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Manuscript:**An Integrated Exploration of the Social Dynamics of Suicide Among Women**

Introduction:

Existing accounts of female fatal suicides are unsatisfactory and problematic. In cohort studies of suicide, masculine considerations dominate and female death is comparatively overlooked. In those rare studies which solely examine female suicide, there is a powerful focus on mental illness and the reproductive cycle, framing it within a distinctly biomedical space. Such approaches routinely and systematically fail to account for the impact of society's gendered practices and expectations in contributing to the suicidal actions of these women.

The aim of this paper is to reframe our understanding of women's suicide by placing the female gender as a central, rather than an incidental factor in the analyses. We examine the subject by reviewing the literature, initially providing a broad overview of gender and suicide before demonstrating how in historical studies the issue of women's fatal suicide has effectively been '*othered*' in the sense that it is '*defined and differentiated with reference*' to male death (De Beauvoir 1956:16). We further suggest it conforms to De Beauvoir's assertion of women as the 'Second sex', by describing how in the literature the female gender often appears '*incidental*' in analyses which predominantly compare their suicidal behaviour with that of their male counterparts. We argue this has been reinforced by the recent trend towards male-only cohort studies which render the topic of women's suicide '*inessential*' in contemporary suicidology. We conclude our review of the literature by examining women only studies, drawing attention to the ways in which they constrain and limit our current understanding of women's suicide.

In the main part of the paper, we present an empirical analysis of a cohort of female deaths by suicide. Demonstrating how three overarching themes; bereavement, motherhood and sexual assault and two

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3 minor themes; family/relationship issues and deteriorating physical health, can be used to explore
4 these women's hopelessness. In doing so, we add to the field of knowledge in two key ways. Firstly,
5 by examining these deaths separately from male suicide we offer an alternative to the dominant
6 discourse which 'others' women's suicide. Secondly, by applying a modified version of the
7 Sociological Autopsy method to data on the deaths of 78 women, we contribute to our understanding
8 of how methodological approaches that carefully acknowledge both the limitations and possibilities of
9 documentary data, can be used to illuminate the social issues associated with women's death by
10 suicide.
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20 **Gender and Suicide**

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22 Since the 1990s there have been a few insightful and critical reflections of the broad issue of gender in
23 suicide research. Canetto (1992, 1997) published a number of studies in which she challenged the
24 gendered assumptions made about rates of suicidal behaviour. In a now well-cited study she
25 demonstrated that the terminology used in suicide literature was highly gendered with female
26 behaviour typically spoken about judgmentally and as a 'failure', while male suicidal behaviour more
27 likely to be labeled positively or as "success" (Canetto 1992-1993). In a further study on suicide in the
28 elderly she suggested that men and women's behaviour in this regard were partly influenced by
29 internalized social roles (Canetto, 1992).
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39 A critique of gender in suicide research re-emerged early in the new millennium when Jarworski
40 (2003) applied feminine ideologies to the topic. By applying Butler's (1993) notion of performativity
41 she suggested that the reiteration of normalised practices in the production of knowledge about
42 suicide must be questioned if we are to understand how suicide is framed within ritualized and
43 gendered antecedents that frame how "knowledge about suicide becomes knowledge" (Jarworski,
44 2014 p. 36). Her recent comprehensive monograph of gender and suicide is a first attempt to
45 challenge our assumptions about gender within a spectrum of arenas, including the media and the
46 Coroner's office (Jarworski, 2014). She concludes that suicide is "conditioned by specific value
47 assumptions and norms so that the gender of suicide turns out to be masculine and masculinist"
48 (Jarworski, 2014, p.153).
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The 'Othering' of Women's Suicide

Jarworski's (2014) findings are intriguing because many studies published in suicidology claim to enhance our understanding of the nature of suicide by contrasting male and female suicide (O'Connor and Sheehy, 1997), thus arguably representing both masculine and feminine issues equally. Such studies often contrast the deaths as though they occur within two distinct homogenous 'sex' groups (Scourfield, 2005). However, the presence of women's suicide in these studies appears incidental in the sense that it is there to highlight the problem of male suicide. In statistical terms, with a few notable exceptions (namely India and China) it is consistently reported that women come second in terms of numbers of deaths per year (Joiner, 2010). The literature is replete with examples where in the opening line of the paper the problem of *high* male suicide rate is established by 'othering' *lower* female suicide rates (Alson, 2012; Cleary, 2012; Joiner, 2010). Other studies exemplify the problem of male suicide by comparing the rising suicide rates in men with the falling rate of female suicide (Hawton, 1992). The seriousness of male behaviour is highlighted by drawing attention to the '*less violent*' and '*less successful*' methods used by females (Hawton, 2000; Schapira et al., 2001; Joiner 2010). This terminology continues to discuss women's suicide pejoratively, as if they are of reduced significance (Canetto, 1992). High levels of mental illness among female suicide cases have been used to highlight the social nature of male death by suicide (Hawton, 1992). Furthermore, high levels of help-seeking among females prior to suicide are rarely problematised (Canetto 1994); instead, such statistics are typically used to highlight the low levels of help-seeking among men (Prior, 1999). These studies only consider the issue of feminine suicide as it exists in comparison to masculine suicide, thereby 'othering' suicides by women.

Suicide prevention policies also specifically target the reduction of male suicide rates (Department of Health, 2012). The 'crisis' of male suicide has caused a significant shift toward research into the suicidal behaviour of men and recent reports in the United Kingdom (UK) and the Republic of Ireland have tended to examine the topic of male suicide in isolation from female suicide (Jordan et al., 2012; Richardson et al., 2013; Samaritans, 2013). New approaches such as sociologically and qualitatively driven papers have added significantly to our understanding of male suicide (Owens et al., 2005;

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3 Scourfield, 2012; Shiner et al., 2009). Notably, the discourse underpinning these studies strongly
4 acknowledges the contextual phenomenon of male suicidal behaviour. Crucially, within this highly
5 visible framework, explanations and responses for suicide are deeply embedded in the male gender
6 and the 'crisis of masculinity' (Scourfield, 2005).
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10 11 **The 'Inessential' Nature of Women's Suicide**

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14 By direct contrast, a specific focus on issues related to women's suicide is almost invisible within the
15 literature. Women tend to be overlooked in policies on suicide prevention (Rugkhla, 2011).

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17 Furthermore, we were unable to identify any significant large-scale reports in the grey literature
18 exploring issues that relate to female-only suicide. Studies of female-only cohorts are also harder to
19 identify in the peer-reviewed literature. As a clear example, the Psychological Autopsy method is
20 highly regarded in suicide research and is widely applied to studies of suicide, however, we were able
21 to identify only a single female-only study using this method (Asgard, 1990). Qualitative and
22 sociologically driven studies of women's death by suicide are particularly rare suggesting that such
23 studies are 'inessential' or unnecessary.
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33 Neurginger (1982) called the lack of women only studies an 'unintentional slighting' and suggested
34 there were various "non-anti-feminist" reasons for it, namely their smaller numbers (p.94).

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36 Jarworski's (2014) critique of the role of masculine forms of knowledge in suicide suggest otherwise.
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38 In the final section of the literature review, we critique publications where women's suicide were the
39 primary focus of investigation to further support.
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43 **Women Only Studies of Suicide**

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45 Studies of female only suicide are relatively rare. There are a number of notable individual case
46 studies within the published literature on female-only suicide, of which Katie's diary (Lester, 2004)
47 and 'Savage God' (Alvarez, 1990) are two well-cited examples. A valuable contribution has also been
48 made by psychoanalysis (Gerisch, 1993; Kaplan & Klien, 1990). While Lester's (1988) edited
49 collection, *Why women kill themselves*, is a cross-disciplinary publication that contains a number of
50 insightful chapters discussing female cognitive processes when undertaking lethal actions and
51 psychological characteristics evident in their suicide notes. However, the collection also reflects the
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3 propensity to study female suicide in relation to their reproductive cycle. Studies of menstruation and
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5 suicide remain inconclusive, Lester (1988) acknowledges that their results are “not easy to
6
7 summarise” (p.113). For example, studies have demonstrated lower than expected rates of suicide
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9 among pregnant and perinatal women (Appleby, 1991; Barno, 1967; Marzuk et al., 1997; Gissler et
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11 al., 1996; Robinson, 1998). Despite Lester’s conclusion, and earlier suggestions that the relationship
12
13 between physiology and suicide is likely to be complicated and affected by ‘social roles’ (Neuringer
14
15 & Lettieri, 1982) some studies of suicide continue to rest on what the authors referred to as the
16
17 questionable notion that ‘having or lacking a penis implies a difference in brain structure and
18
19 functioning (p.93).

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21 This reflects the clear stereotyping that emerges in the categorisation and presentation of female
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23 suicide completers in which their behaviour is stereotypically linked to particular aspects of a
24
25 woman’s nature rather than her social conditions (Gerisch, 1996). Occasional studies have examined
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27 how women have been ‘prepared for victimhood’ because of their interpersonal histories (Counts,
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29 1987; Stephens 1988) but broader feminine issues are not afforded independent investigation in the
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31 same way that male only studies claim to allow us to understand “the diversity of suicidal
32
33 masculinities” (Scourfield, 2005: 18). This gap means we have a limited understanding of the
34
35 diversity of suicidal femininities.

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37 Overall, comprehensive, cohort studies of female-only death are now largely dated and have tended to
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39 examine specific groups of women who are considered to be particularly vulnerable (see Iga et al.,
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41 1975; Johnson, 1979). Similarly, recent concern about levels of suicide among female prisoners has
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43 led to research in this area (Liebling, 1994; Moore & Scraton, 2014). Focusing on vulnerable groups
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45 of women, rather than population cohorts of female deaths, contrasts with the approach taken to male
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47 suicide.

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49 To summarise, the majority of studies in suicidology, including recent methodologically innovative
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51 and sociologically driven approaches, remain focused on men. The present study examines a
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53 population cohort of female suicide deaths in an attempt to counterbalance this tendency.
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Methods

Data Access

The data analysed here are part of a larger retrospective cohort study of every death in Northern Ireland (NI) determined to be suicide by the NI Coroner Service (NICS) between 2007 and 2009. Over the two-year study period, 403 suicides were recorded by the NICS, 325 men and 78 women. The primary objective of the study was to focus on help seeking behaviour prior to death by suicide. As part of this remit we accessed the GP data of the individuals we identified at the Coroner's office. Access to personal confidential data in both the Coroners' and the General Practitioners' (GP) records was granted via the 'research exemption' within Section 33 of the Data Protection Act. Ethical approval for the study was obtained from the NI branch of the UK Office for Research Ethics Committee (ORECNI).

In this paper, we focus on the deaths of the women identified in the Coroner's data. All 78 female suicides from the two-year study period were included. As far as the researchers are aware they were granted access to all the information held by both the Coroner and the GP, therefore no gatekeeping issues regarding access to the data are thought to have influenced the sample. We were able to access the GP records of 70 of these 78 females. Eight GP records were not available to the research team during the data collection phase. All 78 cases are included here; we indicate in the text when referring to cases for which no GP records were accessed.

Social construction of documentary data

From the outset of this study we were mindful of the situated nature of information contained within both sets of documents. We acknowledge the broad limitations of bureaucratic records noted by other documentary researchers working with medical records (Berg & Bowker, 1997) and coroner's records (Langer et al., 2008). Nevertheless, it is pertinent to draw attention to the problems associated with the collection and analysis of documentary data in the specific context of suicide research and to set out the discursive framework and context in which we produced the accounts of the 78 women's deaths. We do this here, rather than in the discussion section of the paper, because we believe the

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2
3 assumptions made in suicide research carried out with documentary data, play a crucial role in
4
5 influencing how suicide can, and cannot be explained. For example, Jarworski (2014) has been
6
7 critical of how suicidology explains its methods 'in concrete and factual ways' while forgetting that
8
9 the methods distinctly frame how it is possible to understand suicide (p. 8).

10
11 Death, removes the ability of the deceased to speak directly to us (Davis, 2004), but suicide is a form
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13 of death which challenges our ontological security (Seale, 1998) thus creating a need for meaning and
14
15 context which drives us to want to continue a dialogue with the deceased. Suicide research is a direct
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17 response to this need. However, regardless of how this data is derived and analysed, suicidology
18
19 creates knowledge "that speaks of and for, those who are no longer alive" (Jarworski, 2014, p.4). As a
20
21 direct consequence, of the deceased's silence, there are a number of relevant issues to consider when
22
23 undertaking suicide research:

- 24
- 25 • a consideration of the type of information gathered;
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- 27 • the original purpose for which it was obtained;
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- 29 • how, when and by whom it was collected, and
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- 31 • how researchers decided which data were relevant for their purposes.
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34 We will firstly examine these issues in relation to Coroner's data before considering how they may
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36 also affect GP records.

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38 Coroner's files typically contain information from both professional and lay sources. Langer et al
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40 (2008) have attested to the challenges posed to researchers by the lack of standardization in data
41
42 collection. They also note that while this information is routinely and unproblematically used by
43
44 suicide researchers to construct explanatory accounts of the deceased's suicide, it is collected
45
46 predominately by police and coroner's officers for the sole purpose of assisting the Coroner determine
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48 the cause of death. It has been suggested that within this exclusively medical approach the associated
49
50 socio-psychological context surrounding suicide may be diminished (Tormey, 2011; Authors, 2014).

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52 Information recorded in lay interviews will almost undoubtedly be filtered by the professional
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54 judgment of the police and coroner's officers who are skilled in asking questions designed to elicit
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56 responses that attest to a suicidal state of mind. Individuals will typically be asked to offer their
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3 opinions on the state of mind of the deceased in the weeks/months prior to their death and questions
4 are likely to be attuned to issues relating to mental health diagnoses or short-term stressors. This
5 approach leads to the neglect of social and/or longer-term issues which are likely to have affected the
6 long term emotional wellbeing of the deceased.
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10 Finally, all of the accounts recorded in the Coroner's file, are constructed after the death has taken
11 place. Although some files contain original copies of GP records, most contain only reports
12 constructed by the GP in response to a request received after the death has taken place. As a result,
13 these accounts will be influenced by the implicit need of the healthcare professional to account for
14 their actions with regard to treating and/or assessing the individual. In instances where suicide risk
15 was known, this may include responsibility for failing to prevent the suicide. The accounts of family
16 members are likely to be similarly influenced by feelings of guilt and responsibility (Langer et al.,
17 2008). As Douglas (1970) has suggested suicide is a socially meaningful act and these accounts are
18 not an objective representation of the events that took place. In this sense, Coroner's data represent
19 both a bureaucratic paper trail and a subjective account of another individual's state of mind,
20 influenced and fundamentally altered by the event of the death itself. Knowledge of the suicide will
21 influence what individuals are willing to say about the deceased and may cause them to draw
22 assumptions about the casual nature of events (Fincham et al., 2011) thus fundamentally shaping any
23 research undertaken.
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GP records, are also a bureaucratic account of events for which individuals sought help (Berg &
Bowker, 1997). As such they are potentially constrained by the biomedical framework of the
consultation room. Crucially, from the point of view of suicide research, they are written by
healthcare professionals, about a consultation with the patient, at time when the professional had no
knowledge of that person's eventual fate. As a source of data, therefore they are uninfluenced by the
death itself, are based directly on accounts from the individual who died and pertain to issues they
believed were affecting their health. In this sense, while we acknowledge they are a reflection of, and
limited by, both the diagnostic process and the individuals' propensity to seek help, we do not
necessarily believe this to be an entirely negative point. While the medical practitioners lens mean
that social issues are likely to remain under reported, lifelong GP records, when interrogated by

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3 researchers attuned to such issues, may have the potential to create explanations for the suicide which
4 are at least open to the possibility of social causes. In the next section we will discuss our approach to
5 data collection and analysis.
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8 9 **Data Collection**

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11 Our experiences of collecting data from the Coroner mirrored that reported by Langer et al (2008) in
12 that we found a lack of standardisation in relation to both the type and amount of information. We
13 made the decision to collect data from all types of reports contained within these records. Our
14 objective was to understand the social context of the deaths therefore, our approach to the study was
15 influenced by the Sociological Autopsy method developed by Scourfield et al (2012). This method
16 focuses on sociological aspects of data in order to bring insights to our understanding of the social
17 causes of suicide. It has already been established as a useful means of exploring gender based issues
18 in this area (Scourfield et al., 2012; Shiner et al., 2009). The techniques developed by this group came
19 to influence both our data collection and our analyses techniques.
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30 In contrast to previous sociological autopsy studies, we were granted access to both the Coroner and
31 GP records and were thus able to collect data in relation to life events reported to both sources. This
32 required adaptation of the analytic approach to incorporate multiple data sources. Data contained
33 within GP records was privileged in our initial coding, not on the basis that they represented a more
34 valid or truthful opinion, but on the basis that they represented an account over a longer period of
35 time, linked to a primary engagement between the individual who died and a professional unimpeded
36 with knowledge of the circumstances of the death. We therefore relied on data from this source to
37 initially develop a coding scheme, triangulating and supplementing this coding with Coroner's data.
38 It was possible in 68 cases to use GP records to consider the circumstances surrounding the deaths. In
39 the remaining 10 cases the women had never engaged in help-seeking at the GP in relation to mental
40 health problems. However, in these cases, we were able to use Coroner's data to consider the
41 experiences of these women. In some of the cases where GP data was not available we were able to
42 use data reported by the GP to the Coroner to thematically code the deaths.
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3 Researchers approached the data collection process from both sources in a similar manner but given
4 the variability of available data, we regarded it as an iterative process. From the outset, we took a
5 broad approach to data collection and coding, refining the data for analytic purposes at a later point.
6
7 This involved gathering free text verbatim statements from both sources in relation to key life events
8 and issues that appeared to have an enduring impact on the women's emotional state and social
9 circumstances. We noted all evidence of emotional and/or social issues reported to the Coroner as
10 having affected the women in the run up to their death and from the GP records we were able to
11 extract the same information across their entire life span. We used inter-rater reliability across ten
12 cases to ensure consistency in coding across the researchers. To ensure the maintenance of
13 confidentiality, individuals were given a unique code. In order to protect anonymity we have limited
14 the amount of detail presented here and carefully considered how and what data might be presented.

25 Findings

26
27 We identified 78 women for inclusion in this study. They were aged between 14 and 82 years,
28 average age was 39 years. Records indicated that in 85% (n=66) of cases these women had at some
29 point been diagnosed as having a mental illness; in 69% (n=54) of cases this was described as on
30 going at the time of their death. We provide this information as evidence of the extent to which the
31 explanatory framework for these deaths might have been closed down by a traditional psychological
32 autopsy study focused on the presence or absence of mental illness. A primary objective for us was to
33 go beyond diagnostic labels to examine the social context of these suicides. Therefore in the
34 remainder of this section while we occasionally refer to diagnoses, the foci of our study are broader
35 social issues.

46 *Factors associated with women's emotional distress*

47
48 There were three overarching themes identified in the data; these were bereavement, motherhood and
49 sexual assault. There were also two minor themes; family/relationship issues and deteriorating
50 physical health. It is worth noting that we did not set out to focus on characteristically female issues in
51 our analysis, instead we found that as we undertook our systematic analysis of the available data,
52 these gendered factors naturally dominated our coding schemes. An illustration showing the overall
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spread of these issues across the life span can be seen in Table 1 and a detailed description of these factors follows. We provide only brief details of the minor themes because they did not act independently but were closely linked to the dominant themes.

Table 1: Types of issue identified as contributing to the suicide

	≤24	25-44	45-64	>65	Total
Bereavement (Incl. Bereavement by Suicide)	5 (30%)	10 (30%)	9 (45%)	2 (28%)	26 (34%)
Motherhood	4 (24%)	16 (47%)	3 (15%)	2 (29%)	25 (32%)
Sexual Assault	4 (24%)	9 (27%)	7 (35%)	-	20 (26%)

Bereavement including bereavement by suicide

In 34% (n=27) of cases, bereavement was identified as a partial trigger for the mental distress. In these bereaved cases, half (n=14) were the result of a death by suicide, ten of these cases were a direct family member. In most cases (n=9) this appeared to be a direct and fast acting form of suicide ‘contagion’, that is, the time from the preceding suicide to the death in all these cases was typically short, varying from two days to just over a year. In four cases the data supported the notion that the loss created a long-term predisposition towards suicide, in that when faced with emotional distress suicide appeared to become an option (Lester, 2009). Fincham et al (2011) describe this as a repertoires of action, as how the persons perception of what they might do changed in response to the suicide. Similarly almost half (n=6) of suicides which occurred after a bereavement from natural causes, were events that occurred quickly after having been bereaved.

Motherhood

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3 Motherhood or maternal issues were linked to 32% (n=25) of deaths and in nine of these cases, were
4
5 noted to be a long-term trigger to enduring mental health problems. In the remaining sixteen cases, the
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7 time between onset of psychological distress and death was brief, and thus, had a more 'spontaneous'
8
9 appearance. Problems with motherhood (including but not exclusively infertility and loss of custody)
10
11 mapped closely onto the reproductive life course, with a peak among those aged 25-44 (n=16). In
12
13 those aged over 65, the suicide took place shortly after the women were reported to have lost caring
14
15 responsibilities for their grandchildren (n= 2).
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18 Failed fertility was noted in five cases, two of these women had undergone IVF treatment. In a further
19
20 three cases the women had experienced multiple miscarriages. Notably, no help-seeking had been
21
22 undertaken for the emotional consequences of the failed attempts at motherhood but from the records
23
24 we noted that the suicides took place shortly after a final failed fertility event. In only one case could
25
26 the death of the woman be related to an unwanted pregnancy. Abortion was historically listed in the
27
28 notes of some of the women who died, however, there was no evidence to suggest that the abortion
29
30 histories were a prominent feature in the suicide pathway.
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33 A diagnosis of postnatal depression was recorded in four cases. In each of these, the involvement of
34
35 services permitted us to track some of the events which occurred prior to the death. Two women had
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37 experienced post-partum depression, apparently unrelated to their social circumstances. Family
38
39 members were fully involved in both referring the women for treatment and encouraging their
40
41 engagement with services. In two other cases, postnatal depression formed part of a more complicated
42
43 picture in which alcohol, drugs and social services involvement. According to relatives, this created a
44
45 state of hopelessness. The loss of custody of children was prominent in an additional five cases. As
46
47 might be expected, the loss formed only part of a narrative in that these women were also
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49 experiencing addiction problems and issues relating to family conflict and breakdown.
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51 *Sexual abuse and sexual assault*

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54 It was recorded that twenty-six percent (n=20) of women had experienced some form of sexual
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56 violence, for 13 of these women the abuse had taken place in childhood. In all but one of the cases of
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58 childhood sexual abuse, the perpetrator was reported to be a family member, typically a father, uncle
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3 or brother. In most cases the abuse was revealed after many years and in three cases there was a
4
5 strong correspondence between the death of the perpetrator and a first attendance of the woman at the
6
7 GP in relation to emotional issues. Typically at the point of consultation, the woman presented with
8
9 bereavement issues and it was only later that the full significance of the death was revealed.

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11 In half of such cases (n= 11) the sexual abuse was not reported to the Coroner at the time of their
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13 suicide. Instead these women were noted by the Coroner only to be suffering from severe mental
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15 health problems. However, upon reviewing the GP records it was apparent that all these women
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17 became engaged with services only after the sexual assault. Records were characterised by high
18
19 numbers of attendances at the GP and high numbers of overdose as well as alcohol and drug abuse.
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21 The assault could thus be seen to act as a trigger point for enduring problems which gained no lasting
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23 recovery.
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25 26 *Deteriorating physical health*

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28 Deteriorating physical health was a minor issue in this cohort. In total 6 women were affected.
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30 Although these issues predominantly affected women aged over 45 (n=4), it was never the sole
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32 trigger, but rather combined with issues such as loss of work or inability to care for loved ones.
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35 36 *Coroner's records and women's suicide*

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38 As previously stated, in some cases, we were able to cross-reference the descriptions of the
39
40 circumstances reported in Coroner's records with information contained within the GP records.
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42 However, we were able to identify ten women who had never sought help for emotional distress from
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44 their GP, accounting for 13% of the female cohort. This group were distinctly younger than the rest of
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46 the cohort (ranging from 14-22 years, mean age 17.5 years). Coroner's data were used to categorise
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48 the life events of these women. In six cases family members reported short-term relationship
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50 problems with family or boyfriends as being linked to the suicide. In the other four cases, major life
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52 events for which no help had been sought were identified from family statements; these included two
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54 rapes and two recent bereavements, one of which was bereavement by suicide. These have already
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56 been included in the figures reported in Table 1.
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3 As part of the cross referencing process we also discovered some interesting contrasts in the manner
4 in which mental illness was recorded. There was some qualitative evidence of over representation of
5 mental health problems. For example, on a number of occasions details recorded in the Coroner's
6 office differed with recorded medical consultations. Specifically, it was noted in one case that the
7 woman had experienced "*depression for 11 years*" whereas examination of the GP notes for this
8 woman showed a single consultation for low mood two days before the death. The woman's
9 preceding consultation for mental health had taken place over 10 years prior to the death, when she
10 was discharged from psychiatric services as the episode had "*resolved*". Similarly, another woman
11 was labelled as "*chronically depressed*" in the Coroner's notes on the basis of information collected
12 from family members. However, she had never attended the GP in relation to mental health problems.
13 We discuss the possible implications of these findings in the discussion section.
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25 26 *Discussion*

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28 A decade ago, Scourfield (2005) argued that research was needed which considered masculine *and*
29 feminine identities and the role that gender identity differences may play in suicide. However, since
30 then the literature has been dominated by studies which examine only the role of the masculine
31 identity in suicide. In this paper, we have asked questions about the representation of gender-based
32 suicide by raising awareness of the '*othering*' of women's suicide in historical studies and by
33 illustrating how recent male only studies reinforce the idea that women's suicide are '*incidental*' and
34 '*inessential*' in comparison to male suicide. The rates of suicide in Western societies are higher in
35 males than in females and by comparison the numbers of women's deaths are relatively stable.
36 However, this only partially accounts for the recent trend towards male-only studies. Nuanced,
37 gender-specific approaches in suicide research may provide insights that recognize the need, and
38 allow for the development, of gender-appropriate interventions in order to reduce the number of
39 suicides among women – 1,000 per annum, approximately, in the UK alone (ONS, 2013). It is worth
40 noting too, that approximately half of these women will have been seen by psychiatric services in the
41 year preceding their death compared with only 29% of male suicides (Confidential Inquiry, 2013).
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3 The aim of this paper was to apply the Sociological Autopsy method to a cohort of female only deaths
4 to add to our understanding of the social and personal issues that appear to prompt these deaths. The
5 literature suggests that while mental illness is the predominant factor in suicides of both genders, it is
6 strikingly dominant among women's suicide (Qin et al., 2000). It is possible that our study only
7 serves to reinforce and reiterate these findings. Thus, 69% of these women had diagnostic labels
8 which may have been sufficient in a Psychological Autopsy study to account for their death.

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11 However, Hjelmeland & Knizek, (2010) are critical of simplistic biomedical explanations, demanding
12 instead, rigorous qualitative approaches that reflect the complexity of suicidality. Our Sociological
13 Autopsy analysis shows the dangers of using qualitative documentary data that is dominated by
14 professional biomedical perspectives for this purpose. By re-centering social issues, however, we
15 have also shown it is possible to allow for contextual depth to the female experience that is otherwise
16 lost.

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19 Our use of GP data written prior to the death means our analysis is less subject to the repetitive
20 emphasis that situates women's suicide within established 'truths' (Cannetto and Lester, 1998). Issues
21 of bereavement were noticeable across the lifespan; this varies from previous research which found
22 such issues increased with age (Shiner et al., 2009). Some of the issues prominent in these cases also
23 vary from those traditionally associated with women's suicide and there was some evidence that
24 Coroner's files were likely to contain over emphasized accounts of mental ill health or issues such as
25 relationship breakdown which is stereotypically associated with female suicide (Cannetto, 1992-1993;
26 McAndrew and Garrison, 2007). Our data suggests this finding may be intimately related to nature of
27 data within Coroner's files because it is collected from relatives and GP practitioners after the death
28 has taken place, for the purposes of ascertaining the cause of death (Langer et al., 2008). By contrast,
29 the application of Sociological Autopsy methods to GP records collected over the lifetime of these
30 women may be particularly appropriate to women's studies of suicide. High levels of help-seeking
31 mean such records are a comprehensive source of data which can be used to contextualize the mental
32 health diagnoses which might otherwise be reported to the Coroner in isolation from their social
33 context.

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3 We have also highlighted how some areas such as sexual violence and issues relating to infertility,
4 were under reported in Coroner's data. These findings are intriguing; they mean that certain
5 normative biomedical discourses (for example menstruation and pregnancy) are privileged over
6 others. Suicide has consistently been identified as the leading cause of maternal death (Oates, 2003).
7 However, it is also known that suicide risk decreases with increasing number of children (Hoyer,
8 1993). Here, we identified how in some cases the failure to become a mother had a significant impact
9 on the mental health of these women. The importance of managing women's emotional responses to
10 issues of infertility may be significant and responses are currently in their infancy with government
11 guidance in the UK only recently calling for research in this arena (NICE, 2013).
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22 The medical framework for understanding the suicides of women who had been the victim of sexual
23 assault was particularly notable. Our finding is supportive of previous studies that suggest female
24 suicide sometimes takes place in the context of serious neglect and/ or abuse by the significant male
25 figures in their lives (Canetto & Lester, 1995; Stephens, 1988) and provide further evidence that such
26 trauma needs specific intervention at an early point in time. Our research found that half of the cases
27 of sexual abuse noted in GP records were not reported to the Coroner at the time of their suicide.
28 Instead, these women were noted by the Coroner only to be suffering from severe mental health
29 problems disconnected entirely from the sources of emotional distress, leaving a more sanitized
30 version in which the role of violence is expunged from official reports. It appears likely therefore that
31 the use of Coroner's data alone in suicide research leads to an under reporting of unresolved trauma of
32 sexual violence as a trigger to mental distress. This finding may be a recording or investigatory error
33 that is unfounded in gender bias, however as previously studies have suggested, we speculate that the
34 Coroner's process prioritizes medicalised accounts of the suicide (Langer et al., 2008; Prior, 1989)
35 and we repeat Atkinson's (1977) call to question the use of Coroner's records as a source of data on
36 psychiatric conditions.
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In summary, analytic approaches, such as those critiqued by Hjelmeland & Knizek, (2010) thus fail women because they do not take into account the social nature of the trauma that may trigger their mental ill health. In cases of sexual violence, it is misrepresentative to describe these women as being

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3 mentally ill without contextualizing their lives with the background of abuse. Similarly, it is
4
5 inaccurate to describe women who have complex reactions to issues relating to motherhood or
6
7 infertility as simply suffering from depression. It would appear from the data here that the social
8
9 sequelae of such events are inadequately being addressed by services. This is perhaps in direct
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11 contrast to current models of prevention for male suicide that suggest alterations in social factors are
12
13 particularly suited to suicide prevention (Shiner et al., 2009).
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16 There are a number of limitations to the study beyond those we have already highlighted in our earlier
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18 consideration of documentary data. In general terms we have a relatively small cohort of 78 women.
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20 However, female-only studies of suicide are rare and this cohort is reflective of the numbers included
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22 in similar male only studies such as Shiner et al (2009). In addition, we do not infer these experiences
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24 are representative of all women who die by suicide. For example, there may be important cultural
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26 differences in terms of both the particular issues presented by females and the proportion of
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28 individuals experiencing them (Cannetto and Sakinofsky, 1998). There are also some notable
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30 absences in the data from groups of women, such as adolescents and prisoners, who have been
31
32 identified as being particularly vulnerable to suicide (Russell & Joyner, 2001; Moore and Scraton,
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34 2014). In addition, our original study design did not include the collection scales Scourfield et al
35
36 (2012) suggest may add methodological rigor to this type of sociological based account of suicide.
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38 Our analysis may therefore be limited in the sense that the data collection and variable-based coding
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40 was open to interpretation by the researchers. In response to this, we have limited our speculation on
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42 the contribution that particular life events made to the suicide but have instead tried to follow a
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44 pathway approach.
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47 Finally, our data suggests that accessing and analyzing data from multiple sources, using alternative
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49 methods such as the Sociological Autopsy approach, has the potential to expand our understanding of
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51 suicide beyond traditional bio-medically driven explanations. The findings reported here also suggest
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53 that different sources of documentary data may generate different types of explanation of suicide.
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55 However, our experience of data collection and analysis on this study also lead us to the conclusion
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57 that although these accounts may complement each other, in some instances they will problematically
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3 differ from each other. It is beyond the scope of this paper to comment further on this issue or to
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5 suggest if this is a feature of female accounts. Nevertheless, if the value of multiple sources of data is
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7 to be fully exploited in future Sociological Autopsy studies, we suggest research is urgently needed to
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9 explore the relationship between these different kinds of data and to suggest the best ways of
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11 combining them.

12 13 ***Conclusion***

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16 Our study highlights some of the residual mechanisms that underpin suicide research, in particular a
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18 reliance on documentary data, leave women vulnerable to an underlying and troublingly masculine
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20 discourse (Jarowski, 2014). Under this discourse, it is implied that male death by suicide is an
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22 indication that masculinity is visibly in crisis. By contrast, female death by suicide is largely invisible
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24 and can be accounted for by an increased propensity towards mental illness which is unrelated to their
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26 gendered identity.

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29 Analysing the lives of women who die by suicide, using methods which excludes the social nature of
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31 their distress, is unhelpful to practitioners and in light of the rise of social studies into male suicide, is
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33 discriminatory to the female gender. Simplistic explanations, such as those currently offered for
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35 female suicide, cannot be maintained if we are to contextualize the lives of these women in a way
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37 which will help to further reduce the rate of suicide in this group.

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39 Petersen (1997) and Fullagar & Gattuso's (2002) call for a broader range of analytic approaches to
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41 counter the ways in which women's experiences are made invisible within public health policy. To
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43 conclude, we echo this call and expand it into the field of suicide research. Further sociologically
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45 driven analyses are urgently needed which incorporate and extend the methodological rigor of the
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47 Sociological Autopsy approach. A move towards enhanced, narrative understandings of female
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49 suicide will help support and develop the translation of such findings into innovative policy and
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51 practice.
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