

The Gender Paradox and Stories from the Edge of Living

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Abstract: *In most countries where there has been a developed epidemiological interest in suicidal behaviour, there exists a gender paradox, where male rates of suicide exceed those of their female counterparts. Paradoxically, females deliberate self-harm and contemplate suicide more than men. This gender paradox is well discussed and documented in Ireland and elsewhere, but serves as a springboard into the discussion of ethnographically collected data about the difference between men's and women's stories from the edge of living, where suicide and deliberate self-harm are seen as real options. This paper concludes that ethnography has a part to play in our understanding of suicide as being part of larger tension between feeling part of 'normal' society, and that there are very real differences between men and women in narrating their stories from the edge of the living.*

Key Words: *suicide; gender paradox of suicidal behaviour; ethnography; narratives; cultural scripts; lethality; socialisation; 'numbness' and 'rassell'*

Introduction

There have been historical incidences where populations have been politically blinded to the rates of suicide and associated behaviour; for example, in China, records were not made available to the public until 1989 (Pearson & Liu 2002). There have been examples of serious under-reporting of suicide rates which makes it difficult to understand their rise and fall historically (Walsh 2008). In Ireland, suicide and mental health promotion have become the cornerstones of models of prevention and debate, (NOSP 2009) and are a sharp contrast to the politically-hidden, under-reported and legally-sanctioned suicides of the past (Sheehan 2003). However, there are still areas of the world where little is known about suicide rates. For example, suicide on the continent of Africa is almost undocumented, and parts of Euro-Asia, Oceania, and South America present little or no data on suicide rates.

With that in mind, every year, almost one million people die from suicide, accounting for a global mortality rate of 16 per 100,000. Over the last 50 years, there has been a sharp increase in suicide rates of 60% globally, and it is also estimated that the rate for suicide attempts is twenty times higher than completed suicides. In Ireland, there has been a keen political interest with the establishment of various task forces (such as the National Task Force on Suicide Prevention established in 1996) to deal with mental health promotion and suicide prevention. In addition, there have been commendable research and health promotion offices established, for example, the National Office of Suicide Prevention (NOSP) and the National Suicide Research

Foundation (NSRF). Pearson and Lui (2002), note that international attention focused on suicide rates in China when records were made publically available in 1989, and there was considerable reaction to the higher rate of female suicide.

Comparisons can be drawn between Ireland and China, where a collision of forces focused international attention on suicide rates in Ireland. Underreporting was commonplace, for both structural and cultural reasons. Suicide was not decriminalised until 1993 - perhaps an outdated hangover from British rule, but a deterrent none the less - and a consideration for coroners, medical clinicians and the police who all have a role in determining causes of deaths in Ireland. Following changes in reporting structures and decriminalisation, it became clear that young male suicide rates were a cause for concern in Ireland, as are female suicide rates in China.

Rates

In Ireland, there is a comparatively moderate rate of suicide accounting for, on average, 400-500+ deaths per year, or 9.2 per 100,000. Out of 26 EU countries, Ireland is ranked 20th with Lithuania having the highest rate of 30.5 per 100,000, and Greece the lowest rate at 3.5 per 100,000. However, when examining the 15 to 24-year-old male suicide rate, Ireland is ranked 4th, with 14.4 per 100,000; again, Lithuania is highest with 20.1 per 100,000 and Malta is the lowest with less than 1 per 100,000. Greece is the second lowest with 3.5 per 100,000. These figures do not convey the impact that high rates of youth male suicide have on the collective consciousness of local and national populations. When conducting research during 1999-2003, it was clear that people I spoke with believed that rates were nowhere near the true level of suicides, and these documented suicide rates - as opposed to what people believed to be the true level - were being described as an epidemic (Sheehan 2003). I observed that people often associated death caused by external causes (for example, overdoses, road traffic accidents, murder) with suicides, as being a risk to young men. There was a strong local sense that young men were dying needlessly. Among the people I did my research with, there was a collective grouping of all deaths, regardless of cause and year of the event. The following exchange exemplifies this collective grouping of deaths. A young man died of an overdose, and, after the funeral, the following conversation took place among a group of men:

'Name all the people that have killed themselves?'
Ben answered, 'Turkey, Marksy [overdose].'

Then Lee said, 'Redo', and then another, 'Shaker [accident] and Matty [overdose] and Phillo and that fella [sic], you know, Will's brother' [disputed suicide]. 'Then there was John, he died of an overdose, but he was well used to it, and then there was Mark, and the fella [sic] that went to prison, and he died then after that.'

As Will - one of my sources - explained about the estate that he lived in all his life (as did all those mentioned above) 'This place is the place of the dead, so many young people have died, it is like death row'.

These exchanges and conversations were a striking example of how ethnographic research can illuminate collective memory about suicide and death and, perhaps, provide an explanation regarding the sense of suicide epidemic that people experience and convey.

The Gender Paradox

In part, the collision of social events which has made suicide in Ireland a predominantly male problem, has overshadowed the levels of deliberate self-harm and suicidal behaviour among the female population. In Ireland and Western Countries, deliberate self-harm rates are often higher among women than men. The rate of suicide, for example, for men and women in 2010 in Ireland, was 486 (10.9 per 100,000) and 100 (4.4 per 100,000) respectively. In 2010, there were almost 12,000 presentations for deliberate self-harm in Irish hospitals, equating to a female rate of 231 per 100,000, and a male rate of 205 per 100,000. It would be unimaginable for socio-moral, cultural, and economic consequences, if all those engaging in self-harm resulted in deaths. It must also be noted, that the gap between female and male rates of deliberate self-harm, has narrowed from 37% in 2004-2005 to just 13% in 2009-2010.

The high rate of deliberate self-harm amongst women, when compared to the rates of suicides, is called the gender paradox (Canetto & Sakinofsky 1998). As with suicide rates, caution must be taken when considering the universality of the gender paradox of suicidal behaviour. This is similar to the argument about global figures of suicide rates as Canetto argues.

Some consider the gender paradox of suicidal behaviour to be a manifestation of basic differences in the nature of women and men. In reality, the gender paradox of suicidal behaviour is not constant within or across countries, especially when factors such as age or ethnicity are considered. It is also important to note that national suicide mortality data is available only from about half of the world's countries. Furthermore, the data on suicidal behaviour, including the World Health Organization (WHO) national suicide data, comes from selected, primarily industrialized, countries. Thus, based on available data, the gender paradox of suicidal behaviour appears to be a dominant, not a universal pattern, suggesting the importance of cultural perspectives on suicidal behaviour. (2008:259)

The gender paradox of suicidal behaviour is the dominant pattern in Ireland. However, there are countries (for example, China), and small-scale societies, where the pattern is inverted, and more women die from suicide than men. In Ireland, the gender paradox of suicidal behaviour is becoming less clear and, if the trends continue, it is easy to imagine Irish males dying by suicide and engaging in deliberate self-harm more than their female counterparts. Rates and patterns change, and as Lee and Kleinman point out: 'Even if two societies have the same suicide rates, the local causes, meanings and impacts of suicide can still be quite different. As a social index, suicide may therefore be indexing different things across different communities' (2003:296). In the case of Ireland, there is also evidence to suggest that suicide as a social index and associated causal factors may be locally variable.

There was widespread variation in the male and female deliberate self-harm rates when examined by city/county of residence. The male rate varied from 104 per 100,000 for Leitrim to 484 per 100,000 for Cork City. The lowest and highest female rates were recorded for Roscommon and Limerick City residents at 136 and 416 per 100,000 respectively. (NSRF Annual Report 2011:1)

Following Lee and Kleinman's (2003) assertion of different social indices, the gender paradox of suicidal behaviour in Ireland is variable across different communities. This variation of rate may diminish the validity of the gender paradox of suicidal behaviour. However, the variation is within the parameters of the pattern, and is epidemiologically important. It is the contention of Canetto (2008) and Canetto and Sakinofsky (1998) among others, that the gender paradox of suicidal behaviour is best analysed through cultural scripts. The gender paradox is a culturally scripted pattern of behaviour, and in the case of Ireland, men die more by suicide, and women engage more in suicidal behaviour, variations aside. There has been considerable interest in explaining the gender paradox. For example, Mościcki (1994) argued that the gender paradox could be explained by four possible reasons: lethality, recall bias, differential rate of depression due to alcohol abuse, and socialisation. In this paper, I will discuss lethality and socialisation. For a more detailed review, see Mościcki (1994), and Canetto and Sakinofsky (1998).

The Gender Paradox, Methods, Lethality and Intent

In Ireland, the most common means of suicide for both men and women is hanging, which is more common in males (64%) than females (43%). It is more prevalent in younger cohorts, with drowning the most common in older cohorts. The use of other methods, such as drug overdose and cutting, are also common among men and women. While hanging is the most common method of suicide among females (43%), poisoning and drowning combined, account for half of all female suicides. In cases of deliberate self-harm, overdose is

the most common method. In 2011, drug overdose accounted for 69% of all acts, with more women (75%) than men (62%) overdosing. The second most common method of deliberate self-harm was cutting, accounting for 25% of registered acts, with men accounting for 27% and women 22%. Attempted hanging accounted for 6% of all deliberate self-harm, with men three times more likely to choose this method than females. Central to the lethality theory as an explanation of the gender paradox, is that it is an artefact of different rates of survival from suicidal acts, as men choose more lethal means, and are less likely to survive or be rescued, whereas women are more likely to be rescued or to survive. The difficulty with the lethality theory is that it does not take into account the intent of the individual. Intent and lethality are not easily equated as Canetto and Sakinofsky explain:

[. . .] suicide method is not a substitute measure of considered intent. The same method may be used with very different intentions. A low-lethality method may be associated with high death intentionality, and a high-lethality method may be used on sudden impulse by someone whose considered desire would be in favor of life.' (1998:9)

It is also conceivable that there is no one single intention associated with a suicidal behaviour; in my own research, sources often discussed multiple intentions, as Stephens (1995) explains: 'Most behaviour rarely arises from a single intention but it is accompanied by a complexity of purposes' (1995:91). Moreover, from my research, it was clear that all the suicide attempts involved a vision or imagining of the reactions of others to their death. The lethality - at first glance - is a promising explanation of the gender paradox. However, it does not consider intent as a variable, and is not constrained by lethal or non-lethal means, as one source explained to me: ' . . . I wish I was dead, I often hold my breath while lying in bed waiting to die, or I stop eating for a few days at a time . . . I wish I was dead' (Sheehan 2003).

The Gender Paradox and Socialisation

Several authors have argued that suicide is viewed as a masculine behaviour, whereas deliberate self-harm is more feminine. It has also been argued, that at the core of this gendered bias, is the belief that suicide is unsuited and unnatural for women. This argument is central to Durkheim's thought on the gender paradox: 'Being a more instinctive creature than man, woman has only to follow her instincts to find calmness and peace.' (Durkheim 1951:272) By positioning women as being less civilised, and acting instinctively, Durkheim argues that women are 'less concerned with civilizing process . . . [She] thus resembles certain characteristics found in primitive culture' (1984:192). According to Canetto:

A corollary of this theory is that women were assumed to be immune to suicide as long as they acted 'like women', that is as long as they stayed subordinate to men within 'traditional' institutions. By contrast, women who acted 'masculine', that is women who ventured into such masculine activities as education and employment, would do so at the risk of becoming suicide casualties, like men. (2008:261)

Canetto goes on to point out that authors in the past have argued that women were unable to plan their own deaths as they became hysterical, and have borderline personality disorders. Women are more at risk if they move away from more traditional roles and enter employment. They are susceptible to suicide attempts for trivial reasons, and are more open to suicide attempts following the ending of a relationship. Men were not presented in this light.

Jean Baechler presents this view of women, and their disposition towards non-fatal suicidal behaviour:

Women endure misfortune better than men. Their social roles require them to face unbearable problems less frequently. As daughters, wives and mistresses, and conforming to the dependency which nature and culture encourage, women have a greater tendency to reach their ends by the threat of trying to kill themselves . . . Dangerous and aggressive behaviour generally is not characteristic of women. (1979:291)

I do not endorse this view of women. On the contrary, it has been shown in numerous studies that men and women equally attempt suicide after the ending of a relationship (I also observed this in my research) and that employment is a protection factor when considering suicide ideation and risk. Is it possible however, that these prevailing and historical notions associated with fatal-male suicide, and non-fatal suicide (the feminine 'cry for help') have come to be the cultural scripts associated with the gender paradox of suicidal behaviour? As Canetto and Sakinofsky explain:

According to the 'socialization' theory, the gender paradox in the epidemiology of suicidal behaviour, flows from these gendered narratives of suicidal behaviours. It is suggested that women and men will tend to adopt the self-destructive behaviours that are congruent with the gender scripts of their cultures. (1998:17)

Similarly, Wolf, in her early study of female suicide in China, points to the importance of cultural scripts: 'In the West, we ask of a suicide, "Why?" In China, the question is more commonly "Who? Who drove her to this? Who is responsible . . . ?" For a woman, it is the most damning public accusation she can make of her mother-in-law, her husband, or her son.' (Wolf

1975:112). This is not to suggest that cultural scripts on gendered suicidal behaviour simply allow for a woman to die by suicide. Quite the reverse, in fact. This death is a last resort, as Lee and Kleinman (2003) explain: 'Whatever the individual motives involved, suicide is often seen to be a rejection of everything in society on the level of cultural production, and compels the members of society to doubt its core values' (2003:297). Is it possible to understand and trace these cultural scripts?

Lee and Kleinman go on to argue that - depending on the observer - there is much bias and contextualisation of cultural scripts:

Depending on the observer's disciplinary bias and discursive context, the life of a suicide examined microscopically can support different causal interpretations: depression and/or borderline personality disorder for a modern psychiatrist, negative cognition for a psychologist, anomie for a sociologist, patriarchy for a feminist, or change of local meanings for an anthropologist. (2003:294)

Observational Bias

The local meanings of suicide and self-harm that I set out to explore in Dublin from 1999-2003 were found in the lives of men and women with histories of mental illness, psychiatric disorders, drug addiction and people with 'normal' pathologies and lives. Looking back, it was a mishmash of ethnographic encounters. It wasn't simply contextualised by my own observational bias, but directed by my contacts who considered suicide to be as a result of a psychiatric disorder, diagnosed or undiagnosed. For this reason, I contend that observational bias is not restricted to discipline, but also includes personal belief, access to sources, and the prevailing dominant ethos in Ireland at the time of conducting research, i.e. that suicide and self-harm were caused by psychiatric disorders. Even if I contested, and, at times, rejected the medicalization of suicide, the dominance of medical models impacted on my own observational bias and, perhaps, became a boundary within ethnographic observations. I observed the gender paradox first hand during my research and in the subsequent years after completing my PhD, where all my male sources - whom I spent time with getting to know, interviewing, and later acting as their drug counsellor - are now dead (suicide, homicide, and overdose) or in prison. It is a humbling fact that of the twenty men I spent time with, none achieved what they so dearly wanted - a 'normal' life, a sense of integration and social value. The women I interviewed, and spent time with, have all survived, despite they having had diagnosed psychiatric disorders, addictions problems and brutal pasts.

In the next section of this paper, I will follow two narratives - one male, one female - and discuss the validity of the gender paradox, and the cultural scripts associated with suicidal behaviour.

'Numbness' and 'Russell' (Wrestling)

Both Linda and Bon are from the same estate. Their houses are no more than one hundred metres apart. Linda is slightly older, and was once married. Bon, like Linda, had children. He had an on-off relationship with his partner, with whom he has a young son and an older child from a previous relationship. Bon had been in and out of prison and had a history of addiction. Linda had a history of mental 'breakdowns' and had regular contact with the psychiatric services. The following narratives show that there are gendered differences in the choice of language, in notions of normality and abnormality, and in perceptions of suicide and the lasting impact of a suicidal attempt.

I interviewed Bon on a number occasions. He was a vocal man who had opinions on nearly every subject. Bon explained that the move towards suicide or suicidal ideation was like the winding of string, the piece winding tighter and tighter. Bon, in his words, got involved needlessly in a 'tit for tat' personal war with a local drug dealer. It escalated to the point whereby they were taking pot shots at each other openly, attacking each other's homes and property. As Bon depicts:

I was going around armed. I was sleeping in different gaffs, and I had a knife and gun on me. People must have known. I would be sitting on the bus with a shot gun up my coat or my sweater. I went to this guy's house one day with a hatchet. I break the window in his car; I get on the roof and I 'hatchet' that. He is taking shots at me from the window.

Eventually the strain took its toll on Bon. He was sleeping in different houses every night, and carrying a knife, shot gun and hatchet. He then found himself in his father's home, with his family screaming through the letter box as they witnessed him step close to the edge of living.

How did I end up with a shot gun in my mouth? How did I end up on the edge of living? The day I put that [gun] in my mouth . . . and I had a shotgun in my gaff at that time and other things as well and I was robbing things with other people and things went missing and the person that took them was the psycho... me [sic] mind was just messed up. I know tha' much and I just gave up and I remember sitting on the stairs saying it was just too much, no matter where you go or what you do, there was no way out. I couldn't see any future and you know the way people say that "it will be better tomorrow", but you can't see fucking tomorrow. You are in that black bleedin' space, tha' black hole and it is there at tha' moment and every minute is an hour and so like how can you see into tomorrow? How can you see any fucking brightness coming or any fixtures happening? Because at that very

fucking bleedin' moment, you can't see past your eyes, you can't see past your nose. It is just gone, you are in the moment.

He went on to explain that this was not his only suicidal attempt.

It was like a rassell [fight or wrestle] in your head. I cut meself [sic] a few times, I even planned accidents in the house, and I set a local school on fire hoping to die in the fire, [I] burnt down the school to nothing. The rassel, it is . . . you know . . . it is a winding of string, getting tighter and tighter and then, bammm . . . it snaps . . . then you are in the moment.

All the men I spoke with for my research, explained their suicidal behaviour as being a fight in the mind, and framed their narratives in the context of not being part of 'normal' society. All the men rejected the notion that they were suicidal, and when I asked them to explain their suicidal attempts, they would all respond by shouting, 'I am not fucking suicidal!'. Once over, the suicidal attempt for the men receded into the past; the fight or 'rassell' was over, and they were extremely reluctant to narrate their experiences in the context of mental health, or their current identity. It was a past action, and, at times, I was a burden to them, asking questions of moments (albeit important) in their lives, which did not pertain to the sense of self.

I met Linda through the psychiatric services. Linda lived with her youngest son. Her marriage had ended badly and with great animosity, but the defining characteristic of Linda's narrative, and perhaps the root of her psychiatric problems, was the disappearance of her eldest son, who is still missing. She told me that she had become numb to the world, and became fixated on death.

Do you want me to explain how I went from normal to suicidal? I've tried to kill myself eight times. A couple of weeks ago, I tied a rope around my neck, I still wish I had died. But I didn't have the nerve. Maybe men can only do this; they seem to be more violent? It is like you can't do normal and you get this feeling in you . . . it is in your stomach. Well, I know the signs now. First of all you don't want to talk to anybody and you find yourself turning off the mobile, then you start giving the kid the key to the house so you don't have to get up and answer the door. Then you don't want to get dressed and you eat a lot of chocolate for some reason or you don't want to eat at all and you just want to stay in bed, and never wake up. I just want to shut off the rest of the world. You get a feeling in your body and the world is crap and that is it and then you get a feeling it is like . . . like you get a 'numbness' in your stomach and then it's all over

you and then you don't want to talk to anybody and then you can't handle anything. When you are like that you just can't handle big things, but everything is a fucking problem . . . so you are just numb and everything around you is numb to the world."

Numbness, as described by Linda and all the women I interviewed, was first located in the stomach, and this led gradually to a lack of appetite for bodily care, sexual gratification, and social contact. The numbing of the sensations - as described by the women - was a slow and absorbing process. The women vividly recounted the sensation taking over their bodies and their social lives. They expressed an understanding of their suicidal attempts as being valid to a creation of their personal histories and identities; they did not reduce their numbness to an artefact of the past. The men dismissed their actions as momentary, and did not see any value in their actions. Those actions were in the past and not part of their identity. The winding of the string, the growing tension, the emotional pain, as they all had described, ended with the attempted suicide or, as Bon described it, 'Being the moment, not being able to see past your own face'. Are numbness and 'rassell' part of the gendered cultural scripts associated with suicidal behaviour in Ireland, or at the very least in the estates where my sources lived? Is it possible to draw conclusions that men and women experience suicidal behaviour differently? Are the men and women acting within the cultural scripts associated with suicidal behaviour? Are men predisposed to violence, and have women learned the importance of the suicidal narrative to their own identity? It is perhaps beyond ethnography to answer these questions, but it is in this questioning that ethnography smashes head on into humanity's uneasiness with simple categorisation. Suicide and self-harm are never black and white; they are multi-layered, imbued with all the depths of human imagination and suffering. It is an epidemiological fact that the gender paradox of suicidal behaviour is evident in Ireland, and it is probable that these patterns are important to the (cultural) scripts that dictate the cultural and social norms of suicidal behaviour. Linda, who attempted suicide eight times, unintentionally explains these cultural scripts: 'A couple of weeks ago, I tied a rope around my neck. I still wish I had died. But I didn't have the nerve. Maybe men can only do this; they seem to be more violent!'

The majority of men in this research are dead. The women, who accepted their narratives, are no longer living on the edge. As Linda told me in 2006, 'I am not like that anymore, I know I was normal then, but I don't wish to die anymore'.

Conclusions

Bound to the macro narrative of suicide in Ireland are the efforts to prevent and stop as many people dying by suicide or deliberately self-harming. It

makes economic and social sense to have preventive campaigns, aimed at de-stigmatising mental health and suicide, by having open discussions and to be socially inclusive of those who have mental health problems, as ably demonstrated by the recent Amnesty International campaigns. For example, the banner line in one of the posters seen throughout Ireland during 2012 reads: 'Caroline survived suicide. The gossip left deeper scars.' However, inclusion and social acceptance of mental health conditions and suicidal behaviour are still dominated by the larger macro narrative that depression and psychiatric disorders (diagnosed and undiagnosed) are the root cause of suicide. As Lee and Kleinman argue:

Current medical research on suicide, such as case-controlled studies of risk factors or psychological autopsy studies, uniformly conclude that suicide is the result of depression or other psychiatric disorders. From an anthropological perspective, such studies fail to attend to the layers of privacy and equivocality that typically envelop suicide, or to evaluate the consequences of suicide on the socio-moral processes that maintain suicidal behaviour in a local world. (2003:313)

For the men and women in my research in the estates of Dublin, the socio-moral processes were bound to tensions between what people perceive as being part of normal society. The men lamented their unease with society, how they had not achieved a standard of occupation and social standing. They 'rasselled' within themselves as much as they did with others. The fight, the 'rassell', was an internal strain, winding tighter and tighter, until they found themselves sitting on the edge of the stairs with a gun in their mouths. For the men, it was a deep seated feeling of being lost, without a social or, at times, a moral anchor, that caused the deepest internal fight; and most of these men lost their fight. For the women, being normal was a demonstration of self-belief; that despite the psychiatric care, the endless stays in hospital, the repeated overdoses, the cutting and the numbness, they believed uniformly that they were not insane, but normal in the context of their socio-moral worlds. They did not reject the help of their doctors and community mental health nurses; they embraced their mental health as being normal. As Linda pointed out to me more than once: 'What the fuck is normal? I mean you sit and listen to me all the time, and I think that's nuts!'

Ethnography is not a perfect discipline; it is nothing without the trust and the belief of one's sources, and the people that you meet know that your interests are genuine. Often - as ethnographers - we have to forgo our own moral compass, and shed all our ideals, our naïve understandings and prejudices, to be able to hear the narratives about an ever-changing and challenging human world.

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