THE PATH TO LIFE: 
OBSERVATION, NORMALIZATION, AND POWER-KNOWLEDGE IN SUICIDE PREVENTION

by

Toryn Rogers

A Thesis
Presented to the
Faculty of
Rocky Mountain College

In Partial Fulfillment
of the Requirements for the Degree
Bachelor of Arts
in
Communication Studies
THE UNDERSIGNED FACULTY COMMITTEE APPROVES

THE THESIS OF TORYN ROGERS

Erin Reser, Chair
Associate Professor of Communication Studies

Shelby Jo Long-Hammond
Associate Professor of Communication Studies

Matthew O’Gara
Director, RMC Honors Program

05.01.2014
Date

5/1/14
Date

5/1/14
Date

Rocky Mountain College
Spring 2014
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>SECTION</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>i</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>HISTORICAL BACKGROUND</td>
<td>4</td>
</tr>
<tr>
<td>The Advent of Mental Health</td>
<td>4</td>
</tr>
<tr>
<td>A Resurgence of Prevention Efforts</td>
<td>5</td>
</tr>
<tr>
<td>A Re-Emergence of the Forum: Getting Communities Involved</td>
<td>7</td>
</tr>
<tr>
<td>METHODOLOGY</td>
<td>10</td>
</tr>
<tr>
<td>Research Questions</td>
<td>10</td>
</tr>
<tr>
<td>Cluster Criticism</td>
<td>10</td>
</tr>
<tr>
<td>Artifact Selection</td>
<td>12</td>
</tr>
<tr>
<td>ARTIFACT</td>
<td>13</td>
</tr>
<tr>
<td>FINDINGS: CLUSTER CRITICISM</td>
<td>15</td>
</tr>
<tr>
<td>“Suicide”</td>
<td>16</td>
</tr>
<tr>
<td>“Walk”</td>
<td>17</td>
</tr>
<tr>
<td>“Awareness”</td>
<td>19</td>
</tr>
<tr>
<td>“Prevention”</td>
<td>20</td>
</tr>
<tr>
<td>Summation of Findings</td>
<td>22</td>
</tr>
<tr>
<td>FOUCAULT’S THEORIES</td>
<td>24</td>
</tr>
<tr>
<td>Biopower</td>
<td>25</td>
</tr>
<tr>
<td>Panopticism</td>
<td>27</td>
</tr>
<tr>
<td>Normality and Normalization</td>
<td>28</td>
</tr>
<tr>
<td>FINDINGS: FOUCAULT</td>
<td>30</td>
</tr>
<tr>
<td>Encouraging Observation</td>
<td>31</td>
</tr>
<tr>
<td>Seeking Treatment</td>
<td>34</td>
</tr>
<tr>
<td>Knowledge as Control</td>
<td>37</td>
</tr>
<tr>
<td>Setting Limits to Deviance</td>
<td>39</td>
</tr>
<tr>
<td>DISCUSSION</td>
<td>42</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>46</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

This thesis has undergone a dramatic transformation from its conception in the spring of 2012, which would have been impossible without several people. Large credit goes to the faculty who took the time to sit on the 2013 Honors Proposal Committee: Clete Knaub, Amy Neuman, Jenifer Parks, Derek Sjostrom, and Andrew Wildenberg. I would also like to acknowledge and thank Professor David Strong, whose course on existentialism sparked my renewed interest in examining cultural attitudes regarding suicide from a critical philosophical perspective, and thus began the journey that culminates here.

Special thanks goes to Dr. Matthew O’Gara, faculty director of the RMC Honors Program, for his advice regarding the completion of a scholarly research project and indispensable morale boosts. My deepest gratitude also goes to my faculty reviewers, Dr. Erin Reser and Professor Shelby Jo Long-Hammond, as well as Dr. Jolane Flanigan, all of the Communication Studies Department. Your guidance and feedback was vital to the completion of this project as an academic and professional work as well as personal achievement.

Finally, my sincerest appreciation for all of my family, friends, colleagues, and mentors too numerous to mention by name here. Death is never an easy topic to discuss in any setting, even less so when it is suicide. I cannot thank you enough for accepting my implacable desire to delve into controversy and for listening throughout the entire process.
ABSTRACT

Suicide has recently become the object of increased attention due to the rising numbers of attempts and successful suicides among the general population and the recent suicides of several high-profile athletes from the American National Football League. Non-governmental organizations often draw attention to the issue through awareness and prevention initiatives. This paper examines the rhetoric of prevention campaigns through analysis of the American Foundation for Suicide Prevention’s Out of the Darkness Walks (OOTD). Cluster criticism explores how suicide and responses to it are characterized by OOTD through examining key terms and the associations created by surrounding symbols and phrases. Second, applying French literary critic Michel Foucault’s theories of biopower and panopticism to the cluster criticism findings answers the question of how these campaigns reflect or challenge broader social trends and attitudes. The study shows a dichotomy between portrayals of suicide as a passive natural phenomenon and awareness and prevention efforts as deliberate human action contributing to the creation of a science of prevention. This paradigm encourages observation of symptoms and treatment-seeking behavior, views knowledge as a means of control, and sets limits to acceptable social deviance.
Suicide only really frightens those who are never tempted by it and never will be, for its darkness only welcomes those who are predestined to it.
– Georges Bernanos

INTRODUCTION

The American perception of suicide is one of tragedy and loss. 2006 saw suicide listed as the 12th leading cause of death in the United States due to 33,300 deaths (Smith, Cukrowiez, Poindexter, Hobson, & Cohen, 2010, p. 871), and in 2010 38,364 deaths led to suicide being ranked as the tenth leading cause of death for all age groups with an estimated economic cost of $41.1 billion in work lost and medical expenses from both successful and failed attempts (Centers for Disease Control and Prevention [CDC], 2012). This is all in spite of millions of dollars being invested into educational programs, legislative lobbying, treatment and recovery programs, and scientific and sociological research on the causes and effects of suicide and suicide attempts over the past few decades. However, the crux of these efforts and the perception which drives them is not purely economic or material, especially when compared to other social ills. Economic costs related to alcohol consumption and misuse approximated $223.5 billion in 2006 (CDC, 2013, para. 1) and were tied to 25,692 deaths (Murphy, Xu, & Kochanek, 2013, p. 11), while tobacco expenditures reached over $297.8 billion for health-related effects and advertising between 2009 and 2012 (CDC, 2014, para. 2). These two behaviors therefore each incur a much higher annual material cost than suicide, yet are far more accepted in their daily practice. The core issue is then sociocultural in nature; the ethical sanctions attached to it stem from cultural attitudes and group beliefs rather than a materially based cost-benefit calculus. Much of the discourse surrounding the occurrence of suicide addresses the question of how to
best characterize, understand, and accept or disavow – and consequently prevent – this phenomenon.

The following historical background presents a contemporary picture of the position of suicide in the United States and the attempts that have been made to engage with it. The primary objective of the historical background is to characterize the dominant perception of suicide in the United States, its connection to mental illness, and the root of the enormously negative attitude toward both, with the secondary aim of foreshadowing the source of our cultural compulsion to treat mental illness and thereby avert suicidal behavior. Recent attacks at public gatherings by individuals with mental illness, the suicides of prominent national athletes as a possible result of injury during play, and a general rise in the annual number of suicides has elicited varied, frequently strong responses from the American public as well as private and public agencies. An understanding of these responses will provide insight as to how and why we respond to certain social controversies. The first section explores the rise of the concept of “mental health” in the United States and what organizations were initially imbued with the power to analyze, discuss, and act. The second describes the recent trend of organizational interaction with the public, particularly in the form of non-governmental organizations (NGOs) acting independently of and occasionally with formal, predominantly federal, government agencies. The third section notes the strategy of voluntary participation, or the attempt to involve local communities and citizens outside of the organization in regular events.

Since cluster criticism is used to discover the value assumptions and judgments of rhetors, or producers of rhetoric, the goal of this study is to question the ways in which suicide is discussed in public discourse as well as how its portrayal is linked to or separated from other social issues. Following the background is the methodology, which contains the research
questions which guide the study; an explanation of cluster criticism, which is the first method of analysis used; a brief description and justification of the artifacts selected for examination; and a detailed preview of the rest of the study covering the artifacts and theories to be used, the project’s findings, a discussion of the report’s implications and limitations. It is especially important that this exploration take place within the American public sphere, since existing literature mainly examines the discourse and policies of European nations. This investigation expands the scope of scholarship regarding mental health rhetoric to include Western perspectives and approaches besides those of continental Europe.
HISTORICAL BACKGROUND

The Advent of Mental Health

Beginning in the late 1940s, the United States began to act on its concern regarding the mental health of its citizenry. The idea of mental health as sanity dates back to the ancient Greeks and even before. Throughout continental European history mental health and suicide were addressed in an increasingly rationalistic fashion. The 19th century in particular, with the rise of Austrian neurologist Sigmund Freud and the analysis of French sociologist Émile Durkheim, reflected the growing attempts of the politically active to understand and control insanity. However, the mid-20th century is when “mental health” as a concept began coming into its own in the United States. It was at this time that it assumed its modern character as a scientific (meaning empirical, sociological, and biological) and almost entirely secular practice. The agent which embodied this best was the National Institute of Mental Health, the federal government agency authorized in 1946 and formally established in 1949 (National Institutes of Health [NIH], 1999). NIMH’s mission was, and continues to be, to conduct research into the causes of mental health problems and the most effective solutions to those problems.

The American public soon began to supplement government efforts with private cooperatives. In keeping with the nature of its civic life consisting of voluntary organizations, the first prominent non-government organization (NGO) founded to address suicide was the American Association of Suicidology. Established in 1968, the AAS was the first significant private sector equivalent to NIMH. Today it functions as a hub for coordinating and supporting suicide prevention agencies nationwide (American Association of Suicidology [AAS]).
A Resurgence of Prevention Efforts

Increased encounters with suicide and mental illness in the 1980s and 1990s fueled a growth in attempts by private citizens to inform the public and entreat it to action. Several NGOs were founded for this very purpose during those two decades, organizations which still exist today with the same mission of research, advocacy, and deterrence: the National Alliance on Mental Illness (NAMI), established in 1979; the American Foundation for Suicide Prevention (AFSP), established in 1989; Suicide Awareness Voices of Education (SAVE), established in 1990 following the suicide of the founder’s daughter in 1979; and the Treatment Advocacy Center, established in 1998 to eliminate legal and other barriers to intervention in cases of severe mental illness. An additional federal agency was also established during this time in 1992: the Substance Abuse and Mental Health Services Administration (SAMHSA). All of these were involved with a growth in the number of research and prevention centers as well as legislation designed to address suicide through the medium of mental illness, such as Kendra’s Law (New York Mental Hygiene Law § 9.60), a statute enacted in 1999 which authorizes involuntary outpatient commitment (“assisted outpatient treatment”) and regular psychiatric evaluation of patients who meet certain criteria. These criteria include being unlikely to voluntarily participate in treatment and being at risk of a relapse into a state of dangerousness to one’s self and others (Treatment Advocacy Center [TAC], 2001, para. 3). A growing perception of the prevalence of suicide and the dangerousness of the mentally ill created a demand for public action.

The perception of risk was neither a sudden epiphany nor a contrived realization. The Columbine High School Massacre on April 20, 1999 was a validation of decades, if not centuries, of growing concern at the possible link between insanity and violence. The effect of media on conceptions of mental illness, physical danger, and psychiatry as an interventionist
discipline cannot be understated in the construction of this link. Media institutions, to be sure, did not fabricate from nothing a cultural paranoia; yet the growth of a view of mental illness inherently coupled with violence accompanied an exponential growth in the availability and pervasiveness of media and information outlets. Mental illness was and continues to be portrayed as always accompanied by a drawback, even in its most productive forms. Media portrayals draw on common cultural tropes such as the coupling of genius and madness or creative prowess balanced by crippling social ineptitude, and employ common narrative devices to create a compelling, engaging anecdote which, while certainly based on real-life events, may not represent them faithfully to their actual occurrence (Nesseler, 2011, p. 125; Nairn, 2007, p. 141). Real life is perceived and in its retelling embellished to fit into particular existing frames of reference.

The effects of this common depiction resulted in a shift in focus to limiting harm via intervention. Mental health policy development in the West, such as in the UK, increasingly concerned itself with prevention through the means of social control, punishment for deviance, and the ideas of moral guardianship (Hewitt, 2008, p. 190). Moreover, it struggled to delineate between the mentally healthy and ill, the psychotic ill and the merely ill, and those likely to act on compulsions versus those unlikely to act. The element of prediction and of accounting for numerous variables in the equation of the violent mentally ill preoccupied experts (Fisher, et al., 2012, p. 549). Media and psychiatry also created their own obstacles to treatment; while the use of the term illness may convey a sense of “suffering that requires attention,” it may also be the case that “referring to illness may be stigmatizing” because of concerns of transmission and the lack of control involved in the condition (Fisher, et al., 2012, p. 544). By their attempts to reduce
instances of outright violence, prevention efforts created a separate harm of isolation which also seemed to demand a response.

**A Re-Emergence of the Forum: Getting Communities Involved**

In contrast to the closing of the 20th century, the opening of the 21st century did not see a proliferation of new independent agencies. Instead, new programs and collaborations arose to advance in new ways the agendas of the already existing mental health infrastructure. Among these were the AFSP’s Out of the Darkness Walks (OOTD), first taking place in 2002 after the suicide of creator Dan Pallota’s partner in 2000; the Suicide Resource Prevention Center (SRPC), established in 2002 as a division of SAMHSA and home of the National Suicide Prevention Hotline network (itself incorporated in 2004); and the Jonathan O. Cole, MD Mental Health Consumer Resource Center, established in 2003 as a consumer-oriented resource center. There was also the National Action Alliance for Suicide Prevention (NAASP), established in 2010 as a public/private partnership between SAMHSA and numerous NGOs to work on the 2001 National Strategy for Suicide Prevention (NSSP). All of these organizations worked, and continue to work, to support cooperative government-private efforts by increasing the size of the volunteer pool, thereby increasing the amount of available resources and channels of influence. Legislation also continued to be introduced and passed which emphasized a proactive approach, such as Laura’s Law. Inspired by Kendra’s Law, the California bill was enacted in 2002 and authorized court-ordered assisted outpatient treatment as well as forced use of anti-psychotics. Top-down approaches, however, no longer proved sufficient. The focus shifted from consciousness-raising and legislating behavior to encouraging participation.

The need for voluntary involvement grew in large part to the increase – both in occurrence and visibility – of instances where mental illness was shown to be a significant
danger to others. The Virginia Tech shooting of April 16, 2007; the Aurora, Colorado theater shooting of July 20, 2012; and the Sandy Hook Elementary School shooting of December 14, 2012; all of these high-profile events and their coverage were used to contribute to the imperative that knowledge of resources and programs needed to be accompanied by a willingness to take advantage of that access. Moreover, the construction of compliance extended the responsibility to the social networks of those at risk – even risky – individuals whom the programs were targeted at to begin with: “Compliance here might be understood as applying at two levels. First is adherence to prescribed pharmacological therapies … On another level, compliance can refer to obedience to laws of conduct, the violation of which signifies the threat to society” (Glick & Applbaum, 2010, p. 230). Dissemination of these obligations through traditional media – radio, print, and especially television – proved an effective method for spreading information and values. The surge of new media technologies, such as Web 2.0 (the non-static, more interactive Internet page) and ensuing social media has allowed and continues to encourage an exponential circulation of content.

As with any successful public campaign, buy-in from the target audience is a prerequisite for success. This includes not only the mentally healthy public, but the population of the mentally ill as well. A degree of acceptance of common values is already indicated in some research; however, what is accepted is an overwhelmingly negative interpretation of mental illness. By and large, mental health system patients tend to share the same interpretation of their experience as the institutional staff – an interpretation that is negative and incorporates beliefs of untrustworthiness, unreliability, and dangerousness (Hansson, Jormfeldt, Svedberg, & Svensson, 2011, p. 51). Combined with the tendency of media outlets to emphasize similarities across stories of suicide and violent mental illness, including themes of unpredictability, risk, and
criminality, the American public has accepted a linkage between mental illness and suicide, and thus between mental illness and a loss of control as well as increased likelihood of violence (Stuart, 2006, p. 102). The primary effect of this viewpoint is a guarded interaction between the mentally healthy and the mentally ill, and an attachment of a negative perception leading to a push for segregation and isolation (i.e. stigmatization). Most damaging, as a general rule this position has been adopted by the mentally ill themselves in a sort of internalized victim-blaming that constitutes another obstacle to their rehabilitation (they are too damaged or dangerous to live normal lives, therefore seeking treatment or isolating oneself from others is the best means of securing public well-being). The current state of affairs is to overcome this barrier of stigma among the mentally ill. A large number of the non-mentally ill public already participate in local and national community functions such as the Out of the Darkness Walks and October’s Yellow Ribbon Month campaign (established in 1994 to highlight suicide awareness and prevention, and a precursor to more recent contemporary voluntary participation campaigns). Attention increasingly turns to the mentally ill to become involved with their own acknowledgement and treatment.
METHODOLOGY

Research Questions

Although suicide prevention campaigns do take many rhetorical forms, employ various communicative strategies, engage with specific publics, and are created with a particular purpose or set of motives in mind, most of them share certain commonalities. In the United States, the majority of centers and initiatives do not arise directly from the state but instead from collectives of citizens that sometimes solicit state recognition, funding, and other support. There is also a strong, continuous emphasis on a biological model of disease. This model is ubiquitous, even across lines of religiosity and secularism (though obviously carrying far more weight in the latter category of organizations). Given these conditions, it is pertinent to inquire exactly what commonalities are shared as well as how knowledge of suicide and mental illness connects to the ability for and appeal to treatment. The following research questions emerge: In these campaigns, how (if at all) are suicidal tendencies, both as action and as a state of being, framed by voluntary civil associations? Does a biological or medical characterization of suicide imply an obligation for treatment and/or prevention?

Cluster Criticism

An exploration of an act of communication should begin with an account of three things: an understanding or definition or what the author means when they employ the term rhetoric; the text(s) to be studied, labeled the artifact(s); and the method of analysis to be used. This study employs the definition provided by communication scholar Sonja K. Foss (1996), who identifies rhetoric as “the actions humans perform when they use symbols for the purpose of communication with one another” (p. 4). Rhetoric as interplay between symbols is thus more
than mere description. It is a constitutive activity which humans may engage with individually or collectively: “It is the process by which our reality or our world comes into being; reality or knowledge of what is in the world is the result of communication about it” (Foss, 1996, p. 6). A rhetorical artifact is both a tangible representation of how the rhetor perceives the world and her or his attempt to influence and shape it.

The discovery of meaning within an artifact can be achieved through a variety of methods. One of the most effective is the technique of cluster criticism. Developed by rhetorician Kenneth Burke as part of his theory of rhetoric, cluster criticism enables a rhetorical critic to “discover a rhetor’s worldview” (Foss, 1996, p. 63). Its fundamental premise is the tracing of groupings, or clusters, of symbols around other symbols which are key to the meaning of the artifact and demonstrate their importance through their frequency or intensity. These key terms can often be grouped into one of two categories: *god* terms, which represent the rhetor’s notion of the ideal or ultimate good; and *devil* terms, which represent the ultimate negative or evil (Foss, 1996, p. 65). However, the nature of these key terms is fully disclosed when a critic takes an account of the surrounding clusters. Burke observes that through clusters “significance [is] gained by noting what subjects cluster about other subjects (what images b, c, d the poet introduces whenever he talks with engrossment of subject a)” (Burke, 1959, p. 232). The tracing of associations made and the network of relations between terms reveal what the rhetor consciously or unconsciously perceives to be in accordance with or in opposition to his or her own beliefs. These beliefs may also be reflective of broader cultural values, depending on the rhetor’s social position. Cluster criticism thus allows for the identification of not only arguments, but the assumptions and motivations undergirding them.
Artifact Selection

As raw data, an artifact’s suitability is evaluated according to two main qualities. These are its relevance to the field in question (importance), and how often it or similar instances appear (frequency). An artifact may be the only one of its kind in a particular field of human communication and yet be an irreplaceable product which is a major influence on subsequent productions. Conversely, an artifact may not be important by itself but instead garners significance because it is one of several comparable pieces of rhetoric which together represent a pivotal movement or concept. An artifact that is similar to many others may also be suitable for study in isolation as a representative of an entire class of rhetoric (Foss, 1996, p. 7-8).

A balance between importance and frequency was central to the study. However, importance was privileged above frequency as it corresponded more closely with certain aspects of suicide that were highlighted in recent controversies. The chosen artifact is the Web site of the AFSP’s Out of the Darkness Walks. This artifact was selected for four reasons. First, as a Web 2.0-based site it was easily accessible, both to members and non-members of their respective target demographics. Second, it is a direct publication of the AFSP and is quality-checked for adherence to official stances on areas of controversy. Third, it represents a well-known organization, as the OOTD Walks are annual events which are heavily publicized. Fourth, the campaign is an example of timely responses to salient controversies. The OOTD campaign has addressed the social issue of suicide linked to mental illness since 2002. OOTD is ideally representative of suicide awareness and prevention campaigns and was selected for study for this very reason.
The Out of the Darkness Walks began as a fundraising and conscious-raising event with a centerpiece of a 26-mile overnight walk. Its founder, Dan Pallotta, came up with the idea for a community-oriented fundraising event for suicide prevention and awareness two years after the suicide of his boyfriend Alan in 1999. Having already designed the charity events AIDS Rides and Breast Cancer 3-Days to increase support for those causes, bolstered by research into the statistics involved with suicide in the United States, and moved by personal experience, Pallotta organized the first overnight walk in Washington, D.C. in 2002 (Pallotta, 2008). Since then the Walks have expanded among 250 communities across the United States, creating more than 50 local chapters in 35 states, and involved more than 85,000 participants in 2011 alone, raising $6.6 million that year (OOTD, 2014).

The Out of the Darkness Walks serve multiple aims. The primary purpose of the Walks is as a fundraising event. However, this is not the end-goal of the Walks. Fundraising allows for several measures aimed at deterrence and recognition, including: lobbying and drafting of legislation and policy at the federal, state, and local level; education of the public about the facts of suicide; consulting for media outlets on how to cover suicide; establishing crisis centers and recovery programs for potential suicides and survivors; and scientific and clinical research into suicide. The OOTD is an ostensibly self-sustaining event; the AFSP claims that only 18% of funds raised go to management and fundraising, while 82% supports research and consciousness-raising ventures (OOTD, 2014). The regular scheduling of the Walks – not to mention their extensive presence – also allows for a coordination of support among those affected by suicide. They serve as a focal practice, a point around which suicide prevention advocates can rally and exchange resources. They are therefore interactive memorials, not places but events that set aside
a recurring time and place for remembrance, and sites for the introduction of those interested or affected by suicide to understanding and prevention enterprises.
FINDINGS: CLUSTER CRITICISM

The Out of the Darkness Walks site’s rhetoric exhibited, through four key terms, three tendencies. All of the rhetoric cited in this section was taken from the OOTD’s official Website at www.outofthedarkness.org. The devil term was “suicide.” It is associated with loss, mental illness, and ignorance. The god terms were “prevention” and “awareness.” They are associated with knowledge and conservation as well as one another. The final key term was “walk,” which related to the multiple goals of the campaign and also related to the construction of an imperative to action. Although not itself a god term, its recurring use of an active tense stressed the purposeful nature of “prevention” and “awareness.” From these key terms and their clusters, three major themes emerged. First is a dichotomy between suicide and preventative efforts and organizations such as the AFSP and OOTD. Suicide was characterized as being a passive natural phenomenon which happened to and thereby affected people. The OOTD and other actions by the AFSP were framed in the active tense as deliberate interactions with and against suicide. Second is the existence of multiple levels of involvement. There were several ways one could be involved with OOTD and AFSP, all of varying inclusivity. There was also a tension between how exclusive OOTD and other efforts were with the existence of suicide. The third and final theme is advocating for the creation of a technology of power over suicide. This technology is not an actual piece of equipment, but instead a method of acquiring and applying useful knowledge to the problem of suicide. Through these motifs OOTD created not only a conception of the problem and its harms but also a solution; a good in response to an evil.
“Suicide”

The associational clusters around suicide linked it to existing conditions and portray it as a result of their presence. Citizens are encouraged to observe “psychiatric illnesses that can lead to suicide” and to be a part of outreach efforts targeted at “people with mental disorders and those impacted by suicide,” or “people who are depressed and suicidal.” Other programs are designed to educate the public about “mood disorders and suicide prevention,” doing so by “providing education and information about depression and suicide to professionals, the media and the public.” They are also designed to stress “the magnitude of the problems of depression and suicide.” Suicide becomes easy to read post hoc into mental illness, especially after someone diagnosed with mental illness commits suicide. Mental illness almost always seems to precede a suicide. The victims are often officially diagnosed before their death, meaning that a clinical and biomedical evaluation has taken place. This generates an automatic, learned association. Where there is mental illness there likely will be suicide, and where there has been a suicide (attempt) there is almost certainly some sort of mental disease, explicitly recognized or not. However, since suicide’s appearance is so dependent on these other conditions, two properties are revealed: its intensity and its danger. The first is suicide as an intensification or extension of mental illness. Indeed, it is the ultimate extension; it is the most extreme of all possible responses. Second, suicide becomes as much of a hazard as the disorders which precede it. Although often there are prerequisites to be met before it takes place, suicide’s finality makes it a more serious occurrence than any mental illness. Its ability to appear anywhere – especially across diagnoses of various mental illnesses – also makes it a matter for concern: “This [suicide] is a public health issue that does not discriminate by age, gender, ethnicity, or socio-economic status.” Although mental
illness may not be a controllable phenomenon, suicide is – which provides all the more reason to act whenever mental illness manifests, so as to avoid the sequential appearance of suicide.

Suicide is also characterized as an object of inquiry. It is described both as an “issue” and a “problem.” Just as it is connected to mental illness, it is also linked to a hostility and sense of shame born of general ignorance. Part of the funding raised from OOTD is sent to work “to eliminate the stigma surrounding mental illness and suicide.” One cannot mention the negative without invoking its positive correlate. Every problem should have a solution, every issue a means of exploration. Stigma is paired off against knowledge acquired and exercised through “understanding,” “research,” “education,” and “advocacy.” In addition, this intellectual examination is exercised upon a passive subject – literally a nonhuman object of scrutiny. Suicide is a natural phenomenon like any other disease. It proceeds from existing phenomena which are beyond human control, although not understanding. Suicide is something that happens to people more than it is caused by them: “a person dies by suicide every 13.7 minutes, claiming more than 38,000 lives each year;” “suicide is a national health problem that takes an enormous toll;” “suicide is a public health issue that does not discriminate.” Those who are directly affected – those who attempted suicide but failed, and those who know a successful or failed suicide attempter – are described as “survivors of suicide loss,” in much the same way a coastal community might suffer a loss of property from a storm or a cancer patient is the victim of genetics or circumstance. Although a behavior, suicide is depicted as more of a passive ailment than as an exercise of will.

“Walk”

In contrast to suicide’s passive character, walking is a decisive act of resolve. The use of “walk” creates two core impressions. The first is a constructed interventionist appeal. This sense
of imperative is due to the constant presence of an active tense. “Walk” is the most obvious embodiment of this deliberate interaction, but by no means is it the only way the rhetoric generates a feeling of activity. The audience is encouraged to become involved with implied commands to: “walk,” “raise,” “honor,” “save,” “find,” “register,” “learn,” “donate,” “start,” “volunteer,” “organize,” “ask,” “spread [the word],” and “join.” Two pages of the site – “Fundraising Tips and Tools” and “Be a Team Captain” – are clearly formatted to draw attention to the recommendations for how to act; each bullet point begins with an active verb. The rhetoric also describes the organization’s own labors in an active tense. The AFSP uses funds to “educate,” “fund,” “promote,” “provide,” “involve,” “offer,” “support,” “improve,” “assist,” “advocate,” “conduct,” “generate,” and “save.” In the past it has “mobilized,” “connected,” “reached,” “attracted,” “established,” “educated,” “created,” “merged,” “[substantially] increased,” and “communicated with” many groups and individuals. Not only does OOTD present a history of accomplishment, but it also uses this background to justify an expectation of continued, and hopefully transmittable, action.

The second impression received is a sense of purpose. By attaching specific objectives to “walk” – “walk to honor loved ones,” “walk to raise funds,” “walk to save lives” – the rhetoric gives direction to the constructed desire for involvement. Since an interventionist spirit is more effective when it subscribes to a guiding principle, one is provided under the guise of specialized modes of engagement. Each verb is accompanied by a goal or an achievement, so that a complete picture of the ends and its means, the destination and the journey to it, is summoned to the audience’s mind. Their promotional materials utilize a poster which includes an image of a pair of boots next to an image of a group walking on a broad sidewalk (four persons wide) holding an AFSP banner across the front of them. These images both evoke both the motion of walking and
its setting. The boots are worn work boots, referencing the planned nature of the walks and their connection to a greater end, while the people stress the need for the individual to join a communal movement, not wandering whimsically but as part of a coherent whole with a measurable objective in mind. These are not so much walks as races, marching toward a suicide-free finish line.

“

Buttressing this rallying cry is the role of knowledge. “Awareness” as one of the dual god terms is reinforced by symbols such as “advocacy,” “education,” “outreach,” “research,” and “understanding.” These are contrasted with the social ostracization and lack of knowledge inherent in “stigma.” This network of importance surrounding the collection of information is consistent with the modern perspective on the place and role of knowledge in human affairs. Dating back to the Enlightenment and the roots of modern intellectualism, rationality derives its power through applying logical methods to natural processes. As more and more knowledge is gained, the predictive power of the natural and the social sciences increases, in turn fueling an interest in controlling for variables in order to achieve the most desirable or productive outcomes (Borgmann, 1984, p. 25). This is best exemplified in the promise of technology. Technology being “the characteristic way in which we take up with the world,” its promise is its ability to liberate humanity from burdens such as manual labor and disease (Borgmann, 1984, p. 35). Awareness as disciplined comprehension is central to this assumption that knowledge can and should be utilitarian, or at least acquired and harnessed in a utilitarian fashion.

“Awareness” also serves as one of two processes in the way OOTD creates levels of involvement with the AFSP and compatibility with the existence of suicide. Awareness constitutes the inclusive domain of OOTD through its connection to the notion of publicness.
When coupled with “public” as a noun, awareness emphasizes the grassroots nature of its campaign and the need to incorporate laypersons into its efforts, either through participation or in audience adaptation for the messages it wishes to send out. The campaign aims to “educate the public” by “providing education and information … to professionals, the media, and the public.” Without popular attentiveness and support, the campaign fails. When used as an adjective, “public” reinforces this welcoming stance and opens up the possibilities for potential members to join and even solicit support (via donations) from their own social networks. The suggestions for potential donors under *Fundraising Tips and Tools* reference multiple dimensions of social relations: interpersonal (friends, family, romantic, etc), economic, religious, educational, political, and geographical affiliations (neighbors). By emphasizing interconnectedness and openness, OOTD increases its appeal, expands the number of potential audiences, and makes participation appear more attractive.

OOTD’s inclusiveness extends, albeit conditionally, to the existence of suicide. As a prevention campaign – an initially reactive and later proactive program – it stands in opposition to something which nonetheless must continue to exist, if only as an object of opposition. In other words, suicide actually must take place to better highlight its causes and effects. Without suicide as an exhibit or an object of lecture, any effort to raise awareness loses its value because the constructed system of signs will have no point of reference; the signifier will exist without a signified. Therefore, suicide is tolerated inasmuch as it becomes the ultimate evil, to be connected to lesser evils and juxtaposed to sources of virtue and respectability.

“Prevention”

“Prevention” provides the practice to awareness’ theory. As the twin god term, prevention is also frequently associated with variations on knowledge: “education,”
“understanding,” and “research.” However, other versions – “advocacy” and “outreach” – offer a slightly different interpretation when coupled with “treatment.” Knowledge under “awareness” was utilitarian information; it was applicable. Under “prevention” its potential is actualized and it becomes applied knowledge or theory. In the same interventionist spirit found through “walk,” prevention as treatment of symptoms enacts the promise of technology articulated via awareness. Disburdenment is no longer a possibility, but an actuality whose proof is found in every successful suicide stopped and every person who comes forward wanting to help or being helped by the programs already in place. Research becomes “scientific,” meaning it is both privileged above non-scientific discoveries and conducted with eventual implementation in mind: “AFSP has invested over $10 million in new studies, including research into treatments.” Through advocacy, the creation of legislation and policy, and through programs designed to disseminate an understanding of the causes and effects of suicide, there emerges a measurable sense of intent and record of accomplishment.

These successes occur on the basis of prevention’s exclusive quality, both in regard to community participation and the presence of suicide. Whereas “awareness” embodies an open, publicized approach and welcomed laypersons as well as experts, “treatment” is a specialized endeavor. Expert testimony and knowledge is privileged over lay support, which is confined to contributing funding that is distributed according to a preexistent calculus. At risk populations are strongly encouraged to seek out credible institutions, such as AFSP, for aid through “programs and resource for survivors of suicide loss and people at risk.” The AFSP also provides training and specialized initiatives to corporate professionals and media outlets, implying a hierarchy of knowledge and skill in matters of discourse about suicide. Similarly, the existence of suicide is subservient to the AFSP’s “vision to create a world without suicide.” Compared to
the relationship between “awareness” and “suicide,” which was antagonistic but accommodating, the relationship between “prevention” and “suicide” is one of mutual exclusion. If prevention projects are successful, then there are no suicides or attempts. If prevention measures fail, then it follows that failed and successful suicides will continue to take place. Prevention is thus a much stricter and much more dynamic strategy than fostering awareness.

**Summation of Findings**

The cluster analysis of the OOTD rhetoric shows the main conflict to be between suicide along with its correlates, such as mental illness, and knowledge-based prevention programs. These programs are the manifestation of collective human will and action. Conversely, suicide is less a choice or conscious behavior than it is an outcome of natural phenomena (notably disease). To this end, clusters around suicide framed it as a naturally occurring harm. It was also portrayed as a naturally occurring event which one could enter into competition with and subjugate through informed struggle:

<table>
<thead>
<tr>
<th>Associations made with “suicide”</th>
<th>Contrasts</th>
</tr>
</thead>
<tbody>
<tr>
<td>loss, toll</td>
<td>prevention, conservation</td>
</tr>
<tr>
<td>public health issue/problem</td>
<td>treatment</td>
</tr>
<tr>
<td>mental illness, depression/depressed</td>
<td>advocacy</td>
</tr>
<tr>
<td>stigma</td>
<td>understanding, education, awareness</td>
</tr>
<tr>
<td>pain</td>
<td>recovery, prevention</td>
</tr>
<tr>
<td>survivor(s)</td>
<td>involvement</td>
</tr>
</tbody>
</table>

Rather than presenting suicide as a personal choice, the campaign used the idea of struggle as a frame. Under this matrix, the question became not of eradicating all of the root causes of suicide ideation and behavior. Instead, the audience was urged to act in ways that they could control; not to prevent the outbreak of disease but to respond to it and to limit the spread of its symptoms. The rhetoric offered a view of the creation of a technology of prevention, which
was founded on the principal element of scientific knowledge – knowledge acquired with a plan for application and dissemination:

<table>
<thead>
<tr>
<th>Associations made with “prevention,” “awareness,” and “walk”</th>
<th>Contrasts</th>
</tr>
</thead>
<tbody>
<tr>
<td>scientific research</td>
<td>(lay) experience</td>
</tr>
<tr>
<td>education, understanding, advocacy</td>
<td>stigma</td>
</tr>
<tr>
<td>treatment</td>
<td>nonintervention, isolation</td>
</tr>
<tr>
<td>public</td>
<td>private</td>
</tr>
<tr>
<td>community</td>
<td>personal</td>
</tr>
<tr>
<td>active</td>
<td>passive, natural</td>
</tr>
</tbody>
</table>

The rubric provided through the rhetoric also highlighted multiple levels of involvement in addition to a methodical approach to deterrence. The differing domains were created by the campaign’s portrayal of prevention and awareness efforts, which began as radically inclusive measures and progressively became more demanding of qualification the more one wished to become involved in advancing the cause. This hierarchy of authority exemplifies the technology of prevention’s focus on the acquisition of knowledge, diffusion of said knowledge to various publics, and its use in a proactive manner. It is most effective and most productive when tested in small elite spaces and later distributed to non-experts. It therefore created not only a technology of prevention but also a community for it to reside in, with specific niches reserved for the multiple levels of membership.
FOUCAULT’S THEORIES

The OOTD rhetoric is a rhetoric of action. It espouses diagnosis, cure, and prevention. It is also a rhetoric of dominance. It not only establishes an opponent and an obligation to engage it, but then overlooks this constructive act by assuming that both the problem and the duty to solve it have always existed. Given how the OOTD campaign takes so much for granted, a critical examination of the cluster analysis findings would address a few concerns. These would include the origin of an imperative to action, the basis for portraying suicide as a predominantly biological problem, and the effects of proactive prevention campaigns’ rhetorical appeals. An appropriately critical perspective is found in the work of Michel Foucault.

Although remembered as a literary critic, Foucault made several significant contributions to other fields that have earned him a position of influence in academia and beyond. His attempts to catalogue the development of ideas and values in Western culture typified his historical approach to knowledge and its construction, while his tracing of the implications of that same development and its impacts on ensuing social movements marked him as both a philosopher and political theorist. As a scholar of communication, his critical perspective traced the flow of power in society. Not only did he study the origins of its formal and informal channels, but he also revealed the changes they underwent through successive historical and cultural periods to form the basis for modern power structures and social institutions. Thus, he offered a view of how contemporary society came to be and the reasons for those particular expressions of value. Foucault’s most prominent theme is normalization: the process through which cultures and societies establish and enforce boundaries around thought, appearance, behavior, et cetera. The best examples of his work which share this thread are his theory of biopower and his theory of panopticism.
Biopower

Biopower is a technology of social power, a technique of disciplining the body politic (community) through regulation of the condition and activities of the politic body (citizen). Its chief field is medicine, since it is preoccupied chiefly with the physical individual. More specifically, it is concerned with the health of the citizen and the incarnations of sickness they fall prey to. This was the great shift in Western medical practice, to articulate that medicine must no longer be confined to a body of techniques for curing ills and of the knowledge that they require; it will also embrace a knowledge of healthy man, that is, a study of non-sick man and a definition of the model man. (Foucault, 1994, p. 34, emphasis original)

In order to conduct its affairs more efficiently with broader scope, medicine was required to expand its jurisdiction to lay claim over the physical being of not only the sick, the infirm, and the aberrant, but the healthy, the strong, and the exemplary.

As the preferred mode of interaction, medicine also linked together power, knowledge, and the object of what Foucault calls the medical “gaze.” The power-knowledge-object triad is particularly important when understanding the aim and process of biopower. Foucault’s own case study, sexuality in the West, contains a power-knowledge-pleasure frame which questions the nature of the discourse surrounding sexuality: how often it was talked about, the link between numerous discourses, their relation to distributions of power (did they reflect or construct networks of influence), and how sexual pleasure was incorporated into this discourse on itself (Foucault, 1990, p. 44-45, 73). Biopower is centered not on silence, but a proliferation of discussion: “discourse was meant to yield multiple effects of displacement, intensification, reorientation, and modification of desire itself” (Foucault, 1990, p. 23). What is driven out of sight cannot be understood, cannot be managed; only by subjecting it to constant examination through dialogue can it be supervised and made decent.
The main tool or expression of biopower is therefore the gaze. First instituted in practice in the clinics that served as both medical and educational establishments, the gaze posits itself as a neutral uncoverer of what already exists, an interpreter of signs:

The clinic brings into play what … was the fundamental relation between the perpetual act and the element of language. The clinician’s description, like the philosopher’s analysis, proffers what is given by the natural relation between the operation of consciousness and the sign. (Foucault, 1994, p. 95)

Clinicians are therefore not ostensibly creating anything new. They supposedly apply a framework for the discovery of knowledge to existing signifiers to derive identification of the signified. This framework is premised on two tenets. The first is the attachment of significance to signs. Foucault notes that the gaze ‘reads’ the body and its health or disease much like a scholar would read a text; symptoms gain meaning only in relation to other symptoms’ presence or absence. The product of this reading is the masking of the act of construction. The meaning of signs – the relationship of the signifier to that which it signifies – is taken for granted. The second is the reductionist nature of the gaze. As it collects symptom-signs and moves toward a more recognizable picture of the disease as a whole, certain features are glossed over or forgotten. Symptoms that appear to be serious and weighty individually become less significant as their numbers multiply. Moreover, diseases which share symptoms but not their spatial-temporal arrangement (the severity and sequential order of their appearance) are collected into a single category, encouraging approaches that focus more on commonality than on idiosyncrasy (Foucault, 1994, p. 91-92, 101, 118). Hence the gaze is both a revealing and concealing force, exposing conditions of health and sickness while simultaneously veiling its own artificial, interventionist character.
Panopticism gives a name to the social background against which the gaze is possible. Foucault acknowledges that the medical gaze is not the only institution keeping watch over society. It is paralleled by a configuration which lends itself to supervision. The medical gaze finds itself confronted by non-biological interpretations of health and illness, the reactionary character of many of its initiatives, and constraints such as the Hippocratic Oath that limit the prescriptions for action it may offer as a branch of medicine. The panoptic gaze faces no such restrictions; it is a cross-disciplinary force that observes the past, present, and future simultaneously, and exists to extend its presence. It is not ubiquitous on the basis of its physical presence but because of the extensive way in which citizens internalize the demands of the social arrangement; they evaluate their past and present in line with this frame, and plan for their future accordingly.

Hence the major effect of the Panopticon: to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power. So to arrange things that the surveillance is permanent in its effects, even if it is discontinuous in its action; that the perfection of power should tend to render its actual exercise unnecessary; that this architectural apparatus should be a machine for creating and sustaining a power relation independent of the person who exercises it; in short, that the inmates should be caught up in a power situation of which they are themselves the bearers. (Foucault, 1995, p. 201)

Panopticism thus entails a structure which is conducive to pervasive, constant surveillance that originates from above but is preserved from below – or more accurately, from within.

Discipline is thus not reductionist in the sense of being a limited and simplified understanding. Indeed, its knowledge of the subject is extensive and comprehensive. No aspect of a thing or phenomenon is beyond meticulous examination. But it is reductionist in its construction of categories of analysis. The subject is continuously divided into smaller, more separate, and more individualized segments. Its context, the network of relations which informed
its identity, is removed to a hidden background whose existence is denied. The parts of the whole become increasingly specialized to a particular purpose and impoverished to the conditions of their existence, blinded to the quality of their collective character (Foucault, 1995, p. 138). Discipline necessitates the creation of an infinite number of synonymous individuals, all of whom are subject to the exercises of power and control of the state according to the intersection of social forces that make up their identities. Individuals are therefore collected clusters of probability and group membership that can be manipulated to satisfy or advance the demands of larger social bodies.

**Normality and Normalization**

Foucault’s notion of the gaze is therefore a description of a process which creates a method of control (biopower), justifies its existence and unique character (panopticism), and locates an object for this technique to be brought to bear on (madness); in short, he chronicles the rise of a regulatory practice. Regulation points in turn to the creation and maintenance of power. Yet power for Foucault does not refer back to social institutions or techniques for ensuring domination and subservience. Power is a process, the ways in which relationships exist and network in specific spheres to produce interactive strategies and establishments that serve as repositories of influence (Foucault, 1990, p. 92-93).

As a product of power relations the gaze is a constitutive force, shaping our perception of the world around us and thereby influencing how we interact with said reality. Ostensibly, it is a neutral tool of observation. Yet none of its attributes are inherently passive, objective, or nonjudgmental. As a means of evaluation, it emphasizes particular features and ignores others. In revealing some aspects of an object, it hides others. Through seeing certain things, it blinds itself to others (Foucault, 1994, p. 107-109, 115). Seeing is inseparable from producing, especially
since it enlarges the body of “empirical knowledge that covered the thing of the world and
transcribed them into the ordering of an infinite discourse that observes, describes and
establishes the ‘facts’” in order to “reproduce, in concentrated or formalized form, the schema of
power-knowledge proper to each discipline” (Foucault, 1995, p. 226-227).

The principal effect of this practice is segregation, premised on acceptability. So long as
the insane refuse to abide by convention (whether they commit deliberate or inadvertent
transgressions), they are denied entry into society; they are social as well as literal outsiders.
Once they begin complying with those norms laid out for them, however, they begin their
transition to a new world of surveillance and judgment from one of neglect and censure:

Instead of submitting to a simple negative operation that loosened bonds and delivered
one’s deepest nature from madness, it must be recognized that one was in the grip of a
positive operation that confined madness in a system of rewards and punishments, and
included it in the movement of moral consciousness. (Foucault, 1988, p. 250)

Madness was thus invested with a moral dimension, a new sector of assessment wherein one’s
character, especially the idiosyncratic expression of personality and illness, could be called upon
as testimony; it would act as support for pardon or condemnation, and would justify any actions
stemming from that pronouncement. It was, and continues to be, subject to principled appraisal.
Insanity became a matter of ethics.
FINDINGS: FOUCAULT

Inasmuch insanity and the way society interacted with it became an ethical matter, the ramifications of intervention and isolation received little to no attention. Those same methods and justifications continue to be understudied. This leaves us in a position wherein powerful actors, like NGOs or state-run agencies, craft policy and issue proclamations with little input from the population directly affected and little understanding on the part of those implementing these policies of the effects of those same statutes. The measures by which we set conditions of acceptance and rejection as well as their underlying logic go largely unquestioned. We do not question the presence of large-scale advocacy initiatives or the social conditions which give rise to them and under which their appearance seems sensible. Preoccupied with how and why we accept some people into our communities and reject others or create separate locales for them, Foucault’s theories are ideally positioned to question the effects and intent of a public advocacy campaign, especially one that concerns itself with the health of a group of citizens.

Four points are revealed when the cluster criticism results are examined through the lens of Foucault’s theories of biopower and panopticism. First, the rhetoric of OOTD encourages observation of symptoms commonly associated with suicide; by extension, constant monitoring of mental illness becomes a necessary prerequisite. Second, an obligation to seek treatment is made explicit and framed as an essential corollary to supervision of disease. The viewing and articulation of disease becomes irrevocably linked to the handling of the illness. Third, knowledge acquires a specific character in OOTD’s rhetoric that is not only utilitarian, but obtained for the purpose of limiting the expression of suicidal tendencies. Fourth, the cluster criticism findings reveal a simultaneous inclusion and exclusion of deviant thought and behavior; a process of normalization occurs. While being diagnosed with mental illness or suicidal ideation
falls within the limits of acceptable abnormality, failing to prevent suicidal actions and not responding to symptoms via the initiatives AFSP provides or endorses shifts those behaviors outside the bounds of acceptability to become unconscionable deviance. The association between mental illness and dangerousness (not to others, but to self) lends added weight to these arguments, creating a perception of risk and necessity for preventative intervention. OOTD’s rhetoric is therefore largely consistent with lay views of mental illness as well as a science-based interventionist ethic.

**Encouraging Observation**

OOTD’s emphasis on awareness highlights the active nature of observation and individual responsibility embodied in Foucault’s panopticism. The audience is encouraged to maintain a state of alertness that encompasses not only those around them – friends, family, and colleagues – but even their own person. Moreover, it is self-surveillance with a goal: the reproduction of social roles and norms, without challenge and with minimal alteration. The gaze’s performance is constructive; it is a glance laden with judgment that compels us to shape ourselves in accordance with its implicit desires, so that we may better attend to creating an image of conformity with the expectations placed upon us by the community in which we live (Bartky, 1997, p. 103). An entirely new experience arises that supplements and eventually replaces the individual, subjective experience of suicide with a collective, allegedly objective encounter that is repeated over and over. The disease – brain disorders caused by chemical imbalances or abnormal physical structures, et cetera – is replaced by an illness; what is negatively affecting a single body is transformed into an attack on the entire social body (Crossan, 1994, p. 91-92). When the question of suicide becomes everyone’s problem to deal with, rather than a single person’s struggle, the measures taken to address it increase in severity
and reach to constitute an appropriate response to the raised stakes. It is no longer a small part of society that is in jeopardy; the entire body politic risks destruction.

Observation as a means of obtaining security and other benefits is most effective when the entirety of society, or as many elements as possible, are involved in this endeavor (Foucault, 1995, p. 209). This extensive practice is necessary because of the various places suicide can originate. Suicide is strongly linked to mental illness by OOTD; however, that is so broad as to encompass many different conditions, and is not the only cause of suicidal behavior. When mental illness includes conditions from extreme disengagement with reality (paranoid schizophrenia) to mild debilitation (bipolar disorder, forms of clinical depression) or even intrusive habit (obsessive-compulsive disorder), it may seem as though it can appear at any time in any place through anyone. Moreover, it is not the only cause of suicidal ideation, although it may be the most prominent. Combating this threat requires that all of society fall under the purview of the panoptic gaze. The more a society can extend its reach over its various parts, the more it can extract resources – labor, time, health – for its continued optimal operation (Foucault, 1995, p. 154). In order to best enact its goal of prevention through stressing the observation of potential symptoms – signs in the narrative of suicide – OOTD needs every person exposed to its rhetoric to not only believe in its message, but to represent that belief through action, i.e. conscious surveillance of oneself and those around him/her.

Vigilance is particularly important considering the risk of violence. While professionals may not witness violence among the mentally ill at the same rates that the general population perceives as true, expert opinion concurs with lay beliefs that the mentally ill present a greater physical threat to themselves and to others than the mentally healthy, along with other negative qualities that are attributed to the mentally ill (Hansson, Jormfeldt, Svedberg, & Svensson, 2011,
This is in spite of more than 70 years of dedicated research into the link between the presence of mental illness and violence against either others or the self, varying greatly in their definitions of violence, insanity, and in their methodologies of discovering any link between the two. Analysis of these findings leads one to the conclusion that the risk of violence of greatly overstated (Langan, 2010, p. 86). Yet stereotypes persist. This is in no small part due to the coverage given to instances where violence is perpetrated by someone officially diagnosed with a mental disorder or exhibiting behaviors and thoughts that, to the conditioned eye, constitute symptoms of a recognized mental disease. This discourse is often grossly exaggerated, providing distorted depictions of mental illness and leading the audience (including mentally ill individuals) to overwhelmingly negative reactions (Stuart, 2006, p. 100-101). But it does not arise spontaneously. Media institutions draw on cultural tropes, common understandings of insanity and traditions dictating an uncompromising disapproval of suicide, seeing it as selfish violence which deprives society of an asset and affronts the divine (Foucault, 1988, p. 212-213, 233-234).

The tacit tenet of observation is thus not simply for pleasure, or to impartially record events as they occur; it is with an eye toward action. So long as someone or a community is aware of what they should and should not be seeing, they perpetuate established notions of behavior, ranging in severity from risk-averse or risk-free (safe or ordinary) to at-risk (suspicious) and finally to high-risk (imminent danger). Paranoia is an inevitable result of a constant, focused alertness; any practice that relies on unceasing watchfulness is prone to constructing signs of significance that may or may not actually exist. It becomes impossible to perceive without also evaluating and judging. Although this process is perfected in the psychiatric evaluation, in the office of the therapist or the physician, it can be found outside of
formal establishments and specialized settings in the institutions of everyday life such as the school, the office, and even in interpersonal networks like family and friends. It is a rigorous presence of mind that furthers the goals of the existing social order: “The success of disciplinary power derives no doubt from the use of simple instruments; hierarchical observation, normalizing judgement and their combination in a procedure that is specific to it, the examination” (Foucault, 1995, p. 170). The awareness of OOTD is a practice that leaves no individual unobserved, whether it is by others or his/herself. It brings everyone under the sway of the public by enlarging the public sphere to reach every possible corner; as soon as one is socialized, they have internalized the same values and habits which mark them as a member of society (Foucault, 1995, p. 172, 177). Once this is achieved then it is possible to not only note what happens but also the appropriate reaction. Attentiveness goes hand in hand with responsiveness, guided by credible knowledge and techniques.

**Seeking Treatment**

A logical consequence of activist intervention is to have avenues of action ready and waiting to be used. Discipline requires more than the capability to act, or awareness of one’s ability and duty; it also demands the will to act, to take advantage of the means of access that have been provided (Foucault, 1995, p. 138, 170, 175). OOTD encourages the seeking of specific modes of treatment as a means of suicide prevention. While it certainly aims to persuade the mentally ill that they should at some point seek aid, it overwhelming focuses on the social network of at-risk individuals to act as proxies, seeking help and providing support for those who are unable and/or unwilling to do it themselves as well as addressing conditions that may lead to suicidal behavior (Cox, et al., 2013, p. 4; Caine, 2013, p. 6). As a preventative effort, OOTD derives its effectiveness from proactive behavior; it cannot afford to be a reactive initiative,
especially in the case of suicide where the damage is irreversible. To this end it also relies on actively constructing a sense of danger, creating its own vision of the existing harms and directing attention to common cultural narratives such as media coverage to underscore the riskiness of the status quo (Glick & Applbaum, 2010, p. 231-232; Thornton, 2010, p. 313-315). The ensuing message is that whatever concerns one may have at the moment the advantages of acting in a socially prescribed manner outweigh the disadvantages, and therefore an obligation to act exists that should not and cannot be ignored.

In the course of incentivizing treatment-seeking behavior, OOTD constructs a hierarchy of remedy. There exists an order of importance among the functionaries of the state and the dominant social order, while the perspectives of the abnormal become devalued in comparison and are consequently ignored (Foucault, 1988, p. 252-253, 266; 1995, 173-174). The credibility and efficacy of other coping mechanisms, especially self-medicating methods, become suspect and less reliable than the programs sponsored by the AFSP. By constructing this hierarchy it ensures that not only do at-risk individuals seek help in general, but that they do so through the proper channels and with satisfactory results. Working with a professional therapist is preferable or concomitant with a regimen of prescription medication; prescription medication is preferable to self-medication like substance abuse or repression of emotion; self-medication is preferable to pretending that a problem does not exist or using others as personal scapegoats. OOTD appropriates the caretaking and advising role that belonged previously to the family and the local community, recasting it as a responsibility that eventually becomes too much for small groups to handle. In this way it continues the trajectory of Western efforts to manage madness by transferring the center of authority over treatment from the family and friends or colleagues to the community and the state, from the individual to the collective (Foucault, 1988, p. 254). Part
of this effort is to provide a new take on individuals who make use of professional treatments. Portraying treatment-seeking behavior as beneficial and devoid of shame and public ridicule is key to making professional healthcare seem more appealing, especially as a counter to social constructions such as masculinity (Haddad, 2013, p. 50; Gardner, 2007, p. 546-548).

Another means of accomplishing this is to eliminate responsibility from the subject through scientific discourse. By labeling suicide as an illness, the presence of symptoms is no longer a matter over which the individual has any control. Where they are able to exercise agency is in their response, which is often goaded toward utilizing licensed therapy sessions and pharmaceutical antidepressants (Gardner, 2003, p. 115, 119). Opposition to treatment is framed as unsound or irrational, sharing a basis with the very object of treatment and reinforcing the need for specific professional assistance (Simon, Levenson, & Shuman, 2005, p. 178). Properly accredited expert aid is legitimated against most critiques, while those same criticisms lose standing by virtue of their very standpoint (Foucault, 1988, p. 248-249). The implication in the rhetoric becomes clear. The suicidal person is not guilty because they have suicidal thoughts, but because they obey them rather than contesting them and seeking out available prevention efforts. They are not inherently immoral, but they may become corrupt by yielding to innate tendencies; it is their deeds and not their nature that justifies their condemnation.

Intrinsically predisposed toward erroneous decisions, the mentally ill should be exposed to more enlightened perspectives according to OOTD. Once they are aware of the scientific and apparently objective truths behind suicide, they should come to the right (i.e. acceptable or normal) conclusions with minimal coercion. This process, however, silences the objections of any patient by ignoring them or framing their dissent as destructive. The doctor-madman dialectic of two opposing equals becomes a one-sided dialogue of the clinician about the patient.
The only perspective that is allowed to speak, to speculate, and to suggest is the privileged position of medicine and the interests of the community, as represented in the persons of the physician, the advocate, and the legislator. In this way the control of the state and of society is upheld even in the face of adamant dissent, since said dissent is reconstituted as further evidence of the problem which can only be solved by increasing the severity and scope of collective techniques of power (Foucault, 1988, p. 246-247). The viewpoint which is the source of discovery, in effect the creator of knowledge, is the viewpoint which situates that information in a network of influence and thus is in the position of power over the subjects and objects of inquiry (Foucault, 1994, p. 162-164).

**Knowledge as Control**

As an object of pure use-value, knowledge in OOTD loses its neutral character to become a tool for modifying and reinforcing existing attitudes toward suicide. Knowledge, especially utilitarian knowledge, is never neutral despite its claims to objectivity (Foucault, 1994, 121-122). It is incorporated into the networks and flow of power, lending itself to reinforcing or challenging the social order and more frequently supporting it than not; in this way it often becomes a tool of domination and repression (Foucault, 1990, p. 11). By characterizing knowledge as scientific and linking it to a goal of prevention, OOTD implicitly – and perhaps unconsciously – rejects the explanatory power of knowledge in favor of its power to modify, all the while maintaining that it is simply a body of facts that is given purpose. This is not the case; this collection of data, because it is targeted to a single subject and collected with a specific purpose in mind, is not a body of facts but an assembly of verdicts on different phenomena. It is information that can be employed in the service of liberation from mental illness and eradication of suicide; it is a technological wisdom (Borgmann, 1984, p. 36). In spite of its comprehensive
quality, it is also an impoverished wisdom; it is specialized and reductionist knowledge indicative of its discipline – in this case the medical institution (Mond, 2013, p. 2). Being a biomedical paradigm, it neglects the influence of other factors of suicide such as socioeconomic standing and the state of interpersonal relationships – the body as a convergence of several sociological and natural networks (Fox, 2011, para. 24). Awareness and education retain a structure that is masked when possible and justified when unavoidably visible.

The knowledge of the resident authority is often vast and unquestioned because it already resides in a position of power (Foucault, 1988, 251-253). However knowledge, and its acquisition, is also subjected to an assessment of its credibility. If it is to be useful, it must be reliable; this reliability can only be ascertained by evaluation of its source. Certain fields and personnel automatically become more credible on the basis of their role, their social-academic or social-professional role. This is in spite of their questionable claims to authority and objectivity; epistemologically they are as susceptible to error and bias as any other branch of human knowledge, even as they claim otherwise (Arrigo & Williams, 1999). Moreover, these perspectives carry with them several implications, some trivial and some profound, for handling mental illness and the individuals diagnosed as such. One of these implications is privileging certain knowledge over others, such as giving more weight to the statements and arguments of physicians and other healthcare providers over the testimony of patients (Scheyett, 2006, p. 76, 80-81; Gault, 2009, p. 508-511). The prevention of suicide is not a cooperative venture, nor was it ever intended to be. It is an exercise of power on a subject, compliant or unwilling, an “endless monologue of the person watched… the new structure of language without response” (Foucault, 1988, p. 250-251). It does not matter what the suicidal person has to say, aside from their
suicidal ideation. What does matter is the knowledge of the therapist and their ability to persuade the patient of the truth of that knowledge.

**Setting Limits to Deviance**

OOTD constructs boundaries around acceptable behavior and thought; in other words, it sets forth norms for a community as well as how to adhere to those norms. By taking this approach rather than a complete ban on suicidal states of being or ostracization of suicidal ideators, it extends its authority over the at-risk demographic it seeks to influence. The procedure of identifying what is and what is not acceptable, as well as how the latter can be transformed into the former through compliant action, is the same disciplining and normalizing process that forms the foundation for modern society, especially in its institutions of the prison and the hospital (Foucault, 1990, p. 68-69; Foucault, 1995, 215-216). As OOTD attempts to persuade its audience that suicide is a problem with a particular character and that they should take specific action to respond to it, it simultaneously constructs notions of the normal and the abnormal – not only whether suicidal thought itself is aberrant, but whether our potential responses to that phenomenon are appropriate or inappropriate, i.e. whether they themselves also lie within the bounds of normality. Normalization is as much concerned with the irregular, maybe even more so, than it is with what is considered to be typical. This concern most often takes the form of suppression, segregation, or eradication.

OOTD confronts a deviant behavior, one that cannot be eliminated entirely (at least not easily); what it can do in the meantime is to set limits around it to limit its effects and trace its causes. When the rhetoric links the occurrence of suicide to the presence of mental illness or similar symptoms, it constructs an association that invokes various other connotations that are not necessarily true, either in and of themselves or in combination with other suggestions. The
symbolic representation of causality, that mental illness leads to suicidal behavior (Nairn, 2007), establishes ground for intervention. If there is a chain of causation, then there are stages at which the chain may be broken. Therein lies the burden; one cannot control being born predisposed to mental illness and suicidal behavior, but one can – and thus should – act in order to prevent suicide from coming to pass. The reason suicide still occurs then is not a question of access but of will; the even treatment with a 100% success rate is only useful if it is employed. This is a notion that is disseminated not only through awareness/prevention campaigns like OOTD but also via mainstream media narratives; each “episode reflects and reinforces existing cultural models for mental illness, including its status as straightforward biological disease amenable to pharmacological therapy but which remains uncontrolled due to widespread noncompliance” (Glick & Applbaum, 2010, p. 229). Cooperation is paramount in service to the overall cause of prevention – so vital that it carries with it the force of moral sanction.

In this conversation surrounding the nature of deviance, the deviant is denied a voice. It is because they are the violator of convention that their credibility among the normal population is lost, or more accurately denied. This is in large part due to the moral sanction laid upon the absence of sanity, that those who do not or cannot reason lie at or outside the margins of civilization (Foucault, 1988). When the subject perceives themselves to be in the wrong, or on the losing end of a social controversy, they are less willing to voice their opinion; their perspective is figuratively gagged (Glynn, Hayes, & Shanahan, 1997, p. 453). An unwillingness to speak up is understandable when dissent is framed as not only unreasonable and ignorant, but also as amplifying the existing dangers posed by suicide (Thornton, 2010, p. 317, 319-320). It is also logical when both service users and service providers internalize negative attitudes regarding the mentally ill as untrustworthy, unreliable, and ultimately dangerous to others and
especially themselves (Hansson, Jormfeldt, Svedberg, & Svensson, 2011, p. 51). The suicidal subject is only the object of study, not an equal partner in the discourse surrounding their condition (Foucault, 1988, p. 250-251). Silence is the preferable alternative given to the suicidal outsider by the sane community, since to speak would necessitate an additional violation of taboo and risk not only punishment, but lack of comprehension by the intended audience (Foucault, 1990, p. 18, 100-101). The allocation of power and its jurisdiction is completed; the suicidal deviant is judged and sentenced without being able to defend themselves through their own words and experiences in the court of sanity.
DISCUSSION

The overall goal of the study was to uncover the assumptions behind contemporary American attitudes toward suicide and voluntary efforts to prevent it. In so doing it answered two questions: how is suicide rhetorically framed by those advocating for its prevention, and is there an inherent obligation to act on a biomedical understanding of a social ill? The answer to the first question is that suicidal tendencies are portrayed as being inevitable as a side effect of mental illness but avertable as a reaction to the same. In other words, we cannot control whether or not we are genetically susceptible to mental disorders. What we can control is how we respond to those same disorders, whether we succumb to their pressures or mitigate them through endorsed methods. Moreover, it is a problem that conceivably anyone can address with the proper understanding of the phenomenon. This understanding, at its face impartial and devoid of suggestion, actually invites us to consider certain activities over others to the extent that some courses of action may not even enter our deliberations as an acceptable option. It follows then that the answer to the second question is yes; the obligation is implicit but present. It is often taken for granted that because we have the ability and information necessary to change our world, we do. Yet this line of logic is not difficult to trace and, when explicitly articulated, appears as such: because we can, we should; because we should, we must; because we must, we will. Inaction becomes an inexcusable dereliction of duty, and so the medical motto of “do no harm” becomes “do no harm by acting or failing to act”. As a result, those who do not seek official help are pitied but also blamed, while those who cooperate are pitied but forgiven. Together, control – over oneself, others, and nature – is the principal purpose of a prevention campaign.
OOTD is largely consistent with other Western approaches to suicide characterization and prevention. The more relevant areas of commonality include the (equal parts perceived and actual) relationship between mental illness and violence, especially violence directed against the self; the limited social engagement mentally ill individuals can and should engage in; the biological as opposed to social or cultural causes of suicide; and the need for proactive, interventionist policies and programs. However, the question this raises is whether such campaigns are worth the associated costs; is their presence an acceptable imposition, given the possibilities of their absence?

However, there are differences that are quantitatively negligible yet qualitatively significant. Whereas the burden of action lies with state agencies in Europe, the seat of responsibility in the United States rests with the public. Legitimacy is derived not from identifying with a governing body, but through claiming a mandate from the people. NGOs are thus a more popular and credible vehicle for addressing social ills such as suicide than the various bodies of government. This is especially important when considering the need for participation in a panoptic society. Panopticism is premised on compliance, on the citizen-subject becoming an outlet for observation. Ubiquitous surveillance, especially of the self, is impossible without the conformity and acquiescence of the populace. Similarly, normalization can only succeed if norms are adopted by a majority; otherwise, they are simply cultural mores. Once a pattern of obedience is established, then both consent and approval are assumed. This allows an organization or agency greater freedom to act without fear of backlash or resistance to policy.

In accordance with this democratic quality, persuasion is afforded a position of importance in American discourse. The public does not have to be convinced that a problem exists; they are often aware of current affairs, and are occasionally confronted with it through
personal experience. The public must instead be persuaded that the problem possesses a particular character and that they have both the ability and duty to mitigate it. To this end campaigns stress the consequences of ignorance and inaction. Activity gains a moral character; to act is to be just and compassionate, while to disregard circumstances or fail to educate oneself carries with it notions of callousness and injurious indifference. Appeals to emotion, cultural conventions and traditions, and descriptions of an ideal future are therefore fair methods for advocacy, on par with scientific evidence. Suicide is an enemy which must be defeated at almost any cost, a plague to be eradicated like polio in the 20th century; the war must be won before it is fought in earnest. Every person who has been affected or is capable of being affected by suicide is encouraged to enlist and to do their part for the cause. To maintain a vigil is to watch out for one’s community as well as oneself. To help another obtain treatment, or to recognize the need for help in oneself, shows the proper level of dedication and investment in the vision of the good life set forth by the culture. Panopticism and prevention both rest on the internalization of values, the turning of the gaze inward as well as outward. Willing participation is the crux of consciousness-raising and proactive care campaigns.

As a result, it becomes difficult to claim the dangers of prevention campaigns are more harmful than their absence, or the hazards of other possible responses. While there are potentially negative outcomes which may result from the pressures campaigns like OOTD create, these may in fact be the lesser of two evils when considering the possibilities of other responses or even a lack of engagement with the quandary suicide represents. To complicate matters further, there is at the very least an atmosphere of desire for a response. It is not clear exactly what approach is advocated for above all others; there are many policies and agencies competing for support and supremacy. Instead, there is a sense that there is a problem (suicide) and something – anything –
should be done in order to resolve it. It therefore becomes problematic to claim that nothing should in fact be done, or to suggest that there either is no problem or that its magnitude and scope have been exaggerated. Similarly, it becomes tiring to conceive of a solution which combines all of the strengths of other initiatives without also incorporating their weaknesses. As such, the imperfect situation we find ourselves in may be the scenario with the fewest flaws, rather than the greatest number of benefits.
REFERENCES


