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Bad Death:
Sociology and the moral regulation of suicide in New Zealand

A thesis presented in partial

fulfillment of the requirements for the degree

of

Doctor of Philosophy

in

Sociology

at Massey University, Palmerston North.

Ruth McManus

2003

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Te Kunenga ki Pūrehuroa
Inception to Infinity: Massey University's commitment to learning as a life-long journey

Abstract

This thesis investigates the moral regulation of suicide in New Zealand. In classical sociology, moral regulation is conceived as the placing of external constraints upon social actors, a conception that fails to acknowledge moral agency. In response to classical dualities, Foucauldian studies of governmentality theorise moral boundaries and actors as simultaneous discursive constructions. Regulation is achieved through the enablement of subjectivity. Analysis undertaken on these terms shows that suicide regulation in New Zealand consists of three discrete periods – criminalisation, pathologisation and, in the current era, riskification. Currently, suicide regulation is achieved by constructing subjectivity as rational and instrumental individuals who take responsibility for their own lives. Although in many respects useful, this Foucauldian analysis fails to consider relations between governors and governed. Consequently, an implicit logic of assimilation devolves governmentality into a theory of elite domination that, like classical sociology, fails to recognise moral agency. In response, the thesis investigates discursive relations centred on bereaved by suicide support groups. Analysis shows that the governed refuse to assimilate official discourses. Rejecting responsibility as a stigma, the governed develop an ethic of self-care that constructs compassionate selves. In theoretical terms, then, moral regulation is an outcome of hierarchical discursive conflict. Moral agency is developed through lay resistance to authority.

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Epigraph

Because our judgements about others are often superficial or unfair, it does not follow that one must never judge at all; or, indeed that one can avoid doing so. As well forbid all men to count, because some cannot add correctly.

Berlin *Four Essays on Liberty*

I dedicate this thesis to my big brother Ray who set me on this route and my dad who died just short of its completion.

For Ray and dad

Chapter One – Introduction

> The sound of hand-wringing was audible from Wellington last week over an increase in the number of women having abortions. ... Much the same has been happening with youth suicide. There was a report of the Youth Suicide Prevention Project in 1992, followed by a Steering Group on Youth Mental Health and Suicide Prevention established in 1993. It reported in 1994, after which a monitoring group was set up. It filed two reports. Now a youth suicide prevention strategy is being devised – to co-ordinate developments – and is due out in September.
>
> Throughout this time, the number of suicides has steadily increased, and the adolescent mental health services which have been identified as far back as 1992 as a key need have, by and large, not materialised. ... In the old days, the Health Department issues instructions and its agents, the area health boards carried them out. Under the health reforms, the minister puts out vague guidelines and the RHA's simply buy. They do not plan, provide or co-ordinate services (Sandra Coney, *Sunday Star Times*, 18 May 97:C5).

Introduction

This thesis is a sociological study of the moral regulation of suicide in New Zealand. Although this study includes an historical dimension, its emphasis is upon the contemporary situation. New Zealand is now widely perceived to have a pressing problem with suicide, and with youth suicide in particular. The statistics certainly suggest that this perception is justified. Disley's (1994:7) *Suicide Prevention Initiatives: Youth Suicide The World Picture* shows that 'New Zealand is the third highest ranking country in relation to male suicide rates and the highest in relation to female suicides in this group'. Suicide in New Zealand is often described as an alarming 'epidemic' and many have called for more effective government policy and intervention to counter this threat to the nation's health. These calls have been made in the context of radical changes in the New Zealand welfare state (Kelsey 1995). Whereas in previous years the

central state had both planned for and provided a vast array of health services, since the mid-1970s it has been increasingly positioned as the purchaser of services delivered by secondary bodies. This development has profoundly altered the political landscape in which suicide is addressed.

Critics such as Sandra Coney often lament the passing of 'the old days'. In the absence of central instructions and agents, it seems that no-one is taking responsibility for the suicide problem and that ineffective 'hand-wringing' is the order of the day. Such criticisms point to the centrality of moral judgement in the consideration of suicide. However, when critics chastise a lack of responsibility they inadvertently draw attention to what is in fact a characteristic feature of the contemporary period. As this thesis will show, judgements about morality are not somehow absent from the contemporary scene. Indeed, moral instruction and agency are pivotal aspects of the regulation of suicide in New Zealand today.

Suicide has always been linked to considerations of the power of moral judgement. Certainly the two are deeply entwined in sociology. In part this reflects the discipline's origins, in particular its ties with the grand traditions of philosophical speculation. Western philosophies have long used suicide as a muse for contemplating the morality of conduct and the absoluteness of truth. Both Plato and Aristotle, for example, condemned suicide in their elaboration of 'the good life' (Plato 1970:391; Aristotle 1996:134). Each used suicide as a vehicle to deduce and elaborate the fundamental principles of moral conduct. The founders of sociology, such as Auguste Comte (1964:15), broke from such philosophical traditions and took instead the path of science and empiricism; rather than speculation, they sought substantive knowledge about human society. Despite these departures, however, the new science carried forward the old link between suicide and moral conduct.

This carrying forward is particularly evident in the mediating role played by the 19th-century tradition of 'moral statistics' (e.g. Masaryk 1881). As Giddens (1970:xxxi) comments, moral statisticians discussed suicide

> in a contrary way to the reasoning of the seventeenth-century philosophers; whereas the latter had used the right to suicide as an attack upon established morality, many 19th century tracts on the subject took the rise in suicide to be evidence of the deleterious consequences of the undermining of the traditional order.

Moral statisticians treated suicide as 'a reflection of the pathological state of societies which had lost their grounding in a firm moral order' (Giddens 1970:xxxi). Clearly, then, and despite the emphatic move from metaphysical to empirical analysis, the issue remained framed in fundamentally moral terms. Emile Durkheim incorporated moral statistics under the banner of positivism in his 1897 groundbreaking work, *Suicide: A Study in Sociology*. As a self-conscious attempt to found the new discipline, Durkheim's book bears testament to the centrality of suicide in the sociological study of social life.

Given these disciplinary anchors, it would seem at first glance a relatively straightforward task to bring sociology to bear upon the problem of suicide in this country. However, such is not the case. Suicide has the status of a classical problem in sociology. As Chapter Two argues, this has meant that the study of suicide has been divided by the sorts of methodological and theoretical dualisms that constitute the familiar battle-lines of the discipline. These dualisms have sustained an inadequate account of moral regulation. Resolving this problem is a crucial preliminary step for any analysis of the social significance of suicide in New Zealand.

Moral regulation and sociological dualism

As noted above, the philosophical tradition approaches suicide as a touchstone for moral conduct. Plato and Aristotle discuss the issue in terms of their visions of 'the good life', a life which is guided by appropriate rules, a morally regulated life. Moral regulation thus necessarily involves a relationship between the moral boundary and subjectivity. A moral boundary is 'that line between morality and immorality', a line that defines 'just when one leaves the territory of good and enters that of evil', or vice versa (Goode and Ben-Yehuda 1994:52). Subjectivity is 'the self-conscious awareness' that informs intentions and actions (Abercrombie 1994:417; MacIntyre 1984:23). In theoretical terms, moral regulation defines and co-ordinates boundaries and subjects in a specific way. Such regulation seeks to direct future action by making a connection between who you are and an evaluation of what you do. Crucially, these rules must guide conduct without recourse to a brute exertion of domination. Agency is thus a central feature of moral regulation.

Small wonder, then, that suicide has figured so continuously in discussions of the good life. Self-killing surely provides a test case for deliberations about moral agency. Moving away from philosophical abstraction, sociology poses moral regulation as a substantive problem in need of empirical investigation. When posed in these terms, the problem becomes in the first instance a matter of determining an appropriate methodology. From Durkheim on, the sociology of suicide has been defined above all as a methodological problem. There is, of course, a strong link between method and theoretical argument. The way that a theory and method are tied together both inscribes and circumscribes the account produced (Fielding 1988). Within sociology, these ties have sustained an inadequate account of moral regulation.

As Chapter Two shows, the sociology of suicide literature is organised along

the familiar lines of the classical methodenstreit (Tribe 1996:379). Persistent quarrels about what constitutes the appropriate method have divided the discipline into a dualism that pits the analysis of objective structures against the interpretation of patterned meanings. These two positions have been entrenched through reiteration. Despite such conflict, however, the contenders have certain important similarities. Significantly, the 'structuralists' and 'interpretivists' are both committed to a philosophical anthropology; both adhere to a priori conceptions about what constitutes social subjectivity. In keeping with such anthropologies, and irrespective of their particular differences, social subjects are conceived as distinct from the moral boundary according to which their actions are regulated. Given their mutual externality, rules exert themselves from outside the subject. Moral regulation is thus theorised by structuralists and interpretivists alike as a process of constraint.

For classically-framed sociology, suicide becomes a problem when there is a lack of appropriate degrees of moral constraint. This emphasis upon constraint, however, relies upon the force of external domination and as such fails as an account of moral regulation. Such arguments lack a convincing account of the agency that is central to this mode of social life. A sociology of suicide in New Zealand must therefore seek to overcome the dualisms that classically divide the discipline.

Re-viewing suicide in New Zealand

The search for a more convincing account of moral regulation led me to consider the relevance of Cultural Studies and the analysis of hegemonic discourses. Cultural Studies has often been defined as an attempt to overcome the sociological dualities of structure and culture. As many critics have argued, however, this attempt has not been successful, in part due to a theoretical tendency towards a structural

subjectivism that replicates rather than moves beyond the classical dualism (Wood 2001:5; Kingfisher 1996:53). Furthermore, and significantly given the empirical intent of this thesis, the Cultural Studies approach to moral regulation does not square with the New Zealand suicide situation.

Drawing upon Cohen's (1972) founding study, Cultural Studies approaches moral regulation as the intensification of hegemonic rule generated by moral panic (Hall et al.1978; McRobbie 1994:198). Moral panics occur when certain people are identified as fundamental threats to social order and their deviance is amplified by intensifying exchanges in the media, exchanges that culminate in calls to increase social regulation to protect accepted values (Cohen 1972:18). Moral panic needs deviancy amplification through the mass media. In New Zealand, however, media reporting on suicide is severely restricted through legislative censure by the Coroners Act (1988 Section 29). Furthermore, historical research shows that the media exercise a 'self-imposed' code of censure with respect to the reporting of suicide (Luke 1982:5).

Even though health professionals and government institutions do identify the suicide of young, poor, Pakeha men as a fundamental threat to social values, there is relatively little hegemonic intensification of this identification. Rather, there is a tendency for exchanges to be defused by stressing the complexity of suicide. According to one expert, for example,

> the task for reducing the high rate of youth suicide in New Zealand is not an easy one. The sheer complexity of what brings a person to want to end their life means that efforts must be made at a range of levels and by a range of organisations and individuals (Beautrais 1998:2).

This sense of 'sheer complexity' often means avoiding rather than seeking out media involvement. A journalist, for example, notes that

> some experts contacted cautioned the Sunday Star-Times about printing this article, fearing it would spark more

deaths (Catherall *Sunday Star Times*, 29 Nov 1998:A6).

These factors raise doubts about the usefulness of analysing media representations as a means to explore institutional activity about suicide in New Zealand.

The case of suicide may not be exceptional. Wood (1999) argues that, unlike their counterparts in the United Kingdom, New Zealand panics have lacked the hegemonic depth and breadth needed to construct fears about the social order in general. The moral regulation of suicide in New Zealand must operate in ways other than those highlighted by Cultural Studies. By comparison with overseas alarms, New Zealand's suicide 'epidemic' seems graver and more attuned to complexity. Such an emphasis on a somewhat cool expertise led me to believe that recent studies of regulatory trends undertaken from a post-structuralist, Foucauldian standpoint were more relevant to the problem investigated by this thesis.

Chapter Two thus concludes with a detailed consideration of Foucault's approach to moral regulation. Foucault's work seeks to explicitly overcome the classical dualism causing so much difficulty for the sociology of suicide. He makes two key and related moves. On the one hand, he develops a pluralistic discourse analysis that breaks with the methodological one-sideness of the classical debate. On the other hand, Foucault's post-structuralist commitments lead him to abandon all philosophical anthropologies. On these terms, moral boundaries and subjectivities are theorised not as external to each other but rather as co-constitutive. Instead of the constraint highlighted by classical sociology, moral regulation is a process of enablement, a process that relies on the operation of moral agency. These theoretical advances underpin post-Foucauldian genealogical investigations of the historical record and contemporary interpretations of govemmentality. Chapters Three and Four put these conceptions to work, using them to produce an analysis of suicide regulation in New Zealand.

Foucault calls for a revisioning of the present by breaking with the conventional sense of historical linearity. Analysis must generate detailed historical accounts and refuse to assume that the regulation of suicide is a process of either continuous moral improvement or failure. Chapter Three undertakes this task. As the first substantive moment of the thesis, the chapter develops a finely grained genealogy of past practices of suicide regulation in New Zealand. This genealogy identifies two distinct eras. The early, colonial period (1840-1893) was dominated by the judicial regime and characterised by 'criminalisation'. Suicide was framed as a crime to be punished. In contrast, the second, Public Health era (1893-1974) was characterised by 'pathologisation'. Here suicide was constructed as a form of mental illness amenable to medical treatment and cure.

Chapter Four uses the preceding historical accounts to identify specific features of the present-day control of suicide in New Zealand. In the current period (1974-2000), suicide is regulated by governmentality and is characterised by practices of riskification. Suicide is now framed as a risk to be addressed by community self-care. Governmentality seeks to enable subjects to assume responsibility for their situation and to manage for themselves the various moral difficulties they encounter when their lives are touched by suicide.

Recovering the voice of the governed

The historical record is one of often dramatic discontinuities. The current regulation of suicide in New Zealand is quite unlike that of the past. The discourses of suicide as an evil, criminal or insane act regulated by moral condemnation, criminal prosecution or psychiatric intervention have given way to the construction of suicide as an alarming 'epidemic' to be regulated by strategies of population risk management.

This historical interpretation draws upon Foucauldian conceptions. Chapters Three and Four thus demonstrate that these conceptions have considerable analytical power; they inform a telling account of suicide regulation in contemporary New Zealand. But it is not a complete account.

Chapter Five critically evaluates the gains and limits of governmentality theory. The emphasis upon a simultaneous discursive construction of both moral boundary and subjectivity allows for an advance beyond the dualism that characterises the classical positions in sociology. On these terms, moral regulation is theorised not as constraint but rather as the enablement of a responsible subjectivity, a theorisation that rightly emphasises the importance of moral agency. However, the role of this agency is not secured in the governmentality account. For all their emphasis on discursive plurality, governmentality accounts tend towards a one-sided methodological focus on official discourse, a limitation that stems from certain ambiguities in Foucault's formulations.

Governmentalist interpretations characteristically concentrate on the voice of the governors. By focusing on official statements and ignoring more ephemeral lay discourses such interpretations implicitly assume that official views prevail because they are assimilated by those who are governed. As such, governmentality theory risks devolving into conventional accounts of elite rule, with regulation reduced to the domination of the civilian many by the official few. On these terms, enabled subjects lack effective agency and the resulting social arrangements are more a matter of real-politick than moral regulation.

The thesis responds to these criticisms by developing a less restrictive methodological strategy. In particular, it seeks to hear the discourse of the governed. Chapter Six draws upon both official statements and everyday discourses to develop a

fuller account of current New Zealand practices that morally regulate suicide. This chapter marks the second substantive movement of the thesis argument. Chapter Six studies the interaction between experts and Bereaved by Suicide Support Groups. As a site for the study of moral regulation, these groups have a number of advantages. They are voluntary organisations already in operation throughout the country. In such groups, people talk outside of professionally controlled situations; they constitute a communal and safe space, not one artificially set up for research purposes.

Bereaved by Suicide Support Groups are investigated as an exemplar of community activity and as sites where lay discourses are generated. As Chapter Six shows, these groups do not conform to expert expectations. Far from assimilating official discourse, they persistently refuse to legitimise its claims. Through the exertion and development of this moral agency, the groups construct a subjectivity that is characterised not by the assumption of responsible risk management but rather by compassion for themselves and for others. Chapter Seven concludes the thesis by considering the theoretical implications of this officially unintended construction of compassionate subjects.

Conclusion

With many sociologists, our chosen areas of research often have tangible personal connections. My research is no different. The impetus to study this area came from an unannounced experience of confusion, fear and ostracism generated by losing my brother to suicide. As I lived this experience, my sociological training guided me to explore the reasons for people's reactions to 'our' situation. A need to make sense of the subjective and formal or institutional behaviour, of which I was part, developed into a fascination over how everybody else seemed to understand suicide, and yet I had such a

strikingly different perception of what was happening to me. I came to realise that suicide bereavement is experienced in many ways, that these ways are heavily ranked and subjected to often rigorous processes of moral evaluation. My topic came to be, very broadly, how suicide is regulated in society.

My initial research proposal was to undertake a comparative analysis of public and community responses to suicide in New Zealand. In particular, I wanted to conduct a community study in a place that had received a high degree of media attention due to the occurrence of suicide in its locale. I made preliminary enquiries to representatives of the Mental Health Foundation, Justice department, counsellors association, coroners and, most significantly, a Mayor whose community had been subject to intense media attention after a spate of youth suicides. As I talked with these people about my original research idea, it became clear that the community would not allow an independent researcher to come in. The only professional people that would be granted access would be trained clinical psychologists or counsellors. I came to reject that strategy, partly because if I were to access people through counselling or psychological services I would be interviewing people solely on the terms of the experts.

These early developments in the research process are telling. They reveal the extent to which public discourse is dominated by the voices of experts. But they also suggest that communities can refuse 'access' and create spaces outside the official domain. At heart, this thesis is an exploration of this gulf between expert and lay discursive practices. The refusal and reworking of official interpretations, I believe, is a central aspect of the moral regulation of suicide. Analysis of this process reveals the operation of a regulatory agency that empowers not the responsible subjects of governmentality but rather the compassionate selves of a more everyday moral life. Appreciating the powers of this agency calls for a theoretical approach that breaks with

the classical dualisms that characterise the sociology of suicide and that sustain its faulty conception of moral regulation as a process of constraint. This theoretical work is the task of Chapter Two.

Chapter Two - From moral science to moral governance

Introduction

There is great concern over suicide in New Zealand and the need for sociology to engage with this concern is pressing. Bringing the sociology of suicide to bear on the New Zealand case, however, is not a straightforward task. As in the grand philosophical traditions, sociology approaches suicide as an issue that concerns whether suicide is a good or bad act. Suicide involves analysis of the relationship between a course of action and the moral rules that guide conduct. Sociological approaches to suicide thus entail accounts of moral regulation. Reviewing these approaches is the concern of this chapter.

Typically, the sociology of suicide has been framed in grand theoretical terms. As such, it has been characterised by a focus on methodological issues. This focus reproduces what is for sociology a classical dualism that pits structural explanation against intentional interpretation. Debates between these contending positions have sustained a theorisation of moral regulation as constraint. I argue that this conception of constraint fails to adequately account for the regulation of suicide. A more discursive approach that draws upon the work of Foucault theorises regulation as a process of enablement. This conception has the potential to move the sociology of suicide on from its classical impasse.

The sociology of suicide as moral science

The sociology of suicide has classical status in the discipline. That is to say, answers to the question 'what is suicide?' tend to be put forward as answers to the question 'what is sociology?' This is evident in a founding disciplinary moment. Emile

Durkheim's 1897 classic, *Suicide*, was explicitly presented as the first 'manifesto' to 'demonstrate the possibility of sociology' (Tiryakian 1978:188; Durkheim 1897:37). Durkheim used the study of suicide to proclaim sociology as the science of society under the banner of positivism. This proclamation set the terms of debate as primarily a matter of methodology. On these terms, seventy years after the publication of Durkheim's work, Jack D. Douglas (1967) responded with *The Social Meanings of Suicide*, an interactionist manifesto that contested the usefulness of positivist principles.[1] These two works, and in particular the dispute between them, can be used to map out the characteristic sociological approaches to suicide and I begin with a consideration of their arguments.

For Durkheim, suicide is of sociological interest as a statistical rate. It is the relative number of people who have succumbed to suicidogenic social forces in any given society in any given year. To be specific, the social forces of integration and regulation generate four social currents - egoism, anomie, altruism and fatalism - and when each is in balance they enable individuals to live their lives. When out of balance, one current comes to dominate and intensifies to such a point that a person cannot withstand it. Each social current has a specific suicidogenic effect. Egoism causes the positive contemplation of emptiness associated with self-absorption and can lead to 'melancholic languor' and 'indifference to life' (Durkheim 1897:278). Altruism, where the goal of conduct is exterior to itself, can produce such an energetic submission to these social goals that the individual acts regardless of consequences (Durkheim 1897:221). Anomie is a sense of normlessness that can lead to profound disillusionment

[1] Durkheim's disciplinary position is further elaborated in *The Division of Labour in Society* (1893) and *The Rules of Sociological Method* (1895). Douglas's position is further outlined in *Deviance and Respectability: The Social Construction of Moral Meanings* (1970a) and *Understanding Everyday life: Toward the Reconstruction of Sociological Knowledge* (1970b).

and disappointment (Durkheim 1897:258). Finally, fatalism - not regarded by Durkheim as a significant current in modern society - is associated with the 'ineluctable and inflexible nature of rule against which there is no appeal' (Durkheim 1897:276) and so can produce a suicidal sense of hopelessness.

The theory of suicide advanced by Jack D. Douglas is very different from that of Emile Durkheim. For Douglas, suicide is of sociological interest not as a statistical rate but as an intentional act. Suicide occurs when an already present subjective orientation toward suicidal thoughts overrides alternative interpretations that militate against such an act (Douglas 1967:330, footnote 22). The social context contains many ambiguous meanings about suicide. These meanings are thus available to a motivated and consistent interpretation that supports an individual's already held intention to kill themselves. As Douglas (1967:320) puts it, a particular individual commits suicide 'because of the specific construction [of meanings] which seems plausible to him and in some way fits his intentions'. Suicide is thus an outcome of the way in which individuals who intend to take their own life interpret morally ambiguous meanings.

The differences between Durkheim and Douglas' theories of suicide are rooted in their contrasting methodologies. Durkheim's theory is based on positivist commitments made clear in his famous exhortation to 'treat the facts of moral life according to the methods of the positive sciences' (1893:XXV). Durkheimian sociology studies the workings of a social order that exists over and above individual activity, focusing on the traces of these workings that are evident as 'social facts'. These facts are social phenomenon that exist beyond the level of personal comprehension; they are 'realities external to the individual' (Durkheim 1897:37). Suicide rates, for example, are not subjective meanings held by individuals but rather convey key movements at the level of the social structure. In practical terms, Durkheim advocated the study of such

facts through the analysis of official bureaucratic records, such as statistics and legislation. These records, he believed, derive from practices that are largely devoid of subjective input. Ideally, social facts are to be analysed inductively to identify their essential characteristics. On this basis, social causes would become apparent and laws discovered (Durkheim 1897:145).

Douglas's theory of suicide is driven by an interpretative methodology that draws explicitly on Weber's link between meaning and action (Douglas 1967:235). Douglas focussed his attention solely on subjective meanings. In this account, the social world ultimately derives from individual intentions. Even apparently objective or external social phenomenon can only be understood with recourse to such intentions. Subjective interpretations, for example, motivate the suicidal act and hence lie behind any translation of these acts into statistical phenomena such as rates (Douglas 1967:229-231). Accordingly, Douglas (1967:256) advocates not statistical abstraction but rather the study of 'what people say and do in the real-world situations'. Only such studies can shed light on the world of subjective intentions. Instead of external facts, sociologists should investigate the 'uninformed and informed experience of everyday phenomena', as is revealed in such sources as professional reports, diaries, personal letters and newspaper reports (Douglas 1967:269).

Durkheim eschews the subjective realm as irrelevant whilst Douglas rejects the external, positive dimension. They do not simply disagree with but indeed contradict each other. Durkheim and Douglas frame their methodologies as mutually exclusive. Positivism refuses to take cognisance of intentions because social facts are utterly external to the individual's internal world. Likewise, interpretivism refuses the analysis of positive facts because social life is ultimately entirely a matter of individual intention. The dispute between Durkheim and Douglas is thus organised by a classical

methodological dualism. As there is no quarter between positivism and interpretivism, their conflict offers no prospect of resolution. On these terms, reiteration of entrenched positions is the order of the day. This lack of resolution is significant when we turn to examine the wider corpus of work that constitutes the sociology of suicide. This work is organised by the methodological dispute that divides the positivism of Durkheim from the interpretivism of Douglas.

Durkheim's proponents can be categorised as belonging to either 'social factor' or 'sociologistic' research traditions. When *Suicide* was translated into English in the 1930s, a body of work developed that continued Durkheim's focus on the study of statistical rates. Social factor research, exemplified by Sainsbury (1955) and Dublin (1963), searched for correlations between specific factors and suicide rates. Sociologistic studies, on the other hand, took this a step further and focused on the *relationship* between the various parts of society, as in the work of Halbwachs (1930), Henry and Short (1954), Gibbs and Martin (1964) and Maris (1969).

The sociologistic studies assume that social integration is the key variable in accounting for suicide rates. Halbwachs took up Durkheim's thesis and re-appraised it in the light of new statistical evidence. *Les causes du suicide* (1930) argued that the relative differences in social isolation explain the variation of suicide rates between urban and rural communities. Maris (1969), on the other hand, focussed on the impact of material factors that physically constrain individuals. Henry and Short (1954) combined a sociological approach with psychological theories about the effects of frustration and aggression. Gibbs and Martin (1964) similarly argued that suicide statistics can be explained as the outcome of conflicts between role and status (Giddens 1971:58,67). Although Gibbs, Martin, Henry and Short all assume that suicide is the result of internalised aggression, their positivist commitments forestall any developed

analysis of social intentionality. Consequently, their work lacks determinacy; it fails to explain why some people murder, others suicide and the vast majority, subject to the same societal frustrations, do neither.

These studies are continuous with Durkheim's positivist project; they analyse a range of structural factors in order to uncover the causes of variable suicide rates. In contrast, the interpretivist paradigm, as exemplified by the work of Douglas, underpins both the ecological and interactionist strands of the sociology of suicide. Ecological research, typified in Chicago-style case studies (Coser 1978:313) and exemplified in the work of Ruth Cavan (1928) and Calvin Schmid (1939), concentrated on micro-sociological fieldwork in order to uncover the realm of intentional motivations. This emphasis on situated interactions and on the interpretation of their meanings produced two important studies of suicide by Harold Garfinkel (1967) and Maxwell Atkinson (1978).

Garfinkel's (1967) *Practical Sociological Reasoning: Some Features in the Work of the Los Angeles Suicide Prevention Centre*, used conversation analysis to examine suicide certification practices. The study established that these practices relied on member's accounts of everyday activities, on the 'practical reasoning' that generates 'prescriptions for locating, identifying, analysing, classifying, making recognisable, finding one's way around in comparable occasions' (1967:177). Emphasising the significance of common sense understandings in the compilation of statistical records, Garfinkel's work showed that many sociologists, especially in America, believed that interpretative methods offered significant gains over positivistic approaches. Maxwell Atkinson's *Discovering Suicide* (1978) further elaborated upon Garfinkel's findings. Atkinson also used conversation analysis to interpret official decisions that categorised certain people as suicides. And like Garfinkel, Atkinson (1978:183) concluded that the

ability to account for these categorisations demonstrated the capacity of ethnomethodology to solve the fundamental problem of sociology, that is, how social order is accomplished.

More recent work on the sociology of suicide evidences the same polarity of positivism versus interpretivism outlined above. Stack's (2000) review of research since 1985 concentrates wholly on summarising studies that adopt positivistic methods, a tradition that he himself works within (Stack 1997). Current interpretivist studies, although numerically rarer and more commonly categorised as social psychology, continue to be produced. The works of Szasz (1999) and Klug (1996) exemplify the ongoing vitality of this tradition.

As a whole, then, the sociology of suicide remains divided by a methodological dispute between positivism and interpretivism, as exemplified in the arguments of Durkheim and Douglas. This dispute investigates suicide primarily in order to specify the character of sociology and the social world in general. As such, the sociology of suicide has been organised as an exercise in grand theory. I turn now to consider some of the implications of the way in which the field has been framed, focusing once more on the work of Durkheim and Douglas in particular.

For Durkheim and Douglas, the study of suicide is an occasion to develop generalised accounts of the social world and how its affairs are ordered. Durkheim (1895:136) seeks to explain social order in terms of external social forces. These forces sustain the solidarity of the *conscience collective.* Individuals are socially regulated through a sense of belonging, a belonging generated by 'constantly breaking, and being punished for breaking the moral order' (Durkheim 1897:362). In contrast, Douglas explains social order in terms of subjective intention. These intentions generate enduring meanings that pattern action and patterned action is the mainstay of social life (Douglas

1967:247). These two competing visions of society are linked with quite different understandings of the science of society, sociology. That said, however, there is an important similarity between the methodological positions adopted by both Durkheim and Douglas.

Durkheim and Douglas are committed to science. In the pursuit of their scientific objectives, both elect to study a singular entity - either suicide rates or meanings - and each accordingly makes use of only one methodological strategy - statistical positivism or subjective interpretation. It is assumed that the study of society can be scientific only if it relies upon a single, internally coherent method. Durkheim and Douglas are thus committed to methodological exclusivity. Indeed, they explicitly and systematically refute the validity of all methods other than the one they have adopted.

Durkheim devotes the first section of *Suicide* to exhaustively rejecting alternative attempts to explain suicide rates. He concludes not only that sociology provides the only legitimate methodology but also that this methodology is only sociological when it analyses external social facts as the traces of collective phenomenon (Durkheim 1897:145). Similarly, Douglas expends considerable effort refuting all positivist explanations. For him, it is vital to 'begin *as far away as possible* from this hypothetical-deductive approach with a study of the real phenomena, above all with a study of the meanings of these phenomena to the social participants' (Douglas 1967:82 emphasis in the original). Durkheim and Douglas assume that the social world is reducible to and can be exhaustively studied by one method of investigation.

The belief that the world can be analysed scientifically only according to a 'singular and primary logic' is conventionally called 'monism' (McLennan 1995a:10). Such methodological monism, and the disciplinary dualism it sustains, is a characteristic

feature of sociology as an exercise in grand theory. Grand theory assumes that society is a real and coherent entity whose analysis must thus rely on an equally coherent methodological strategy. As the socially significant can be comprehended by such a science, grand theory promises a command of history.

The truths produced by grand-theoretical sociology enable us to improve society (Wright Mills 1959:25). In Durkheim's words, 'the progress of a science is proven by the progress toward solution of the problems it treats' (Durkheim 1897:35-36). Douglas similarly aims for 'a scientific treatment' better able to 'predict and explain specific types of social events such as suicide' in the hope that some may be prevented (Douglas 1967:270,339). Taken as a whole, then, grand theory promises sociology both scientific truth and moral rectitude. No doubt such commitments have a certain appeal. However, their effect on the sociology of suicide has been to sustain an inadequate theorisation of moral regulation as a process of constraint.

Grand theory and moral regulation as constraint

In this section I am not primarily concerned with determining whether or not the specific accounts of suicide advanced by Durkheim and Douglas are right in empirical terms. Rather, I am concerned with the general conception of moral regulation that underpins these accounts. Despite their differences, both Durkheim and Douglas draw on the conceptions of grand theory. On these terms, moral regulation is held to be rooted in a notion of what makes us human and what makes us human is the struggle with ourselves to accept an authority other than ourselves, an external authority. Moral regulation is thus understood as a process of constraint. Despite Durkheim and Douglas's divergent accounts of social order, their works evidence a strikingly similar approach to subjectivity.

Durkheim theorises social order as the outcome of social forces that curtail individual instincts by generating a sense of attachment to the group. This argument relies on a dualistic conception of subjectivity that he called *homo duplex*:

> Far from being simple, our inner life has something that is like a double centre of gravity. On the one hand it is our individuality - and more particularly, our body in which it is based; on the other is everything in us that expresses something other than ourselves (Durkheim 1914:152).

Douglas theorises social order on quite different terms. People purposively generate meanings about themselves from a stock of existing instrumental decisions; their actions are similar and so replicate patterns of action or society. The purposive generation of meanings relies on moral evaluations that determine appropriate courses of action. This theory also relies on a dualistic conception of subjectivity, here between the 'substantive' and 'situated' self. The substantial self is 'the independent seat of consciousness', while a situated self is imputed to a person 'resulting from his involvement in and commitment to certain types of socially defined patterns of action' (Douglas 1967:281).

According to Durkheim and Douglas, the two components of the self are in an antagonistic relationship. Durkheim highlights an inner clash between society's morals and an individual's instincts:

> We cannot pursue moral ends without causing a split with ourselves, without offending the instincts … [T]here is no moral act that does not imply a sacrifice' (Durkheim 1914:152).

Douglas similarly draws attention to an inner tension between perpetually judging oneself as good or bad. The substantial self must constantly deal with the conflicting moral evaluations imputed to its various situated selves (Douglas 1970a: 6-8; 1967:283). For both Durkheim and Douglas, it is obedience that resolves this

antagonistic duality.

Durkheim explains individual obedience as the result of a projection that locates authority in society as a whole (Durkheim 1914:152). The *homo duplex* tension is habitually channelled toward an external moral order that is more sacred and commands more respect than subjective desires: 'The ideas and sentiments that are elaborated by a collectivity ... are invested by reason of their origin with an ascendancy and an authority that cause the particular individuals who think them and believe in them to represent them in the form of moral forces that dominate and sustain them' (Durkheim 1914:158-160). For Douglas, obedience flows from an unconscious acceptance of previous actors' intentions. Tensions between the substantive and situated self are resolved by moral judgements and these judgements rely on decisions made by preceding social actors. These intentions have become objectified as received meanings and so constitute a moral order that is effectively, from the point of view of the individual, 'absolute' (Douglas 1970a:14-17).

These arguments rely on an a priori conception of human nature. The conception of subjectivity is given as a philosophical anthropology, as a universalised account of what it means to be human. Durkheim and Douglas both assume that the antagonistic duality of subjectivity is intrinsic and given. Durkheim refers to 'the constitutional duality of human nature' (Durkheim 1914:150), Douglas to 'the dual and oppositional nature of reality' (Douglas 1970a:4). On the terms of such a philosophical anthropology, social order is to be theorised as the internalisation of and obedience to an externally sourced moral authority. Durkheim highlights the 'social constraint that stems … from the prestige with which certain representations are endowed' (Durkheim 1895:44). Douglas similarly emphasises that

> one is not free to construct just any meaning for the new situation. The logic of moral decision making itself

involves an important constraint (Douglas 1970a:18).

Moral regulation, then, is essentially a matter of enforcing constraints that restrict individual freedom.

On these terms, suicide is to be accounted for as a lack of appropriate constraint in the moral order. Durkheim and Douglas make a sociological distinction between normal and abnormal suicide. For both, there will always be some people who, for whatever reason, are more susceptible to either suicidogenic currents or ambiguous meanings (Durkheim 1897:323; Douglas 1967:284-319). However tragic this is, such suicides are normal, given that there is inevitably a degree of failure in the everyday operation of moral constraints. Abnormal suicide, on the other hand, occurs when the whole system of constraint is no longer appropriate. For Durkheim, the repressive suicide laws associated with mechanical solidarity are no longer an appropriate form of regulation for modern societies, societies characterised by organic solidarity and an overabundance of anomie in particular (Durkheim 1897:366; Durkheim 1893:191-193). For Douglas, the absolute morality that historically constrained suicide has become ineffective in a society marked by specialisation, technological advancement and moral pluralism (Douglas 1970a:14).

The solutions that Durkheim and Douglas offer flow from their analysis of socially inappropriate and hence morally ineffective constraints. Durkheim puts forward a structural solution aimed at rebalancing the *conscience collective*. A massive increase in social differentiation has weakened the hold of the moral order upon individual lives, creating abnormal levels of anomic suicide. Durkheim thus recommends the development of an abstract respect for human personality, for example by promoting functional groupings that can generate the external authority needed to regulate individual actions (Durkheim 1897:359,378). Douglas similarly if less sternly

recommends the exercise of an external authority, focusing in particular on the therapeutic interaction between specialists and patients who have communicated an intention to suicide. As he puts it, 'the therapist must avoid giving suicidal thoughts to the patient' (Douglas 1967:331). In their communications, therapists should 'point out to the patient the other meaningful possibilities of this situated relationship' (Douglas 1967:334).

Commitments to grand theory underpin the classical positions adopted in the sociology of suicide. By forging an exclusive link between concept and method, grand theory unleashes a series of dualisms that divide the contending positions. Despite these divisions, however, there is significant common ground. Notably, both Durkheim and Douglas adhere to a philosophical anthropology, as is evident in their dualistic conceptions of human nature. Given their anthropological commitments, Durkheim and Douglas argue that societal mores flow from sources external to the individual. That is, they theorise individual subjectivity and the moral boundary as independent of each other. On these terms, moral regulation is the exercise of an external authority upon individual inclinations. In classical sociology, then, suicide is an outcome of the lack of appropriate constraint in the moral order.

The task of critique

Sociology, of course, proceeds both through the elaboration and critique of established positions. In this section I turn to consider the task of critique. I focus in particular on a body of criticism within the sociology of suicide literature that, although often far-reaching and insightful, ultimately replicates the dualising paradigm of the classical terrain. These critics tend to argue either that Durkheim and Douglas are not doing positivism or interactionism in the 'right' way, or that they are 'wrong' precisely

because they carry out their studies in keeping with their particular methodological commitments. Such critiques reproduce the grand-theoretical polarity between positivism and interpretivism. As such, I argue that they fail to address core problems that beset the sociology of suicide.

Some critics have focused on identifying mistakes or shortcomings. For instance, Pope repeated Durkheim's study in *Durkheim's Suicide: A Classic Analysed*, arguing that although innovative its findings were empirically unsupported (Pope 1976:201). Similarly, Atkinson argues that Douglas' argument is not scientifically corroborated because his version of an interactionist methodology cannot separate researcher's imputations of meanings from the 'true' meanings of those involved in the situation under investigation (Atkinson 1978:79). Such criticisms do not question the classical methodological perspectives, rather they seek to refine and improve them.

Other critics focus on identifying internal inconsistencies in order to support the alternative methodological stance. Taylor, for example, criticises Douglas's argument that as many suicides are concealed there is a systematic bias in the statistics. This presumes that some suicides are unambiguous, a position counter to Douglas' insistence that defining a death as suicide is fundamentally ambiguous (Taylor 1982:101, in Varty 2000:62). On these grounds, Taylor advocates a structuralist approach to the issue. Giddens and Lukes identify similar paradoxes in Durkheim. For Giddens (1981), Durkheim studies suicide in a way that refuses to acknowledge the (subjective) interpretations of meanings that are necessary for suicide to be suicide. For Lukes, Durkheim's notion of constraint highlights 'conflict, power and unpredictability' and so needs to be based in a theory of politics, a theory that Durkheim fails to develop (Lukes 1982:23). Giddens and Lukes use such criticisms to lend weight to the interpretivist approach.

As argued above, the sociology of suicide has classical status in that it has developed as a site for arguments about the character of sociology as social science. Criticisms of Durkheim and Douglas thus often move quickly from the specific to the general. In *The Centrality of the Classics* (1987) for example, Alexander uses the critique of Durkheimian positivism to highlight the interpretive stance that he believes is most appropriate for sociology (Alexander 1987:20) [2]. Taken as a whole, the criticisms considered above either refine or promote the already existing methods within each perspective. As such, they replicate and so reinforce the classical duality of positivism versus interpretivism. In this sense, they constitute what may be called a conservative critical tradition. This tradition fails to adequately identify and address the problems that attend to the classical conception of moral regulation as a process of constraint. The task of critique must be undertaken in more radical terms.

More radical criticisms of the classical terrain come from those who directly challenge the dualism of externality and intention. These criticisms are often associated with the general 'turn to language' in social theory (Lemert 1992:29). Lyotard's 'incredulity to meta-narratives' is a well-known attempt to undermine the polarities of grand theory (Lyotard 1984). Similarly, Elias' concept of 'figuration' and Giddens' 'structuration' theory explicitly seek to go beyond the 'false dualisms' associated with the scientific method and universal subject (Elias 1970:13; Giddens 1984, 1991). Here, however, I concentrate upon the work of Foucault in particular. As my concern is primarily with methodologically-driven critiques, Foucault's work is highly relevant. His critique of 'negative power' speaks directly to the conception of moral regulation as

[2] These more general criticisms are often also carried out in political terms. For criticisms of Durkheim's political motivations see Bellah (1973), Cladis (1992), Giddens (1986) and Zeitlin (1968). For criticisms of Douglas's political motivations, see Varty (2000). As such criticisms typically accept that the study of moral regulation

constraint. Moreover, Foucault's writings have inspired contemporary investigations of governmentality that have a strong bearing on the problems investigated in this thesis.

The Foucauldian alternative

As Weber's well-known definition has it, power is 'the chance of a man or a number of men to realise their own will in a communal action against the resistance of others who are participating in the action' (Weber 1958:180). To be powerful is to be able to prevent people from doing other than what you desire. Power is thus conceived in basically negative terms. Such conceptions are common in the social sciences. As I have shown above, for example, the sociology of suicide typically poses moral regulation as a matter of constraint. Regulation stops people from acting in certain ways that are perceived to be undesirable. For Foucault, however, such negative conceptions of power are fundamentally misleading.

Foucault argues that the negative conception of power has five principal features: the 'negative relation', which means that 'its effects take the general form of limit or lack'; 'the insistence of the rule', an insistence that centres the 'function of the legislator'; a 'cycle of prohibition' that suppresses the self; a 'logic of censorship' that links the illicit with the inexpressible; and the uniformity of the apparatus, such that power is exercised 'in the same way at all levels' (Foucault 1976b:82-85). This 'juridico-discursive' power is restrictive and centred on the statement of laws and the operation of taboos that produce obedience. According to Foucault, despite the range of historical situations, this representation of power is tied to the notion of a sovereign. It has 'remained under the spell of the monarchy' (Foucault 1976b:88).

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is to do with finding solutions to social problems, they continue in the tradition of grand theory.

This 'spell of the monarchy' is apparent in the classical framing of the sociology of suicide. The theories of Durkheim and Douglas register Foucault's five characteristics of negative power. For both, moral regulation is based on a 'negative relation' that constrains individual inclinations in the service of more general, social principles (Durkheim 1897:365; Douglas 1971a:269). The operation of laws - either as registers of social solidarity (Durkheim 1893:28) or as objectified public meanings (Douglas 1970a:20) - is at the centre of this negative relation, as are the prohibitions and censorships that resolve internal tensions by enforcing individual renunciation. The accounts offered by Durkheim and Douglas also exemplify Foucault's notion of the uniformity of apparatus. Moral regulation is a ceaseless attempt to curtail the asocial tendencies inherent in human nature. This attempt is carried out in the name of a sovereign entity, conceived by Durkheim as 'Society' and by Douglas as an 'absolute' realm of objectified meanings.

Foucault has developed a radical alternative to such negative conceptions of power. The motivations for this move are diverse. In part, his critique flows from a belief that constraint theories are themselves an unjustified attempt to dominate (Foucault 1984b:32; Foucault 1988a:1-20; Hindess 1996a:152-156). Given the empirical intentions of this thesis, of perhaps more interest is his contention that the 'rule of law' is 'utterly incongruous with the new methods of power' (Foucault 1976b:89). The problem for Foucault is that although the times have changed 'we still have not cut off the head of the king' (Foucault 1976b:89).

Rather than rely on the grand assumptions of sovereignty, Foucault insists on studying power in the 'concrete and historical framework of its operation' (Foucault 1976:90). This emphasis on the concrete and the historical is no call to empiricism but rather a prompt for conceptual innovation. Foucault systematically departs from a series

of grand theoretical commitments. Against objective, scientific truth, he specifies a much more intimate relationship between power and knowledge. Against methodological monism, he moves to a pluralistic form of discourse analysis, a move that entails a profound reconceptualisation of subjectivity and its relationship to moral boundaries.

Borrowing from and adapting Nietzsche's notion of the 'will-to-truth [3], Foucault argues that knowledge cannot be understood in separation from the consideration of power:

> We should admit rather that power produces knowledge; that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations (Foucault 1977a:27).

On these terms, truth is transformed from an abstract universal into the partner of power techniques, a partnership that constitutes the distinctive focus of Foucauldian analysis – power-knowledge (Foucault 1977a:28).

Foucault studies power-knowledge by developing a variant of discourse analysis. Rather than being somehow about pre-existent objects, discourses are 'enunciative modalities' that 'systematically form the objects of which they speak' (Foucault 1972:49-52). Discourses are 'the places in which a tangled plurality ... of objects is formed' (Foucault 1972:48,38). When conceived discursively, power is understood not as flowing from a stable, sovereign point but rather as something 'exercised from innumerable points', an unstable and reversible 'interplay of mobile relations' (Foucault 1976b:94-96). Discourse analysis is thus not tied to any specific

[3] Nietzche famously argued that 'what is taken to be fixed and binding about truth ... is an unrecognised motivation serving [the] unacknowledged purposes' of a 'will-to-power' (MacIntyre 1990:35).

kind of data (such as second-order statistics or imputed meanings). Instead, it considers a multiplicity of complexly intertwined power-knowledges. Foucauldian analysis, then, is characterised by a commitment to what is known as methodological pluralism (McLennan 1995a:67-73).

In breaking with methodological monism, Foucault also renounces the philosophical anthropologies that characterise grand-theoretical conceptions of subjectivity. Instead of treating human nature as an anthropological given, he uses discourse analysis to develop a constructivist 'history of the different modes by which ... human beings are made subject' (Foucault 1982c:208). Discursive practices problematise objects and these problems are resolved by explicit attempts at normalisation (Bell 1993:148). These resolutions are the dispositions and capacities that constitute subjectivity.

The two strategies of methodological pluralism and constructive subjectivity allow Foucault to break with the grand theory tradition in sociology. Instead of juxtaposing externality and intention, his power-knowledge concept highlights how objects and subjects 'emerge together in a space set up by social practices' (Dreyfus and Rabinow 1982:108). Power is a creative force that instigates and constructs rather than prohibits and destroys that which is already there. This emphasis on the positivity of power produces a radical alternative to the classical conception of moral regulation as a process of constraint. Power-knowledges establish ways for 'guiding the possibility of conduct' (Foucault 1982c:221). Instead of domination by rules applied from the outside, Foucault emphasises the enabling constitutions of subjectivity that operate 'with a minimum of domination' (Foucault 1988a:18).

Power-knowledge discourses construct both who you are and the significance of what you do. On these terms, then, moral boundaries and subjectivities are

established simultaneously, rather than as the distinct processes conceived by grand-theoretical sociology. This conception offers an advance on the classical dualities of sociology and on constraint theories of the moral order. As such, it can be used to produce an innovative analysis of the suicide regulation in New Zealand.

To study the governance of suicide

A Foucauldian approach promises to move the sociology of suicide beyond the dualities that frame the classical terms of debate. Accordingly, this thesis proposes to investigate suicide regulation in New Zealand by rejecting the conception of moral regulation as constraint. Instead, I focus on the analysis of historically specific strategies of problematisation and normalisation that enable varying modes of subjectivity.

Detailed accounts of a range of discursive constructions of subjectivity are available in the Foucauldian literature. For instance, there are Foucault's own works on disease (1963), madness (1965) and punishment (1977a). Extending this form of analysis, research has been undertaken on the poor and unemployed (Dean 1991, 1995), on neo-liberal workers (Larner 1998a), alcoholics (Valverde 1998), the incestuous (Bell 1993) and single mothers (Little 1998). There is also a Foucauldian literature that focuses on the enabling strategies of moral reform. Valverde's analysis of the Salvation Army and Temperance Movement (1991) is a case in point, as is Strange and Loo's work on legal institutions (1997). To date, however, Foucauldian analysis has not concentrated specifically on the construction of the suicidal [4]. This thesis takes on that

[4] Foucault's studies never focussed on suicide directly; the only mention made refers to the effects of 'melancholia' in a more broad-ranging analysis of insanity and reason (Foucault 1965:213). Furthermore, although Foucauldian scholars have embarked upon a wide range of research, they have yet to engage with the topic. Two extensive Foucault web sites failed to return any hits for suicide. See ://ourworld.compuserve.com/homepages/jeffreyhearn/bibfou~1.htm(accessed10.4.2003) and http://www.foucault.qut.edu.au/ (accessed 10.4.2003).

task.

As power is a 'question of government', moral regulation is a form of government[5]. According to Foucault, 'government' is rooted in webs of social networks. The analysis of these networks calls for something other than the command of History claimed by sociology in the grand theory tradition, a command evident as the teleological 'progress' from traditional to modern morality outlined by Durkheim and Douglas. Against such grand claims over the past, Foucault calls for histories of the present by developing what he dubs genealogical analysis. Genealogy focuses on a diverse field of 'dispositions, manoeuvres, tactics, techniques and functionings', attempting to 'decipher in it a network of relations, [so] constantly in tension, in activity ... that one should take as its model a perpetual battle' (Foucault 1977a:26).

In order to conduct a genealogy of suicide in New Zealand, I propose to make use of a number of Foucauldian principles to collect and organise the historical material. Foucauldian studies of subjective enablement have concentrated upon formal realms as these are taken to provide signifiers of prevalent discursive formations (Dean 1999:18; O'Malley et al. 1997). These studies have focused on interpreting a range of texts as the traces of formal rule. For example, Bell (1993) bases her analysis on legal texts, Valverde (1991) on documents produced by moral reformers in Canada, while Dean (1995) investigates bureaucratic writings on the unemployed. The relevant formal texts are diverse, including pamphlets, gazettes, administrative handbooks, policy documents, legal codifications and the like.

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[5] Defining moral regulation as a form of governmental practice has proved a contentious issue in the Foucauldian literature. Debate has focused on whether or not the construction of ethical subjects is distinct from other, more general practices of rule. See for example Corrigan (1981), Valverde and Weir (1988), Valverde (1991), Dean (1994) and Hunt (1999). However, as the concern of this thesis is to investigate historical modes of subjectification as moralised power-knowledge strategies, I take moral regulation to be a form of governance rather than regard the two as mutually exclusive.

This thesis turns now to investigate a range of formal texts about suicide in New Zealand. The interpretation of these texts will reveal the complex 'network of relations' that morally regulate by enabling distinctive modes of subjectivity. I use the following terminology to guide the analysis of this network. I use the term 'mode of regulation' as the most encompassing category that denotes the central problematising theme within a specific discursive formation. A mode of regulation is an historically specific configuration of discursive practices. These practices construct the object of regulation as a particular sort of problem requiring a specific sort of response. The genealogy undertaken in the following chapter identifies three modes of regulation: criminalisation, pathologisation and riskification. These modes are complex articulations of distinctive fields of discursive practice that I call 'regimes of regulation'. Each of the three modes identified in the genealogy is characterised by the dominance of one specific regulatory regime.

The genealogy distinguishes between four regimes of regulation - ecclesiastical, judicial, medical and executive. As the term 'regime' refers to specific techniques, instruments and expertise that are used to achieve regulation, the domination of one regime means that its practices precede and inform the other three in some tangible and traceable way. Each regime has particular discursive characteristics. The ecclesiastical regime is identified with religious practices, specifically those of the Christian Church, and achieves regulation with constructions of the soul and its salvation, such as through penance (Foucault 1976b:63). Death centres the medical regime and its characteristic practices of treatment and cure (Foucault 1963:126). The judicial regime is concerned with justice and the rule of law, and hence with the punishment of those who transgress (Foucault 1977a:24). Lastly, the executive regime is that collection of practices which focus on mastering fate, the begetter of future

misfortune, through prudential and economic management to secure against misadventure (Foucault 1982b:90-93; Rose 1999:158-160).

In keeping with the Foucauldian approach, the judicial and executive regimes are not interpreted as formalised branches of a superordinate 'state apparatus', in which the judiciary interprets and applies the law while the executive secures the due performance of Government. Instead, all regulatory regimes are to be understood as more diffuse and 'technical forms of governmental action' (Gordon 1991:19). A mode of regulation is also made up of sites and objects. 'Sites' are the places where governance is enunciated, while 'objects' are the constructions of regulative activity through which specific subjectivities are announced.

Conclusion

The study of suicide inevitably raises questions about morality. As it starkly poses the relationship between action and the rules that determine value, it is not surprising that suicide has classical status in sociology. This chapter has reviewed the sociology of suicide, showing how it is organised by the terms of a grand methodological debate between positivism and interpretivism, as exemplified in the works of Durkheim and Douglas. The terms of this debate are set by shared commitments to methodological monism and philosophical anthropology. On these terms, suicide is theorised as the outcome of a lack of appropriate constraints in the moral order.

The grounds for an alternative approach have been developed through a consideration of the work of Foucault. This work outlines a form of discourse analysis that expressly critiques the negative notion of power dominating the classical tradition. By allowing for the simultaneous theorisation of moral boundary and subjectivity, the

Foucauldian alternative produces a theory of moral regulation as enablement rather than constraint. The following two chapters use this alternative conception to account for the regulation of suicide in New Zealand. Chapter Three investigates past practices from the 1840s to the mid-1970s, while Chapter Four completes the genealogical analysis by focusing on contemporary developments. The gains and limits of this Foucauldian history of the present will be further discussed in Chapter Five.

Chapter Three – Past practices: A genealogy of suicide in New Zealand

Introduction

This chapter embarks on a genealogy of the moral regulation of suicide in New Zealand. The analysis is guided throughout by Foucauldian principles. I use concepts of regulatory mode, regime, site and object to frame the discussion. Moral regulation is understood as the exercise of positive power in complex 'networks of relations'. These networks exert moral governance by discursively constructing specific modes of suicide subjectivity, modes that, as will be shown, have significantly changed over time. In order to manage the considerable quantity of historical detail, I have organised the genealogical account into two chapters. This chapter examines past practices. Chapter Four uses this analysis as a counterpoint to isolate the specific features of the contemporary period in particular.

These genealogies were developed through a process of gathering and sorting an array of historical materials pertaining to the formal regulation of suicide in New Zealand. Inevitably, the practice of this research encountered significant gaps in the availability of historical accounts. There are few if any first hand, informal accounts of suicide regulation in the public archives. Although there is material held by the Coroner's Office, I was not granted permission to research its archives (personal communication from Coronial Services Officer Leahy, 10 July 1997). Accordingly, the following genealogies are limited by the lack of first hand accounts, especially in those eras before living memory. Within the terms of these practical limitations, I sorted the available materials genealogically by looking for traces of conflicts, struggles and

unexpected continuities. These investigations highlighted a number of significant events in which judicial, ecclesiastic, medical and executive concerns were complexly intertwined. The analysis of these complex relationships underpins the following accounts of suicide modes, regimes and subjectivities.

The following genealogies are based on the detailed analysis of a host of archival documents accessed from the extensive range of original material held in the Pacific Collection of Massey University Library. These documents include lineages of legal statutes and their associated parliamentary debates, court case proceedings, Parliamentary Bills, House of Representatives Annual Reports, Official Statistical Publications, Ministerial Consultation and draft strategy documents. I also searched various newspapers, magazine periodicals and academic articles. I have drawn upon a range of professional practice manuals, historical theses and institutionally produced histories. To clarify and corroborate points that were not fully documented, I conducted telephone interviews with key spokespeople in government ministries, professional and voluntary organisations and the church.

The account of past practices begins in 1840 and ends in the mid-1970s. I start in 1840 because New Zealand became a colony in that year. I suspend the genealogy in the 1970s as this was a time of rapid and significant transformation in the networks of moral regulation. Over the 130 or so years considered in this chapter, New Zealand experienced two consecutive modes of suicide governance: criminalisation and pathologisation. Criminalisation emerged as a colonising application and adaptation of the system of governance already in place in Britain. I therefore begin by outlining the British situation, in order to define more clearly the contours of the New Zealand scene.

Albion's fatal tree: The British criminalisation of suicide[1]

While engaged in colonial expansion in the South Pacific, at home Britain criminalised suicide. Criminalisation is brought into effect by deeming specific acts to be an infringement of the principles of a sovereign legal authority. This makes those who do this act guilty of committing a crime and therefore subject to the punishments meted out in the name of that authority.

The British criminalisation of suicide is built on the common-law category of *felony of a man's self* or *felo-de-se:*

> A *Felo-de-se* is he that deliberately puts an end to his own existence; or commits any unlawful, malicious act, the consequences of which is his own death, as if attempting to kill another he runs upon his antagonist's sword; or shooting at another the gun bursts and kills himself (Clift v. Schwabe, [1846] 3 Common Bench 437 [476]).

The principle site for the construction of suicidal subjectivity as criminal was the Coroner's Court. This Court was duty bound to mount an inquiry into events that may have been the result of *felo-de-se.* The ability of the Coroner's Court to prosecute *felo-de-se* rested upon two historic events – first, the separation of the duties and powers of coronial and Criminal Courts within the judiciary and, secondly, the shift of responsibility for *felo-de-se* from the Catholic Church to the British State. Prior to these two events, suicide was not regarded as a felony. Instead, it was categorised as a mortal sin and so fell under the jurisdiction of the ecclesiastical courts. As the internal reorganisation of the British judiciary takes historical precedence, I will deal with this issue first.

The judicial courts had been bound to investigate possible felonies[2] since the

[1] Section heading taken from Hay et al. *Albion's fatal tree: Crime and society in*

Northampton Court of Assizes in 1176. The Coroner's Court was set up shortly after and held extensive legal powers.[3] Under the reign of Edward I (1272-1307), 'travelling' courts were created and legislation enacted that included the Coroners Act of 1276. This Act expanded previous Coronial duties to include inquests into sudden death. At this point, however, the Coroner's duties were restricted to 'the dead' (Curzon 1979:29). The Coroner's Court did not gain authority over *felo-de-se* until 1536 when Henry VIII usurped the Church of Rome and brought about a radical transformation in the political landscape.

In 1536, English common law enclosed ecclesiastical law. With this move from ecclesiastical to judicial modes of rule, death by one's own hand changed from a 'mortal sin' to a 'felony' (Curzon 1979:29). From 1536, inquests were triggered by 'searchers' or 'honest old women' who were paid to 'view' the body, identify it and give the cause of death to the clerk or minister of the Parish. The clerk was then obliged to pass on the information to the Coroner in cases of sudden death (Forbes 1979:120). The expansion of the judiciary into formerly ecclesiastical domains meshed with the internal division of responsibilities between the Coronial and Criminal Courts. Under British law, the Coroner's Court had full common law jurisdiction over *felo-de-se* from 1536 up until and including the 1840s.

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eighteenth century England (1975).

[2] A felony is a category of crimes developed during the Norman Conquest to secure law and order over the local, Saxon peoples. A felony is considered to be less heinous than treason and more serious than misdemeanours (Curzon 1979:232).

[3] The Coroner's Court emerged as a site of judicial governance when the position of Coroner was created under the reign of Richard I (1189-1199). Its extensive legal powers included keeping rolls of those suspected of crimes, the holding of inquests, outlawry proceedings, appeals of felony and approvers (informers and self-confessed criminals who sought pardon through trial by battle), abjurations of the realm (taking oaths to leave the country for ever), and deodands (where an animate or inanimate thing that brought about a death was surrendered to the king or lord of the manor). See Curzon (1979:215).

The criminalisation of suicide was constructed through the investigation and prosecution of *felo-de-se* in the Coroner's Court. As Coroners were restricted to dealing with the dead, their official duties centred on the conducting of an 'inquest' (short for inquisition) by jury to reach a verdict. Juries were typically made up of whoever was available in the locale and the inquests were held in the nearest practicable building – usually a public house:

> An inquest was irretrievably associated with undignified proceedings which went on in hired rooms in public houses, before very humble jurors (who might sometimes be allowed to solace themselves with beer and tobacco), amidst the comings and goings of stray cats, dogs, infants, and members of the public, and by law it included a view of the body, often unclothed and usually in some outhouse, by all the jury (Anderson 1987:33).

The Office of Coroner was appointed either through local elections, by feudal fiat, or by charter franchise. As this suggests, there was no central set of rules to guide Coroners' legal deliberations (Anderson 1987:15-16). During an inquest, all concerned were required to view the body and the jury was required to listen to the evidence about the death and reach a judgement for passing on to the Coroner.

As a Court of Law, the Coroner's Court is charged with determining whether or not a crime has been committed and, if this is the case, is responsible for enacting the prescribed punishment. The reaching of a verdict is thus a crucial moment in the criminalisation of suicide. It marks the act as a crime and sets various effects into play. British regulation thus focused on identifying and punishing the completed suicide in particular. A *felo-de-se* was a crime and it was punished. However, although dominant, the judicial regime relied upon other regimes to discharge its duties. Both the determination and punishments for *felo-de-se* were a mesh of disparate practices associated with co-present ecclesiastical, medical and executive regimes.

In the British context, it was an ecclesiastical discourse of *self-murder* that defined the legal problem of *felo-de-se.* According to the Catholic Encyclopaedia, *self-murder* belongs among a group of conducts regarded as mortal sins that are categorised as 'death-dealing'. Unlike merely venial transgressions, mortal sins are commissioned 'with full knowledge and full consent of the free will' (McBrien 1995:1192-3). Mortal sins thus represent a deliberate rejection of God's divine authority. This ecclesiastic discourse defined the terms of the problem with suicide. Fundamentally, suicide was a wilful rejection of the absolute authority of the law against murder. The link between this ecclesiastic construction and the judicial process was forged through the latter's use of the principle of *mens rea* to define felony and hence *felo-de-se* (Spiller 1995:185). *Mens Rea* is an admission of guilt grounded in *malice aforethought* or deliberate criminal intention. Such deliberate rejection of authority encompassed the act of suicide.

The ecclesiastics not only set the parameters of the judicial problem, they also provided the terms of punishment. If wilful suicide utterly rejected absolute authority, then that authority must respond in kind. This rejection of the completed suicide was played out as practices aimed at denying the possibility of eternal life in the hereafter. In ecclesiastical terms, the worst punishment that could be visited on Christian sinners was spiritual denial or excommunication, first detailed at the Synod of Arles AD 452, Braga AD 536 and Antisidor AD 590 (Retterstol 1993:19). Such punishment was a terrifying prospect when political, community and family life was lived through the auspices of the Church. In practical terms, excommunication translated into corpse mutilation and a refusal of permission for self-murderers to be buried within church grounds. According to Llewellyn, these practices enacted beliefs in the resurrection of the body on the Day of Judgement (Llewellyn 1991:40). In some communities, self-murderers, as well as being denied religious rites, were often buried with a stone on their face and a stake

through their heart. Given that the suicidal soul had been denied entry to heaven, it was believed that such practices would stop it from wandering the earth (Friar 1996:436).

The judiciary extended these disavowals from the spiritual to the corporeal realm. The authorities denied *felo-de-se* any future in the spiritual world by refusing to consecrate their burial. They were also denied a future in the material world by demanding forfeiture of their property to their Lord or the Crown and refusing the right to inherit or transmit land by descent (Curzon 1979:233). Public and deliberate disrespect of the deceased by the authorities was central to the regulatory practices of this refusal.

Upon reaching a verdict, the Coroner was required to release a burial form that specified what was to count as a legal burial of the deceased (Forbes 1979:120). The following extract, taken from the Coroner's Inquest on Amy Stokes in the Parish of St. Botolph in 1590, reveals both the harsh terms in use and the construction of the suicide body as an object that regulated the conduct of others:

> ... by the sayed crowner that she should be carried from her sayed howse to some cross way neare the townes end and theare that [she] should ha[ve a] stake dreven thorowgh her brest and so be buried with the stake to be seene for a memoryall that others goinge by seeinge the same myght take heed for committinge the lyke faite (*Aldergate Chronicles*, pp 165-9; quoted in Forbes 1979:136).

Even after the public 'execution' of the suicide, Coroners often bequeathed the corpses to medical schools for public dissection, or to art suppliers who would pose and plaster-cast the already mutilated bodies for 'life-drawing' classes (Williams 1975:149; Llewellyn 1991:40).

British judicial regimes drew upon and extended already existing ecclesiastical

concerns with transgressions against moral authority. There remained, of course, ample scope for conflict between the two, given that the judiciary appealed in the first instance to the authority of the rule of law rather than God. The judiciary also drew upon a medical regime to discharge its duties. Medical discourses were important players in the investigation and punishment of *felo-de-se*. If doctors thought a death was suspicious[4], they were duty bound to not issue a death certificate without a Coroner's burial certificate and formal verdict. Medical practitioners thus often directly triggered Coronial investigations.

As well as triggering the Coroner's inquest, and thus bringing into play the judicial discourse of *felo-de-se*, medicine assumed responsibility for those who escaped the rule of law. When the Coronial verdict about a completed suicide was one of 'insanity', the case was not viewed as criminal and punishments for felony were not applied. If, however, insanity was upheld while the *felo-de-se* accused was still alive, then medicine extended the realm of judicial punishment. The offender was often sent to a madhouse and treated in terms of the medical discourse of melancholia. This discourse afforded punishment in that lunatics were forcibly withdrawn from the community. 'Treatment' also often included being physically restrained in chains in dark, cold, solitary environments with little or no human contact (Hunter and McAlpine, in Busfield 1986:169).

Although medical discourses were key to punishment both inside and outside the rule of law, they operated upon suicide without relying on the judicial principle of intention. The medical regime constructed 'death by one's own hand' through the general concept of 'madness' and the specific concept of 'melancholia', as understood

[4] The UK Registration of Deaths Act of 1836 replaced 'searchers' with medical practitioners (Forbes 1979:120).

through the doctrine of Galenic humors. According to this thermodynamic model of organic dysfunction, there were four fluids - blood, choler (yellow bile), phlegm, and melancholy (black bile) - whose balance ensured bodily and spiritual wellbeing. Mania, associated with wildness and violence, 'was caused by much bloude, flowing up to the braine', while melancholics had an overabundance of black bile, leading to

> an alienation of the mind troubling reason, and waxing foolish, so that one is almost beside himself. ... Moreover they desire death, and do verie often behight and determine to kill them selves, and some feare that they should be killed (Philip Barrough (1583), quoted in Busfield 1986:168).

The medical discourse was concerned not with intention but rather with the internal balance of a person's humors, a balance that manifested itself in action. As with the ecclesiastical regime, then, medicine both worked alongside and was in tension with the judicial discourse on suicide.

Medicine brought the rule of law into play by bringing bodies to the Coroner's attention and extending judicial denials to the insane. The British regime of executive power also extended the punishment of forfeiture beyond the criminal domain. The executive regime, by which I mean the bureaucratic techniques, instruments and expertise used to achieve institutional security, notably extended judicial regulation in the form of life assurance policies. In the closing decades of the 18th century, 'life annuities' emerged in Britain (Defert 1991:217). These life assurance policies, underwritten by private companies, were subject to several standard conditions and regulations that explicitly regulated suicide. Policies would become void if 'parties whose lives have been assured shall die on the high seas, shall go beyond the limits of Europe, [or] go on active military service without paying the extra risk premiums'.

Furthermore, 'every policy effected by a person on his or her own life shall be void, if such person shall commit suicide, or die by duelling, or by the hands of justice' (Clift v. Schwabe, [1846] 3 Common Bench 437 [440,441]).

Certain kinds of death were ruled as falling beyond the scope of assurance policies. Such rulings extended the judicial approach to suicide, conceived fundamentally as a problem of intention, into the realms of private commerce. Moreover, in general terms, the executive regime increased the capacity for the judiciary to punish by extending and regulating the houses of confinement that had emerged during the 16th and 17th centuries.[5]

Although the British judiciary governed suicide by bringing together the ecclesiastic, medical and executive regimes, the resulting 'network of relations' was not a rationalised and monolithic system. As there were numerous points of difference and tension, the various relationships were continually shifting. The situation was particularly volatile in the decades immediately before and after 1840. Shifts were evident across the ecclesiastical and judicial relationship.

Although longstanding in common law, the crime of *felo-de-se* was drawn into a wide-ranging review of British legislation. A Liberal, humanist lobby called for a general restriction on judicial punishments, alongside its specific campaigns for Abolition and the Franchise. As a result of this campaign, *felo-de-se* was transferred from common-law to Statute by the new British Criminal Law Act of 1823. The

[5] Codified in the Lunacy Act of 1845, 19th century Britain had a two-tiered system for confining the deranged - pauper asylums, provided by the State, and 'private mad houses', funded by the solvent lunatic. At first, these mad houses provided unsupervised residential care. However, public enquiries throughout the 18th century led to legislation in 1774 that required their formal inspection and registration, along with the medical certification of inmates, thus paving the way for the creation of medically controlled 'asylums' in the late 18th and early 19th century (Busfield 1986:172).

ecclesiastically grounded retributions of ignominious burial and mutilation were abolished and replaced with less spectacular, more 'hidden' punishments (Sweet and Maxwell 1971:325).[6] This break from ecclesiastical practices was couched as a response to the growing failure of public punishments to secure law and order (Gatrell 1994). Felons, including *felo-de-se*, continued to forfeit their property; to remove such punishment was seen as unduly 'weakening the law's ability to deter serious crime in general' (MacDonald and Murphy 1990:346). Although judicial authority was challenged and transformed in the early 19th century, it retained its leading position in the regulation of suicide.

The instability of judicial authority was apparent in a discursive dispute that erupted over the use of the word 'suicide', which at this time was in fact a relatively new term.[7] Despite its rapid adoption by lay, literary and philosophical circles since 1749, the word 'suicide' was not discussed in a legal proceeding until 1846, in a dispute sparked by the death of a Mr Schwabe. Schwabe's insurance company had cancelled his life assurance policy and this decision was appealed by his administratrix, eventually reaching the Appeals Court, where it generated great controversy and became a benchmark case that marked a change in judicial terminology. It was asserted that Mr Schwabe had

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[6] In 1814, forfeiture was limited to 'the life interest of the felon' (Curzon 1979:233). After 1823, 'ignominious burial' was banned and replaced with burial 'privately in some churchyard or other burial ground during the hours of nine and midnight' (Friar 1996:436; Forbes 1979:137).

[7] What we today call suicide had a variety of names prior to mid-18th century, including 'death by one's own hand', 'self-murder' and '*felo-de-se*'. There is some debate over when the word 'suicide' was first published, though it is agreed that Britain can lay claim to the word. According to Skeat, 'suicide' was coined in England in 1749 from a translation of Montesquieu's use of the New Latin *suicidium* in his *Spirit of Laws* (Skeat 1961:614). Simpson and Weiner date its appearance to 1732 in the *London Magazine* (Simpson and Weiner 1989:252). This debate notwithstanding, the word established itself quickly, as is signalled by its inclusion in Blackstone's *Commentaries* of 1769

> effected a policy on his own life, subject, amongst others, to the following conditions - that the policy should become void, if the assured should die on the high seas, or should go beyond the limits of Europe, or enter the military or naval service, except with the permission of the assurers - and that 'every policy effected by a person on his or her own life should be void, if such person should commit suicide, or die by duelling or the hands of justice' - A. died in consequence of having voluntarily, and for the purpose of killing himself, taken sulphuric acid, but under circumstances tending to shew that he was at the time of unsound mind. - In an action by the administratrix of A. upon the policy, the defendants pleaded that A. did commit suicide, whereby the policy became void (Clift v. Schwabe, [1846] 3 Common Bench 437).

The appeal was complex and turned on the use of the modern 'committed suicide' as compared with the older legal term *felo-de-se*. The presiding judge presented a long and detailed discourse upon the meanings of the two terms, concluding that

> the word 'suicide' ... does not embrace self-killing by accident, or unintentional self-destruction. But there is nothing to restrain it to a felonious killing. Suicide may be felonious or otherwise, according to the circumstances (Clift v. Schwabe, [1846] 3 Common Bench 437 [447]).

On these terms, suicide incorporates both wilful and insane self-killings. The judge ruled that as *felo-de-se* covered only deliberate acts of self-killing, the life assurance premiums should be returned to Elisa Schwabe. He noted that as the expression 'committed suicide' was legally ambiguous, it should be used with caution in insurance policies.

This case highlighted legal ambiguities around the core issue of intentionality. In the words of Pollock, 'if a man is *non compos mentis*, he is beyond the law' (Clift v. Schwabe, [1846] 3 Common Bench 437 [454]). As has been shown above, the role of intentions was often contested in debates about suicide. Although these conflicts made

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(Blackstone 1769: iv, xiv, 189).

for a tense and shifting web of discursive relations, the judicial system remained in its leading position. Thus, at the time of New Zealand's annexation in the early 19th century, the governance of suicide in Britain was primarily a matter of criminalisation. And so it was to remain in the new colony.

Colonial hangovers: The New Zealand criminalisation of suicide, 1840-1893

Some time in the afternoon of the sixth of February 1840, the Treaty of Waitangi was signed. From that moment, suicide in New Zealand was governed through the British rule of judicial law (Spiller 1995:55).[8] As in Britain, in New Zealand suicide was regulated through a judicial criminalisation that drew upon ecclesiastic and medical discourses. However, the transposition from Britain to the colony mutated this network of relationships in such a way as to increase the relative significance of the executive. In contrast to Britain, New Zealand relied heavily on executive discourses to criminalise suicide. This shift reflected a British struggle to maintain authority both at home and in the new colony.

The decades surrounding 1840 were marked by drastic alterations to the British social and political landscape. Unprecedented industrial expansion and urbanisation, along with the very active political movements associated with these transformations, led to wide-scale civil unrest. A heightened concern with lawlessness spilled beyond the existing boundaries of the British Empire. Immediately prior to annexation, New Zealand had been colonised haphazardly, mostly by British emigrants fired by speculative resettlement schemes. Wakefield's New Zealand Company promised

[8] The 1840 Treaty of Waitangi was succeeded by the Supreme Court Ordinance of 1842, which made New Zealand a Crown Colony and deployed the British system of common, equity and Statute law in New Zealand (O'Keefe and Farrand 1980:133).

'scientific colonisation' as an escape for the Scots newly dislocated by the Highland Clearances and as a lucrative business investment (Palmer 1971:21-32). Even though British subjects were theoretically bound by common law conventions that stretched back to feudal times,[9] judicial rule over British colonists was next to non-existent. The nearest magistrates were in Australia and the Crown had no legal jurisdiction in New Zealand. The Crown at first attempted to secure effective rule, without legally expanding its Empire, by appointing a 'Resident'. As this appointment failed to secure law and order in the outpost, the dilemma was resolved by making New Zealand an annex of Britain. This included regulating colonisation by entering into an agreement with the New Zealand Company. The Company ostensibly gave up the title to all the lands it had purchased before annexation, on the understanding that it would be the official agent for the British Crown (Adams 1977:181-2). Subsequent to annexation, New Zealand was organised into Provinces answerable to the Governor of New Zealand. These developments indicate the distinctive features of the new colony. The ultimate authority for colonists was the British rule of law, a rule that relied on a hastily secured and dispersed executive regime in the form of the New Zealand Company and the Provincial governments.

The British problems with securing the rule of law had a profound impact upon the way in which suicide was criminalised in New Zealand. At first glance, the British web of regimes seems to have been directly transposed. When New Zealand was annexed, the judiciary put in place the Coroner's Court and the various common law punishments for the crime of *felo-de-se:*

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[9] Common law conventions stipulated that British subjects were under obligation to the British Crown and held rights to be protected. Accordingly, British colonists who committed crimes outside the national territory could still be held accountable to British law and tried in existing courts of law. Equally, the colonists had the right to demand

> By the 6th section of "The Coroner's Act 1858," it is enacted that Coroners within the Colony of New Zealand, shall have *all the powers* and *privileges,* and be liable to all such duties and responsibilities *as Coroners* by law *have* or *are liable* to *in England* (Johnston 1864:255).

In its criminalisation of suicide, the colonial judiciary reconstructed familiar relationships with the ecclesiastical and medical regimes. In New Zealand too, the judiciary drew upon both the ecclesiastical 'refusal of absolute authority' and medicine's role in the tabulation of verdicts.

The coronial verdict sheet replicated the ecclesiastical focus on an intentional refusal of authority. As specified in Johnston's formulary, a verdict of *felo-de-se* was to be recorded as follows: that 'in and upon himself, in the peace of God, and of our said Lady the Queen, then being feloniously, wilfully, and of his *malice aforethought* did make an assault' (Johnston 1864:181).[10] In terms of punishment, Johnston's formulary stated that 'the said X.Y. is to be buried privately at some churchyard', noting that the 'office and duties' regarding indictable offences were 'explicit about the burial restrictions for those found guilty of *felo-de-se*' (Johnston 1864:176). The role of a medical regime was also registered in Johnston's chapter on inquests:

> In all cases *where* the *cause* of death is *not very apparent*, it is most desirable that competent *Medical men*, (who from reading and experience ought to know the most proper course to be adopted for ascertaining the facts and phenomena most likely to throw light upon the cause and circumstances of the death), should have the earliest opportunity of making a proper examination of the body, for the purpose of giving evidence at the inquest (Johnston 1864:258).

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protection from the Crown (Adams 1977:54).

[10] Johnston's *New Zealand Justice of the Peace, Resident magistrate, coroner and constable* (1864) is commonly referred to as 'Johnston's Formulary'. A 'formulary' is literally a 'book of forms' that details the wording to be used for judgements, directives, orders, and missives that Coroners and Magistrates may be required to write. The Formulary is further discussed below.

Despite all these evident similarities with the British regime, there were important differences in the New Zealand situation. In Britain, the executive extended the judicial finding of *felo-de-se* through life assurances and houses of detention. In New Zealand, however, the criminalisation of suicide relied more explicitly on executive practices. This reordering of the network of relationships stemmed from the difficulties encountered by attempts to implement legal punishments in a far-flung colony with a small and dispersed population. Colonial Coroners simply did not have the same scope to punish *felo-de-se*. Moreover, a loophole between the British and New Zealand legal systems meant that Coroners, although able to apply restricted burial and forfeiture to the completed suicide, were unable to instigate the punishment of attempted *felo-de-se*. This loophole was caused by a specifically British failure to fulfil legal expectations.

At the time of annexation, legal activism in Britain was focussing on an attempt to bring the criminal and penal codes together under one overarching Statute, specifically so as to slow the escalating list of common law capital offences (Cornish et al. 1978:14). Presuming that this activism would succeed, Johnston's Formulary included a caveat, which stipulated that 'all attempts to commit offences are indictable as misdemeanours if not made felony by Statute,' (Johnston 1864: *supplementary appendix* 11* *asterisk in the original*). This caveat foreshadowed a decision that New Zealand was to be ruled through Statute. However, in effect it opened up a legislative gap that prevented the New Zealand judiciary from being able to punish attempted *felo-de-se* as a felony.

Attempts in Britain failed to achieve the goal of an encompassing Criminal Statute. A situation that persisted until 1961 (see Garrow and Caldwell 1981:155). As

New Zealand remained tied to British common law regarding punishment until 1893, it could only indict attempted offences as misdemeanours. In New Zealand, then, attempted suicide was transformed from a felony to a misdemeanour and death by hanging was replaced by 'fine or imprisonment with hard labour or both' (Johnston 1864:*supplementary appendix 41* asterisk in the original)*. Other, more practical difficulties were also encountered. New Zealand did not have the same sites of punishment. Due to its recently arrived and dispersed population, the Colony lacked a network of detention sites. Indeed, in the beginning there were no prisons, asylums or private mad houses for the incarceration of attempted suicides. The resolution of this problem showed the New Zealand judiciary's growing reliance on the executive regime.

The Colony's population could not generate enough charitable aid to provide separate institutions for felons and the insane. The tensions between the need to securely contain lunatics and the lack of specialised detention centres resulted in challenges to judicial authority. Temporarily housing lunatics in gaols often tried the patience of both 'normal inmates' and their gaolers. For example, in 1852 a Sheriff complained of a case in which

> the patient suffers from continual fits of the most severe description ... .In fact he ought never to be left. Various prisoners, and one in particular, have been told off in pairs and threes to attend upon the patient. The service has been incessant day and night until the prisoners have become fairly worn out, and will no longer perform the duty without force (Sheriff to Colonial Secretary, Auckland, 21 January 1852, from Jermyn 1951:45).

Such difficulties produced public outcries that threatened colonial rule at the community level. In Auckland in 1851, for example, a Public Meeting resulted in the appointment of three clergymen and a doctor to a committee entrusted to approach the Governor and ask for the establishment of a Lunatic Asylum (*The New Zealander*, Saturday 18

January 1851, from Jermyn 1951:45). Such activity was evident throughout New Zealand's major settlements, as groups of people approached provincial and colonial executives to demand the provision of adequate facilities.

The identification and containment of lunatics was a serious point of contention between the upper echelons of the Provincial administration and the Emigration Commission in England. For example, in 1854 the Emigration Commissioners 'pointed out that even a rigid examination could not hope to detect all cases of physical or mental weakness where this was concealed by the emigrant' (Fourteenth Report of the Colonial Land and Emigration Commissioners (1854), in Jermyn 1951:130). Even so, Provincial administrators sought the authority to punish those who were perceived as bringing 'dangerous' people into the Colony and undermining its stability and health. In 1858, for example, the Nelson Provincial Council raised the question of whether it had the power to fine masters of vessels that landed lunatics in the Colony (Nelson V. and P., Session 5, 14 April 1858, in Jermyn 1951:130).

During these anxious times, practical difficulties were often resolved in an impromptu fashion. In 1842, a local magistrate ordered the incarceration of William Brooks, lunatic, in the local gaol. Conditions there were so bad that the New South Wales authorities were asked to receive him in Sydney's Lunatic Asylum. This request was refused and he was eventually found a place in Wellington gaol. Brooks is said to be the first lunatic incarcerated in Wellington. A small wooden building was erected for him in the grounds of the Wellington gaol, but conditions were so cramped with the influx of immigrants that that the Sheriff arranged for the use of the 'Immigration Tenements' from the New Zealand Company Agent (Jermyn 1951:23-24). In Auckland

in 1845, part of the debtor's prison was turned into a gaol hospital and after that date lunatics were confined there. The General Colonial Hospital was also established in Auckland in 1845 (Ernst 1991:71).

Subsequent to these tensions and homespun remedies, the judiciary asserted its authority with the New Zealand Lunatics Act of 1868. This legislation set up a system in which the centralised colonial authorities were in charge of overseeing the provision, licensing requirements, duties and supervision of Public Asylums and Hospitals. The new law also charged the Provincial bodies and charitable trusts with the day-to-day management and financial support of these institutions (Tennant 1989:14).[11] In availing themselves of a mixed provision for the long-term care of lunatics, a provision that included hospitals, immigrant holding facilities and reliance on families in the community (Ernst 1991:69), the judiciary showed the extent to which it relied upon executive practices to secure law and order. This dependence has been interpreted as an extension of the imperial relationship between the central, colonial administration and the peripheral provincial authorities (Brunton 1996:66-68).

The judicial regime also sought to overcome its difficulties by drawing upon executive practices that sought consistency in the application of the law, specifically in the Coroner's Court. This consistency in the central administration of Coronial practices was notably furthered by the creation of a rulebook, Johnston's Formulary, as discussed above. The Formulary provided rules to guide the Coroners, such as by detailing

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[11] As Tennant notes, government schemes incorporated the provision of mental hospitals through the Lunatics Ordinance 1846, which 'provided for the apprehension and safekeeping of 'dangerous lunatics' and, most important, for the cost of their maintenance to be met by the colony' (Tennant 1989:13). Mental illness was more fully incorporated into government aid at a time when much energy was spent developing a system of provision both independent from and cheap for the colonial administration because 'mental illness was a threat to public order and an obvious area of concern, but was also expensive to manage and unattractive to private charity'(Tennant 1989:13).

practices for dealing with *felo-de-se*. This book is a significant document in that although it attempted to sponsor the replication British practices in New Zealand, it in fact indicates the extent to which the Colony broke away from Britain's trajectory.

The Formulary laid out the manner in which Coroners were supposed to replicate the British inquest. It used the same terms to decide when an inquest is to be held, how and where to call a jury, how a verdict is to be decided and the appropriate burial practices for suicides. Every Magistrate and Coroner was issued with a copy in order to ensure consistency of application across the dispersed and transient population of the colony. Although driven by a mission to replicate the British situation, the Formulary evidences a subtle alteration to the British network of relationships. The very existence of a formulary tells of a greater reliance on executive powers to ensure the rule of law. By contrast, coronial practices in Britain were 'neither uniform nor centrally controlled' (Anderson 1987:15). As a set of standardised guidelines, the Formulary transformed the relationship between judicial and executive regimes. The judiciary now needed the rulebook, a set of administrative guidelines to deploy the means of criminalisation, the Coroner's Court. The Formulary thus operated *executively*, as a bureaucratic mechanism that secured the rule of law.

The increasing importance of executive practices in the New Zealand criminalisation of suicide is also evident in the uses made of the executive ability to generate statistics. Suicide statistics were produced through the collection and collation of information about colonial activities that was necessary to work out schedules of fees and dues owed. A concern to portray New Zealand as a safe, prosperous and well-regulated settlement lay behind the use of statistics in many Colonial publications. Suicide statistics were constructed as a barometer of moral and economic prosperity.

British settlement campaigns aimed to specifically encourage the emigration of those Wakefield called the 'uneasy class' (Ernst 1991:66). Prospective British investors and emigrants who sought information about the colony could peruse the *New Zealand Gazette*. Settlers wanting to keep abreast of developments could refer to *Statistics of New Zealand.* [12]

The very first *Statistics of New Zealand* (1858) provided information for the years 1853 to 1856. Completed suicide was not presented as a cause of death in the Coroners' returns and attempted suicide was not categorised in the returns of the Resident Magistrates Courts. However, suicide was presented as a cause of death among British troops (*Statistics of New Zealand* 1858:Appendix A, 2-3). By 1872, however, when immigration was in full flight, the truncated and renamed *Statistics New Zealand* provided a full breakdown of those who were taken into custody on charges of attempting suicide. It is recorded that 17 people, all men, were taken into custody. Of these, eight were discharged, one was summarily convicted and eight were committed for trial. Of the latter, three were convicted and sentenced, while one was acquitted (*Statistics New Zealand* 1874: part V, table no 10). Although Maori defendants were included in these statistics, a separate breakdown of offences by Maori revealed that none were charged with attempted suicide. That said, however, it was 'common knowledge' among early settlers that suicides occurred among the Maori, and especially Maori women.[13]

[12] From 1840 to 1953, when New Zealand was governed through Provincial executives, statistics were collected from parishes and local boroughs and forwarded to the relevant provincial administrations. Initially, these statistics were published as 'Blue Books and used to apply for funds from the colonial purse (*Statistics of New Zealand* 1858:III). Commencing publication in 1858, *Statistics of New Zealand* was 'the first attempt to present to the public the General Statistics of the entire Colony in one comprehensive and authorised compilation' (*Statistics of New Zealand* 1858:III).

[13] 'Ward in 1840 says that jealousy often leads to suicide in Maoris. Suicide was

That these early statistical compilations dealt only with settler male suicide indicates that colonial concerns were not driven by an attempt to somehow accurately render all events in the colony. Instead, moral concerns led suicide to be portrayed as a very rare event that would not be tolerated. In particular, it was settler men, the 'uneasy class', who would be subject to a full judicial enquiry and punishment. As suggested by Ernst, this governance focus on the male settler population 'fulfilled an important ideological function in maintaining the colonial order' (Ernst 1991:67).

The colonial organisation of asylums, standardisation of coronial practices and the incorporation of suicide statistics point to the more pronounced presence of the executive regime compared to the situation in Britain. This executive presence generated a relatively distinct process in criminalising suicide in New Zealand. This criminalisation operated through the predominance of bureaucratised infrastructures of containment, colonial security and the governance of male settler transgressors in particular. However, it is important to note that executive predominance mainly took the form of private companies and dispersed, independent Provincial bureaucracies that serviced judicial rule. It was not a fully centralised 'State' system.

Nor was it a stable system of relationships. It was a dynamic balance of forces rather than a rigid hierarchy. In particular, there were significant tensions about the role of the ecclesiastical regime. These tensions were apparent in the public scandal over the suicide of Ann Folks of Howick, Auckland, in 1873. The scandal focused on the burial of this elderly woman, who had hung herself. On discovery, her body was left to hang for thirty-two hours; dozens came to view the corpse. When the body was finally cut

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common among widows. The head widow in particular was likely to kill herself subsequent to the husband's death. Likewise the Maori might kill himself in pique because of humiliation. Mrs Henry Williams had been perhaps the first white person in New Zealand to revive a Maori who had tried to hang herself' (Gluckman 1976:230).

down, the Anglican minister arrived and 'refused to perform the burial rites over her or allow her to be placed within the area of the burial ground where the other interments had been made', even though her husband was buried there (Luke 1982:209).

These events were condemned in the *New Zealand Herald*, whose headlines focused on the 'EXTRAORDINARY CONDUCT OF THE PEOPLE AT HOWICK' and the 'STRANGE VERDICT OF THE CORONERS JURY' (*New Zealand Herald* 6.3.1873:2). This article sparked letters to the editor, claiming that 'the report was false', 'untruthful and exaggerated' (*New Zealand Herald* 8.3.1873:3). A later editorial exonerated the actions of the Minister, Reverend Hall, as a man merely following orders from his superiors. Instead, the paper condemned the 'highly educated and enlightened evangelical clergy throughout the world who have allowed such a rule to remain part of the rubric of the church without making any effort to have it expunged' (*New Zealand Herald*, Supplement 13.3.1873:1). As Luke comments, the public dissatisfaction with Ann Folks' treatment was framed in terms of an opposition between 'the cause of enlightenment and civilisation versus barbaric and anachronistic customs of the clergy' (Luke 1982:210).

The New Zealand scene showed a greater reliance on executive practices and more controversy over the ecclesiastical role. However, as in Britain so too in the colony, suicide was governed through criminalisation. This mode of governance focused regulatory efforts in particular upon completed suicides, on punishments directed at their body and their property. The suicide corpse was a particularly intense focus of rule. Suicide was constructed as the wilful refusal of an absolute legal and moral authority. This mode of criminalisation remained to the fore throughout the nineteenth century. In 1893, however, it was torn asunder. At this time, continued

attempts to secure law and order through the executive radically transformed relations between the various regulatory regimes. The medical regime in particular emerged to a new prominence. With this development, regulation as criminalisation gave way to discursive constructions of the pathological.

A savage state: Universal security and the pathologisation of suicide, 1893-1974

In the colonial period, medicine understood suicide in terms of insanity caused by an imbalance of humors, an imbalance that at best could be restrained. Even though medicine had a disregard for intention, the judiciary relied on the medical regime to trigger Coronial investigations into completed *felo-de-se* and to restrain 'lunatic' attempted suicides who fell beyond criminal prosecution. However, from the 1890s the medical model for understanding illness metamorphosised from a Galenic to an empirically-based model of clinical diagnosis (Foucault 1963, especially chapters 8-10). Clinical diagnosis aims to deduce pathologies from observed signs and symptoms. It relies on the practice of taking detailed patient case notes based on long term observation. Clinical treatments developed out these observational notes. Records about changes in the patient's condition were used to deduce the results of medical intervention (Foucault 1963:124-148). The general model of pathology was part of a shift in medical discourse from madness to mental illness.[14]

[14] The shift from madness to mental illness is attributed to the German psychiatrist Emil Kraeplin, who in 1899 'identified common characteristics in a number of previously unrelated diagnoses and applied the single term "dementia praecox"' (Fann and Goshen 1977:6). From that point, madness was regarded as the effect of illness derived from either organic-physical or dynamic-behavioural origins. These categorical distinctions were stabilised into three prominent psychiatric diagnoses: neuroses, affective disorders and psychoses. Neuroses were 'emotional disorders generally categorised by unresolved conflicts and anxiety'. Affective disorders were 'characterised by disturbances of mood of such seriousness that the individual is significantly limited in his ability to function',

As the clinical practices of mental illness emerged, suicide was incorporated into the new diagnostic categories. This was achieved by 'assigning the victims to various diagnostic groups and linking the suicide composite phenomena with the psychological and psychobiological dimensions with each of the nosological entities' (Botsis 1997:v). People who had suicided were given a diagnosis that linked their suicide to specific psychiatric disorders. In particular, suicide was consistently linked to the depressive illness that was regarded as a form of affective disorder (Mann and Stanley 1986: preface). Suicide, or rather the mental illness that 'presented' as attempted suicide, was treated as the symptom or effect of deeper psychological disturbance (Lester 1988:3). In this new clinical discourse, human illness was viewed as a disorder of specific systems and functions, a disorder that was amenable to treatment and cure.

The most common forms of medical intervention for depressive illness within psychiatry were 'physical treatments' and 'practical moral management'. Physical treatments focused on bodily applications, while moral management focused on controlling the physical and social environment, in particular of the asylum in-patient. New Zealand's psychological medicine favoured a disease model of mental illness and physical treatments for suicidal patients (Styles 1997:118). In the 1920s, physical treatments included hot baths, massages, and purgatives. Physical and convulsive therapies like insulin and electric shock treatments were developed in Europe in the early 1930s and hailed as great successes. Particular treatments became associated with specific illnesses and were quickly taken up around the world. During this era,

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such as depression and manic depression. Psychoses was characterised by delusional or disorganised thinking, hallucinations, memory disturbance and 'gross inability to respond appropriately to the regular requirements of everyday life' (Fann and Goshen 1977:6-7).

'electroconvulsive therapy [was] used in depressions with suicidal risks more than in any other condition' (Stengel and Cook 1958:15).

New Zealand medicine quickly followed suit, with the first use of electroconvulsive therapy (ECT) taking place at Porirua Psychiatric Hospital in 1944:

> Dr Medlicott described the procedure as it was carried out at the time. The patient remains in bed on treatment mornings, has no breakfast and should be persuaded to empty his bowels and bladder prior to treatment. The treatment is given on a hard mattress under which is placed a fracture board. A bolster, easily made by rolling blankets, is placed under the mid-thoracic spine and, during convulsion, the patient is held by several nurses; one nurse holds the shoulders firmly down on the bed, another holds the hips down, while another restrains the arms. A gag is placed in the mouth at the commencement of the seizure and the lower jaw supported to prevent dislocation. Respiration should commence immediately after the convulsion (Medlicott 1945, in Williams 1987:164).

Although force was sometimes necessary to carry out the medical intervention, the intention was to treat rather than restrain. As said, clinical diagnosis and treatment relied upon taking detailed case notes and ascertaining which interventions improved the condition.

This form of medical intervention was seen to work best in isolated conditions, where those being treated were free from distractions and influences that might jeopardise the effectiveness of treatment. Clinical treatment of mental illness was seen as most effective if conducted in a controlled and secluded environment - the asylum. The explicit environmental control embodied by the asylum was also understood as a matter of 'practical moral management'. Asylum staff, as patients' only source of human contact, were seen as an effective source of moral guidance. As staff deported

themselves impeccably, so patients would learn through the example set by their protectors. This practical moral management supported and extended asylums' physical regime of treatments (Tennant 1989; Williams 1987). The intent was to treat through sequestration and practical moral management. This discourse 'instilled a faith that insanity could be cured' (Brunton 1996:8).

The new medical discourse of pathology problematised suicide by regarding it as the symptom of a dysfunction that is amenable to treatment. The role of treatment is to effect cure - to bring the organism back to a state of wholeness, of optimum function. As such, the new medicine is a recuperative discourse vastly different from the judicial regime, with its concern for punishing those who reject its authority. In New Zealand, this medical discourse came to usurp the previously dominant place of the judiciary in the regulation of suicide.

In 1893, an event unique to New Zealand heralded a fifteen-year period of transition in which the regulatory balance of forces moved from the judicial to a primarily medical mode of governing suicide. The transition from criminalisation to pathologisation was part of a much broader transformation of New Zealand society from a colony to a nation-state. Executive practices were expanded so as to 'modernise' the country by formalising many aspects of its government. The formalisation of government begun in the mid-1890s undermined the core laws and procedures upon which the judicial criminalisation and punishment of suicide rested. It allowed medicine to expand into judicial procedures, such that the judiciary became dependent upon medicine to effect any kind of criminalisation.

In the political realm, reform took shape as an attempt to formally codify all the laws that were in place in New Zealand. The laborious legislative process of

translating British common laws into New Zealand Statutes was initiated by the Constitution Act (1852). This formalisation had the most profound and unexpected consequences for the incumbent mode of criminalising suicide. While the codification of New Zealand Criminal Law was being organised, the judiciary shifted from an approach to law and order based on repressive justice, which understood punishment as effective due to the fear of retribution it generated, to 'modern' principles of restorative justice that focused on rehabilitation. Punishment itself was to be understood as a way of rehabilitating the offender (*The Laws of New Zealand* 1999 vol. 25:4). This change in attitudes made itself felt as existing British common laws were reviewed for inclusion in the new Statute.

The common laws for 'crimes against the person' were reviewed in the early 1890s and re-formulated into the New Zealand Criminal Code (1893). Section 172 and 173 dealt with the issue of suicide:

> **S.172** Everyone is liable to imprisonment with hard labour for life who counsels or procures any person to commit suicide actually committed in consequence of such counselling or procurement, or who aids and abets any person in the commission of suicide.
>
> **s.173** Everyone who attempts to commit suicide is liable to two years' imprisonment with hard labour (New Zealand Statutes 1893:354).

When the Criminal Code was enacted, the common law crime of *felo-de-se* ceased to exist and was replaced by the crime of attempting and aiding and abetting suicide. In terms of Statute, then, completed suicide has *never* been a crime under New Zealand law (Garrow and Caldwell 1981:155).

The reasoning behind leaving completed *felo-de-se* out of the statute books became apparent in a subsequent debate in the House of Representatives, when

politicians discussed the role of the Criminal Courts in passing sentences and deciding punishments. The debate centred on the futility of retributive punishments and the advantages of restorative sentencing for the moral rehabilitation of prisoners (NZPD – New Zealand Parliamentary Debates - 1893:595-15). This debate indicated that judicial governance was turning from a concern with punishment above all else (even if the accused was already dead) to a concern with 'active transgressors' where punishment had the potential to rehabilitate. The focus of regulation thus moves from the dead to the living.

According to this logic, the formal punishment of completed suicides made no sense as there was no hope of rehabilitation. This logic also justified the retention of the crimes of attempted suicide and aided and abetted suicide, as codified in the Act. As they were still alive, these criminals could benefit from rehabilitative punishment. Moreover, the relationship between the kind of crime and the extent of rehabilitation required signalled that attempted and aiding and abetting were seen as qualitatively different crimes. There were different sentences for each. Those convicted of attempted suicide were to receive two years hard labour, while those convicted of counselling or procuring another's suicide were sentenced to hard labour for life.

The abrogation of the crime of *felo-de-se* reverberated throughout the judicial regime. First and foremost, the de-criminalisation of suicide displaced the disposal of the dead body as a pivotal point of rule. Now that *felo-de-se* no longer existed as a crime, Criminal Courts could not implement forfeiture and the Coroner's Inquest could not apply burial restrictions to completed suicides. The judicial regime was thus unable to problematise and punish suicide in the old way. As well as abrogating *felo-de-se*, the Crimes Act of 1893 drew judicial attention to attempting and aiding and abetting

suicide, offences that fell within the preserve of the Criminal Court. Historically, the Criminal Court was notorious for finding 'insanity' in cases of attempted suicide.[15] More interesting still, there is no documentary evidence that the Criminal Court ever prosecuted anyone under s.172 during the period under review.

The 1893 abrogation of *felo-de-se* tended to split the focus of the judiciary. On the one hand, it maintained the Coroner's role in investigating suicide yet at the same time prevented Coroners from punishing completed suicide. On the other hand, by only allowing suicide attemptors and abettors to be punished, it transferred jurisdiction to a Criminal Court that had become beholden to the medical regime's notion of insanity. Overall, the effect was to split the judiciary's focus and de-stabilise the long held hierarchy between the Coroner's Court and the Criminal Court. The de-stabilisation and reorganisation of the internal configuration of the judicial regime was compounded by the next wave of modernisation that took place around 1908.

In colonial New Zealand, executive powers were dispersed in the Provincial system of government and a network of commercial organisations. In the early years of the 20th century, however, these powers were further formalised by a concerted effort to professionalise, bureaucratise and centralise. These developments de-stabilised the external configuration of the mode of criminalisation. The 1908 Coroner's Amendment Act dropped the jury system and removed the Coroner's Inquest from the local community to Magistrate's Courts, a move that effectively disabled the 'old' combination of medical and ecclesiastical support that had underpinned the judicial regime. In the colonial system, the medical regime had supported the judiciary in that

[15] British criminal courts were well known for tending to judge the *felo-de-se* as insane and so sending them to pauper asylums or madhouses (Forbes 1979:137). There was a longstanding perception that 'jurors behaved as if the very act of suicide is an evidence of insanity; as if every man who acts contrary to reason, has no reason at all'

doctors were used to trigger coronial inquests that relied on the Coroner and jury to judge intention and culpability. The new and more direct encroachment of medicine into judicial procedures is apparent in what was taken *out* of the Coroners Act by the 1908 Amendment.

Not only was the jury dismissed as 'informal, untrained and expensive', but also the need for Coroners to view the body was done away with. It was presumed that Coroners' deliberations could rely completely on the medical autopsy and police reports (NZPD 1908:164). As autopsies were (and are still) built around ascertaining the physical cause of death, and as police reports were (and are still) required to establish circumstantial evidence, it is clear that Coroners were now required to conduct evidence-based inquests. This requirement had a profound effect. The new procedures worked with the presumption that *intention* was not a significant issue in ascertaining cause of death. It was presumed that those people who killed themselves were by definition insane. What was important was how death had been caused physically and who had brought it about, not whether the person had intended to deliberately end their life or not. In this new environment, 'suicide ... must be proved by facts and not by conjecture' (R. v. Huntbach, ex parte Lockley [1944] 2 ALL ER 453).[16]

The Coroner's Inquest now operated through a medical discourse that constructed suicide as, by definition, a result of insanity. Old ecclesiastically based definitions of free will that had been used to support judicial deliberations of culpability were swept aside. Once the 1908 Amendment Act was brought in, doctors became central to the operation of the Coroner's court: they were already used to trigger

(Blackstone's *Commentaries on the Laws of England* (1769), in Jones 1973:189).

[16] It is significant to note that the New Zealand judiciary continued to use British case law to formulate their verdicts on suicide even though New Zealand had embarked upon a radically divergent legal course (personal correspondence, Coronial Services Officer,

inquests but were now relied upon to conduct post-mortems to produce evidence-based findings (NZPD 1908:164; Coroners Amendment Act 1908 s.6). Medicine was now an indispensable aspect of the Coroners' system, just as it had already become indispensable in the Criminal Court. Judicial reliance on the medical profession slipped into medical control over judicial proceedings. The medical regime now played a pivotal role in the regulation of suicide.

The clinical approach to pathology that emerged in the early years of the twentieth century was *ad hoc*, intermittent, and not well received (Williams 1987:61). All this changed dramatically, however, with the elaboration of executive powers. From 1906 to 1911, the executive shifted from a perspective characterised by 'insurance against', which focused on dealing with the aftermath of events, to a perspective characterised by 'safety from', defined as a concern with public health and social security. This movement sponsored an unprecedented expansion of the executive branch of government and was eventually consolidated and codified by the Social Security Act of 1938, a piece of legislation that brought together the myriad of existing health and welfare Statutes (Tennant 1989). As the famous adage has it, this new system provided the New Zealand population with security 'from the cradle to the grave'.

Prior to the executive consolidation, it was difficult to identify psychiatry as a credible profession. As Belgrave points out, psychiatrists suffered from a lack of credibility by association because for doctors in general

> there was no national system of medical licensing, no professional organisation and little other than the name 'doctor' to distinguish (them). Those who did treat patients often had little but their pretensions to distinguish them from chemists, teeth-pullers and itinerant drug-vendors (Belgrave 1991:7).

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10 July 1997).

This situation was met with a concerted effort to establish the professionalism of psychiatry. The first academic journals and chairs were inaugurated in 1923.[17] Professionalisation generated new specialities, including 'suicidology' in 1929.[18] The first Australasian Association of Psychiatrists was formed in 1946 in Melbourne and New Zealand psychiatrists remained under the auspices of Australian initiatives for some decades (Rubinstein and Rubinstein 1996:3).

The professionalisation of psychiatry is a significant moment in the transition from a judicial to medical mode of suicide governance. As the executive worked towards the implementation of the welfare state, it required medical services to fulfil its stated aims. As medicine and psychiatry were the only professionally organised providers of physical and mental health treatment, the executive came to depend on the services their members provided. Medicine and psychiatry came to dominate the provision of health care. Psychiatry's influence led to the implementation and expansion of clinical treatment of attempted suicide within a nationalised asylum system. This development signalled that pathologisation had supplanted criminalisation as the mode of governance.

Although previous governments had already organised the provision of asylums and some health and welfare initiatives, the first Labour Government embarked upon a comprehensive 'Welfare State' that aimed to provide free education, public

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[17] *The Australasian Journal of Psychology and Philosophy* was inaugurated in 1923 and ran until 1946, when it was superseded by the *Australian Journal of Psychiatry*. The first Australasian chair of psychiatric psychology was founded at the University of Sydney in 1923, though not tenured until 1956. The first New Zealand chair was founded at Otago University in 1962 (Rubinstein and Rubinstein 1996:129).

[18] 'Suicidology' entered the lexicon of psychological discourse in 1929, in the *Psychiatrisch-Juridisch Geselschap* and is attributed to a W.A. Bonger (Simpson and Weiner 1989:145).

health initiatives, salaried medical services, a free public hospital system, adequate standards of housing, a basic minimum wage and full employment (Shirley 1994:137). In part, these aims were achieved by incorporating existing charities into newly formed government departments dedicated to the provision of social security through welfare support, health care, social work and public hygiene (Rae 1983:6-7).[19] In the process, medicine gained an unprecedented independence and authority.

As executive expansion was built on the notion of public health, it depended on medicine to bring that vision to fruition. Medicine's support was garnered by allowing medicine a large measure of autonomy within the health system (Belgrave 1991:12-13; Fougere 1994:150-153). One outcome of this autonomy was the development of an 'asylum system' for mental health, a solution preferred by psychiatry at the time. A national network of asylums was set up to treat mental illness, including attempted suicide (Tennant 1989:40). Between 1920 and 1950, nine asylums that serviced major urban centres and extensive rural areas were established. These included Carrington, Oakley, Kingseat, Raventhorpe, Tokanui, Porirua, Ngawhatu, Seaview and Lake Alice (Fung-Mo Ng 1998:Appendix 8).

Medicine had control over how these institutions were understood. The change in the names given to Parliamentary Acts reveals a new way of viewing asylums as sites of treatment. The first major name change, from the Lunatics Act (1868) to the Mental Defectives Act (1911), clearly signifies the acceptance of an organic model of dysfunction. However, use of 'defective' was problematic as it suggested incurability; hence the name change to the Mental Health Act in the same year (1911). This new

[19] For example, when the Hospitals and Charitable Organisations Act (1895) inaugurated the Department of Health in 1895, it was separate from the Department of Hospitals and Asylums. In 1910, the Department of Health subsumed the Department of Hospitals and Asylums (Tennant 1989:35).

name specified the objective of committals to an asylum – the regaining of health. Paradoxically, this discourse of faith in the ability to cure is observable as an escalation of the proportion of asylum patients deemed incurable. The application of a '6 months curability test' (Brunton 1996:13) to all inmates testifies to the centrality of the discourse of treatment and care. Such tests reinforced beliefs in the general efficacy of treatment by identifying and isolating particular inmates as incurable.

The medical profession also gained control over entry to asylums. The history of committal procedures clearly shows the growing extent of medical authority. Prior to 1908, a person had to be legally committed by a magistrate to receive care in an asylum. The 1908 Mental Defectives Act allowed people to enter asylums on a voluntary basis, dependant on a letter signed by a doctor. The committal procedure, which included attempted suicide as a justifiable reason, took longer to medicalise. In the 1908 Act, application to a magistrate for a reception order to detain a person could be made by any legal citizen over the age of 21, accompanied by one medical signature. The 1911 Mental Health Act modified this procedure in cases of emergency. The applicant could go directly to a medical superintendent with one medical signature, and the superintendent was to forward the application to a magistrate. By 1928, the Mental Health Amendment Act stated that a medical superintendent and two medical signatures had to agree to a committal before a request could be submitted to a magistrate (*The Public Acts of New Zealand* RS vol. 5:741).

Medicine also gained institutional control over procedures within asylums. Increased professional status generated an independent mode of doctoring. Once psychiatrists became professionally qualified, 'the College has assumed that they have been fully able to administer the best possible treatment to patients and that the methods

used, subject to ... normal medical practice, were their own business' (Rubinstein and Rubinstein 1996:153). Patients were in a relationship of dependency upon their psychiatrists. Doctors decided and administered treatment, patients submitted. As Litman says, 'psychiatrists focused treatment of suicidal patients on the theme of mental illness, especially depression ... [where] the basic element in treatment was a continuing stable and dependable doctor-patient relationship' (Litman 1994:123).

The cumulative effect of all these medical powers was a comprehensive reconstruction of the regulation of suicide. Asylums, defined as places for the treatment of a mental illness that had 'presented' as a suicide attempt, became the quintessential site of suicide governance. Medical governance was characterised by the pathologisation and clinical treatment of attempted suicides within a nationalised archipelago of asylums. This pathologisation reordered the network of regulatory relationships. Medical practices insinuated themselves into co-present regimes. In the new order, neither judicial nor executive nor ecclesiastical powers worked without recourse to the medical model of pathology and treatment.

The powers of medicine inflected executive insurance technologies. Drawing upon the medical discourses of mental illness, nationalised insurance schemes moved from a focus on life assurance to a concern with public health and social security. These moves included the development of compensation legislation, notably the Deaths by Accidents Compensation Act (1952). This Act allowed compensation claims for the dependants of suicide on the condition that the suicide had followed some kind of physical injury inflicted at an earlier date. Coote (1976) outlines two precedents for the Act's ruling. The positive precedent was the NZ Court of Appeal case, Murdoch v British Israel Foundation [1942] NZLR, 600), in which the deceased,

> a tramway worker, had been crushed between a motorcar and a tram and had suffered amputation of one leg and serious injury to the other. He became depressed and eventually killed himself (Coote 1976:54).

The logic of this precedent presumed that an act of suicide was due to mental illness and that only a connection between a previous injury and the onset of mental illness had to be proven. A negative precedent for the Act was based on a 'liability' appeal, in which the deceased was given the opportunity to take his or her own life through the negligence of a caretaker. Such claims were excluded from compensation. In the test case of the liability of a custodian, (Palliser v Waikato Hospital Board [1974] NZLR 561, 569-575), compensation was not allowed as to do so would allow 'accreditation of a benefit to the estate or representative of a man who has committed suicide whilst responsible in law for his actions' (Coote 1976:58).

Suicide compensation was thus available only if there was a case for mental illness induced by physical injury. Once again, medicine had infiltrated the executive methods of achieving security. The executive's concept of security through health and compensation was based upon a pathologisation of attempted suicide. Security from suicide worked by intervening in the lives of people once the pathology had presented and been diagnosed.

In contrast to the often more overtly antagonistic relations of the previous era, medicine discretely inflected the ecclesiastical regime. In New Zealand's Catholic Seminaries of the 1950s, priests were encouraged to understand suicides as 'people pushed over the brink' by mental illness. The priest's role was to support parishioners in their grief and not to add to their burden by condemning the sins of their departed

ones.[20] The Second Vatican Council of 1956 detailed a change in burial restrictions that, although belated in secular terms, acknowledged the powerful influence of the medical discourse of suicide as mental illness:

> The law expressly forbids burial to six classes of Catholics who are enumerated in CIC c. 1240.
>
> (3) "Those who, in full possession of their faculties have killed themselves." In modern practice, and according to most medical authorities, a person who commits suicide is considered deprived at least temporarily of the full possession of his faculties. Psychiatrists and medical examiners regularly issue a certificate, and it is considered sufficient proof by most ecclesiastical authorities. ... The deceased is to be given Christian burial, but in a way that avoids scandal (*New Catholic Encyclopaedia* vol. 13, 1967:781).

Despite medicine's undoubted dominion, there was throughout this era a persistent tension with the judiciary over the management of attempted suicides in particular. As discussed above, medicine had gained a foothold in the 1893 legislation that de-criminalised completed suicide. However, the pathologisation of suicide was soon under threat when the judiciary responded to the appearance of a legal loophole. The abrogation of *felo-de-se* created a legal loophole in that attempted and abetted suicides were excluded from legal prosecution on a technicality called 'the anomaly of the principal defendant' (Larremore 1904).[21] The judicial regime regained authority by changing the legal understanding of suicide from a *felo-de-se* to manslaughter in the Crimes Amendment Act of 1906 (Garrow and Caldwell 1981:133).

Attempting and abetting suicides were thus redefined as crimes and so subjected to punishment. Abetted suicide was bracketed alongside murder (as the charge

[20] Personal communication, Father McAloon, 8th June 2000).

[21] Attemptors and abettors could avoid prosecution because there was no principal

of abetted suicide could only be brought if the defendant could prove that murder had not been committed). It was subject to the harshest sentence: hard labour for life. Attempted suicide was subject to two years hard labour if the defendant was regarded as sane or to confinement in an asylum if not. In the main, attempted suicides were placed in psychiatric care.[22] Despite the judiciary's response, then, pathologisation tended to prevail over criminalisation. As noted above, there are no records of anyone being charged with aiding and abetting suicide in New Zealand until 1992. Even though the judiciary retained legal authority over attempted suicide, this authority was not put into practice.

Jostling between the judiciary and medicine was also evident in 1960, with the passing of the Health Amendment Act. The Act specified attempted suicide as a distinct category over which the Health Authority had the discretionary power to commit people to institutions for their own 'security'.[23] The judiciary responded by quickly expanding its discursive repertoire. The 1961 Crimes Act specified the crime of aiding and abetting suicide and alongside this defined a new crime of inciting suicide 'pacts' (Crimes Act 1961s.179-180 RS vol.1 1979:319). The difference between these two misdeeds rested on whether someone had caused the death of another (helped them drink poison), or whether they had failed to intervene to prevent the death (didn't stop them drinking poison). The judicial gaze thus generated new legal categories for suicide that were focused on whether actions were directed towards others or oneself. Only actions directed at oneself were regarded as suicide attempts. Inaction directed at others attempting suicide was regarded as culpable and liable for up to five years

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defendant, (a requirement for the prosecution of a felony).

[22] Personal communication, P. Cullinane (Barrister), September 2000.

[23] The Health Act 1956 was refined in 1960 to include a specified sub-class of attempted suicide (Health Amendment Act 1960 s126A).

imprisonment. Actions directed at achieving another's suicide were regarded as most culpable and liable for up to 14 years imprisonment.

The judiciary expanded the categories of suicide crimes by elaborating the aiding and abetting clauses. This expansion suggests an attempt to regain some leverage over suicide governance, although it must be said that throughout this era the attempt remained largely a matter of paper-work. The first charge of aiding and abetting suicide did not occur until well after the era of suicide governance through pathologisation (R. v Ruscoe [1992] 8CRNZ 68 (CA)). As of 2002, the charges of failing to prevent suicide and suicide pacts have yet to be applied in a court of law.

The predominance of the medical regime meant that in New Zealand the governance of suicide was primarily a matter of pathologisation. The regulatory focus was upon the treatment of attempted suicides in a nationalised archipelago of asylums, stand-alone institutions situated in isolated rural areas far from general hospitals and urban centres. Despite such physical isolation, these regulatory practices had clear general moral import for the population at large. The medical regime governed others by providing and endorsing a model of the 'healthy' and 'normal'. In particular, the pathologisation of attempted suicide constructed the image of an emotionally strong Pakeha man as the normal, healthy subject.

Styles' study of admission and diagnostic data from Sunnyside Hospital in the 1920s and 1930s highlights the models psychiatrists used to understand mental illness. As Styles shows, the categories used to define mental illness 'endorsed a nationalistic construction of healthy "manhood" that was characterised by willpower and emotional invulnerability' (Styles 1997:5). They also reveal a 'construction of women's mental illness associated with reproductive function' (Styles 1997:122). The medical

pathologisation of suicide endorsed the construction of a gendered subjectivity, a construction that recurred throughout 20th century New Zealand. According to Phillips, for example, the period from 1920 to 1950 was dominated by images of 'the family man', characterised by a 'strong yet benevolent will' that provided for his dependent wife and child (Phillips 1987:238). The pathologisation of attempted suicides was one of the practices that contributed to the formation of this identity.

The pathologising mode of suicide governance was in place by the 1920s and held sway for some fifty years. In the 1970s, however, the regulatory network of relations was to once more undergo a radical transformation.

Conclusion

This chapter has undertaken a genealogical analysis of past practices of suicide governance in New Zealand. The analysis has revealed two distinct historical periods, the first running from the 1830s to the 1890s, the second from the 1890s to the 1970s. In the first era, suicide regulation was characterised by criminalisation. This process relied heavily on judicial practices focused in the courts. It was primarily concerned with enacting legal punishments directed at completed suicides. The second period, on the other hand, regulated suicide through pathologisation. Here the emphasis fell upon medical practices centred in the asylum and concerned primarily with the treatment of attempted suicides.

Moral regulation can clearly operate in a range of often dramatically different ways. Historically, the discourses of suicidal subjectivity have turned from the criminal to the pathological. This genealogical account will be extended in the following chapter.

As will be shown, present-day New Zealand has constructed a new and quite different subject of regulation.

Chapter Four- The move to governmentality

Introduction

Conducting genealogical analysis involves interpreting practices to see how the present has come to be as it is. The previous chapter charted developments from 1840 to the mid-1970s. This chapter concentrates on current practices from the mid-1970s to 2000. I stop the genealogy in 2000 in order to ensure that the account is coterminous with a period of fieldwork undertaken that year.

In New Zealand, the governance of suicide through practices of pathologisation prevailed until the mid-1970s. At this time, a series of unforeseen crises instigated a thoroughgoing realignment of the regulatory network of relationships. Whereas in previous eras this network had centred on either the judiciary or medicine, in the contemporary period it is the executive regime that sets the terms of regulation. In the process, the mode of governance has moved away from a focus on the criminal and the pathological to a new concern with those at 'risk' from suicide. In the current period, suicide is morally regulated through practices that I dub 'riskification'.

The onset of riskification indicates a shift to a form of regulation characterised by what Foucauldian scholars have theorised as governmentality. The objective of this chapter is to present a detailed account of this new mode of positive power, a mode that seeks to regulate by constructing subjects as responsible for themselves. It must be noted that current practices of suicide governance are unfolding as we speak. It is more difficult to discern trajectories and accurately identify all the significant factors. Although under development now for some 25 years and hence relatively well established, regulation through riskification remains a mobile process that can be

expected to change in the future.

The riskification of suicide, 1975-2000

We live in an age of suicide risk. In the preceding, medicalised mode of governance, the executive regime framed suicide as a problem to be dealt with upon 'presentation'. People had to attempt suicide before the practices attendant to pathologisation were visited upon them. The executive approached attempted suicide as an existing breach of security. It responded by providing asylum-based, medical treatment to repair that breach. Since the 1970s, however, the executive approach transformed from repairing known breaches to anticipating potential breaches and heading them off at the pass, so to speak.

The executive came to view suicide as a category of risk. As Ewald explains,

> the notion of risk goes together with those of chance, hazard, probability, eventuality or randomness on the one hand, and those of loss or damage on the other ... that is formalised by the calculus of probabilities (Ewald 1991:199).

As a category of risk, suicide is calculable and, on these terms, its probability and therefore potential cost can be determined (Coggan et al. 1995:83). This in turn allows for decisions to be made about 'how much is too much?', decisions that trigger the prevention of risks that are seen as too great, as too costly. Assessing and responding to risk involves the statistical calculation of risk categories and the identification of at-risk populations, in order to determine appropriate prevention practices and where to target them. The anticipation and prevention of potential risks, called risk management, involves the community. As risks are omnipresent, they are in the community at all times (Levi 2000:578). Accordingly, the community is the site where prevention practices will be located. As repositories of risk, community members are implicated in

their prevention.

Within the executive discourse of risk, suicide becomes a calculable problem to be resolved through community-based initiatives. This discourse, then, proceeds on terms quite different from those of medical pathologisation. Rather than focussing on the treatment of those who have attempted to kill themselves, it is concerned with the management of potential suicides. In New Zealand during the 1970s and 1980s, the executive regime displaced medical practices from their formerly leading position. This displacement was brought about as a response to a series of crises, crises that dismantled the medical hold over the governance of suicide.

The 1970s saw the development of an international crisis of confidence in the use of asylums. The asylum system was no longer regarded as an acceptable form of mental health care. Conventional treatment practices in the asylum were challenged by the exposés of an international anti-psychiatric movement.[1] These challenges intensified with a series of critical public enquiries. In New Zealand, for example, the 'Oakley Inquiry' of 1982-3 focussed upon concerns to do with 'ECT procedures, the administration of certain medications, and the general issues of respect for patients' rights and freedoms' (Williams 1987:290). As the old system came to be increasingly seen as untenable, there was a general shift away from asylums to mental health services based in 'the community' (Haines and Abbott 1986:v; de Lacey 1984:17).[2]

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[1] See for example Erving Goffman's *Asylums* (1961), Thomas Szasz's *The Manufacture of Madness* (1971) and *The Myth of Mental Illness* (1974), R.D. Laing's *The Divided Self* (1969) and Michel Foucault's *Madness and Civilisation* (1965). These works all sought to expose mental illness as a social construct, psychiatry as a form of social control, and asylums as houses of correction.

[2] A Special Advisory Committee on Health Services Organisation was set up in 1976 by the Department of Health to look at applying this new 'community' model of health (de Lacey 1984:16). The first community mental health project, based in Christchurch, was granted funding in 1977 (de Lacey 1984:112). In 1980, the 'beer'n'baccy' tax was used to fund initial moves toward health promotion in the community (de Lacey 1984:17).

The medical hold over suicide governance was also weakened by the onset of and response to a pervasive crisis in public finances. When the 1970s international oil crisis developed, New Zealand at first sought shelter in the isolationist economic policy of the then Prime Minister, Robert Muldoon. Seemingly uncontrollable and soaring budget deficits were fuelled by escalating welfare provision costs during a time of plummeting export revenues. Politically, the situation came to a head in 1984, when the fourth Labour government was elected. Under Prime Minister David Lange, the new Labour government was confronted by International Monetary Fund threats to withdraw support unless New Zealand swiftly implemented what one commentator has called the 'Washington Consensus' (Harris 1999:20). Based on 'tight fiscal discipline', this 'consensus' reduced government activity, removed foreign investment barriers and generally 'deregulated' markets, notably by privatising and commercialising many government service provisions (Harris 1999:20-21).

New Zealand was confronted by a profound change in the ethos and organisation of executive responsibilities. The executive abandoned its previous mode of achieving security through universal provision and aimed instead for the selective provision of resources to targeted populations. That is, the executive moved to a 'risk' mode of security. Accordingly, the executive reorganised the ways in which it provided resources. Instead of supplying both finances and services, the executive's new role was framed in managerial terms as an overseeing of the operation of independent providers who vied for public revenue in a quasi-market of contestable funding (Shirley 1994:143). This redefinition had the effect of increasing the executive interest in medicine.

Health became a specific target for executive reforms. The health service was regarded as a primary source of fiscal blowouts and as suffering from poor accessibility,

inefficiency and restricted care options (Shipley 1994:5; Fung-Mo Ng 1998:8). In the preceding period, health and security had been tied together by a universalistic intention to provide a basic level of welfare and medical treatment for all (Fougere 1994:150). Health care was constructed as a centralised system that both developed the national policy and provided the services. This system focussed on treating conditions that had already surfaced in the population. In the new era, however, security and health were tied together by a prevention model. The focus now fell upon predicting what factors increased the likelihood of potential conditions becoming manifest and then managing these 'risk factors' in such a way as to lessen or prevent their occurrence.

'Risk management' was institutionalised by splitting policy development from service provision. Health policy was now developed and monitored by a core set of Ministries. Health provision, on the other hand, was based on buying in services from independent, community-based providers. These services focussed on preventive strategies that targeted specific 'at risk' populations.[3] It was hoped that by transferring at least some charge onto the community, the new health system would represent a financial saving and ease the fiscal crisis (Shipley 1994:5). More immediately, however, the new system transformed the governance of suicide by breaking medicine's monopoly over the asylum system and the treatment of mental illness.

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[3] The executive elaborated these initiatives by developing classifications of risk prevention – 'primary prevention' seeks to decrease the incidence or number of new occurrences of a particular disorder; 'secondary prevention' seeks to lower the number of established cases; and 'tertiary prevention' seeks to minimise the disability or recurrence of an already diagnosed disorder. As secondary and tertiary prevention are regarded as dealing with existing conditions, 'risk management' strategies concentrate on primary prevention. These strategies are also categorised – 'universal interventions' are designed to reduce the risk of disorder for all members of a group (for example, universal immunisation against small pox); 'selective interventions' target individuals who are regarded as having an increased risk of future disorder; and 'indicated interventions' target individuals or groups who have early symptoms but not the full condition (Ellis 1997:29-30).

The executive accelerated its new initiatives by transferring mental health funding away from asylums to community care programmes. This funding transfer effectively dismantled the asylum system. In the seven-year period from 1987 to 1994, three of the country's nine psychiatric institutions were closed down.[4] More generally, services were re-deployed from separate psychiatric institutions to hospital outpatients, as is indicated by the sharp drop in psychiatric bed numbers (Fung-Mo Ng 1998: 89). Hospitals developed a new sense of priorities. In 1986, for example, Porirua Hospital 'realigned' its psychiatric services in order to reduce in patient numbers and facilitate community release (Williams 1987:292). These initiatives were not new – the development of psychiatric wards in general hospitals predates the executive transformation by approximately thirty years (Hall 1988:55) and community care is a perennial issue in the annals of psychiatric care (Brunton 1996:7). However, in the period prior to these executive reforms, 'community based mental health services in New Zealand have tended to *follow* in an *ad-hoc* manner, trends in psychiatric hospital care, rather than *initiate* changes in the role of the hospitals' (Hall 1988:55 italics in original). By contrast, in the new era these community-based initiatives were developed systematically as a general initiative that transformed the role of hospitals.

The dismantling of the asylum system effectively disestablished medicine's power to deploy the pathologisation of suicide. Within the asylum, psychiatrists had monopolised the treatment of mental illness. This monopoly was broken when the executive, seeking to introduce market competition, broadened the definition of mental health care providers. Changes to the Accident Compensation legislation in 1992

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[4] Auckland's 'Oakley' institution was closed in 1987 (Mason 1988:10), Dunedin's 'Cherry Farm' in 1992 (Kavanagh 2001:168) and the Manawatu's 'Lake Alice' in 1994 (Manawatu/Wanganui Area Health Board 1992: 34).

opened up the provision of community mental health.[5] The 1992 legislation used the term 'counselling' to cover the wide range of community mental health services available (ACC Regulations Review Panel 1994). These legislative changes enclosed medical psychiatrists within a much broader category of competing mental health care providers. More specifically, the loss of medicine's monopoly over treating mental illness broke its monopoly over treating attempted suicides.

To compound matters, the link that formally tied attempted suicide to medicine was severed in 1992. Previously, medicine drew upon the judiciary to ensure access to the mentally ill. Now the executive used the judiciary and rephrased mental health rights in terms of 'community care'. The Mental Health Act 1992 repealed section 126 of the Health Act 1956 that enforced committal to a psychiatric institution upon attempted suicides (Bell and Brookbanks 1998:7). From now on, attempted suicides (presenting in hospital emergency wards and GP surgeries) would be *asked* to attend community mental health day facilities.

As medicine lost the practices and sites that pathologised suicide, it began to adopt the executive discourse of risk. Medical discourse changed from constructing suicide as a pathology to be treated and instead posed suicide as a preventable outcome of poor mental health. This discursive shift entailed a new way of accounting for mental

[5] The Accident Compensation Amendment Act 1992 provided compensation and rehabilitation support to those who had received 'mental distress' by the action of others. Clients could access health services through the ACC system by using an 'approved provider' who would, upon completion of the correct paperwork, be reimbursed for their services by the executive. 'Approved providers' were defined using the following criteria: 'approval requires a course of education to acquire understanding of specific areas, supervised practical experience of at least one year, an understanding of the Maori and Pacific cultures, an understanding of gender issues and membership of an approved organisation ... [The] requirement for some tertiary education ... does not require an university degree or even attendance at a university. We see no reason why agencies working in the field cannot arrange with for example polytechnics to provide a

illness. 'Pathology' conveys the sense that mental illness is caused by internal dysfunction, whether physiological, organic or psychological. It also identifies the attempted suicide as the primary object of regulatory activity. On the other hand, when posed as an outcome of poor mental health, suicide is viewed as the result of a confluence of external factors acting upon the person. Accordingly, the primary object of regulatory activity lies in the realm of managing these external factors to bring about good mental health.

What has been called 'a new generation of suicide research' emerged, a generation which devoted itself to 'identifying suicide risk factors' (Botsis et al. 1997:6). New Zealand medical studies of suicide in late 1980s and early 1990s evidenced the new ways of thinking. For example, epidemiological methods were used to generate two large-scale studies. The first was a longitudinal study of a cohort of Canterbury children born in the middle of 1977. Conducted by Professor David Fergusson, the study tracks the cohort by interviewing and monitoring at regular intervals. Analysis of that data came on line in the early 1990s. Although not intended as a suicidological study, the analysis of early teenage sex found 'co-morbidity' with a range of problems that included suicidal ideation, attempts and completions (Brett 1993:92).

The 'Canterbury Suicide Project', started in 1991, was a 'multiple case control study of suicidal behaviour' based on psychological autopsies that aimed to identify the prevalence of suicide and attempted suicide, individual characteristics of suiciders, and 'the extent to which psychosocial characteristics contribute to the risk of suicidal behaviour' (Beautrais et al. 1994:33). By focussing on these 'co-morbidity' problems,

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course of training which meets the requirements of the Committee' (ACC Regulations

the study aimed to identify risk-factors for suicide (Beautrais et al. 1994: 36-37).

These two Canterbury studies were the first in New Zealand to identify potential suicide risk factors. They are significant because the first publications of their initial results coincided with calls upon the New Zealand executive to attend to the problem of youth suicide in particular. In 1989, the World Health Organisation charged New Zealand with improving its youth health statistics. The *Health of Youth Report* (WHO 1989) specifically condemned New Zealand's rates of youth suicide. Under authority of the Ottawa Charter for Health Promotion (WHO 1986), New Zealand was asked to improve its record by the year 2000. This call led to a burgeoning of executive activity focussed on analysing and reducing the risk of youth suicide (O'Reagan 1992: 14).[6]

Clearly, by 1992 suicide was well and truly the executive's charge. The executive seeks to regulate suicide with discourses that focus upon 'youth at risk'. This focus, like the WHO study, seems to suggest that suicide statistics showed a clear and radical increase in only youth killing themselves. However, the focus on youth does not clearly correspond to changes in the statistical profile of suicide. From the 1970s to the 1980s, the statistics on attempted and completed suicide by males show a change from a single peak in elderly male age groups to a double peak in youth and elderly age groups. This double peak occurred along with a general increase in the overall level of suicides across all male age groups (New Zealand Government 1974:114). The female distribution of suicide follows a longstanding pattern: it is much lower than the male and gradually increases though the age groups, peaking between 55 and 64 and then

Review Panel 1994:14).

[6] In 1989, New Zealand's rates of youth suicide were claimed to 'rank first ahead of Australia, Canada, and the United States' (Disley 1992:8). By 1992, literature reviews and workshops had been commissioned to 'generate effective risk management strategies' to reduce this rate (Barwick 1992).

falling away again (New Zealand Government 1978:107). The executive's concern with youth in particular thus seems to selectively concentrate on one of two statistical spikes that are part of a more general increase across the whole population.

The executive's construction of the youth problem is evident in an exemplary text, *In Our Hands: New Zealand Youth Suicide Prevention Strategy* (Ministry of Health 1998).[7] The *In Our Hands* initiative not only includes the formal document itself but also the related body of research reports, policy reviews, consultation documents, steering group and commission reports and recommendations, in-house directives, news releases and guidelines.

As discursive practice, *In Our Hands* problematises suicide by calculating and ameliorating risk. Population-wide statistics produced by the New Zealand Health Information Service were analysed for correlation across a range of variables. When a statistically significant correlation was found, the category was deemed a suicide risk factor (Barwick 1992:29). This risk calculation built a profile of those *most* at risk of suicide.

> A particularly high risk patient would be a male adolescent who had a depressive disorder and additionally a conduct disorder or substance abuse disorder, and recent stressors such as a break-up with a girlfriend, or arguments with parents; a previous suicide attempt; suicide in a family member or close friend; recent suicide in school or recent representation of actual or fictional suicide on TV or in other media; who has poor social support (Mental Health Services 1993:12).

Statistical calculations are used to delineate populations at risk of suicide. In New Zealand, the central target population is Pakeha youth, or young men of European

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[7] *In Our Hands* is an exemplary text because it is the largest, most ambitious and most widely disseminated set of documents about dissipating suicide risk in New Zealand.

descent, between the ages of 15-24 (Barwick 1992:21), with the bereaved by suicide representing a significant secondary risk population (Picton et al. 2001). The calculation of risk is translated into a calculation of probability and projected cost. Coggan, for example, has estimated that the total cost to society for all suicides in 1992 was at least $156,460,090 (Coggan et al. 1997:90). The implicit assumption of *In Our Hands* is that such costs, and especially those associated with the high risk probability of youth, are too high and should be reduced.

The logic of the strategy was laid out in *Adolescent Health: Potential For Action* (O'Regan 1992), a text that further elaborated upon the parameters set by *In Our Hands*. *Adolescent Health* understands suicide as the consequence of dangerous behaviour. Adolescents are seen as taking unnecessary risks that signal a lack of care about themselves. This lack of self-care is a sign of low self-esteem and so is indicative of poor mental health and an increased risk of suicide. On these terms, executive practices are to be geared toward helping people help themselves by changing their self-understanding from low to high self-esteem (Dickinson, Hirsch and Coupe 2000:14). People involved in suicide prevention (epidemiologists, counsellors, policy analysts and so on) should guide youth toward 'the recovery of well-being' by helping them to adopt a 'healthy lifestyle' (O'Regan 1992:10). Such practices will motivate youth to care for themselves, take fewer risks and *ipso facto* reduce the rate of youth suicide.

The executive thus focuses on generating self-care practices in the community, practices that foster individual self-care among those at risk. This self-care is institutionalised by dividing tasks between the executive and the community. The development and monitoring of services is undertaken by ministerial task forces. These task forces have laid out a series of performance targets and intervention strategies in terms of the following five goals: (1) promoting wellbeing in the community (through

mental health education initiatives that will increase family, youth, whanau and community resilience to life stressors); (2) early identification and help (through directing community institutions to develop protocols that will identify those individuals at risk and in need of referral); (3) crisis support and treatment (through setting up crisis support teams within existing mental health provision); (4) support after suicide (through grief counselling); and (5) gathering information and collating research (Ministry of Health 1998:13).

On the other hand, the actual implementation of services is undertaken through the contestable funding of community-based providers, including psychiatric treatment centres, community mental health programmes, school-based identification programmes, crisis phone lines, programmes targeting high-risk groups, media-based prevention programmes, and programmes for the family and friends of suicide victims (Barwick 1992:2). The new approach thus calls for extensive community participation.

> The challenge is for groups in communities to work in partnership to access the skills, strengths and local knowledge to enable communities to actively participate in youth suicide prevention initiatives (Dickinson, Hirsch and Coupe 2000:2).

Sets of guidelines have been developed that call on the community to participate in the development of an ethic of care. One notable example is the so-called *Community Kit.*

A direct output of *In Our Hands*, the *Youth Suicide Prevention Community Information Kit* makes explicit what ‘we need to do as communities’:

> We as communities are to examine our practices regarding young people; to examine how we include them; to involve them in meaningful and purposeful ways; to enable them to make a contribution; to support them when they take risks; to hear and act on their ‘voice’; to show that we are aware by the way we develop policies; to demonstrate that we are able to reflect on our attitudes; to collectively communicate and to build a safe

> community for youth (Dickinson, Hirsch and Coupe 2000:4).

The community is called on to ethically examine itself continually - this is the only way to make sure that 'we' are helping. This self-reflection inspires an ethic of care: 'How to help? Show you care' (Dickinson, Hirsch and Coupe 2000:12).

Fostering ethical care at the community level will, in turn, foster an ethic of care in target populations. In the words of Dickinson, Hirsch and Coupe, 'if our communities achieve this we will surely have an environment that facilitates the HEALTHY DEVELOPMENT OF YOUNG PEOPLE' (2000:4; emphasis in the original). The centrality of the community in managing suicide risk is reinforced by a refusal to offer a centralised solution:

> Given the multitude of factors which contribute to suicide, the government alone cannot adequately respond to this challenge. What is required is a co-ordinated response involving all levels of the community to tackle the serious self-harming behaviours of teenagers and young adults (Ministry of Health 1998:6).

In general, then, the executive regulates suicide with a 'riskification' discourse. This discourse concentrates on the anticipation and prevention of youth suicide. Its core site is not the asylum but rather a wide spread of community-based initiatives. Rather than the treatment of medical pathologies, this risk discourse aims to develop an ethic of self-care. This New Zealand finding closely parallels the conclusions drawn by Pertersen and Lupton's (1996) study of the 'new public health' initiatives in Britain. According to Petersen and Lupton (1996:173), 'within the neo-liberal framework 'community participation' is represented as 'empowering' (pre-social) subjects through the deployment of rational knowledge and rational techniques of administration' (Petersen and Lupton 1996:173). Armstrong (1983: 102) has argued that the discourse

of 'public health is a point of emergence of a new clinical gaze directed at the community rather than the body'. Although New Zealand developments similarly emphasise community participation, they significantly diverge from the British case. Armstrong, Petersen and Lupton all situate these transformations within the realm of public health, a significant point of contact between medical and executive discourses, whereas my account locates the discourse of community participation within the executive. Although present in medical discourses, in New Zealand the rhetoric of community participation has been rigorously pursued and brought to fruition by a complex web of *executively* driven practices.

In post-1970s New Zealand, the executive dominates the network of relationships between the various regulatory regimes. As noted above, the executive has tended to concentrate on one specific statistical phenomenon: the 'youth' spike. Through the late 1980s and the 1990s, the medical, judicial and ecclesiastical regimes focussed on the other, 'elderly' statistical spike. Accordingly, their suicide discourses concentrated on the issue of euthanasia in particular. The problematisation of euthanasia, however, reinforced rather than departed from the executive project to foster community ethics.

From the early 1980s on, euthanasia became a national and international issue for the medical regime. Advances in medical technology enabled indefinite life support. Death, it seemed, could be forestalled. With the indefinite delay came the potential for prolonged physical and/or mental suffering, as well as an unacceptable loss of quality of life. A perceived increase in the incidence of doctors helping people to suicide signalled a change in the discourse. This aid in dying, 'euthanasia', presented the medical profession in a paradoxical light. As they could prolong life, they also had the technical skills to end life painlessly and quickly. Medicine became a potential risk factor for

suicide.

This medical risk was addressed by the development of explicit ethical codes. The Australia and New Zealand Society of Palliative Medicine (ANZSPM) published a set of Ethical Guidelines on Voluntary Euthanasia that advocated for the respect of patients rights alongside the duty to provide 'care, understanding and support' (ANZSPM 1998). Medical euthanasia guidelines thus fostered an ethics of care in tune with the executives' riskification of suicide.

The euthanasia issue also drew the judiciary to the deployment of community care. Voluntary euthanasia organisations emerged in New Zealand in the late 1970s and gathered momentum in the early 1990s. In part sparked by the notoriety of Dr Kevorkian, an American doctor who developed a 'suicide machine' and published *Prescription Medicide* (1991), voluntary euthanasia groups began to lobby Parliament for legislative change and to publicise existing rights.[8] The Auckland Voluntary Euthanasia Society, formed in 1979, supported a private members bill introduced to parliament by Michael Laws in 1995. The Bill was however defeated (private correspondence; 11 August 2000: Secretary VES, Auckland).

The refusal to alter legislation in favour of euthanasia rights left the judiciary in a difficult position, particularly with respect to the terminally ill. This became evident when the very first charge of aiding and abetting suicide was tried and appealed amidst widespread publicity:

> The deceased (N) had suffered an accident in 1990, rendering him almost totally paralysed. There was no hope for recovery and N was very unhappy and desperately wanted to die. Eventually, N and the appellant (a long-

[8] The Voluntary Euthanasia Society developed a 'Code of Health Consumers Rights' by building upon a clause in the 1990 Bill of Rights Act that gave an 'unambiguous right to refuse medical treatment'. The Code confirmed this statuary right to passive euthanasia and the appropriate use of an Advanced Directive (www.geocities.com/vesakl/).

> standing friend) agreed that the appellant would administer sedatives to N and then smother him with a pillow. This was done. Later the appellant confessed his involvement to the police and pleaded guilty to the offence. N's family did not want the appellant to be imprisoned. ... The judge felt bound to impose a custodial sentence in the interests of the *sanctity of life principle* and the need for deterrence (R v Ruscoe [1992] 8 CRNZ 68 (CA)).

Bound by existing law, the judge invoked 'the sanctity of life', the fulcrum of a caring community.

The ecclesiastical regime also asserted a community ethic of care through the euthanasia discourse. Ecclesiastics often vigorously criticised 'euthanasia advocacy groups' in the mass media, in Parliamentary debate and in the religious community. Changes to ecclesiastical codes softened traditional condemnations of the suicider. The *Codex Luris Canonici* of 1983 failed to mention suicide specifically in its detail of burial restrictions (Clarke and Linzey 1996:807). However, the modification of the Catechisms of the Catholic Church, republished in 1994, refused to legitimise euthanasia. Although personal stresses 'can diminish the responsibility of the one committing suicide', any 'voluntary co-operation in suicide is contrary to the moral law' (Vatican1994:550). A 'Pastoral Letter to the people of New Zealand on Euthanasia' reaffirmed the Catholic Church's anti-euthanasia stance, and did so in a way that called upon an ethic of community care: 'As Christians, we cannot be free from blame if there are people in our communities unable to find human comfort and assistance as they approach the end of their lives' (*Catholic Bishop's Pastoral Letter, New Zealand*,29 August 1995).

The medical, judiciary and ecclesiastical regimes have concentrated on euthanasia rather than youth suicide. However, despite this departure these regimes

have if anything reinforced and extended the executive's emphasis on risk management and community self-care. Risk calculations focus regulatory activity on specific population targets – youth, the bereaved by suicide, the terminally ill and severely incapacitated. How then does the attention to these specific populations construct a more pervasive moral regulation? How does 'targeting' govern others who are not young, bereaved by suicide, terminally ill or otherwise incapacitated?

Risk discourses necessarily implicate the total population from within which specific at-risk groups are culled. Identifying at-risk populations is expressly linked with claims that the 'community' is the key to reducing risk. In effect, such claims impute blame on the community at large. This diffuse sense of blame serves as a means to incite community ethics of care. How else can 'we' discharge 'our' culpabilities and duties? It is this diffuse call to community care that fully deploys the governance of suicide as a network of regulatory relationships.

In response to unforeseen crises, the New Zealand executive has shifted its concern with security from one centred on universal provision to risk prevention with targeted resources. The characteristic object of governance is now not those who attempt suicide but rather the 'potential suicide'. The asylum has been replaced by the community as the leading regulatory site. Moral regulation is now constructed as population risk management rather than the medical treatment of individual pathologies. This riskification of suicide has been the dominant mode of governance in New Zealand since the late 1970s and is set to continue into the immediate future.

A genealogy of governmentality

The genealogies of suicide undertaken in chapter three and above identify the present day as a network of regulatory relationships organised by an executive concern with risk management and the development of ethical self-care practices. The genealogy has thus produced an account of the present that highlights the emergence of a new mode of positive power, a mode that has been dubbed 'governmentality'. Like genealogy itself, the analysis of governmentality was inspired by Foucault and has been developed by those following in his path. Both forms of analysis focus in particular on the discursive construction of subjectivity as the key lever of power. However, whereas genealogy is a methodology for analysing positive power, governmentality is a historically specific form of positive power. The remainder of this chapter develops the notion of governmentality in order to theorise the moral regulation of suicide in New Zealand.

Governmentality is marked by the pre-eminence of the 'art of government'. This 'art' means to achieve governance by concentrating upon the 'problematic of government in general' and is articulated through questions about 'how to govern oneself, how to be governed, how to govern others, by whom the people will accept being governed, [and] how to become the best possible governor' (Foucault 1982b:87-88). Fundamentally, government is the art of managing conduct; it is 'the conduct of conduct' (Foucault 1982b:92). Foucault directs our attention to 'the complex composition of men and things':

> The things with which in this sense government is to be concerned are in fact men, but men in their relations, their links, their imbrication with ... other things ... [including] accidents and misfortunes such as famine, epidemics, death, etc.(Foucault 1982b:93).

In addressing such specific 'things' as death, governmentality inevitably expands its powers over a very wide terrain. Those 'who write on the art of government constantly recall that one speaks also of "governing" a household, souls, children, a province, a convent, a religious order, a family' (Foucault 1982b:90). As a constant reflection about government, it is driven 'to observe the nature of what is governed' (Foucault 1988b: 75). These observations seek to discover 'regularities' that have a distinct 'moral form', and on this basis to construct rationalities that legitimate and guide the exercise of rule (Rose 1999:26).

According to Foucault, governmentality 'has as its primary target the population and as its essential mechanism the apparatuses of security' (1982b:102). Foucault argues that the history of early modern Europe evidences the development of this specific form of positive power. Associated with the rise of Liberalism and the nation-state, this broad movement is characterised by three 'phases', with each phase dominated by a distinctive rationality. On these terms, Foucauldian analyses have highlighted shifts from disciplinary to pastoral and then to neo-liberal forms of rule. This movement has established the pre-eminence of government as 'the conduct of conduct'.

A defining feature of 'the conduct of conduct' is ethical subjectivisation. Rather than externally apply some behavioural code to an already existing subject, governmentality is concerned with

> the manner in which one ought to 'conduct oneself' – that is, the manner in which one ought to form oneself as an ethical subject acting in reference to the prescriptive elements that make up the code (Foucault 1985:26).

This emphasis on the construction of ethical subjects that can take care of themselves accords with the above analysis of the regulation of suicide in present-day New

Zealand. More generally, the New Zealand periodisation corresponds with the pattern of historical development outlined by Foucault.

The criminalisation of suicide in colonial New Zealand was an exercise in disciplinary power. Focusing on the punishment of completed suicides, this mode of regulation exemplifies the characteristic disciplinary emphasis upon 'the materiality of power operating on the very bodies of individuals' (Foucault 1980a:55; Smart 1985:81). The subsequent era of pathologisation evidences a move to pastoral power. Foucault defines pastoral power in terms of the evolution of a centralised state, a notable feature of 20th century New Zealand. State power techniques are 'orientated towards individuals and intended to rule them in continuous and permanent ways'. Centralising powers in the state thus involves the development of a pastoral, 'individualising power' whose 'role is to constantly ensure, sustain, and improve the lives of each and every one' (Foucault 1979:60, 67).

Pastoral power is thus simultaneously universalising and individualising. The good shepherd has 'got to know his flock as a whole, and in detail' - his aim is to save 'them all, all together' through 'constant, individualised, and final kindness' (Foucault 1979:61-62). In similar fashion, the welfare era in New Zealand combined the identification of individual needs with universal provision by state bureaucracies. The pathologisation of suicide clearly replicates a pastoral relationship. The medical regime acted as a means by which the centralised state attended to its flock both as a whole, by means of a nationalised system of healthcare, and individually, by means of psychiatrists who treated attempted suicides in an asylum environment that facilitated minutely directed care and attention.

The riskification of suicide in post-1970s New Zealand exemplifies the features of contemporary neo-liberal governmentality highlighted by Foucauldian analyses.

Neo-liberal power is preoccupied with economic constructions of the self. In his influential *Résumé des cours*, Foucault considered this new mode of power by discussing post-war German neo-liberalism, the 'Ordoliberalen', and American neo-liberal political theorist Gary Becker (Foucault 1989). Neo-liberal discourses construct a need for 'frugal government' in broad terms, not only in markets but also in 'domains that are not exclusively or primarily economic such as the family and children, and delinquency and crime'. Rather than the old *homo oeconomicus*, the subject of government activity is the 'manipulable man' of behaviourism, 'perpetually responsive to modifications in his environment' (Gordon quoted in Dean 1994:192).

Conceived in these broad terms, the subject is constructed as 'an enterprise of himself or herself', an enterprise ultimately concerned with the 'care of the self' (Gordon 1991:44). This neo-liberal discourse is clearly articulated by the riskification of suicide in contemporary New Zealand. The concern with self-care through community projects instigated by the executive, for example, is typically linked with calls to 'trim the fat' from an expensive and unresponsive state infrastructure. More significantly, present-day suicide regulation in New Zealand is characterised by the construction of subjects dedicated to rational 'care of the self'. The move away from pathologisation has evidently involved a move toward ethical subjectivisation. The subject of regulation must take responsibility for and manage its own status as a 'potential suicide'. This emphasis on subjective responsibility has been noted by many Foucauldian studies (for example, Kinsman 1996).

The community solutions outlined by *In Our Hands* entail the construction of responsible subjects. Consider, for example, the strategy of setting up of bereaved by suicide support groups. These groups are constructed as a community response to the escalating risk of suicide. The space for developing such a response was created in the

late 1980s, when Post-Traumatic Stress Disorder (PTSD) was articulated as a legitimate mental problem. As those bereaved by suicide were assumed to have a high risk of PTSD, they could now claim payment for counselling by registered community health care providers (ACC Regulations Review Panel 1994).

The late 1980s link between suicide bereavement and PTSD coincided with an expansion of victim reparation practices. 'Victim Support', a voluntary organisation that informed 'victims of crime' of their rights to entitlements and support, was formed in 1986.[9] A common practice emerged in which the Police would refer suicide 'victims' to Victim Support as part of their obligations under the 1987 Victim of Offences Act, even though a crime had not been committed.[10] This practice assumed that suicide has an impact on those bereaved similar to that experienced by the victims of crimes.

Medical and judicial activity effectively doubled the ways in which community organisations could link with those bereaved by suicide – as the sufferers of PTSD and as the victims of an offence. These developments synchronised with increased executive concerns about youth suicide in particular. The executive responded by sending out health care workers on a preventative mission to educate the community about suicide bereavement as a suicide risk and to facilitate those bereaved by suicide to set up support groups. Counsellors liased with their 'clients' through local education facilities. This mental health outreach initiative combined with a grass-roots move toward the recognition of suicide bereavement and in a handful of towns in New Zealand it sparked

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[9] The Victims of Offences Act 1987 aimed 'to make better provision for the treatment of victims of criminal offences' (*NZ Statutes* (1987) 173,2334). A Victims Task Force was established to develop guidelines and assess existing services and gaps. As a result of this initiative, the first independent Victim Support Group was established in Gisborne in 1986 (www.victimsupport.org.nz: 28.7.2000).

[10] This common practice was corroborated by personal conversations with both Chris Allerman, a police recruit in 1998, and an anonymous member of the Hawkes Bay Victim Support Group. The practice is investigated by Mist (1998).

the creation of bereaved by suicide support groups.

Only one account of the emergence of bereaved by suicide support groups exists to date in published form. Calder's *Who Cares?* (1995) gives a social history of the Canterbury Bereaved by Suicide Society. A public meeting was arranged in mid-1988 at the Community Mental Health Centre in Christchurch. The meeting was called by the Community Mental Health Team in response to a perceived local need.

> This first meeting was attended by about twenty people. It confirmed the need for a self-help group. After the first meeting, a support group for those bereaved by suicide began to meet fortnightly and a committee was formed (Calder 1995:58).

Similar support groups were formed elsewhere in the country. These groups are a direct outcome of youth suicide discourses.

As youth kill themselves, it is their parents who are left behind and likely to suffer from PTSD. As adults and therefore full members of the community, bereaved by suicide parents are to be managed through targeted mental health education initiatives that expect them to take on the practices of self-care. They should be encouraged to set up their own support groups. The discussion of these groups by *In Our Hands* makes it clear that executive attempts to foster community self-care involved the construction of community members as responsible subjects.

As *In Our Hands* puts it, 'support groups for people who have lost someone through suicide aim to reduce their personal risk of suicide in that they can help prevent further fatalities and assist in the grief process' (Ministry of Health 1998:19). These community-based groups are expected to provide authority figures that act as facilitators and educators, teaching participants about the stages of grief and personal coping strategies (Dickinson, Hirsch and Coupe 2000:17). According to *In Our Hands*,

the support groups foster instrumentality. They serve one purpose: to help people help themselves to get through the grief process. In keeping with such instrumentality, the emphasis is upon attention to individual needs. Rather than significant entities in their own right, the groups are little more than transfer points between experts who assist bereaved individuals to care for themselves.

Individuals are to take charge of their own well being. They need to be reconstructed according to an ethic of self-care. As the discourses about bereavement support groups indicate, in contemporary New Zealand suicide is regulated by practices geared toward the enablement of responsible subjects.

Conclusion

This chapter has completed the genealogical analysis of the regulation of suicide in New Zealand. It has also expanded upon the analysis of present-day arrangements by investigating contemporary regulation as an exercise of governmentality. The current mode of governance is configured by an executive-dominated riskification of suicide. The problem is constructed as a matter of 'potential risk'. The solution to this problem is to be found in practices that foster a community ethic of care. Through these practices, individuals are constructed as responsible subjects.

The Foucauldian analyses undertaken above afford a sense of historical complexity unavailable to the classical account of moral regulation. Instead of the monolithic forms of constraint presumed by Durkheim and Douglas, we have a detailed empirical account of the tangled and highly unstable practices that make up a given period of suicide governance. Social change is more complex than a shift from one homogenous type of constraint to another, equally homogenous. Rather, it is a tangle of

allegiances and contradictory effects that shifts in unpredictable ways in response to unforeseeable events. From out of this tangle emerge historically specific, discursive constructions of subjectivity.

The analysis of New Zealand materials has revealed something quite different from the expectations of classical sociology, with its conception of regulation as the placing of constraints upon subjects who already exist in some established form. Instead, a radically discontinuous series of subject constructions has been highlighted. Historically, the subject of regulation has moved from completed suicides to attempted suicides to potential suicides. This movement culminates in practices of ethical subjectivisation that do not constrain but rather seek to enable people to take care of themselves.

Given the empirical persuasiveness of this account, the Foucauldian approach seems to have conclusively proved its advance over the stalemates of classical theory. The following chapter considers the theoretical strengths of governmentalist interpretation. It also reveals, however, the persistence of some rather old problems.

Chapter five – Critical reflections on governmentality

Introduction

At present, suicide in New Zealand is regulated by a governmentality that seeks to construct subjects able to assume responsibility for their own situation and manage for themselves the moral morass brought about by their encounters with suicide. This account of the contemporary situation has been underpinned by Foucauldian conceptions and so clearly demonstrates their analytical value.

This chapter reviews the Foucauldian approach in general theoretical terms in order to determine the adequacy of its history of the present. The genealogical method and governmentality concept have made for decisive advances over classical sociological theories of moral regulation. However, as this chapter will show, a cluster of important problems persist around the issue of moral agency in particular. The Foucauldian account is incomplete and further empirical investigation of New Zealand regulatory practices is needed.

The discursive construction of subject and boundary

The Foucauldian approach advances upon the classical formulation of moral regulation by highlighting the positivity rather than negativity of power. On these terms, moral regulation is a matter of enablement rather than constraint. This reformulation is underpinned by a distinctive theorisation of the relationship between social subjects and moral boundaries. The Foucauldian approach poses this relationship in a way that is radically different from the classical renditions of Durkheim and Douglas.

The classical rendition conceptualised moral regulation as constraint by theorising the moral boundary and the subject independently. From the point of view of

the social actor, the moral rules that separate the good from the bad are an a priori reality. Moral boundaries can thus be known independent of the particular viewpoints of particular subjects. On these grounds, classical sociology presented itself as a science of morality. This science has both command of the historical record and moral rectitude. Durkheim (1897:35) elaborates generalised laws of society, while Douglas (1967:284) discusses universally generalised patterns of meanings. As scientific knowledge states universal truths about the world, it can generate answers to social problems that are morally correct. Science lets us know the right thing to do.

Confident expressions of the True and the Good are characteristics of grand theory. In classical sociology, this confidence is underpinned by the theorisation of moral boundaries and subjectivity as distinct entities. As noted above, both Durkheim and Douglas pose the moral boundary as something that can be known independently of the viewpoints of particular actors. So too can the character of subjectivity itself. Durkheim and Douglas both develop philosophical anthropologies. Durkheim and Douglas provide answers to questions about what it means to be Man. This universal 'human nature' is theorised as somehow outside or above all the detail of individual lives. Moral boundaries and subjectivity are thus theorised as external to each other. On these terms, moral regulation is conceived as the application of rules upon social actors. As these rules derive from an external source, they constrain subjects to act in morally appropriate ways.

Foucauldians have sought a radical alternative to the classical conception of constraint. They have subverted the grand theoretical position by disputing its claims to provide an independent and commanding 'scientific' account of social organisation. Classical sociology's command of history is a 'transcendental imposition on the fields of life, language and labour' (Lemert and Gillan 1982:108). This imposition turns history into the taken-for-granted home of Man. History becomes 'for the subject in

question, a place of rest, certainty, reconciliation' (Lemert and Gillan 1982:23). As Foucault puts it, 'empirical contents are given life, gradually pulling themselves upright, and are immediately subsumed in a discourse which carries their transcendental presumption into the distance' (1970:341). Paradoxically, Foucault calls this giving of life an 'anthropological sleep' (1970:340). With Man in place, history loses any sense of radical disjuncture and becomes instead an 'inert grey space of empiricity' (1970:341).

Foucault disturbs this anthropological sleep with genealogical studies that break with the assumption of historical linearity and moral certitude. The analytical force of this turn to genealogy is evident in Chapters Three and Four. The history of suicide in New Zealand evidences radical shifts between three distinct regulatory modes: criminalisation, pathologisation and riskification. These shifts are driven by unpredictable and unstable alliances between a complex plurality of regulatory practices. By identifying and tracking these alliances, the genealogical account produces a narrative of historical discontinuity.

The Foucauldian approach refuses the traditional sense of moral Progress in which things and Man both persist and continuously develop. The New Zealand moves from criminalisation to pathologisation to riskification are not examples of a necessary evolution of human society toward its ultimate state of freedom. Each period is not a refinement of that which preceded it. Rather than the progressive amelioration of formerly harsh constraints, the genealogy brings to light modes of positive power. Unlike the philosophical anthropologies of classical sociology, these modes construct radically discontinuous subjectivities.

On the surface, the three periods of suicide regulation in New Zealand demonstrate a continuous concern with one section of the country's population in particular. All of the periods tend to concentrate on relatively young, Pakeha males as

the main source of problems in need of resolution. Such apparent continuity, however, is misleading. As regulatory practice, each of the three periods constructs a quite different type of subjectivity. Rather than the progressively improved rule of the same social actor, 'the suicide' to be regulated itself changes over time. Criminalisation focuses on the completed suicide, pathologisation on the attempted suicide and riskification on the potential suicide.

The genealogical method sheds light on these discontinuities by emphasising the discursive construction rather than anthropological givenness of the subject. By viewing moral regulation as a form of positive power, Foucauldians reformulate the articulation of moral boundary with subjectivity. The two are theorised simultaneously rather than independently. In one move, discursive practices construct both the boundary between good and bad and the subject who lives in the world thus morally defined. On these terms, regulation is not the application of external rules that constrain social actors. Rather, it is the empowerment of actors. In contemporary New Zealand, for example, the discursive problematisation of suicide generates both the boundary between ethical caring and immoral irresponsibility and, at the same time, constructs self-regulating, caring and responsible subjects

Foucauldians emphasise the positivity of power and resolutely move away from History, Truth and Man. Here, moral regulation appears in a new light. Combining philosophical anthropology with an externalised moral boundary, the classical tradition posed regulation as a matter of constraint. In contrast, for the Foucauldians the subject and boundary are co-constructed and, on these terms, they pose regulation as practices of discursive enablement. This reformulation generates analyses that are sensitive to radical disjunctures in the historical record and the peculiar characteristics of present arrangements. However, there are serious problems with the Foucauldian approach to

moral regulation, problems that centre in particular on the discursive construction of subjectivity.

The limits of governmentality

A system of moral regulation presupposes that people are ruled by way of judgements about the good and the bad. Social actors engage with moral rules that set the boundary between appropriate and inappropriate conduct. This engagement implies a moral evaluation, an adjudication that determines the relationship between rule and action. Moral regulation thus necessarily entails some form of moral agency. If, for example, a rule is obeyed instinctively then the action may be either good or bad but its intention is not moral. Alternatively, if a rule is obeyed merely to avoid negative sanctions, then again the behaviour may be either good or bad but it is not moral action.

Moral action involves the exercise of agency. In general terms, agency refers to the capacity to act independently of social structures (Abercrombie et al. 1984:9). More specifically, moral agency exercises this capacity for independence in order to act 'for the sake of moral considerations' (Wallace 1998:499). In order to act morally, one must have the capacity to act in a range of different ways. Moral agency thus involves a judgement of appropriateness and the making of a decision. Since at least the time of Aristotle, the capacity to judge has been understood as a necessary component of any agency that decides by choosing between different courses of action (Watt 1996:xvi). Moral regulation presumes the operation of a subjectivity endowed with such agency.

Any account of the relations between moral boundary and social actor must include the conceptual space for a moral decision to take place. The classical and Foucauldian approaches conceive the relationship between boundary and actor in diametric ways - either as constituted independently or as co-constructed. In both

accounts, however, moral agency is a problem. Despite their differences, the theories of regulation as constraint and as enablement lack the conceptual space for moral deliberation.

Classical sociology poses subjectivity as external to the moral boundary. Theorising the two independently generates the account of moral regulation as constraint. Regulation is achieved when actors capitulate to external rules, a capitulation that is built into 'human nature' itself. This mechanistic and pre-ordained system denies actors the scope to participate in a morally meaningful way. The Foucauldian emphasis on the co-construction of boundary and subject produces much the same result. This is surely paradoxical, given that the Foucauldian conception of enablement seems if anything to insist upon the importance of agency. However, the Foucauldian approach can be criticised for treating subjective enablement as the assimilation of evaluations made by others. Such assimilation has no room for moral agency.

The devolution of enablement to assimilation springs from the theorisation of power-knowledge. There is a paradoxical singularity in the Foucauldian account. It is true that this account does not singularly focus on the State; indeed this refusal is often held to be a major point of distinction from Marxist analyses (Miller and Rose 1990). Foucauldians characteristically emphasise an expansive and diversified field of discursive practices. Dean, for example, highlights 'a plurality of governing agencies and authorities; of aspects of behaviour to be governed, of norms invoked, of purposes sought, and of effects, outcomes and consequences' (1999:10). This plurality, however, is limited. Foucauldian studies tend to focus on one plane of power-knowledge in particular, the plane comprised of apparatuses that produce formal statements.

Foucault proposes to analyse the rationalities and analytics of discursive relations that are already well-established.

> Of course, I shall take as my starting-point whatever unities are already given ... We must choose, empirically, a field in which the relations are likely to be numerous, dense, and relatively easy to describe [and] consider all the statements out of which these categories are constituted (Foucault 1972:26-29).

Starting with the 'already given', Foucauldians have concentrated upon the detailed discursive regularities that can be found in the formal statements of official texts (Foucault 1972:28; Dreyfus and Rabinow 1982:xxiv). Their work typically relies heavily on materials produced by the pre-eminent practices of government.

Foucauldian work tends to restrict enquiry to regular, explicit and highly elaborated 'serious statements'. Governmentality theorists, for example, have focussed on rationalities that embody 'certain relatively coherent ways and understandings of the tasks and objects of rule, which were codified and rationalised in particular texts and were linked to a range of regulatory practices which would be hard to understand otherwise' (Rose 1999:24). Critics have pointed out that the focus on such highly 'particular texts' 'tends to generate ideal typifications which often are in danger of being little more than the systematised self-representation of rule' (O'Malley, Weir and Shearing 1997:504). Foucauldian 'rationalities' may be little more than rationalisations produced by the government in residence.

The focus on 'serious statements' effectively sidelines the more implicit, and inchoate discourses of everyday life. This 'officialisation' of power-knowledge is not inevitable and indeed in many respects runs counter to Foucault's intention. Foucault characteristically insists on discursive multiplicity and instability. He seeks to expand upon the powers of subjugated knowledges, to hear the 'voice as silent as a breath' (Foucault 1976a:82, 1972:25). Despite these general claims, however, a singularisation of power-knowledge is evident in Foucault's own studies. His influential account of governmentality, for example, centres upon one sustained and elaborate statement,

Machiavelli's *The Prince* (Foucault 1982b).

Subsequent governmentality analyses have similarly relied on formal texts as the exemplars of rule. Bell's *Interrogating Incest* (1993), for example, is based on the analysis of legal texts. Dean's *Governing the Unemployed Self in An Active Society* (1995) focuses on institutional documents used to bureaucratically regulate the unemployed. Such singularised accounts of power-knowledge overlook the significance of other, more everyday discourses which, though more muted and less detailed, are nevertheless a crucial aspect of moral regulation. In particular, they risk hearing only the voice of those who govern and to be deaf to the voices of the governed. On these terms, Foucauldian studies become a traditional form of elite analysis that in many ways resembles Weberian sociology.

According to Frankel (1997) the Foucauldians' myopic focus on the formalities of rule means that, for all intents and purposes, governmentality becomes a theory of elite domination. Others have made similar charges. By concentrating on texts about government, Foucauldians have failed to pay attention to the extent to which actual regulation departs from formal expectations. Their account of government is idealised. For example, Foucauldians proceed as if the governed 'actively believe' what the governing texts proclaim (Frankel 1997:85). Assuming that there is no distinction in beliefs between the governors and the governed, they study only the former. In sociology, the classic term for this lack of differentiation between the dominant and the subordinate is assimilation.

According to Simpson (1968), assimilation is the process whereby those of subordinate status (due for example to racial or ethnic backgrounds) come to interact with the larger community by absorbing the beliefs that dominate in that community. Assimilation is to be distinguished from accommodation, in which the subordinate and

the dominant negotiate some kind of compromise, and acculturation, in which the two fuse to generate a qualitatively different community. Simpson argues that, unlike accommodation and acculturation, 'complete assimilation would mean that no separate social structures based on racial or ethnic concepts would remain' (1968:438).

The Foucauldian lack of attention to the governed produces an account of governmentality as elite domination because it effectively equates enablement with assimilation. It is assumed that governors' texts are sufficient and therefore superior to those of the governed (cf. Berlin 1969:152). If, however, the governed merely assimilate what the governors' proclaim, then they fail to exercise agency. As Frankel argues, the assumption that people actually believe in 'formal statements' has the effect of restricting agency to the governors. This restriction, moreover, reduces the actions of governors to a realpolitik that rules others through brute power rather than ideals.

Foucauldian analysis advances upon classical sociology by theorising the simultaneous construction of moral boundary and subjectivity. However, when combined with the focus on 'serious statements', this emphasis on simultaneity becomes a point of theoretical weakness. Moral regulation requires that subjects find themselves in problematic situations where the good course of action is not immediately apparent. A judgement must be made. However, if subject and situation are established simultaneously, then subjects lack deliberative distance. As subjects and moral boundaries are one and the same construction, the Foucauldian account has no place for moral agency. Failing to hear the voice of the subordinate, it is also silent on the network of relationships between the governors and the governed. The governed offer no more than mute compliance. To do as one is told is not to exercise moral agency. On these terms, then, governmentality is produced by a non-moral actions and enablement is not a form of moral regulation.

The silence of the governed

Problems with governmentality have been recognised and tackled by stalwart supporters. Sympathetic critics have disputed the methodological restriction to 'serious statements' and launched programmatic calls to attend to multiple discourses (Rose 1999:foreword; Larner 2000:4). Such calls, of course, were also made by Foucault himself. Typically, these more recent attempts to diversify the power-knowledge field have failed to adequately resolve the problem.

In 1988, Valverde and Weir highlighted the dangers of uni-dimensional approaches to regulation. In liberal democratic states, they insisted, studies of regulation must take account of non-institutionalised discourses. Democratic and rights based conceptions of the state establish significant distinctions between public and private domains. If the state is to operate as a system of regulation, there must be 'tortuous (and necessary) relations between official and non-official organisations in the moral domain' (Valverde and Weir 1988:32). Studies of regulation must attend to 'the dialectical interplay between rulers and ruled, regulation and resistance, and the internal contradictions within both rulers and ruled' (Valverde and Weir 1988: 33). This plea to focus on the relations between rulers and ruled encourages methodological attempts to go beyond official discourses.

Valverde responded with a study of 18th–19th century social purity movements in English Canada (Valverde 1990, 1991). Conducted as a case study of social purity rhetoric, Valverde concluded that 'mixed metaphors and "excessive" allegories were crucial elements in the constitution of certain practice-based social subjectivities' (Valverde 1990:61,71). With this attention to evidently 'non-serious statements', Valverde attempted to shed light on the relationships between governors and governed. However, typically Foucauldian methodological problems persisted.

Valverde sought to solve the problem of uni-dimensional accounts of rule by analysing texts produced by non-official organisations.

> If there are conflicting discourses aimed at the same individual or group, rather than assume that one wins and the other loses, it is worth examining the possibility that several of them succeed to different extents and in different ways, thus generating an internally contradictory but usefully flexible subject position which can be adopted by people whose experiences of both life and discourse are contradictory (Valverde 1990:65).

By introducing non-official pamphleteers, and so on, Valverde succeeds in diversifying the discourses of government and so allows for the 'flexibility' required for the exercise of agency. However, Valverde still concentrates on texts that seek to regulate. Although she has pluralised the account of governors' discourse, she has not moved beyond the focus on governors' discourse per se. A plurality of governing discourses does not circumvent the issue of elite rule; the hierarchy between noisy governors and silent governed remains in place.

In a similar study, Valverde and White-Mair investigated how Alcoholics Anonymous (AA) teaches people to 'alter their relation to their own desires and their own freedom', specifically by developing techniques for coping with the 'trivial' details of life (Valverde and White-Mair 1999: 393). This appreciation of the trivial lead to the conclusion that the AA's inane slogans are significant techniques for the 'practical management of people's lives' (Valverde and White-Mair 1999:406-7). In keeping with the Foucauldian tradition, Valverde and White-Mair focus on texts that seek to govern. They contend that these slogans are 'the very opposite of the serious texts favoured by academics' (Valverde and White-Mair 1999: 406). The point is poorly made. From the point of view of the AA, these slogans are indeed 'serious statements', and in effect Valverde and White-Mair are simply calling on 'academics' to recognise this fact.

Despite best efforts, Foucauldian analysts continue to consistently exclude

everyday discourses from consideration. Valverde regards non-official discourses as everyday statements. However, the division between what she calls official and non-official organisations does not equate with the divide between the serious and the everyday. Valverde's non-official texts are produced by organisations that seek to govern and as such are serious statements.

Enduring, formally instituted documents are not the characteristic mode of everyday discourse. Everyday discourse is ephemeral and mundane. As it fails to hear such expressions, the Foucauldian approach finds it extremely difficult to avoid elitist accounts. As it fails to tap into the field of everyday discourse, governmentality cannot access the relationship between the governed and the governors. This relationship, however, can surely be expected to generate many boundary situations that provoke moral activity. The study of this network of relationships clearly requires a methodology less preoccupied with the analysis of serious statements.

Advancing on governmentality

As was the case with the classical sociological theory of moral constraint, so too the Foucauldian notion of enablement fails to generate a subjectivity that exercises moral agency. On both counts, this failure can be tracked to methodological limitations. The grand theoretical tradition of classical sociology insists on forging a necessary and exclusive relationship between the method used and the theory developed. Durkheim's theory of suicide is inextricably linked with his procedures for the analysis of social facts. Similarly, Douglas's theory totally relies on the methodical interpretation of subjective meanings. As was discussed in Chapter Two, the Foucauldian approach attempts to do away with this sort of exclusive relationship between theory and method. Why then has it also fallen prey to a restricted methodology?

Foucault claims that he takes formal documents as a 'starting point'. However, his analyses typically never move beyond this point. Consequently, 'serious statements' tend to be generalised across the whole discursive field. This generalisation limits the Foucauldian advance over classical theory. The move beyond a constraint model of moral regulation hinges upon the co-construction of moral boundary and subjectivity. However, when governing texts are generalised across all discourses, the simultaneous formation of boundary and subject turns enablement into a type of assimilation.

In response to this problem, it needs to be emphasised that there is no necessary relationship between the generalisation of 'serious statements' and the conception of moral boundaries and social actors as coeval. As the relationship between methodological generalisation and theoretical assertion is contingent, it can be broken. The two can be decoupled. I wish to hold onto and develop the gains offered by the co-theorisation of boundary and subjectivity. And in order to do this, I propose to break with one of the defining features of governmentality, its exclusive analysis of formal texts, and move toward a less one-sided, more catholic discursive diet.

As shown above, the call for studies of a more diversified discursive field is already present in the Foucauldian literature. Valverde is emphatic on this point. On similar grounds, some have called for a rapprochement between governmentality theory and more traditional sociological methods. Garland, for example, calls for the use of sociological methods that can reveal how governmental rationalities 'function in context' (1999:32). The sociological tradition contains many studies of non-official contexts. A range of methods have been developed to shed light 'on the effects of power structures and spontaneous social controls in non-state organisations, such as closed institutions, communities, families, workplaces and professional settings' (Garland 1999:37).

Garland implies that micro-sociology in particular offers a methodological approach that can advance the account of regulation beyond the limits that have ensnared governmentality. I take his suggestion seriously. Micro-sociology, for example, has focused on 'symbolic interactions' in mundane contexts, exactly the area occupied by everyday discourses. I propose to follow through the suggestions of Garland and Valverde by undertaking field research designed expressly to attend to the missing voices of the governed. I investigate one particular point of crisis in the current mode of suicide regulation in New Zealand, a point at which the risk of suicide has emerged as a real and pressing danger. Bereaved by suicide support groups are in such an emergency situation. Moreover, these support groups are a site of intersection between the discourses of the governors and the governed. Although called into being by the executive, the groups maintain significant autonomies and generate a rich field of non-official discourse.

Within executive discourses, bereavement support groups are sites for the elaboration of 'serious statements' that foster the individuality and instrumentality of responsible subjects. But what actually takes place in these groups? Drawing upon Garland's suggestion, I seek answers to this question by using the familiar micro-sociology method of interviewing. I interview bereaved by suicide support groups in order to learn more about how the discourses of the governed operate in the current era of riskification. Moreover, as noted above, formal documents such as *In Our Hands* shed little light on the actual relationship between governors and governed. To recover this dimension, I have also interviewed relevant experts in the field. A detailed description of interview methods, ethical approval and the group interview schedule are included in Appendices I and II.

The governing and the governed are discursively present in different ways.

Governors contribute to the discourse of suicide prevention by way of their own area of expertise. The governed contribute to the discourse in terms of group activities. I dealt with this issue by constructing two interview schedules. For groups, the interviews concentrate on people's activities as group members. No attempt is made to gather any personal information above and beyond that relevant to group activity. Experts' interviews concentrate on their capacity as professionals associated with the *In Our Hands* initiative. The questionnaires were semi-structured in order to allow participants to expand on points and discuss at length whatever they deemed necessary.

Experts tend to be present in the discourse as discrete individuals who work independently in a professional capacity. Accordingly, I conducted one-on-one interviews at their place of work. The bereavement groups were another matter entirely. I had to seek the group's permission to come and interview participants. This involved a lengthy process of liasing with each groups' designated contact person, who put my request to the group and let me know whether and under what conditions the interviews could go ahead. As it turned out, the groups invariably asked me discuss my questions with them by attending one of their usual meetings. Each interview was audiotaped and transcribed verbatim. These transcripts are the discourse of the governed. All transcripts were sent back to the groups and experts for them to read and emend as they wished.

Conclusion

This chapter has critically reviewed the strengths and weakness of the Foucauldian notion of governmentality as an account of moral regulation. The Foucauldian emphasis on the simultaneous construction of both moral boundary and subjectivity advances beyond the objectivist and interpretivist dualism of classical grand theory. It allows for a theorisation of moral regulation, not as the imposition of a

disabling constraint, but rather as the construction of an enabling ethical responsibility. That said, this chapter has also identified significant problems with the Foucauldian approach.

The Foucauldians' methodological focus upon 'serious statements' and their subsequent generalisation of these texts across the entire discursive field effectively reduces enablement to assimilation. On these terms, governmentality is unable to account for moral agency and devolves into a traditional form of elite domination. This failure is anchored in a methodological restriction to formal texts. Accordingly, in response I have called for more systematic attention to the network of relationships both between the governors and the governed and between the governed themselves. On these terms, the following chapter undertakes field research into the operation of bereaved by suicide support groups in particular.

I embarked on this fieldwork in order to determine whether or not suicide bereavement groups take on board the strategies promoted by such 'serious statements' as *In Our Hands*. I came out with a surprising finding. These groups do not foster self-care through individualising and instrumental practices. Rather than responsibility, it is compassion that they contribute to the moral regulation of suicide in New Zealand.

Chapter six - From responsibility to compassion

Introduction

The theorisation of moral regulation as governmentality remains problematic for the sociology of suicide. The Foucauldian conception of subjective enablement is an advance over the classical concern with external constraints, but this advance is threatened by an implicit logic of assimilation. Actors that merely 'assimilate' prescribed judgements lack moral agency. They lack the capacity to consider and decide that is central to moral subjects and hence to any convincing account of moral regulation. I have argued that the limits of the Foucauldian approach stem from a restricted methodological diet of formal discourses. An account of moral regulation requires a more expansive, less official-centred method that attends to everyday discourses. On these terms, analysis can be brought to bear on the relations between governors and governed, which my critique of governmentality has suggested is a crucial component of the network of relationships that comprise moral regulation.

As discussed in the preceding chapter, in order to analyse the relationship between the governors and the governed, I have used field research to collect and transcribe discursive practices centred on bereaved by suicide support groups. A total of nine interviews were conducted. Two were one-on-one interviews with representatives of the expert discourse, one of whom was a prominent researcher whose work had been used extensively throughout the policy development and implementation. The other was a senior policy analyst heavily involved in developing 'In Our Hands'. The other seven interviews were with representatives of the group discourse. They comprised five one-on-group semi-structured interviews and two one-on-one semi-structured interviews.

Although seven interviews were conducted, one was eventually excluded from analysis because it was undertaken with the chapter organizers of an international self-help bereavement network, 'Compassionate friends', who had no direct experience of suicide bereavement support groups. In practical terms, the one-on-group semi-structured interviews ran using a schedule of questions delivered during a regular support group meeting. I asked open-ended questions to all present and guided discussions into particular areas, as outlined in the schedule contained in Appendix Two. Throughout the duration of the interviews, if and when a person began to talk about an issue in a way that prompted a support moment, attention turned to that and then returned to the schedule. Each one-on-group interview had approximately 12 people present. Of the two one-on-one interviews with group representatives, one was with an individual who was heavily involved in the group, wanted to be part of the discussion, but could not attend the meeting. The final interview was with a person who had been given permission by the group to discuss my questions as the group could not convene while I was in the field. [1]

Although governmentality theory leads us to expect that these groups, as emergency sites of governance, will foster practices that construct an enabled, responsible subject, this is not borne out. What we find is something unexpected.

The call to responsibility

As emergency sites of governance, bereaved by suicide groups are extraordinary rather than mundane sites of everyday interaction. Their extraordinariness

[1] A note on the presentation of extracts from the interview transcripts. To retain the authenticity of the discussions, many extracts are made up of blocks of conversation between numerous people. All names used are fictional. Speech is italicised and includes the following textual devices: to signal pauses (...), people speaking simultaneously i.e. multiple voices (**mv**) and the names of the deceased (*).

is constructed through a discursive interplay across official and civil domains that stigmatises those bereaved by suicide and calls for the creation of support groups to repair that stigma. In essence, extraordinariness is established through official procedures and everyday incidents that call out the suicide bereaved as guilty subjects.

Official procedures actively call people into the suicide discourse as 'the bereaved'. People are called on directly through the official procedures set in motion by the discovery of a body (New Zealand Police 1999). In New Zealand, a death certificate detailing the exact physiological cause of death must be issued before anybody can be buried. Usually, a doctor who knew the deceased and can attest to the cause of death issues the certificate. It is a legal requirement that certain deaths cannot be issued with a certificate until they have been formally investigated. These special deaths include those that have no apparent cause, that involve the suspicion of suicide or foul play, or take place in an institution. Typically, the police are informed of unusual circumstances, arrange for the body to be identified formally in writing and also contact the Coroner. The Coroner will arrange for a post-mortem to establish the exact cause of death. Once established, the Coroner will decide whether an inquest is in order. The body is then released for burial.

The legal procedure surrounding suicide can take weeks to conclude. Sometimes months elapse between burial and inquest. The inquest is a legal hearing run by the Coroner to establish the fact that a person has died, their identity, when, where and how they died, the cause of death and the circumstances surrounding the death (Coroner's Act 1988). At the inquest, Coroners draw upon witnesses including the police, medical experts, close friends, work mates and family members to help them come to a verdict about whether the cause of death warrants further criminal investigation. Coroners can pass judgement on the cause of death and have the powers

to both make public recommendations and control the media release of information to the public. If there is legal culpability, they are not able to prosecute. That responsibility is passed on to the criminal courts, which have the legal power to press charges.

As discursive practices, these official procedures call in those who are required to engage with suicide in a 'formal capacity'. These people include medical professionals (emergency support, pathologists), the judiciary (police and coroner), burial professionals[2] (including church and funeral directors) and the institutional state bureaucracy (for example, registrars who collect the details and translate them into statistics used to inform public policy). In the process of calling together these suicide professionals, these discourses simultaneously identify those 'informally' associated with and affected by the death as 'those bereaved by suicide'.

The suicide bereaved are called in by way of officialised bureaucratic procedures that bestow suspicion. A possible suicide event is automatically regarded as suspicious and the police and the coroner's court are duty bound to ascertain the cause of death. Such procedures establish the issue of responsibility as a central concern. With the need to establish responsibility comes the inflection of suspicion and blame. The procedural summoning of people into the subjectivity 'bereaved by suicide' is supported and amplified by everyday face-to-face encounters that apportion blame. People suddenly realise that they are now discredited because of the suicide. For instance, for **Karen**, her work life altered drastically: *'when my son suicided, seven years ago, at work, I was like treated like a leper'*. **Liz** was shunned while going about her everyday tasks:

[2] At some level, the bereaved have to confront the issue of burial – if and what kind of ceremony they will hold to mark the life and death of the deceased. This necessitates a negotiation with existing burial practices and so involves the ecclesiastical domain to some degree, deciding if and what religious ceremonies are available and finding an official celebrant willing to conduct it.

> *I have neighbours that pulled their curtains for damn near a year. ...every time I went to these neighbours, they, or went passed, they'd have their curtains drawn. I had people turn their backs on me when I was with the other children at netball. People do. At the supermarket, at the checkout, someone I knew from tennis just ... I went to say 'hello', cause I knew I didn't look good. I knew I hadn't done my hair! And I knew I was, you know, dragged out to go and do my first lot of shopping, and she just turned her back right on me. I still have difficulty going to the supermarket on my own.*

Both institutional practices and the more everyday encounters construct 'the bereaved by suicide' as an extraordinary social status. Furthermore, these official and civil encounters are premised on the assumption that those who are somehow associated with suicide are marked by it in a pejorative way. This means that the extraordinariness of the suicide bereaved is based on stigma. The sociological concept of stigma, as developed in Erving Goffman's (1963) classic exposition, addresses a special kind of intersubjective relation, whereby a particular group or individual, negatively judged by 'normals', accepts that judgement and works to manage its consequences.

A stigmatised identity is one that acknowledges the incongruity between themselves and the 'normals' and so can be 'shamefaced' (Goffman 1963:29). To be shamefaced is to feel self-blame and guilt for discreditation. People who are bereaved by suicide are stigmatised: they feel self-blame and guilt, for instance:

R	*Somebody mentioned a little while ago that all deaths are hard and they can be a bit embarrassing, or difficult for people to cope with. But you were saying that suicide is a bit more than that. Why do you think it's a bit more difficult?*
Robert	*I think we all blame ourselves,*
mv	*yes,*
Robert	*Could we have done more*
Gloria	*Yes you do.*
mv	*You're right*
Karen	*Even though you knew it, you didn't really actually know why they did it. They can leave a note but it still doesn't always tell you why, so you have to ...*

	wrestle with yourself for the rest of your life. Why?
Liz	*You say 'why didn't I?', 'Why didn't I?', 'If only'...*
Gloria	*You're so mixed up with the, there was a certain amount of shame attached but, feeling a failure as a parent, because parents, children are supposed to outlive their parents, so you felt you've failed your child somehow. The circumstances are out of you control - the police, the autopsy, the coroners court.*

Similarly:

Anne	*I think its, em, a blame thing that's tending to go on. That people want an answer. OK like an accident, like they drove too fast, but THIS, this isn't like that. So, hey, somebody must be to blame. You know that's, people don't know how to handle it.*
R	*Why do you think they have to blame somebody or something?*
Anne	*Because there has to be a reason for things, something tangible.*
R	*Who do you think does the blaming?*
Anne	*I think we do.*
Fiona	*Some of us bring it on ourselves*
R	*What, like you blame each other or you blame yourselves.*
mv	*No, yes*
Rose	*The guilt is so, I mean you wonder whether you had a part to play in the thought processes of that person taking their own life. You know, events leading up to it, what were my last words to that person? Did I see the subtle signs, you know, the guilt is a very hard part to get past.*

And:

Pauline	*There's so many other issues involved in suicide. It's, for the survivors, it's the guilt,*
May	*We've got to come to terms with the person who did that to themselves. It was their choice to do it,*
Pauline	*Yes, but there is just so many other issues, always asking why. Most people will never know why.*
Margaret	*You can't explain questions. you can explain it, ... you get hit by a car, BANG OK, but, you've got heaps there, or medical condition, it can be explained more easily than*
Pauline	*like even a murder is, you know, it wasn't their fault.*
Margaret	*This is a deliberate choice that somebody has made,*

Pauline *and I think, coming to terms with that as a parent or as a partner or whatever is a very, very difficult thing.*
Steve *Our oldest boy said that our daughter didn't want him as part of her life and that's a very difficult thing to have to go through, to try and grapple with these feelings*
Margaret *Yes, its almost like a kick in the guts, isn't it.*
mv *Mmm, yes,*
Pauline *For you as a parent or, the*
Margaret *Yes, cause it also makes a parent feel like a failure. They have failed.*
Pauline *Yes, exactly,*

The above discourses clearly acknowledge the stigma of suicide bereavement as guilt and blame. They also indicate that stigma and grief come to be seen in terms of each other. Grief is the sense of loss and stigma in the sense of feeling blame for the loss. **Robert** articulates the connection precisely when he says *'it's a blaming pain'*. To acknowledge self-blame is to assent to a pejorative sense of responsibility.

The feeling of intense blame and its attendant guilt is regarded as unbearable by the people experiencing it. In the following extract, **Ria** talks of how her sense of losing control prompted her to come along to her group:

> ** was dead three weeks and I thought, I'm just slowly going round the twist here. Cause I couldn't remember anything, I couldn't say a sentence without stopping, I couldn't stop crying, I wanted to kill somebody, I didn't know who and I thought 'this can't go on'. And one of the (support people) that had visited me the day after *'s death, I think it was, and I thought, who's this tart coming up my drive, and she suggested coming here, and gave me a flyer about it, and I just put it to one side, I didn't want any groups, nothing the matter with me, so em, it was three weeks when I was nearly going out of my tree. I picked this thing up, read it and I did come along, and I came on my own, I didn't know a soul, walked into a room full of people and its just been marvelous for me. Just so grateful that she did come round and leave me something, cause otherwise I might not have known about it.*

The sense of intense blame and guilt is also regarded as untenable by the 'normal' support networks that surround people in their everyday lives. These networks close off

from the suicide bereaved. Individual family members are too immersed in their own grief:

Liz *Did you find, I found that I didn't get a lot of support at home. 'Oh she's going, I think she's going a bit'*

Teresa *The trouble is that they are all going through it so, and this is why it's so hard. Your husband's going through it, your kids are going through it, and it was amazing, the aunties and uncles that we didn't expect to be so affected, they didn't know how to cope because they were trying to cope, so what were they going to do with us?*

Friends eventually become weary of the strain that grieving puts on relationships.

Steve *With friends, you've got to stop talking, because you know that they've either switched off and they are not listening,...*

Kirsten *And people who have been close to you for a long time, just don't even acknowledge it's happened.*

The broader community is also in general unsympathetic to their plight. As **Steve** says,

> *People in the street will only put up with it for so long and think 'look, why haven't you got over it?' You know, it might be a year down the track and they say 'haven't you got over that yet?'*

The bereaved sense that, in general, everyday support has been withdrawn because of the complications that suicide poses:

Fiona *But, the suicide grieving process is different, nobody wants really to know.*

R *To know what?*

Fiona *To well, they don't ask you how you are or you know, they avoid that issue because they're not actually sure of what's going on. I mean I work with a group of health professionals, not one person, after I came back from leave, it was the 'how are you?' and that's where it stopped! Nobody, nobody...*

Rose *As you say, 'really how ARE you feeling?'*

R *So do you think that's because it was a suicide death?*

Fiona *Yes, absolutely. Absolutely.*

Chris *It's the violence, I think, of suicide, that puts people at a disadvantage. Where they perhaps want to put out their hands to you and they are*

	afraid. They don't know what is there and they don't know how you're taking it but they don't want to find out. At least that's...
Rose	*They don't want to understand it, cause they're probably scared that it's going to get them anyway.*
Fiona	*Or do they think there isn't a grief? If a person has committed suicide, that's the end of it. Total banned.*

Alongside the withdrawal of everyday support networks, the bereaved also find that the 'normal' professional suppliers of support are unable to deal with their extraordinariness. Take for instance **Gerrie's** typical tale:

> *A lot of them don't know how to handle it anyway. ...We went to the doctor, my face blew up, I got covered in a rash and everything and I went in to see the doctor and he looked at me and says 'I don't know what you're looking like that for!' Cause I didn't walk in and say 'hello, my son's dead'. I went in presuming the nurse knew, cause she talked to me out at the door. Went in and he says 'oh you've had nothing dramatic happen to you', he says, 'I don't know why you've come out like that.' And he says 'what have you been doing?' Now when * had lived here, he was his doctor too and I just said, 'oh * died', and 'whoah'. I had to comfort him, because he didn't know how to comfort me. Cause he didn't know how to handle it. He says. 'What happened?' So I sat there and told him. Well, he just went to pieces. Gave me some pills, couldn't get me out of there quick enough.*

As normal support practices fail the bereaved, they seek out sites that can cope with their extraordinary situation and the stigma it entails. Take for instance Karen's account of events leading up to the formation of her group:

R	*What made you take the step to ... getting a support group together?*
Karen	*It was only through, we are all grasping at straws, and suddenly there was this workshop, at polytech that was advertised in the paper, so we all honed in on it, there was probably from 14 -20 people at it. Not all of us came to this group, but there was so many people there, and she got us to do drawings, to speak about it, everything like that, and that's when *****'s suicide support group,*

	we went up to them and visited them one day, and they gave us pamphlets and bits and pieces, so we just carried it on from there.

And:

Anne	*It sort of came home to us when we ran that seminar. We just put a couple of ads in the paper about this seminar, when * from Melbourne came over, and em we turned people away at the door because there wasn't enough room. We could have got a bigger venue had we known. But the people there were all so genuine and it had taken a lot for some of them to pluck up the courage and come. One boy came from --------.*
Rosemary	*And the road had been closed, and he had driven all night, he came through ---------. He'd lost his twin brother to suicide and he came because he felt that he needed to come, and talk to someone and listen.*
R	*Did they give you answers?*
Rosemary	*Probably not, but at the end of the day, you suddenly realise that within yourself, and you just get on with life. You can just go over and over and over, but it just helps you work through.*
Yvonne	*You can go on like that for years. But that fact there is other people out there that have been down the same road, helps somehow.*

By self-selecting into groups, people are now explicitly hailed as *members* of the officially targeted 'at-risk' population.[3] As members of a targeted group, individuals can now be addressed by expert practices that aim to foster a responsible subject. The fostering of a responsible self turns on the double-valency of responsibility – its pejorative and positive connotations. To be responsible means to be the cause of something (often bad). To be responsible also means to be someone who will take on the responsibility for what has happened, to feel obliged to take steps to prevent or rectify that for which one is responsible in the pejorative sense.

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[3] Most people bereaved by suicide do not go to support groups and so fall outside the bounds of this study. Groups acknowledge that they are a minority of those bereaved by suicide and they, like many formal participants in suicide regulation, generate a host of

In the expert discourses, responsibility in the first instance is constructed as an acceding to the guidance offered by those who offer to guide. To be responsible is to take one's extraordinariness into one's own hands and to take steps to rectify the 'risk' one represents. As has been shown above, those who self-select to go to suicide bereavement support groups have internalised responsibility as guilt, as 'self-blame'. They have acknowledged to themselves a sense of being culpable, of being pejoratively responsible for the suicide. They have also recognised the need to do something about the unbearable character of this of responsibility.

The untenable extraordinariness of 'the bereaved by suicide' leads to the formation of support groups under the aegis of experts. The expert guidance directed at groups aims to empower subjects as responsible, as self-regulating. Self-regulation is achieved through practices that construct an instrumental subjectivity dedicated to self-repair. Interviews with two key expert spokespeople make it possible to build a more detailed picture of what this entails.

For the experts, the bereavement support groups are to serve one, therapeutic, purpose. They are sites where individuals come to fix themselves. The centrality of self-repair is established through the way experts seek to organise the groups as places to conduct formal courses in grief therapy:

> *Effective bereaved by suicide groups that I've seen overseas work on a time limited support group, so it's 8 weeks highly structured, run by, or co-ordinated, at least initially by a bereavement or grief counsellor with responsibility being given in progressive weeks to members of the group, and working through a very highly structured approach. And it's this week, the next week, the week after, not this month, next month and the month after and with a very clear idea being, very clear aim that we will help you work though this in two months and then they may meet again* **(Expert #2)**.

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discourses about this fact. Further research is required to investigate this field of discursive interaction.

The instrumentality of expert intentions is further intensified by their expectation that groups will be organised hierarchically, both institutionally and internally, with experts in a guidance relationship. The terms of this guidance are specified by *In Our Hands* as a systematic list of targets and strategies developed by experts for use in the community. Experts may not be successful in formalising support group interactions, but such is certainly their desire: *'my, [sigh], they would seem to be more effective if they ... are more structured'* **(Expert #2)**.

The hierarchical relationship between experts and groups is apparent in plans for the implementation of *In Our Hands*:

> *Most of the co-ordination is done at a national level with the government agencies. And each government agency has different links to the community. So say, the Department of Internal Affairs, and Crime Prevention Unit has links into say the Community Councils. The HFA - Health Funding Authority - has links, they fund services. So they can get right into communities* **(Expert #1)**.

On order to 'get right into communities', it is expected that experts will have authority over the group participants. This is shown in the *Youth Suicide Prevention Community Information Kit* guidelines for the support group's internal structure. Community-based groups are expected to be organisations that provide authority figures as facilitators and educators who teach participants about the stages of grief and personal coping strategies (Dickinson, Hirsch and Coupe 2000:17).

The formalisation and hierarchisation of expert-group interactions ensures a uni-directional flow of communications that construct an instrumental sense of subjectivity. The person who is at the receiving end of the advice, the person who is seen to come to groups for the explicit purpose of making use of that advice, is a subject defined through their singular concern with their own self. It is this singular concern

with their own self that defines the person as self-regulating.

Expert practices construct subjectivity as a self-regulating instrumentality focused on self-repair. These practices, then, promote a highly individualised subject. Groups are understood as aggregates of individuals who have come to make use of resources to better themselves. Experts understand groups as places where 'issues' are to be 'addressed' rather than as occasions where friendships are born.

(Expert # 2)	*Well, I mean maybe they need to make a clear distinction between a suicide bereavement group and a bereaved by suicide support group in that one addresses attempts to address the issues of bereavement by suicide, within a kind of professional framework if you like, and the other one is for a loosely aligned group of people who have had the experience of the loss of someone,*
R	*Like a support network*
(Expert #2)	*A support network who can meet on anniversaries or at particular times and that may go on for years, and forge friendships. So, I think there's almost two opposing aims.*

For the governing experts, the key moral outcome of their intervention is a self-regulating subject geared toward fixing up frailties. One frailty of particular expert concern is the depression triggered by suicide bereavement: *'People have argued well why are they in there, you know they shouldn't be part of the strategy, well, they are at risk themselves. Depression and whatever...'*(**Expert #1**). People need guidance to get themselves through a period of prolonged grief: *'I've got concerns ...concerns about sometimes needing a bit of outside input to actually guide them and get them through, because the bereavement process can get really stuck'* (**Expert #1**). People are helped to help themselves. It is expected, for example, that groups will, through expert intervention, self-regulate:

> *When I went to a conference in Australia a couple of years ago. They've got a model where they're having like a social worker, but with a person who had been bereaved by suicide and they had like a team, and they would actually facilitate these groups. And eventually that social worker could leave and the group could be self-fulfilling and help itself* **(Expert #1)**.

Experts teach groups how to be groups:

> *Well we've been looking at developing a pack, a bereavement pack for people who have been bereaved by suicide. That's umm meant... you know health services can give out and GPs can give out. And funeral directors and coroners, that sort of thing. But also then there's the, you know, they give some sort of guidance to the groups and how to kind of set one up* **(Expert #1).**

Bereaved by suicide support groups are 'set up' through complex and protracted calls to responsibility. Expert and official statements certainly demonstrate the assimilation expectations implicit in governmentality discourses. By taking expert guidance and dedicating resources to therapeutic practices, the groups become sites for the enablement of individualised and self-regulating subjects. Group members thus become responsible by accepting the governors' discourse as their own. In the event, however, this is not what takes place.

'They don't know bugger all'

Once hailed into expert discourses, group members are expected to slough off their stigma and get on with the job at hand – individual self-repair. However, the trajectory of expert practices leads to a paradoxical situation. Although everyday stigmatisation empowers the experts, in fact their discourse is largely silent on this issue. Experts regard stigma as contrary to enablement. The experts' silence prompts discourse that generates a social boundary between experts and groups. Moreover, the construction of this social boundary launches a moral discourse that ultimately

delegitimates expertise.

Experts view stigma as contrary to enablement because it is seen to block their attempts to treat people for mental illness. Experts regard lay understandings of suicide as not only inaccurate but also a hindrance:

R	*how would you describe in a very general way, society's attitude to suicide?*
Expert #1	*Oh right, the attitude. I think there's a fascination about suicide. Sort of along the lines of the sex-suicide-death related context. There is a complete quandary about why New Zealand might have a high rate, when we're feeling that we're relative, we're doing quite well, economically, socially etc, etc. Over the last two years there's much more of a recognition that people, or people have known a lot more of the people who have died by suicide, or made serious suicide attempts. But there's still a real, umm they usually attribute the act of suicide to the precipitating event rather than more long term ... .So it's a bit sort of confused. Can't understand why someone would want to take their lives.*
R	*Do you think they're accurate?*
Expert #1	*No.*
R	*Why not?*
Expert #1	*I reckon most of the misconception is that, is the sort of stigma about mental health problems, and people don't actually associate suicide with the fact that most people are depressed. I mean you're not going to want to kill yourself if life is a bunch of roses, really are you. And there's a great stigma about saying you've got a mental health problem, or you're depressed, or you've got anxiety problems, or drug and alcohol problems.*
R	*So people don't want to connect the two together? Or because they're afraid of mental ill health?*
Expert #1	*I think, ... yeah there's a whole lot of stigma. Its much easier to say you've got the flu, you've been off work because they've got the flu than, you got, you know been under stress, or depression or whatever. And for some reason, when they think of mental health problems they think of schizophrenia and bi-polar and the really serious ones, and we'll talk about the risk factors for suicide, as, as you put it, they say 'no, no, no that didn't happen to my daughter, she didn't have a psychiatric illness, she was really depressed'. So a lot of it's*

language, and understanding of, yeah what causes people to suicide.

As far as experts are concerned, the social stigma associated with mental illness prevents people from acknowledging the 'real' causes of suicide and it is this 'blocking' that makes stigma contrary to enablement. The expert response is simply to fall silent about the normative experiences of stigmatisation. Stigma, for example, is viewed simply as the unavoidable social isolation caused by rare events:

R *So do you think there's something quite distinctive about say suicide, compared to all these things that in some ways you could say are, they're sort of reasonably similar?*

Expert #1 *The stigma is similar. And it's dealing with that that tends to isolate the family. Murder is one.*

R *Why do you think it isolates them?*

Expert #1 *Because its a rare event for one. And secondly that, people feel uncomfortable about, how to, personally just talking to people about bereavement is hard enough let alone, and they talk about, most people talk about bereavement and yes that happened to me when my grandmother died and dar-de-dar-de-dar. And with suicide it's very difficult to be able to do that. Because they won't have their own experiences, of suicide or a murder or an AIDS death.*

This devaluation of stigma is linked to a more general devaluation of everyday experience in experts' scientific discourse. Experience becomes merely a piece of raw data to be incorporated within statistical generalisations:

R *Do you think experience is enough?*

Expert #1 *I think it's valid. But I wouldn't rely on experience. I think that, we have got a study which has looked at things, you know 300 suicides, so it means you can't negate having a consistent view, of looking at the all, the whole, the similar things. And that's you know completely rich, and likewise to look at both, yeah what's happening in your region, or what's happening the country, what's happening internationally as well, is valid. The other thing, people interpret what has happened in their own lives quite differently to doing that in a scientific*

	study, or a sociological study or whatever.
R	*If you had information say from a professional outfit and a community group, what source would you feel more comfortable with? Like if you had to chose between, what one would you give more weight to?*
Expert #1	*It would depend on the issues. If it was for example a review of, ah not a review, a gathering of opinions of parents who have been bereaved by suicide and their views of how supportive the services were prior to the suicide and maybe afterwards. I'd probably give much more weight to the family. But if its about risk factors or the most effective prevention strategies I'd probably go to the professional or expert.*
R	*Do you think people can understand suicide if they don't have experience of it themselves?*
Expert #1	*I, they can be as effective. ... But often the easiest way is actually going through research. Where they've actually already done that. People have been very busy about it all. What was going on pre-suicide, how do you manage this, da de da de da.*

Experts' silence on stigma prompts discourse in the groups. However, rather than assimilate the expert silence, this discourse is emphatically and explicitly centred on stigma. Groups see the experience of stigmatised grief as definitive of suicide bereavement. Without fail, each group saw this experience as qualitatively different from all others.

R	*A lot of support groups are set up by people who have been bereaved by suicide and decide OK there isn't a support group here, I need one. Do you think there would be better or other ways of doing that? Setting them up?*
Iris	*What do you mean, by people who don't have these experiences?*
R	*Do you think its possible?*
Morag	*Only if it was run by bereaved by suicide people.*

As far as the support groups are concerned, expert discourses are themselves stigmatising. Groups regard themselves as judged negatively, excluded and undermined by experts. For example, community meetings held by professionals to

explain and inform about suicide were seen as moments when blame was publicly apportioned.

> *I went to a meeting in the church and there was this psychologist there or something, he got up and he said, he was lecturing, talking about it, and he said that mothers were to blame. This was a few years ago now, but, I went up to him afterwards and say, you want to be careful what you are saying in a public meeting, and that's not like me, but I was really, really annoyed* (**Gloria**).

The sense of being under scrutiny is common: *'I think perhaps with counsellors, they are more judgmental'* (**Beverly**). Similarly:

Rose	*I think sometimes when they know there is a trained facilitator and they are professionals, and sometimes they just don't em...*
Hazel	*Because you could tell!*
R	*What was it you could tell?*
Hazel	*Well, you could tell straight away, our business, she said, 'now as soon as you, nobody is allowed to leave here blah, blah, blah, upset and whatever, and if we need to, we can call in blah, blah, blah'. 'Oh, shit, what have I got myself into here?' I mean that was my first meeting. This is my second meeting, and tonight its not as, god, she's not going to drag me off if I, you know,* ***say the wrong thing*** *(*stage whisper*).*
mv	*laughter*

By seeing the professionals as stigmatising, groups generate a distance between themselves and expert discourses. Groups frequently discussed experiences of being excluded:

> *We got this feeling we were more or less hidden in the back, and if say people turned up for the meeting and Lifeline had already booked the room, although we booked it ahead, we would be moved* (**Moira**).

The experience of exclusion leads to the perception of a boundary between experts and groups. Group members close themselves off from experts.

> *It is my experience with counsellors and all, that I close myself more up, because I can't say. ... But, like I say, for*

> *me, when I went to counselling, in the end I closed up, I was feeling the difference when I was with the counsellor and then others here. But for me this set up works better than with counsellors* (**Andrew**).

The separation between experts and group expectations is evidenced in the groups' life-span. According to experts, groups should be a permanent service that endures beyond any given set of members. However, the support groups do not endure. They have waxed and waned according to the ever-changing needs of members.

Expert prompting from the late 1980s on founded the bereaved by suicide support groups I visited. The earliest group had been set up in 1987, the others began in 1988, 1993, 1997 and 1998. Two groups that I contacted in my preliminary search had closed down, another had stopped meeting and was giving only phone support by the time the interviews were conducted. Half-way through my field research, a support group I belonged to went into recession when key members left the district. Since 1999, at least three other groups have come together, only one of which continues to meet.

Institutionally, the support groups are in many respects insulated from expert intervention. As un-registered, voluntary self-help groups, they are independent of formal bureaucracies. They all run in isolation from each other. Participants are aware that other groups exist and some have made contact with more than one. However, there is no network that links the groups together or activities aimed at developing their affiliations.

Groups do not attempt to somehow surpass the boundaries that mark them off as distinct entities. Instead, they use the space thus created to discursively refuse expert guidance. Groups persistently undermine the epistemological authority of expertise. Eloquently put by **Paula**, groups reject scientific knowledge as real knowledge:

> *Our mental health, I don't think mental health professionals actually know bugger all. They don't really*

know bugger all.

The legitimacy of scientific knowledge is questioned by linking it to failures in medical advice and treatment.

Paula *With my daughter she was going to the university counsellor, and she stopped going to him a month before and I went to see him after and he said of all the ones he was seeing at that time, she was the one he thought was the one that was least at risk. And it was only a month before.*

(---)

Hazel *Well my son was in the psych unit, and they sent him out saying he was not suicidal and a week later he was dead. But I mean he's spent time in there. So, our professionals, they don't know any more than you or I do, they probably don't know as much as you and I know.*

Iris *But we look on them as professional people that should provide some answers.*

As the above discourse suggests, group members not only reject the claimed superiority of scientific knowledge but also, significantly, replace it with the knowledge present in the groups. This knowledge is experiential: *'we've been there, we've literally been there, and we know'* (**Martha**).

The refusal of scientific knowledge is an act of epistemological de-legitimation. Groups reject the hold of received science and set about developing and sharing an experientially-based knowledge. In essence, 'our' knowledge is better than 'their' knowledge. This epistemological boundary is seen in strong terms – it is a matter of negation and dispute.

> *See, they just sit behind their ivory desks. ...They're sitting there in this other place making decisions, life and death decisions as it turned out for us. Um and they've really got no idea and that really got to me, the fact that they are in a different world and yet they're making judgements* (**Martha**).

Groups and experts are socially closed off from each other. Groups do not feel they have any kind of formal contact with the professionals. As **Kirsten** says, *' we don't*

have any contact, they don't know, there is no liaison'. Experts reiterate the same lack of engagement:

> *The impression I get is that the groups in NZ are, do not want to work with research groups.... Because they tend to be politically inactive, they have tended not to get in touch with me also, because I think that their concern has been self help* (**Expert #2**).

The social boundary and its epistemic form provide a platform for moral evaluation. The integrity of experts is called into question. Experts are perceived as unable to face up to the responsibilities that attend ultimately very painful situations.

> *And they're not accountable, and then when they get it wrong, as they did in our case, when I asked for help and they denied me, and two hours later she was dead, and that hurts, they denied me that help and it hurts. I have big problems with that. They sit there behind their desk and they say 'oh we'll do this do that' and I said 'she needs help today' and they said 'she isn't bad enough, we can't put her in a place because she's not naughty enough' and that day she was dead* (**Martha**).

The lack of integrity is linked to the inappropriateness of professional conduct that refuses to be informed by personal experience.

Moira	*Eventually, he went for professional counselling because his grief just knew no bounds and well he went through for this counselling session and em he got put with a very young person, who 'knew it all' from a book, had it all there and he stormed out ... and he came back to us and said how dare she even try to talk to me of my loss when she had no children of her own.* [...]
Nanette	*I think there is an arrogance about a lot of psychiatrists.*
R	*Where do you think that comes from?*
Nanette	*Oh. They've only ever learned it out of books; they don't have the experiences.*
Brenda	*That's right.*
R	*What else?*
Steve	*They don't listen.*
Margaret	*They don't listen*
Kirsten	*don't listen.*

Most pointedly, experts are seen as setting up counselling situations for their own financial gain and thus as exploiting the vulnerable:

Janet	*Well the thing is, you know, like, I had some counselling initially prior to us really getting involved in setting up this support group, now I was being charged $80 per hour, now I was told I would need like 20-30 sessions to really have some benefit, so that I could move on with my life, you know.*
Hazel	*That's what they first offered me, it was counselling or something they offered me and I said 'very sorry, but are you taking my food bill?' It's not fair if a person can't afford it.*

Although it is possible to get free counselling, access is convoluted and unpredictable:

> *For myself ... the counsellor ... he could see I wasn't coping and referred me to a psychiatrist and one of the senior counsellors and they decided then that I was suffering from major depression, and I received counselling free of charge. But, by the same token, my youngest son, he recognised, when he was looking inside, he found lots of pain and grief there which he hadn't acknowledged before, and so I asked the counsellor then if they could see him, if he could get some help because I was afraid for him, I still am. And they looked at him and they saw that he wasn't clinically depressed so in order to receive free counselling, this was in October, he was referred on to family health counselling service and he came here and we waited for an appointment at the health clinic and we had to go over seas and the time we'd left, we got a letter in the post to say there was an appointment in February. And so what happens to him?* (**Margaret**).

The condemnation of specific experts is extended into a condemnation of medical expertise in general.

R	*What are your perceptions of the medical professional?*
Rose	*Well, its an easy solution isn't it where they write out a prescription as you leave, so that you are not in danger of doing the same.*
R	*Why do you think they take that approach?*
Andrew	*It's the easiest way.*
Fiona	*It's the easiest way out.*
R	*What makes it easy?*

Andrew	*Because you don't have to listen.*
mv	*We've got to be better than that.*

Similarly, for the government:

R	*So do you know of anything that the government's doing?*
Hazel	*Mason report one, Mason report two, Mason report 15! That's all they seem to be doing.*
Janet	*I don't like the way that they have a big 'don't talk about suicide then its going to stop happening', which is what I see happening, kind of like there's a pile in the corner and they've covered it and no one will see it because its covered.*

The stigmatising desire to 'cover it up' operates in unexpected ways that divide experts from suicide bereavement groups. Experts are seen as part of the problem that groups face. Stigma separates group members from the field of expert discourse and so forestalls the assimilation process assumed by governmentality. Rather than seek to overcome the boundary that divides them from the professional world, groups deepen and extend its significance by delegitimising scientific expertise. Expert authority is rejected as unaware of its own failures or limitations and as exploiting the vulnerable.

Group members repeatedly and emphatically condemn the professionals for refusing to listen and talk, for denying the significance of shared experience. This condemnation directs groups away from expert help toward the cultivation of resources that they themselves can generate. Listening and talking, the sharing of experience, these are privileged as the core concern of the support groups. Through these discursive activities, they make their decisive contribution to the moral regulation of suicide.

The construction of compassionate subjects

As groups close off from experts, they turn to their own concerns. These concerns have already been foreshadowed in way that groups have inveighed experts. It

is the perception of experts' inability to confront their own failures or limitations, their refusal to acknowledge personal experience, to listen or talk and above all, their exploitation of the vulnerable, that riles groups. Groups' anger points to the significance that they attach to acknowledging limitations, respecting others experience, listening and talking to each other and cherishing vulnerability. These are the resources that groups use to cultivate a sense of themselves. The discursive practices developed on this basis construct the moral subject as a *compassionate* self, a self-understanding that stands in stark contrast with the experts' abstract notion of a responsible subject.

What does it mean to help others? Experts aim to help people help themselves by guiding individuals to move on from their paralysing feelings of failure and pain. Experts show they care by helping people 'get over their depression'. Individuals are to return to their pre-suicide bereavement condition, back to a position of wholeness and full functional capacity. This 'recovery' is achieved by getting individuals into a space where they no longer have feelings of failure and pain. The impact of the suicide on their lives is to be removed. Experts help individuals fix themselves so they can be strong and robust once more. They seek to overcome vulnerabilities. For experts, individuals' strength is in inverse proportion to their vulnerabilities.

Groups formulate help in quite different terms. Group help is directed toward and centred on coping with vulnerabilities, not dissipating them. Coping means to recognise and be able to handle a condition that is enduring.

> *Suicide is lasting until the day you die. Other things can get you for the moment or for a few months. But suicide gets you for the rest of your life* (**Karen**).

How clearer can people be about the permanence of their circumstance? This permanence requires endurance, the ability to cope with a condition of everlasting vulnerability:

R	*Do you think having lived through suicide, do you think it's changed you as people?*
mv	*Mmmm, yes*
R	*In what kind of ways?*
Anne	*More tolerant, more understanding*
Fiona	*Of what it's like to be really fragile...*

> *I think that what's good about coming to a suicide bereavement group, because, you know that everyone there has had their life fall apart, they've been shattered and em, they're still alive and they've still got lives and careers and jobs, and if they can do it, it must be possible* **(Janet)**.

Groups are about coping with perpetual fragility. How is this done? Groups cope by talking – *'it's the only thing we've got, is to talk about it really'* **(Iris)**.

> *I think once you put it out there, its gone from you to a degree. Once you share it and it's picked up, it's actually come out of you. So the grief doesn't go away but in mouthing it you sometimes hear things that help you* **(Moira)**.

As Moira points out, it is the sharing of talk that is important. This is borne out in the seating arrangements found in all groups. People sit on chairs usually organised into a loose circle in an open space. This arrangement allows everybody to share in any conversations taking place. If talk is to be shared, it is important to listen.

> *I think its also got to do, especially if you are a quiet person, you are listening to other people and you are saying to yourself ' gee, that's how I feel, that's how I feel, that's how I feel'. Now I don't feel like that, but I do feel like that* **(Steve)**.

A capacity to listen and be empathetic is more important than anything else. It is certainly more important than 'sounding off' on the basis of formal qualifications.

Liz	*That's right, but I mean its just all you need is someone who enfolded you, like the group did. You didn't need someone to sound off all this wonderful medical jargon, or these wonderful*

	terms, you just needed to say 'how, how are you, that's terrible, I understand'.
Gloria	*someone to listen, not tell you what to do.*
Liz	*You don't need to be told what to do.*

The informality conducive to talking together far outweighs the potential benefits of formal organisation. Preserving this informality takes precedence over giving the groups a firm institutional basis with government funding.

Robert	*I think if we were government funded we'd blimmin loose our identity.*
mv	*Yes*
Robert	*And we'd have to conform to their standards*
Karen	*Yes, rules, regulations, everything like that. We wouldn't be the very light-hearted informal relaxed group we are now.*
Gerrie	*You'd have to go and have a meeting every month at least.*
Karen	*All that kind of stuff, that we're not into.*
Gloria	*And don't forget all the rules that go with it. You must not say this, you must not do that. You must not. And it takes away the spontaneity.*
Karen	*People don't always feel like, you know your free will to say what they like, I mean, here, if we were wanting to say 'gawd we had a shit of a bloody day! Gawd!' We can say that, but at a formal meeting, we couldn't say that. No you couldn't say that.*
R	*So do you think that would...?*
Karen	*Take it away.*

Although central, group members do not compel each other to talk; they create opportunities for talk. This is apparent when a new person is introduced to the group. In the following discourse, the new person, **Sheena**, (underlined) is listening but does not share till she is ready.

Morag	*Em being a person whose been to the group quite a few times, do you think it would be better to let us introduce ourselves to these new people*
mv	*yes, mmm, yes it might be better that way for the new people*
Morag	*these people, I mean, its all fine with us, we all know each other, know our situation*
mv	*yes*

R	*Yes, yes that's fine*
Iris	*em we've had apologies from * and * who are usually here, so... my name's Iris I lost my son ten years ago, em * got into the drugs scene and ended up with a drug induced schizophrenia and ended up shooting himself in our shed at home. ....*
Paula	*I'm Paula and my daughter took her heart pills and took her life five years ago at * University, em she was studying to be a vet, ...em yea...*
Martha	*I'm Martha and been just over four years since our fourteen year old killed herself, hung herself in the shed. ... yeah ...*
Morag	*I'm Morag and I lost 22-year-old daughter who gassed herself in the car*
Simone	*I'm Simone and I'm a friend and neighbour of * ... who killed himself last September... I'm friends with his mother Sheena, and ... I was sort of involved with what went on before ...and at the time and now here I am*
Sheena	*... ... ...*
Iris	*you don't have to say anything if you don't want*
Sheena	*... ...no*
Paula	*it's a bit early*
Sheena	*... yes*
Carol	*my name's Carol and we lost our son 16 months ago ... by a gun*
Hamish	*I'm Hamish, I'm here to support my wife, and she...*
Selma	*I'm Selma, lost my son ... ...*
Sheena	*Until * died, I never realised that people just, don't have a clue what people are going through,*
Morag	*It's one of those things that you have to go through it.*
Selma	*You know that saying 'to walk in another person's shoes' and look at it and go through and through it and saying,*
Sheena	(describes the last scene where she knew her son was dead)
Morag	*we know that feeling too,*
Sheena	*...it's so hard to forget, it's so hard*
Paula	*It's a pretty hard image to rub out.*
Iris	*From * point of view, he probably felt so useless and hopeless*

People talk about themselves and their own experiences. They use proper nouns and personal stories to introduce themselves to each other. This discourse lets people identify with each other's experiences. It does not construct an abstractly

singular identity. It is about shared particularities: "*Eh, its a good opportunity to talk with people who have gone through the same thing as you*" **(Ingrid).**

The bereavement support groups work with experiential discourses. They air different viewpoints about each other's experiences rather than construct a single resolution for a common condition. For example, there is no one 'group viewpoint' about the extent of government responsibility for suicide.

R	*Do you think that the state has a certain responsibility in relation to suicide?*
Robert	*No, if the state becomes responsible, we become responsible, we can't be with them 24 hours a day, so what's the state going to do? What can you do?*
Karen	*Well, there's a whole sociological view, this stress, the unemployment, that everything that the government is creating is causing a lot of this disarray. Its becoming a more viable option for people to suicide rather than carry on because of the stress that the government is putting on the people. So they've got to look at it and take back a certain amount of responsibility, OK they can't watch a person 24 hours a day, or anything like that, but they are closing the books on a lot of young people. So they do have a definite responsibility in that aspect, not of watching a person or anything like that, but lift the whole social standing and stresses and look at the country as a whole and what are we going to do for our people. I mean N Z is a very much I people, you get on with your life, you get on with your life, we need to be a lot more a we people. And look overseas. A whole little village will look after a teenager or a baby, what do we do here? Look after you own sort of style. NZ government does need to change it.*
Robert	*But that's society, not the government*
Karen	*Well, the government has created a lot of it though.*
Robert	*But we are a very materialistic society, so that's our attitudes.*
Karen	*We need to go back to grass roots again, and look, I love you missus and I love you misses, and I'll take your kids for a holiday, and you'll take mine, and if I've got an extra couple of dollars and you're broke, and you're broke, this is what we*

	need to get back to, but NZ isn't like that. The government has made it very much like that too.
Gloria	*Perhaps as far as young people go, if the government put in work schemes again, of some sort, to give children a, well young people, I should say a purpose in life, a reason to get up in the morning. Now, that doesn't give you a total purpose, but it certainly helps.*
Robert	*But, the majority of ones that are doing it now are through relationship break-ups.*

This discourse continued further as a general discussion of the differences between the education system when they were children and the education system now. No firm resolutions were reached.

Although not leading to resolution or closure, the discussion of experiences translates into a bond between group members.

Karen	*We all had bleeding hearts didn't we.*
Gloria	*We were all in the same boat, aren't we.*
Robert	*We formed a bond.*
Gloria	*Common bond.*
mv	*Yes, mmm.*
Liz	*It was a very supportive welcoming group. And still are, and I know that in, everybody keeps in touch, I know I don't participate, but I know they are there if I needed to come, and I can talk on the phone, when we get on the phone together, I'm, we, it all comes out again, and we yak, yak, yak*
Gloria	*... in this, we've got a relationship for a lifetime. Which makes a difference.*
R	*Why does it make a difference?*
Gloria	*Because it's ongoing, and it's supportive ongoing. It's just knowing every time I can ring up and we all understand.*

Experience-based discourse constructs a sense of caring for each other as particular individuals. Group members concern themselves with what is happening in each other's lives – *'You know that they care'* (**Nanette**). Taking care of others is healing.

> *I think that there is a way of healing is ... ... well after talking about it, this is helping somebody else through it, I think that's your greatest healer* (**Iris).**

Taking care of the particular concerns of others means that the bereavement groups develop relationships of trust. Vulnerabilities are to be respected.

> *I would trust this group. I would say anything I liked to anyone here. And I know that that's where it will stay, I trust implicitly every one of these people here. Implicitly. [...] I don't participate any more, but, they are here for me if I needed them, the contact is still maintained. And if I needed them, they are here* (**Liz**).

The sense of fellow-feeling generated by group discourses is grounded in an appreciation of concrete, shared particularity. By helping people cope with the permanence of their fragility, this appreciation makes people stronger.

R	*What things have come from your experience?*
Liz	*It has made me a lot more aware, it's made me a lot harder in myself, I think ...I think I've become a better person.*
R	*What other things have come from your experiences, you talk about more understanding, more patience, what other things for you as people?*
Janet	*For me as a person, I've come a lot less scared of things now. The worst thing that could possible happen has already happened, so, it's like over and done with now and anything else that happens in my life, that's OK.*
Anne	*You are that much stronger in yourself.*
Janet	*The worst has already happened, nothing could be as bad.*

The bereavement support groups construct subjectivity by acknowledging members' experiences of stigma and loss. They recognise enduring frailties. This subjectivity desires to give help to others in need, wherever, whenever.

> *It's made me, I'm in another organisation, and if it happens, somebody rings me, I will get help, no matter what. Cause that's the way I feel now* (**Robert**).

Hazel	*I was driving down the road, and there was this poor woman walking down the road tears rolling down her eyes, and I slammed on the brakes, got*

out, and said 'what on earth is the matter, can I help?

Fiona *I'm like that now.*

The sense of self cultivated by bereavement groups is compassionate. This is a subject built with practices that recognise mutual suffering. Such recognition defines compassion (Simpson and Weiner 1989:597). *'Okay, we had suffered a lot, but we had a lot to give' (***Moira**).

Conclusion

This chapter has focussed on the network of discursive relationships that centre upon bereaved by suicide support groups. To be bereaved by suicide is an extraordinary condition marked apart by pervasive stigmatisation by both the executive and the community. For the executive, to be so bereaved weakens the subject and makes it a 'potential suicide'. In response to this 'risk', suicide professionals call on the bereaved to join support groups that will strengthen the subject by constructing a responsible sense of individual instrumentality. Those at the receiving end of these calls, however, proceed otherwise.

The study of lay talk in bereavement groups demonstrates that group members refuse to assimilate the constructions of those who seek to govern. Group members experience responsibility as stigma. This stigma generates a social boundary between the groups and both executive agencies and the community. The support groups engage with this boundary and in so doing launch a moral discourse. Rather than seeking to 'assimilate' the boundary, lay discourses fortify it with a comprehensive delegitimation of scientific expertise. Against such expertise, group discourses maintain and expand upon the value of personal, experiential knowledge.

In the discursive practice of this experiential knowledge, the support groups

construct a sense of subjectivity that strongly diverges from professional expectations. The experts envision a responsible subject that robustly manages individual risk through instrumental self-regulation. Group discourses, on the other hand, strengthen the subject by acknowledging shared experiences of suffering and acting upon this recognition. They construct a compassionate self. The following chapter will conclude this thesis by considering the implications of this finding for the sociology of moral regulation.

Chapter seven – Conclusion

Introduction

This thesis has investigated the moral regulation of suicide in New Zealand at the turn of the 21st century. It has contextualised present-day arrangements by undertaking detailed analyses of suicide regulation during the preceding colonial and welfare state eras. It might be expected that the history of suicide in this country is a story of progressive amelioration, in which regulatory practices steadily become both less harsh and more effective in their control of 'the problem'. The New Zealand record, however, is one of radical discontinuities. The history of suicide regulation is not the placing of steadily improved controls on an unacceptable action that is abiding but steadily diminishing. The very 'problem' itself is posed in radically different ways.

Rather than always focusing on the same problematic action, 'the suicide' of concern shifts from completed to attempted to potential acts The regulatory responses constructed on these terms are profoundly different. As the suicide problem is redefined, regulatory emphases move from the punishing of criminals to the treating of pathologies to the management of those at risk. In the contemporary era, suicide is regulated by a dense network of relationships between two distinct fields of social activity – on the one hand, formal agencies that practise risk and responsibility; on the other hand, informal agencies that practice frailty and compassion. It is the complex relationship between these social practices that morally regulates suicide in New Zealand today.

This thesis has made an important empirical contribution to the sociology of suicide. It is the first study of its kind in New Zealand. This contribution is underpinned by conceptual work. For sociology, the study of suicide is a classical problem that determines the discipline's character. Accordingly, the classical sociology of suicide is

characterised by the familiar ambitions and dualities of grand theory. On these terms, classical sociology has inappropriately theorised moral rules as constraints. In contrast, the Foucauldian critics of grand theory have more usefully conceived regulation as an enablement of action. This thesis has reviewed the theoretical relations between classical and Foucauldian accounts. I have argued that both fail to appreciate the importance of moral agency and, on the basis of this critique, I have outlined a more adequate theory of moral regulation.

The regulation of suicide in New Zealand

The historical record of suicide regulation in New Zealand does not follow a pattern of progressive, linear continuity. Instead, it is organised by a complex and shifting network of relationships between four distinctive regulatory agencies. The ecclesiastic regime concerns itself with the salvation of the soul while the judiciary concentrates on the rule of law. Medical regimes aim to produce healthy bodies and minds, while the executive seeks to manage security. Rather than conceive these agencies as the source of constraints, it is best to view them as positive powers that produce different problems to be regulated – sin, criminality, pathology and risk.

The history of suicide regulation in New Zealand is a series of different articulations between the practices of ecclesiastics, the judiciary, medical doctors and officials of the executive. Changing relationships between these four regulatory regimes divide the historical record into three distinct eras. Within each era, the character of suicide regulation as a whole is inflected by the concerns of one regulatory regime in particular.

During the colonial period, from 1840 to 1893, suicide regulation was dominated by the judicial regime. The judiciary took possession of the act of self-killing, previously the preserve of the ecclesiastical domain, by constructing laws

against it. Making self-killing a crime meant that the core means of regulating suicide were no longer discourses about the soul but rather discourses about the capacity to be rational and therefore legally accountable. Suicide was criminalised in Coronial Courts that adjudicated over the completed suicides' rational capacity. This adjudication entailed punishments for those found guilty of deliberately acting against the law, punishments that included property forfeiture and ignominious burial for the corpse of the completed suicide.

The criminalisation of suicide was radically displaced in the decades either side of the turn to the 20th century. From 1893 to 1974, suicide was regulated by discourses of pathologisation. Driven by the authority of the medical regime, suicide was transformed from a matter of legally accountable reason into an issue of mental health. Rather than a completed crime to be judged, suicide signalled an individual's psychological dysfunction, a symptom of encroaching death, medicine's ultimate foe. The pathologisation of suicide was deployed through an asylum system that treated attempted suicide as mental illness. Treatment entailed sequestration from everyday life to facilitate the application of physical treatments and practical instruction.

Since 1974, the pathologisation of suicide has been superseded by practices of riskification. Rather than a matter of individual mental health to be treated in isolation, suicide is now constructed as a statistical risk that pervades the country's population. As a risk, suicide signals potential misfortune or fate, the executive's nemesis. In executive discourses, risk-taking actions are regarded as a failure to take responsibility for one's own actions, not in the sense of refusing legal accountability but rather in the sense of being unable to 'master our fate' (Rose 1999:159). In response, executive practices regulate suicide by targeting at-risk populations and enabling community practices of self-care.

This thesis investigated the operation of community-level practices in detail by conducting field research of bereaved by support groups in particular. The research showed that executive discourses regulate by constructing individualised and instrumental subjects who can mange their own potential risk of suicide. However, the responsible subject projected by executive agencies is disputed and transformed by lay talk within the bereavement groups themselves. Driven to refuse responsibility as a stigma, lay talk constructs a fellow-feeling that acknowledges the persistence of adversity and human frailty. Ultimately, then, suicide is morally regulated in contemporary New Zealand through a complex network of relationships that construct a sense of compassion.

Changing relationships between the various regimes have generated different core sites for the regulation of suicide. The centre of attention has shifted from Coronial Courts to an asylum system and, more recently, to the community. Each new configuration has also produced a particular object of regulation - the completed suicide, the attempted suicide and the potential suicide. The suicide subject is constructed in correspondingly distinctive ways, as either the criminal, the pathological, or the at-risk. The contrast between these three modes of regulation is stark. There is no steady progress that enlightens the response to suiciders. Instead, regulatory efforts have both remained strenuous throughout the historical record and radically changed in their mode of operation.

The problem of moral agency

The problem of agency is central to any account of the moral regulation of suicide. A moral act cannot be simply the unwitting or merely obedient following of given codes of conduct. In order to act morally, one must have the capacity to choose

between alternative courses of action and to decide what to do on the basis of judgements about the good. Any theory of moral regulation must take account of a subjectivity endowed with these powers. The sociology of suicide, however, has failed to develop such a theory. Neither classical sociology nor the more recent, influential Foucauldian approach adequately theorise moral agency.

The sociology of suicide literature is classically organised along the familiar lines of the quarrel over an appropriate methodology for the discipline. The discipline has divided into an entrenched dualism that pits the analysis of objective structures against the interpretation of patterned meanings. As the work of Durkheim and Douglas exemplifies, the objectivist and interpretivist approaches are alike in that each is committed not only to methodological exclusivity but also to both the grand science of social life as a whole and to the use of philosophical anthropologies.

On these classical terms, social actors are conceived as distinct from the moral boundaries according to which their actions are regulated. Given their mutual externality, rules exert themselves from outside the subject and moral regulation is a process of constraint. Here, suicide becomes a problem when attempts to stop it from happening fail. However, as agency is precisely what is prevented by such constraints, classical sociology has failed to theorise moral regulation.

In recent years, the grand theory tradition has been challenged by a Foucauldian approach that entails a radically new way of thinking about social regulation. Foucault sought to overcome classical dualities by developing a pluralistic discourse analysis of positive power and by abandoning all philosophical anthropologies. On these terms, moral boundaries and social actors are theorised not as external to each other but rather as co-constitutive. Instead of the constraint highlighted by classical sociology, moral regulation is a process of enablement.

The emphasis on subjective enablement speaks to the self-determination required by moral actors. However, Foucauldian analyses of governmentality have been carried out in ways that take them back to the problems associated with grand accounts. The analysis of governmentality has been characterised by a methodical focus on the 'serious statements' of official discourses. Interpretations drawn solely from the voice of those who seek to govern others implicitly assume that those who are governed assimilate official views. On these terms, enabled subjects lack agency and governmentality theory devolves into a conventional account of elite rule.

The thesis has responded to these problems by developing a more catholic methodological strategy, one that attends to discursive relations between the governors and the governed. This analysis revealed not assimilative equivalence but rather a rich field of intense conflict. Subjects and moral boundaries are indeed formed simultaneously. They take shape, however, as radical disjunctures between official and everyday discourses. From this conflict, a moral discourse develops that transforms the responsible subject of governmentality into the compassionate self of everyday life.

This theoretical re-interpretation has been made by focusing on one regulatory site in particular - bereaved by suicide support groups. As such, questions of empirical generalisation inevitably arise. The bereavement groups are small in number. A maximum of ten existed in New Zealand when the field work was underway. As noted in Chapter Three, suicide regulation is currently practised in other discursive fields, such as euthanasia. Numerically, group members represent a very small proportion of those who have been bereaved by suicide in the country. At all the groups I attended, there was the shadowy presence of those who remained in their darkened cars in the car-parks and the more ephemeral trace of those who make no more than a telephone

enquiry. Further research is required to encompass both those on the periphery of the bereavement groups and other discursive sites where suicide is regulated.

Conclusion

While acknowledging its empirical limitations, this thesis nevertheless suggests the outline of a new theory of moral regulation. Given the centrality of agency, moral actors cannot simply follow or assimilate acceptable codes. Consequently, they must persistently experience dilemmas.

Moral dilemmas arise in situations where, 'whichever action the subject takes, he or she does something wrong, or that given the circumstances, what he or she did was right, or as right as any alternative, and that the action leaves a residue of guilt' (Blackburn 1996: 250). Lay discourses are rich in the experience of such dilemmas.

Selma	*...we come along and tell all the bits you know?*
R	*Like what? Like all the bad bits or good bits or?*
Andrew	*...No,*
Pamela	*All the disasters, we've had nights outs where we've sort of I've thought 'well maybe I shouldn't have given her such a whack for doing such and such', and you know, it hasn't always been em the nice things we've done for your children. We've sort of thought 'well, should we have ... I shouldn't have done this and I shouldn't have done that'*
Iris	*It's, there's been a lot of letting guilt out and,*
Simone	*What I was going to say is that I can't actually understand how, what I can't relate to what you are saying that the guilt because you're saying like you ... when you're bringing up children, you're guiding them all the time, and correcting them and disciplining them to various degrees and it looks like its your 'I wish I hadn't done that' but actually, you didn't know what the consequences was going to be. Em, of this result, and as parents, we're heading for that, we're heading for another direction and*

> *for that direction you needed to discipline them and you couldn't have done better.*

Moral interaction must preserve rather than firmly resolve such dilemmas, for only in this way can actors exercise the capacity to judge, a capacity crucial to agency. An account of moral regulation thus must take stock of both problems that are resolved and those that abide.

Moral regulation is as much about conflict and disjuncture as it is about agreement and unity. In particular, conflict between official and everyday life is central. Antagonistic relationships generate a social boundary between the two and this boundary clears the space for the development of moral discourses. The complex and fraught mediation of formal and informal discourses constructs oppositional practices that ethically empower subjectivity. On these terms, moral regulation is to be theorised neither as constraint nor enablement but rather as everyday resistances to formal pronouncements.

There is a certain irony in making these suggestions for the development of a new theory of moral regulation. This thesis has persistently criticised theoretical extrapolations drawn from restrictive substantive fields. Durkheim and Douglas have been criticised for generating social laws from one-dimensional investigations. Likewise, the critique of Foucault rested upon the unwarranted generalisation of one set of voices. Ultimately, this thesis falls foul of the same charge. I suggest a theory of moral regulation on the basis of my own restricted research about bereaved by suicide support groups.

Surely, however, the problem of theoretical extrapolation from a narrow empirical base is an abiding existential problem that limits and so defines all sociological endeavour. We must learn how to cope with the dilemmas this situation produces.

Appendix one- Field research methods

Conducting the study

I contacted identified suicide experts directly with a letter that explained the purpose of my study, requested their participation and provided an information sheet. Finding groups to participate proved more complicated. Contact details were gathered from local newspapers by word or mouth and from leaflets sent to the support group I attended. First contact was made by telephone call to the person identified as the contact point for each group. I explained who I was and what wanted to do before asking permission to send a written request to their groups.

I negotiated with the experts and groups to get permission to interview them. Representatives of both acted as gatekeepers by questioning the validity of my research. In hindsight, it is striking how experts and group representatives couched validity in ways that resonated with their distinct discourses. One expert questioned the objectivity and rigour of the project. A group representative questioned my motivations and intentions. Each refusal was negotiated differently. The expert was assured of the sociological credibility and rigour of the research, whilst the group gatekeepers were assured of my intentions in a very different way. Some contact people for the groups were not sure whether they would permit entry - they were suspicious of people who had no understanding of what they were doing or what their members were going through. I made the decision to divulge that I also was bereaved by suicide and had attended a bereaved by suicide support group. Once the group representatives knew that I had personal experience, they were more willing to allow me to come and study them.

When I went to meet the groups, I was introduced in terms that acknowledged the importance of this personal experience: *'I gave Ruth a bit of a hard time when she*

rung up to make sure she (# laughter) she wasn't just being nosy. ... Ruth, for those people who don't know, em is from Massey, and Ruth's doing a study on bereaved by suicide groups. She's lost a ------ by suicide, so, she's one of us, (laughter) ... but em, so...lets get on with it' (**Iris**). I was granted permission to interview seven groups out of ten contacted. Of the three other groups, one had stopped running altogether, one had become a sporadic telephone support service and the other declined to take part.

A total of nine interviews were conducted. Two interviews were with representatives of the expert discourse. One participant was a senior policy analyst who was heavily involved in developing the national *In Our Hands* initiative. The other was a prominent researcher whose work had been used extensively in the initial stages of policy development. The other seven interviews were with representatives of the group discourse. All interviews were conducted in 1999. I travelled to the interviewees' location and conducted the research at a time and place that they specified. This involved extensive travel in the North and South Island. At each interview, I requested and was given permission to audio tape the discussion, on the understanding that the tapes would be transcribed fully and returned to the participants for them to change what they wanted before they were analysed. All changes were minor.

The experts and groups had distinctive characteristics. The experts were professional women between the ages of thirty-five and fifty-five, Pakeha with tertiary qualifications. Typically, the members of the support groups were women in their mid-forties to early sixties and self-identified as a bereaved by suicide parent. I assessed the members' ages subjectively based on observation and circumstantial evidence. Although each group was predominately made up of middle-aged women, it was not exclusively their preserve. Of the five groups visited, four had one man present.

Although I did not ask members directly about their class status, when certain issues were discussed that involved financial resources, voluntary time outside work, family commitments, and attitudes to dealing with professionals, it was clear that members saw themselves as people with limited financial resources, free time and tertiary education who were frustrated by attempts to 'use the system' effectively. For example, group members often talked about those other, 'middle class' people who could afford and had the inclination for the long-term counseling (starting from a minimum of $70 an hour).

Ethnically, the groups did not self-identify as Maori. Members did not talk about themselves in terms of being Maori in the group, or about Maori approaches to death and suicide as integral to the group, or about following Maori practices in any kind of explicit way as part of their group activities. Even so, group members often showed an awareness and appreciation of Maori perspectives. For instance, some talked about being involved in tangi (Maori funerals) for members of their extended family (though not of 'their' suicide), There were also a number of more general conversations that discussed differences between Pakeha and Maori approaches to death, burial and bereavement.

Ethical Approval

The Massey University Ethics Committee granted the interview process ethical approval in 1998. Approval required assurances of confidentiality for the participants and protection for the researcher. Permission was granted on condition that participants would be assigned a fictitious name and agree to contact the researcher for reasons only pertaining to the research. No group location details are given as it would be relatively easy to connect participants in this study with specific groups and so undermine their right to confidentiality. A copy of the ethical approval certificate is included below.

Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099

19 November 1998

Ms Ruth McMANUS
School of Sociology & Women's Studies
TURITEA

Dear Ruth

Re: Human Ethics Application - HEC98/187
"Representations of Suicide: An Analysis of the Relationship between Official and Lay Discourses on Suicide in 1990's New Zealand"

Thank you for your amendments in response to our letter of 15 October 1998.

The amendments you have made now meet the requirements of the Massey University Human Ethics Committee and the ethics of your application are approved.

Yours sincerely

Professor Philip Dewe
Chairperson
Massey University Human Ethics Committee

cc Dr Mary Murray, Dr Brennon Wood, School of Sociology & Women's Studies - Turitea, Massey University

Appendix two- Support group interview schedule

Moral stance: **Time:______**

Thinking about society's attitude to suicide

Do you think that suicide brings shame on people?
What else does suicide bring?

Lets focus on a few of these effects of suicide,

Who does this? I.e. who does the shaming?
Is it strangers? Family? Friends? Workmates? Clergy?
Government? **Examples**
What is it that people do to trigger these feelings?
Is it e.g. verbal abuse, a throwaway comment,
gossiping, the 'cold shoulder'? **Examples**

Why does suicide bring these things?

Do you have the same effect in other kinds of death?
a sudden loss in a car crash, or Aids patients.
What's different?
Why is it different?

Inexperienced lay discourses: **time:______**

Thinking about people who have NOT lost somebody to suicide,

Do you think people can understand suicide if they
don't have the experience themselves?
If not, what is it they can't grasp?
Do you think that a very kind caring and listening
person could appreciate what its like?

Do you think your understanding of suicide has changed since you have become bereaved by suicide?

What has changed?

Why has it changed?

Could any other experience have changed you in this way?

Could someone give me an example of how you see 'the experience' of loosing someone to suicide?

Any other examples?

Thinking about people outside of the group,

How do you think 'outsiders' would look on a group like this? E.g. morbid, healthy?

Why do you think they might look on it this way?

Internal discourse: **time:_______**

Often support groups refer to themselves as 'suicide survivors'

What do you think about being called 'suicide survivors?

Why?

In your group meetings

What kinds of stuff do you cover in the group?

Is it shared, just 'thrown out there' or...?

Thinking about trust

Is it important here?

Could someone give me an example? Another?

What makes it not/important?

Why is it /not important?

Thinking about expectations

What is expected or OK for people to do in your group? E.g. cry, talk, get angry, express themselves.

Why are these OK or good? (**Push**)

What is not expected or not OK for people to do in your group? (E.g. being violent, hurting other members verbally, not talking)

Why are these things not good? (**Push**)

As you go through each meeting,

How does the talking and listening work?

Do the same people say the same things every time?
What if someone rambles on and talks about unrelated things? What do you do?
What about people who are silent?

Thinking about silences, or quiet times,

Can you have good silences?
What is an example of a good silence? Someone else?
Can you have bad silences?
What is an example of a bad silence? Someone else?

Do you think that the group has got better at 'it'?

What has it got better at? Why?

When you reflect on the meetings

What makes you feel positively/warmly about the group? Why?
What makes you feel negatively/coldly about the group? Why?

Thinking back to your group history,

Over the time you've been involved, has the talk in the group changed?
Are these individual changes, or has the whole group dynamic changed?
What's changed?
Why do you think it's changed?

Problematic outsiders: **time:_______**

Thinking about it, the vast majority of people who have been bereaved by suicide are not in support groups.

How, as members of one, does that make you...
Why don't more people use them?
Do you think more should?
Why?
How could that be achieved?

Who do you think should be responsible for this?

Why and why them?

Sometimes people only come in for one or two sessions -

What do you feel about that?

Why?

How does it reflect on you as a member and on the group?

Can you think of anything that might be off-putting?

Why is that off-putting?

Some say that self-help groups are more suited to women's ways of grieving - do you think that's accurate or fair?

Why do you think this?

Is it important that people have to make their own way to the support group?

Why?

Thinking back on how you came to the group,

What was the decisive point/ incident that made you take that first step? Anybody else' decisive point?

STOP FOR FIVE MINUTES

Construction of other (state): **time:_______**

Thinking about the state i.e. government ministries, laws etc.

The state has a certain responsibility to uphold,

What do you think that responsibility is? E.g.-

Do you think the state is achieving that? E.g.-

Why?

Are you aware of anything that the state is doing about suicide?

What are they doing? E.g. school awareness programmes

How do you feel about what they are /are not doing?

Why do you feel/think this?

Have you ever seen anything produced by the state on suicide?

E.g. recommendations, policy documents, press releases.

What have you seen?

What is your opinion of them?

Why do you hold that opinion?

The government often focuses on risk factors and youth suicide -

What do you think about this focus?

Why?

Do you think the government listens to support groups enough - why/not?

What do you think support groups give that the state can't?

What do you think the state gives that support groups can't?

How would you, as a group, offer your services to the state?

If you could give them a 'wish list' - what would be on it?

There is a lot of discussion on the pro's and con's of the Privacy of Information Act,

What is your opinion of this legal control over what professional's can disclose?

Why do you think this?

Construction of other (medical profession): **Time:______**

Thinking about the medical profession i.e. doctors, mental health workers, hospitals, etc. The health profession has certain responsibilities to uphold,

What do you think these responsibilities are? E.g.-

Do you think the profession is achieving that? E.g.-

What helps /hinders them achieve it?

Why?

The medical profession often focuses on individual mental illness and depression,

What do you think about this focus?

Why?

As survivors, what do you think about health professionals? E.g. mixed feelings, good, bad, indifferent?

Why?

Do you as a group use health professionals? E.g. as speakers, facilitators, educators

How do you use them?

Why do you use/ not use them?

Do you as a group offer your services to health professionals e.g. making them aware of your existence?

Why do you offer/not offer your services?

What do health professionals give people that support groups can't?

Why can't groups give this?

What do you think support groups give people that health professionals can't?

Why can't health professionals give this?

Thinking about health professionals and support groups, what do you think health professionals expect support groups to do?

Do you think this is OK? Why/not?

Thinking about researchers - What are your thoughts about researchers coming in and exploring your group, myself included?

Construction of communication: **time:_______**

Moving on to the final section of our discussion a couple of questions on the media. The media is controlled through the Coroners Act on the kind of details it can publish about specific cases of suicide. However, it is up to the media's discretion in fiction or entertainment for example in soap operas, weekly magazines, music, documentaries.

How do you think suicide is presented in the media?

Can you give me examples of 'bad' publicity?

What was bad about it? Why?

Can you give me examples of 'good' publicity?

What was good about it? Why?

How do you think suicide should be presented in the media?

Why should suicide be presented in this way?

Do you think the media needs to be controlled more tightly?

If so, what kind of restrictions would you want to see in place?

Who should enforce these restrictions?

Why should they be enforced?

Do you think the media needs more freedom to talk about suicide?

If so, how would you like to see suicide discussed?

Who should ensure these freedoms?

Why should they be enforced?

What do you think about 'suicide clusters'? Why?

Closure: **time:_______**

We have now completed the interview.

If you want to contact me in the future, my details are on the information sheet I gave out at the beginning. I'll be sending you a summary of our discussion, hopefully for distribution at your next meeting. May I again thank you for your time and insightful comments.

Bibliography

Abercrombie N., Hill S. and Turner B. (1994) *The Penguin dictionary of sociology*, London: Penguin.

ACC Regulations Review Panel (1994) *Report of the ACC Regulations Review Panel*, Wellington: Government House.

Accident Compensation Amendment Act (1992) New Zealand Statutes 1992 vol. 1 no. 6 pp 39.

Adams P. (1977) *Fatal necessity: British intervention in New Zealand 1830-1847*, Auckland: Auckland University Press/Oxford University Press.

Alexander J. (1987) The centrality of the classics. In: Giddens A., T.J., (Ed.) *Social Theory Today*, pp. 11-57. Cambridge: Polity Press.

Alexander J. and Colomy P. (1992) Traditions and competition. In: Ritzer George, (Ed.) *Metatheorising*, 1st edn. pp. 27-52. California: Sage.

Alexander J. and Smith P.(1996) Durkheim's religious revival. *American Journal of Sociology* **102**, 585-592.

ALL ER *All England law reports*, London: Butterworths.

Allderidge P. (1979) Management and mismanagement at Bedlam,1547-1633. In: Webster C., (Ed.) *Health, Medicine and Mortality in the sixteenth Century*, pp. 142-164. Cambridge: Cambridge University Press.

Allen N. (1977) History and background in suicidology. In: Patton C.L., Valente S.M and Rink A, (Eds.) *Suicide: Assessment and Intervention*, pp. 1-19. New York: Appleton-Century-Crofts.

Alpert H. (1967) *Emile Durkheim and his sociology*, New York: Russell and Russell.

Altrocchi J. (1980) *Abnormal behaviour*, New York: HarcourtBraceJovanovich Inc.

Anderson O. (1987) *Suicide in Victorian and Edwardian England*, Oxford: Clarendon Press.

Antoniadis N. (1988) *Suicide risk & prevention: A study of New Zealand Coroner's files*, New Zealand: Department of Health.

ANZSPC Australian and New Zealand Society for Palliative Care (1998) *Guide to ethical principles on voluntary euthanasia*, www.anzspm.org.au/guidelines/euthanasia.html:ANZSPM.

APA American Psychiatric Association (1994) *DSM IV: The diagnostic and statistical manual of mental disorders vol. IV*, Washington: American Psychiatric Association.

Appel Y. and Wrobleski A. (1987). Self-help and support groups: Mutual aid for survivors. In: Dunne E., McIntosh J. and Dunne-Maxim K. (Eds.) *Suicide and its aftermath: Understanding and counselling the survivors*, pp215-233. New York: W.W. Norton and Co.

Aristotle (1996) *The Nicomachean ethics*, Ware, Hertfordshire: Wordsworth Classics.

Armstrong D. (1983) *Political anatomy of the body: Medical knowledge in Britain in the twentieth century*, Cambridge: Cambridge University Press.

Armstrong N. (1994) State. In: Spoonley P., Pearson D. and Shirley I., (Eds.) *New Zealand Society*, pp.113-129. Palmerston North, New Zealand: Dunmore Press.

Atkinson J.M. (1975) Some cultural aspects of suicide in Britain. In: Faberow N.L., (Ed.) *Suicide in different cultures*, pp. 135-158. Baltimore: Baltimore University Press.

Atkinson J.M. (1978) *Discovering suicide: Studies in the social organisation of sudden death*, London: MacMillan.

Bailey V. (1998) *This rash act: Suicide across the life cycle in the Victorian city*, Stanford California: Stanford University Press.

Banton M. (1968) Voluntary associations: anthropological aspects. In: Sills D., (Ed.) *International Encyclopaedia of the Social Sciences*, pp. 357-362. New York: MacMillan Company & the Free Press.

Barnhart R. (1988) *The Barnhart dictionary of etymology*, USA: The H.W. Wilson Co.

Barrett T. and Scott T. (1990) Suicide bereavement and recovery patterns compared with nonsuicide bereavement patterns. *Suicide and life-threatening behaviour* **20**, 1-15.

Barry A., Osborne T. and Rose N. (1996) *Foucault and political reason: Liberalism, neo-liberalism and rationalities of government*, 1st edn. pp. 1-18. London: University College London (UCL).

Barry A., Osborne T. and Rose N. (1996) Introduction: Foucault and political reason. In: Barry A., Osborne T. and Rose N., (Eds.) *Foucault and political reason: Liberalism, neo-liberalism and rationalities of government*, 1st edn. pp.1-18. London: University College London (UCL).

Barwick H. (1992) *Youth suicide prevention project: Workshop report and literature review*, Wellington, New Zealand: Department of Health..

Bauman Z. (1992) *Intimations of postmodernity*, London: Routledge.

Beauchamp Tom L. (1991) *Philosophical ethics: An introduction to moral philosophy*, New York: McGraw-Hill Inc.

Beautrais A. (1998) *A review of the evidence: In Our Hands - the New Zealand youth suicide prevention strategy*, Wellington: Ministry of Health.

Beautrais A., Coggan C., Fergusson D. and Rivers L. (1997) *The prevention, recognition and management of young people at risk of suicide - development of guidelines for schools*, Wellington: National Health Committee.

Beautrais A., Joyce P. and Mulder R. (1994) The Canterbury suicide project: aims, overview and progress. *Community Mental Health in New Zealand* **8**, 32-39.

Beier L.M. (1987) *Sufferers and healers: the experience of illness in seventeen-century England*, London: Routledge and Kegan Paul.

Belfrage C. (1962) Suicides in hospital. *New Zealand Monthly Review, Wellington* 9

Belgrave M. (1991) Medicine and the rise of the health professions in New Zealand 1860-1939. In: Bryder, (Ed.) *A Healthy country: Essays on the social history of medicine in New Zealand*, Wellington New Zealand: Bridget Williams Books Ltd.

Bell S. and Brookbanks W. (1998) *Mental health law in New Zealand*, Wellington: Brookers.

Bell V. (1993) *Interrogating incest: Feminism, Foucault and the law*, London: Routledge.

Bellah R. (1973) *Emile Durkheim on morality and society,* Chicago: University of Chicago Press.

Bennett T. (1992) Putting policy into cultural studies. In: Grossberg L, Nelson C and Treichler P, (Eds.) *Cultural Studies*, 1st edn. pp. 23-37. New York: Routledge.

Berlin I. (1956) Introduction. In: Berlin I., (Ed.) *The age of Enlightenment*, 1st edn. New York: Mentor Books.

Berlin I. (1969) *Four essays on liberty*, London: Oxford University Press.

Berman A. and Jobes D. (1991) *Adolescent suicide: assessment and intervention*, Washington: American Psychological Association.

Bernauer J. and Rasmussen D. (1988) *The final Foucault*, Boston, Massachusetts: MIT Press.

Blackburn S. (1996) *The Oxford dictionary of philosophy*, Oxford: Oxford University Press.

Blackstone W. (1973) *The sovereignty of the law: Selections from Blackstone's commentaries on the laws of England (1723-1780); edited with an introduction by Gareth Jones*, London: MacMillan.

Bloom A. (1979) Introduction. In: Rousseau J.J., (Ed.) *Emile* , pp. 3-28. USA: Basic Books, Toronto.

Bock K. (1979) Theories of progress, development, evolution. In: Bottomore T. and Nisbet R., (Eds.) *A history of sociological analysis*, pp. 39-79. London: Heinman.

Bok S. (1998) Suicide. In: Dworkin G., Frey R.G. and Bok S., (Eds.) *Euthanasia and physician-assisted suicide*, pp. 93-106. London: Cambridge University Press.

Botsis A., Soldatos C. and Stefanis C. (1997) *Suicide, biopsychosocial approaches*, Amsterdam: Elsevier.

Bottomore T. and Nisbet R. (1978) *A history of sociological analysis*, London: Heinman.

Branaman A (1997)Goffman's social theory. In: Lemert C. and Branaman A, (Eds.) *The Goffman reader*, pp. xlv-lxxxii Massachusetts: Blackwell Publishers Inc.

Brandt R.B. (1959) *Ethical theory: the problems of normative and critical ethics*, Engelwood Cliffs, New Jersey: Prentice-Hall.

Brandt R.B. (1975) The morality and rationality of suicide. In: Perlin S., (Ed.) *A handbook for the study of suicide*, pp. 61-76. New York: Oxford University Press.

Brett C. (1993) Lost boys: the young and the dead. *North and South* 88-97.

Brookes B. and Thomson J. (2001) *Unfortunate folk: Essays on mental health treatment 1863-1992*, Dunedin, New Zealand: University of Otago Press.

Brunton W. (1986) Deinstitutionalisation : A romance for all seasons. In Haines H. and Abbott M., (Eds.) *The future of mental health services in New Zealand: deinstitutionalisation,* pp. 44-63. Auckland: Mental Health Foundation of New Zealand.

Brunton W. (1996) Colonies for the mind: The historical context of services for forensic psychiatry in New Zealand. In Brookbanks W. (Ed.) *Psychiatry and the law* pp3-58. Wellington: Brooker's.

Bryder L. (1991) *A healthy country: Essays on the social history of medicine in New Zealand*, New Zealand: Bridget Williams Books Ltd.

Bullock A., Stallybrass O. and Trombley S. (1988) *The Fontana dictionary of modern thought*, London: Fontana.

Burchell G., Gordon C. and Miller P. (1991) *The Foucault effect: Studies in governmentality*, Chicago:

University of Chicago Press.

Burkitt I. (1991) *Social selves: Theories of the social formation of personality*. London: Sage Publications Ltd.

Busfield J. (1986) *Managing madness: Changing ideas and practice*, London: Hutchinson.

Buttrick G.A.(1962) *The interpreters dictionary of the Bible: An illustrated encyclopaedia*, Nashville: Abington Press.

Calder K. (1995) *Who cares? A social history of the Canterbury bereaved by suicide society 1988 -1994*. Christchurch: Canterbury Bereaved by Suicide Support Group.

Callinicos A. (1989) *Against postmodernism*. Cambridge: Polity Press.

Campbell I. (1989) *The economics of safety*, Massey University: Department of Management Systems.

Carlton P. (1997) The impact of attitudes and suicidal thoughts on adolescent's intentions to seek professional help. Massey University.

Catherall S. Suicide on the farm. *Sunday Star Times* November 29 1998 pp A6.

Catholic Bishops' Pastoral Letters (29 August 1995) *Pastoral letter to the Catholic people of New Zealand on Euthanasia*. Accessed on the 24 April 2003 – http:www.catholic.org/newzealand/documents/letters/euth.html

Cavan R. (1928) *Suicide*, Chicago: University of Chicago.

Chambliss W. (1973) *Sociological readings in the conflict perspective*, Massachusetts: Addison-Wesley Publishing Company.

Chatterjee S., Conway P., Dalziel P., Eichbaum C., Harris P., Philpott B. and Shaw R. (1999) *The new politics: A third way for New Zealand*, Palmerston North, New Zealand: Dunmore Press.

Cladis M. (1992) *A communitarian defence of Liberalism*, California: Stanford University Press.

Cladis M. (1996) Book review of debating Durkheim. W.S.F Pickering and H. Martins, Routledge: 1994. *British Journal of Sociology* **47**, 372-73.

Clarke P.B. and Linzey A. (1996) *The dictionary of ethics, theology and society*, London: Routledge.

Clift v. Schwabe (1846) 3 Common Bench Pleas 437

Cody P. (1996) Women psychiatrists in New Zealand 1900-1990. University of Otago.

Coggan C. (1995) *Intentional injury in New Zealand: analysis and monitoring report number 4*, Wellington, New Zealand: Public Health Commission.

Coggan C. (1997) Suicide: qualitative data from focus group interviews with youth. *Social Science and Medicine* **45**, 1563-1570.

Coggan C., Fanslow J. and Norton R. (1997) *Economic costs associated with suicide and attempted suicide in New Zealand*, Wellington, New Zealand: Injury Prevention Research Centre.

Cohen S. (1971) *Images of deviance*, Harmondsworth: Penguin.

Cohen S. ([1972] 1980) *Folk devils and moral panics: the creation of the mods and rockers*, Oxford: Martin

Robertson.

Comte A. (1964) The progress of civilisation through three states. In: Etzioni A. and Etzioni E. (Eds.) *Social change: Sources, patterns and consequences*, pp. 15-20. New York: Basic Books.

Coney S. (1997) *Sunday Star Times* 18 May C5.

Constitution Act (1852) NZ New Zealand Statutes 1852-54.

Cooper D. (1998) *Governing out of order: Space, law and the politics of belonging,* London: River Oram Press.

Coote B. (1976) Suicide and the claims of the defendant. *New Zealand Journal of Law* 54-60.

Cornish W.R. (1978) *Crime and law in nineteenth century Britain,* Dublin: Irish University Press.

Coroner's Act (1858) NZ New Zealand Statutes 1854-61 pp 115.

Coroner's Act (1988) NZ Retrieved from Status Library of New Zealand Statutes Annotated to 1995 no 95-31 January 1996.

Coroner's Amendment Act (1908) NZ New Zealand Statutes 1908 vol. 2 pp 40.

Corrigan P. (1981) On moral regulation: some preliminary remarks. *Sociological Review* **29**, 313-337.

Corrigan P. and Sayer D. (1985) *The great arch: English state formation as cultural revolution*, Oxford: Basil Blackwell.

Coser L. (1978) American Trends. In Bottomore T. and Nisbet R. (1978) *A history of sociological analysis*, pp 283-321 London: Heinman.

Coser L. (1984) Introduction In: Durkheim E., (Ed.) *The Division of Labour in Society*, pp. ix-xxiv London: MacMillan.

Cotter M. (1999) *Inter-agency committee on youth suicide prevention: work programme 1999/2000, the New Zealand youth suicide prevention strategy*, Wellington, New Zealand: Government Publications.

Cotterrell R. (1999) *Emile Durkheim: law in a moral domain*, Edinburgh: Edinburgh University Press.

Craig E. (1998) *Routledge encyclopaedia of philosophy*, London: Routledge.

Crimes Act (1893) NZ New Zealand Statutes No. 56 pp354.

Crimes Act (1908) NZ RS vol. 3 1908-1957 pp 319/320.

Crimes Act (1961) NZ RS (1979) vol. 1 pp319/320.

Crimes Amendment Act (1906) NZ In. Garrow and Caldwell 1981 pp 133.

Criminal Code (1893) NZ New Zealand Statutes No. 56 pp354.

Criminal Law Act (1823) UK. In Sweet and Maxwell,1971pp 325.

Crook M. (1992) *Please listen to me! Your guide to understanding teenagers,* Vancouver, B.C.: Self-Council Press.

Curzon L. B. (1979) *English legal history*, London: McDonald & Evans.

Davies B. (1991) The concept of agency: A feminist poststructuralist analysis. *Social Analysis* **30**, 44-53.

de Lacey A. (1984) *Community groups working for health : issues and experiences*, Wellington, New Zealand: Department of Health.

de Saussure F. (1974) *Course in general linguistics*, London: Owen.

de Tocqueville A. ([1840] 1953) *Democracy in America*, New York: Alfred A. Knopf.

De Vault M. (1996) Talking back to sociology: Distinctive contributions of feminist methodology. *Annual Review of Sociology* **22**, 29-50.

Deaths by Accident Compensation Act (1952) New Zealand Statutes 1952 vol. I pp191.

Dean M. (1991) *The constitution of poverty: toward a genealogy of liberal governance*, London: Routledge.

Dean M. (1994) 'A social structure of many souls': moral regulation, government, and self-formation. *Canadian Journal of Sociology* **19**, 145-168.

Dean M. (1995) Governing the unemployed self in an active society. *Economy and Society* **24**, 559-83.

Dean M. (1999) *Governmentality power and rule in modern society*, London: Sage Publications.

Defert D. (1991) 'Popular life' and insurance technology. In: Burchell G., Gordon C. and Miller P., (Eds.) *The Foucault effect: Studies in governmentality*, Chicago: University of Chicago Press.

Denzin N. (1989) *The research act: A theoretical introduction to sociological methods*, Engelwood Cliffs, New Jersey: Prentice-Hall.

Dickens D. and Fontana A. (1994) *Postmodernism and social enquiry*, London: The Guilford Press.

Dickinson P., Hirsh L., and Coupe N. (2000) *Youth suicide prevention community information kit,* Wellington: Ministry of Health Government Publications.

Disley B. (1992) New Zealand tops the youth suicide stakes. *Mental Health News* 9

Disley B. (1994) Suicide prevention initiatives: youth suicide the world picture. *Community Mental Health in New Zealand* **8**, 5-11.

Douglas Jack D. (1970a) *Deviance and respectability: The social construction of moral meanings*, New York: Basic Books, Inc.

Douglas Jack D. (1967) *The social meanings of suicide*, Princeton New Jersey: Princeton University Press.

Douglas Jack D. (1970b) *Understanding everyday life: Toward the reconstruction of sociological knowledge*, Chicago: Aldine Publishing Company.

Douglas Jack D. (1971a) *American social order: social rules in a pluralistic society*, New York: The Free Press.

Douglas Jack D. (1971b) *The technological threat*, New Jersey: Prentice-Hall.

Douglas Jack D. (1977a) The origins of existential sociology. In: Douglas Jack D. (Ed.) *Existential Sociology*, pp. 291-297. Cambridge: Cambridge University Press.

Douglas Jack D. (1977b) A sociological theory of official deviance & public concerns with official deviance. In: Douglas Jack D. and Johnson John M., (Eds.) *Official deviance: readings in malfeasance,*

misfeasance, and other forms of corruption, Philadelphia: J.B.Lippincott Company.

Douglas Jack D. and Johnson J. M. (1977a) *Official deviance: readings in malfeasance, misfeasance, and other forms of corruption*, Philadelphia: J.B.Lippincott Company.

Douglas Jack D. and Johnson John M. (1977b) *Ethnomethodology and existential sociology*, Cambridge MA: Cambridge University Press.

Dow D. (1991) Springs of charity?: The development of the New Zealand hospital system, 1876-1910. In: Bryder L., (Ed.) *A healthy country: Essays on the social history of medicine in New Zealand*, pp. 44-64. New Zealand: Bridget Williams Books Ltd.

Downey P.J. (1997) Euthanasia: life, death and the law. *New Zealand Law Journal* 88-94.

Dreyfus H. and Rabinow P. (1982) *Michel Foucault: beyond structuralism and hermeneutics*, Chicago: University of Chicago Press.

Droge A. (1992) *A noble death: suicide and martyrdom among Christians and Jews in antiquity*, San Francisco: Harper.

Drummond W. (1996) *Suicide in New Zealand*, Palmerston North: Nagare Press.

Dublin L. (1963) *Suicide: a sociological and statistical study*, New York: The Ronald Press Company.

Durkheim E. ([1883] 1973) Address to the Lycees of Sens. In: Bellah R., (Ed.) *Emile Durkheim on morality and society*, pp. 25-33. Chicago: University of Chicago.

Durkheim E. ([1890a] 1957) *Professional ethics and civic morals*, London: Routledge and Keegan Paul.

Durkheim E. ([1890b] 1973) The principles of 1789 and sociology. In: Bellah R., (Ed.) *Emile Durkheim on morality and society*, pp. 34-42. Chicago: Chicago University Press.

Durkheim E. ([1893] 1984) *The division of labour in society,* London: MacMillan.

Durkheim E. ([1895] 1982) *The rules of sociological method*, London: MacMillan.

Durkheim E. ([1897] 1979) *Suicide: A study in sociology,* New York: Free Press.

Durkheim E. ([1898] 1973) Individualism & intellectuals. In: Bellah R., (Ed.) *Emile Durkheim on morality and society*, pp. 43-57. Chicago: Chicago University Press.

Durkheim E. ([1900] 1973) Sociology in France in the nineteenth century. In: Bellah R., (Ed.) *Emile Durkheim on morality and society*, pp. 3-24. Chicago: University of Chicago Press.

Durkheim E. ([1912] 1995) *The elementary forms of religious life*, New York: The Free Press.

Durkheim E. ([1914] 1973) The dualism of human nature and its social conditions. In: Bellah R., (Ed.) *Emile Durkheim on morality and society*, pp. 149-166. Chicago: University of Chicago Press.

Dworkin G., Frey R.G. and Bok S. (1998) *Euthanasia and physician-assisted suicide*, London: Cambridge University Press.

Elias N. (1970) *What is sociology?*, London: Hutchinsons.

Elias N. (1994) *The civilising process*, Oxford: Blackwell.

Elias N. (1985) *The loneliness of the dying,* Oxford: Basil Blackwell.

Ellis P. (1997) *Mental health in New Zealand from a public health perspective*, Wellington: Public Health Group, Ministry of Health.

Engel P. (1977) *The abolition of capital punishment in New Zealand 1935-1961*, Wellington, New Zealand: Department of Justice.

Ernst W. (1991) The social history of Pakeha psychiatry in nineteenth century New Zealand: main themes. In: Bryder L., (Ed.) *A healthy country: Essays on the social history of medicine in New Zealand*, pp. 65-84. New Zealand: Bridget Williams Books Ltd.

Etzioni A. and Etzioni E. (1964) *Social change: sources, patterns and consequences*, New York: Basic Books.

Evening Standard (Nov 20, 1997) *Evening Standard* 6

Evening Standard (Oct 29, 1997) Suicide 'epidemic' raging in Auckland. *Evening Standard* 4

Ewald F. (1991) Insurance and risk. In: Burchell M. , Gordon C. and Miller P., (Eds.) *The Foucault effect: Studies in governmentality*, pp. 197-210. Chicago: University of Chicago Press.

Faberow N.L. (1975) *Suicide in different cultures*, Baltimore: Baltimore University Press.

Fann W., G.C. (1977) *The language of mental health*, Saint Louis USA: The C.V. Mosby Company.

Fielding N. (1988) *Actions and structures: Research methods and social theory*, Newbury Park, California: Sage.

Firth A. The rise of the personal: Disciplinary rationalities and the teaching of sociology. TASA conference Brisbane, December 1998.

Flax J. (1990) *Thinking fragments: Psychoanalysis, feminism, and post-modernism in the contemporary West*, California: University of California Press.

Forbes T. (1979) By what disease or casualty: the changing face of death in London. In: Webster C., (Ed.) *Health, medicine and mortality in the sixteenth century*, pp. 117-140. London: Cambridge University Press.

Forth C. (1993) Durkheim-as-author/suicide-as-text. *Current Perspectives in Social Theory* **13**, 227-246.

Foucault M. ([1963] 1994) *The birth of the clinic: An archaeology of medical perception*, New York: Vintage (Pantheon).

Foucault M. ([1965] 1988) *Madness and civilisation: A history of insanity in the age of reason*, New York: Vintage Books, Random House.

Foucault M. ([1970] 1994) *The order of things: An archaeology of the human sciences*, New York: Vintage Books.

Foucault M. (1972) *The archaeology of knowledge and the discourse on language*, New York: Pantheon Books.

Foucault M. ([1976a] 1980) Two lectures. In: Gordon C., (Ed.) *Michel Foucault: power/knowledge*, pp. 78-108. New York: Harvester Wheatsheaf.

Foucault M. ([1976b] 1990) *The history of sexuality vol. I: Introduction*, London: Penguin.

Foucault M. ([1977a] 1995) *Discipline and punish: The birth of the prison*, New York: Vintage Books.

Foucault M. ([1977b] 1984) Nietzche, genealogy, history. In: Rabinow P., (Ed.) *The Foucault Reader*, pp. 76-100. New York: Pantheon Books.

Foucault M. ([1979] 1990) "The Tanner Lectures" Omnes et singulatum: Towards a criticism of political reason. In: Kritzman L.D., (Ed.) *Michel Foucault: politics, philosophy, culture: Interviews and other writings 1977-1984*, pp. 57-85. New York: Routledge.

Foucault M. (1980a) Body/power. In: Foucault M., (Ed.) *Power/knowledge: selected interviews and other writings 1972-1977 edited by Colin Gordon*, pp. 55-62. London: Harvester Wheatsheaf.

Foucault M. (1980b) Truth and power. In: Foucault M., (Ed.) *Power/knowledge: selected interviews and other writings 1972-1977 edited by Colin Gordon*, pp. 108-133. New York: Harvester Wheatsheaf.

Foucault M. ([1982a] 1988) The political technology of individuals. In: Martin L., Gutman H. and Hutton P. (Eds.) *Technologies of the self: A seminar with Michel Foucault*, pp. 16-49. Amherst: The University of Massachusetts Press.

Foucault M. ([1982b] 1991) Governmentality. In: Burchell G., Gordon C. and Miller P., (Eds.) *The Foucault effect : Studies in governmentality*, pp. 87-104. Chicago: University of Chicago Press.

Foucault M. ([1982c) The subject and power. In: Dreyfus H. and Rabinow P., (Eds.) *Michel Foucault: beyond structuralism and hermeneutics*, pp. 208-226. Chicago: University of Chicago Press.

Foucault M. ([1984a] 1988) *The history of sexuality Vol. III: The care of the self*, New York: Random House.

Foucault M. ([1984b) What is Enlightenment? (Was ist aufklarung?) In: Rabinow P., (Ed.) *The Foucault reader*, pp. 32-50. New York: Pantheon Books.

Foucault M. ([1985] 1990) *The history of sexuality vol. II: The use of pleasure*, New York: Vintage Books.

Foucault M. (1988a) The ethic of care for the self as a practice of freedom. In: Bernauer J. and Rasmussen D., (Eds.) *The final Foucault*, pp.1-20. Boston Massachusetts: MIT Press.

Foucault M. (1988b) Politics and reason. In: Kritzman L., (Ed.) *Michel Foucault: politics, philosophy, culture: interviews and other writings 1977-1984*, pp. 57-85. New York: Routledge.

Foucault M. (1989) *Resumé des cours 1970-1982*, Paris: Juliard.

Fougere G. (1994) Health. In: Spoonley P. and Pearson D., (Eds.) *New Zealand society*, 2nd Edition edn. pp. 146-160. Palmerston North, New Zealand: Dunmore Press.

Fowler H.W. and Fowler F.G. (1970) *The Concise Oxford dictionary of current English*, Oxford: Clarendon Press.

Francis L. (1997) Ideology and interpersonal emotion management: Redefining identity in two support groups. *Social Psychology Quarterly* **60**, 153-171.

Frankel B. (1997) Confronting neo-liberal regimes: the post-Marxist embrace of populism and realpolitik. *New Left Review* **22**, 57-92.

Fraser M. (1997) *The unknown country: Death in Australia, Britain and the USA* London: MacMillan.

Frazer J. (1997) *Suicide trends in New Zealand*, Wellington: New Zealand Health Information Service, Ministry of Health.

Freer W. (1961) Mental health. *New Zealand Monthly Review* **October 1961**, 9-10.

Friar S. (1996) *A companion to the English parish church*, Gloucestershire: Sutton Publishing.

Fung-Mo Ng G. (1998) *Contracting for mental health services: an examination of service contracting strategy and options for mental health care in New Zealand,* Victoria University, Wellington New Zealand.

Galaway B. and Spier P. (1992) *Sentencing to reparation: Implementation of the Criminal Justice Act 1985*, Wellington: Department of Justice.

Gane M. (1992) *The radical sociology of Durkheim and Mauss* London: Routledge.

Gane M. (1994) A fresh look at Durkheim's sociological method. In: Pickering W. and Martins H., (Eds.) *Debating Durkheim*, pp. 66-87. London: Routledge.

Garfinkel H. (1967) Practical sociological reasoning: some features in the work of the Los Angeles suicide prevention centre. In: Shneidman E., (Ed.) *Essays in self-destruction*, pp. 171-187. New York: Science House.

Garland D. (1999) 'Governmentality' and the problem of crime. In: Smandych R., (Ed.) *Governable places: Readings on governmentality and crime control*, pp. p15-44. Aldershot: Ashgate.

Garrow J. (1981) *Garrow and Caldwell's criminal law in New Zealand, 6th Edition*, Wellington: Butterworths.

Gatrell V.A.C. (1994) *The hanging tree: Execution and the English people 1770-1868*, Oxford : Oxford University Press.

Gemin J. (1997) Manufacturing codependency: Self-help as discursive formation. *Critical Studies in Mass Communication* **14**, 249-266.

Gergen K.J. (1992) Social construction and moral action. In: Robinson D., (Ed.) *Social discourse and moral judgement*, pp. 10-27. San Diego: Academic Publishers.

Gerth H. and Wright-Mills C. (1958) *From Max Weber: essays in sociology*, New York: Oxford University Press.

Gibbs J. and Martin W. (1964) *Status integration and suicide,* Eugene, Oregon: University of Oregon Press.

Gibson-Graham J.K. (1996) *The end of capitalism (as we knew it): A feminist critique of political economy*, Cambridge MA.: Blackwell.

Giddens A. (1970) Introduction. In: Mazaryk T. (Ed.) *Suicide and the meaning of civilisation*, Chicago: University of Chicago

Giddens A. (1971) *The sociology of suicide*, London: Frank Cass and Company Ltd.

Giddens A. (1981) *Durkheim*, Glasgow: Fontana Modern Masters.

Giddens A. (1984) *The constitution of society*, Cambridge: Polity Press.

Giddens A. (1986) *Durkheim on politics and the state*, California: Stanford University Press.

Giddens A. (1991) *Modernity and Self-identity: self and society in the late modern age,* Cambridge: Polity.

Giddens A. (1994) *Capitalism and modern social theory: An analysis of the writings of Marx, Durkheim and Max Weber*, Cambridge University Press.

Giddens A. and Turner J. (1987) *Social theory today*, Cambridge: Polity Press.

Gilbert L. (1996) *Youth and the law*, Wellington ,New Zealand: Legal Resources Trust.

Gluckman L.K. (1976) *Tangiwai: A medical history of New Zealand prior to 1860*, Auckland, New Zealand: Whitcoulls Ltd.

Goffman E. (1961) *Asylums: Essays on the social situation of mental patients and other inmates*, Chicago: Aldine Publishers.

Goffman E. (1963/ 1990) *Stigma: Notes on the management of spoiled identity*, London: Penguin.

Gold H. (1992) *New Zealand politics in perspective,* 3rd edn., Auckland: Hyman Paul.

Goldthorpe J.C. (1974) *An introduction to sociology*, London: Cambridge University Press.

Goode E. and Ben Yehuda N. (1994) *Moral panics: The social construction of deviance*, Cambridge MA: Blackwell.

Gordon C. (editor) (1980) *Michel Foucault: Power/knowledge*, New York: Harvester Wheatsheaf.

Gordon C. (1991) Governmental rationality: An introduction. In: Burchell G., Gordon C. and Miller P., (Eds.) *The Foucault effect: Studies in governmentality*, pp. 1-52. Chicago: University of Chicago Press.

Grodin D. (1991) The interpreting audience: The therapeutics of self-help book reading. *Critical Studies in Mass Communication* **8**, 404-420.

Groves W.B. and Lynch M. (1990) Reconciling structural and subjective approaches to crime. *Journal of Research in Crime and Delinquency* **27**, 348-375.

Hacking I. (1991) How should we do the history of statistics? In: Burchell G., Gordon C and Miller P., (Eds.) *The Foucault effect: Studies in governmentality*, Chicago: University of Chicago Press.

Haines H. and Abbott M. (1986) *The future of mental health services in New Zealand: Deinstitutionalisation*, Auckland: Mental Health Foundation.

Halbwachs M. [1930] *Les Causes du Suicide.* Paris: Felix Alcan (Translated by Harold Goldblatt, 1978 Routledge and Keegan Paul: London).

Hall G. (1988) Monitoring and predicting community mental health utilisation in Auckland, New Zealand. *Social Science and Medicine* **26 (1),** 55-70.

Hall Robert T. (1987) *Emile Durkheim: Ethics and the sociology of morals*, New York: Greenwood Press.

Hall S. (1980) Encoding/decoding. In: Hall S., Hobson D., Lowe A. and Willis P., (Eds.) *Culture, media, language: Working papers in cultural studies, 1972-79*, pp. 128-138. London: Routledge in association with the Centre for Contemporary Cultural Studies.

Hall S. (1990) Cultural identity and diasphora. In: Rutherford J., (Ed.) *Identity, community, culture, difference*, London: Lawrence and Wishart.

Hall S., Critcher C. and Jefferson T. (1978) *Policing the crisis: mugging, the state, and law and order*, London: MacMillan.

Hall S., Hobson D., Lowe A. and Willis P. (1980) *Culture, media, language: working papers in cultural studies, 1972-79*, London: Routledge in association with the Centre for Contemporary Cultural Studies.

Hall S. and Gieben B. (1992) *Formations of modernity*, Cambridge: Polity Press.

Hamel J. , Dufour S. and Fortin D. (1993) *Case study methods: qualitative research methods series no. 32*, Newbury Park, California: Sage University Paper.

Hamilton P. (1992) The Enlightenment and the birth of the social sciences. In: Hall S. and Gieben B., (Eds.) *Formations of modernity*, Cambridge: Polity Press.

Harre J. (1986) Voluntary organisations, professional standards and the funding bind. In: Haines H. and Abbott M., (Eds.) *The future of mental health services in New Zealand: Deinstitutionalisation* , pp. 157-160. Auckland: Mental Health Foundation.

Harris P. (1999) Rogernomics, the 'Washington consensus' and New Zealand economic policy. In: Chatterjee S. et al., (Ed.) *The new politics: a third way for New Zealand*, pp. 19-32. Palmerston North, New Zealand: Dunmore Press

Hatton C. , Valente S. and Rink A. (1977) *Suicide: Assessment and intervention*, New York: Appleton-Century-Crofts.

Hay D., Linebaugh P. and Thompson E.P. (1975) *Albion's fatal tree: Crime and society in eighteenth-century England*, London: Penguin Books.

Health Act (1956) NZ RS vol. 6 1908-1957 pp78.

Health Amendment Act (1960) NZ RS vol. 6 1908-1957:79

Heelas P. (1996) *Detraditionalization: Critical reflections on authority and identity*, Oxford: Blackwell.

Hegel G.W.F. (1967) *Preface to the phenomenology of mind*, New York: Harper and Row.

Hekman S. (1994) The feminist critique of rationality. In: *The polity reader in gender studies*, pp. 50-61. Cambridge UK: Polity Press.

Henry A. and Short J.(1954) *Suicide and Homicide,* Glencoe: The Free Press: 1954.

Hercock F. (1991) Professional politics and family planning clinics. In: Bryder L. (Ed.) *A healthy country: Essays on the social history of medicine in New Zealand*, pp. 181-197. Wellington: Bridget Williams Books Ltd.

Hill M. (1997) *The policy process in the modern state,* 3rd edn. London: Harvester Wheatsheaf.

Hillman J. (1997) *Suicide and the soul*, Woodstock, Connecticut: Spring Publications, Inc.

Hindess B. (1996a) *Discourses of power: From Hobbes to Foucault*, Oxford: Blackwell.

Hindess B. (1996b) Liberalism, socialism and democracy: variations on a governmental theme. In: Barry A., Osborne T. and Rose N., (Eds.) *Foucault and political reason: Liberalism, neo-liberalism and rationalities of government*, pp. 65-80. London: UCL Press.

Hindess B. (1997) Politics and governmentality. *Economy and Society* **26**, 257-272.

Hospitals and Charitable Organisations Act (1895) In. Tennant 1989:35.

Hunt A. (1999) *Governing morals: a social history of moral regulation*, Cambridge: Cambridge University Press.

Hunt A. and Wickham G. (1994) *Foucault and the law: towards a sociology of law as governance*, London:

Pluto.

Irwin K. (2001) Legitimating the first tattoo: moral passage through informal interaction. *Symbolic Interaction* **24**, 49-73.

James J.S. (1986) *Stroud's judicial dictionary 5th edition vol. 5*, London: Sweet and Maxwell.

Jermyn R.L. (1951) The treatment of the mentally ill in New Zealand, 1840 - 1880. Massey University.

Johnson J. M. (1977) Ethnomethodology and existential sociology. In: Douglas Jack D. and Johnson John M., (Eds.) *Existential sociology*, pp. 153-173. Cambridge MA: Cambridge University Press.

Johnston A. J. (1864) *The New Zealand justice of the peace, resident magistrate, coroner and constable guidelines*, Wellington: McKenzie and Muir.

Jones G. (1973) *Introduction to Blackstone's commentaries on the laws of England (1723-1780)*, London: MacMillan.

Jones R. A. (1986) *Emile Durkheim: an introduction to four major works*, London: Sage.

Joseph P. (1997) Maori youth suicide in Aotearoa: selected interviews with Maori elders. University of Auckland.

Kane T.C. (1967) *The new Catholic encyclopaedia Vol. 13*, New York: McGraw-Hill.

Kaplan A. (1964) *The conduct of inquiry: methodology for behavioural science*, San Francisco: Chandler Publishing Company.

Kavanagh J. (2001) Cherry Farm 1952-1992: social and economic forces in the evolution of mental health care in Otago. In: Brookes B. and Thomson J., (Eds.) *Unfortunate folk: Essays on mental health treatment 1863-1992*, pp. 168-184. Dunedin, New Zealand: University of Otago Press.

Keat R. and Urry J. (1975) *Social theory as science*, London: Routledge & Keegan Paul.

Keesing R. (1981) *Cultural anthropology: a contemporary perspective*, Fort Worth: Harcourt Brace College Publishers.

Kelsey J. (1995) *The New Zealand experiment: a world model for structural adjustment?*, Auckland: Bridget Williams/ Auckland University Press.

Kevorkian J. (1991) *Prescription-Medicide: the goodness of planned death,* Buffalo, N.Y.: Prometheus Books.

Kingfisher C.P. (1996) Women on welfare: conversational sites of acquiescence and dissent. *Discourse and Society* **7**, 531-557.

Kinsman G. (1996) 'Responsibility' as a strategy of governance: regulating people living with AIDS and lesbians and gay men in Ontario. *Economy and Society* **25**, 393-409.

Kirk S. and Kutchins H. (1992) *The selling of DSM: the rhetoric of science in psychiatry*, New York: Aldine De Gruyter.

Klug C. (1996) *Suicide: The constructive/destructive self*, Ontario: Edwin Mellen Press.

Kritzman L. (1988) *Michel Foucault: Politics, philosophy, culture: interviews and other writings 1977-1984*, New York: Routledge.

Kubali H.N. (1957) Preface. In: Durkheim E., (Ed.) *Professional ethics and civic morals*, pp. ix-xi London: Routledge and Keegan Paul.

Kubler-Ross E. (1997) *The wheel of life,* London: Bantam/Transworld Publishers Ltd.

Kuhn T. S. (1970) *The structure of scientific revolutions*, Chicago: University of Chicago Press.

La Capra D. (1972) *Emile Durkheim, sociologist and philosopher*, Ithaca: Cornell University Press.

Laing R.D. (1969) *The divided self*, London: Penguin Books.

Lamont M. and Fournier M. (1992) *Cultivating differences: Symbolic boundaries and the making of inequality* , Chicago: University of Chicago Press.

Larner W. (1997) The legacy of the social: Market governance and the consumer. *Economy and Society* **26**, 373-399.

Larner W. (1998a) The discourse of restructuring: Employment in the New Zealand telecommunications industry. *Journal of Sociology* **34**, 264-280.

Larner W. (1998b) Sociologies of neo-liberalism: Theorising the 'New Zealand experiment'. *Sites* **36**, 5-21.

Larner W. (2000) Neo-liberalism: Policy, ideology, governmentality. *Studies in Political Economy* **63**, 5-25.

Larremore W. (1904) Suicide and the law. *Harvard Law Review* **17**, 331-341.

Larson E.J. and Amundsen D.W. (1998) *A different death: Euthanasia and the Christian tradition*, Downers Grove, Illinois: Intervarsity Press.

Lawson-Te Aho K. (1998) *Kia piki te ora o te taitamariki*, Wellington, New Zealand: Ministry of Maori Development.

Layder D. (1994) *Understanding social theory*, London: Sage.

Leahy C. Coronial Services Officer Letter to Ruth McManus, July 10, 1997.

Lemert C. (1992) General social theory, irony, postmodernism. In: Seidman S. and Wagner D., (Eds.) *Postmodernism and social theory*, pp. 17-46. Cambridge MA: Blackwell.

Lemert C. (1997) Goffman. In: Lemert C. and Branaman A., (Eds.) *The Goffman reader*, pp. ix - xliii Massachusetts: Blackwell Publishers Inc.

Lemert C. and Branaman A. (1997) *The Goffman reader*, Massachusetts: Blackwell Publishers Inc.

Lemert C. and Gillan G. (1982) *Michel Foucault: social theory as transgression*, New York: Columbia University Press.

Lester D. (1988) *Suicide from a psychological perspective*, Illinois: Charles C. Thomas.

Lester D. (1989) *Questions and answers about suicide*, Philadelphia: The Charles Press.

Lester D. (1994) *Emile Durkheim, Le suicide 100 years later*, Philadelphia: The Charles Press.

Levi R. (2000) The mutuality of risk and community: the adjudication of community notification statutes. *Economy and Society* **29**, 578-601.

Levi-Strauss C. (1963) *Structural anthropology*, New York: Basic Books.

Litman R. (1994) Long-term treatment of chronically suicidal patients. In: Shneidman E., Faberow N. and Litman R., (Eds.) *The psychology of suicide: A clinician's guide to evaluation and treatment.*, II pp. 119-131. Northvale, New Jersey USA: Jason Aronson Inc.

Little M. (1998) *No car, no radio, no liquor permit: The moral regulation of single mothers in Ontario, 1920-1997*, Toronto: Oxford University Press.

Llewellyn N. (1991) *The art of death*, London: Victoria and Albert Museum & Reaktian Books.

Lock S. (1982) *Statistics in practice*, London: British Medical Journal.

Lueker E.L. (1954) *Lutherian cyclopedia*, London: Concordia.

Luke P. (1982) Suicide in Auckland, 1848-1939. Masters Thesis, University of Auckland.

Lukes S. (1973) *Emile Durkheim: his life and works*, London: Penguin Press.

Lukes S. (1982) Introduction. In: Durkheim E., (Ed.) *The rules of sociological method* , pp. 1-30. London: MacMillan

Lunacy Act (1845) UK. In. Busfield 1986 pp172.

Lunatics Act (1868) NZ. NZ Statutes 1868 pp55.

Lunatics Act (1908) NZ RS vol. 5 1908-1957 pp741.

Lunatics Ordinance New Zealand Ordinances 1841-53 pp240

Lyotard J.F. (1984) *The postmodern condition: A report on knowledge*, Minneapolis: University of Minnesota Press.

MacDonald M. and Murphy T. (1990) *Sleepless souls: suicide in early modern England*, Oxford: Clarendon Press.

MacIntyre A. (1984) *After virtue: A study in moral theory*, Indiana: University of Notre Dame Press.

MacIntyre A. (1990) *Three rival versions of moral enquiry: Encyclopaedia, genealogy, and tradition*, London: Duckworth.

Mahoney L. (Jun 13, 1998) Spirited away: the complex cultural causes of Maori prison suicide are finally being acknowledged. *The Listener* 36-37. Wellington:

Malpas J. and Wickham G. (1995) Governance and failure: on the limits of sociology. *Australian and New Zealand Journal of Sociology* **31**, 37-50.

Manawatu/Wanganui Area Health Board (1992) *Mental health strategic planning document 1991-96: implementation timetable for period 1992-94*, Wellington: Mental Health Service.

Mann J. and Stanley M. (1986) *Psychobiology of suicidal behaviour*, New York: New York Academy of Sciences vol. 487.

Maris R.W. (1969) *Social forces in urban suicide*, Illinois: Dorsey Press.

Martel J. (2001) Examining the foreseeable: assisted suicide as a herald of changing moralities. *Social and Legal Studies* **10**, 147-170.

Martin L., Gutman H. and Hutton P. ([1982a1988) *Technologies of the self: a seminar with Michel Foucault*,

Amherst: The University of Massachusetts Press.

Masaryk T. ([18811970) *Suicide and the meaning of civilisation*, Chicago: University of Chicago.

Mason K. (1988) *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients*, Wellington: Ministry of Health.

Mason K. (1996) *Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services : report of the Ministerial Inquiry to the Minster of Health Hon. Jenny Shipley*, Wellington: Ministry of Health.

May T. (1993) *Social research: Issues, methods and process*, Buckingham, England: Open University Press.

McBrien R. (1995) *The HarperCollins encyclopaedia of Catholicism*, San Francisco: Harper Collins.

McGeorge J. (1942) Attempted suicide. *The Medical Journal of Australia* 67-74.

McLaglan E. (1965) *Stethoscopes and saddlebags: An autobiography*, Auckland, NZ: Collins.

McLennan G. (1991) Post-Marxism and retro-Marxism: theorising the impasse of the left. *Sites* **23**, 46-62.

McLennan G. (1995a) *Pluralism,* Minneapolis: University of Minnesota Press.

McLennan G. (1995) Feminism, epistemology and postmodernism: Reflections on current ambivalence. *Sociology* **29**, 391-409.

McLennan G., Ryan A. and Spoonly P. (2000) *Exploring society: sociology for New Zealand students*, Auckland: Pearson Education New Zealand Limited.

McManners J. (1981) *Death and the Enlightenment*, Oxford: Clarendon.

McRobbie A. (1994) *Post-modernism and popular culture*, London: Routledge.

Mental Defectives Act (1911) NZ RS vol. 5 1908-1957 pp 741.

Mental Health Act (1911) NZ RS vol. 5 1908-1957 pp 741.

Mental Health Act (1992) New Zealand Statutes 1992 vol. 2 no. 46 pp671.

Mental Health Amendment Act (1928) NZ RS vol. 5 1908-1957 pp741.

Mental Health Services (1993) *Guidelines on the management of suicidal patients*, Wellington, New Zealand: Ministry of Health, Government Publications.

Miller P. and Rose N. (1990) Governing economic life. *Economy and society* **19**:1, 1-31.

Miller G. and Silverman D. (1995) Troubles talk and counselling discourse: A comparative study. *The Sociological Quarterly* **36**, 725-747.

Ministry of Health (1994) *Looking forward: strategic directions for the mental health services*, Wellington, N.Z.: Ministry of Health.

Ministry of Health (1996) *Moving forward: the national mental health plan for more and better services*, Wellington: Ministry of Health.

Ministry of Health (1997a) *An approach for action: Phase two in the development of a national strategy to*

help prevent youth suicide in New Zealand, Wellington, New Zealand: Government Publications.

Ministry of Health (1997b) *Preventing suicide: guidelines for the media on the reporting of suicide*, Wellington New Zealand: Ministry of Health.

Ministry of Health (1998) *In our hands: New Zealand youth suicide prevention strategy*, Wellington: Government Publications.

Ministry of Youth Affairs. SPINZ (suicide prevention information New Zealand). www.spinz.org.

Mist K. (1998) The social construction of grief associated with sudden death. MA thesis. Massey University.

Monro D.H. (1972) *A guide to the British moralists*, London: Fontana/Collins.

Murdoch v. British Israel Foundation (1942) NZLR 600.

Murray Parks C. (1972) *Bereavement: Studies of grief in adult life*, New York: International Universities Press Inc.

New Catholic Encyclopaedia (1967) vol. 13. New York: McGraw-Hill.

New Zealand Government (1849-) *The New Zealand gazette*, Wellington: Government Publications.

New Zealand Government (1858) *Statistics for the colony of New Zealand from 1853 -1858*, Auckland: Government Publications.

New Zealand Government (1874) *Statistics for the colony of New Zealand for 1872*, Wellington: Government Publications .

New Zealand Government (1893) *The official year book of New Zealand*, Wellington: Government House.

New Zealand Government (1914-) *New Zealand monthly abstract of statistics*, Wellington: Government Publications.

New Zealand Government (1932) *The Public Acts of New Zealand (Reprint) 1908-1931, vol. 2*, Wellington: Government Publications.

New Zealand Government (1974) *The official yearbook of New Zealand*, Wellington: Government Publications.

New Zealand Government (1978) *The official yearbook of New Zealand*, Wellington: Government Publications.

New Zealand Health Information Service (1997) *Suicide trends in New Zealand 1974 - 1997*, Wellington,: Ministry of Health.

New Zealand Herald 6 March 1873 pp 2

New Zealand Herald 8 March 1873 pp 3

New Zealand Herald Supplement 13 March 1873 pp 1

New Zealand Police (1999) *A guide for bereaved families*, Porirua, New Zealand: New Zealand Police College.

Nilson H. (1998) *Michel Foucault and the games of truth*, London: MacMillan Press Ltd.

Novak D. (1975) *Suicide and morality: The theories of Plato, Aquinas and Kant and their relevance for suicidology*, New York: Scholars Studies Press.

NZLR (New Zealand Law Reports) *New Zealand Law Reports*, Wellington: Published for the Council of Law Reporting by Butterworths & Co. (Australia).

NZPD (1893) *New Zealand Parliamentary Debates (1893)*, Wellington: Butterworths.

NZPD (1908) *New Zealand Parliamentary Debates (1908)*, Wellington: Butterworths.

NZPD (1960) *New Zealand Parliamentary Debates vol. 324 (1960)*, Wellington: Butterworths.

NZPD (1960) *New Zealand Parliamentary Debates, vol. 325* (1960), Wellington: Butterworths.

O'Keefe J.A.B. and Farrand W.L. (1980) *Introduction to New Zealand law 4th edition*, Wellington: Butterworths.

O'Malley P., Weir P. and Shearing C. (1997) Governmentality: Criticism and politics. *Economy and Society* **26**, 501-517.

O'Regan K. (1992) *Adolescent Health: potential for action*, Wellington, New Zealand: Department of Health, Government Publications.

Onions C.T. (1966) *Oxford dictionary of English etymology*, Oxford: Clarendon Press.

Orcutt J. (1983) *Analysing deviance*, Illinois: The Dorsey Press.

Outhwaite W. (1987) *New philosophies of social science: Realism, hermeneutics & critical theory*, London: MacMillan Education.

Outhwaite W. and Bottomore T. (1996) *The Blackwell dictionary of social thought*, Oxford: Blackwell.

Palliser v. Waikato Hospital Board (1974) NZLR 561.

Palmer M. (1971) The New Zealand and Australian land company in nineteenth century New Zealand (Vol. I). University of Otago.

Parsons T. (1968) *The structure of social action: a study in social theory with special reference to a group of recent European writers* , New York: Free Press.

Patton M.Q. (2002) *Qualitative research and evaluation methods*, London: Sage.

Pearce F. (1989) *The radical Durkheim*, London: Unwin Hyman.

Perlin S. (1975) *A handbook for the study of suicide,* London.: Oxford University Press.

Petty M. (2000) SOS and the retelling of suicide. *Health* **4**, 288-308.

Phillips J. (1987) *A man's country? The image of the Pakeha male - a history-*, Auckland: Penguin.

Pickering W. and Martins H. (1994) *Debating Durkheim*, London: Routledge.

Pickering W. and Walford G. (2000) *Durkheim's Suicide: A century of research and debate*, London: Routledge.

Picton C., Cooper B., Close D. and Tobin J (2001) Bereavement support groups: Timing of participation and reasons for joining. *Omega* **43**, 247-258.

Pitkin H.F. (1993) *Wittgenstein and justice: On the significance of Ludwig Wittgenstein for social and political thought*, Berkley: University of California Press.

Plato (1970) *The Laws*, Middlesex: Penguin.

Polity Press (1994) *The polity reader in gender studies*, Cambridge UK: Polity Press.

Pope W. (1976). *Durkheim's Suicide: A Classic Analyzed.* Chicago and London: University of Chicago Press.

Prado C.G. (1995) *Starting with Foucault: An introduction to genealogy*, Boulder, Colorado: Westview Press.

Public Health Group (1996) *Youth mental health promotion*, Wellington, New Zealand: Ministry of Health, Government Publications.

Purvis T. and Hunt A. (1993) Discourse, ideology, discourse, ideology, discourse, ideology ... .*British Journal of Sociology* **44**, 473-499.

R v. Huntbach ex parte Lockley (1944) 2 ALLER, 453.

R v. Ruscoe (1992) 8 CRNZ 68 (CA).

Rabinow P.(1984) (Ed.) *The Foucault reader*, New York: Pantheon Books.

Rae S. (1983) *Changing patterns of Presbyterian social service: Presbyterian historical society annual lecture*, Dunedin: Presbyterian Historical Society of New Zealand.

Ramazanoglu C. (1993) *Up against Foucault: Explorations of some tensions between Foucault and feminism*, London: Routledge.

Ransom J. (1993) Feminism, difference and discourse: the limits of discursive analysis for feminism. In: Ramazanoglu C., (Ed.) *Up against Foucault: Explorations of some tensions between Foucault and feminism*, pp. 123-146. London: Routledge.

Ransom J. (1997) *Foucault's discipline: The politics of subjectivity*, Durham: Duke University Press.

Registration of Deaths Act (1836) UK. In Forbes 1979 pp120.

Retterstol N. (1993) *Suicide: A European perspective*, Cambridge: Cambridge University Press.

Rimke H. and Hunt A. (2002) From sinners to degenerates: the medicalisation of morality in the 19th century. In. *History of the Human Sciences* **15**, 59-88.

Ritzer G. (1992) *Metatheorising*, London: Sage.

Ritzer G. (1996) *Modern sociological theory*, New York: McGraw-Hill.

Rivers L. (1995) *Young person's suicide*, Wellington: Special Education Service.

Robertson R. (1980) Aspects of identity and authority in sociological theory. In: Robertson R. and Holzner B., (Eds.) *Identity and authority*, pp. 218-265. Oxford: Basil Blackwell.

Robertson R. and Holzner B. (1980) *Identity and authority: Exploration in the theory of society*, Oxford: Basil Blackwell.

Robinson D. (1992) *Social discourse and moral judgement*, San Diego: Academic Publishers.

Rose N. (1996) Authority and the genealogy of subjectivity. In: Heelas P. (Ed.) *Detraditionalization: Critical*

reflections on authority and identity, pp 294-327 Oxford: Blackwell.

Rose N. (1998) *Inventing ourselves: Psychology, power and personhood*, Cambridge: Cambridge University Press.

Rose N. (1999) *Powers of freedom: Reframing political thought*, Cambridge: Cambridge University Press.

Ross Jack C. (1972) Toward a reconstruction of voluntary association theory. *British Journal of Sociology* **23**, 20-32.

Ross Jack C. (1976) *An assembly of goodfellows: Voluntary associations in history*, Westport, Connecticut: Greenwood Press.

Roth J. K. (1995) *International encyclopaedia of ethics*, London: Fitzroy Dearborn Publishers.

Rousseau J. J. (1979) *Emile*, Toronto: Basic Books.

Rubinstein D. (1981) *Marx and Wittgenstein: social praxis and social explanation,* London: Routledge and Keegan Paul.

Rubinstein W.D. and Rubinstein H.L. (1996) *Menders of the mind: a history of the Royal Australian and New Zealand College of Psychiatrists, 1946-1996*, Oxford: Oxford University Press.

Ruscoe W. and Shanks G. (1994) *A long goodnight: the tragic story of mates Warren Ruscoe and Greg Nesbit*, Auckland NZ: Rugby Publishing Ltd.

Rutherford J. (1990) *Identity, community, culture, difference*, London: Lawrence and Wishart.

Sainsbury P. (1955) *Suicide in London*, London: Chapman Hall.

Schiffrin D. (1987) *Discourse markers*, Cambridge: Cambridge University Press.

Schmid C.F. (1939) Suicide in Minneapolis, 1928-1932. *The American Journal of Sociology* **XXXIX**, 30-48.

Scott J. (1990) *A matter of record: Documentary sources in social research*, Cambridge: Polity Press.

Scott James C. (1990) *Domination and the arts of resistance: Hidden transcripts,* New Haven: Yale University Press.

Seidman S. (1992) Postmodern social theory as narrative with a moral intent. In: Seidman S. and Wagner D., (Eds.) *Postmodernism and social theory*, pp. 47-81. Cambridge MA: Blackwell.

Seidman S. and Wagner D. (1992) *Postmodernism and social theory*, Cambridge MA: Blackwell.

Shils E. (1968) Consensus. *International encyclopaedia of the social sciences* **vol. 3**, 260-266.

Shipley J. (1994) Introduction. In: Ministry of Health, (Ed.) *Looking forward: strategic directions for the mental health services*, pp. 1-7. Wellington: Ministry of Health.

Shirley I. (1994) Social policy. In: Spoonley P. and Pearson D., (Eds.) *New Zealand society*, 2nd edn. pp. 130-145. Palmerston North, New Zealand: Dunmore Press.

Shneidman E. (1967) *Essays in self-destruction*, New York: Science House.

Shneidman E. (1993) Some controversies in suicidology: toward a mentalistic discipline. *Suicide and Life Threatening Behaviour* **23** , 292-298.

Shneidman E., Faberow N. and Litman R. (1994) *The psychology of suicide: a clinician's guide to evaluation and treatment.*, Northvale, New Jersey USA: Jason Aronson Inc.

Shuker R., Openshaw R. and Soler J. (1990) *Youth, media and moral panic in New Zealand*, Palmerston North, New Zealand: Delta.

Sills D. (1968) Voluntary associations. *International Encyclopaedia of the Social Sciences* **16**, 362-379.

Silverman D. (1985) *Qualitative methodology and sociology*, Aldershot: Gower.

Simmel G. (1955) *Conflict and the web of group affiliations*, New York: MacMillan.

Simpson G. (1951) Editor's Preface. In: Durkheim E., (Ed.) *Suicide: A study in sociology*, 1st edn. pp. 9-12. Glencoe, Illinois: The Free Press.

Simpson G.E. (1968) Assimilation. *International Encyclopaedia of the Social Sciences* **vol. 1**, 438-444.

Simpson J.A. and Weiner E.S.G (1989) *The Oxford dictionary 2nd Edition vol. XVII*, Oxford: Clarendon Press.

Sinclair K. (1991) *A history of New Zealand*, Auckland New Zealand: Penguin Books.

Skeat W.W. (1961) *Etymological dictionary of the English language*, Oxford: Clarendon Press.

Smandych R. (1999) *Governable places: Readings on governmentality and crime control*, Dartmouth: Ashgate.

Smart B. (1985) *Michel Foucault*, London: Routledge.

Social Security Act (1938) New Zealand Statutes 1938 2 Geo. VI session III pp62..

Somerville A. (1996) Ashburn Hall and its place in society 1882-1904. University of Otago.

Soper M. Crown Counsel (1992) *The laws of New Zealand: Coroners*, Wellington: Butterworths.

Spiller P. (1995) *Butterworths New Zealand law dictionary 4th Edition*, Wellington: Butterworths .

Spoonley P. and Pearson D. (1994) *New Zealand society*, Palmerston North, New Zealand: Dunmore Press.

Sprott S.E. (1961) *The English debate on Suicide: From Donne to Hume*, USA: Open Court Publishing Company.

Stack S. (1997) Homicide followed by suicide: An analysis of Chicago data. *Criminology* **35**, 435-453.

Stack S. (2000) Suicide: a 15- year review of the sociological literature part I: cultural and economic factors. *Suicide and Life Threatening Behaviour* **30**, 145-162.

Stack S. (2000) Suicide: a 15-year review of the sociological literature part II : modernisation and social integration. *Suicide and Life Threatening Behaviour* **30**, 163-176.

Steering Group (1994) *Report and recommendations of the steering group in youth mental health and suicide prevention*, Wellington: Ministry of Health.

Stengel E. and Cook N. (1958) *Attempted suicide: Its social significance and effects*, Connecticut: Greenwood Press.

Stenson K. (1999) Crime control, governmentality and sovereignty. In: Smandych R., (Ed.) *Governable*

places: Readings on governmentality and crime control, pp. 45-74. Aldershot: Ashgate.

Stevenson R. (1995) *Everybody hurts A New Zealand story: Coping with our son's suicide*, Auckland: HodderMoa Beckett.

Stevenson R. (1997) *The emotional clock : The depression beater*, Auckland: Project Hope Educational Fund.

Strange C. and Loo T. (1997) *Making good: Law and moral regulation in Canada, 1867 - 1939*, Toronto: University of Toronto Press.

Stubbs M. (1983) *Discourse analysis: The sociolinguistic analysis of natural language*, Oxford: Blackwell.

Styles J. (1997) Men and the development of psychiatry in New Zealand in the 1920s and 1930s. Masters thesis, Department of History, University of Canterbury.

Sweet and Maxwell (1971) *Criminal law and practice in New Zealand*, Wellington: Butterworths.

Szasz T. (1971) *The manufacture of mental illness*, London: Routledge and Keegan Paul.

Szasz T. (1974) *The myth of mental illness*, New York: Harper and Row.

Szasz T. (1997) Forward. In: Hillman J., (Ed.) *Suicide and the soul*, 2nd edn. pp. 6-10. Connecticut: Spring Publications

Szasz T. (1999) *Fatal freedom : The ethics and politics of suicide,* Westport CT.: Praeger.

Sznaider N. (1998) The sociology of compassion: a study in the sociology of morals. *Cultural Values* **2**, 117-139.

Taylor S. (1982) *Durkheim and the study of suicide,* London: MacMillan.

Taylor S. (1994) Suicide and social theory. In: Lester D., (Ed.) *Emile Durkheim: Le suicide 100 years later*, pp. 1-10. Philadelphia: The Charles Press.

Tennant M. (1989) *Paupers and providers: charitable aid in New Zealand*, Wellington, NZ: Allen and Unwin & Historical Branch Dept. of Internal Affairs.

The Laws of New Zealand (1999) Vol. 25. *Sentencing,* Wellington: Butterworths.

The Listener (Jan, 1998) *The New Zealand listener* p28

The New Zealander 18 January 1851.

Thompson K. (1985) *Readings from Emile Durkheim*, London: Tavistock Publications.

Thompson K. (1997) *Media and cultural regulation*, London: Open University and Sage Publications.

Thompson K. (1998) *Moral panics*, London : Routledge.

Thompson M. and Rayner S. (1998) Risk and governance part two: policy in a complex and plurally perceived world. *Government and Opposition* **33**, 139-166.

Tiryakian E.A. (1978) Emile Durkheim. In Bottomore T. and Nisbet R. (1978) *A history of sociological analysis,* pp 187-236 London: Heinman.

Todd S. (1992) *The laws of New Zealand: tort and accident compensation*, Wellington: Butterworths.

Tolich M. and Davidson C. (1999) *Starting fieldwork: An introduction to qualitative research in New Zealand*, Auckland, NZ: Oxford University Press.

Tooms S. (2002) Understanding regulation? *Social and Legal Studies* **11** , 113-133.

Travers A. (1994) Destigmatising the stigma of self in Garfinkel's and Goffman's accounts of normal appearances. *Philosophy of the Social Sciences* **24**, 5-40.

Tribe K. (1996) Methodenstreit. In: Outhwaite W. and Bottomore T., (Eds.) *The Blackwell dictionary of social thought*, pp. 378-379. Oxford: Blackwell

Turner L. (1997) Euthanasia and distinctive horizons of moral reasoning. *Mortality* **2**, 191-205.

Vallance E. (1975) *The state, society and self-destruction* , London: George, Allen & Unwin Ltd.

Valverde M. (1990) The rhetoric of reform: Tropes and the moral subject. *International Journal of the Sociology of Law* **18**, 61-73.

Valverde M. (1991) *The age of light, soap and water*, Ontario: McClelland & Stewart Inc.

Valverde M. (1994) Editorial: studies in moral regulation. *Canadian Journal of Sociology* **19**, vi-xii.

Valverde M. (1998) *Diseases of the will: Alcohol and the dilemmas of freedom*, Cambridge : Cambridge University Press.

Valverde M. and Weir L. (1988) The struggles of the immoral: preliminary remarks on moral regulation. *RFR/DRF* **17**, 31-34.

Valverde M. and White-Mair (1999) 'One day at a time' and other slogans for everyday life: The ethical practices of alcoholics anonymous. *Sociology* **33**, 393-410.

Van Dijk T. (1985) *Handbook of discourse analysis, Vol. 3 discourse and dialogue*, London: Academic Press.

Varty J. (2000) Suicide, statistics and sociology: assessing Douglas' critique of Durkheim. In: Pickering, W. and Walford, G., (Eds.) *Durkheim's suicide: A century of research and debate*, pp. 53-65. London: Routledge.

Vatican (1994) *Catechisms of the Catholic Church*, Homebush, New South Wales, Australia: St. Pauls.

Victim Support Groups www.victimsupport.org.nz: accessed on the 28th July 2000.

Victims of Offences Act (1987) New Zealand Statutes 1987 pp173.

Walker D. (1980) *The Oxford companion to law*, London: Clarendon Press.

Wallace R.J. (1998) Moral agents. In: Craig E., (Ed.) *Routledge Encyclopaedia of Philosophy*, London: Routledge

Wallwork E. (1972) *Durkheim: Morality and milieu*, Cambridge Massachusetts: Harvard University Press.

Watt S. (1996) Introduction: Aristotle's Nichomachean ethics . In: Aristotle, (Ed.) *The Nicomachean ethics* , pp. ix-xxiv Ware, Hertfordshire, UK: Wordsworth Classics.

Webb M. (1994) The politics of 'medicine' in New Zealand: A cautious proposal for physician aid-in-dying. *Canterbury Law Review* **5**, 438-464.

Weber M. (1958) Class, status, party. In: Gerth H. and Wright-Mills C., (Eds.) *From Max Weber: Essays in*

sociology, pp. 180-195. New York: Oxford University Press.

Weber M. (translated by E.C. Hughes) (1972) Max Weber's proposal for the sociological study of voluntary associations ("Geschaftsbericht" im Verhandlungen des Ersten Deutschen Soziologentages vom 19-22 Oktober, 1910 in Frankfurt a.M. Tubigen, 1911, Pa 52-60). *Journal of Voluntary Action Research* **1**, 20-23.

Webster C. (1979) *Health, medicine and mortality in the sixteenth Century*, London: Cambridge University Press.

Weedon C. (1987) *Feminist practice and poststructuralist theory*, Oxford: Basil Blackwell.

Weisman Avery D. (1995) A benefiting and appropriate death. In: Williamson J. and Shneidman E., (Eds.) *Death: Current Perspectives* , pp. 14-17. California: Mayfield Publishing Company.

Widiger T. et al. (1994) *Diagnostic and statistical manual of mental disorders Vol. IV,* Washington: American Psychiatric Association.

Widiger T. et al. (1996) *Diagnostic and statistical manual of mental disorders sourcebook vol. two.* Washington: American Psychiatric Association.

Widiger T. et al. (1998) Final work group report DSM +V child disorders. In: Widiger T. et al. (Ed.) *DSM IV - Source Book Vol. IV*, pp. 974-975. Washington: American Psychiatric Association.

Williams G. (1958) *The sanctity of life and the criminal law*, London: Faber and Faber.

Williams G. (1975) *The age of agony*, London: Constable.

Williams W. H. (1987) *Out of mind out of sight: The story of Porirua Hospital*, Porirua , NZ: Porirua Hospital.

Williamson J. and Shneidman E. (1995) *Death: Current perspectives*, 4th edn. California: Mayfield Publishing Company.

Willis E. (1995) *The sociological quest: An introduction to the study of social life*, New South Wales: Allen and Unwin Pty Ltd.

Wolff K. (1978) Phenomenology and sociology. In: Bottomore T. and Nisbet R., (Eds.) *A history of sociological analysis*, London: Heineman.

Wood B. (1998) Stuart Hall's cultural studies and the problem of hegemony. *British Journal of Sociology* **49**, 399-414.

Wood B. (1999) Panic, what panic? The moral deficit of new right politics in Aotearoa New Zealand. *New Zealand Sociology* **14**, 85-110.

Wood B. (2000) Social justice and the mentality of neo-liberal rule. *SITES* **38**, 89-106.

Wood B. (2001) Cultural domination and the problem of rule. Unpublished working paper.

Wooton D. (1993) *Political writings of John Locke*, London: Mentor (Penguin).

World Health Organisation (WHO) (1986) *Ottawa charter for health promotion*, Geneva: World Health Organisation.

World Health Organisation (WHO) (1989) *The health of youth*, Geneva: World Health Organisation.

Wright Mills (1959) *The sociological imagination*, New York: Oxford University Press

Wright Mills C. (1973) The higher circles. In: Chambliss W., (Ed.) *Sociological readings in the conflict perspective*, pp. 270-296. Massachusetts: Addison-Wesley Publishing Company.

Zeitlin I. (1968) Emile Durkheim. In: Zeitlin I., (Ed.) *Ideology and the development of sociological theory*, pp. 234-280. USA: Prentice Hall

Zeitlin I. (1968) *Ideology and the development of sociological theory*, USA: Prentice Hall.