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Migrant Suicide: A Case for Intersectional Suicide Research

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Abstract

It has now been recognized that official suicide recording, reporting, and prevention in the United Kingdom is lacking intersectional analysis (Cohen, Katona, & Bhugra, 2020). By recording age and sex but not ethnicity, death certificates hystericize a male suicide 'crisis' while perpetuating colour-blindness (El-Tayeb, 2011). But while intersectional suicide recording will lead to more representative reporting and more targeted prevention, the very foundations of suicide: its meanings, understandings, and performances are deeply embedded within colonial structures of inequality, and if not interrogated, 'adding' intersectional statistics will not be enough to reimagine suicide practice, research, and prevention.

Key words: Antipsychiatry, colonization, critical mental health, critical suicide studies, decolonization of suicidology, discourse analysis, intersectionality, labelling theory, migratism, narrative analysis, qualitative methods, racism, social deviants, suicide

What Can Qualitative Suicide Research Bring?

Tuhiwai-Smith (2012), an indigenous researcher, states research is probably one of the dirtiest words in the indigenous world. Scientific research has a 'dirty' colonial history, with its development in the West necessitated by the creation of the Orient (researched) and the Orientalist (researcher) vis-à-vis the research relationship (Said, 1978). Scientific research has become a central tenet of the West's supposed superiority in comparison to the 'non'-West, at the expense of the colonization, subjugation, and classification of indigenous people's bodies and minds. Quantitative research has

dominated because of scientific research's positivist lens: thought to be more robust via its ability to distance from research, therefore achieving status of objectivity and impartiality.

To meet these rigorous standards of scientific research, qualitative researchers have been required to lay out their positionality as though on a plate, putting forward their biases and what they hope to gain from their research, as if this can be known (Finlay, 2002). Bantjes and Swartz (2019) caution their fellow qualitative researchers for favouring personal narrative, a qualitative movement away from the more rigid statistic-gathering quantitative methods. The authors argue centering narrative accounts assumes there is an objective authentic reality 'out there' to be found by the researcher, that narrative accounts are subject to imperfect memory and are only ever partial at best. But a positivist lens has prevented the authors and many other researchers from realizing that all research is subject to positionality, preference, and exclusion. They miss the point that critical qualitative accounts add nuance and depth. Mazzei and Jackson (2012) refuse to "Let Participants Speak for Themselves";–instead of disregarding narrative as partial and therefore somehow lesser than quantitative research, the authors adopt a post-structural lens, situating narrative accounts as contextual, fluid, and subject to the relationship between researcher and researched, rather than assuming the researcher has the power to 'let' the researched speak their single truth.

Two-Dimensional Suicide Research

So it is clear that qualitative research has a somewhat precarious position within scientific research. My research project starts from a point of 'flawed' quantitative research and seeks to use qualitative methods to enhance this area. In the United Kingdom, death certificates record age and sex, and the Office for National Statistics records suicide based on these (Ons.gov.uk., 2016). Thus we are told there is a male suicide 'crisis', a 'crisis' of masculinity, particularly among middle-aged men, sparking debates on whether men are on the one hand victims of feminism (see Jordan and Chandler, 2019 for a critique of 'traditionalist' debates on women having reached equality) or on the other and more prevalent in mainstream suicide prevention campaigns: victims of masculinity (see Chandler, 2019 for a complication of the oppression/privilege dichotomy). Particularly exemplary of this is CALM (Campaign Against Living Miserably) whose 2019 male suicide campaign tell men #DontBottleItUp. Such campaigns are common among suicide prevention charities (see also Samaritans, 2016) and reify gender stereotypes of women as open and emotional and men unable to

deal with their feelings[1].

But death certificates do not record ethnicity or migrant status (Cohen, Katona, & Bhugra, 2020), so we are not graced with a plethora of suicide prevention campaigns on suicide inequality among ethnic minority people; instead, the men in the male suicide crisis are assumed to be the universal white male (Jordan & Chandler, 2018). There is a growing body of literature finding ethnic minority people and migrants are more likely to die by suicide than white or 'host' communities in the UK (Forte et al., 2018), and an even bigger body of literature on mental health inequality among ethnic minority and migrant people (Bhui et al., 2018). The failure to record ethnicity and migrant status on death certificates (and the subsequent prevention campaigns such reporting would bring) could be read in a number of ways. As I see it, it results either from a wish to perpetuate the myth of whiteness in Britain (Tudor, 2017), or willful racism (Bhui et al., 2018).

Alternative meanings of suicide

The inadequate (non-intersectional) statistics available calls for intersectional qualitative suicide research to substantiate the gap in suicide recording, reporting, and prevention. This is the reverse of what is often called triangulation: whereby qualitative methods are required to legitimate their findings with quantitative methods. Such practices demean qualitative methods as powerful in their own right.

My father is a second-generation migrant who died by suicide when I was young, and most of my ideas or 'knowledge' about him I have learnt as I have gone along, since his passing and as an adult researching suicide. Before I started my research as a post-graduate student, I had not thought of my father as a migrant, and when I first heard of his death he had died in a car 'accident'. As a method, writing makes unambiguous the power of narrative to shape our discursive realities. We can only imagine and 'know' within the limits of what is available to us. The study of suicide, known as Suicidology to reflect its authorship by scientists and medical professionals (see Marsh, 2010) cannot be divorced from scientific research's colonial roots and as such has dominated understandings of suicide since the seventeenth century (Marsh, 2010). Now pathological: before being decriminalized it was sinful and prior to that its meanings were plentiful (Macdonald & Murphy, 1990). As a discourse,

[1] For discussion on the focus on preventing stigma to prevent suicide, see Marzetti (2021); Oaten (2021)

suicide as reduced to its association with medicine has become "so taken for granted as to be invisible or assumed" (Cheek, 2004, p.1142). Suicidology's monopoly on suicide research and understanding has been secured using the authoritative power of statistics, so disrupting suicide recording and reporting statistics opens up a space for new types of suicide: meanings, experience, and research (Hjelmeland & Knizek, 2010; White, 2017).

The majority of research on the suicides of ethnic minority or migrant people has found these groups to disproportionately experience suicide, but these 'inconsistencies' have more often than not been 'explained away' via cultural difference (Cochrane & Bal, 1987). These studies are stilted by colonial amnesia because they can only rationalize high suicide rates among ethnic minorities as being due to the receiving countries' high rates of pre-existing mental illness (Forte et al., 2018; Lipsedge & Littlewood, 1997). Studies on second-generation migrant suicide – the children of migrants – disrupt these 'causal explanations' since second-generation migrants are born in the UK (Forte et al., 2018; Polanco-Roman & Miranda, 2021). Mental illness and suicide inequalities cannot be explained away via physical migration or a failure to integrate since they were born and raised here (Bhugra & Jones, 2001). Instead, such studies point to 'host' cultures and 'host' communities as productive of the mental health and suicide inequalities in their home countries. While many critical suicide researchers have tried to move away from associating suicide with mental illness because of suicidology's 'compulsory pathology of suicide' (Marsh, 2010), it is a legacy of the reduction of suicide's multiple meanings to pathology alone that makes it easier to stop short at pathological explanations of suicide, rather than interrogating the environmental and social production of both mental illness and suicide (Bhugra & Jones, 2001; White, 2018). Such a landscape implores intersectional qualitative suicide research to explore culture 'clash' (Brah, 2012) between the migratized and white Britons.

Migratism (Tudor, 2017) refers to the ascription of migrant status onto non-white Brits, regardless of their British citizenship (Bhambra, 2009). It relies on colonial amnesia which de-historicizes and 'forgets' Britain's colonial history – which has relied on the migration of Britain's colonies for labour and resources (see Ong, 2006, 'living resources') – presenting the idea that migrants should be grateful to be here (Amar, 2004). Then-health secretary Theresa May's 2016 'hostile environment' (Global Justice Now, 2018; The3million.org.uk, 2019), which introduced the settled status scheme for 'migrants', granted only for those living in the UK for 5 years or more, and

the UK's 2019 Brexit campaign slogan 'make Britain great again' both rely on and produce an anti-immigrant narrative, framing migrants as a 'drain' on 'our' NHS and benefits systems (despite the disproportionately high number of migrant NHS workers prior to Brexit) and create an imaginary white Britain in times past, without migration. Intersectional qualitative research does not underestimate or disregard the power of these narratives to shape understanding, experience, and reality for 'us' and 'them'. It seems no wonder that many ethnic minority people feel unwanted in Britain and 'choose'[2] to die by suicide. Historicized thus, it is no wonder the UK chooses not to record and report suicide inequalities among ethnic minority and migrant communities, or else expose its immigration policy as willful killing (see Berlant, 2007)

The current landscape of suicide, its meanings and contemporary practices to predict and prevent it must be understood within scientific research's colonial history and suicidology's dominance in this framework. So positing intersectional suicide recording, reporting, and prevention as the answer would be misleading without understanding that the very categories of ethnic minority and migrant have always been destined for suicide. That is, it is not only that ethnic minority people are more likely to experience mental distress – subject to racism (Lipsedge & Littlewood, 1997; Bhui et al. 2018) and migratism in the UK: the barriers they disproportionately face to life-building (Berlant, 2007) as well as the spectrum of inequality (Warwick.ac.uk, 2019), from hate to 'colour-blindness' (El-Tayeb, 2011) – but mental illness diagnoses have always been reserved and destined for 'social deviants'[3], those othered as abnormal, unbelonging, abject. Critical mental health studies, in particular labelling theory and antipsychiatry, make clear that mental health and suicide inequalities are not merely the product of contemporary racism – the ever-expanding bank of symptoms for mental illness disproportionately diagnoses and labels ethnic minority people with insanity (Sjöström, 2018) – but that the positions of ethnic minority and migrant people are themselves risk-making of suicide (Burstow, 2018).

Conclusion

This article seeks to map the colonial conditions of possibility for suicide's contemporary pathology (Marsh, 2010; for Foucault (1965) its 'regime of truth'), in order to discourage present day

[2] This refers to debates within critical suicide studies on whether people have agency to die by suicide, or are pushed by social inequality (Marsh, 2010; Mills, 2018)
[3] Breaking the rules of normality

suicide research and prevention from taking the easy route. That is, making the case for intersectional suicide recording, reporting, and prevention but making clear that it is not just clerical error that presents the dichotomy between noisy male suicide prevention and the invisible[4] suicides of ethnic minority and migrant people. While recording ethnicity on death certificates will raise awareness of migrant suicide, 'adding' migrant suicide prevention campaigns is not the 'answer'[5] in that this would mask the synonymous relationship between categories of mental illness (and its prescribed suicide risk) and social deviancy. Instead, by revealing suicide as socially constructed, perceptions of authority as laying among psychiatrists and scientists can be dismantled, making way for many and nuanced accounts to re-populate suicide as situated, contextual, and multi-faceted/polysemic.[6]

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[4] This is complicated by Amar (2004)'s 'logic of hypervisibility' whereby the UK government separates 'good' model minorities as a hypervisible examples in contrast to 'bad' migrants, those presented as being a drain on taxpayer's money. But the contradictory nature of hypervisibility leads individuals to "remain invisible as social beings" (Amar, 2004: p.305).
[5] In that 1) assuming there is a solution 'out' there suggests an objective authentic reality and 2) in critiquing suicidology's monopoly on suicide I am trying to trouble there being a 'single' solution.
[6] To have multiple meanings, as opposed to being reduced to pathology.

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