children. These conversations about the failings of the system or of how to better care for those suicidal and to prevent further suicides would all too often took a philosophical or even existential turn. Although this illuminated much about the understandings of suicide on the part of both myself and my participants, it often led to a despairing sigh, and the questioning of the efficacy of even trying.

As I have mentioned above, I have focussed this thesis around the experiences of seven parents who lost their children to suicide. Given that their suffering, their grief, and bereavement have come to inform this research, it is important that I give them the proper introduction. In the following sections I shall introduce each of my participants. For the sake of authenticity, I believe the best way to introduce my participants is through my initial fieldnotes and impressions of our interviews.⁵ Although my main focus is on these seven parents, I will be augmenting their experiences with three others employed in professional care. Firstly, Phillip, one of the sixteen coroners in New Zealand. As a coroner, he rules on suspected suicides, determining whether the death was intentional and self-inflicted. Phillip is an extremely valuable participant given his status within suicide prevention in New Zealand. Daniel is a clinical nurse at a psychiatric in-patient ward in Wellington. He was able to give me professional insights into mental health and suicidality. By talking to Daniel I was also able to speak of the complaints that parents had of mental health facilities and care that they received. Although he was not familiar with their cases, he could speak of standard practice and the difficulties of maintaining those levels of care. Finally, Trevor trains clinical psychiatric nurses at another psychiatric hospital in the South Island. Trevor, with many years' experience in both nursing and research on suicide prevention had insights into common issues surrounding care for

⁴ Suicide postvention related to the interventions with families and communities that have lost someone to suicide. The organization that conducts postvention measures in New Zealand is Victim Support.

⁵ These are mostly in their original form other than the use of pseudonyms.

suicidality and suicide prevention. We spoke of many of the conversations that were circulating the public imagination, and of certain cases around the country. With professional participants augmenting the experiences of these bereaved parents, I was able to see a more nuanced and balanced picture of suicide prevention in New Zealand.

Tanya

Tanya, a middle-aged Pākehā woman, lost her son to suicide five years ago. He was at University at the time and although she and her son sought professional care, he was still able to end his life. Tanya is extremely vocal on Facebook and has also coordinated with various professional media outlets to let her voice be heard. Although Tanya was very forthright about many topics, she still held her son's story close to her chest, and chose to give me few details about his suicide.

This was quite a humbling experience from the beginning. And very enlightening. I was very expectant of Tanya being happy to just do an interview. However, she wanted to get to know me first, this was treated as a conversation just to get to know what each other is about and if she would fit with my research. I feel as though I should follow up and explain that she is exactly the kind of person that I am looking for. I'm not entirely sure if she was just worried that her story and experiences wouldn't be important enough to share, however, I must again assure her that her stories are precisely what I am researching. There was an unease as I was in a situation that I hadn't been in before when speaking to participants. By the sounds of her emails and our correspondence before the interview she sounded as if she was absolutely keen to speak with me, which she was, but she also seemed hesitant. It was an interesting experience. Following her seemingly hesitant comments at the beginning, she proceeded to speak about the mental health system, coronial laws, and attitudes toward suicide in New Zealand. She seemed to have a great breadth of knowledge of the mental health system and also of suicide prevention within New Zealand. She brought up many of the thoughts that I had on suicide, such as this idea of human sovereignty and the inability to stop certain people suiciding. Along with this she spoke at length about the tensions surrounding the Coroner's act and the suppression of reporting on suicide and of those within the community who believe that there needs to be an end to the silence, and thus stigma, of suicide. I am really looking forward to speaking to her again and hearing about the experiences that she has had and with the suicide of her son. Through this she has real insights into the realities of the system of intervention, prevention, and postvention of suicide and suicidality.

The themes that immediately came from this interview seem were reinforced every time that I spoke to someone. The notion of putting an end to stigma, silence, and shame, which was the same as the slogan that many advocates use, was very strong throughout. As I was to find through later interviews and analysis, this is a type of mantra that all my participants use in some way or another. Through this they are able to articulate much of the difficulty of bereavement, and drives them to make their complaints heard.

Tanya spoke about the networks of people around New Zealand that she was in contact with, she even brought up several of those with whom I have already spoken. She spoke of Carol, Jane Stevens and Dave McPherson, and she eventually put me in touch with Terri. Interestingly, she was relatively well versed in much of the foundational research on suicide. She spoke of Thomas Joiner, Emile Durkheim, and others. This seemed to be part of a personal journey of hers, her grappling with her son's suicide, and her trying to make sense of it, trying to understand why her son had taken his own life, but also wishing that no one would have to go through what she has been through. From here she noted how vulnerable to suicide those bereaved can be, going on to paint a picture of suicide postvention in New Zealand that was virtually non-existent.

As she was trying to work through the pain and the confusion, by speaking to others about suicide, she was met by the government saying that it was against the law to speak about it on Facebook. She felt actively silenced. Her sentiment was that if we want to have an emotionally mature conversation about suicide, which we aren't at the moment, how can we have the government telling us that we cannot speak of it? It is not only a cultural norm, but it is a norm that is enforced at the state level. This is very concerning from a government that is saying that they are doing their best to lower the suicide rate and create a country that promotes the well-being of its citizens.

Carol

Carol's son died by suicide in 2013. He was undiagnosed when he died, however the Coroner's inquest suggested that he suffered from schizophrenia. He was engaged in several mental health services; student health while he was at University; Emergency Psychiatric Services; and his doctor. He was under the Mental Health Care Act in compulsory care a year before he died. He was 19. Since his death, Carol has started a suicide prevention trust. The trust, and its Facebook page, is largely for education and advocacy for suicide prevention. Through this Carol shares her journey of bereavement, but also uses the trust as a medium for others to voice their complaints.

This interview was by far the most intense I have had yet. We began by speaking of my research and then of her work with the suicide prevention trust. She said she was very happy to speak of anything, of what she had heard in her time working in advocacy, and of what she had personally gone and is still going through. Carol, a middle-aged woman with a lingering South African accent, is a very strong woman; she is assertive in her speech and says exactly what she means. This put me at ease, there wasn't the awkwardness of being over polite, not to say that she wasn't polite, rather her manner just made me feel like I too could say precisely what I felt and ask what I wanted to ask. As she brought up that she was happy to speak of her son's death and the ongoing dealings with the SDHB, I asked her if she would be comfortable sharing this story with me. She obliged. Carol was one of the first, but certainly not the only, to use the idiom 'can of worms' to speak of suicide prevention and care in New Zealand. This is a term that many have used to describe the mess that they have gone through as either suicide bereaved, or suicide survivors.

Carol began telling her story and as she did she became noticeably increasingly emotional. However, this is not to say that she was only tearful. She became increasingly angry. Her anger ebbed and flowed, hitting its crescendo when she spoke of her son doing the right thing and asking for help, but to no avail. In Carol's eyes none was given. They were left out of the loop, isolated as caregivers to their son. There was a complete disconnect from the care he was given professionally and the care that he was receiving at home. Carol and her husband did not even receive notice from the DHB, where he received psychiatric care, that their son was suicidal. How can they be expected to give the appropriate care to their son when they do not even know the circumstances around his mental health? What struck me from her speaking about emergency care is the level of care given. This is not even in terms of mandate versus reality, but rather simply mandate. For the SDHB, when mental health patients come in they are to be seen by a triage nurse for 10 minutes only and they are not even to be asked whether they are suicidal.

Carol's interview showed a clear narrative. Her story was one that she has clearly told many people. However, the detail that she gave of her son and the care that they were given brought to light some of the half-formed ideas that I had in my mind. Ideas of care and parenthood, or even more particularly motherhood; of how fraught the path for accountability was; and how care and responsibility are linked.

Bill

Bill's son died 13 years ago. Bill is a few years older than the others parents I spoke to, which is unsurprising given the year of his son's death. He was under the Mental Health Act in compulsory care in a psychiatric facility in the weeks leading up to his death. He suffered from paranoid schizophrenia. The day he died he was able to leave the ward unattended and killed himself. He was 26 when he suicided. Since his son's death, Bill has started a fellowship in his son's name with the purpose of furthering professional education on suicide prevention. The fellowship pays for a visiting scholar for a year who brings expertise to the field of suicide prevention.

I stepped out of the elevator and felt immediately intimidated by the air of power that wafted down the corridors. Where I was used to cardboard, plastic, and stucco, polished oak flourished; desks, shelves, chairs, everything polished oak – or what seemed like oak. I slowly walked down the corridor, there was no one around, everyone too busy at their desks. Looking for room 1105 I scanned the doors of every office I passed. 1102, 1103... I turned right and I spotted the name Belinda, Bill's executive assistant, with whom I had scheduled the meeting with Bill. She came to the door as I slowly approached, it must have been clear that I was not fully comfortable wandering these corridors. After all I am a lowly anthropologist in the belly of the powers of the faculty of commerce. In saying this, much of my nervousness was put to ease once I had met Bill. We shook hands, he asked me to sit down and we began to talk. I was in awe of his office, looking out over all of Wellington, from Parliament to Miramar Peninsular. He was unsure as to what exactly I wanted, so we spoke about that, he told me briefly about himself and the fellowship. We began the interview. He had told me that he had other appointments and could only give me a little of his time so I had that in mind throughout. This perhaps made the interview shorter than intended but I feel that was always going to be the case. He after all is must be a very busy man.

What I gained from the interview is that these incidences and this kind of disillusionment or dissatisfaction with the mental health system in New Zealand is far from isolated to a few families or a few cases. It is also not isolated historically, for Bill's son killed himself 13 or 14 years ago. He spoke of the mental health system using similar language to those that I have

already spoken to and also from what I have seen around the internet and on the news. This is clearly a reality that is felt by many New Zealanders.

Bill and his family threatened a law suit against the DHB for the death of their son. However many do not have the financial means to do this, or even threaten this. He was in a position whereby he could influence the DHB to get something done about the ward, even if it was simply an inquiry. Although we have seen this with Jane Stevens following the death of her son, Nicky, I'm sure that many around New Zealand would have a tough time having this kind of influence over DHBs and other government agencies.

Jane and Dave

Jane and Dave's son, Nicky died two years ago. At the time of Nicky's death, he was under compulsory care under the Mental Health Act in a psychiatric facility in Waikato. Before being placed in compulsory care, Nicky had been diagnosed with bipolar disorder. He had been engaged in various capacities with Child and Adolescent Mental Health Services, and other community services. When under compulsory care in a mental health facility he walked out the front door to have a cigarette, later that day he was dead. Nicky was 21 when he suicided.

Jane and Dave have been the most vocal of any of my participants. They use the media very well, having had many articles written about their son. Dave has also given radio interviews. They are very active on Facebook also.

I had spoken to Jane twice on the phone before we decided that it would be best for me to go to their home and speak with them in person. I had been told to contact Jane by Grant, my gatekeeper, so to speak. On the phone we had spoken about Nicky, her son's, suicide and what they had been trying to achieve since his death. However, the most meaningful interaction with her was visiting her home and sitting down over a coffee and biscuits with her and her husband, Dave.

When I arrived at their home, a short drive out of the city on a sizable rural property, I immediately noticed the eclectic ornaments, cars, and farm equipment that lay around between their large shed and their house. The house, I was later told, was an old school building that had been relocated from Hawke's Bay. Jane and Dave, who had obviously seen my car pull up in the driveway opened the door and greeted me with warm smiles. Putting me at ease almost instantly, I greeted them and handed them the gift of chocolates and banana cake that I had picked up on the way. I was ushered into the house. This was a house where the death of their son was a memory that remained fresh. A framed picture of Nicky hung on the wall opposite the main entrance, what seemed to be the pamphlet from Nicky's funeral was attached to the fridge, and a bonsai

that I had seen on their Facebook page and was a gift from one of Nicky's close friends sat on the table outside, where we were to soon sit.

I gladly took up Jane's offer of coffee and we went to sit at the outside table overlooking their property. I could see the river in the distance and between the house and the river bustled with life. Birds, from pūkeko to paradise ducks and peahens, could be seen and heard. There were cows scattered in the distance and a lonesome horse solemnly eating. I uncomfortably turned on the recorder and we began to speak about Nicky, his care, and their fight for accountability since his death.

Like Carol, speaking with Jane and Dave showed me how vehemently these parents strive for accountability for the death of their sons. There is a constant underlying anger behind each comment, even if it is masked in humour or disbelief. They have tried, and are continuing to try every avenue to find even recognition of a failure in care. The similarities in my participants' stories became clearer each time I either speak to them or listen to their interviews. And thus the themes become striking.

Terri

Terri's son died five years ago to suicide. He suffered from dyspraxia from birth causing high levels of anxiety throughout his life. Terri and her son had been involved primarily with Child, Youth, and Family and the Police when he was a teenager, as he was exhibiting suicidal behaviour. They had interactions with Child and Adolescent Mental Health Services, although there were limited. He had overdosed six months before his death. Terri and her family had communicated on numerous occasions their fear that their son would kill himself. He was 16 when he suicided. Since her son's death, Terri has taken on the role of counsellor to teenagers in her community. She is often the first point of contact for those suffering with suicidality.

I called Terri after I had been put in touch with her by Tanya. Tanya told me her story, only roughly of course, and sent me a link to a news article that was about her efforts to commemorate her son and also to create more awareness around suicide. After reading the article I decided to give Terri a call. The feeling as though I was intruding into these parents lives never left me, it felt as if I were from a telemarketing company cold-calling potential customers, despite the fact that they were often expecting the call.

Terri was a very pleasant woman whose casual tone allowed me to speak, and thus feel, more comfortable. She never hesitated to swear, when appropriate, usually when speaking about those who cared for her son, or the Health Minister, Jonathan Coleman. This felt like one of the most honest and open conversations that I had had with one of my participants. It may have been, at least in part, because she her activism

was a more grassroots and aimed at her own community rather than an entire nation. She was willing from the very beginning of our conversation to answer anything that I was wished to ask. She also never sugar-coated the actions of her son. For example, she spoke of the trouble that her son got up to – stealing their truck, or selling off scrap metal from their property. She told me of the times that they would be contacted by police to be informed of their son's actions. When it came to his suicide, she was also forthright with how he hanged himself in his sleepout and how his sister was the first to discover him.

What was most interesting about Terri's story was it complicated the narrative that I had in my head about what mental health care is. Up to that point I understood mental health care as being conducted in clinics, hospitals, and other such facilities. The care that Terri sought for her son was not simply aimed at services that specialise in mental health care, but she required the Police to be involved in his care also, given that her son's behaviour, posthumously flagged as suicidal, was reckless and against the law. Terri's complaints reflect this, and are largely aimed at the Police and their lack of regard for her son's mental health and wellbeing.

When hearing their stories, and with the comparisons I made between them, I realised it had become very difficult to understand their stories outside of the narratives that they gave me. For all of these parents, their stories had been told many times, in inquests, to family and friends, and importantly, publicly. As Lambek asserts, "the value of articulating a particular version of the past would be explicitly connected to its moral ends and consequences for relations in the present" (1996, 239). Introducing my participants in this way allows the reader to get a better sense of both my position within the relationships, but also to understand how I have shaped this thesis around their experiences and their bereavement.

Life After Death

In the first chapter of this thesis, *Suicide and Mental Health Care*, I aim to contextualise the positions of my interlocutors. I draw upon historical and contemporary ideas and events to examine how the conceptualisation of suicide prevention – and thus suicide – has been shaped in contemporary New Zealand. Situated in neoliberal restructuring and social change toward the end of the 20th century and into the 21st century, I will first outline the moral panic that was triggered by what politicians and social commentators framed as a youth suicide epidemic of the 1990s. This shows how suicide, particularly youth suicide, can take hold of the public moral imagination. I will then discuss how suicide has come to be framed as a mental health issue and thus prone to a medicalised approach over the last century. Finally, I will examine the liberalisation of mental health care, with particular focus on deinstitutionalisation that followed

a global trend of less-restrictive care with a focus on autonomy and agency of the patient. Throughout this chapter I will show the evolving and emergent context of how suicidality has been viewed and treated, with an emphasis on mental health as this has been the dominant ideology in recent times.

In chapter two, *Charged with Care*, I address my participants' search for recognition, accountability, and responsibility for the deaths of their sons. By understanding the diversity and instability within regimes and forms of care, contradictions become visible; and when attending to responsibility within care all the more so. I discuss how governance of these regimes of care begins to shape my participants' bereavement through biopolitical responsibilisation and other forms of modern governmentality. I show how understandings of care are not always congruent, particularly between the families and professionals. This latter point creates a great deal of tension and conflict both before and after care when that care ended in suicide. The conflict found within these understandings of care lays the foundation for the conflated tensions that arise in their search for recognition and accountability.

In Chapter three, *Making Meaning*, I follow a major theme that became salient throughout the transcripts and recordings of conversations I had with these parents, and also Facebook pages and news articles that illustrated their vehement desire for accountability and justice. I understand much of this to be the search for meaning. I found that meaning, care, and the projects that my participants took part in were all intimately linked. Meaning is a useful lens through which to understand the actions and words of those parents bereaved by suicide. I argue that there are three important points to take into account in this context. Firstly, that meaning, like culture, can best be understood as social and relational. This has become no more illustrative than in the 'Suicide Bereaved Networks' created by my participants. Secondly, that meaning must be understood dialectically, within webs of power. The purpose that lay at the heart of much of the public and private advocacy and activism that these parents took part in was the fight for accountability and justice, a fight against structures much larger and much more powerful than themselves. Finally, through understanding the first two points, we can understand how embodiment, recognition, and identity, are all meaning-laden. They are created and maintained through the meaning-making projects that I have discussed throughout this thesis. Those projects give purpose and meaning through the creation and embodiment of identities based on suffering. These identities are thus recognized through shared experience, socially and meaningfully.

Finally, in Chapter four, *Walls and Barriers*, I discuss the way my participants met with barriers to receiving recognition of their loss and accountability for the perceived failure of care. By focussing on the coroner's inquiries and other official inquests by state and independent agencies I show how contemporary neoliberal regimes of care, particularly in such bureaucratic

situations such as formal inquests, can, for those bereaved, feel cold, uncompassionate, and uncaring, as if the state were indifferent to the death. These suicide bereaved parents felt the oppressive force of silence on a daily basis. This silence however, was a force which they vehemently fought against, and was one of their most symbolic battles. Through the lens of biopolitics, I show that how responsibility is understood and conveyed shapes the attitudes and actions of the state agencies in response to these parents' claims. In the final section of this chapter, and of this thesis, I wish to bring together the potential effects of these parents' bereavement journey, and of the fight for recognition and accountability of the loss they say they have wrongfully suffered. There is a negative feedback loop, whereby the increased distrust and anger with state agencies involved in mental health care and suicide prevention creates resistance and unwillingness to engage with their services if needed. Their voices too can shape further resistance. There is a possibility that the voices can influence people around the country to feel disillusioned with mental health services and be reluctant to engage with them. As I will discuss, this could be problematic as engagement and trust are integral in the efficacy of mental health services. The tensions created in these interactions can be detrimental to regimes of mental health care in New Zealand.

1. Suicide and Mental Health Care

One suicide is too many, but where are the highest rates in this country (Waitemata, Canterbury, Waikato...), which groups face the highest risk (20-24 year olds and Māori males), and what the heck is the Government's strategy to deal with a problem that is far worse than the terrible road toll? - Nicky "Autumn" Stevens (Facebook page)

During my three-months of fieldwork, public debate among politicians, social commentators, and other stakeholders in mental health became extremely visible throughout New Zealand. There have been ongoing calls for increased funding (NZ Herald 2016a; Hague 2016b) or even full inquiries into mental health services (Hague 2016a; Stuff 2016a). Management of DHBs and mental health services have asserted that these “personalised social media campaigns targeting individual clinicians, service leaders and staff” (The Spinoff 2016) are taking a toll on staff morale and retention. These ongoing and evolving debates indicate a high degree of tension and conflict between mental health professionals and the public. The tension ebbs and flows with changes in policy and legislation and events that capture the public imagination. These debates are dialectic and can highlight the certain questions surrounding what constitutes moral and ethical care. In this chapter I frame the trajectories of contemporary conflicts within wider debates in recent history; from the liberalisation of mental health care to the moral panic that accompanied the beginning of the so-called ‘youth suicide epidemic’ of the 1990s.

Attending to conflict brings challenges. For me these challenges lie in conflicting perspectives, not only historically, but also among my participants. The tensions that arise between professional and filial accounts of suicide prevention point to the opposing, yet

complimentary, understandings and expectations of care, illness, and suicidality itself. To attend to this conflict, I shall employ what Didier Fassin has called a “critical perspectivism” (2013a, 2013b). In recounting a scene with conflicting accounts from police and urban youth, Fassin (2013b, 376) asserts:

Instead of pronouncing the impossibility to conclude, I have proposed to situate each perspective in its broader context and in relation with the position of the protagonists. The sort of ‘truth’ that emerges from this process is certainly not an absolute one. It is rather an interpretation that seriously takes into consideration both perspectives and renders them co-intelligible. Ethnography is crucial here, but it cannot do it all: it must be substantiated by historical and sociological knowledge.

Following Fassin, it is thus imperative to situate the perspectives of my participants within the aforementioned trajectory of conflict within New Zealand in recent decades. As conflict and socio-political change have a symbiotic relationship, these debates shall too be situated against a backdrop of the governance of suicide and mental health – a landscape with a tumultuous legacy.

To understand the changes in governance of mental health care in recent history, the perspective of governmentality can prove useful. Derived from earlier works by Michel Foucault (1977, 1978) and since developed (Rose 1996a, 1996b; Miller and Rose 2008; Fassin 2015), an important aspect of governmentality is the conceptualisation of the state. Rather than viewing the state’s governance as top-down, I wish to emphasise the role of actors of the state, that is, those that enact policies and legislation, in this case, mental health professionals. As Fassin asserts, “[state] agents are confronted with explicit and implicit expectations formulated in discourses, laws and rules while keeping sizeable space to manoeuvre in the concrete management of situations and individuals” (2015, 4). This is what many anthropologists (Brodwin 2013; Das 2007) have called ‘everyday’ or ‘ordinary’ ethics. Thus it is important, as this thesis aims to show, to attend to discourse between products of the state (policy and legislation) and their producers (agents).

To attend to these questions, and to contextualise the positions of my interlocutors, both professional and intimate, I will draw upon historical and contemporary ideas and events to examine how the conceptualisation of suicide prevention – and thus suicide – has been shaped in contemporary New Zealand. Situated in neoliberal restructuring and social change toward the end of the 20th century and into the 21st century, I will first outline the moral panic that was triggered by what politicians and social commentators framed as a youth suicide epidemic of the 1990s. This shows how suicide, particularly youth suicide, can take hold of the public

moral imagination. I will then discuss how suicide has come to be framed as a mental health issue and thus prone to a medicalised approach over the last century. Finally, I will examine the liberalisation of mental health care, with particular focus on deinstitutionalisation that followed a global trend of less-restrictive care with a focus on autonomy and agency of the patient. Throughout this chapter I will show the evolving and emergent context of how suicidality has been viewed and treated, with an emphasis on mental health as this has been the dominant ideology in recent times.

Epidemics and Moral Panic

The national suicide rate is often employed in public forums to show the reality of what many call a ‘crisis’ or ‘epidemic’ (NZ Herald 2016b; Stuff 2016a, 2016b). The salience of suicide rates within New Zealand began to take hold of the collective conversation late in the twentieth century. The late 1980s and 1990s saw a significant increase in the youth suicide rate, bringing with it social and political commentaries questioning the socio-economic conditions that they saw as causal to this spike.

Rather than simply presenting the suicide rates of recent history, it is imperative to contextualise these figures because they are often the basis for moral panic and public conflict, both of which shape the national moral imagination and in turn legislation and policy. Public debate over how to address these issue gives these statistics what Jocelyn Chua (2014; 2015) has called “moral textures and social meanings” (2015, 147). That is, it illuminates moral tensions of much more than just suicide itself; it highlights questions of life and death; of ethical care; and of adolescence. Jocelyn Chua writes, “While well-circulated statistics have represented certain dimensions of suicide in state and media discourse... there are important moral textures and social meanings to suicide that cannot be captured by the Durkheimian fact of its prevalence” (2015, 147)⁶. Within social science critique of statistics and their purpose largely centre on power, whereby statistics are understood as a form of social surveillance⁷ (Foucault 1977). Of this critique, Justin Lewis (2008, 655) writes, “once we wrest the use of statistics from a pure or empiricist scientific realm and thrust it into a cultural domain, we can see the ways in which it becomes interlaced with forms of power.... We can observe the ways in which state or corporate power is extended by market research and other forms of statistical observation, in ways designed to further the interests of the observers rather than the observed”

⁶ This is in relation to Chua’s work in the South Indian state of Kerala (Chua 2014; 2015), however it is relevant to public debates of suicide in general.

⁷ Not only surveillance, but also political projects of counting and discounting specific aspects of life.

Suicide generally affects males disproportionately. This is true not only of New Zealand, but a trend that is observed wherever suicide has been counted. Furthermore, in (post)colonial states the rate of suicide for Indigenous populations is generally much higher than that of Europeans (Stevenson 2014). Therefore in New Zealand, for Māori, who face higher rates of poverty, criminality, and drug use, suicide rates are approximately twice that of Pākehā. The current national suicide rate⁸ of New Zealand is 12.33 per 100,000 people⁹ (Ministry of Justice 2016). This rate has stayed relatively stable since its peak in 1998 (Suicide Mortality Review Committee 2016, 21). However, males and Māori remain disproportionately represented in these statistics. The male rate is currently 17.71. For Māori, 21.57. However, to break it down further by age there is another startling picture. For males from the age of 15 to 60 the rate remains above 20, at its highest in the 25-29 age bracket where it is 31.80.

Throughout the twentieth century there have been several notable trends in suicide statistics. The first of these was in the middle of the century, when the average age for a suicide dropped significantly. However, from the 1970s the national suicide rate, despite steadily falling from the end of the Great Depression in the 1920s, began to rise at a rate of knots, particularly among youth. The rate began to drop around the turn of the century, however the number of youth suicides in the 1990s had already taken hold of the public imagination (Weaver 2014).

In the 1990s there were clusters of suicides – in Takapuna, Ashburton, and Marton – that thrust youth suicide to the forefront of national discourse. Moral panic set in, with “commentators freely asserted that New Zealand led the developed world in the rate for young males” (Weaver 2014, 227). This was perhaps true given the rate of males aged 20-24 in the 1990s reached above 50 per 100,000 (Weaver 2014, 257). In the decade before this ‘epidemic’, neoliberal restructuring of the 1980s began to erode the welfare state. Social safety nets were drastically reduced, and the welfare of the citizens became vulnerable to market forces. The effects of restructuring were acknowledged at the time. John Werry, a psychiatry professor at the University of Auckland commented, “the things that’s most likely to have an effect in the long run is social policies which aim to give children, adolescents, and their families a fair break in life” (Werry, quoted in Weaver 2014, 229). The visibility of youth suicide in the media and other public forums meant that suicide inevitably became politicized. With suicides claiming national headlines opposition politicians’ voices became louder. However, there was disagreement over how much information in public debates was healthy, and coupled with uncertainty over the degree of emphasis on sociological or psychological factors, opinions “differed over whether youth suicide was best tackled as a mental health or socio-economic matter” (2014, 229).

⁸ As of the latest statistics for the 2015/2016 year. Statistics are compiled for the year July to June.

⁹ Suicide statistics are invariably calculated per 100,000 of the population.

Compared to suicide among any other group, suicide among youth and adolescents brought heightened moral alarm. During this time it was the middle-aged and elderly that seemed to be neglected from the national conversation despite rates being comparable to that of youth (Weaver 2014, 257-8). However, it must be noted that by 1989 the youth rate had overtaken that of the elderly, whose suicide rate was previously disproportionately high. Weaver argues that, “1989 was the turning point in the development of the panic, after which topics in youth suicide (including jail suicides, hospital suicides, and failings in psychiatric care) were seldom out of the news” (2014, 231). The prioritisation of youth suicide in the public imagination illuminates what I argue is an extremely significant point; care, as a moral and social act, is extended past death to certain groups, namely youth. As responsibility is at the heart of care, youth, as opposed to adults or the elderly, remain a moral responsibility until the often arbitrary transition to adulthood. This responsibility is often held by parents, and can contribute with understanding the actions of parents after their child’s suicide. However, within the milieu of contemporary governance in New Zealand, this responsibility is shared by the state, despite neoliberal ideologies of self-responsibilisation.

How these suicides were framed and the attention they received highlights the moral uncertainty different suicides can create. Just as the threat itself of suicide brings certain moral discussions that are remarkably different from other types of death, suicide among the young is takes hold of the moral imagination all the more. Notions of care and responsibility are attached to the threat of suicide, and with youth suicide comes a higher responsibility on others for the care of those not yet deemed to have full autonomy over their own lives. This moral panic captured the nation’s attention during the 1990s and has yet to wane. The morality of suicide will become increasingly clear in later chapters. This illuminates just one salient aspect of the conceptualisation of suicide among my participants.

Suicide and Mental Health

The growing influence of the ‘psy’ disciplines¹⁰ throughout the twentieth century unsurprisingly led New Zealand, like many other western and non-western nations to address suicide prevention through the lens of mental health. It is difficult to separate suicide from mental illness, and I must make it clear that the aim of this thesis is not to make assertions as to the correlation between the two. However, it must be acknowledged that mental health services are

¹⁰ The ‘psy’ disciplines refer to psychiatry, psychology, and psychotherapy. The term ‘psy’ has been used as a catchall for those disciplines that dominate the study of mental health. Although it is a term that can often be employed as critique of the increasingly biomedical approach of psychiatry in particular, I do not have this intention. I simply use it to refer to those disciplines mentioned above.

the primary institution providing interventions into the lives of those suicidal in contemporary New Zealand. A recent report conducted in New Zealand by the Suicide Mortality Review Committee indicated that of those who died by suicide between 2007 and 2011, approximately half had engaged in mental health services in the 90 days prior to their death (2016, 108). Without undermining social-economic and cultural explanations, the importance of their role must be discussed.

In the early 1990s, as moral panic heightened throughout the decade, “Internal government memos reveal confusion, contradiction, and scepticism about intervention to reduce youth suicide” (Weaver 2014, 234). Perhaps due to pragmatism, the government’s response became focussed increasingly on mental health. Psychiatrist, David Schaffer, “wanted the entire subject of suicide sequestered, claiming that prevention programs gave people dangerous ideas. It was best, he maintained, to let psychiatrists work with the mentally ill and for government to avoid addressing the problem through awareness and education” (Weaver 2014, 232). However, this was rebutted by social workers, youth counsellors, coroners, and educators, who advocated for socio-economic causes and greater public awareness. If medical experts were to maintain that youth suicides were in fact caused solely by mental illness, then how were they to explain the recent rise in suicides?

It is important to pay attention to the changing cultural, social, and material landscape when attending to conceptions of, and thus, interventions targeting suicide. Of the socio-political environment of the late twentieth century, Weaver (2014, 5) writes:

In all years, the [coroner’s] files disclose the strains of daily living and the physical and mental states of men and women of diverse ages, cultures, and walks of life as they encountered disappointments. They also capture changes in such matters as hazardous vices, the sources of shame, work credentials, sexual freedom, attitudes about self-euthanasia, and trends in youth culture including nihilism... Amidst changing cultural circumstances, people thought about their pains, their illnesses, and an afterlife. Changes on the economic and cultural fronts, products of the human factor in history, undermine theories about suicide.

This statement follows in the sociological tradition of Emile Durkheim, citing social cohesion and moral rigidity as significant correlations to suicidality (Durkheim 2012[1897]). These sociological, economic and material factors became largely overlooked toward the end of the twentieth century, despite neoliberal restructuring bringing economic and social reform affecting the outlook for young New Zealanders looking to secure their financial future. Interests in mental health and medicine averted any attention away from these issues, and expertise and knowledge of suicide became entrenched in the medical realm (Weaver 2014, 225). Within

modernising mental health care, socio-economic stagnation became hopelessness; political indignation became apathy; and individualism became loneliness. They all had to sit back as medicalised explanations took centre stage.

Emerging and evolving debates within mental health care shape the way that mental illness and suicide are framed and understood within the professional and political sphere. For some, policies and legislation can feel restrictive, which can bring a feeling of not allowing them to adequately care for those suffering. This can be particularly true for those who occupy the lower rungs of the professional hierarchy, notably, social workers or psychiatric nurses. For those who occupy these positions, it can provide conflict when navigating their position as a caregiver (Brodwin 2013). One such debate that significantly shaped mental health care surrounded the deinstitutionalisation and the liberalisation of care.

Liberalizing Mental Health Care

Mental health care changed dramatically throughout the twentieth century, in two distinct but entirely connected ways. The first of these, and perhaps the most visible, was the dissolution of mental asylums and long-term institutional care in the decades following World War II. This was not simply a change in the environment *where* care took place, but was an ethical shift in *how* care was provided. The second of these shifts was the neoliberal restructuring that began in the 1980s. This restructuring was not just social and economic, but also ideological, affecting the governance of those suicidal. Alun Joseph and Robin Kearns (1996) assert that deinstitutionalisation was consistent with neoliberal logics of restructuring. The largely unanticipated consequences of restructuring that I shall speak of throughout this chapter were created due to care becoming highly influenced by market forces and the voluntary sector (Joseph, et al. 2009, 79).

At the beginning of the twentieth century mental health facilities consisted of “spacious facilities on ample grounds” (Weaver 2014, 207). In the decades following World War II however, there became an emphasis on self-discipline and efforts at “individualization assisted by medication” (Weaver 2014, 213). Outdoor recreation, work, and rest, once thought to be restorative, were overtaken by psychotropic drugs aimed at cerebral function. The rights of citizens were limited, particularly if admitted to an asylum. In 1900, it was families and general practitioners who first dealt with the mentally ill, however, influence of families toward the end of the twentieth century had significantly diminished. They remained, however, spirited and vocal, a change from decades prior when a doctor’s word would often go unquestioned. Professionals began to be challenged by dissatisfied and angry family members aided by

lawyers. Recreational drugs too became prolific in the later decades of the century, many psychiatrists arguing the harmful effects, often even asserting that they cause psychosis. As Weaver asserts, “de-institutionalization of mental health and the enabling pharmacological revolution revived an Enlightenment-era ambition to restore people to mental health” (2014, 215). It is likely due to the rights, freedoms, and logics of care involved in contemporary mental health care that the quality of life for many suffering with mental illnesses is significantly better than of those in the first decades of the century.

The liberal shift away from long-term institutionalization was not uncontested. As Weaver asserts, “the transformation left victims in its wake, because accidental gaps, liberal practices, and government retrenchment contributed to suicides” (Weaver 2014, 213). During this time inquests into care practices led to important questions being asked of the mental health system and its practitioners. Weaver argues that “at these intense moments when trust in medical care was fragile, medical professionals could have admitted their limitations as healers and reduced their responsibility” (2014, 215). Opinions were divided during these decades as to the ethics behind this liberal movement or philosophy.

Although with benevolence, early discharges marred the landscape of psychiatric care in this time (Weaver 2014, 206). The consequences of the rush to discharge often pushed by financial pressures, and ended in preventable suicides. Mental hospitals shut down in this era of de-institutionalization, and psychiatric wards at regional hospitals and out-patient clinics rose in their place. Admissions rose as quickly as the facilities that they entered. Reports showed that multiple re-admissions were common due to this so-called ‘revolving door’ (Weaver 2014, 208). Weaver argues that, “while the mental health system in the 1980s and 1990s projected an air of comprehensive care with reduced coercion, it had flaws that frustrated coroners and that were repeatedly identified at suicide inquests” (2014, 208). The Schizophrenic Fellowship in 1979 stated, “it was felt that the law under the current Mental Health Act is designed to protect the patient to a point where it may no longer be protecting him at all” (Weaver 2014, 209). Those who had a psychotic episode had to go to community or regional hospital. This could lead to frustration at waiting to be seen and thus leaving, which could then lead to worsening psychosis, or self-harm. Staff inattention were greatest in times of financial cutbacks, particularly in the 1980s. Although patients received attention, it was largely through community mental health services and the community itself, rather than in-patient care. During the period of de-institutionalisation and decades following, governance of mental health services had shifted from long-term in-patient care to community out-patient care, supplemented by short periods of in-patient care. This shift was situated within wider neoliberal economic and social restructuring during the 1980s, which brought significant change in the governance of public services.

With the youth suicide epidemic of the 1990s, suicide was increasingly framed as a public health issue. There were numerous calls for greater attention to be drawn to the current epidemic, as well as interventions to be carried out by the government. To understand the changes in governance of mental health care since restructuring of the 1980s, the perspective of governmentality can prove useful. Drawing on Peter Miller and Nikolas Rose (2008), and in the tradition of Michel Foucault (1977, 1978) I argue that contemporary governance, which was once based on what they call ‘the social’, has shifted to governance enacted through ‘the community’ (Rose 1996b). Peter Miller and Nikolas Rose (2008, 84) write:

One saw the privatisation of public utilities and welfare functions, the marketization of health services, social insurance and pension schemes, educational reforms... the introduction of new forms of management into the civil service modelled upon an image of methods in the private sector, new contractual relations between agencies and service providers and between professionals and clients, a new emphasis on the personal responsibilities of individuals, their families and their communities for their own future well-being and upon their own obligation to take active steps to secure this.

The strategies that governments implemented acted upon the actions and dynamics of communities (Miller & Rose 2008, 88), and created new political rationalities. One’s which changed the way moral and social relations are conceptualised (2008, 88). Neoliberalism, however, is not a political rationale or ideology that was created in a vacuum in the post-war Anglo-Saxon world, it has evolved as a form of “advanced liberalism” (Rose 1993, 294) which proliferated in the nineteenth-century. Rose (1993, 298) argues,

‘Advanced liberalism’, as a formula of government, is a much more significant phenomenon than the brief flowering of neoliberal political rhetorics may indicate. Whilst welfare sought to govern through society, advanced liberalism asks whether it is possible to govern without governing society, that is to say, to govern through the regulated and accountable choices of autonomous agents – citizens, consumers, parents, employees, managers, investors.

When discussing neoliberal forms of governance, it is within Rose’s formation of ‘advanced liberalism’ that I define modern governance.

For mental health care this included decentralised health care and competition between not-for-profit community organisations. Health care, including mental health care, in New Zealand has since the initial wave of neoliberal restructuring in the 1980s, found a “third way” (Prince, et al. 2006, 254), by which care is still provided by government through localised DHBs.

In response to the epidemic, the government created the Youth Suicide Prevention Strategy (MoH 1998) – one of the first multi-sectoral action plans implemented at a national level in New Zealand. The Youth Suicide Prevention Strategy subsequently led to the New Zealand Suicide Prevention Strategy 2006-2016 (MoH 2006) and all subsequent revisions. Although this was a national strategy, in reality it was enacted regionally by autonomous DHBs.

Despite neoliberal policy being rolled back by changes in government in the late 1990s, neoliberal ideologies remain, having a deep effect on professional subjectivities. These ideologies “are embodied in the ways in which a whole series of issues are problematized – made amenable to authoritative action in terms of features of communities and their strengths, cultures, pathologies. They shape the strategies and programmes that address such problems by seeking to act upon the dynamics of communities. They configure the imagined territory upon which these strategies should act – such as community mental health” (Miller & Rose 2008, 88). Neoliberal ideologies remain within mental health care, creating transactional care, which becomes clear through the language and transactional interactions between these ‘consumers’ and clinicians. It was even a common strategy throughout the 1990s for clinicians to ask consumers to sign suicide contracts, requiring that they state that they would not kill themselves (Farrow 2002). These proved to be ineffective.

Autonomy and privacy came to be two key ethical tenets of contemporary mental health care. Although mandated under the mental health act, the privacy of the patients has not always been without controversy. The link between families and professionals can be extremely important, especially when there is an emphasis on quick discharge into the community, often back into the care of families. Tensions begin to become visible through the emphasis on privacy and autonomy. Problems arose as “new therapeutic tactics meant respecting the narratives, culture, privacy, and liberty of patients” (Weaver 2014, 208). Privacy and such therapeutic relationships between client and clinician meant that the space for family involvement decreased. This has marginalised families.

Conclusion

In this chapter I have marked the historical trajectory of contemporary debates surrounding suicide prevention. These have been influenced by certain ideological, political, and socio-economic shifts surrounding the care for the suicidal, such as the liberalising of mental health care, neoliberal restructuring, and the rising youth suicide rate. The conflict and debate I have discussed in this chapter points to why for many, mental health care in New Zealand can be seen as disjointed. There exists a multiplicity of understandings of suicide, mental illness, and the

care that these require. Often these understandings are complementary. However, there are significant times when they contradict one another.

How suicide has been framed and the attention it receives highlights the moral uncertainty different suicides can create. Just as the threat of suicide itself brings certain moral discussions that are remarkably different from other types of death, suicide among the young is takes hold of the moral imagination all the more. During the 1990s this moral panic captured the nation's attention and has yet to wane. The morality of suicide, and its relation to care and responsibility, will become increasingly clear in later chapters, illuminating one salient aspect of the conceptualisation of suicide and care among my participants.

Emerging and evolving debates within mental health care shape the way that mental illness and suicide are framed and understood within the professional and political sphere. For some, policies and legislation can feel restrictive, which can bring a feeling of not allowing them to adequately care for those suffering. This can be particularly true for those who occupy the lower rungs of the professional hierarchy, notably, social workers or psychiatric nurses. For those who occupy these positions, it can provide conflict when navigating their position as a caregiver (Brodwin 2013). One such debate that significantly shaped mental health care surrounded the deinstitutionalisation and the liberalisation of care.

For New Zealand, and more specifically for the governance of mental health services in New Zealand, processes of de-institutionalisation and neoliberal restructuring are extremely significant in understanding the current landscape of mental health care. For those engaged with these services, these gaps and contradictions are felt keenly, creating tensions between families and staff. Tenets of liberalised care have become paramount to the ethics of modern mental health care; namely, autonomy and privacy. As will become apparent throughout this thesis, there are significant tensions that arise out of the neoliberalisation of mental health care. This becomes no clearer than when families feel that they are left out of the care of their loved ones. In the following chapters I shall show the ways that such contradictions and tensions are felt and negotiated by those involved.

2. Charged with Care

How many more people have to die before the Government wakes up to the mental health crisis in this country? – Jane

Jane and Dave, Carol, Tanya, Bill, and Terri all navigated the systems of care that were in place for them and their sons. They were all actively trying to get help for the illnesses that they were told afflicted them. They all knew of the chance their sons would suicide. They went directly to those services available to them, within their region and within their means to get advice and treatment. These largely public services were charged with the care of their sons. However, each of their sons died by suicide. In certain cases their sons were placed under the Mental Health Act in compulsory care of the state. In other cases they were in and out of voluntary outpatient care. However, all of whom reportedly received a level of care that was insufficient to prevent their suicides.

Although these bereaved parents did not explicitly state that they were searching for blame as can often be attributed following a death, particularly a suicide, they all wished that the perceived failings on part of the institutions and facilities that they charged with their sons' care were recognised. For some, this recognition went further than a simple apology, or a change in procedure; they sought legal and moral responsibility for their suicides. For some a departure from care has been recognised, and for some this has meant that the DHB or organisation that their sons were in the care of have taken responsibility. However, for most, and given that some, such as Jane and Dave, are still at the beginning of the coronial inquest, accountability, let alone culpability, remains unrecognised.

Responsibility has been shaped by biopolitical and modern forms of governmentality. Through a biopolitical lens we begin to see how shifts in governance, as mentioned in the previous chapter, have restructured responsibility for mental and emotional affliction, among other sufferings of modern life, increasing responsibility for self-care upon the individual and their immediate community. This completes the shift from state-down care to community care in line with the modern governance put forth by Miller and Rose (2008). Biopolitical responsabilisation affects the individuals and their families, and also how the search for recognition of accountability or even culpability can be obstructed.

The bereavement of my interlocutors is situated within these forms of governmentality, of biopolitical responsabilisation. However, when navigating the investigations, inquests, and formal proceedings following their sons' suicides, their desire for at the very least recognition, let alone accountability or responsibility for their deaths faces many barriers. The search for recognition and accountability is a theme that runs throughout any narrative given, be that on Facebook, radio interviews, or when speaking to me.

For governments, including public facilities and DHB, there is a double-bind, meaning it is detrimental to concede accountability, whether for individuals, or the organisation. However, as this thesis shows, there are significant consequences to remaining silent. Silence, one of the main themes of this thesis, can be as harmful as action, however, the balance of power remains in favour of those who control what is said. For the organisations involved with my participant's sons before their deaths, the power of silence is immense. It leaves in its wake bereaved families wanting to know what happened; wanting to know how it was that their sons were able to leave their facility despite their known suicidality; or how they were pushed from one organisation to the next without receiving the care that was needed.

In this chapter, I will address my participants' search for recognition, accountability, and responsibility for the deaths of their sons. By understanding the diversity and instability within regimes and forms of care, contradictions become visible; and when attending to responsibility within care all the more so. I will discuss how governance of these regimes of care begins to shape my participants' bereavement through biopolitical responsabilisation and other forms of modern governmentality. I will also show how understandings of care are not always congruent, particularly between the professionals and the filial. This latter point creates a great deal of tension and conflict both before and after care when that care ended in suicide. The conflict found within these understandings of care lays the foundation for the conflated tensions that arise in their search for recognition and accountability.

Care and Responsibility

The notion of care and responsibility can be very closely linked. In following Mol's logic of care (2008), Susanna Trnka and Catherine Trundle (2014, 142) assert, "Unlike models of patient choice, relationships of care... cannot be reduced to a transaction, with clear beginnings and end points of responsibility, but involve open-ended relationships in which power is negotiated between parties". It is extremely important to first understand the concept of care within the anthropological literature. In unpacking care and responsibility contradictions that lay at the heart of conflict between professionals and families arises. In this section I seek to show what these contradictions are.

As Trnka and Trundle (2014, 142) note, "care is enacted across various levels of relationality, manifested through intimate, face-to-face relationships (such as between parent and child) or in relationships between collectives (for example, teachers and students; citizens and the nation)". Relations of care can be enacted locally or globally, and with varying degrees of temporality. When attending to care and responsibility, deep assumptions become visible about life and death, and what is salient to this research, the state and the individual. These assumptions are shaped not only by the circumstances of the individual, but by wider political and social shifts throughout history.

Joao Biehl's (2012) work on the morality of care can help here to articulate the ways in which these relations of care, with particular note to medical care, can paradoxically disregard its intended benefactors. Biehl asserts, the "ways in which clinical medicine and psychiatry – disciplines that pledge to do no harm, at the very least – are made instrumental in blaming victims for their own suffering and disqualifying them from care and human connection" (2012, 248). As I will discuss in this chapter, the feeling of disregard is felt by these families, those bereaved by suicide. Uneven relations can often lead to tensions as the contradictions mentioned above become visible. These tensions that often lie at the intersections of care, between those that are giving care and those that are being cared for, are at the heart of what this research is focused on. Care involves social relations, includes moral ideals of responsibility and obligation, but prior to this requires the recognition of those in need.

Given that care is an unstable concept, it is understandable that there be much debate as to what care in fact entails in the context of mental health care and suicide prevention in New Zealand. It is clear, as I will discuss in further detail in later chapters, conflict arises at least in part due to the instability and often contradictory definition of care, particularly between professionals and families. It follows too that responsibility can cause this same kind of conflict.

Responsibilising Suicide

When I was first introduced to these families that for varying lengths had been coming to terms with their sons' suicides, it struck me that they were very vocal on social media and through other outlets. They told their stories with such detail that I could not help but choke up for the pain and suffering that they – and their sons – had gone, and are still going through. Their stories were published through media outlets such as the New Zealand Herald and online media such as Stuff. Their stories were so captivating because it made me doubt the very institutions that were in place to stop suicide; public psychiatric facilities, community mental health organisations, and other governmental and non-governmental organisations. These were often targets of these articles and posts on Facebook – that is those very organisations and institutions that were charged with the care of their sons. I began this chapter with a post that was published by Jane on the Facebook page her and her husband, Dave, created following the suicide of her son, Nicky. She wrote, “How many more people have to die before the Government wakes up to the mental health crisis in this country?” This is a sentiment that is held by many, if not all of those parents I spoke to that had lost their sons to suicide. They unceasingly and vehemently urge the government, facilities, and professional staff to take responsibility for suicide throughout the country. More specifically, they were asking those that they perceived to be responsible for the deaths of their sons to recognise their culpability. In this section I will elaborate on this framework of biopolitical responsibilisation to understand how this affects the individuals and their families, and also how the search for recognition of accountability or even culpability can be obstructed.

As I discussed in the introduction to this thesis, understanding the role memory and narrative is imperative to understanding the work of telling these stories. As Lambek and Antze (1996, xxv) write, “Memories are acts of commemoration, of testimony, of confession, of accusation. Memories do not merely describe the speaker’s relation to the past but place her quite specifically in reference to it. As assertions and performances, they carry moral entailments of various sorts”. In telling their stories responsibilities of care are placed on state institutions, and in death the actions taken by their parents are undoubtedly of commemoration and accusation. However, in their placement of responsibility, it is not simply shaped by acts of memory and narrative, but is also shaped by wider political projects.

Biopolitical responsibilisation within the context of governmentality is key to understanding the search for accountability for these suicides. Shifts in governance, as mentioned in the previous chapter, have redistributed responsibility for mental and emotional affliction, among other sufferings of modern life, upon the individual and their immediate

community. This transfers responsibility of care from the state to community, and furthermore to individuals and families. Miller and Rose (2008, 87) write,

The human beings who were to be governed – men and women, rich and poor – were now conceived as individuals who were to be active in their own government. And their responsibility was no longer to be understood as a relation of obligation between citizen and society enacted and regulated through the mediating party of the State; rather, it was to be a relation of allegiance and responsibility to those one cared about the most and to whom one's destiny was linked.

The strategies the governments have implemented are to act upon the actions and dynamics of communities (Miller & Rose 2008, 88). For Miller and Rose (2008, 88) “they extend to the specification of the subjects of government as individuals who are also, actually or potentially, the subjects of allegiance to a particular set of community values, beliefs and commitments”. These new political rationalities change the way “micro-moral relations among persons are conceptualised and administered” (2008, 88). Not only does the term, ‘community’, profess self-responsibilisation, but it is the vagueness of this term that makes it so useful within political projects. It has an ability to be utilised for a multiplicity of groups and institutions, tangible and intangible ¹¹, such as community health care or community education, however, the communities that it represents are far from stable, discrete, or even defined in any meaningful way. When Tanya spoke to me about a recent series of meetings throughout the country to update the Suicide Prevention Action Strategy that she attended, she told me:

When, I think it was before our meeting, when we had a break for a cuppa, I mean within that time, I kid you not, there would have been six different people, seemingly from six different organisations, like six people, the crowd people that were there for Auckland who told me the same thing... Admin or mental health position holders of the future, they seemed to have this mantra, all of them were coming out with this sort of quip, which was, “suicide's not a DHB problem, it's a community problem”. And I kept hearing it, and it's like you've all been brainwashed, you've all been psyched to push it back, and that is where I think this next draft is going. I just kept hearing it, slight versions, but that concept that, “DHBs aren't responsible, stop blaming us. It's a community problem. It's a community problem”.

These parents have become extremely cognizant of the ways in which responsibility for their sons' illnesses and thus suicides continues to be transferred onto communities, and thus

¹¹ See Anderson (1991)

themselves. This has the effect of softening responsibility on part of the DHBs, or other government agencies. Miller and Rose (2008, 84) write, "At the level of governmentality... it seemed as if we were seeing the emergence of a range of rationalities and techniques that seek to govern without governing society, to govern through regulated choices made by discrete and autonomous actors in the context of their particular commitments to families and communities". It is the congruence of families and communities in which governance is enacted that self-responsibilisation takes hold.

Ideologies of self-governance can also be seen through linguistic markers. For Miller and Rose (2008, 88), "Contemporary political rationalities also think in terms of another language which is just as important, which is highly morally invested and which intersects markets, contracts and consumption in complex and surprising ways: 'community'". For mental health care, and suicide prevention, this has included decentralised health care and competition between not-for-profit community organisations. Health care, including mental health care, in New Zealand has since the initial wave of neoliberal restructuring in the 1980s, found a "third way" (Prince, et al. 2006, 254), by which care is still provided by government through localised DHBs. In response to the suicide 'epidemic' of the 1990s, the government created the Youth Suicide Prevention Strategy (Ministry of Health 1998) – one of the first multi-sectoral action plans implemented at a national level in New Zealand. The Youth Suicide Prevention Strategy subsequently led to the New Zealand Suicide Prevention Strategy 2006-2016 (Ministry of Health 2006) and all subsequent revisions. Although this was a national strategy, in reality it was enacted regionally by autonomous DHBs. The effects of the organisation of mental health care with neoliberal ideologies can be profound, and felt by those who experience failings first-hand. Dave, when speaking about community mental health organisations told me,

But there's no leadership around this stuff coming from the organisations who are funded to do that work and that's been a problem, where resources are given in such a way that you are then beholden to then not be critical of the government or the DHB for fear of losing your funding. We've had the heads of organisations tell us that, "oh I'd really like to speak out but I can't. You're doing a great job. Keep it up. Keep fighting". And when you say, "Actually we need your voice". "Oh, we'll do things behind the scenes, but we can't speak out because we've got a government contract". And they're the people that should be speaking out. And yet a family that is grieving, that has no support, that is trying to get by, is expected to do all that. That's just not right.

The shift from 'society' to 'community', what Rose (1996) called 'the death of the social', can be seen in the way that biosocial subjectivities are shaped by the shifting forms of governance, ultimately enacted through the responsabilisation of mental and emotional affliction, including

suicide. The bereaved community have needed to fight for the recognition of suicide and suicidality for the country. They fight against silence and what seems to them like political apathy. It is this very dissolution of responsibility for suicide prevention, that has been stretched so thin throughout the country and is shared by so many organisations, agencies, and actors that when parents look for answers as to how their child could have been allowed to leave a facility unattended or be given scant attention despite cries for help by their parents, they are left wanting.

This raises certain questions regarding the role of the state in suicide prevention – projects of maintaining life. As mentioned in the previous chapter, there seems to be an acceptable level of suicide, one which is perhaps indicated by the maintenance of stable rates of suicide. Lisa Stevenson, writing of her work among the Canadian Inuit, wrote, “The inevitability of each Inuit death is meticulously described, gauged as a symptom of inadequate intervention, inadequate social planning. The state takes responsibility for each death; in this way, the dead Inuk is ‘had’ by the state” (2012, 593). She goes on to assert, “What becomes clear through the ethnographic and archival record is that such forms of bureaucratic, while working to maintain the physical life of Inuit qua Canadian citizens, may also manifest a form of indifference on the part of the state – an indifference that is sometimes perceived by Inuit as murderous, even though it is always couched in terms of benevolence and care” (Stevenson 2012, 593). To compare these statements to the context of suicide prevention in New Zealand, although suicide rates are far lower than in regions of the Canadian arctic, where Stevenson conducted her fieldwork (2012; 2014), there is a comparable maintenance of life, and maintenance of death. This means that the biopolitical governance of suicide is a project of maintenance, of maintaining an acceptable level of suicide. These projects of maintenance rely on statistical surveillance of the population.

It is important to note that the transference of responsibility and governance of preventative measures onto individuals is also enacted by families. The notion of community, I believe, is intended to be local, within smaller social groups that extend from the individual. They go on to write, “While the policies and programmes of the social accorded individuals personal responsibility for their conduct, this individual responsibility was always traversed by external determinations... this configuration of ethical vectors is reorganised under the sign of community” (2008, 91). Zoe Wool (2015) and others (Howell & Wool 2011; Wool & Messinger 2012) speak of the responsibilisation of self-care among returned servicemembers of the United States military. She writes “Members of the armed forces are inundated with messages about being responsible for their own stress reduction, mental fitness, and ability to grow rather than flounder in the face of traumatic events experienced during deployments” (Howell & Wool 2011, 15). This self-care, as mentioned above, is located not only within the individual, but also

with their immediate friends and family, this “displaces the burden of mental health care provision from the military to armed forces members experiencing difficulties, and their peers” (2011, 16). They go on to note that the governments are “increasingly asking... families to be responsible for the care of returning soldiers, in effect, enlisting families, and especially spouses, as unpaid caregivers. Family members, in turn, pay with both their earning ability and their mental wellbeing” (Howell & Wool 2011, 17). Carol told me that, like many of the other parents, she felt like she was being blamed for her son’s condition, even telling me that this was explicitly said to her. She told me, “He was suicidal we were told. He was meant to have a support person with him, I was told by the psychiatrist that I had caused it. These people didn’t know me from a bar of soap. They said, [our son] believed we caused this. Well of course, he was unwell at this point, he would, you know. We have a good relationship with all our kids, he became unwell”.

The conflict that arises with the responsibility for the wellbeing of those in care is often manifested in relations between professionals and families. When speaking with Trevor about responsibility and risk of self-harm and suicide, he told me:

So the idea that it is somebody's own responsibility I think is partly in response to, sometimes clinicians sense that the public, and sometimes working with people who self-harm, idea that clinicians are responsible for risk, and they go, ‘no, it's not our responsibility, we can't possibly... we can do things to help but it's not our responsibility’. And what we try and say here, it's a shared responsibility, it's not just clinicians, it's your whole team and at a wider societal level it's like we're all responsible. It's kind of philosophical, but at a practical level try to say, "We share risk, we share discussions around risk, we involve families, we involve other significant people, we involve the consumer, we involve our colleagues". You sometimes take therapeutic risks, which is trying to get longer term benefit for shorter term risk, but we need to think philosophically that there is a shared risk, which is harder to do, but you get better outcomes.

For Trevor, and other clinicians, responsibility for the wellbeing of their clients is shared between themselves – both as individuals and as actors of the state – the clients, and the clients’ families. It is interesting to note that the one who will be most affected by a lack of care will be the one who is suffering from the affliction, in this case the client. To go a step further, it could even be said that those who will be the least affected would be the professional. If this is the case, when speaking of shared responsibility of risk there is an imbalance in the outcomes.

Recognition and Silence

There are multiple facets to responsibility for those parents that I spoke with, which I have split into two distinct yet entirely related areas. The first of these is recognition by the government and its representatives of the issue of suicide and mental health in New Zealand. The second is the recognition of culpability or simply accountability by the specific agencies, organisations, or facilities of their role in the suicides of their sons. Responsibility, in these contexts, is linked to accountability, culpability, and blame; and it is certainly morally charged. Silence and even stigmatisation of suicide and mental health both by governmental agencies and representatives and as a wider cultural norm, is seen by those who lost loved ones to suicide as the void where this recognition should be placed. Therefore, as much as they fight for recognition of accountability or culpability, they too fight against the silence of those they feel from whom recognition should come.

Laura Dixon and Jennifer Peachey (2012, 2) write, "Recognition constitutes an intersubjective act that is at its base a negotiation of power wherein one party seeks recognition and the other confers it... It is this attempt to render oneself visible in social or political processes according to someone else's framework which simultaneously 'excludes' and 'includes' one from a socio-cultural framework". Charles Taylor (1994, 25) asserts, "Nonrecognition or misrecognition can inflict harm, can be a form of oppression, imprisoning someone in a false, distorted, and reduced mode of being". For political recognition, my participants must narrativise their experiences in certain ways; ways that fit within socio-cultural frameworks of formal complaints. For these parents, this means recognised legal channels, such as coronial inquests, Health and Disability Commission investigations, or private legal action. The concept of recognition can go a long way, not only in understanding the actions taken by my participants in their bereavement, but also in how their experiences shape their identities as suicide bereaved.

The liberalisation of governance from paternalism to self-governance was acknowledged by those bereaved – albeit, not in those terms – and were cognizant to the effects it had on them. It garnered a visceral reaction within them, as if government agencies or their representatives were explicitly blaming them for their sons' suicides. Although Tanya was less forthcoming about the particular circumstances around her son's suicide, when we were speaking about a recent number of suicide prevention strategy meetings conducted by the Ministry of Health, she said to me that the DHBs maintain that suicide is a community problem rather than one of public care. This is very much coherent with the shift from the paternalistic governance to one enacted through community and thus eroding the responsibility and accountability of the state in such matters. This is a recognition of the issue not only by the

government and those who are seemingly responsible for addressing suicide, but also recognition through breaking cultural stigmas and silence. Jane told me about some of the action that they were taking to hold these organisations and agencies charged with suicide prevention and mental health care to account:

We had a hui¹² here in Hamilton with a mixture, but primarily aimed at whanau¹³ that have lived experience, and we actually had people come from all around the country and the outcomes from that was a very united voice around the need for change, the need for a national review of mental health services, the need for better resourcing, the need for our voices to be heard and for people, the families, and not just immediate families but those people who support others going through the mental health system, be seen as a part of the treatment team, not as the enemy and not to be disregarded.

Jane went on to say:

The people that know those people best are currently being ignored, being actively treated like shit really, and in some cases being persecuted, being shut down, being treated as if they are mentally ill themselves, and in some cases being incarcerated, you know, and that's got to stop. There's also a kind of huge denial that people are experiencing from our political leaders around the extent of the problem, that came through really clearly, and the huge issues with the lack of resourcing, the workloads on people providing services, the lack of skill, it's... I was talking about it being a train wreck. I think there's very clear evidence and very strong feeling that mental health service in this country is failing people big time.

For those bereaved, the government must be held to more account over the suicide rate and interventions that they feel are clearly not preventing suicides. There is even the feeling that the suicide rate could be higher than reported by government agencies. This has come to light in media articles as part of the surge of attention suicide has received this year. This news was perhaps unsurprising to those who were well-versed in the coroner's proceedings. Carol posted this along with one of the media articles, "The country's suicide rates may be three times as high as official rates suggest. Something does not add up here". The Facebook pages of my participants mirror the calls from opposition politicians, social commentators and journalists for a review, or even overhaul of the mental health system throughout New Zealand. It is not only this, but coronial processes too are said to be contributing.

¹² Māori term meaning 'meeting' or 'gathering'.

¹³ Māori term meaning 'family'.

Carol, on her Facebook page wrote, "Silence has not worked to bring our statistics down. Sweeping the problem under the carpet has done nothing positive but rather stigmatised and isolated it further". The idea about opening up about suicide and "breaking the silence" is central to almost all messages about suicide and suicide prevention around the country. Perhaps what was more important, and undoubtedly more personal to my participants, was the recognition of accountability, or even culpability, by those organisations and agencies that were charged with the care of their sons. This is not something that was only strived for following their sons' suicides, but even when seeking care for their sons, their words were not heard, the pleas for help were not recognised. When speaking about her seeking care for her son, Terri told me:

And of course they hadn't been very communicative with them, so they rung me and said, 'Look, there's nothing we can do if we won't come here voluntarily and not be stoned, and promptly took him off the books and so that was the end of that. So they discharged him if you will. I remember being very upset at the time, thinking, 'for Christ's sake, where's the law that stops you from... he's a 16 year old kid and you're making him responsible for his own life, when clearly he's not in any state to care for himself, and keep himself alive'.

Because her and her son were also involved with Police due to her son's behaviour when he was unwell, she relied at times on the Police to look out for her son, given that they knew about him and also that Terri had communicated with the Police several times her fear for her son's well-being. However, before her son's death Terri heard from a friend about the Police's attitude toward her son:

Then exactly seven days before he died, his best friend Matt, had got his dad, so Matt's dad had gotten a phone call from a police officer, who was the youth aid officer... and he rung Matt's dad, and said, "you need to keep your son away from him, you mark my words, that kid will be dead within a week". Now Matt's dad went, "What?!", he was in shock. And the police officer hung up on him, this is the youth aid officer. So he got in his car, went to the police station and called him out. And said, "did you just tell me that that kid will be dead within a week?", and he said, "yes I did". And he goes, "What are you going to do about it?", and he said, "nothing", and turned around and walked out. And left him standing in the police station. He did nothing by the way. So nothing was done. He didn't go to his superiors, so he knew what he was like, but he did nothing. So that was the police. OK, so that's cool, so that was sort of that agency.

Jane and Dave had a similar experience when they tried to communicate their fears about Nicky while he was in a psychiatric facility:

Well that was the big problem for us was they did not listen, they didn't listen when he told us that he'd told us he'd already tried to commit suicide twice since he'd been in hospital, they had physical evidence of that, him having all his bandages off and water in his wounds. It was, we could see, we had specifics of when he was going to try and kill himself again, how he was going to do it, where he was going to do it, why he was going to do it, they wouldn't listen to any of it. We did everything that you could possibly do, we went to management, put things in writing, but he kept on going and... As they would see it, harassing medical staff to cancel unescorted leave and you know, they all knew best. The psychiatrist that had met Nick for half an hour reinstated his unescorted leave after we'd managed to have it cancelled by management, he'd met him for half an hour in her whole life, and that's when he went missing and drowned in the river.

Bill received this recognition. With the threat of a lawsuit against the facility and DHB that his son was under compulsory care under the Mental Health Act, the DHB agreed to upgrade the facility and also put in place a fellowship, each year hosting an international professional to advise on strategies in mental health and suicide prevention in New Zealand. Bill told me:

Following all of that in the inquiry we felt that in our experience there was sufficient concern about practice that we felt we needed to try and do something to inject improvements in the care and the... in the mental health ward in Wellington. So we eventually after quite a lengthy series of engagements with Capital Coast DHB we eventually got them to agree to establish a fellowship and the purpose of the fellowship is to bring experts in different aspects of mental health, bring them to Wellington to work with the practitioners both within Capital Coast DHB but others practitioners as well, through a series of workshops, talks, seminars and they will always give a public talk as well. And that's been running there for about ten years. So there's one some's a year, about a year. So that's what the fellowship's about.

Recognition of accountability and culpability for the suicides of their sons is one of the key outcomes for each of these parents. The projects that they undertake following their deaths can stem from this desire. For Bill this came to fruition relatively quickly after the threat of legal action against the DHB under which his son was cared for. However, for the others, recognition has not been so easy, often being met with resounding silence, or at times an admission of underfunding that was beyond the control of the DHB, or certain issues with the facilities

themselves. The latter are little consolation to those parents looking for an admission of culpability. Jane, Dave, and Carol have continued to fight no matter the barriers that they face. They have gone through, and continue to go through lengthy Coronial inquests, and investigations by the Health and Disability Commission.

Given recognition and silence are concepts so central to this thesis and to the lives of my participants that I they will be revisited in the final chapter, where I will explore the more tangible barriers that are created through silence and lack of recognition.

Conclusion

The aim of this chapter has been to begin to paint a picture of the attitudes and desires of those participants that have been bereaved by suicide. I wanted to lay a foundation for the discussion of further interaction with those organisations and agencies that they felt were culpable in their son's deaths.

Biopolitical responsibilisation within the context of governmentality is key to understanding the search for accountability for these suicides. Shifts in governance have redistributed responsibility for mental and emotional affliction, among other sufferings of modern life, upon the individual and their immediate community. Following theories of modern governance put forth by Miller and Rose (2008), what this does is transfer responsibility of care from the state to community, and furthermore to individuals and families.

The tensions that often lie at the intersections of care, between those that are giving care and those that are being cared for, are at the heart of what this research is focused on. Given that care is an unstable concept, it is understandable that there be much debate as to what care in fact entails in the context of mental health care and suicide prevention in New Zealand. It is clear, as I will discuss in further detail in later chapters, such conflict arises at least in part due to the instability and often contradictory definition of care, particularly between professionals and families. It follows too that responsibility brings with it this same kind of conflict. Projects for responsibility go further than simply gaining closure for the loss of their sons, but rather they are to advocate for other families around New Zealand that have gone through similar ordeals, and perhaps to limit the number of families that this happens to in the future.

3. Making Meaning

*There are tragedies in my life that have come here for a reason, and that reason is for me to stand up and do something... start looking into the reasons why, start getting these numbers down – **Tanya***

Clifford Geertz (1973a, 5) writes that anthropology is “not an experimental science in search of law but an interpretive one in search of meaning”. In my first conversation with Jane, she told spoke to me about the positives that have come in the year since her son’s suicide. She said, “I think that’s been a pretty strong common theme for us, people thanking us for speaking out because it’s given them hope and courage and in a lot of ways that makes it worth it for us, as hard as it is. To know that it actually is making a difference to people, as awful a reason as it is that we are in this situation. That helps us as well, knowing that our son’s life can actually still have some meaning”. Finding meaning following the suicide of your son is a project that takes immense strength, time, and patience. In this chapter I will explore the projects of making meaning that these parents bereaved by suicide have undertaken.

In the first two chapters I introduced the circumstances surrounding the suicides of the children of my participants as explored through the conversations that I had with them during my fieldwork. In chapter one I attempted to give historical, political, and importantly a cultural, contextualization to the public mental health care system through which these parents sought care for their sons in the years, months, and days leading up to their deaths. In chapter two I strived to give as much context to the specific circumstance of each participant. One of the key goals of this thesis, and if nothing else but this is achieved, is to give voice to these parents who

are, while continuing to grieve for their sons, are fighting for accountability and a sense of justice that they see as being necessary not only for themselves, but so that no parent should have to go through the death of their child by suicide.

As I discussed in the previous chapter, formal action was taken against the organizations that were charged with the care of their sons in the time leading up to their suicides. This action was taken against small and large state institutions, such as the police, DHBs, and even the state itself. However action that was undertaken through Facebook and other media outlets was, and is, more akin to grassroots activism than formal legal action. In introducing and discussing the meaning-making of these parents in the time since their sons' suicides, I shall discuss the direct activism that relates to their own search for accountability and answers to many of the questions that remain unanswered; and I will discuss how these parent's public action fits within a wider movements of suicide prevention, and for public calls for an overhaul of the mental health system in New Zealand.

This chapter focusses on meaning, a major theme that became extremely salient throughout my fieldwork. As I began to pore over the transcripts and recordings of conversations I had with these parents, and also Facebook pages and news articles that illustrated their vehement desire for accountability and justice. The actions taken by the bereaved parents that I discuss in this chapter, and throughout this thesis, are projects of making meaning. This is of great significance to understanding these projects as an extension of the care-work that was a significant part of their lives before the suicide. In keeping with anthropological tradition, I wish this term to keep some of its vagueness and ambiguity, as defining their journey of grief any more narrowly has the potential to explain away much of the nuance and complexity of their actions and their words. Moreover, I found that meaning, care, and the projects that my participants undertook were all inextricably linked. In addressing what I am calling projects in making meaning for my participants, it is important to understand the sociality and relationality of meaning; the dialectic context of their words and actions; and finally, and more broadly, the ways in which suffering can urge such purposeful meaning to be made. Meaning is negotiated through and between social relations, and thus laden too with relations of power. In this chapter I shall address these three points. Firstly, I shall speak to the most broad of these, making meaning through action; secondly, I will discuss the how these parents a faced with barriers and how a more Foucauldian adaptation of how meaning is made is important; and finally, I will address the meaningful relationships built through bereavement and how these are manifested through their various projects after the suicide.

Making Meaning

Meaning is a concept that has long been a concern of anthropologists. It was the push by Geertz however, in the 1950s, which brought meaning into the centre of anthropological thought. This does not mean that the concept has ever been without variation, ambiguity, and perhaps even vagueness. Matt Tomlinson and Matthew Engelke ask the question, “How can humans tolerate chaos, accept the unexplainable, and endure physical and moral torment, without seeking a reason?” (2006, 2). For Clifford Geertz (1973b[1966], 100) “it does indeed appear to be a fact that at least some men – in all probability most men – are unable to leave unclarified problems of analysis merely unclarified”. This Geertzian approach is one that has undoubtedly come to be held by many cultural anthropologists (Tomlinson & Engelke 2006, 2). These points are extremely important to dwell on if I am to understand the position of my participants, and their projects of making meaning following the suicide of their sons. It speaks to their vehement desire to understand – to clarify – the suicide of their son, despite many social scientists (Durkheim 2012[1897]; Wool 2015) concluding that taking one’s own life is perhaps unimaginable. The clarity that these parents seek is perhaps more akin to giving meaning to both their son’s death and their life after it.

Geertz’s position is not without its critics. Talal Asad (1993, 42) argues that Geertz places too much emphasis on how symbolic meanings and does not sufficiently address the role of power and history, perhaps implying the lack of context in Geertz’s work – a critique that I share. Sherry Ortner (1999, 138) asserts, “The Foucault move was to insist on looking at cultural forms and practices not in terms of their ‘meanings’ (which, in this poststructuralist moment, had become a suspect term in any event) but in terms of their ‘effects’, both on those to whom they are addressed and on the worlds in which they circulate”. According to Tomlinson and Engelke however, the concern with discipline and power is not irreconcilable with a more Geertzian view of religion – and meaning – as a ‘cultural system’ (2006, 5). They write that, “Just as the limits of meaning can be traced and produced in moments of failure, so too – as Asad, Bloch, and Foucault each suggest – can they be traced and produced through attention to discipline, authority, and power” (2006, 5).

Although there are many variations and ambiguities within the study of ‘meaning’ as a cultural category, Gene Blockers ‘being-as’ (1974, 33) is most pertinent to the lives of the bereaved families throughout this thesis. Summarized by Tomlinson and Engelke, “In attempting to explain intellectual mysteries, suffering, and moral paradox, people cast themselves in recognizable roles within imagined cosmologies” (2006, 18). Blocker writes, “The basic character of meaning would seem to be this ability to project purpose on to the world. Meaning is transcendently traceable to purpose, and this brings out the intentional or

‘subjective’ side of meaning” (1974, 41). Blocker’s ‘being-as’ is perhaps most significant due to its relationship to forms of recognition. Webb Keane (1997, 15) writes,

People recognize actions and identities in terms of things of which they already have some understanding. Objectification depends on an act of comparison in which the new event can be recognized as an instance of something that is already known. But... what counts as repeatable is at least in part social. It is subject to the playing out of the interaction between us and thus begins to take on a more dialectical and potentially power-laden quality than that of a simple embodying of an existing type... In this light ‘recognition’ as a known type becomes involved with the social and political dynamics of ‘recognition’ as acknowledgement or affirmation.

Robert Desjarlais (1996, 888) writes of experience, a concept closely linked to meaning. He writes, “To have an experience, or to learn by experience, suggests an education that can accrue in certain skills, knowledge, or wisdom, though the education hinges on a flux of subjective reflections that other kinds of learning, such as operant conditioning do not”. Experiences are things to learn from; they are transformative. David Carr (1986, 30) writes, “experience is directed towards, and itself assumes, temporally extended forms in which future, present, and past mutually determine one another as parts of a whole”. It is narrative that gives form to such temporal integration (Desjarlais 1996, 889). Through narrative experiences are given meaning. It is in their relation to other experiences, past and present, that temporal narratives render experiences comprehensible.

I would finally like to make the link of Blocker’s ‘being-as’ with its emphasis on recognition and relationality – or sociality – and the more general arguments for a relational and power-laden view of culture more generally. To revisit an assertion from Zoe Wool and Seth Messinger, they write, “the regimes of subjectivity within which caring attention is offered, and the social relations it maintains, are always multiple, no single one having an exclusive claim on configurations of people and their respectively ailing and caring bodies” (2012, 26). In this way ‘caring’ and ‘meaning’ are inextricably linked. The actions taken by the bereaved parents that I discuss in this chapter, and throughout this thesis, are projects of making meaning. This is of great significance to understanding these projects as an extension of the care-work that was a significant part of their lives before the suicide.

Taking Action

There were two comments that Jane made to me during our conversations about the action that she was taking, through formal channels but more importantly publicly. Firstly, she told me, “I

think that's been a pretty strong common theme for us, people thanking us for speaking out because it's given them hope and courage and in a lot of ways that makes it worth it for us, as hard as it is. To know that it actually is making a difference to people, as awful a reason as it is that we are in this situation. That helps us as well, knowing that our son's life can actually still have some meaning". Finally, she remarked, "It's a way of honouring our son, I guess. It's a way of expressing our anger, our grief". Honouring their sons and creating meaning through bereavement is perhaps the strongest of the themes that have become salient throughout this research. Almost everything that these parents do, publicly, legally, and through other formal channels, is a project in making meaning.

The online presence that these parents have in the world of suicide prevention advocacy and activism is far-reaching. Before I knew it I was part of this world, and the more I looked, around every corner was a new page or group sharing their own experiences, acting as a forum for others to speak, or advocating for better care and preventative measures for others like the ones that they lost. Their activity online gave an interesting insight into their bereavement. Unlike the conversations that I had with these parents, public statements often made their desires and grievances more straightforward and more easily comprehensible. However, because of this much of the nuance and complexity of their bereavement can be overlooked. Because of this, for myself, in writing this thesis, it was important that I stay aware of this, and furthermore, explore the interplay between those public voices, and those perhaps a little more private in our conversations.

The bereaved parents' online presence was (and is) to create awareness of not only the tragedy in the loss of their sons, but also to create a wider awareness of the culpability of the mental health system in this loss. They see the mental health system in New Zealand as broken, in dire need of repair or replacement. Their voices are very much politically engaged in their vehement desire for change. Their goal is for accountability, and for others to not have to go through the kinds of emotional upheaval that they themselves have gone, and are going through. For my participants, this desire to increase awareness, not only around their own loss but suicides around the country and more generally, has motivated many to create awareness campaigns, Facebook pages, or other projects to raise awareness about suicide in New Zealand.

In describing the aims for her group, Carol said, "So our aims and goals really are to educate, to break the silence, to remove that stigma, provide bereavement support, provide support to people that are struggling to access services". This sentiment, and these goals are shared by almost all of the groups and individuals in advocacy and activist roles within suicide prevention in New Zealand. They show the sociality of meaning, the identities that are created through such shared suffering, and the meaning that these parents gain from them.

These parents have much to say about how people experience mental health services. However, as mentioned earlier, it is felt that the bureaucracy of care does not allow their voices to be heard, making them strive to be louder. Tanya portrayed to me a sense of why these parents continue to – or more importantly, are able to – fight publicly for so long against the perceived odds. Tanya told me:

What they do, is quite insidious, is because they only ever hear the voice of one, I mean in Maria's case, she's just a single Mum with a daughter, Carol has a husband and a family but really it's just Carol standing up. Nicky Stevens is an interesting scenario because again I don't usually talk about them as an object but in the sense of who's going to make a change. Nicky's family, the three of them were very strong on what went wrong and they've stuck to it, they've stuck to the same story and it's all of them together, they're really supportive. They've been, Dave's a councillor, Jane's in community sort of therapy work. They've very strong community minded, I don't think they'd mind the word activist or radical, they're not quite, I mean they're lovely people. Don't be put off, they're nice people. Jane would have to be the kindest, most softly spoken activist I've ever met in my lifetime but they are certainly well connected to a group of movers and shakers, shall we say that instead of radicals, I hate the word radicals. You know, they're well connected to certain people and politicians to people in communities that tend to make a difference.

These public Facebook groups and other avenues to make their voices heard are projects in making meaning. The advocacy, activism, and facilitation of networks of those bereaved by suicide are such projects. Michael Fischer writes, "Culture is not variable; culture is relational, it is everywhere, it is in passage, it is where meaning is woven and renewed often through gaps and silences, and forces beyond the conscious control of individuals, and yet the space where individual and institutional social responsibility and ethical struggle take place" (2003: 7). Meaning is woven in the struggles between these bereaved parents and the state institutions that they fight against. However, it is not simply the fight against more tangible entities where meaning is made, for as Fischer asserts, meaning is renewed through gaps and silences. These parents want accountability for their sons' deaths; they want better mental health services available throughout New Zealand; they want to make aware the culture of stigma and silence that veils the issue of suicide for many; but most of all, they want to give meaning to the death of their son. Their voices get louder and actions turn from advocacy to activism when confronted with barriers and structures that do not allow for them to feel heard, for them to not feel as though their suffering, and their complaints, are recognised by these structures – the state.

Suicide Prevention

I noticed almost immediately the motivation that Tanya felt for seeking out answers as to why her son was able to kill himself despite receiving what was seen as ‘reasonable care’¹⁴. However, what I came to notice, only over time, was that Tanya, and the other parents, were in fact motivated to act in the name of suicide prevention on a national level. Over the time in which I was doing online fieldwork via their Facebook pages and groups, I found that much of their energy was dedicated to promoting awareness of preventative measures for suicide and mental illness, petitioning for an inquiry into the mental health system in New Zealand, and advocating for others around the country that were either going through a similar situation or were in crisis and were seeking help. The following excerpt is from a conversation I had with Tanya:

I do feel that even within the four years that I’ve sort of been talking to other suicide bereaved and I’ve sort of gone out there to involve myself, again a bit of an academic conquest, maybe similar to what you’re doing, I’m actually sort of going back to University. I had never thought of going to anthropology to do suicide but I actually looked into, is there any training, there really isn’t. There’s some stuff running through Griffiths University, I think in Australia that does suicidology, truly doing an academic type, you know, going back to University and looking, you know, doing interviews, the reason why. I think the only pathway... Well, I’m surprised you’ve done it through yours but, social work, or psychology are the only... that seems like the only way and certainly you could pick your papers, your general papers, get more refined but really it is Masters or PhD thesis level before you really get to question sort of suicide stuff in New Zealand. It is, we’re a small country so, you know, it gets more and more refined on the way up I suppose. But it’s for my own interest and perhaps thinking about a career change or I suppose similar to you, there are tragedies in my life that have come here for a reason, and that reason is for me to stand up and you know, do something similar to you, start looking into the reasons why, start getting these numbers down

This excerpt is a stark illustration of this motivation – of a desire, even a need to aid in preventing suicide, and in turn preventing other parents, family, and friends from losing someone to suicide and having to go through the same bereavement journey that they themselves have had to endure. Blocker writes, “The basic character of meaning would seem to be this ability to project purpose on to the world. Meaning is transcendently traceable to purpose, and this brings out the intentional or ‘subjective’ side of meaning” (1974, 41). This

¹⁴ The term ‘reasonable care’ was used in an independent inquiry into Tanya’s son’s death to describe the care he received from the state.

purpose that can be seen in the above excerpt is foundational to all action taken by my participants in relation to suicide. The existential knowledge gained from their experience of their child's suicide seemingly requires that knowledge to be used. Their purpose extends from this knowledge and in this way giving meaning to their otherwise tragic experience of loss.

The role or identity that these parents have adopted in bereavement is a way in which meaning is made for their lives. As Webb Keane (1997, 15) argues, people identify with which they understand. In this instance the role of suicide prevention advocate, understood through an experience of the suffering of suicide bereavement. What is most significant in Keane's notion of meaning and recognition is the social and interactive way that this can manifest in identity and embodiment. I argue that an event such as the suicide of one's son has some kind of embodying effect on the identities of these parents. This perhaps becomes no more visible with actions taken by these parents in the name of suicide prevention more generally, rather than simply the advocacy for their own situation. This too links to a point, which I will go into further detail in the following sections, of the socially constitutive ways in which these identities are meaningfully created and maintained via relationships based on the shared experience of suicide bereavement.

Suicide Bereaved Networks

When speaking to breaking the silence about their bereavement and the suicide of their sons, it is interesting to note that much of the action, voice, and memory happen within the bounds of a collective moral community, a community of those bereaved by suicide. This is what many of my participants call 'Suicide Bereaved Networks'. These networks are created and maintained through various ways, including tradition channels, such as in person meetings and phone called, but also digitally, via Facebook groups. The communities are based on shared experiences of suicide, or mental health crises. They are as much communities based on advocacy and support as they are on activism for greater suicide prevention measures throughout the country. The sociality of suicide bereavement within these projects is of particular importance here, for it points to the argument that I have made throughout this chapter, that meaning is manifested not only through one's own experience, but is relational, and is played out through recognition, and in turn created purposeful and meaningful identities.

Throughout their journeys these parents have made meaning through socially, and dialectically, identifying with, and embodying, suicide prevention. It is visible in the ways that actions – public, and private, formal and informal – were not always towards their own situation, but rather in the name of suicide prevention more broadly. Following this notion,

meaning is made through the relationships formed throughout their journeys, and because of many of the actions that were taken. There is a great deal of meaning that was created through these, and these were even described as therapeutic by many of the parents. Many of my participants were had formed friendships with each other, which was one of the ways that finding participants snowballed so quickly.

When Carol spoke about her suicide prevention and bereavement group, she said:

In the public group, a suicide prevention group, I deal with a lot of people... I maybe, I can't say that I've ever had an emergency call because I make it quite clear that we are not first line, but I often get requests from people such as, "Oh my loved one was admitted to hospital last night, had a suicide attempt, and they're going to discharge him this morning. We don't want him to be discharged, he hasn't had a mental health assessment", and basically they just chuck people out the door. So I get a lot of those sort of calls. People that say, "My loved one is in jail tonight, he's suicidal. He shouldn't be in jail". So those kinds of things.

Her motivations to start this group came from her own experience with the solitude following the suicide of her son: "I just felt really isolated and I felt the need to connect with people so I called a community meeting and I started a Facebook page". This is a great illustration of the kinds of meaning and purpose that these groups gave Carol. Not only this, it was perhaps her role as coordinator, as advocate, that gave her the most sense of purpose at a time which she was feeling isolated and disconnected. Jane too has a large network of suicide bereaved. She told me:

Huge numbers of families have made contact with us. It's mind-blowing and, I mean, I know so much about, you know, what's happened to people that you get never, ever have imagined. And the stories are horrific of what's happening in this country. And I know that we've probably, you know we've kind of been inundated with it". She went on to say, "It's a way of connecting with people that previously you just couldn't do. And it's a way of keeping with conversations going not just about our own personal case, but the bigger picture. It's a way of giving voice, and giving people a voice.

All of these parents told me that the relationships that have been formed following the suicide of their sons have become extremely meaningful and even therapeutic. Terri told me, "They probably did more towards my healing in the sense that they're very honest, so they don't try and fill you up with crap to make you feel better". She went on to illustrate this with a story

of how she sought professional help through her bereavement, but the most meaningful thing that came from it were relationships with other bereaved. She told me:

So the WAVES program was essentially eight weeks of us bonding with others which had shared losses. So the coordinators may as well have not been in the room, and we were all agreeable on this, sorry, because the only time we would actually talk, and get serious about talking was when we went out for a smoke, or afterwards. So coordinators were a waste of time, everybody got a couple of weeks' worth of what they wanted to get out of it, which was helpful, which was cool because that was better than nothing at all. And we formed relationships and friendships that meant that our healing journey was more able to be done because when you lose somebody to suicide, you talk about stigma toward mental illness you should try being a mother of someone that killed themselves, it's seriously like cross the street stuff. So we become quite untrustworthy, we feel very much to blame, and so we hide in our home, and we only talk to others that understand that shame and stuff anyway.

Meaning-laden social relations and recognition are related through what could be understood as perceived empathy. For suicide bereaved, it is perhaps more meaningful to surround oneself with those that recognize through experience rather than a more forced recognition or empathy; people that embody the same kinds of suffering that you yourself do. The communities are based on shared experiences of suicide, or mental health crises. They are as much communities based on advocacy and support as they are on activism for greater suicide prevention measures throughout the country. The sociality of suicide bereavement within these projects is of particular importance here, for it points to the argument that I have made throughout this chapter, that meaning is manifested not only through one's own experience, but is relational, and is played out through recognition, and in turn created purposeful and meaningful identities.

Conclusion

Meaning is a useful lens through which to understand the actions and words of those parents bereaved by suicide. I have argued throughout this chapter that there are three important points to take into account in this context. Firstly, that meaning, like culture, can best be understood as social and relational. This has become no more illustrative than in the 'Suicide Bereaved Networks' created by my participants. Secondly, meaning must be understood dialectically, and within webs of power. The purpose that lay at the heart of much of the public and private advocacy and activism that these parents took part in was the fight for

accountability and justice, a fight against structures much larger and much more powerful than themselves. Finally, through understanding the first two points, we can understand how embodiment, recognition, and identity, are all meaning-laden. They are created and maintained through the meaning-making projects that I have discussed throughout this thesis. Those projects give purpose and meaning through the creation and embodiment of identities based on suffering. These identities are thus recognized through shared experience, socially and meaningfully.

The actions taken by the bereaved parents that I discuss in this chapter, and throughout this thesis, are projects of making meaning. This is of great significance to understanding these projects as an extension of the care-work that was a significant part of their lives before the suicide. Meaning, care, and the projects that my participants undertook were all linked. It is through suffering that such purposeful meaning is made. It is negotiated through and between social relations, and thus laden too with relations of power.

4. Walls and Barriers

Well they've been threatening. I know one Mum who's been threatened with it several times. And she's the one, who they've just done that story about her getting muzzled in the paper a couple of weeks ago. – Tanya

Throughout this thesis I have traced the bereavement of Jane and Dave, Carol, Bill, Tanya, and Terri, all whose sons died by suicide. I have discussed the ways in which their bereavement and action taken against those that were charged with their sons' care in the years and months prior to their deaths. I began by giving historical and cultural context to the shifting regimes of care, particularly mental health care, in New Zealand to the current day. I have showed the effect the liberalisation of mental health care has had on the ways in which care is received, and also how responsibility for care is understood, by those giving care, those receiving care, and importantly, by those governing regimes of care. The structures of neoliberal care, as viewed through the lens of biopolitics can be extremely useful in understanding not only the gaps in modern mental health care, but also why and how activism, advocacy, and resistance is shaped. In this, the final chapter of this thesis, I wish to discuss the ways in which, through the conditions that mental health care in New Zealand is shaped, my participants are met with walls and barriers to receiving recognition of their loss, accountability for the perceived failure of care, and for their voices to be heard as suicide bereaved.

I will begin by focussing on the coroner's inquiries and other official inquests by state and independent agencies into not only the suicide itself, but the care that their sons received prior to their deaths. In this section I will show how contemporary neoliberal regimes of care,

particularly in such bureaucratic situations such as formal inquests, can, for those bereaved, feel cold, uncompassionate, and uncaring, as if the state were indifferent to the death.

In the following section I shall shift my focus to the silence and stigma surrounding suicide. These suicide bereaved parents felt the oppressive force of silence on a daily basis. This silence however, was a force which they vehemently fought against, and was one of their most symbolic battles. Although the silence was largely culturally shaped, in the ways by which friends, co-workers, and strangers would avoid speaking about suicide and mental health, the fight also encapsulated their fight for recognition of their loss and of their bereavement by state agencies and officials.

Following this, and through the lens of biopolitics, I show that how responsibility is understood and conveyed shapes the attitudes and actions of the state agencies in response to these parents claims. In this section I wish to bring together the issues of neoliberal care, as discussed in chapter one, biopolitical responsabilisation, as discussed in chapter two, and meaning as discussed in chapter three. By bringing together these points I will illustrate not only how these ideas can be useful in explaining the barriers that my participants face, but in their words the effect that coming up against walls and barriers has.

In the final section of this chapter, and of this thesis, I wish to bring together the potential effects of these parents' bereavement journey, and of the fight for recognition and accountability of the loss they say they have wrongfully suffered. The increased distrust and anger with state agencies involved in mental health care and suicide prevention creates resistance and unwillingness to engage with their services if needed. Their voices too can shape further resistance. There is a possibility that the voices can influence people around the country to feel disillusioned with mental health services and be reluctant to engage with them. As I will discuss, this could be problematic as engagement and trust are integral in the efficacy of mental health services. The tensions created in these interactions can be detrimental to regimes of mental health care in New Zealand. There is required a level of trust between client and professional in order for the therapeutic relationships to be effective.

Inquests and Inquiries

Coroner's inquests are the primary legal channel for bereaved parents to make sure their child's death is not in vain, and that the perceived departure from care is addressed and accounted for. The disconnect between state institutions and family's notions of care is no more salient than when hearing these parents talk about the inquests and inquiries into their sons' deaths. This section outlines the inquiries and processes that those bereaved went through – or even

endured – in order to gain some insight into why their son was able to take their own life while in the care of the state. This was backed up by what both coroner, and other front line professionals told me, that these formalities could be a harrowing time for those grieving.

Lisa Stevenson's (2012, 593) work with the Canadian Inuit is very useful in understanding how biopolitics can be understood by those receiving state care in that forms of bureaucracy and neoliberal regimes of care "can manifest a form of indifference on the part of the state". To further add to an understanding of the experience of the bereaved throughout inquests, I wish to revisit the first chapter, in particular the neoliberalisation of the state, and state care. Despite neoliberal policy being rolled back by changes in government in the late 1990s, neoliberal ideologies remain within state apparatus, having a deep effect on personal subjectivities. These ideologies "are embodied in the ways in which a whole series of issues are problematized – made amenable to authoritative action in terms of features of communities and their strengths, cultures, pathologies. They shape the strategies and programmes that address such problems by seeking to act upon the dynamics of communities. They configure the imagined territory upon which these strategies should act – such as community mental health" (Miller & Rose 2008, 88). Neoliberal ideologies remain within mental health care, and are extended in addressing deaths within state care.

According to the Coroner's Office (Coronial Services of New Zealand 2017),

A coroner holds an inquiry to find out more about who the person was, and where, when and how they died. Inquiries also help coroners make recommendations or comments that might prevent a similar death happening in the future. Inquiries are usually opened soon after the death but sometimes it can take a few weeks for the coroner to decide if there should be an inquiry.

Not all deaths receive an inquiry. Such is the case with many natural deaths whereby the Coroner may deem it unnecessary. However, all deaths under violent, unexplained, or suspicious circumstances, must receive an inquiry. Along with this, deaths where the person was in state care must also receive an inquiry. Although coronial inquests are the primary channel for investigations into deaths in state care, the Health and Disability Commission (HDC) can also conduct investigations into state care practices. Most of these parents exercised this channel. Once the commission has gathered evidence and conducted their investigation, "If the Commissioner finds that a provider has breached the Code in relation to your care, he or she will often be asked to apologise to you. The Commissioner may also recommend that providers make changes to their practice in order to prevent similar events" (Health and Disability

Commission 2017). Like the Coroner, their recommendations are not binding. On top of this, neither the HDC nor the coroner can award financial compensation.

When speaking to the coroner, they told me of the difficulties families can face during coronial inquests and other such formal hearings. Interestingly, they spoke of the kind of cold environment of these hearings, in which any kind of emotive or personal language is forfeited for legal jargon. In this way these families can understand this as the kind of indifference of which Stevenson writes. To illustrate this, the coroner said:

So it's really helpful to hear from families. But of course, inquests are traumatic, they're court hearings, and families are not usually in a position of giving evidence in court, so it's a foreign environment for them. Plus, of course, they're re-traumatised by an inquest because they have to hear all the evidence again, how their loved one did this, how they were found, and the fact that the post-mortem was performed, and what the cause of death was. So it's very hard for families to attend inquests and we don't often go to an inquest with a suicide unless there's reason to.

Although coronial inquests are not the only legal channel with which to search for state accountability, many of the bereaved become exhausted and begin to believe that their complaints are not going to be heard even in formal inquiries. Within the coroner's hearings, although families are encouraged to be involved, their capacity is limited by the structure of inquiries. What is interesting to note is a point made by the coroner regarding these inquests, and accountability. The coroner spoke of misguided attempts to lay blame on certain institutions, and certain state processes. Of these complaints the coroner said:

If they do that, it's usually in the wrong direction. For example if somebody dies who's been under mental health care, and I have an inquest coming up, and this was raised in a pre-inquest conference the other day. Family wanted me to look at access to mental health services. Now that's a legitimate concern, but unfortunately it's not part of the inquest, because this person died from natural causes, but they've got issues with the mental health care system because they felt that he should have been admitted to hospital a lot sooner as an inpatient and that would have meant that he would have received better health care.

As Miller and Rose have asserted, neoliberal ideologies "are embodied in the ways in which a whole series of issues are problematized" (2008, 88). This is not only true in the way that care for those citizens who require it is organized and administered, but also in the way that failure in state care is approached. The departure from the paternalistic state could not be clearer.

Although the coroner seemingly acts as independent throughout the inquiries, there is previewed combativeness on behalf of those state institutions that are being called to account by my participants. In this way, a search for some kind of objective truth can be blinded by power imbalances where clearly the means of state intuitions is far greater than that of these parents. During then formalities of the inquests, and pre-inquest meetings that occur, Tanya felt that there was even active resistance against her complaints. This starkly illustrates my argument above. She told me:

So he [coroner] called them, the police, Child and Adolescent Mental Health Services, the DHB. There were seven lawyers sitting in the room for these agencies. They even had the head lawyer from the Ministry of Social Development there because they'd done such a shit job with [my son].

The length of time that inquests can take, even to begin, along with the amount of work families need to do in order to receive coronial inquests and HDC investigations can take a toll on these parents. When I met with Jane and Dave, over a year after Nicky had died, they were yet to receive an official word on when the coronial inquest into his suicide would begin. Even once they begin, they can take years to conclude. Tanya had to wait almost four years to hear the coroner's ruling on her son's suicide. Throughout this thesis I have made the argument that the projects and actions undertaken by these bereaved parents is an extension of the care-work when their children were alive. Jane told me about a case that she had heard about:

He suppressed the means of her death after the coroner's hearing, and that's in the coroner's report. I don't, I didn't, I haven't seen anywhere that the family were muzzled before then. And certainly, the family made a complaint so they, to the Health and Disability Commission, which is one of the processes that are supposedly open to people, although we've been told not to bother, until everything else is done. But the coroner, I mean... I suspect they're totally burned out and need to move on after all that time, to have it all brought up again. It's incredibly hard. So, she's kind of died and it's just been buried, you know everything that's happened to her. And I just find it quite shocking.

The effort that these parents give to receive inquests and investigations, and the emotion-work¹⁵ that is exerted to give evidence in these proceedings is a stark illustration of this. Jane makes much of this clear through her complaints about the process of receiving an inquest. At the time that I spoke with her, she was still unsure as to whether or not her son's suicide would receive a coronial inquest. She told me:

¹⁵ See Hochschild (1983)

It's been a bit frustrating, because there's this whole domino thing that goes on, I mean, I... we, even knowing whether there's going to be a coroner's inquest or not has been quite up in the air because of some of the political things that have been going on, all talk of less coronial inquiries and stuff. We had people saying, "Yes, there has to be one", and then people going, "not necessarily". We didn't have a lot of contact with the coroner's office and that's still very frustratingly vague. We hear that the coroner's hoha with the police, because the police aren't giving the information they need to start their inquiry. So I've sort of become the go between, between the coroner's office and the police half the time. That shouldn't be the case. And the guy from the coroner's office who rings me is really friendly but he seems to be very ineffectual. And says all the right words but doesn't actually do much. And I guess, you know, I'm not going to hold my breath around the coroner's... I mean the problem that we've seen happen time and time again is the length of time it takes, it's appalling.

Tanya too told me of the wait she had to know if her son's case would go to inquest:

Some, you know within the bereaved community, I mean I waited nearly three years for my coronial inquest and another year for the finding. There are people that wait four years for an inquest if it is a complicated case, particularly if mental health services are involved so, can you imagine that for four years, publicly you're not allowed to say that your loved one died by suicide. And mean what a bizarre situation isn't it?

Inquests prove to be very difficult for bereaved families; from the length of time that they need to wait to receive them, to the legal barriers they face when they finally get their seat at the table to voice their complaints. When faced with legal formalities such as these inquests, they feel them as cold and uncompassionate – uncaring. The state is seen as indifferent to their concerns and complaints, even to their loss. The walls and barriers that these parents face at these inquests are only on part of the challenges they face in their search for accountability. In the following sections I will discuss the further challenges they have and will face.

No Shame, No Stigma, No Silence

One of the greatest challenges for these parents, particularly in daily life, is coming to terms with stigma, shame, and the silence of such experiences. In this section I will discuss the cultural shifts that they are striving for, less tangible change than that which they often desire through formal channels, but a change that comes from their own experiences nonetheless. My

participants' self-proclaimed mantra, "No Shame, No Stigma, No Silence" encapsulates this desire for cultural change. However, it is not only an outward expression and communicatory device, it is also an inward self-reflective tool to give them strength and importantly to give their journey meaning. Along with the desire for this cultural change, and what links back to the previous section, my participants are confronted by what they see as archaic laws of media suppression surrounding suicide. They see these laws as very much complicit in the stigma. When thinking about the meanings of silences it is important to think about the links between memory and forgetting, action and inaction, voice and silence, and the collective and the individual. For what is interesting to acknowledge in this case is that although there is a perception of imposed silence in certain – perhaps quotidian – settings, within communities of suicide bereaved, of which I will discuss in this section, no such silence exists.

Carol wrote Facebook, "Silence has not brought our statistics down. The power of the people is in talking in a healthy way and to bring about hope. Love to these families for speaking up about their pain and loss". For those mothers whose sons have suicided, they wished that they could have more easily spoken to their children about suicide, and they now feel the stigmatising effect of having lost their child to it. This sentiment is seen in this post on Carol's page,

Youth are already talking about issues to each other on social media and in person so why would we not want to be part of that discussion. Listening to youth and how they come up with solutions is the way forward. Talking about suicide does not cause it. Talking about it in a safe way can provide opportunities to discuss help and to provide hope and support. Often young people have to carry that burden alone and that is not fair. We need to step up and get to their level.

Silence is a symbolic fight for these parents. They see it as a scapegoat for state inaction, and as an oppressive force in gaining state recognition of the neglect that killed their children, and the systemic neglect that kills hundreds each year. Of silence, David Morris (1997, 26-7) writes,

Silences are not all identical, of course, but convey a wide range of significance, from the contemplative depth of a pregnant pause to outrage, disbelief, and stunned wonder. In addition to metaphorical links with an inexpressible or unknowable experience, the silence of suffering also points to very practical breakdowns of speech. Its silence, that is, reflects something not ultimately ungraspable but merely resistant to description. Suffering tends to make people inarticulate, and in this sense the voicelessness of chronic pain, who discover that months or years of remedied complaint finally exhaust care-givers or even family. Such patients withdraw into an uncommunicative isolation,

constructed in response to an environment where effective help and concern have all but vanished.

This is not to say that these silences are self-made through the experience of suffering, but that the complexity and multiplicity of silences must be understood. This point can again be linked to the contexts of power that I have mentioned above, whereby the meaning of these silences cannot be understood in isolation. Given that my participants are far from publicly silent in their bereavement, and in their complaints of the care that their sons were given, it would perhaps seem unlikely that silence was a salient idea of which to write. However, it is less the silence of my participants but the perceived silence of others that is significant. Morris' point that suffering makes people inarticulate and that silence holds "metaphorical links with an inexpressible or unknowable experience" (1997, 26-7) is significant in understanding the perceived silences surrounding these parents' experiences. Silence, here, is maintained through an unknowable experience. However, those that do hold the experience of suicide bereavement are far from inarticulate.

Much of the stigma was portrayed to me by my participants in relation to the laws on media restriction on the reporting of suicide. The law is an indication, too, of the ways in which their suffering was not being properly recognised by the state. The Coroner's Act, until a recent amendment in June of 2016, stipulated that until the coroner rules that the death was indeed a suicide it is illegal to publicly say so. As I discussed in the previous section, inquests into suicides that occur while in state care can take up to four years in some cases, with Tanya's taking over three. To be left this long without being able to publicly state that your son had in fact killed himself can leave the parent in an uncertain state – betwixt and between. New Zealand is alone in its use of legislature to restrict the reporting of suicide through media outlets. The Coroners Act 2006 restricts "making public of details of self-inflicted deaths" (Law Commission 2014, 3). This is also not simply specific to professional media, for the Act states, "No person may, without the coroner's authority, make public any particular relating to the manner in which a death occurred" (Law Commission 2014, 3). This too includes any detail of any inquiry that is taking place. Although there have been recent amendments to the Coroner's Act¹⁶, at the time that I spoke with these parents, the restrictions were still in place, and thus many of the parents were in fact flaunting this law. This kind of resistance was significant in breaking the kinds of silences that my participants spoke about. Tanya told me:

We're, everybody is on social media, most people don't buy a newspaper, most people don't even watch TV these days, you know, our news stuff is reading it online and, you

¹⁶ See Coroner's Amendment Act 2016 (Parliamentary Council Office 2016)

know, that's all over the world if you're interested in reading about it. You're going to be able to read about all kinds of information you're not going to find in New Zealand media because of our antiquated restriction. So that, I mean, that in itself is pretty stigma inducing, isn't it?

The state's reluctance to allow unrestricted reporting on suicide finds itself apparent also in the governing of fictional shows such as *13 Reasons Why*. This controversial television show that recently aired on Netflix, has received a unique rating of RP18 by the New Zealand Classification Office, requiring someone under the age of 18 to view the programme with a parent or guardian (Stuff 2017). With strict governance surrounding public portrayals of suicide, bereaved parents believe that this is an active silencing by the government. This however, gives these parents further motivation to push for recognition of the state's failure to care for their children. Jane too spoke of this:

We've in sense, we could be arrested for things we've said, we could be put in jail. But let them. Let them. And actually, it's interesting the media have begun to breach the current laws of reporting. Because, you know, they can't... it's all over social media now, you know, we've had people, families say, "How can you be saying those things?". We've been in touch with a lot of families who've been, who are in the same circumstances, "How can you be saying these things? We've got suppression order". You know, "If you say these things, you're breaking the law". And we're like, "Actually, the worst has happened already". "Bring it on". It's got to be spoke about, it's got to come out of the bloody shadows.

The laws surrounding suppression of suicide reporting in New Zealand has had a deep effect on the suicide bereaved. Bereavement and grieving are already such complex, difficult, and stressful one's life, and to deny these parent's the ability to freely and candidly about their child's death has profound consequences on the bereavement journey. The governance of suicide and mental health with certain laws can stifle bereavement. In a similar vein as coronial inquests, the biopolitics of suicide give these parents the feeling of state indifference. These regimes of care, despite their benevolent intent, can even feel "murderous", words used by Jane to describe mental health care in New Zealand. Jane, speaking about a suicide bereaved parent she knows, told me:

Well they've been threatening. I know one Mum who's been threatened with it several times. And she's the one, who they've just done that story about her getting muzzled in the paper a couple of weeks ago.

Tanya, speaking of the same parent, also told me:

I've got another friend of mine that's down South, Meredith. She's also been vocal and she's been stomped on. Her son died within a mental health facility while he was there. So she initially released a how did this happen type thing and then she was told, reminded strictly about the suppression and how she wasn't allowed to mention it was a suicide. And for her, who actually, she's got a law degree, she's an intelligent lady, so of course she went, "What?", and I've just been talking to her about the suppression order, "does it delay grieving? Is it causing more problems for suicide bereaved?" You know, people's reputations that they don't want, I think that. It's like it's a... I don't know....

The barrier of suppression for some is a paradoxical one, it furthers their need to fight for accountability and recognition. However, it also means that they experience what they see as a state-imposed stigma on their lives as suicide bereaved. Their mantra of “No Shame, No Stigma, No Silence”, is often directly aimed at this law, while at the same time acts as a self-empowering mantra in their journey. In a similar vein to the indifference by the state that is felt by these parents as they fight for answers through formal inquests and inquiries, the laws of suppression are understood as a tool of this indifference, a technology of silence. It follows that this becomes a target of resistance for these parents, not only against state silencing of their sons' deaths, but more symbolically of the stigma that they feel daily.

Recognition and Responsibility

The inquests, formal complaints, and conflict with suppression laws are all significant barriers to both seeking accountability and recognition of their complaints. What I identified in the previous chapter as projects of meaning, are built upon the goal of recognition of insufficient care and some form of accountability for that. Given the sociality of this type of meaningful bereavement, as illustrated through the suicide bereaved networks, these projects have extended to advocacy for other suicide bereaved within New Zealand, and also for suicide prevention more generally. In this section I wish to bring together the issues of neoliberal care, as discussed in chapter one, biopolitical responsabilisation, as discussed in chapter two, and meaning as discussed in chapter three. By bringing together these points I will illustrate not only how these ideas can be useful in explaining the barriers that my participants face, but in their words the effect that coming up against walls and barriers has.

The shift from a paternalistic to neoliberal self-governance was acknowledged by those bereaved – albeit, not in those terms – and were cognizant to the effects it had on them. It garnered a visceral reaction within them, as if government agencies or their representatives were explicitly blaming them for their sons' suicides. Trnka and Trundle (2014, 148) write:

The realm of healthcare provides many trenchant examples of responsabilisation programs that successfully devolve some forms of decision-making onto patients and yet also encounter significant counter-pressures through the persistence of pre-existing networks of responsibility and care.

When Tanya spoke about the recent suicide prevention strategy meetings conducted by the Ministry of Health, she said to me, "I just kept hearing it, slight versions, but that concept that, 'DHBs aren't responsible, stop blaming us. It's a community problem. It's a community problem'". This is very much coherent with the shift from the paternalistic governance to one enacted through community and thus eroding the responsibility and accountability of the state in such matters. This is a recognition of the issue not only by the government and those who are seemingly responsible for addressing suicide, but also recognition through breaking cultural stigmas and silence.

Jane told me about some of the action that they were taking to hold these organisations and agencies charged with suicide prevention and mental health care to account:

The people that know those people best are currently being ignored, being actively treated like shit really, and in some cases being persecuted, being shut down, being treated as if they are mentally ill themselves, and in some cases being incarcerated, you know, and that's got to stop. There's also a kind of huge denial that people are experiencing from our political leaders around the extent of the problem, that came through really clearly, and the huge issues with the lack of resourcing, the workloads on people providing services, the lack of skill, it's... I was talking about it being a train wreck. I think there's very clear evidence and very strong feeling that mental health service in this country is failing people big time.

For these parents the barrier of recognition must be overcome, and acknowledgement received for there to be any path to accountability. Advocacy projects can focus on particular people and events, or more broadly of institutions and agencies. Tanya told me:

To me it would seem obvious that at those points, when something does go wrong like that and I mean, the ministry of health love declaring it a rare event. Suicide bereaved

shudder because to them it's not a rare event, it's a tragedy in their own life time. It's really insulting that where they're saying it's a rare event, you know the percentage of deaths. Again the converse to that from bereaved is, "well, wait up, our suicide rate's nearly twice the road toll, are you saying road deaths are a rare event? Because we all know about that?"

I wrote in the introduction of this thesis how knowledge is socially situated; how it is culturally and politically created. People's narrativisation of illness is "impregnated with expert knowledge" (Vanthuyne 2003, 14). In following this notion, not only are people's narrativisation of illness impregnated with expert knowledge, but so too are their narrativisation of epidemics. The above excerpt shows Tanya speaking about suicide in biopolitical terms. She speaks of suicide in relation to statistics using comparisons to the road toll. However, contradictions and departures from expert narratives occur. As Catherine Trundle (2011, 883) writes:

When patients and experts disagree over diagnosis, patients often resist medical authority and forge collective action aimed to decentre medical expertise. At the same time state mechanisms commonly objectify and bureaucratised the measures of illness and suffering, delegitimising the realms of self-reporting and assessment from which concerns arose and through which contested illnesses became socially visible.

Although speaking of illness and diagnosis, Trundle's assertions hold true for those seeking answers posthumously. Through the state measures of inquests, investigations, all of which result in non-binding recommendations, the objectivity and bureaucratisation of these measures delegitimises the complaints and contestation of the care that their children received.

With the cold and uncompassionate feel of bureaucratic channels and the legal provision of public silence, it is understandable that the families of those that suicide while in state care feel as though the perceived neglect and culpability of these services is being silenced, and thus they themselves are being silenced. In the following section I will show how these walls and barriers outlined in this chapter and throughout this thesis have had a significant and profound effect on both these families and potentially on suicide prevention and mental health care within New Zealand.

Resisting Care

The barriers that these parents have faced – and continue to face - have a significant effect on how they engage with state institutions and mental health services. The way that they are treated, or are perceived to be treated, makes it difficult to receive any kind of formal state care following the suicide. This can be extremely significant; those bereaved by suicide are more likely to suicide themselves – it is one of the identified risk factors for suicidality.

I would like to bring together the points that I have made throughout this thesis into a picture of the difficulties of suicide bereavement. This is ultimately illustrated through the resistance to care that many of these parents not only spoke of in ideology, but enacted. The kinds of resistance to state care not only occurred after the suicide but throughout the period of seeking care. When speaking of the options for care for her son, Terri told me of when she was seeking mental health care for her son before his suicide:

We were told to take him, when they brought him back, we were told to take him to Child and Adolescent Mental Health Services, and then I went to once and it was so appalling that I was actually proud of him for telling them to get stuffed and walk out. Because it was so appalling and we never went back. The clinician was inappropriate, treated him like he was two, made no pretence of actually trying to find out who he was. He was a really intelligent young guy and just, he had the bullshit radar, metre on and she completely stuffed it up. He could tell, and he said, "You're just doing a job, you don't give a stuff about who I am. I'm not staying here". And he was right, sadly. Right from the get go, we had a young teenager who had a really bad experience with mental health services and didn't want a bar of them so it, yeah... The, and there wasn't and still isn't a lot of options.

However, most of the resistance to state care came after the suicides. These parents had lost all trust, and thus all desire to engage in any kind of state care, whether that be for mental health issues, or suicide postvention measures. What was perhaps the most common response was one that actively and vehemently resists care those from the same agencies and institutions that were involved in the care of their sons before their suicides. Terri told me of the first time she was contacted by postvention services following her son's suicide:

They did ring me and say, "do you need..." about [our other son], you know, our, because 8 weeks after, we had our son who was 14 at the time that his brother died, and him and Simon were like twins. They had slept in the same bed together until Simon was 11. They were just the most, they were close it was scary. Best friends. Eight weeks after Simon died, [our other son's] best friend killed herself. She'd been at our house that week that Simon died, then eight weeks later she killed herself. He, we refer to it as got double whammied, and they rung and said you know, we've got him on our alert list, I said,

“Fuck off and get away from my kids. Get the hell away from my family”. I was damaged. And didn’t let them anywhere near him, for obvious reasons at the time, well even now I wouldn’t.

Dave too shared this sentiment:

If it’s the same authorities that were in charge of your family member when they died, there wouldn’t be much trust. But if there were genuine people in the community of their families had been through that, possibly have more, especially if they had a profile of being independent in the community and that.

What was interesting however, is that, for Bill, the inverse occurred. In Bill’s case, because he and his family were seeking legal action against the DHB thus there was hesitation on part of the DHB to engage in postvention and support for the family. Bill told me:

After the incident no there wasn’t a lot of support but then it’s perhaps not too surprising because we had to... we had to take an action to say that we were going to sue them in order to then get them to take some action and... So discussions with them weren’t particularly helpful until we took that legal action. The purpose of the action as to actually get them to confront our concerns, we ultimately didn’t sue them for... for damage... but we did have the desired result that they sat around the table with us and to then listen to our concerns, which would have been over a year later, maybe 18 months later. So it’d had the desired effect and then they, when we had the discussions we told them what we thought they should do in order to improve things there. And we conveyed them the opinion of the coroner’s hearing and so on. It was initially felt that they were on the defensive and didn’t want to engage with us immediately afterwards.

Resistance to support and care from the state, the same institutions and agencies that were seen to have failed their sons, can be understood as a continuation of the project of making meaning in their lives after the suicide of their son. As Tomlinson and Engelke assert, “Just as the limits of meaning can be traced and produced in moments of failure, so too – as Asad, Bloch, and Foucault each suggest – can they be traced and produced through attention to discipline, authority, and power” (2006, 5). In this way, resistance is a meaningful act, not insofar as it is retaliation to certain events, but is rather created by the context, and it is an action that can be taken. To reassess Trundle’s (2011, 883) assertion that, “When patients and experts disagree over diagnosis, patients often resist medical authority and forge collective action aimed to decentre medical expertise”. This shows that in this same way, resistance is purposeful, it is meaningful.

As I have discussed throughout this chapter, many of the barriers that these parents face can hinder further engagement with mental health care and suicide prevention and postvention services. The effects of these barriers can be easily understood given their openness to share their complaints via many media. There too is a possibility that the voices can influence people around the country to feel disillusioned with mental health services and be reluctant to engage with them. This could be problematic as engagement and trust are integral in the efficacy of mental health services. Given that many of those the parents engaged with within the mental health system were engaging, perhaps this points to complaints being aptly directed at more systemic failures, or structures that do not allow for the level of care that is required being met. The effects that negative experiences can have on those who do not actively voice their concerns, but simply disengage, is not clear, and although beyond the scope of this thesis, must be addressed.

When speaking to Daniel and Trevor, both involved in clinical care as psychiatric nurses, they told me that one of the key tenets of their job is to create therapeutic relationships. These relationships involve many of the tenets that bereaved participants wished they had seen in care. Daniel said to me:

Building rapport, establishing, maintaining and then terminating a therapeutic relationship... and there's steps you do for each one and it's a specific way of... this is how we do it, I mean tailored to the individual but you have to meet your person, establish a therapeutic relationship, maintain that relationship while providing treatment and then, it's broken down into little steps in each one.... And then basically terminate the relationship when it's time to end it. So because if you don't terminate the relationship there's... I'm getting a bit airy-fairy now but... there's a psychic energy between nurse and client that's... that's unfinished... no, not unfinished... un... hasn't resolved, what would you call it, like... come to its final conclusion, there's a word, there's no unravelling of the meaning of that relationship and that can be quite an intense relationship because that requires brutal honesty umm... complete open communication about all sorts of very private and personal things, and with any nurse working anywhere umm... knowledge of complete confidentiality um... and a lot of integrity and all that and it can be very, very deep relationship, it cannot be like a friendship or a romantic relationship or anything like that.

Daniel too, illustrates the need for building trust and rapport through his discussion of teaching new clinicians:

When the new staff come in I try and teach them... it's like, 'look, your best tool and your best skill is how well you can engage people, especially if they don't want to listen to you'. Umm... because medication isn't going to stop that behaviour, it might help but how long does that take to kick in? So the best way to get in is to spend that time with the clients, build that rapport, and then when things aren't going so well it's so much easier.... I've never lied to them. I don't care what it is, you never lie, if they're yelling and screaming in your face and you're worried, you still tell the truth because they'll remember if you lie, or if you don't keep your word, if you promise something, done that's it, game over, they're not going to believe you, and I'd be the same so... teach them, that's what you've got to be like, well how would you like to be treated? And if you can't promise, if you can't make your promises, and keep your promises, don't make them otherwise. Your name's mud and they'll talk to the next client and the client's going to say, 'Don't trust you', they'll talk to the next one and you're screwed. I've seen a lot of staff, they don't so much do it in front of me now because I'm in charge but they'd lie to them, blatantly lie! Like if you don't know, just don't say! 'I'm sorry, I don't know the answer to that, I'll get back to you', it's ok not to know, you know. Go a lot further than that, if you're just honest, and straight up with the clients.

The bereaved parents that I spoke with communicated a large variation in the care that their sons received before their suicides. Many, if not all of my participants spoke to me about there being some care was great and extremely helpful. There were nurses or support workers who would engage and support either themselves or their loved ones when they needed it most. These professionals held various positions in various organisations. However, sometimes it took far too long to find these people. And this was often after months if not years of engaging with professionals whose efficacy was lacking.

Conclusion

Toward the beginning of this thesis, in chapter one, I argued that to understand the changes in governance of mental health care in recent history, the perspective of governmentality can prove useful. Derived from earlier works by Michel Foucault (1977, 1978) and since developed (Rose 1996a, 1996b; Miller and Rose 2008; Fassin 2015), an important aspect of governmentality is the conceptualisation of the state. Rather than viewing the state's governance as top-down, I have emphasised the role of actors of the state, that is, those that enact policies and legislation. Although there were many care workers that their children were engaged with, restrictions could often obstruct the parents' expectations of care being met. In this way, accountability and responsibility can often be difficult to place. If 'reasonable care' is

deemed to have been given, then it is perhaps systemic issues that lay to blame. However, given the scope of HDC investigations and coroner's inquests these avenues cannot be given the attention that parents desire. In this way, the structures of neoliberal care, as viewed through the lens of biopolitics can be extremely useful in understanding not only the gaps in modern mental health care, but also why and how activism, advocacy, and resistance are created and shaped.

Neoliberal ideologies remain within mental health care, creating transactional care, which becomes clear through the language and transactional interactions between these 'consumers' and clinicians. For Miller and Rose (2008, 88), "Contemporary political rationalities also think in terms of another language which is just as important, which is highly morally invested and which intersects markets, contracts and consumption in complex and surprising ways: 'community'". The tensions between families and professionals is an illustration of these intersections. Community groups such as the suicide bereaved networks become the primary voice for mental health reform, and for systemic issues to be acknowledged and addressed by the government. It is communities such as these that have been shaped by neoliberal responsibilisation.

Conclusion

Care is a concept inextricably linked with responsibility; to understand suicide prevention, both are very important concepts. By understanding the diversity and instability within regimes and forms of care, contradictions become visible; when attending to responsibility within care all the more so. Governance of these regimes of care begins to shape bereavement through biopolitical and neoliberal responsabilisation. Understandings of care are not always congruent however, particularly between the professionals and the filial. This creates significant tension and conflict both before and after professional care when resulting in a suicide. The conflict within these understandings of care lays the foundation for the conflated tensions that arise in their search for recognition and accountability. For parents of children and young adults that die by suicide, the care that they gave extends beyond death. The action taken following the suicide of their children is an extension of the care that these parents enacted throughout their children's lives, and more specifically, in the times of mental and emotional affliction that lead up to their suicides. The meaning, which is made through care, is what gives these parents purpose in their lives after the suicide of their children. What I have aimed to achieve in this thesis, is to explore these actions, and to understand the motives and desires of these parents.

By focussing on coroner's inquiries and other official inquests by state and independent agencies I show how contemporary neoliberal regimes of care, particularly in bureaucratic situations such as formal inquests, can, for those bereaved, feel cold, uncompassionate, and uncaring, as if the state were indifferent to the death. These are diametrically opposed to being

treated empathically or compassionately; they are the experiences of being treated as a name on paper; as a case number; as someone who the state must manage. In bereavement parents and families are faced with coroner's inquests into the deaths of their loved ones, all the while legal suppressed, stipulating they cannot publicly speak of their son's suicide. During this, they seek formal action against the DHB that was charged with their care. These experiences can take a toll, particularly amidst grief and bereavement. They feel the oppressive force of silence on a daily basis. This silence however, is a force which they vehemently fight against as one of their most symbolic battles. Although silence is largely culturally shaped, in the ways by which friends, co-workers, and strangers would avoid speaking about suicide and mental health, the fight also encapsulated their desire for the recognition of their loss and of their bereavement by state agencies and officials. Biopolitical responsabilisation shapes the attitudes and actions of the state agencies in response to these parents' claims.

For my participants their complaints did not begin, nor did they end, at the neglect that they argue was the cause of their child's death. They trace back the times that they felt that their expectations of care were not lived up to. They talk of the first time that they encountered a mental health professional, and how they were received with perceived disdain, or apathy. They told me that their concerns for their children were disregarded. These encounters have profound effects on the way that any further engagements with mental health services occur. In a profession where trust, rapport, and active engagement are paramount to the efficacy of their work in achieving positive outcomes, creating resistance and tension between families and mental health services can have profound consequences both during and after care.

Following the suicide families can become active in their search for answers and accountability. This can happen in various ways. However, one very common theme is that they are all extremely assertive in their complaints. The mantra, "No Stigma, No Shame, No Silence" is used to fight legal suppression, which they feel as a way of muzzling them from vocalising their complaints. This often leads them to with a sense that their case is being covered-up. Some of my participants have chosen to ignore suppression orders as a form of resistance. Families in similar situations mobilise on social media groups. However, these groups are not simply to vocalise their complaints, they are therapeutic. They allow those bereaved to connect with others that can empathise with their grief and with their bereavement of a suicide.

Vocalising complaints is seen as necessary in order to allow others around New Zealand to know that there are some serious issues surrounding mental health services in the country. However, this can reinforce the resistance of engaging with mental health services. Parents' voices can shape further resistance. There is a possibility that the voices can influence further disillusionment with mental health services and reluctance to engage with them. This has the potential to be extremely problematic as engagement and trust are integral in the efficacy of

mental health services. The tensions created in these interactions can be detrimental to regimes of mental health care in New Zealand. Engagement, trust, and rapport are critical to effective treatment within mental health services and must be regained.

Many of the concepts within this thesis, such as responsibility, care, and meaning, have been given little attention in relation to suicide. I hope to begin a conversation within both anthropology and suicidology that can lead to significant theoretical and methodological changes in the way that we research and address suicide. This thesis adds to the debates within both suicide and care in understanding how care, via responsibility, can continue beyond death. This can inform the way further research on care is theorized. However, what I have also achieved is addressing some extremely important questions that require answering with suicidology; what is the role of care in youth suicide; and, how do contemporary forms of governance affect care? How people live their lives after a suicide can answer many of these questions. Understanding the role of responsibility and meaning in care is significant for all care-work, and a greater understanding of how these intersect can bring greater social, physical, and emotional health for those involved. Greater understanding can help alleviate the tensions between families and professionals in striving for care, and in turn allow for an evolution of mental health care.

At the beginning of this thesis I gave a quote from James Staples and Tom Widger's (2012, 186), asserting, "Suicide should not simply be understood as a destructive act, but as a constitutive one as well". This research has aimed at understanding what happens after a suicide; in this case a suicide of one's child. There is a correlation between suicide bereavement and suicide (Ministry of Health 2017), however the mental and emotional affliction that these parents suffer is complex and must be understood not as a 'red flag' or risk factor, but something that can create better futures for others who are suffering. The uniqueness of their experience can bring great insights into suicide prevention in New Zealand, not only influencing others around them in their communities, but they should be involved at some level in how policy is created. It would be a great tragedy for their experiences and their voices to not be heard by those who govern mental health care within New Zealand. In the same way that Lisa Stevenson (2012; 2014) discusses how regimes of care, although benevolent in their intent can feel indifferent or even murderous, so too can neoliberal regimes of mental health care in New Zealand. Experiences of mental health care, at their most effective – and at their least – must be acknowledged and understood in order to maintain effective governance of care. Through understanding the actions of bereaved parents as an extension of the care for their children we can understand how these actions are shaped by the governance and regimes of care within New Zealand.

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