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**MOVING BEYOND PSYCHOCENTRIC PERSPECTIVES OF
SUICIDE: TOWARDS AN ECOLOGICAL AND SOCIAL
JUSTICE UNDERSTANDING**

A Thesis

submitted in fulfilment

of the requirements for the degree

of

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Abstract

Suicide is a fundamentally political and deep moral concern within Aotearoa, New Zealand. The act of suicide is best understood as a complex phenomenon occurring within multiple biological, psychological, philosophical, moral, sociocultural, historical, anthropological and economic dimensions. While suicide is a complex phenomenon, the issue of suicide within an Anglocentric context such as Aotearoa is mainly understood from an individualistic, psychocentric conceptualisation that favours biological, medical, and psychological factors. This master's thesis explored an alternative framework that aimed to go beyond an individualised, psychocentric perspective through using the social determinants of health and an ecological understanding of suicide. The theoretical framework for this research is informed by humanistic and community psychologies, narrative and phenomenology. The study involved an interpretative phenomenological analysis of six autobiographies written by authors who had survived a previous suicide attempt. First, thorough notes were taken through three readings of each book to supplement the interpretative phenomenological analysis approach of the six autobiographical works. The second part of analysis used Bronfenbrenner's ecological theory to extend the themes that were gathered from the interpretative phenomenological analysis and connect them to broader societal structures and social inequalities. The analysis is spread across three chapters. Chapter four discusses Brian's rationality for suicide. His understanding of suicide challenges the mainstream understandings of suicide, which attribute suicide to being an act of irrationality and madness. Chapter five takes a look across all of authors' accounts to see how societal inequalities and neoliberalism are intertwined with the complex and long process that can lead a person towards attempting suicide. Chapter six further discusses the authors' accounts in relation to how social inequalities and social hierarchies foster violence and suicide. Chapter seven closes the thesis with a discussion of the analysis

and how a theoretical framework from community psychology provides an understanding of suicide from a broader viewpoint. The discussion considers possible ways of reconceptualising suicide and advocates for an upstream approach to suicide prevention.

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Chapter One: Introduction

Suicide is a deep moral concern in Aotearoa, New Zealand. The act of suicide is best understood as a complex phenomenon occurring within multiple dimensions of biological, psychological, philosophical, moral, sociocultural, historical, anthropological and economic factors (Button, 2016; Button & Marsh, 2019; Marsh, 2010, 2013, 2020; Minayo et al., 2006; Samaritans, 2017; White et al., 2015; White, 2012; White & Kral, 2014). A suicide represents an avoidable and tragic loss of life and potential. The loss of a loved one to suicide can encompass feelings of shock, sadness, blame, guilt, or helplessness, and can be one of the more difficult and shocking forms of grief to cope with (Conway, 2014; Ministry of Health, 2019a, 2019b; Button, 2016). For the person that took their own life, the deeply painful emotions and distress they felt burdened with, is passed on to those that loved them and cared for them deeply, such as their parents, peers, and surrounding community (Associate Minister of Health, 2006; Conway, 2014; Gluckman, 2017;).

Though suicide is a multidimensional issue, best understood with a comprehensive approach, in Aotearoa suicide is predominantly treated from an Anglocentric perspective. From this perspective, suicide is conceptualised as an individualistic issue which means favouring the biological, medical, and psychological dimensions of suicide (Marsh, 2010, 2013, 2020). From an individualistic viewpoint, suicide can be conceptualised as an intense personal struggle that can lead to a motivation to relieve unbearable distress, psychological pain, deep despair, hopelessness, and purposelessness (Beck et al., 2006; Joiner, 2007; Shneidman, 1998). This mainstream understanding of suicide perpetuates the (re)production of knowledge focused on risk factors and the medicalisation of personal human struggles (Marsh, 2020; Shneidman, 1998).

While framing suicide from this individualistic viewpoint can be useful in understanding what a person may be going through when they struggle with suicidal behaviours, it is only one piece of the complex and puzzling problem of suicide. Suicide as framed by solely an Anglocentric understanding diminishes the complexity of suicide. Unfortunately, this viewpoint also lays the foundation for suicide prevention at the individual level. This means that there is little to no emphasis on addressing harsh social conditions or exploring the lived experiences that may have led to the creation of the personal feelings of hopelessness, despair, purposelessness, and the unbearable distress without stigmatising that person (Button, 2016; Button & Marsh, 2019; White, & Kral, 2014).

Brief History of Suicide

Historically, suicide has been conceptualised in different ways across time, space and culture, as a moral concern, existential crisis, self-murder, crime, sin, or a consequence of mental illness (Marsh, 2013, Noon, 1978). The word 'suicide' only started to be more widely utilised in the early 17th century and was recognised by English dictionaries in the middle 18th century (Noon, 1978). Previous to that recognition, the understanding of suicide was equated to words such as self-murder or self-destruction (Noon, 1978).

While historical understandings of suicide as an act of self-murder or crime still prevail in our society today, the dominant understanding that is promoted to the public in Aotearoa and in other similar Anglocentric contexts is the attribution that suicide is a consequence of mental illness (Hjelmeland & Knizek, 2017; Marsh, 2010, 2013, 2020; Pridmore, 2015). In contrast to this, Eastern societies, such as those from India, China, or Middle East, have various different explanations and understandings of suicide. This includes being an honoured act in a war, a suicidal mission, a sacrificial suicide, or even an act of protest through self-immolation (Shneidman, 1998). This research will be orientated towards critiquing the dominant

Anglocentric understandings, where suicide is commonly understood as a consequence of mental illness (Hjelmeland & Knizek, 2017; Pridmore, 2015).

Psychocentric Framing of Suicide

The framing of suicide through only a medical or psychological viewpoint is captured through the concept of psychocentrism (Marsh, 2020). Rimke (2000, 2003, 2010, 2016) conceptualises psychocentrism as a way of framing human problems at the individual level, as a human deficit. This framing suggests that any suffering, pain, or other emotional/mental distress that a person is experiencing, is entirely attributed to being a fault of the person's mind or body (Dej, 2016). Such an approach to understanding human problems may help individuals address some of their own personal problems (e.g. through psychotherapy or counselling), but unfortunately "defining problems at the individual level serves to blame the victims, even if this is not intended" (Murray et al., 2004, p. 328). The victims in this case being those who died by suicide (Marsh, 2020). By placing the focus of human problems at the individual level, psychocentrism disrupts the linking of mental and emotional distress to the commonly occurring societal problems that many people face today. These problems include sexism, racism, bullying, employment loss, precarious jobs, cold/damp housing, unaffordable housing, violence, poverty, homelessness, crime, exploitation, and social inequalities to name a few.

Throughout the suicidology academic literature the issue of suicide has been mainly framed through this psychocentric lens and with an individualistic understanding of suicide. The focus on the individualisation of suicide has started to shift recently, but is not yet at a point of influential change (Marsh, 2020). The continued failure to link suicide to the socio-political context in which the phenomenon arises is unwittingly a social injustice. In the academic literature, suicide is frequently treated as a de-politicised and a-historical issue, which means any preventative response will remain at the individual level of intervention while collective or political responses are neglected (Button & Marsh, 2019; Marsh, 2020).

Individualistic Framing of Suicide

The psychocentric understandings that dominate the understandings of health as an individual issue and choice, has influenced the way suicide is viewed, intervened, and prevented (Marsh, 2010, 2013, 2020; White, 2017). Consequently, interventions are focused on individual maintenance, restriction, diagnosis, risk analysis and teaching the afflicted individual to manage and cope with their symptoms. Further, interventions and prevention strategies focus mainly on identifying individualistic risk factors to determine who is at high risk and who is not in order to target specific individuals (Marsh, 2010; White, 2017). Commonly cited risk factors are: suicide ideation, suicidal planning, previous suicide attempt, relationship breakup, feelings of hopelessness, purposelessness and burdensomeness, a mental illness (e.g. depression, bipolar, anxiety, schizophrenia), traumatic experiences (such as physical, sexual or emotional abuse), social isolation, familial conflict, family history of suicide, unemployment, and a lower socioeconomic status (Brown et al., 2000; Caldwell & Gottesman, 1990; Castellví et al., 2017; Chan et al., 2014; Franklin et al., 2017; Gili et al., 2019; Gvion & Levi-Belz, 2018; Hawton et al., 2013; Klonsky & May, 2015; Latalova et al., 2014; O'Connor & Kirtley, 2018; Phillips et al., 2002; Van Orden et al., 2010; Yates et al., 2019). Franklin and colleagues (2017) conducted a meta-analysis by collating the past 50 years of academic research on risk factors and found that while there is value in these risk factors, many are weak or inaccurate predictors of suicidal behaviour. Franklin and colleagues (2017) continue by suggesting that when researching the factors that can predict suicide risk, there is a need to combine them in a complex way, rather than focusing on single risk factors in isolation.

Despite the limitation of risk factors, they are still used extensively to model suicidality. Once a model is generated it serves as an authoritative unquestioned 'evidence base' for initiatives and policies. Aside from Māori and Pasifika models, most suicide prevention models used in Aotearoa are imported from the US instead of being locally generated. There are three

main models outlined in the academic literature: the interpersonal theory (Van Orden, et al., 2010), the three-step theory (Klonsky & May, 2015), and the integrated motivational-volitional model (O'Connor & Kirtley, 2018), with each model getting more complex by building off one another. These and other models have been tested to some extent and contribute to understanding some part of suicidality. Nonetheless, these models do not encompass the full complexity of suicide as the models are essentially reducing suicide to a variable. This reductionism is a key component of psychocentrism (Rimke, 2016). The psychological models of suicide reflect a preoccupation with predicting the end of life behaviour when someone is experiencing suicidal thoughts (Barzilay & Apter, 2014). There is less focus on, or concern about, the suffering that can drive a person to the point where they no longer want to live. Barzilay and Apter (2014) reviewed the current psychological models of suicide and suggested that “broader and more in-depth approaches are still needed to further our understanding of suicidal phenomena” (p. 295). Suicide is complex, as such it is hard to reduce this phenomenon down to one model or to predict an outcome. Despite a proliferation of research on suicide risk factors, the “ability to predict suicide is no better now than it was 50 years ago” (O'Connor & Kirtley, 2018, p. 1).

While preventative efforts are important and sometimes can help a person in distress, most suicide interventions are centred on an “assumption of pathology in those who wish, or attempt to end their own lives” (Marsh, 2010, p. 29). The suicidal individual is also pathologized through the label of suicidal behaviour disorder within the DSM-V, the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). The assumption of pathology in the individual unwittingly further individualises and constrains the issue of suicide within the biological, medical, and psychological domains of intervention. Furthermore, this pathologizing also blocks out and neglects other possible reasons why someone may take their own life and perpetuates the practice of victim blaming

(Murray et al., 2004); in that the blame is placed on the suicidal person and ultimately, the individual has to change rather than the society they live in (Button, 2016; Button & Marsh, 2019; White, & Kral, 2014; White et al., 2015; White, 2017).

Psychocentrism and Neoliberalism

Underneath the umbrella of psychocentrism lies a long history of biological determinism, reductionism (Dej, 2016; Rimke, 2016;), and the political rise of neoliberalism during the 1970s and 1980s (Howard et al., 2013; Stuckler & Basu 2013). Neoliberalism developed within a western cultural framework and refers to values such as individualism, privatisation, free-choice, self-responsibility, independence, productivity, autonomy, and a highly competitive environment. Proponents of neoliberalism argue that the market was too large and complex for the government to manage, hence it would be best for the market to regulate ‘itself’ through individuals themselves acting in their own rational interests (Labonte & Stuckler, 2016; Standing, 2012). Simply put, neoliberalism is a political and economic orientation that includes a systematic set of policies governing a ‘free-market’ and capitalist economy through privatisation and individualisation of economic resources (Rimke, 2010, 2016). A central assumption is that, within this type of economic market, the profits made at the top of the hierarchy eventually trickle down to benefit those at the bottom. Unfortunately, this theorised trickle down effect has been challenged (Piketty, 2014). The gaps between the rich and poor have continued to grow and worsen in contexts where neoliberal political leadership and policies have dominated (Labonte & Stuckler, 2016; Wilkinson & Pickett, 2010, 2017).

Alongside the rise of neoliberalism came the development of the neoliberal-self. Accordingly, people experiencing mental and emotional distress are held personally responsible for their health (Dej, 2016; Marsh, 2020; Rimke, 2000, 2003, 2010, 2016). For example, Rimke (2000) discusses how “self-help is an activity presumed to be voluntary and individualistic. Based upon notions such as choice, autonomy and freedom, self-help relies

upon the principle of individuality and entails self-modification and ‘improvement’” (p. 62). These self-help activities are regulated by a neoliberal framework, such that the development of the social self is dependent on ‘expert’ truths that are promoted widely in a society. These ‘expert’ truths are merged within a neoliberal and psychocentric knowledge base, such that health becomes the sole responsibility of the individual. Self-help books such as Stephen Covey’s *7 Habits of Highly Effective People* reinforce the regulation of the self and individual responsibility (Rimke, 2000). The notions of neoliberalism and psychocentrism reduce health to personal responsibility and self-blame, and therefore these notions play a central part in individualising the significant health concern of suicide.

A Neoliberal Landscape within an Unequal Society

The rise of neoliberalism (Labonte & Stuckler, 2016) is attributed to the increasing wealth gaps and the worsening of social inequalities (Douglas, 2016; Marmot, 2005; Samaritans, 2017; Wilkinson & Pickett, 2017). Health outcomes associated with neoliberalism and increasing inequalities include higher rates of mental illness, obesity and immunodeficiency, with shorter life spans overall, and higher mortality rates (Wilkinson & Pickett, 2017). While some people may argue that the ‘public’ structural economic market formed through neoliberal policies is quite separate from the ‘personal and ‘private’ lives of people; the two are intrinsically linked (Mills, 1959). People’s personal and private lives are commodified. The health of a person is “commodified, depoliticized and individualized, modern subjects are treated and viewed as either successful or failed consumers of mental and emotional health” (Rimke, 2016, p. 6).

Wilkinson and Pickett (2010) argue in their book, *The Spirit Level*, that there are more social ills in more unequal societies (in terms of income and wealth inequality). These social problems include greater prevalence of violence, crime, homicide, drug and alcohol abuse, obesity, teenage pregnancy, and imprisonment. Overall, there are worse outcomes for mental health, physical health, and child wellbeing, and there is decreased social cohesion, social

mobility, trust, social capital, and solidarity between members in society. Wilkinson and Pickett (2010) suggest that one of the reasons for the increase in these social problems is an increase in status anxiety. As inequalities increase, the differences in class and status increase. So, people tend to become more worried about their social status. The maintenance of their status position or gaining a higher status becomes more essential in everyday life. In *The Spirit Level*, Wilkinson and Pickett (2010) suggest that this status anxiety increases the aggression between members of society and decreases their trust, leading to the observation of the previously mentioned social problems and the worse health outcomes overall for the population.

In a more unequal society, there is an increased presence of shame (Wilkinson & Pickett, 2010). Wilkinson and Pickett (2010) suggest that shame occurs more often because there is more for a person to socially compare and evaluate themselves to in a society where status and class differences have widened, creating status anxiety. Shame is a powerful social emotion that a person experiences when reflecting and evaluating situational processes that are a threat to their social bonds due to one or more of their own personal actions (Wilkinson & Pickett, 2010). Threats to their social bonds include social exclusion from a group, humiliation, loss of respect or status in a group (Peacock et al., 2014). Shame accompanies a range of emotions, especially in the face of humiliation and a threat to their social bonds. Wilkinson and Pickett (2010) suggest these emotions range from “feeling foolish, stupid, ridiculous, inadequate, defective, incompetent, awkward, exposed, vulnerable and insecure” (p. 41). A context of shame and inequality is important for understanding suicide from a broader perspective given that the connection of shame and suicide is already well established (Bryant & Garnham, 2015; Chandler, 2019; Fullagar, 2003).

The Class Divide

The concept of social class demonstrates how people's lives are deeply embedded in their social, cultural, economic, and political setting. Although social class is a contested and complex concept, the common perception of social class refers to the cultural and economic distinctions which separate particular groups in a society (Bourdieu, 1987; Hodgetts & Griffin, 2015). For example, Karl Marx (1895/1962) focused on two particular groups, the proletariat (working class) and the bourgeoisie (owners). His motives for theorising these groups were to bring light to the oppression of the working class by the owners and the differences in power relations, employment access, and opportunities in life. Standing (2012) further distinguishes social classes by the elite (highly wealthy people), salariat (well-paid with good income security), proficians (high income insecure work), working class (stable full-time jobs), the precariat (insecure, unsustainable, and precarious work), and the denizens (limited rights and work opportunity). Hodgetts and Griffin (2015) offer a useful approach to the concept of social class as a "dynamic set of psycho-social and spatial relations based around power and the operation of economic, political, cultural, ideological, and psychic relations of domination and subordination" (p. 15). Social class is not just about the income earned but the opportunities, power, and material resources that are afforded by being situated within a particular social class (Bourdieu, 1987; Hodgetts & Griffin, 2015).

The concept of social class is incomplete without an understanding of the social theory of habitus. Habitus refers to a person's set of habits and ways of being that they have accumulated through personal interactions with other people and their social world. Habitus includes the accumulation, embodiment and enactment of group traditions, past memories, personal history and social identities which are place-bound to specific historical moments, materials and relational structures in society (Bourdieu & Passeron, 1977; Bourdieu, 1996). Hodgetts and Griffin (2015) elaborate that habitus is useful for understanding social class

because “the social space of a class of people and their associated habitus, therefore, becomes embodied and intertwined with their everyday lives, practices, and experiences” (p. 13).

Hence, the distinction between groups matters more in unequal societies and can become markers of perceived failure or success. The mannerisms, skills, habits, fashions and practices of affluent groups suggest to the wider public a depiction of what a successful life may look like. However, these affluent lifestyles can be rather impossible to emulate for poorer people. A sense of failure and shame is linked to this unattainability of these class styles or perceived markers of success in life (Chandler, 2019; Peacock et al., 2014; Wilkinson & Pickett, 2010).

The Precariat

Increasing inequality in income and wealth has led to a new social class grouping, the precariat (Hodgetts et al., 2016; Labonte, & Stuckler, 2016; Standing, 2012). A key feature of the precariat class is that they tend to work in more precarious job settings that are more flexible, insecure, and most often do not provide enough to live off. The precariat class typically includes youth, women of all ages, senior citizens, welfare claimants, criminalised people, and migrants (Standing, 2012). The precariousness of the jobs means these people have to juggle multiple part-time or casual jobs (Labonte, & Stuckler, 2016; Standing 2012). This juggling of multiple jobs means there is less time and opportunity to participate in civic and cultural activities, such as their friendships, churches, clubs, and sports. With fewer opportunities present to the precariat, they inevitably are left with inhibited social mobility and community participation.

The socioeconomic disadvantage the precariat class experiences can leave people feeling like a personal failure, unworthy and a burden in relation to other societal members (Bryant & Garnham, 2015). The lack of opportunities and being tied up to multiple jobs can leave someone feeling like they cannot meaningfully participate in society. This leaves people

with feelings of shame, unworthiness, burdensomeness, loneliness, worthlessness, and hopelessness (Samaritans, 2017). Ultimately, leaving some people feeling like they have no other choice but to take their own life. Suicide may be considered as an act of self-agency to take control in their life where they feel they no longer have control or options in life (Jaworski & Broz, 2013).

Conceptualising a Broader Framework for Suicide

To destabilise the individualised conceptualisation of suicide I will draw on accounts of psychocentrism, neoliberalism, societal inequalities, class division and precarity to gain a broader perspective of suicide. In the next section, I explain the social theories of social injustices, social determinants of health and Indigenous views on suicide. These theories are used to supplement and broaden the discussion of suicide as occurring within a society of harsh social conditions and social injustices that leave a person feeling they have no other choice or way out.

Social Justice Approach

A social justice approach to suicide moves beyond the psychocentric and medicalised understandings of suicide. The current political and economic system advantages few people and disadvantages many (Coombes et al., 2016). The relationship between suicide and the numerous forms of social disadvantage, social exclusion, and marginalisation has been well theorised (Button, 2016; Button & Marsh, 2019; Hochhauser et al., 2020; White & Kral, 2014). The social justice point of view claims that socio-political forces are the dominant driver of these issues and inequalities present within our everyday life (Hochhauser et al., 2020). These socio-political forces range from: racism, sexism, classism, heteronormativity, colonisation, prejudice, discrimination, and the economic and political policies or practices that enable these forces.

A crucial aspect of the social justice approach is the focus on fairness and equity of socio-economic resources so that all people within a society can have a fair chance at life and the opportunity to flourish to their full potential (Coombes et al., 2016). Key parts of addressing social injustices include: collaboration with local stakeholders, creating equitable access to social, health, and economic resources, empowerment of individuals, and the redistribution of power, money and resources within society (Hochhauser et al., 2020).

Social Determinants of Health

Action towards addressing the social determinants of health has become a critical public health concern as communities have become more globalised and inequalities have increased across the globe (Raphael & Brassolotto, 2015). Addressing the social determinants of health not only requires local action by individuals, but a combined ecological effort across communities, sectors, agencies, and governments. The social determinants of health are often referred to as the social conditions and situational factors that affect a general population's health. The World Health Organisation defines the social determinants of health as “the conditions in which people are born, grow, live, work and age” (World Health Organisation [WHO], 2020, p. 1). Marmot (1999) defines the ten main social determinants of health as early life circumstances, stress, access to healthy and nutritious food, affordable transport, addiction to drugs and alcohol, social support, unemployment, work pressure, social exclusion, and the social health gradient. In more recent years, scholars have acknowledged that the prevalence of income and wealth inequality, living in impoverished conditions (Allen et al., 2014; WHO, 2020) and societal stigma around issues of health (Hatzembuehler et al., 2013) are also important determinants of a person's health. The concept of the social determinants of health aims to connect personal incidences and experiences of health and illness with broader structural issues and population health concerns.

Social Gradient of Health. The social gradient of health is the intersection and overlapping of multiple social conditions which may affect a person (Marmot, 1999). The more factors which affect a person, the worse their health. However, the social gradient of health is not just a personal issue, but a collective and societal issue where “societies with steeper social gradients and larger inequalities are less healthy overall than those with smaller disparities” (Hodgetts et al., 2016, p. 425). These health gradients are influenced by personal and national access to resources as well as the distribution of power and wealth at the local, communal and collective levels (Allen, et al., 2014; Marmot, 1999, 2005; Marmot et al., 2012).

Social Determinants of Health and Suicide. Social determinants have been well connected to the personal and collective health of a population (Marmot, 1999), but few studies have focused on connecting all the social determinants of health specifically to suicide. However, that said, there is research connecting suicide to the situational factors and social conditions that people experience. In different areas of the world, a rise in suicide rates has been associated with a rise in income inequalities (Inagaki, 2010; Machado et al., 2015; Samaritans, 2017), or a rise in national unemployment rates (Coope et al., 2015; dos Santos et al., 2016; Labonte & Stuckler, 2016; Milner et al., 2012; Stuckler & Basu, 2013). Countries that use austerity measures to cope with an economic recession or the falling of an economy tend to see a higher suicide rate than countries that use protective measures like reinvesting in their local economies (Branas et al., 2015; Mills, 2018; Stuckler & Basu, 2013).

People and communities experiencing socioeconomic disadvantage, living in impoverished conditions or deprivation are also associated with a higher risk of suicide (Iemmi et al., 2016; Kerr et al., 2017; Samaritans, 2017). According to WHO (2018), 79% of suicides occur outside of high-income countries and within low to mid-income countries where the inequalities of income/wealth affect many and where living within impoverished conditions is a common occurrence. Economic and political systems regulate disadvantages, living

conditions, and inequalities that are social conditions that sit in the background of each person's life (Hodgetts et al., 2016). These social conditions influence their experiences, chances to live a fair, meaningful life and are often part of the influence of someone coming to the point of suicidality.

Economic and political conditions regulate situational processes and the social environments in which people are born in and grow up. Adverse childhood experiences are social conditions that can be traumatic for a child as they are born and grow up to be an adult and can have various negative health outcomes later in life, including suicide (Dube et al., 2001; Greenfield, 2010). These experiences include stressful life events like parental separation, familial discord, neglectful parenting, household dysfunction or the emotional and traumatic experiences of violence, such as sexual abuse, molestation, bullying or physical abuse (Brent, 2019; Dube et al., 2001; King et al., 2018; Pompili et al., 2011).

Later in my analysis discussion I will draw further on the social phenomenon of violence. Violence occurs across the political, economic, institutional, and social domains of society (Rodriguez et al., 2014). Violence takes three main forms as either direct, structural, or symbolic. *Direct violence* is visible, directly heard, or physically felt through verbal or physical behaviour to directly harm another person or group. *Indirect violence* is invisibly interwoven into societal structures and everyday en-action of personal and structural habitus. Forms of indirect violence are structural and symbolic. *Structural violence* is rooted in structures and social groups which create social disadvantages. These social disadvantages marginalise certain groups people from having a fair chance at life and meeting their own basic needs. *Symbolic violence* is embodied in the attitudes, ideologies, habitus', cultures, and discourses which oppress and reinforce structures of hierarchy, dominance, power, status, and importance. The key point of these different forms of violence is not to view them as separate entities or as occurring separately from one another. The direct and indirect forms of violence are

intertwined and occur together. In particular, symbolic violence “serves to legitimate direct and structural violence and also to inhibit or repress any response by victims of this violence” (Rodriguez et al., 2014, p. 360).

Indigenous Views on Suicide

Aligning closely with an ecological model, Indigenous scholars commonly advocate for a whole of society approach to suicide prevention (Durie, 2017; Lawson-Te Aho, 2013; Lawson-Te Aho & Liu, 2010). A whole of society approach suggests that addressing psychological symptoms and immediate risk factors is not enough to prevent suicide. Instead, a whole of society approach recognises that the historical and ongoing effects of colonisation, loss of culture, intergenerational oppression and trauma have all contributed to the negative impact on the health of Indigenous communities. The effects of colonisation have led to the weakening social bonds in Indigenous communities, breaking of spiritual foundations and a loss of identity and belonging (Cameron et al., 2017; Lawson-Te Aho, 2013). It is well recognised that the suicide rate of many Indigenous communities is often higher than in the non-Indigenous Population (Clifford et al., 2013). In Aotearoa, the suicide rate of Māori is close to double the rate of non-Māori (Coronial Services of New Zealand, 2020). Due to the higher rates of suicide observed in Indigenous groups and the broader perspective advocated by Indigenous scholars, it is imperative to include an Indigenous perspective of health in this master’s thesis.

Health viewed from an Indigenous perspective ties a person’s health to their culture, history, spirituality, land and their interconnected nature to other people. A holistic, local model developed in Aotearoa is the Māori health model Te Whare Tapa Whā (Durie, 1985). This health model represents a house with four pillars holding up its rooftop. The first pillar focuses on Taha Wairua, which is your spiritual life-force, life-direction, purpose, and hope derived from personal experience, relational connections, and communal structures such as religion or faith in a higher power. The second pillar is Taha Hinengaro, which refers to your mental state,

consciousness, feelings, emotions and mental wellbeing. The third pillar is Taha Tinana, referring to your physical health as well as the material and environmental conditions which sustain or negatively impact health. Lastly, the fourth pillar is Taha Whānau, which refers to familial and social wellbeing. Taha Whānau links health to the present and ancestral connections we relate to, which provide love, warmth, support, and care. If one of the pillars of health is negatively impacted, then other pillars will start to crumble which leads to poorer health. Good health is dependent on each pillar being strengthened and holding up the rooftop. This model of health is important as it connects the health of a person to their community and environment. If the person's health is poor, then the community and environment around them will also suffer consequentially (Hodgetts et al., 2016).

Aotearoa Context

In Aotearoa, the provisional suicide rate is 13.01 per 100,000 individuals from the period of August 2019 to August 2020 (Coronial Services of New Zealand, 2020). The official suicide rate confirmed by the Ministry of Health for the year of 2016 is 11.30 per 100,000 individuals. This rate was the equivalent of the loss of 554 people during the period of August 2015 to August 2016 (Ministry of Health, 2020). Suicide, and the loss of a person to suicide, has been a relevant issue for Aotearoa over the past century (Weaver, 2009, 2014). In addition to devastating personal loss, there have been significant economic costs associated with suicide deaths each year in Aotearoa. In 2004, the impact of suicide in Aotearoa cost the government around 1.6 billion dollars, when accounting for not just individual costs but costs to families, services involved, and the wider surrounding community (O'Dea & Tucker, 2005). When accounting for inflation, this number could be up to 2.2 billion dollars in the year of 2020, not accounting for the possible effect COVID-19 may have had (Calculator used: <https://www.rbnz.govt.nz/monetary-policy/inflation-calculator>).

There have been three suicide prevention strategies to address the issue of suicide in Aotearoa. These strategies have been comprehensively informed by the current psychological literature on risk factors and possible preventive approaches, so the strategies are similarly framed through a psychocentric and individualised framework. The first strategy, created in 1998, was focused solely on preventing suicide of youth and rangatahi Māori, reflecting an awareness of the high youth suicide rate (Ministry of Youth Affairs, Ministry of Health, & Te Puni Kokiri, 1998; Weaver, 2014). Unicef (2017) suggests that out of 36 OECD countries, youth in Aotearoa have one of the highest suicide rates. Māori also have double the rate of the national average (Coronial Services of New Zealand, 2020). The next published strategy was published in 2005, for the period of 2006-2016 (Associate Minister of Health, 2006). This 2006-2016 strategy was much broader and accounted for the possible effects of broader social conditions that can affect a person's health, including personal income, education, their employment status and housing situation. The 2006-2016 strategy also suggested that "New Zealand's suicide rates reflect patterns of inequalities in the broader determinants of health, such as socioeconomic status, ethnicity, gender, age and the geographical region" (p. 6), focusing suicide prevention at the broader, societal level. The 2006-2016 strategy started to account for different pieces of the puzzle (other than just psychological/medical approaches) and created a multisectoral approach for practitioners, services, and communities to use in Aotearoa.

The current 2019-2029 strategy, which was developed between 2016-2019 through public and private consultation (Ministry of Health, 2019a) was published in 2019. The current strategy covers many areas, and it includes an overview of suicide prevention that vaguely mentions that a whole of society approach is needed but does not illustrate how to accomplish such an approach. This omission suggests that the new strategy is still trapped within a psychocentric understanding of suicide that focuses on intervening, maintaining, restricting,

diagnosing and the managing of the suicidal individual (Button, 2016; Marsh & Button, 2019; Marsh, 2010, 2013, 2020; White, 2012). Though individually orientated prevention and mental health focused intervention efforts are essential, they neglect to change the environments and situations that erode mental health (Allen et al., 2014) and can push people to consider suicide as their only option to relieve their distress.

Global Context

The Aotearoa official suicide rate of 11.3 per 100,000 in 2016 is higher than the global average of 10.50 per 100,000 in 2016 (World Health Organisation, 2017). Globally, the issue of suicide is a significant concern with the World Health Organisation (2017) citing that over 793,000 people were formally classified as having died by suicide in 2016. Attempted suicide rates and suicidal ideation rates are much higher still. Franklin and colleagues (2017) estimated that globally over 25 million people attempt and 140 million think about taking their life each year. These global statistics do not account for the suicides which are counted as accidents or covered up because of the familial shame. Nor do such statistics account for the people who feel stigmatised and do not talk about their suicidal thoughts or personal struggles.

Research Justification and Direction

This research seeks to gain a broader understanding of the lived experiences of suicide survivors. The voices of suicide victims are not strongly featured in academic literature. Reasons for this include the taboo nature of the topic of suicide, the widespread fear that discussing suicide more openly increases risk, and the sad fact that many suicide attempts end in death. Much of the focus of the academic literature on suicide is on the quantitative exploration of risk factors. Risk factors can be an important part of understanding suicidal risk, making informed decisions on suicidal behaviour, and understanding how some populations may be at more risk than others. However, suicidal behaviour still remains relatively unpredictable. Carter and colleagues (2017) reviewed studies of psychology scales used to

measure suicidality from the period of 1966 to 2014 and found that the classification of high-risk (multiple risk factors present) was not useful in a clinical setting. The study of risk factors and predicting of suicidal behaviour has been going on since the time of Durkheim's (1968 [1897]) academic contributions to suicidology, however prediction of suicide remains an elusive goal that we are still unable to successfully obtain. Pokorny (1983) found that in a sample of 4800 patients, 803 (17%) were classified as high risk (as they had multiple risk factors), but the majority of the high-risk patients (96.3%) did not go on to complete suicide. One would expect psychological instruments orientated around predicting a certain phenomenon to better predict the outcome but in most cases they do not (Carter et al., 2017; Chan et al., 2016; Large et al., 2017; Nielssen et al., 2017).

Instead of focusing on the risk factors there is a need for a more humanistic approach that seeks to understand suicide. Human life is not linear, it is complex and dynamic. To truly understand suicide, we need to consider the complexity of suicide and life (Bland & DeRobertis, 2020). Much of the quantitative research on suicide is repetitive and formulaic. Qualitative research is needed alongside quantitative research to reveal the complex and dynamic realities of human nature that contribute to suicide. Hjelmeland (2016) argues that:

We now have thousands of risk factor studies, yet we still understand very little about when, where, how (if at all), and for whom the found risk factors are related to suicide and why it is that the vast majority displaying one or more of them do not kill themselves. To improve our understanding of this we need qualitative research (p. 32).

In this thesis, a qualitative approach will be used, focusing on the personal and biographical life narratives in an effort to validate the knowledge and experiences from those who are closest to the issue of suicide. These unique experiences will be drawn on to reflect on the main themes and concepts in academic literature on suicide and to create space for the

inclusion of an ‘insider’ or ‘emic’ perspective of suicide (Barnes, 2006; Conway, 2014; Tzeng et al., 2010).

Chapter Two: Methodology

Personal Statement

In the first section of this chapter, I will start out with a section of introducing myself as the researcher and how I came to this topic. Later in this chapter, I describe the use of reflective journaling as a strategy that I use throughout the research to record thoughts, feelings, struggles and possible assumptions I might have.

An essential part of qualitative research is the engagement in self-reflexivity. Reflexivity is the act of reflecting on your own positioning in society in terms of your values, beliefs, and your personal amalgamation of experiences in order to see how these may affect the ongoing process or outcome of the research (Lazard & McAvoy, 2020). The researcher essentially ‘carries’ their own conceptions of the world, which can contribute to how the research process is carried out. Engaging in reflexivity helps to highlight one’s partial view. Our personal worldview will affect the way we interpret data and qualitative information from the participant(s). This reflexivity is especially important in the process of interpretative qualitative research where the inclusion of the participant’s perspective is vital in the research outcome. Therefore, engaging in the act of reflexivity is an important part of the research of becoming more self-aware of personal assumptions and helping the researcher adjust the research as necessary.

This research topic is personal to me. I know people who have had suicidal thoughts, planned their suicide attempt, attempted suicide, and people who I have known personally that have taken their own life. I have also personally questioned the meaning and purpose of life. For 10 years of my life, I searched for meaning through a Judeo-Christian church, the Salvation Army. For some time, this provided some answers to the need of whether life is worth living

and what life is meant to be lived for. In 2018, I left the church and the Christian tradition to sit within an agnostic perspective. The position I hold now is one where I believe that there are many possible explanations to life's worth and many different routes to finding meaning, purpose and hope in life.

My initial interest in the topic of suicide arose from working as a volunteer youth worker for six years. This youth work involved working as a leader, running bible study groups, and sometimes conversing with youth struggling with personal distress and finding their purpose in life. In 2017, I started orientating my assignments in my psychology degree towards research about suicide. My first assignment was a literature review on child suicide.

Suicide as a topic has not been easy to research in the discipline of psychology, where at times it can be more depressing than it is hopeful. Nonetheless, I sought to increase my knowledge of the topic of suicide. In 2018, I enrolled in my first community psychology class which completely shifted my understanding of the topic. This course taught me about the interconnected nature of a person, and how their experiences and their development of the self is intertwined to within their sociocultural surroundings. This new knowledge led me to develop the understanding that suicide is not just an individual act, but a phenomenon that is connected to societal conditions as explained in the introduction. I came to an understanding of how hard it was to research such a perspective, given that much of the academic literature is focused on identifying risk factors and creating interventions based on these factors (Marsh, 2010, 2013, 2020). In 2019, I continued my community psychology papers and utilised further assignments to research Indigenous suicide and a social determinants of health perspective.

Theoretical Framework

In the following sections I outline the theoretical, ontological, and epistemological perspectives underpinning this master's thesis.

Humanistic Theory

A humanistic perspective on suicide is important for this master's thesis. Humanistic psychology offers a perspective that is less reductionist of people than other psychological approaches (Bland & DeRobertis, 2020). Instead, humanistic psychology offers a more holistic view of the self and human phenomena that is contextually located and not necessarily fixed to one, normative explanation or categorisation. The human self is seen as constantly in flux, moving, developing, evolving, and transcending into higher consciousness rather than just fixed into one state. This conception of the human self is situated in its own unique sociocultural context and acknowledges that people within their own context have aspirations, goals, values, and choices. People viewed from this perspective are consciously aware of who they are and who they are becoming. Humanistic psychology holds this view of the self as derived from a gestalt perspective in that it views the person as a whole, in a holistic way, rather than just their parts and components. Taking a humanistic perspective for suicide would allow us to see life as complex, beautiful, messy, chaotic, spontaneous, ordered and mysterious (Bland & DeRobertis, 2020). This view of the human self is important for understanding suicide as a complex phenomenon that cannot be reduced down to its risk factors.

Narrative Theory

Narrative research focuses on people's stories. The stories people tell are intertwined with their personal experience and the wider social world. Stories are neither just a representation of their social self or purely the social world around them as the social self cannot be fully separated from their sociocultural context. The content of the story is told in a way that illustrates how the social self is situated in a social world, different places, events, situations, and objects (Hodgetts et al., 2010). The social self is often illustrated through stories as dynamic, temporal, and unfolding over time. (Bland & DeRobertis, 2020; Polkinghorne, 1991). Stories can be

either told to ourselves privately as a reflection on life events or narrated publicly to friends, family, and strangers.

Stories are configured through temporal configuration (Polkinghorne, 1991, 1995). In temporal configuration, stories may include collections of the past, present ongoing situations, or extend into future interests, aspirations or plans. This configuration suggests that our conception and understanding of our social self is conceived not only in the present but in reflection of the past and the retention of future possibilities. In many ways, the social self is in a constant state of becoming and continually evolving into something new. This social self develops as our story and the story of the collective (such as sociocultural narratives) intertwines and collectively changes over time.

Polkinghorne (2007) describes stories as “ubiquitous, appearing as historical accounts, as fictional novels, as fairy tales, as autobiographies, and other genres” (p. 471). Later, I will describe how I will be using autobiographies and memoirs for my analysis on suicide. The focus on stories of those who have survived a suicide attempt is important given that mainstream understandings tend to fixate on individualised risk factors and produce a narrow picture of suicide. By attending to the stories illustrated in autobiographical material we can see aspects of the social self emerge and the “sociocultural context because an individual’s story is shaped by the dominant narrative/s within their culture” (Carless & Douglas, 2017, p. 307). A person will draw on these narratives and sociocultural understandings to make sense of their social world (Carless & Douglas, 2017; Murray, 2017). By drawing on Narrative philosophies of stories and the social self, it will help further our understanding of suicide as a complex phenomenon.

Phenomenology Theory

This master’s thesis is closely aligned with the philosophy of phenomenology in order to gain more insight into the lived, first-person experiences of those who have survived a suicide

attempt (Pietkiewicz & Smith, 2014; Schmidt, 2005). Phenomenology is important for its focus on a person's lived experience. By diving deeper into a person's worldview, narratives, stories, and other experiences, we can gain a broader understanding of their lifeworld. A lifeworld is the context that makes up the accumulated personal experiences, acts, beliefs, and relationships that make up the social world of a person (Landridge, 2008, 2017).

To explore a person's lifeworld, there are two different philosophy traditions within phenomenology, Husserl (descriptive) and Heidegger (interpretative) (Landridge, 2008, 2017; Murray, 2017). This master's thesis will be closely aligned with the Heidegger tradition. This tradition takes a reflective stance on one's personal worldview in which research becomes co-constructive. The co-constructive process is where the researcher's personal but informed knowledge on a topic becomes intertwined with the interpretation of the participants' lived experience (Pietkiewicz & Smith, 2014). Co-constructing the analysis of the autobiographical material will be essential in moving beyond descriptive analyses and an individualised focus on suicide.

Ecological Theory

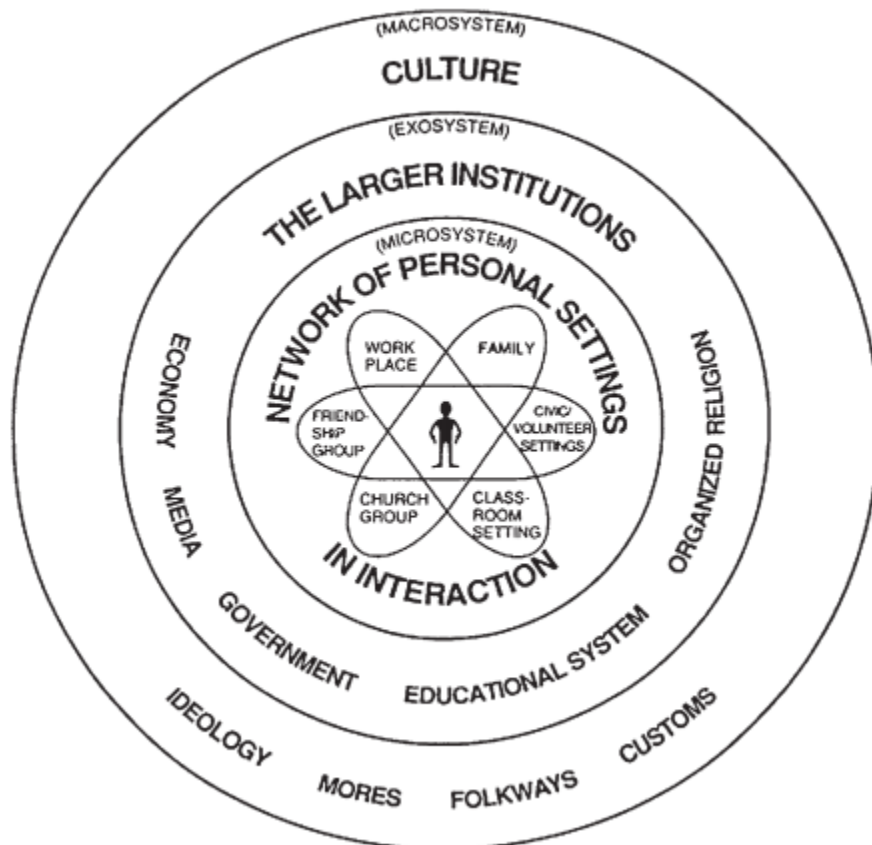
Central to this master's thesis is the ecological model's approach to understanding human nature. The act of suicide has been commonly understood through an apolitical and ahistorical lens that seeks to use individual risk factors as a way of predicting the behaviour of suicide, regardless of the context in which they arise in (Marsh, 2010, 2013, 2020). In contrast, an ecological understanding of suicide seeks to account for the economic, political, environmental, cultural and historical contexts.

An ecological perspective has its theoretical roots in Bronfenbrenner's (1996) ecological systems theory. Bronfenbrenner (1996) proposed that a person lives in different of levels of societal and cultural systems, namely the micro-level (individuals and their relationships), meso-level (interconnections between family members, work colleagues,

friends, and acquaintances), exo-level (societal settings including schools, neighbourhood, local businesses and communities), and macro-levels (societal structures such as healthcare

Figure 1.

Bronfenbrenner's ecological systems theory



Note. This figure demonstrates the interconnections between different system levels in society and how they influence the individual. Reprinted from *Handbook of research on adult learning and development* (p. 82), by C. Hoare, 2008, Routledge. Copyright 2008 by Carol Hoare.

systems, policy, laws, and systemic issues). By considering these different levels we can see the person in their fuller context and how their interactions with each level affect them.

This model shows how a person is influenced by their direct interactions with familial, platonic, romantic, and work relationships. A conflict in one of these relationships may affect the health of the person or affect other relationship areas (such as a conflict arising in work which affects the family). These relationships are also affected by the wider sociocultural

systems around them such as policies supporting different healthcare areas or policies and laws affecting the distribution of resources, money and wealth in society (Bronfenbrenner, 1996).

The ecological model allows for a deeper understanding of the reasons why individuals commit suicide. It shows that the individualistic approach to suicide is not appropriate when the individual is directly influenced by their wider context. The ecological model demonstrates that it is the interactions between the micro, meso, exo, and macro-levels that contribute to the process of suicide, and not simply individual and psychocentric risk factors.

Ontological Perspective: Relativism and Realism

This thesis acknowledges the usefulness of both the relativist and naïve realist approaches for how people understand the world around them, rather than debates which one is right or correct.

Relativism is the stance that there exists no single truth about the universe. It posits that for any given phenomena, event, or situation, there are multiple interpretations. Often what is considered the ‘right’ interpretation at a point in time is influenced by the politics and power given to it in that instance. By accepting that there is no true/correct interpretation of any given phenomenon, the relativist position can lead to new ideas and understandings of topics like suicide. Conversely, naïve realism is the stance that there exists a definitive truth about the world and there is an objective reality (Cupchik, 2001; Smith & Sparkes, 2006). This truth is based off our human senses and perceptions. The importance of integrating a naïve realist stance is to acknowledge that objectively real and material conditions exist in the world that push people to choose suicide as their only option.

Using both a relativistic and naïve realistic approach acknowledges that every individual has unique experiences and personal thoughts about the world around them while also acknowledging that an objectively real and material world does exist. Suicide is a complex phenomenon, approaching it from multiple schools of thought will allow for a broader framework to understand the different reasons people take their own life.

Epistemological Perspective: Social Constructionism

Social constructionism posits that knowledge and personal experience are created through reciprocal, social interactions with people (Burr, 2015; Edley, 2001; Nightingale & Cromby, 2002). It is through languages that people communicate their experiences of the world and give meaning to these experiences. How people use language is affected by their sociocultural context and unique experiences of the world. The interpreter also has their own unique experiences and knowledge which affects how they interpret and comprehend this language. Some social constructionists posit that people live within multiple social realities and therefore have multiple ways of understanding or interpreting phenomena in the world. Other social constructionists acknowledge that there is a material reality but can be experienced differently by people (Burr, 2015). The latter is more useful for understanding suicide because of its ecological focus in acknowledging the material reality which shapes, constrains, or maintains everyday human experiences.

Context for this Thesis and Methodology

The following section is a context to how this master's thesis was prepared and how the social context of COVID-19 affected the approach I took to researching suicide. The start date for this master's thesis was 2nd March 2020, and prior to this date I had already spent at least six months doing preparatory reading and planning. On 25th March 2020, the New Zealand government implemented a four-week Level 4 Lockdown in response to the COVID-19 pandemic. Starting a thesis during this time of national crisis created additional challenges, uncertainties and unforeseen circumstances. Given that I had already been preparing for the thesis research, I had already prepared an initial thesis proposal. This means I was able to promptly submit an ethics application on the 2nd of April 2020, which was during the lockdown period. The ethics application I prepared had two parts. The first contained the research plans I had initially prepared for the master's thesis. The sensitive topic for this thesis created safety

risks. In response, I proposed to do face-to-face repeat engagements with a small number of participants to foster the in-person building of trust and rapport. While I was working on my ethics application in early March, the COVID-19 situation became a more serious concern. As a result of this rapidly evolving situation, I added a second part to my ethics application based on the study of autobiographies of people who had survived a suicide attempt. At the time, it seemed prudent to add a second study, which I could pursue alongside (or even instead of) the proposed research based on face-to-face interviewing. On 25th May 2020, I gained ethical approval (HREC(Health)2020#29) for this research.

In the remaining half of the methods chapter, I first outline the research plans I developed relating to the face-to-face interviews with participants. I discuss my rationales for in-depth qualitative interviews with those who had previously attempted suicide, challenges of the research topic, and how I reduced the risks. I also discuss how the COVID-19 situation impacted on the initial research plans and that in-depth qualitative interviews with people who have survived a suicide attempt was no longer a viable option. This leads into the second section, where I outline and explain the research approach I adopted in response to the challenges of the COVID-19 pandemic. I establish that it was more appropriate to conduct an analysis of autobiographies as a secondary source of data for this study of suicide and the social determinants of health.

The aims of the research were to:

- Explore the life experiences and narratives of people who have previously attempted suicide in relation to the social determinants of health.
- Explore these persons' experiences of distress.
- Connect these persons' experiences of distress to their social environment and wider social processes.

- Explore how the social determinants of health contribute to shaping these persons' experiences of, and responses to, distress.

Research Plans for Face-to-Face Interviews

I used snowball technique to recruit participants. First, I engaged with close and personal social networks and asked whether they knew anyone who had previously attempted suicide. The built-up rapport with these networks helped in the process of identifying participants for whom the discussion of suicide would not pose a significant risk. Due to the nature of the topic, I did not recruit through reaching out via personal social media accounts such as Facebook, Instagram, Messenger, or email. Examples of who I reached out to snowball are people that I had known for four years or longer, in other words those who I can class as close friends or trusted colleagues. These are mature people a bit older than me in their late 30s or above. They have a wealth of life experience, and I had built a close rapport through studying with them over the past four years of my undergraduate psychology degree. I also reached out to people who were already close to me and may have been interested in being interviewed. In terms of the research participant(s), I wanted to recruit a person who had their suicide attempt(s) far enough in the past that they had processed the emotions and trauma that can be associated with such experiences and the life experiences that can occur beforehand. Hence, I was engaged in a personal and close recruitment method. A more impersonal or random recruitment method would not have been appropriate as it could have increased risk of harm. It was important that I could draw on people in my social networks who had a previous understanding, history, and relationship with the potential participants.

However, throughout June and July, I came to an understanding of the distress that COVID-19 had caused for potential participants and personal contacts. COVID-19 caused changes in the environmental and economic conditions in Aotearoa which in turn added additional stressors to their everyday life. Personally, it also became harder for me to get into

contact with some of my contacts during level four lockdown. Some contacts said they would talk to some people they identified as being possibilities, but that also did not go anywhere. It became evident that with the additional stress of COVID-19, that it might not be a good time to be doing interviews on the topic of suicide, at least with the personal recruitment method I had intended on using. It was important to me to not overuse built-up rapport that I already had with different contacts. By July after trying to engage with different contacts, it made sense to call off the second part of the research of doing a case study to instead focus efforts on analysing the autobiographical material.

Interview Focus. The interview focus was going to be open-ended with a semi-structured guide to openly talk about the life experiences leading up to their suicide attempt(s). The interviews would have involved up to four interviews, focused on building a life history of the experiences before the person attempted suicide (see Appendix A. For interview guides).

Visual research methods were also going to be utilised by asking participants to either bring a photo or object that reminds them of their past. These photos or objects could be from a moment in their childhood, an essential place in their life, or something else that is meaningful for them in telling their story. As the researcher I would have also brought something to contribute briefly in the interview as a way of helping build rapport with the participant. Building rapport would have been a crucial aspect of this research to create a safe space for the participant to share their stories on this sensitive topic. The use of these visual and narrative methods moves the interview away from just using traditional interview question and answer methods. Instead, the participant is given greater agency in the direction of the conversation. If required, an interview guide would have been available to help guide the interview and elicit conversation.

Involving people who have survived a suicide attempt is crucial for gaining an ‘insider’ perspective and in-depth account of their life experiences before their suicide attempt. This

‘insider’ perspective is also largely missing from the NZ literature. By giving participants a safe space to talk about their experiences, this space can help counteract the wide societal stigma about discussing suicide (Oexle et al., 2019). It is also vital to involve those with ‘lived experiences’ to gain a more in-depth understanding of suicide and contribute to further research knowledge on suicide. Such insights are hugely valuable to understand the ‘lived experience’ of people who live through such events, however this appears to be largely absent from the literature (Chandler, 2019).

Keeping Risk to a Minimum. To keep risk to an absolute minimum before the interviews, I planned to interview 1-2 people over 25 years of age through utilising my social networks. A smaller number of participants will ensure a good rapport and a safe environment is established for the participant to talk about their experiences. Through my social networks, I would have approached participants that elaborated that their suicide attempt was far enough in the past that they are able to speak about the attempt and have processed their distress that led to their attempt. I was not going to engage in interviewing any person who has recently attempted suicide or are identified as currently experiencing major psychological distress. A formal consent form and an information sheet was drafted for participants. The consent form asked whether they had a support person and if they would like their support person to join with them in the interviews (See Appendix B. For the information sheet and Appendix C. For consent form).

I planned to be responsive to each participant’s safety during the interview. If the participant was getting upset about a particular topic, I would have worked with the participant to address this appropriately. For example, I may have paused the interview, taken a short break, taken time as needed to reassure participants, provide tissues, make a cup of tea, or move the topic of conversation to a less upsetting topic. If it came to the stage of the interview that the participant did not wish to continue with the interview for the time being, I would have

been sensitive to the requests of the participant to stop the interview and look to reschedule for another time.

At the beginning of the project, I met with a counsellor, Dr Paul Flanagan, who has expertise in narrative therapy, counselling, ethics and working with children, young people, and families. In this meeting, I gained a good understanding of how best to conduct the research and interviews safely. These could include noticing changes in the participant's speaking manner (louder/softer), the pace of speaking changes, or possible behavioural changes (such as leg twitching). I would then inquire about these changes in a curious, non-judgemental, and empathetic manner. For example, I notice your... volume has raised? What is that about? This way, possible changes could be assessed in an empathetic and non-judgemental way during the interview, whether they are normal changes or signs of distress.

Research Approach: Analysis of Autobiographical Books

In March 2020, during the start of lockdown Level Three and moving into Level Four of the Aotearoa lockdown during COVID-19, I started the search for suitable autobiographical books and ways to analyse such material. An autobiography is a book a person writes about themselves, their life, and/or particular events in their life (such as an account of a suicide attempt) (Power et al., 2012). I chose not to include biographies as these are usually written by someone else and from an outsider perspective through the collection of notes, transcripts, journal entries and interviews with family members. The focus was to use personally written material created by the author who survived one or more suicide attempts. It became apparent during my searches that memoirs would also be useful to use. Memoirs are similar to autobiographies in which the author is writing about a personal historical account of some or multiple events in their life. The main search terms used through the web search engine google.com to find suitable autobiographies was: 'Suicide' 'Suicide attempt' 'suicide autobiography'. In addition to using these main search terms, I added other words to the main

terms to diversify the search: ‘mental illness’ ‘life story’ ‘memoir’ ‘Māori’ ‘Aboriginal’ ‘Indigenous’ ‘lived experience’ ‘case histories’. I identified some books through these searches and through web articles which reviewed books (See Appendix D. Of websites and articles I looked at). The last searches used were through Amazon, Kindle or books shops (Aotearoa Books, Whitcoulls, and Booktopia) using the previous search terms. Books from Aotearoa were initially prioritised, but I found there was a lack of autobiographical books with a suicide attempt, so I also looked for books outside of Aotearoa. These included other Anglocentric contexts such as Australia, UK, and USA.

Once I identified a potential book, I read the summary and synopsis of the book to determine whether the book would be suitable to use. If a preview was available, I would skim the contents page and the introduction. I looked for books that focused on narrating life stories, events, and situations that lead up to the suicide attempt. Ideally, the author gave some personal interpretation to help me understand their experiences from their perspective. It was important that the author explored their life experiences not just in the moments before their suicide attempt, but also in events throughout their life span before the suicide attempt. See Table 1 for books chosen for analysis.

Table 1. *Information About Authors and Autobiographical Texts*

Author	Gender	Country	Autobiographical Text
Jazz Thornton	F	New Zealand/Aotearoa	Thornton, J. (2020). <i>Stop surviving start fighting</i> . Auckland, New Zealand: Penguin Books.
Kevin Hines	M	USA	Hines, K. (2013). <i>Cracked, not broken: Surviving and thriving after a suicide attempt</i> . Kindle Edition. Amazon.com
Ben Schwipps	M	USA	Schwipps, B., & Merkel, S. (2015). <i>Live to tell: A suicide survivor's struggle with</i>

			<i>depression and anxiety.</i> Kindle Edition. Amazon.com
Craig A Miller	M	USA	Miller, C, A. (2012). <i>This is how it feels: A memoir - attempting suicide and finding life.</i> Kindle Edition. Amazon.com
Holly Younce Roberts	F	USA	Roberts, H, Y. (2018). <i>Suicide: The (unsuccessful) attempts to end my life.</i> Kindle Edition. Amazon.com
Brian A Oard	M	USA	Oard, B, A. (2020). <i>Suicide: A memoir.</i> Kindle Edition. Amazon.com

Analysis Outline

Analysis started with the first reading of each autobiographical book. The initial analysis was adapted through the use of a general guide for *Interpretative Phenomenological analysis* created by Pietkiewicz and Smith (2014). The guide was followed reflexively in a relaxed manner as Pietkiewicz and Smith (2014) suggested that the guide “should not be treated as a recipe and the researcher is advised to be flexible and creative in his or her thinking” (p. 11). This general guide follows a similar way of analysing material to thematic analysis. The analysis was also influenced by narrative analysis, an analysis which focuses on the stories and the narratives that are interweaved through the stories (Carless & Douglas, 2017). So, attention was given to how different stories in each book contributed to the overall narrative of attempting and surviving a suicide attempt.

To begin with, the analysis started with a full reading of the book without making notes to focus on getting immersed in the book and getting to know the author. This immersion process is important within phenomenological research to be able to understand and experience, as the researcher, what it might be like to live in the participant’s lifeworld. The objective of case-like studies and idiographic research is to learn as much detail about the participant as you can, this way we know what it might be like for this specific person to be living their particular life (Smith, 2004). In the second reading, I started taking notes or significant quotes down of each story that the author talked about in their autobiographical

book. By the third reading, I worked with my notes/quotes and made further exploratory comments or notes that summarised key events in each quote. I made sure while working with these notes to check back with the original material. Alongside these notes I would make exploratory notes of areas I might further question later. Once the first three readings had been done on one book, I moved on to the next book to start the next analysis.

This style of analysis worked for the eBooks in which I could easily make notes and save quotes in a private word document, but not with the one book which was paperback. So, for the first reading of the paperback, I read without taking notes. The second reading I used sticky notes to create notes throughout the book. On the third reading, I transferred these notes to a word document with their corresponding page numbers to use to analyse later.

In the next stage of analysis, I continued to work with the notes/quotes and books to go beyond just looking at individualistic framings of suicide and to gain the further understanding of the complexity of suicide. Each book was first analysed as an individual case. Cases were analysed through an ecological lens, where these personal accounts gave insight into societal practices or events. The ecological analysis meant stepping back from the analysis and using an ecological lens to understand how these these authors' personal experiences of distress connected to their social environment and wider social processes. I created a set of questions to engage in a more ecological approach while going back through the books and notes/quotes. I based these questions off Rimke's (2016, pp. 8-10) work '*Introduction–Mental and emotional distress as a social justice issue: Beyond psychocentrism*'.

Questions used to guide my analysis:

- Are instances of social injustices present within this person's account of their narratives? If so, how?
- Are the social determinants of health present within this person's account? If so, how?

- These social determinants included: sexism, racism, heterosexism, neoliberalism, psychocentrism, colonialism, ableism, ageism, classism, employment loss, precarious jobs, cold/damp housing, unaffordable housing, violence (social, spiritual, racial, digital), transport issues, maltreatment, poverty, homelessness, crime, exploitation, and social inequalities.
- What was the person's reaction?
- What does the literature say about this instance?

The ecological stage of analysis took a further three or more readings of each book's notes/quotes to make interconnections between the lifeworlds and the societal conditions occurring within the autobiographical books. Once I had thoroughly worked through using an ecological lens on the autobiographical material, I moved towards creating more coherent, concise and abstract themes to present the experiences of the participant (Pietkiewicz & Smith, 2014).

Reflexive Journaling

The autobiographical material based on surviving a suicide attempt can be challenging for a person to fully process and is sometimes emotionally taxing. So, I engaged in the use of research journaling as a reflexivity practice during readings, note-taking, during the write up of my thesis and a place to put my thoughts about the literature I was reading. This process became particularly important during the Level Three and Four lockdown where normal everyday social contact with other researchers was drastically reduced. It was helpful to get thoughts off my mind and keep track of how my thinking changed or developed overtime during the development of this master's thesis. This research journal also supplemented the analysis process and helped collate my personal thoughts, assumptions, and progress of analysis.

I engaged in this reflective process as a way of making sense of each narrative formed in the autobiographical books and debriefing myself (Dewey, 1933). Some debriefing questions I used to guide myself were:

1. What were my initial thoughts after reading the life story?
2. What would be a brief synopsis of the autobiography?
3. How did the story impact me?
4. Do I notice any connections to social determinants of health or social injustices from their story?
5. What were some of the main narratives present in their story? e.g. narratives about distress
6. Did anything stand out for me? Why?

Chapter Three: Summary of Six Autobiographical Books

Jazz Thornton – Stop Surviving Start Fighting

Jazz Thornton is a mental health activist from Auckland, New Zealand. Jazz's story recounted her life experiences throughout her childhood including: sexual abuse, her father abandoning her, being bullied at school, relationship difficulties with friends, and her experiences with the mental health system. Throughout her story she talked about her difficulties with the psychological distress she was experiencing. Anxiety and depression were key parts of her psychological distress. Jazz first attempted suicide at the age of 12. Her story recounted her multiple attempts of suicide, engagement with therapy and many rehospitalisations. Her book was developed to help those struggling with their own psychological distress. She discussed what helped her and what did not help throughout her journey. Jazz's story is aimed to give hope and advice for the reader. Her story highlights the complex interaction of her past, present, and future events. The story speaks more about the individual things like fears, worries, behaviours but also sheds light on the interactions of broader contexts such as bullying, discrimination, stigma, and the Aotearoa mental health system.

Kevin Hines - Cracked, Not Broken: Surviving and Thriving After a Suicide Attempt

Kevin Hines was born in San Francisco, California. His story started off with a recount about his birth parents and living in a malnourished environment. Later, his parents were taken to jail for their use of drugs. Kevin also lost his older brother to bronchitis who passed away when he was a baby. As Kevin was separated from his parents, he was put into the foster care of Debi Hines and Patrick Kevin Hines. Kevin was able to live a better life and better childhood where he got to grow up with an adopted sister and brother. However, Kevin recounted that not everything was easy, especially in school where he was bullied and ostracised for being and looking different to everyone else. Later in Kevin's life journey, he started to deal with paranoia

and depression. Kevin's story discusses his struggle with paranoia and psychological distress that had arisen during his school years.

Kevin first attempted on September 25th, 2000, where he jumped off the golden gate bridge and fortunately survived. His story discussed the rocky and long journey it took to not only heal physically but also psychologically and emotionally. The way he wrote his story is encouraging to the reader and he discusses the things that helped him thrive and get better in his healing journey.

Ben Schwipps - Live to Tell: A Suicide Survivor's Struggle with Depression and Anxiety

Ben Schwipp's story started off with a summary of his previous nine-year marriage, which ended in divorce. For Ben, this meant that he had lost all he had worked hard for up to the moments of divorce. Ben had lost his home, cars, and personal belongings. It also meant he would no longer get to see his kids grow up each day. Ben's account discussed the struggle he had with anxiety and depression after the divorce. Ben included both the positive and negative moments in his journey to illustrate his up and down struggles with his health. The second part to Ben's story followed a job promotion where he met a new love, Megan. Ben recounted that he had started to feel better and that life was going well with the new promotion and a stable relationship.

That latter part of his story recounted how his struggle for maintaining his mental health had gotten worse over time. Ben experienced job changes, job loss, and relationship difficulties after he had married his next wife. Later, Ben and Megan began to experience many financial difficulties which created further cracks in their relationship, ultimately ending up in another divorce. This led up to his first suicide attempt. Ben's autobiography is a recount of his struggle with depression, anxiety and his suicide attempts. Throughout the book, Ben gave encouraging advice for the reader that he had learned through his struggles and healing journey. The book ended on an encouraging note where he outlined knowledge on suicide prevention.

Craig A Miller - This is How it Feels: A Memoir - Attempting Suicide and Finding Life

Craig's story is powerful and very personal. His story discussed many life events from the beginning of his childhood to adulthood. Craig discussed the main events that led up to his suicide attempt and how it felt to recover from a suicide attempt. The book started with his suicide attempt. After his suicide attempt, the reader is taken back to the start of his childhood from when he is two years old. The reader gets carried throughout multiple childhood stories to experience what it is was like for Craig to be sexually abused, witness domestic violence at home, growing up in a low-income family, being bullied in school and having a lack of social support from family. Craig also had a father he looked up to but was constantly disappointed as his father appeared as a distant and distraught person in his life. Craig's life shows what it is like to live in a low-income situation and in a broken home. The reader got to experience what Obsessive Compulsive thoughts were like in first person. The later chapters of his story moved into his recovery process and his commitment to his healing journey.

Holly Younce Roberts - Suicide: The (Unsuccessful) Attempts to End my Life

Holly's memoir was a short biographical writing about her suicide attempts. Her first suicide attempt was when she was ten years old. Holly used a very personal way of writing, making it easier for the reader to immerse themselves in the reading. Holly told stories about her childhood all the way to her adulthood. However, she focused more on the later part of her childhood and only gave brief excerpts to her early childhood. Briefly at the start of the story, Holly recounted her experience of sexual abuse from a very young age but did not go into full detail, and this affected her deeply throughout the rest of her life. Other parts of her childhood she discussed included her struggle with depression and how she felt neglected as a child. She narrated her experiences of how she grew up around drug and alcohol abuse and family violence.

We follow Holly's story of growth as a young girl, dealing with depression and changes within her familial environment. Ultimately, we see throughout her story how important it was to take responsibility of her two little brothers and to care for them when her mother could not. This responsibility filled her with a sense of purpose and life direction, but throughout her story we see Holly's struggle to fulfil this purpose because of her young age. The story ended with Holly's last suicide attempt and her recovery emotionally, psychological, physically, and financially. Holly ends her story with a brief excerpt about how her faith in God helped her through her struggles.

Brian A Oard - Suicide: A Memoir

Brian Oard's book is told in three parts in which Brian illustrated stories from his childhood leading up to his suicide attempt. Brian is an English literary writer, so his book is written differently to the other books. We get to see throughout the book his immense intellect and knowledge of the English genre and language. The story is powerful and filled with visually and illustrative terms. The first part follows Brian as he looked after his father and remembers past traumatic memories from his childhood. One of those impactful memories was about his father abusing him for engaging in faecal play when he was a little boy. From there his family put him under intense, humiliating supervision throughout his childhood.

The second part of his book follows his father's death and the emotional process Brian went through as his father died in hospital. The third part of his story demonstrates a very thoughtful account of the lead up to his attempt and methods of choice. Brian did not attempt suicide the way people might normally understand. Brian's attempt was more of an aborted attempt. However, throughout the third part of the story we see Brian's preparations for each suicide attempt and thinking carefully of whether it would work or not. He chooses his final method where he carries it out until the last minute where he decides to abort his suicide attempt.

Throughout Brian's story he reflected on his past and the events that took place up to the lead up of his suicide attempt. He rationalised his lost hope and will to continue living life through his experience of living in poverty, low-income, loss of stable jobs, battling a loss of eyesight, and the nearing of homelessness. To Brian, suicide seemed a way out of all his misery and pain he had experienced over the past 50 years of his life.

Chapter Four: Brian's Rationality

In chapter four, I discuss Brian's story and how he rationalises his suicide attempt. Brian did not attempt suicide in the way we commonly understand a suicide attempt. Brian's suicide attempt involved months of planning and thinking through various methods. As Brian got closer to the date he had set for his suicide attempt, he went through a thorough process of checking whether his method would work. If he concluded that the method would not work, he would consider and work through the next method. Brian eventually chose the method and settled on his date. Before Brian carried out his method, he decided to abort. This chapter integrates some of my personal reflections on the individualisation of suicide to supplement the analysis of Brian's rationality for attempting suicide. The analysis discussion takes a look at Brian's rationality and how it contradicts the mainstream understanding of suicide, which often centralises suicide as an individual act of irrationality and madness (Marsh, 2013).

Brian's Rationalisation of his Suicide Attempt

Brian's story reflects how his difficult life situation meant he had come to the point where he no longer wanted to live and bear the unbearable pains of life and suffering illness. He recounts how he had to look after his 92-year-old father who had physically abused and humiliated him throughout his childhood. Brian shows how it was psychologically and emotionally distressing for him to be living in this situation: "I never complained. At least, not out loud. Silently, I seethed, and in the privacy of my bedroom I screamed at the book-covered walls" (Oard, 2020, part one, para 39). It became clear that Brian had thought through his options, reflected on his life, and considered the possible options he had available to him. Brian's reflection on his motives, is very evidently not 'mad' or 'irrational':

These motives are more than sufficient to demonstrate that my death is a calmly, logically chosen end, a rational choice rather than a madman's act. There is not a note of madness in my mind as I write this. I am as clear as a glass bell, as

calm as a sunset, as rational as a geometry proof (Oard, 2020, Part three, para 18).

Brian's quote above challenges the mainstream understanding of suicide, where suicide is associated with faulty thinking, an irrational choice, or a consequence of mental illness (Marsh, 2010, 2013). Brian's honest and lucid account reflects his deep thinking, but he also completely counters an unquestioned moral principle. In a pro-life society, such as the United States, it is taboo to contemplate, let alone rationalise, suicide. The taboo nature of suicide further entrenches the view of suicidality as mad, insane, or crazy.

Brian's story challenges the individualistic conceptualisation of suicide. This also challenged my own thinking of suicide in which my thinking tended to be trapped within a psychocentric view of suicide. I noted this challenge multiple times in my reflection journal. My reflections in September and a conversation with my supervisor suggested that I was still locating the problem of suicide at the individual and family level during the progression of my thesis. My discussions of the social determinants of health and Te Whare Tapa Whā were still reducing suicide down to a specific factor, rather than encompassing the breadth and depth of societal conditions. The extract below illustrates how difficult it has been to shift beyond the individual frame of reference:

A complete focus on social injustices and social determinants [of health] as theoretical concepts in the way I'm thinking of them is not helpful. I'm [just] trying to reduce down to concepts such as racism and sexism... but I'm feeling this is also too simplified (14th September 2020).

My simplification and individualisation of complex human phenomena can be traced back through my mainstream psychology training and my studies in high school. I was taught to explain phenomena by reducing them down to simple concepts or language. Over time, this has become ingrained. Most academic literature on suicide focuses on the personal intent and

motives of suicidal behaviour using psychological and medicalised language. Medicalised language of suicide includes the use of common terms, such as risk factors, symptoms, disorder, illness, diagnosis, and clinical. This terminology reduces a person into a ‘patient’ that needs some intervention to treat their ‘disorder’ or disease (Maddux, 2005). In this case, the disorder is suicidal behaviour disorder or other related diagnoses that are associated with suicide (American Psychiatric Association, 2013). By locating the issue of suicide at the individual level through medicalised language and psychological practice, broader explanations are diminished or become eliminated.

Historical and mainstream understandings locate suicide at the individual level and frame suicide as a crime, a madman’s act, or a consequence of mental illness (Marsh, 2010, 2013). Framing suicide at the societal level requires an understanding of a person’s life and the social world that surrounds them. This broader framing of suicide requires an invitation to see the complexities of life, the complex interactions of many different motives, and an understanding of the occurring societal conditions. In Brian’s story he demonstrates the complex and intertwined connections of the biological, psychological, philosophical, moral, sociocultural, historical, anthropological and economic factors:

Among my multiple motives are, running from the banal to the grandiose: bankruptcy..., poverty ..., blindness ..., the prospect of homelessness...; the forty-five years or so of periodic self-destructive neurotic paralysis that has deformed my life; the long, usually low-grade but at times severe-to-suicidal depression that I’ve suffered under for much of the past decade; the fact that my father’s (and earlier, my mother’s) end had bound me intimately to death ...; the futility of living in a society ... that ignores the things I value most (art, beauty, intelligence) and elevates what I despise (ugliness, stupidity, cruelty);

that old Brian Wilson feeling that “I just wasn’t made for these times” (Oard, 2020, Part three, para 18).

With increasing inequalities in society, groups of people are left with unstable employment, loss of secure income, and lack the opportunities for a fair participation in life (Standing, 2012). In Brian’s situation, he lived with no income, in poverty, and with the prospect of homelessness when his father dies. Brian abhors the fact that he has to look after his father, someone who had previously abused him. But this was the option he was left with in order to have a place to live and means to live. Brian’s story is an example of what life is potentially like for the precariat. People in situations of socioeconomic disadvantage such as the precariat can feel like they have minimal choices or control in their life. In these situations, where the feeling is that one has no escape or options left, the last act of self-agency someone can take is to end their life.

The mainstream conceptualisation of suicide as a crime, sin, faulty thinking, irrationality, or consequence of mental illness all contribute to an individualistic interpretation of suicide. This individualistic interpretation aligns with psychocentrism where complex human phenomena are reduced to being a fault in the mind or body, which perpetuates victim blaming. Psychocentrism and the psy-complex are useful concepts for understanding the tensions arising from the individualisation of suicide and Brian’s rationalisation of suicide. In Rimke’s (2016) discussion of psychocentrism, and the connection of this concept to mental distress, she draws on the idea of the psy-complex. The psy-complex refers to “a loosely defined group of experts connected through their professional and social status, particularly psychiatrists, psychologists, psychiatric nurses, psychotherapists, psychoanalysts, and social workers” (p. 4). The psy-complex suggests that this group or social class holds expert status whereby knowledge is disseminated, legitimised, and utilised through their practices and distributed into society. The psy-complex creates a tension in society where knowledge and

truth belong to the 'experts' and knowledge outside of the experts is less valued or is in some cases viewed as irrational or wrong. In many cases, this psy-complex creates an 'us versus them' social dynamic.

By viewing suicide as an irrational choice through the discourses of faulty thinking or mental illness, the expert becomes positioned as the person who knows 'best'. In this case, since the expert knows 'best' then the expert must make a diagnosis and put an intervention in place to save this person from themselves (Marsh, 2010; Rimke, 2016). In Brian's case, he challenges the idea of psychocentrism and the experts positioning of the psy-complex by rationalising his intent of suicide. Brian makes it clear that he is not mad and that there is nothing wrong with his mind.

In one of my written reflections, I realised that the analysis of Brian's case is not primarily about whether suicide is irrational or rational. The debate around rationality, what is right or wrong, is outside the scope of this thesis. The main point centres on the prospect of a new understanding or possibility that is different from a psychocentric, individualised view of suicide. I empathize with Brian's case for the great pain he experienced, the hard decisions he had faced, and his incredibly tough situation. His view may align with other people's experiences of suicide. However, his view and of those that align with his, become hidden in the psychocentric discourses of faulty thinking, irrationality, or as consequence of mental illness, which ultimately contribute to the taboo nature of suicide.

Chapter Five: Societal Inequalities and Neoliberalism: The Complexity of Suicide Through Experiences of Classism and Precarity

This chapter follows on from the discussion of Brian's rationality to look at different stories within the six autobiographies. In each of the autobiographies, the six authors' accounts reflected a long process towards attempting suicide and coming out the other end. The authors' health in these situations was embodied in personal, relational, and social dimensions (Durie, 1985; Hodgetts et al., 2007). The long process or build up to the suicide attempt of each author was embedded in these connected health domains and mediated by the social conditions they were born into and grew up in (WHO, 2020). These social conditions were influenced by the distribution of political power, resource allocation, and wealth inequality in the society they lived in. Examples of social conditions that were experienced by the six authors varied from stigma, maltreatment and violence, lack of social support, social isolation, food and housing insecurity, precarity, employment difficulties, homelessness, relationship problems, transport struggles, social exclusion, unaffordability of social services, and various other issues. The authors' stories were messy, complex and full of multiple difficulties that contributed to their suicide attempt(s). No single situation or social condition can fully explain the process leading up to each suicide attempt. Rather, a more encompassing understanding of the process emerged through the accumulation or inclusion of all the different moments, stories, narratives, histories, and their present social cultural contexts.

All of the authors were from Aotearoa or USA, so the experiences they wrote about occurred within these Anglocentric contexts. The neoliberal culture and history of these countries were a deep and interconnected reality for each of the authors' accounts. Greater levels of social inequalities in societies such as the USA and Aotearoa, have been associated with higher levels of social problems present in a given society. Social problems such as increased presence of maltreatment, violence, mental illness, physical illness, and drug and

alcohol abuse (Wilkinson & Pickett, 2010). A neoliberal culture further exacerbated social inequalities in class, wealth, and resources in the authors' lives (Labonte & Stuckler, 2016).

What follows in this chapter is an analysis of the authors' experiences in relation to social class, precarity, neoliberalism, and societal inequalities. The chapter will provide insights into the stories and lives of the six authors. These stories can be deeply troubling, and distressing, which gives rise to the understanding of how hopelessness may arise in harsh and unequal contexts. The goal is to reveal new possibilities, different understandings, and the invisible societal structures and social conditions at play in the authors' lives. This goes beyond simply demonstrating how one may become hopeless or go on a path to attempting suicide

A Class Analysis and Experiences of Precarity: Precarious Living Situations

This section explores the connections between the autobiographies and experiences of social class and precarity. Increasing inequality in society has disproportionately left many people facing many more hardships and social disadvantages (Hodgetts & Stolte, 2017; Standing, 2012; Wilkinson & Pickett, 2010). In the USA, over 10.5 percent of the population live within relative poverty and face numerous hardships (Semega et al., 2020). In Aotearoa, one in seven households experience contexts of relative poverty and material deprivation (Stats NZ, 2020). Hardships and social disadvantages experienced by the six authors were lack of job security, food insecurity, unaffordability of transport or health services, impoverished housing conditions, and further financial difficulties. The authors' lives represent elements of what it is like to live in precarity. In the excerpt below, Craig reflected on his starting living conditions:

Craig: My parents had divorced when I was a year old. My mother got to keep me, her two sons from a previous marriage, and the house my father bought. It was a small, box-shaped house, located just far enough away from the city's busy downtown area to give the illusion of a safe rural setting. Our neighborhood was tightly packed with a mix of single-family homes and multi-

level apartment houses all crammed together along narrow streets. Neglected fences separated yards and driveways while bushes grew wildly out of control, serving as the only form of privacy. The inside of our house was just as tight as the neighborhood outside (Miller, 2012, p. 19).

Craig's account reflects an experience of living in a lower-income household and neighbourhood. His story is directly impacted by his wider context—living in a neglected neighbourhood, crammed together, with overcrowding, and lack of privacy (Bronfenbrenner, 1996). Important aspects of housing such as security, privacy, comfort, safety, affordability, and belongingness were also disrupted in Craig's childhood. Craig's exo-system which is the surrounding neighbourhood and environment in Craig's childhood, impacted not only his psychological wellbeing but also his interconnected micro/meso systematic relationships (Bronfenbrenner, 1996). Throughout his childhood he experienced traumatic situations such as family violence, sexual abuse, and bullying. Once he was old enough, he decided to move out and into his friend's garage. Below is Craig's reflection on living in the garage:

Craig: When you're as troubled inside as Dylan and I were, there is something in you that wants the hurt to be seen. A part of you that needs something solid and tangible to reflect the pain you feel. For us, an old, dilapidated garage summed up our entire world. And just like us, the more you looked inside, the more you realized how distressed the garage really was...The beams that once held the floor solid had badly rotted in random places. The uneven boards made the entire surface look like something you might find in an amusement-park funhouse. A poorly constructed set of stairs, loosely nailed together, went up to the second floor where we spent most of our time. The floorboards up there were shoddy and missing in certain sections, making holes that went through to the first floor. The walls and ceiling had no interior finish work, and the nails

from the siding and roof shingles broke through the plywood, surrounding us in a fully spiked enclosure (Miller, 2012 p. 164-165).

Craig's accounts reflect the embodied nature of health (Durie, 1985; Hodgetts et al., 2007). His material living conditions and social experiences are interwoven. Craig connected deeply with his social surroundings and living situation, which reflected and embodied the pain he felt. The social environment in which people grow up in, is interconnected to the personal and relational aspects of health (Durie, 1985). This is reflected in the Te Whare Tapa Whā Model, where all four pillars of the Whare (House) are intertwined and are foundational aspects to hold up their roof top (Health). The four pillars are rooted in the land and surrounding environment. If the land, environment, or pillars are damaged, then the person's health is also damaged in the process. Durie (1985) emphasises that it is not just the person's health that falls but also the community surrounding them. Craig's story illustrates how his health and distress was deeply tied and interconnected to his environment growing up.

Social, political, and economic settings can harm and restrict a person's life trajectory (Marmot, 1999, 2005). Craig's writing highlights how policies, laws, and regulations affect a person's access to basic human needs such as adequate housing and health services. Societal inequalities create barriers and increase the gaps between the rich and poor, which entrenches the disadvantaged life situations (Wilkinson & Pickett, 2017). The living situations for Craig and others in lower socioeconomic classes are typically limited, especially in the context of housing crises and property bubbles (Labonte & Stuckler, 2016; Standing, 2012). Consequently, young people like Craig are often faced with choosing between dilapidated dwellings or paying much higher rent. Poor housing conditions have been linked to poorer health due to the cold, damp and sometimes mouldy environments of these houses (Hodgetts & Stolte, 2017). Lack of safety, security, belongingness, and comfort in deprived situations, which are all essential human psychological needs also contribute to poorer health. Craig's

embodiment of his material conditions reflects how hardship can “get under the skin” creating further mental, emotional and physical distress (Hodgetts et al., 2007 p. 714).

The material, economic and social aspects of a person’s life are influenced by wide societal contexts and policy settings (Marmot, 1999, 2005). For example, in the USA and Aotearoa, important aspects of housing are regulated by the policies and laws that tend to protect landlords and their property rights (Chisholm et al., 2017). In these neoliberal contexts, housing is seen as a commodity in which people can invest and accumulate wealth from the real estate market (Labonte & Stuckler, 2016). For many people, access to the housing market is not easy with the high prices of houses and restrictions around getting a mortgage. In the USA and Aotearoa, the realities of poor housing, housing insecurity, and precarity is mediated by the exacerbation of societal inequalities and the influencing neoliberal culture (Hodgetts & Stolte, 2017; Labonte & Stuckler, 2016; Standing, 2012). The next extract below follows Craig’s story after the friend he lived with in the garage sells Craig’s belongings for drugs. Craig left the garage feeling devastated and hopeless:

Craig: The night quickly set in around me. Rain fell over me, dripped from my hair and soaked my clothes. I had no place to go. I was twenty years old, and the only possessions I had were the clothes I was wearing and a torn-up notebook. I was so burned out by life. I was angry and depressed. I fell deeper inside myself with every step I took, and the thought of ending it all seemed so easy. I continued walking deep into the night, finding my way onto the city train tracks... “Hey!” ... “Jesus, buddy, I thought you were dead,” a guy said, ... “What the hell are you doing?” He was clearly shaken at seeing a body lying across the railroad tracks in the middle of the night. I was shaken myself as I thought of the coincidence of him being out there and finding me... “Nothing,” I said, “I’m all right.”... before I knew it I was surrounded with police

cruisers... “You okay, pal? Why don’t you come here and talk with me for a minute?” one of the cops asked. ...“You don’t have anything?” he asked inquisitively. His question struck me so much deeper than he intended. I stared ahead looking off into the blinding blue and white lights and my eyes began to fill. “No,” I said... “I don’t have anything.” “Where do you live?” Again, his question seemed to stab me. “I don’t know,” I said with total honesty (Millar, 2012, pp. 241-244).

Craig’s feelings of hopelessness, brokenness, and devastation was embodied physically and psychologically. Physically, his hopelessness manifested in the environment around him through the descriptions of the rain soaking his clothes, torn-up notebook, and owning only the clothes on his back and his notebook. Craig had also lost his trust for his one and only friend because of his friend’s actions, further entrenching his hopelessness. It is understandable how a person may end up feeling hopeless in situations like these. Craig is left in a position of precarity and feeling like he is nothing or of no worth. In a neoliberal society, self-worth is often tied to economic value and allocated to those higher up the social hierarchy and can engage in acts of materialism or consumerism (Mills, 2018; Wilkinson & Pickett, 2010, 2017). Other than the clothes on his back and his notebook, Craig owns next to nothing at this point in his story. His situation further reinforces how his self-worth was intertwined with a neoliberal conceptualisation of self-worth. In Craig’s story, he felt like he was nothing because he had lost everything he owned, his friends, the girl he loved, and his family. Within the context of Craig’s situation, his actions and thoughts are given reason, he is in a hopeless situation, and it is understandable why life feels like life is no longer worth living. These are not thoughts of madness or irrationality.

Social Inequalities and the Unaffordability of Basic Life Necessities

The introduction and (re)production of neoliberalism in society has been linked with increasing the gap between the rich and poor (Wilkinson & Pickett, 2010, 2017). In such a society, the private, self-interests of people become valued over the health of people and wider community. Basic necessities such as healthy food, essential household items, affordable transport and accommodation become harder to access and unaffordable, especially for those lower down the social hierarchy (Hodgetts & Stolte, 2017; Hodgetts, et al. 2016, Standing, 2012). The extract below reflects the precarious living situation Ben and his wife, Megan, were in:

Ben: We were no strangers at this point to living paycheck to paycheck (something that once again created numerous cracks), but we were surviving, God knows how. Each night after my first month back, we went to bed with heads on pillows, hoping to hear good news the next day... We sold off things we could do without to alleviate payments and to cover bills and expenses here and there, but soon paychecks being spent before they were even in the account became the norm. On top of all this, the month or so that I found myself waiting for the new position turned into many months (Schwipps, 2015 p. 53-55).

During this time Ben was waiting on his 'new position' in a job which never came. Although Ben and his wife's ownership of a house might suggest they had a middle-class social status, it is clear that they are struggling to get by every week. This struggle led them into a lower income and precarious situation. Ben later recounts that his wife had to sometimes use their credit card just to get by each week which would fuel more debt than they are already in. Ben's story reflects his struggles to secure a job in an insecure and precarious job market. Economic restructuring, competitive individualism, market liberalisation has led to an increased "intensification of job insecurity" across the job market (Standing, 2012, p. 592). Ben shows how many people who face a precarious situation are deeply embedded in this

market where temporary, casual, short-term jobs and insecure earnings are the norm (Hodgetts & Stolte, 2017; Hodgetts, et al. 2016, Standing, 2012). The pressure of Ben's economic situation affects both his personal health as well as his relationship with his wife, creating cracks and eventual divorce later in his story. The dissolution of his relationship then also contributes to poorer mental health. Ben's self-perception is intertwined with the struggle of not fulfilling his role as the provider and father of the home. Macro pressures trickle down into more personal pressures, leading to Ben's sense of hopelessness and despair.

In Holly's autobiography, her situation reveals a tension of living in a middle-class social status intertwined with aspects of precarity after her suicide attempt. Holly is a homeowner, which may suggest she is middle class. Her ownership enables the possibilities of housing security and accumulation of wealth through further participation in the real estate market. However, the excerpt below is after Holly's suicide attempt and suggests that she faced precarity through not being able to afford enough food, rent, power, or other basic necessities:

Holly: Though things were looking up, the financial struggles were real. My house went into foreclosure 3 times. Each time, God sent someone to help me not lose it. Every bill I paid was late. Once, my power was getting shut off, and I just resigned myself to not having electricity until I could save up enough to get it turned back on. I told myself I could do everything I needed light for during the day and I could deal with cold showers for a while. I didn't want to ask anyone else for money, but I was so scared. I mentioned my power problem at work. Several people said that it was illegal to live in a home with no power, so they paid my power bill; anonymously of course. I'm fairly certain I know who it was, but I'm not sure if it was only her. She won't admit that she paid it either. Whoever had a hand in this, I'm eternally grateful for it. I'm so thankful

that God had them right there when I needed them (Roberts, 2018, Chap 13, para 2).

Holly had secured her house under the credit rating and income of her previous marriage, which had ended in a divorce a few weeks before her suicide attempt. Holly solely financed the house under the money she had at the time and her ex-husband did not help. The financing of the house became harder because she was also unemployed, with no income, and little savings to live off. We see in Holly's account how she struggled to pay the bills of the house because of the multiple foreclosures. Holly's position of financial insecurity, facing the possibility of losing her home, and the struggle of finding a stable job, positions Holly within a precarious life position. Since Holly attempted suicide, she would have incurred hospital bills related to ambulance transport, medical procedures, and therapy, because in the USA access to healthcare is often dependant on having insurance. Holly recounts that after a few weeks her insurance was cancelled, and this was likely due to her insurance policy not covering her suicide attempt or mental health concerns (Evans, 2020). Once Holly left the hospital, she would have had the pressures of restarting her life, affording basic necessities, paying off her household payments and hospital bills. For someone still recovering from a suicide attempt, this can be a lot to take on. In her situation, Holly did not just face an issue of significant mental distress, but she faced present and future economic insecurity. Incurring bills and not paying them off in the context of USA can have a large impact on your credit score and affect your future participation in the economic market. Fortunately, she was able to lean on the help of an anonymous colleague who had more material resources available to them. Without the help of the colleague, Holly would have likely lost her home. Holly's story illustrates how fragile life can be with changing circumstances moving from manageable to overwhelming.

Holly's story shows how she has internalised neoliberal messages of individual responsibility and personal deficits as the main causes of poverty (Rimke, 2000, 2003, 2010,

2016). Consequently, Holly is not only suffering from the adversity of her life situation, but she is also burdened by the shame, guilt and despair of being ‘defective’ in meeting neoliberal norms of self-responsibility. Yet, it is a little unrealistic to hold Holly personally responsible for things that she largely cannot control, such as her access to medical care or securing a stable income in a precarious job market. This tendency towards individualised deficit rationalisations obscures explanations that include societal structures (Rimke, 2016). In Holly’s situation she did not have a stable income or assets to lean on to upkeep the financing of her house, pay her power and hospital bills, and afford other basic life necessities. Holly’s story illustrates how in an unequal society it is incredibly easy to fall down the social hierarchy and fall into the trap of poverty and precarity (Wilkinson & Pickett, 2010, 2017).

Precarity, Mental Health System, and Class

From the age of 16, Jazz moved to Auckland where she went from house to house, multiple schools, women’s refuges motels, and different hotels. She described her situation as having no stable abode to live in or place to go to. Housing insecurity and precarity is a prominent feature in Jazz’s story. During the course of Jazz’s autobiography, she described many points where she had come to the point where she no longer wanted to live and attempted suicide. In the extract below, we follow Jazz’s story after she had been released from one of her hospitalisations for attempting suicide. During her hospital stay, Jazz had been made redundant at her job. For Jazz, she had very few options left before and after leaving the hospital. Temporary homelessness became a reality for Jazz. Homelessness is at the extreme end of precariousness, poverty and housing insecurity (Hodgetts & Stolte, 2017).

Jazz: The mental-health crisis team decided that the psych ward wasn’t working for me (I could have told them that!), and they suggested that they would move me into community care. Unfortunately, they decided this at about 1.30 a.m., and as I was released legally under the Mental Health Act, that meant I was able

to just get up and leave. So I did. I got up and walked out of hospital at about 2 a.m. and spent the whole rest of the night walking around the streets of Auckland by myself. I literally didn't have anywhere to go. I had next to nothing – no home, no job, just my government benefit. I had become isolated from all my friends and felt like I had no one to turn to... (Thornton, 2020, p. 16).

Jazz's situation meant the health system had cleared her as ready to go back out into the community through the use of psychometric testing. These psychometric tests only looked at her mental status and assessed her suicidality. Yet, these psychometric tests failed to assess her life outside of her psychological state, such as her precarious living situation, friends, family, and employment, which were things she had lost and were one part of the story explaining why she was hospitalised. Jazz recounted that she had become separated from her family and isolated from her friends, so she was disconnected from her social support structures. It is understandable how feelings of hopelessness may re-arise in these situations.

Jazz's account reflects many issues and systematic failures of Aotearoa's health system. Presumably, the health system and psychometric tests used assumed that Jazz is either capable of looking after herself or that she has the resources she can rely on. Jazz is caught up in the context of deinstitutionalisation. The transition from institutionalisation to deinstitutionalisation in the 1960s in Aotearoa saw a shift of state care towards a reliance on community care (Brunton, 2018). The assumption behind community care was that friends, family, or community trusts would become a social safety net to catch those who are need of support. However, since the 1960s there have been problems arising with this transition. Family members, friends, and community carers may be faced with a lack of support, resources, skills, knowledge, and the time to help care for people with serious mental health distress in the long term and have a continuity of care. In a more well-resourced person's life, the continuity of

care is possible, but it is clear in Jazz's case that she did not have these sort of supports or resources available.

Jazz's story highlights the deep contradictions in neoliberal ideology. On the one hand, neoliberalism favours self-responsibility of oneself and assumes people are able to adequately gain resources in life (Labonte & Stuckler, 2016; Standing, 2012). In a neoliberal society, part of the ideology promoted is that if you work hard enough, you will be able to obtain good health and be successful in life through participation in the economic market. Yet, at the same time the reality for many people is uncertainty, inequality, and a precarious job market making it harder for people to earn stable incomes. On the other hand, neoliberalism also advocates for cutting public spending, through the use of austerity and reducing funding to health and social services. Neoliberalism is based on the assumption that the economic market will provide access to these services. However, access depends on one's economic capital and if they can afford to spend money on health services. It is much harder for those who are in lower-income situations or precarity to access the help they need. Aotearoa is fortunate to have a public health system, but it is clear in Jazz's case that it is well under-resourced and is unable to appropriately help everyone in need of care for serious mental health issues.

Throughout the authors' stories they noted how that it was a long process into suicide and a long process out of suicide. Immediate physical, emotional, and psychological healing often took place in the hospital, but only for a short amount of time. Further, during many of the authors' hospital stays, they also experienced negative situations such as long waiting lists, physical and verbal abuse from staff or patients, lack of therapist options, late interventions and the experience of being sectioned. Jazz described herself as being a "young girl who fell through the cracks of our extremely broken system" (Thornton, 2020, p. 131). Early intervention to prevent the development of diseases, behavioural disorders and serious mental health issues is key to addressing wider societal public health concerns (Allen et al., 2014;

Marmot, 1999, 2005; Marmot et al., 2012). Addressing suicide as an issue for prevention needs to happen long before a person has attempted suicide. Unfortunately, all of the authors only received some intervention after their suicide attempts and in most cases, there was little follow-up. Jazz's story points out how vital it is to have adequate resources allocated to societal structures such as a hospital. This is so that there is enough resources, staffing, time and space for those that need it:

Jazz: Also, I could not tell you the number of times that I have been in hospital with other young people with serious mental health issues who had been told to come back when you have tried to kill yourself. These people, who were clearly suicidal, were 'competing with those who were acutely unwell with schizophrenic or other serious conditions for one of 20 beds in the mental health ward. The funding and resources were just not there for enough people struggling with their mental health, and the system became overloaded to the point where people like myself were falling through the cracks, going months without the help we needed (Thornton, 2020, p. 142).

Jazz's story highlights deep systemic issues within the health system in Aotearoa and, in particular, a lack of resources. In these situations, staff in the hospital who attend to medical emergencies and other interventions face the decision of having to turn people away who are in need. It is not the fault of the staff, but a result of wider societal inequalities and a neoliberal ideology that prioritises low taxes and the cutting of public spending (Labonte & Stuckler, 2016; Standing, 2012). Staff face work overloads, understaffing and hard decisions of putting people in need back in the community or on a waiting list in order to make space for someone who is deemed more at risk. Long waiting lists are still a major concern in Aotearoa (Paterson et al., 2018). Jazz's case highlights how overloaded the mental health sector can get. In most cases, there are not enough resources to employ more medical staff, psychologists, therapists,

or counsellors to help them. A lack of resources in the health sector connects back to societal inequalities where there is an inequitable distribution in wealth, income, and resources across society. Inequalities create further barriers for people accessing health services through the unaffordability of services, transport issues, or simply not being able to meet one's basic needs. In a society, such as Aotearoa and the USA, health becomes a luxury for those who can afford to pay rather than a human right (Rimke, 2016).

Rimke's (2016) discussion of health in a neoliberal context suggests that health is seen as a commodity. If someone is not able to afford this commodity, then they become unsuccessful consumers of health. This obscures the social injustices that the authors' faced. In a neoliberal context people are given the message that if they work hard enough, they will achieve good health and will be able to be successful consumers of health. Yet, it is clear that the inequitable distribution of resources in society remains a barrier for many people. In many cases, lower income people become stuck at the bottom of the social hierarchy and their hard efforts to obtain this successful ideology only results in them further sinking down into debt and socially disadvantaged (Standing, 2012; Rimke, 2020).

Chapter Six: Inequality and Social Hierarchies Fostering Violence and Suicide

Chapter six furthers the discussion on social class by considering the authors' stories in where they experienced traumatic and violent situations. Societal inequalities do not only affect a person's access to basic necessities, but also their exposure to stressors like violence and abuse. Traumatic situations such as sexual, physical and emotional abuse leave a person feeling an array of painful emotions. Trauma is a psychological and bodily response to deeply hurtful, distressing, threatening, frightening, painful or disturbing situations and events. These events can range from a one-time experience (such as injury or abuse) to ongoing psychologically distressing situations (such as domestic violence, relationship breakup, divorce, or bullying). Often trauma can disrupt a person's sense of self, who they are, and their sense of security. This disruption can leave a person feeling distraught, hurt, hopeless, and helpless. Traumatic situations such as violence perpetuated itself and disrupted the everyday lives of the studied authors. The six authors discussed a range of experiences from molestation, sexual abuse, discrimination, shame, stigma, physical abuse, bullying, and domestic violence. Violence in the forms of sexual, physical and emotional abuse early on in childhood can have long-lasting negative effects on the wellbeing of the child (Greenfield, 2010).

Violence such as physical and sexual abuse commonly appears to be associated and treated as only an individual behaviour with a disregard of wider societal contexts (Thomas et al., 2020). This individualisation of violence creates a dynamic in which a person or group becomes blamed (the abuser(s)) and the recipient(s) become the victims (the abused). Individualisation fuels a cycle of hurt and intergenerational trauma by continually locating violence as an individual deficit, reinforcing the neoliberal narrative of 'self-responsibility'. Locating violence as only an individual behaviour can lead to victim blaming and an obscuring of the invisible social forces producing and reproducing violent acts (Rimke, 2016; Springer, 2012; Thapar-Björkert, et al., 2016; Thomas et al., 2020).

Experiences of violence in the authors' stories contributed to further psychological distress and emotional scarring, leaving devastating and painful hurt that lasted throughout their lifetime. This chapter seeks to situate cases of the authors' first-hand experiences of violence with wider societal contexts, social injustices, and the invisible social forces fuelling violence (Springer, 2012; Thomas et al., 2020). These invisible social forces can arise from a neoliberal context creating narratives of self-responsibility and then locating violence as an individual deficit. Contexts of neoliberalism further create and entrench societal inequalities that divide people further from each other in terms of social, economic, and political status. This chapter moves from the understandings brought from the previous chapter on social class and precarity. Symbolic and structural violence theories will be used to see how the long process leading up to suicide was intertwined with experiences of violence, which can be located in wider societal narratives.

Springer (2012) suggests that violence should be conceptualised as a moment in time, rather than a simple and defined 'thing' that detaches violence from its complex social relations. Commonly, violence is viewed as a 'thing', something that occurs without a history and is caused by defects in personality or the moral character of a person. By seeing instances of violence as a moment, it is then possible to explore the past and future possibilities of violence and contextualise within complex social processes. Violence gives a snapshot into the complex, intertwined, and interlacing political economic practices and sociocultural structures which oppress, dominate, and fuel cycles of hurt.

Inequality, Symbolic Violence, Shame, and Social Class

Invisible symbolic violence was weaved throughout the authors' accounts in experiences of social exclusion, discrimination, stigma, and shame. The previous analysis chapter on social class established how precarity, poverty, and low-income status were weaved in the authors' stories. With each social class comes a certain habitus, a way of being and acting, that

exemplifies a person's positioning and power in the social hierarchy (Bourdieu & Passeron, 1977; Bourdieu, 1996). Those in higher social positionings often accrue higher levels of cultural resources, which ensures them the ability to define and shape the interests, tastes, and habitus of the majority. Yet, for the majority, the enactment of this habitus is often either unobtainable or unsustainable. Those in a lower-income or precarious status do not have the material, social and cultural resources in order to live out the perceived and valued habitus of those higher up the social hierarchy. This leaves those in lower-income and precarious positions with less legitimacy and leaves positional prestige to those higher up the social hierarchy who are defining the habitus. With less legitimacy, the options and opportunities afforded by the accumulation of material, social and cultural resources, become less for those in lower-income and precarious positions. Symbolic violence occurs within these unequal power relations between different social classes and the subsequent relations, actions, interactions, and conflicting ways of being (Bourdieu & Passeron, 1977; Bourdieu, 1996; Thomas et al., 2020).

Wilkinson and Pickett (2010) theorised in their book, *The Spirit Level*, that these differences in social class and unequal power relations create status anxiety and shame. Symbolic violence starts from a small scale through the misrecognition of those in a lower social status (Thapar-Björkert et al., 2016). Then symbolic violence further progresses into forms of stigma, social exclusion, prejudice, and discrimination of those whose appearances or actions are perceived as lesser to those in a higher status. These forms of symbolic violence further legitimate those in a higher position and delegitimize those who cannot uphold the 'normal' habitus. In a more unequal society, status anxiety becomes more prominent due to the varying importance placed on different status positions (Peacock et al., 2014; Thomas et al., 2020; Wilkinson & Pickett, 2010). Shame arises when one is not able to obtain a certain status or recognition, or even uphold the possible unsustainability of a social class position. In Craig's

story, his lower-income position meant his family could not afford school lunches while he was growing up. In Craig's position he enacted and lived out a habitus that would usually be associated to those living in impoverished or precarious positions. Food was relatively unaffordable for his family; his only option was to enrol in the school food programme. Unfortunately for Craig, he experienced discrimination and social exclusion from his school peers for being seen to engage in this programme:

Craig: At lunch I was too sick to eat, but that was usually the case anyhow. Eating was a humiliating experience for me by itself. Only a few kids in our school came from low-income families and qualified for free lunch, and I was one of them. The prepacked lunches came in small blue Styrofoam trays wrapped in cellophane and consisted of a soggy sandwich and a cookie. The blue tray was a dead giveaway that I was poor, and it was another thing for everyone to use against me... I always sat alone at the end of the third-grade table. I preferred it that way. I never wanted anyone to sit next to me because I knew it would lead to something bad. If I could have eaten alone in a closet, I would have. I glanced down at the other end of the table to see the rest of the class chatting away. Several of them were making gestures to me with their fists as a reminder of what awaited me at the end of the day. The rest of the afternoon, all I could think about was the fight. My stomach ached with a hot pain, and my eyes burned with restrained tears. I didn't know how to fight, and I didn't want to fight (Miller, 2012, p. 72-73).

In the scenario above, Craig is reflecting on a moment in his past/childhood where other children in the school were planning to physically abuse him for the apparent rumours about Craig. These rumours suggested that he had been willingly engaging in sexual activity with his neighbour, Ben. At the same time, Craig reflects on his low-income position and the physical

signifiers of his lower socioeconomic status which ostracised him. It was also his own shame for being associated with this lower status that led him to stop engaging with others as well. Craig became further socially isolated throughout his story because of these rumours and for being ridiculed for being poor. A cycle of being different and becoming further socially isolated. In actuality, the rumours about Craig were false and Ben had taken advantage of Craig multiple times and sexually abused him while he was younger. Craig reflected on how this was hidden to the public eye:

Craig: The onslaught that ensued was relentless. No one ever spoke about it as child molestation or that it was wrong or that I should tell someone. No one ever showed sympathy or a willingness to help. And they certainly never showed mercy. Instead, I was ridiculed by both the girls and the boys on a daily basis. “Don’t stand next to him! He pulls his pants down.” I was being called a faggot in the second grade and got spit at on a regular basis (Miller, 2012, pp. 60-61).

The two excerpts above from Craig’s story suggests an overlapping intersectionality of both homophobia and the (re)production of heteronormative norms. Heteronormative norms play a big part in Craig’s story, as these norms can produce stigma for those who enact a habitus or way of being that sits outside of these norms in a western culture. In addition to the stigma produced by heteronormative norms, Craig was also further stigmatised for being in a lower-class position. Craig’s story shares an insight into an interweaving of symbolic violence in his everyday life through instances of stigma, discrimination, and social exclusion. The symbolic violence Craig experienced was invisible and normalised to the public eye. His experiences of stigma or social exclusion were reinforced as ‘normal’ behaviours by his school peers. The invisibility of this violence made it harder for Craig to speak out about his experiences as it would be seen as less ‘legitimate’ compared to instances of physical violence which is more easily observable to the public eye. However, this symbolic violence allowed for the

legitimation of direct violence against Craig. In response Craig isolated himself from his peers rather than retaliated (Rodriguez et al., 2014).

Symbolic violence is perpetuated by an unequal, neoliberal society in which people are taught a narrative that movement through the social hierarchy is achievable by pulling yourself up from your bootstraps. This ideology creates conflict and competitiveness between members of a society which then causes distrust and lessens social cohesion. Tall poppy syndrome is a similar colloquial term used in New Zealand in a faux sense of egalitarianism. The term tall poppy syndrome is used to mock those higher up the social hierarchy or those who think more highly of themselves than others. Wilkinson and Pickett (2010) suggest these divides between people through competitiveness, distrust, and less social cohesion create further social status anxiety due to the importance and worth placed on obtaining social status. Violence can be placed as moments or snapshots into a context of neoliberalism and inequality, where the emphasis on social status and hierarchies of worth has intensified the presence of status anxiety. Wilkinson and Pickett (2010) suggest that this increased presence of status anxiety has increased the shame that people experience because there is more to evaluate one's self-worth against.

Shame is a powerful emotion that is often left hidden, invisible, and internalised (Thomas et al., 2020). Shame arises in situations where one evaluates their actions as being dishonourable, unworthy, improper, or disgraceful. Shame can come from stigma or situations of social exclusion because one is left to evaluate what they did wrong. Shame, in Craig's situation, is an additional layer of symbolic violence perpetuated by the self through the internalisation of pain and distress. The ramifications of symbolic violence and shame can be seen in all levels of Craig's context, including his interconnectedness to his context because Craig's own feelings prevented him from wanting to engage with his peers and halted any development of relationships. Craig felt shame for his everyday experiences of symbolic

violence. Craig internalised shame as a personal failure or defect. In many ways, this shame would have exemplified his feelings of worthlessness and had further impact on his mental wellbeing (Thomas et al., 2020).

Brian, in his story, experienced deep, embedded shame for most of his life. This shame that he internalised affected his interactions with his micro and meso-systems (Bronfenbrenner, 1996). At the micro-level, his father had physically abused him for engaging in faecal play when he was at a very young age. Brian was left with resentment, shame, and hatred towards his father and family for the way they treated him. The simple and curious actions of his childhood developed into trauma and shame, which he carried through to his adulthood:

Brian: I kept the shame, the humiliation, the sense of absolute powerlessness. Far into maturity I could still be shaken by an angry, stentorian male voice. Something crucial inside me died that day in my third or fourth year. The lively, loving child was snuffed out, and the deadly, self-destructive man began to be born (Oard, 2020, Part one, para 51).

Abusive and violent situations like what Brian experienced can be overpowering, leaving a person feeling powerless. Brian carried his shame and internalised it as a personal and moral failure from a young age. At Brian's engagement with his meso-system, he recalls further punishment at school, which in turn led him to engage less with his peers at school. As a child he thought his curiosity with faecal play was a bad behaviour because he was punished so harshly. Brian reflected how other behaviours involving faecal matter, such as excretion, were also bad. As a child this meant he was constantly trying to do the 'right' thing by not excreting and holding his faeces in. Brian reflected that this only led to further punishment by his parents, peers, and teachers. Brian internalised these feelings of shame that arose from these situations, which exemplified to him that he was either a 'failure' or 'defective'. It is

understandable how Brian's feelings of hopelessness and worthlessness developed from a young age, and he carried these feelings into adulthood.

Holly's Experience with Sexual Violence and Inequality

Experiences of shame and symbolic violence occurred alongside sexual abuse. Symbolic violence does not just occur within the confines of physical violence. Morgan and Björkert (2006) suggest that symbolic violence maintains relationships of domination through forms of communication, stigma, and psychological abuse. Holly experienced a relationship of domination that was enacted through sexual abuse and the use of favours. When Holly did not comply with requests, she was met with acts of coercion or condescension. Coercion and condescension are examples of psychological abuse, another form of symbolic violence, that is often hidden and invisible compared to physical violence (Morgan & Björkert, 2006). Holly was sexually abused by another family member from a young age. She discussed how she was stuck in a situation where she felt she had to 'return the favour':

Holly: As a child I was being molested repeatedly by a male adult in my mom's family. He was definitely very smooth about it. There was never anyone around, and I was always at his house when it happened. He always made sure he said he did something for me first so of course I had to follow that up by doing something for him. Return the favor so to speak. Yeah, some favor. Around the same time a girl confided in my mama that he was doing the same things to her. No consequences came for our abuser as a result of her confession, and thinking nothing would come of mine either, I stayed quiet (Roberts, 2018, Chap 1, para 3).

Bourdieu suggests that "symbolic violence can only be exercised by the person who exercises it, and endured by the person who endures it, in a form which results in its misrecognition as such, in other words, which results in its recognition as legitimate"

(Bourdieu, 2002, p. 140). In this setting, the male adult used symbolic violence to coerce Holly as a child into returning favours. In Holly's situation, a gender and age power dynamic exists between Holly and this male adult. This relationship of control and dominance is perpetuated by the invisible strands of symbolic violence through simple acts of language, touch, and communication (Morgan & Björkert, 2006).

Davies and Chisholm (2018) suggest that the human body is a political subject, where political ideology such as neoliberalism regulates the personal aspects of the physical, material, and psychological domains of the social self. Davies and Chisholm (2018) further elaborate that "neoliberalism is grafted onto bodies to sustain the political economies of male/masculine entitlement, commodification and naturalization of female/feminine labor, sex, and desire" (p. 286). Holly, in her story, experienced many moments of sexual violence as a young child. This sexual violence was not an isolated instance and occurred alongside wider inequalities in society (Springer, 2012). Violence is sustained in these unequal power relations within society (Wilkinson & Pickett, 2017). Neoliberalism further sustains inequalities such as gendered power dynamics through policies and practices that enable and reinforce forms of gendered labour, relations, and norms (Davies & Chisholm, 2018; Morgan & Björkert, 2006; Thapar-Björkert et al., 2016).

For Holly, her experiences of sexual abuse left her with a sense of disruption in her everyday life. Her early life experiences of maltreatment left her continually haunted each day and contributed to the hopelessness and worthlessness she experienced as an adult. The disruption of her normal, familiar, everyday life demonstrates the interconnection of experiences from the past and continuing to experience them in her present situations. In part, these experiences are connected to habitus, where our previous history, ways of being and knowing the world, continues to exist in our present and future contexts. The present and future contexts often create a place-bound habitus, continually reminding the person of the history

and connection to the place (Bourdieu & Passeron, 1977; Bourdieu, 1996). Holly further recounted how her earlier experiences of sexual abuse took a toll on her all the way into adulthood:

Holly: The mental and emotional repercussions of what he did are still present in my life. I can't watch a rape scene in any movie or television show. I can't hear about another child being molested. If for some reason I happen to encounter either of these things, I enter into a severe panic attack and can't sleep without having nightmares. It takes hours, sometimes days to calm down. It's difficult not to envision what that child or woman went through during the rape or molestation, even if it's only actors in a work of fiction. It hurts me on the inside so much that sometimes I can't even function. I sit around with a blank stare, trying not to cry out loud at the pain (Roberts, 2018, Chap 1, para 4).

Holly did not just experience the childhood moments of symbolic violence through the use of coercion into sexual abuse, but also experienced effects of psychological violence and trauma later in her life. These traumatic situations continued to haunt Holly, refuelling in the form symbolic or psychological violence. Within Holly's wider context we can see how the cycles of hurt, trauma and pain are sustained by the broader culture and inequalities within society.

Kevin's Story of Social Exclusion, Symbolic Violence, and Mental Distress

In the last part of this analysis section, I discuss Kevin's story. His story involves both experiences of physical and symbolic violence. Throughout his story he reflected on experiences of feeling like an outsider and becoming socially excluded. In the excerpt below, Kevin recounts what it was like for him growing up in his school environment:

Kevin: At our school some of the other students would hold me down and beat me up. Everywhere they could. There was nowhere I could escape their calling

me every name in the book. Before and after school when there were no teachers or parents in sight, they would push me to the ground and my palms would collect the grains of loose gravel in them as I'd try to pick myself up again. Once down, they'd chant taunts and racial slurs. "Ginger." "Red nigger." That went on for all seven years I attended this school, without check (Hines, 2013, p. 30).

The quote above shows that Kevin endured this bullying, taunting and physical abuse throughout his attendance at school. Symbolic violence was used in indirect forms of communication such as joking, taunting, and group separation. His quote above speaks to the powerlessness he felt in these situations, where he felt there was no escape. For Kevin, this took a toll on his physical, emotional, and mental health. In Kevin's story, we see another instance where symbolic violence "serves to legitimate direct and structural violence and also to inhibit or repress any response by victims of this violence" (Rodriguez et al., 2014, p. 360). Kevin's response is repressed because of the future possibility that the bullying, discrimination or social exclusion which would get worse than it already is if he was to speak out. In a more unequal society, acts of dominance become more prominent as groups attempt to gain higher social status. In Kevin's case, he was being ostracised for appearing and acting differently to the other peer groups in his catholic school. Over time, Kevin internalised part of the social exclusion as a self-defect, that it was him that was causing the problems that he experienced at school. We see this in the latter part of story where he discusses the development of his paranoia:

Kevin: I became extremely ill during this time. It was an illness and feeling that I could not describe. I believed people conspired and plotted terrible violence against me, even death. I could be walking anywhere, down the hall, or down a street, and suddenly feel as though I was surrounded by dangerous individuals or groups with evil intentions. ... "My fellow classmates sensed something

“off” about me. A trained psychologist would say I had “paranoid tendencies.” Paranoia imploded within. One student who knew I was not doing well, and was all for abusing that knowledge, walked by me in the hallway and whispered in my left ear, “Faggot!” The word echoed in my brain. His assumption was that my odd behavior must have been due to my newly founded sexual preference. Although I was not questioning my sexuality, his words in my psychotic brain resonated and twisted my thoughts for a few days. I felt what it was like to have bipolar for the first time. Of course, then I didn’t know that was what was happening to me—that the chemical balance in my brain had tipped (Hines, 2013, p. 44).

Kevin attributes his paranoia to being a chemical imbalance and a defect of his brain. However, it is quite clear that Kevin had his reasons to be paranoid when he had endured physical, emotional, and psychological abuse, as well as racism, and bullying throughout his school career. These instances would have left him feeling fearful of what is to come next and feeling unsafe in his school environment. It seems that Kevin had internalised a neoliberal message suggesting that he was the problem (Rimke, 2016). This internalisation would have created further feelings of shame and powerlessness for Kevin. The neoliberal narrative that claims such a psychocentric view of the self and human phenomena, will only lead to obscuring of social contexts that had led to the development of such mental distress. In Kevin’s case and the other authors’ stories, there are wider social structures and cultures that sustain violence at the individual and group level, such as what has been previously mentioned, the neoliberal narrative and societal inequalities (Thomas et al., 2020).

Discussion

This section discusses and summarises the analysis of the autobiographies in relation to the research aims. The theoretical framework I used to analyse suicide is from the community psychology sub-discipline which incorporates ecological, phenomenological, humanistic and narrative understandings of the person. Community psychology, as a theoretical framework, has helped broaden my understanding of suicide beyond clinical and mainstream psychology which focuses on individual risks factors and is deficit orientated. Instead, community psychology has enabled me to more broadly understand a person and their sociocultural context (Hodgetts et al., 2016; Murray et al., 2004; Trickett, 2009). This sociocultural context inevitably shapes, constrains, and contributes to the everyday human living experience (Hodgetts et al., 2016). By using an ecological approach to suicide, I have been able to situate suicide as more than just an individualistic act. I have argued throughout this thesis the impact of social conditions and how a given sociocultural context contributes, produces, and sustains the individual risk factors of suicide.

Discussion of Analysis

Suicide is a complex social phenomenon (Minayo et al., 2006). One suicide represents an accumulation of various and diverse life experiences. These experiences can intersect and ultimately lead to the unfortunate event of someone taking their own life. The complexity of suicide is weaved across biological, psychological, philosophical, moral, sociocultural, historical, anthropological and economic domains (Button & Marsh, 2019; Button, 2016; Marsh, 2013). Careful consideration of these various domains is important in preventing each suicide, so an important and loved life is not lost.

Noted throughout the academic literature is the attribution of various risk factors that include these diverse domains. However, much of the academic literature on suicide prevention has focused on the immediate individual and psychological risk factors (Marsh, 2010, 2013,

2020). While these established risk factors provide a good foundation to develop suicide prevention strategies, the focus on individual and psychological risk factors can obscure broader explanations. These broader explanations can express, explain, or suggest possible causes beyond the individual aetiology of suicide. The present study has focused on teasing out these broader explanations in the autobiographical material chosen to contextualise the everyday experiences of psychological distress. I paid particular attention to the narratives that were formed in each autobiography or memoir in order to see how these narratives gave insight into societal practices. Using my own understandings from my journal reflections, humanistic theory (Bland & DeRobertis, 2020), narrative theory (Polkinghorne, 2007) and phenomenology (Landridge, 2017), I was able to explore each autobiographical account deeply and contextually to further comprehend the complexity of suicide. To extend beyond an individualistic perspective on suicide, this thesis was informed by a social justice approach and ecological perspectives on health.

My analysis was spread across three chapters (chapters 4-6). My analysis progression was outlined in the methodology chapter. The first analysis chapter (chapter 4) started with Brian's memoir on his suicide attempt. This chapter was analysed with some of my reflections on suicide which, at the time of writing chapter three, was still focused on the individualistic nature. Although I had created an argument to move beyond individualistic thinking, my vocabulary and some of my own personal thought processes were still stuck in old ways of expressing and exploring the phenomenon of suicide. The reflective part of Brian's analysis represents the journey I went through to move beyond individualistic thinking of a phenomenon such as suicide.

Brian's case presented a unique finding that contradicted how western societies understand suicide and people experiencing suicidal thoughts. His rationality for his thoughts and actions suggests a possibility that there is a rationality for suicide. This contradicts the idea

of suicide being a ‘madman’s’ act or an ‘irrational’ thought process. Brian’s story also challenges the taboo nature of suicide through his rationalisation and contextualisation of his actions later in his story. In western society, a culture of neoliberalism and psychocentrism individualises human problems as human deficits, which can lead to blaming the ‘victim’ for their problems (Rimke, 2010, 2016, 2020). Unfortunately, this obscures broader explanations such as Brian’s situation where he faced impending homelessness, poverty, precarity, and no income. Each of these situations Brian faced can be linked back to wider inequalities in society (Wilkinson & Pickett, 2017). By linking back to wider inequalities in society, Brian’s choices seem less mad and irrational despite how mainstream society might conceptualise his thoughts of suicide. Brian’s story suggests a need for there to be more focus on investigating and exploring broader explanations for suicide that go beyond the individual level. Perhaps by adding this broader focus, we might be able to alleviate some of the societal wide stigma and taboo around talking about suicide. By placing less focus on the individual person, people may fear less of the judgment and discrimination that can happen when talking about one’s personal distress or suicidal thoughts.

Chapter five and six focused on further discussing neoliberalism and societal inequalities. In chapter five, I explored how social class and precarity were intertwined in the authors’ life stories. While in chapter six I explored further how violence is developed and sustained in society through widening societal inequalities. The experiences of social class, precarity, poverty, homelessness, violence, and abuse are often attributed to being a person’s fault for either not trying hard enough to be successful or because they ‘put’ themselves in that position (Chandler, 2019; Peacock et al., 2014; Rimke, 2016; Wilkinson & Pickett, 2010). Neoliberalism promotes a narrative that if you work hard enough, you will become successful and have better health (Rimke, 2016). This narrative affects the way we perceive health, in which health becomes an individual responsibility and a commodity one must afford. So, in

this conceptualisation of health, if a person fails to have good health, then it becomes a failure of their moral and biological character. In order to have good health, self-help and psy-complex modalities are advertised to the wider public as the way to better health. Pharmaceutical companies have actively supported this medicalisation of health and various disorders to make more money. Consequently, this system further increases a societal divide in which some people can afford health and others cannot. By commodifying health as an individual responsibility, experiences such as social class, precarity, poverty, homelessness, violence, and abuse are further tied to the individual as their responsibility and therefore becomes internalised as a failure if they fall into experiencing these situations (Thomas et al., 2020).

The analysis in chapter five and six sought to disrupt this narrative on health. Disrupting this narrative allows for broader explanations of suicide, by connecting experiences such as social class and precarity to wider inequalities in society. Everyday experiences exist as moments, that are (re)produced and sustained by the widening gaps in wealth, income, resources, and power. These widening gaps benefit few and disadvantage many people. Throughout the analysis these gaps contributed to creating an unfair chance at life for the six authors. These gaps between different social classes and sociocultural groups create further tensions in society and more health problems in society overall (Wilkinson & Pickett, 2010, 2017). From analysing the authors' experiences in chapter five and six, I was further able to see the complexity of suicide. The feelings of burdensomeness, worthlessness, purposelessness, and hopelessness, which have been associated with suicidality, all arose in contexts of hurt, hate, violence, trauma, shame, and anguish (Button, 2016, Button & Marsh, 2019). These contexts were mediated and sustained by the politics and culture of the Anglocentric and westernised societies that the authors' lived in. The rise of neoliberalism, widening inequalities, and the (re)production of psychocentrism has created an atmosphere where collective and societal problems are positioned as a personal defect of a person. Social

injustices such as racism, sexism, classism, colonialism, precarity, poverty, and homelessness, are held as a personal defect and a moral failure, rather than part of a larger society which (re)produces and sustains these types of social injustices. Using an ecological analysis of the authors' accounts I was able to explore how instances of social determinants of health and social injustices contributed to the authors' experiences of coming to attempt suicide. By taking such a stance on suicide, I began to further understand how the feelings of burdensomeness, worthlessness, purposelessness, and hopelessness arise in such unjust and unequal contexts.

Suicide in the literal sense (at least from a westernised framework) is the act of giving up on one's hopes, dreams, future, and life. Suicide is often defined through a psychocentric lens as being a sin, crime, self-murder, or a consequence of mental illness (Marsh, 2010, 2013, Noon, 1978). However, in each of the authors' stories is an interwoven account of their strength, resilience, and resistance to pull through the hard times. Each of six authors were not passive victims in the face of oppression, violence, social injustices or societal inequalities. The authors' faced these issues and tried to find a way through before coming to the point where they no longer wanted to live. Suicide was a last resort when the six authors had exhausted many options and had been further worn down by the "presence of systemic social conditions that foster and sustain the kinds of anguished feelings that are highly correlated with suicidal ideation and conduct: hopelessness, burdensomeness, and social isolation" (Button, 2016, p. 275-276).

The act of giving up one's life only occurred after a long process of enduring many events, experiences, and social conditions. Often people experiencing suicidality are positioned as being irrational or as not thinking 'properly'. So, those experiencing suicidality are framed as in need of an intervention that diagnoses, maintains, and restricts them in order to save them from 'themselves' (Marsh, 2013). In the short-term, this narrow focus on the individual may allow one to save a few individuals from 'themselves'. In the long-term, many lives will still

be lost if systemic social conditions are not addressed and additionally are not seen as an essential part of suicide prevention. This approach that focuses on individualisation, psychocentrism, and saving the person from ‘themselves’ can be considered a form of structural violence (Hodgetts et al., 2014; Rodriguez et al., 2014). This focus of saving people from ‘themselves’ can be patronising and deny the person of their personal agency and validity. It can suggest to the person that their personal distress and suffering is less valued or an irrational response to their personal grief, suffering or emotional distress. A humanistic approach is needed when approaching suicide prevention that focuses on helping the person and validating their personal distress and suffering as a more reasonable and rational response to difficult life conditions. This humanistic approach I have taken was influenced by my background in community psychology training and has allowed me to extend beyond a psychocentric lens (Trickett, 2009).

Reconceptualisation of Suicide

Moving forward from the analysis in chapters 4-6, I propose two ways suicide could be reconceptualised. The first reconceptualisation is based on Gestalt psychology through looking at a person in their context. Person-in-context is a key principle of community psychology (Trickett, 2009). A common practice in psychology has been to break down a person into their individual parts, such as their personality or disorder. This dissection means we can lose sight of the context behind how these personalities, behaviours, or disorders arose. Gestalt psychology, however, shifts the understanding of the person to see them as a part of a bigger picture or whole. Gestalt psychology is a part of both humanistic and phenomenology frameworks (Assis, 2016). In humanistic psychology, the social self is viewed in a holistic way that sees the social self as being derived and integrated in a larger sociocultural context. The social self is viewed as a whole self rather than being broken down into its individual parts and components. Instead of isolating individual behaviours, actions, and personalities as void of

context, these aspects of the social self are observed and construed within the contexts in which they arise in. Taking a humanistic perspective for suicide would allow us to see life as complex, beautiful, messy, chaotic, spontaneous, ordered, and mysterious (Bland & DeRobertis, 2020).

Gestalt psychology is also viewed similarly in the phenomenology tradition. Phenomenology focuses on the personal lived experience and lifeworld of a person. The person's lifeworld is contextualised as being a part of a larger 'whole'. The whole refers to the larger sociocultural context. Part of this tradition is the idea of moments. Moments act interdependently to the larger whole (Landridge, 2017). By viewing suicide from a Gestalt and phenomenological perspective, we can view suicide as a moment in a larger whole, where suicide is interdependent on the local, global, and historical contexts in which it arises in. This is similar to how Springer (2012) conceptualised violence as being a 'moment'. By viewing violence as a 'moment', it could then be theorised as this 'moment' occurred alongside moments of neoliberalism and even as part of larger context of societal inequalities. I propose that suicide should be seen simultaneously from both Gestalt perspectives in humanism and phenomenology. Suicide would then be seen as a moment or a part of a larger whole.

The second reconceptualisation is to view suicide as a wild, unstable, and unpredictable phenomenon. In White's (2012) article, she discusses how youth suicide as a social issue has become viewed as a 'tamed' problem. The complex problem of youth suicide and other suicide(s) have become an object of scientific study for a long time (Marsh, 2010). This type of scientific study has been used by positivistic models with an emphasis on empiricism. In order to carry out empiricism from a positivistic stance, there needs to be control over the phenomenon that is being studied. This control is needed to create measurable results that are replicable across other contexts. In the case of suicidology, suicide has been commonly studied retrospectively by using psychological autopsies (White, 2012). By using psychological autopsies, scientists have been able to research the factors that may have contributed to a

person's suicide attempt. These factors are called risk factors and they give an appearance of something that is stable and predictable. There are many risk factors that have been associated with suicide. Using risk factors to create and organise suicide prevention policies and programmes, gives an appearance that the problem of suicide is 'tamed' and can be predicted (White, 2012). However, it is quite clear that the problem we call suicide is nowhere near being 'tamed' and in most many cases is more unpredictable than it is predictable (Carter et al., 2017; Chan et al., 2016; Large et al., 2017; Nielssen et al., 2017; Pokorny, 1983).

White's (2012) article is an invitation to think of alternative understandings and knowledge on the topic of suicide. The conception of stability, predictability, and control of suicide undermines the very complex nature of the phenomenon. The very nature of complexity is unstable, unpredictable, vast, confusing, and is ultimately hard to maintain or control due to the various factors that may contribute to the construction of this complex phenomenon. Throughout the authors' accounts in the analysis, we see this complexity arise in their lifeworld. This complexity arises as the political, sociocultural, existential, psychological, and economic domains intertwine to create personal lived experiences. White (2012) explains her reasoning to reconstruct youth suicide as a wild phenomenon in the extract below:

By unsettling the stable, singular and individualized construction of youth suicide and by re-imagining it as a "wild" and unruly problem that is deeply embedded in local, historical, political and relational contexts, it is suggested that more expansive possibilities for thinking, learning and responding might become available (p. 42).

Alongside youth suicide, I suggest that White's (2012) discussion be expanded to all suicide(s). Perhaps then the full breadth and depth of the phenomenon can be digested so that new and diverse ways of thinking can be used to discuss and prevent suicide. The idea of unsettling or reconceptualising suicide is not to undermine the current models, practices, and

services we have in place for people who need that help. Instead, it is to expand and explore novel ways of approaching suicide prevention. By viewing suicide as a wild phenomenon that is unstable, unpredictable, and complex, then perhaps localised solutions that are not generalised from global models can be explored without contention. Additionally, solutions can be explored that focus less on locating the problem in the individual and focus more on local to national pathways which allow for people to have a better chance to a fair and meaningful life. This conceptualisation aligns well with community psychology's ecological orientation and emphasis on social change (Murray et al., 2004; Trickett, 2009). The next section focuses on how to approach social change and ecological focus using an upstream approach to suicide prevention.

An Upstream Approach to Suicide Prevention

The field of community psychology highlights the need for both ameliorative and transformative intervention (Trickett, 2009). An ameliorative approach is needed because there will always be individuals in need of help through either a health service or an immediate intervention, such as those who attempt suicide. Current suicide prevention models are commonly based off an ameliorative stance compared to a transformative stance. An ameliorative stance focuses on identifying and creating interventions around preventing individual risk factors, often when they occur (Marsh, 2010, 2013, 2020). A transformative stance seeks to change the environment and social conditions that produce these individual risk factors and is needed in the long-term to prevent these factors from arising.

These two different stances of prevention relate to a metaphor of a waterfall (see figure 2.). The waterfall metaphor has been used throughout the public health discipline to illustrate differences in upstream and downstream approaches (Talley, 2011). In the waterfall metaphor, there is a big waterfall and a large river flowing through a city. In that river, there are people

falling in and consequentially drowning because of how strong and powerful the river is. Health professionals and rescue workers attempt to save every person that falls into the river. But no matter what they try, they cannot save everyone. The approach these health professionals and rescue workers are using is a downstream approach by working at the immediate forefront of the issue. An upstream approach in the waterfall metaphor would seek to explore how people are coming to the waterfall and why they fall down the waterfall.

Any approach to addressing suicide from an upstream perspective should start from a social determinants of health perspective and seek to address the social injustices that people experience. As discussed in the introduction, addressing the social determinants of health requires collective efforts ranging from local action by people to combined efforts across communities, sectors, agencies, and governments (Raphael & Brassolotto, 2015). However, a combined collective effort and an ecological focus is not an easy task to accomplish. To accomplish this task a multisectoral and whole of society approach is needed. Using a whole of society approach, it is essential to recognise the different interconnections between various policies in relation to suicide. Ideally, a multisectoral approach is set up so that it reaches a variety of stakeholders and the whole of society through multiple life courses, different age groups, genders, sexualities, and ethnicities. For example, the 2006-2016 Aotearoa national suicide strategy outlined a multisectoral approach. This multisectoral strategy pooled together and gave an example of well-established resources in society that could work together to prevent suicide (See figure 3.). The importance of collaborating with various stakeholders

Figure 2.

Picture of a waterfall

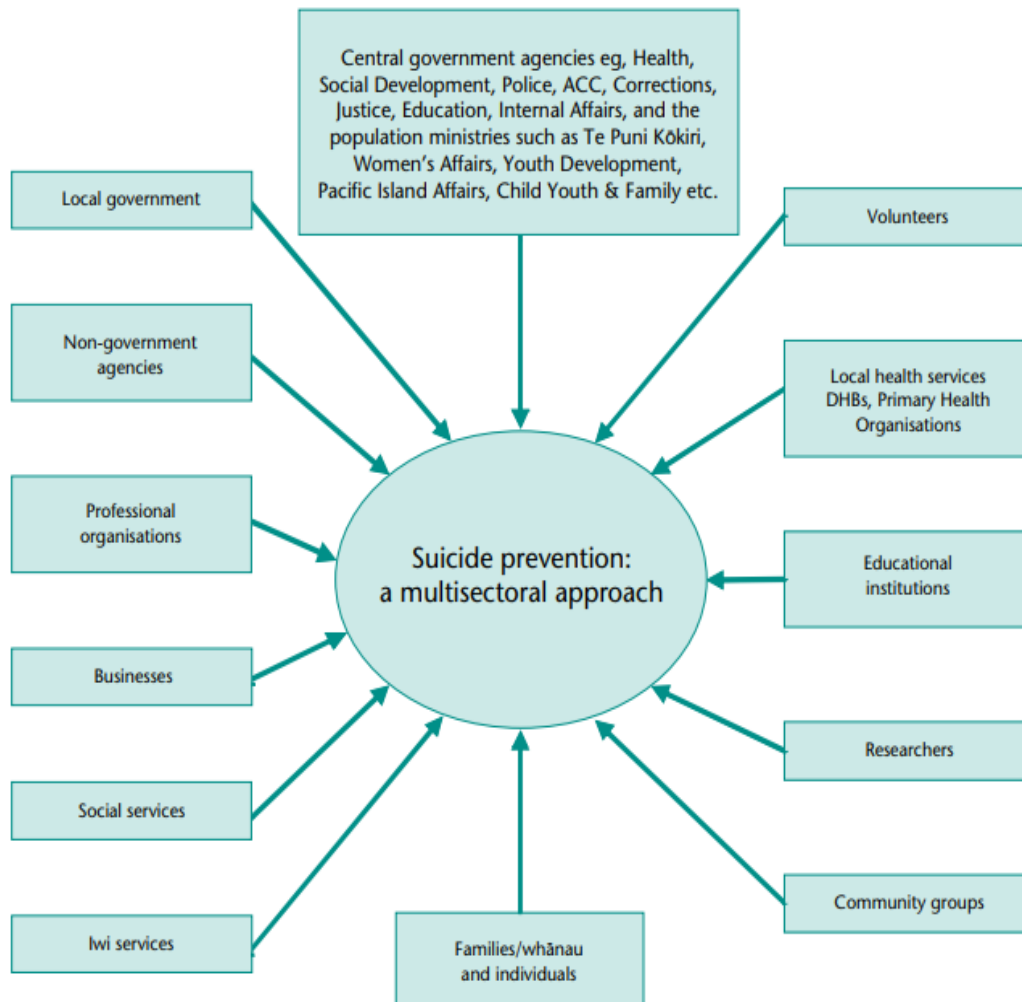


Source: Photo I took of Wairēinga, Bridal Veil Falls in Raglan, Waikato

allows for the empowerment and participation of those who are closely impacted by suicide (Murray et al., 2004; Trickett, 2009).

Figure 3.

Example of a multisectoral approach to suicide prevention



Note. This figure demonstrates the different interconnected parts in a societal structural to approach suicide prevention from a multisectoral approach. Reprinted from *The New Zealand suicide prevention strategy 2006–2016* (p. 7), by Associate Minister of Health, 2006, Ministry of Health. Copyright 2006 by Associate Minister of Health.

The second part of an upstream approach to suicide includes recognising the social injustices and societal inequalities that prevent people from living a fair and purposeful life (Button & Marsh, 2019). This approach aligns with community psychology's ecological focus on the human condition and everyday life (Murray et al., 2004; Trickett, 2009). This focus

allows for the community psychologist to view the person in their sociocultural context and how these influencing conditions have contributed to the development of their strengths or their personal distress (Murray et al., 2004; Trickett, 2009). This focus further influenced my approach to analysing the autobiographical material from a humanistic and an ecological viewpoint in order to see how varying social conditions and narratives contributed to an author's suicide attempt.

The analysis of the authors' autobiographies revealed the complexity of their everyday lives and the various struggles they went through. These struggles were related to various socioeconomic factors which were embedded in an unequal society that (re)produced and sustained these factors. Any approach to suicide prevention should seek to integrate both downstream and upstream approaches. A downstream approach 'catches' those who are already prone to suicide risk factors by their experiences in an unequal and inequitable society. An upstream approach sees a person in their context and how their particular context has (re)produced unfair or less meaningful life situations. By identifying local and contextual solutions, the upstream approach seeks to address the causes of the causes to suicide and create more meaningful life situations (Talley, 2011). Key values of community psychology are important in creating local and contextual solutions to suicide. These values include the value of diversity and inclusion, the participation and collaboration of key stakeholders, and having a diverse range of views and understanding coming together (Murray et al., 2004; Trickett, 2009). These contextual solutions can attempt to address local struggles and disparities in a way that is useful for that community.

Future Directions and Limitations

There were two main limitations of this study. The first limitation is that I was not able to interview people due to how the evolving situation of COVID-19 affected the research direction. Being able to interview someone would have given me the possibility to ask

questions or go deeper into topics during the interview. Throughout my readings of the autobiographies there were times where I wanted some of the authors to go deeper or expand on what they were saying to further my understanding. There were times where some of the authors would say something, and it would not be clear to the reader what they meant exactly or in some cases they skimmed over an interesting event or story. The second limitation was that I could not find suitable autobiographies from people who are either a sexual minority, an ethnic minority, or from an Indigenous person's perspective. Future research should focus on collaborating with people from either a sexual minority, an ethnic minority or an Indigenous person's background to explore the intersectionality of factors that can lead to suicide. The experiences from these people's background may give other useful insights into the varying social injustices that people face each day.

Final Words

The development of this thesis has been a long journey for me. It challenged me to think deeper and more analytically of suicide from an interdisciplinary perspective. I have learnt to see the phenomenon of suicide as more than just an individual behaviour or personality attribute. Instead, I understand suicide as a complex phenomenon that is hard to reduce down to simple explanations. Another insight from this thesis is that I am more accustomed to with the idea that there is no simple explanation or simple answer to complex phenomenon like suicide. The study of suicide is not an easy topic to discuss due to the sensitivity and stigma that surrounds the topic. I attempted to approach the topic in a humanistic way so that I could extend current explanations of suicide in mainstream psychology. The contribution of this thesis to psychology is the integration of broader explanations of suicide that extend beyond modelling and risk factor analysis. My research has relevance beyond the specific topic suicide and extends to other areas like mental health, disability, poverty, and homelessness as some

examples. I intend to integrate these learnings in my future practice as a community psychology practitioner where I intend to approach such topics in a holistic and humanistic manner.

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Appendices

Appendix A. Interview Guides

First Interview Guide

Introduction

This interview will be loosely structured to allow for an open natural exploration of the participants life history before their first suicide attempt. Food and drink will be available from the start as way to connect.

The purpose of the first interview

- Get to know more about you and for you to learn more about me.
- Explore your life experiences before your first suicide attempt in relationship to the social determinants of health (briefly explain these).
- See these interviews as an informal and relaxed chat so try to relax as we explore your life stories. If you have any questions, feel free to ask.
- Explain confidentiality.

While we won't be exploring your suicide attempt till our final interview, before we start this interview it would be important for me to know when abouts you had first attempted to help guide the interview. About what age were you when you first attempted?

Go over briefly the topics that could be covered (adjust for the age at which the first attempt was).

For our first topic I would like to explore life before your first suicide attempt. Tell me a bit about what your life was like?

Using a mapping out chart/timeline chart during the interview might be useful. From what the participant starts to talk about, you can explore into these areas:

Childhood/Home/Family:

- Tell me a bit about what it was like growing up in [insert hometown]
- Tell me a little bit about your family while growing up? What were/was your parent(s) like? I'm curious to know more about your home life while growing up?
- Are there any key moments that stand out to you about your childhood? Difficult events? How did you get through them? Positive events? What did you learn from them?

Exploring other life stages:

- Looking back over ...Adolescence/Young adulthood/Adulthood/Older age... are there any difficult events or periods that stand out? What about positive events or periods?
- Parenthood (if applicable) – similar exploration – e.g. What has been like for you being a parent?

Photos/objects:

If participant bought a photo or object to share:

- Tell me why you bought this photo/object
- What is significant or meaningful about this photo/object for you?

While the participant explores and tells their life story it may open up to other areas which you could explore. The below areas are examples, but it is important to allow the participant to naturally tell their story and only prompt further as needed.

Relationships:

- What social support did you have during growing up? Parents? Friends? Family?
- Do you have any childhood friends that you remember? Tell me a bit about the friendships you had during your childhood/adolescence/young adulthood/adulthood/older age?

- Did those friendships you had during childhood carry on to different life stages? Did you gain different friends?
- Who were/are the people that are important to you?
- What connections have been most important to you?
- How did your relationships with people changed overtime?
- Tell me a little bit about partners you may have had?
- Difficulties of sexuality may an important topic for the individual to discuss or talk about.

Education:

- Tell me a little bit about the education you have attained? Did you encounter any barriers? How did you overcome them? What were some highlights during your education?
- What was school like during childhood/adolescence?
- What was university like?

Work:

- Did you have to work during your childhood? Tell me about that?
- What jobs have you had? What was your favourite job? Why?
- What has your work situation been like? Have you ever become unemployed? What was that like? Have you experienced long term unemployment? Or redundancy?
- What was your income like? Sufficient? Good?

Financial:

- Did your family have any financial problems? What about yourself?
- Did your family ever worry about making ends meet? What about yourself?

- What about being able to afford all expenses? (e.g. looking after children, leisurely activities, schooling, food, clothes, etc)

Food:

- Did your family ever worry about getting food on the table? What about yourself?

Housing:

- What was your housing like childhood/adolescence/young adulthood/adulthood/older age? Did you have any problems with mould, dampness, cockroaches, or rats? Do you think this caused any health problems?
- How often have you moved to a new house? Have you ever had any problems with paying rent?

Transport:

- Have you had any difficulties with accessing or having adequate transport? To work?

Violence:

- Did you ever feel unsafe at home? Did you ever feel threatened? Do you want to talk about what happened? How was the conflict resolved?
- Ask a little bit the areas the lived in. Did you feel safe in the areas you lived in? did you ever feel unsafe? Why?

Addictions:

- Did you ever experiment or explore the use of alcohol? Drugs? Tell me about that time?

Closing an interview

- Summarise what has been talked about so far? Is that an accurate summary?
- Is there anything else you would have liked to bring up today? Or any questions?

- How are you feeling after exploring these life stories? Discuss support available and talking about their support person they indicated on the consent form
- Set up next meeting – check preferred contact method

Second/Third Interview Guide

Introduction

This interview will be loosely structured to allow for an open natural exploration of the participants life history before their first suicide attempt. Food and drink will be available from the start as way to connect.

The purpose of the second interview:

- Continue to explore your life experiences before your first suicide attempt in relationship to the social determinants of health (briefly explain these).
- See these interviews as an informal and relaxed chat so try to relax as we explore your life stories. If you have any questions, feel free to ask.
- Explain confidentiality.

Summarise previous interviews

Talk about areas you may want to explore more further in the interview to help fill in gaps.

Using a mapping out chart/timeline chart during the interview might be useful. From what the participant starts to talk about and what they talked about previously, you can continue to explore into these areas:

Childhood/Home/Family:

- Tell me a bit about what it was like growing up in [insert hometown]
- Tell me a little bit about your family while growing up? What were/was your parent(s) like? I'm curious to know more about your home life while growing up?

- Are there any key moments that stand out to you about your childhood? Difficult events? How did you get through them? Positive events? What did you learn from them?

Exploring other life stages:

- Looking back over ...Adolescence/Young adulthood/Adulthood/Older age... are there any difficult events or periods that stand out? What about positive events or periods?
- Parenthood (if applicable) – similar exploration – e.g. What has been like for you being a parent?

Photos/objects:

If participant bought a photo or object to share:

- Tell me why you bought this photo/object
- What is significant or meaningful about this photo/object for you?

While the participant explores and tells their life story it may open up to other areas which you could explore. The below areas are examples, but it is important to allow the participant to naturally tell their story and only prompt further as needed.

Relationships:

- What social support did you have during growing up? Parents? Friends? Family?
- Do you have any childhood friends that you remember? Tell me a bit about the friendships you had during your childhood/adolescence/young adulthood/adulthood/older age?
- Did those friendships you had during childhood carry on to different life stages? Did you gain different friends?
- Who were/are the people that are important to you?

- What connections have been most important to you?
- How did your relationships with people changed overtime?
- Tell me a little bit about partners you may have had?
- Difficulties of sexuality may an important topic for the individual to discuss or talk about.

Education:

- Tell me a little bit about the education you have attained? Did you encounter any barriers? How did you overcome them? What were some highlights during your education?
- What was school like during childhood/adolescence?
- What was university like?

Work:

- Did you have to work during your childhood? Tell me about that?
- What jobs have you had? What was your favourite job? Why?
- What has your work situation been like? Have you ever become unemployed? What was that like? Have you experienced long term unemployment? Or redundancy?
- What was your income like? Sufficient? Good?

Financial:

- Did your family have any financial problems? What about yourself?
- Did your family ever worry about making ends meet? What about yourself?
- What about being able to afford all expenses? (e.g. looking after children, leisurely activities, schooling, food, clothes, etc)

Food:

- Did your family ever worry about getting food on the table? What about yourself?

Housing:

- What was your housing like childhood/adolescence/young adulthood/adulthood/older age? Did you have any problems with mould, dampness, cockroaches, or rats? Do you think this caused any health problems?
- How often have you moved to a new house? Have you ever had any problems with paying rent?

Transport:

- Have you had any difficulties with accessing or having adequate transport? To work?

Violence:

- Did you ever feel unsafe at home? Did you ever feel threatened? Do you want to talk about what happened? How was the conflict resolved?
- Ask a little bit the areas the lived in. Did you feel safe in the areas you lived in? did you ever feel unsafe? Why?

Addictions:

- Did you ever experiment or explore the use of alcohol? Drugs? Tell me about that time?

Closing an interview

- Summarise what has been talked about so far? Is that an accurate summary?
- Is there anything else you would have liked to bring up today? Or any questions?
- How are you feeling after exploring these life stories? Discuss support available and talking about their support person they indicated on the consent form
- Talk about next interview
- Set up next meeting – check preferred contact method

Appendix B. Information Sheet

Participant Interview Information Sheet

Title of project: Social Determinants of Health and Suicide

An invitation: I am a Community Psychology student at the University of Waikato. I invite you to take part in my research project.

Purpose: In this research I am interested in listening to your life story and experiences before your suicide attempt.

Outcome: The outcome of this research is to produce a master's thesis investigating the broader societal dimensions of suicide and how the social determinants of health are relevant for understanding the distress that can lead to suicide.

What are the social determinants of health? These are broader factors that affect our health in our everyday life. These could include stress, early life circumstances, food affordability, transport access, addictions, social supports, employment and income, social inclusion, poverty, and societal inequalities in money, power, and wealth.

How can you participate? I want to conduct four interviews with you. These interviews will be held at a mutually agreed location. Ideally, this location will be private and quiet so that the interviews can be audio recorded and then transcribed. These four interviews will focus on your history and life stories before your suicide attempt. I invite you to think about some photos or objects you would like to bring that remind you of your past and will help you narrate your life stories before your suicide attempt. Each interview may take up to 60 to 90 minutes. Your experience is vital in improving understandings of suicide. You are welcome to bring a support person (such as a friend or family member) to the interviews. If you would like to bring a support person, please indicate this in your consent form and let the researcher know.

Benefits of participating: The information you provide will be valuable for understanding suicide from a broader perspective, and as a way to challenge the view that suicide is just an individual mental health problem. There can also be a therapeutic benefit for people to talk about their life story and about their experiences around their suicide attempt in safe space.

Your rights:

1. You can decide not to take part in the research.
2. You can withdraw from the research up to two weeks after your first interview by contacting the researcher.
3. You can decline to answer any questions.
4. Your information will be kept confidential, and any personal identifying information will be removed.

If you participate, how will your information be managed? Your information will be stored securely in password-protected electronic files at the University of Waikato for five years after completion of the project when it will be destroyed.

If you have any concerns, you may contact:

The principal researcher, Shaun Foley: smf35@students.waikato.ac.nz

Or my supervisor, Dr Otilie Stolte: ottilie.stolte@waikato.ac.nz

This research project has been approved by the Human Research Ethics Committee of the Faculty of Arts and Social Sciences. Any questions about the ethical conduct of this research may be sent to the Secretary of the Committee, email alpss-ethics@waikato.ac.nz, postal address, Division of Arts, Law, Psychology and Social Sciences, University of Waikato, Te Whare Wananga o Waikato, Private Bag 3105, Hamilton 3240

Appendix C. Consent Form

UNIVERSITY OF WAIKATO

DIVISION of ARTS, LAW, PSYCHOLOGY & SOCIAL SCIENCES

PARTICIPANT CONSENT FORM

Name of person interviewed: _____

I have received a copy of the Information Sheet describing the research project. Any questions that I have, relating to the research, have been answered to my satisfaction. I understand that I can ask further questions about the research at any time during my participation and that I can withdraw my participation at any time up to two weeks after the first interview.

During the interview, I understand that I do not have to answer questions unless I am happy to talk about the topic. I can stop the interview at any time, and I can ask to have the recording device turned off at any time.

When I sign this consent form, I will retain ownership of my interview, but I give consent for the researcher to use the interview for the purposes of the research outlined in the Information Sheet. I understand that my identity will remain confidential in the presentation of the research findings.

Please complete the following checklist—Tick [✓] the appropriate box for each point.	YES	NO
I wish to review a summary of my transcript (provide email)		
I wish to review the findings of the study before final submission (provide email)		
I wish to have a copy of the findings at the end of the project (provide email)		

Participant :

Researcher :

Signature :

Signature :

Date :

Date :

Contact Details :

Contact Details :

Preferred Pseudonym :

If the need arose to ask
for some support who
would they be?

Appendix D. Websites and Articles Used to Help Find Possible Autobiographies

Section below is some websites and articles I accessed along my search to find suitable autobiographies for this master's thesis analysis. I would check out the books that were recommended by websites or articles and read the synopsis. If the synopsis was suitable, I would try find a way to acquire the book.

1. 10 Must-Read Memoirs From People With Bipolar Disorder
<https://www.bphope.com/bipolar-buzz/10-must-read-memoirs-from-people-with-bipolar/>
2. Resources for survivors: <https://uksobs.org/resources-for-survivors/books/>
3. A Surprisingly Long List of People Who've Attempted Suicide:
<https://www.mentalfloss.com/article/16920/surprisingly-long-list-people-whove-attempted-suicide>
4. Books About Death by People Who Committed Suicide:
https://www.vice.com/en_us/article/yv55qv/books-about-death-by-people-who-committed-suicide
5. Palissery, G. K., Kuhn, A., Brasier, D. J., & Wegener, M. A. (2018). Six autobiographies and two realistic fiction books as tools to engage students in neurobiology of disease: A guide for instructors. *Journal of Undergraduate Neuroscience Education*, 17(1), R4.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6312130/>
6. Suicide Attempt Survivors and the Value of Lived Experience:
<https://www.suicideinfo.ca/resource/suicideattemptsurvivors/>
7. Suicide Survivors Share Their Stories and Advice in These Photos:
<https://www.healthline.com/health/photo-essay-portraits-suicide-survivors-resilience#16>

8. Fourteen Insightful Memoirs about Mental Illness and Addiction:
<https://writingcooperative.com/fourteen-incredible-memoirs-about-mental-illness-and-addiction-1d5d426cb6ab>
9. 3 Memoirs That Explore The Many Facets Of Mental Illness:
<https://www.npr.org/2019/06/28/736612462/3-memoirs-that-explore-the-many-facets-of-mental-illness>