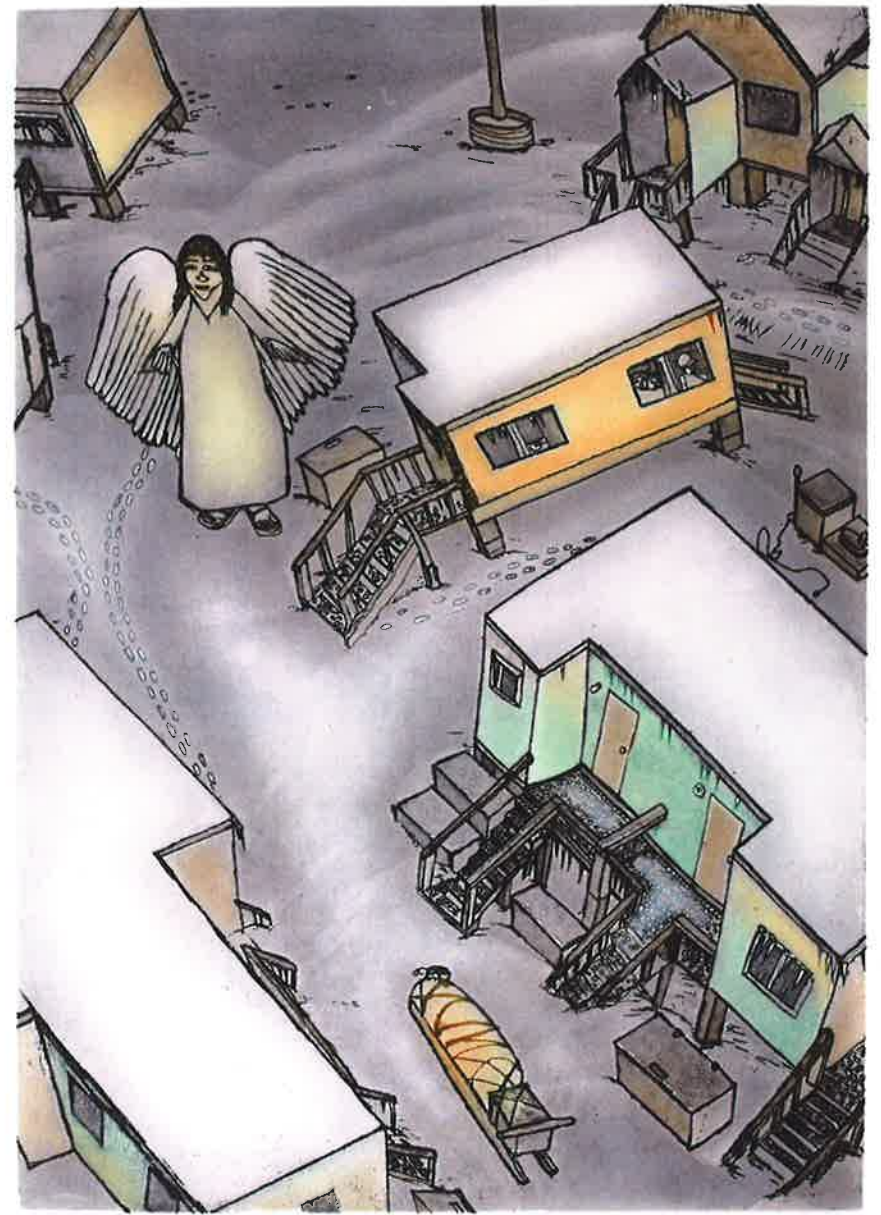


Life Beside Itself



IMAGINING CARE IN THE CANADIAN ARCTIC

Lisa Stevenson

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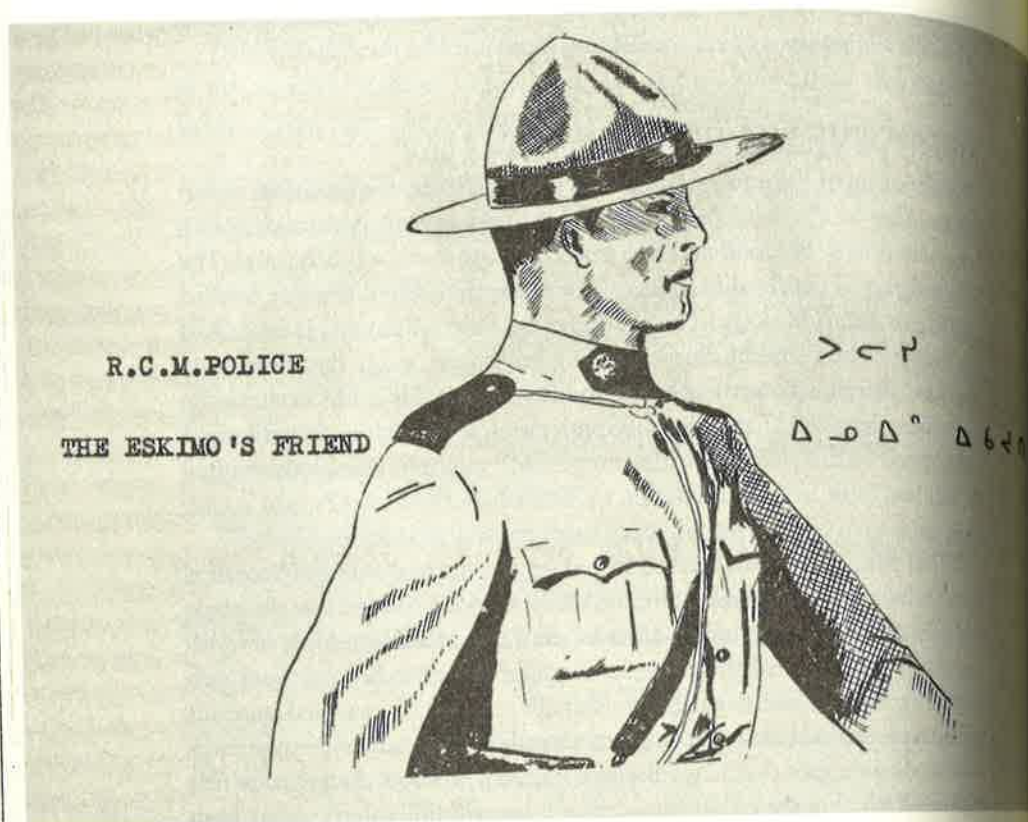
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CHAPTER 3

I was constantly on the move when I lived in Iqaluit. The housing shortage was acute, and I had neither the money to rent one of the few privately owned apartments, nor a job through which to secure subsidized housing. On one occasion, while house-sitting for an Inuit friend who was out of town, her brother flew in the open door without knocking (doors were often unlocked in Inuit communities, and I was told that the only people who knock are the RCMP or social workers) and was startled to find me sitting alone in his sister's kitchen drinking tea. I offered him some tea, which was awkward since people in Iqaluit usually help themselves to tea when they want it without asking. But Joan-nasie didn't seem to mind and we started to talk. He asked me about my research, and after I had stuttered something about the suicide epidemic, he looked at me with steel in his eyes and said, "Qallunaat are too professional." Then he proceeded to tell me the story of the first suicide he could remember in the community where he grew up.

teenager's house. He gave the boy a stern lecture with his family watching from the living room.

"So my friend, eh? That night he got a high-powered rifle and blew his brains out underneath the RCMP's window." Joannasie watched carefully for my reaction and then added, "He took it personally, eh?"

The RCMP had a specific professional mandate to fulfill in the colonial North—to enforce the law. But because they were often the only representatives of the Canadian state in the North, whenever necessary they also acted as "registrars of vital statistics, collectors of various kinds of government revenue, inspectors of fisheries, Indian agents, postmasters, and administrators of pensions, family allowances and other welfare provisions" (Rea 1968: 49). In *The Book of Wisdom for Eskimo* (that "civilizing" tract the Canadian government distributed to the Inuit in the 1940s instructing them on proper comportment, cleanliness, and hunting practices) there is a line drawing of an RCMP officer in uniform (see page 74). He looks to be midstride. The caption reads "R.C.M. Police, The Eskimo's Friend" (Bureau of Northwest Territories and Yukon Services 1947: 19).¹

What does it mean to be both a friend and an enforcer of the law, a friend and the executor of bureaucratic reason? In Joannasie's mind, the fact that Qallunaat were "too professional" was at the heart of the Inuit suicide epidemic. Inuit, he went on to argue, often take personally what is intended as a professional interaction.

Joannasie's point is related to the one Quvianaqtuq made in his letter to Yatsushiro fifty years earlier and that Max Weber made at the turn of the twentieth century. It's a simple one: in a bureaucracy, "life is focused not on persons but on impersonal rational goals" (Weber 1968: 1200). That is, a bureaucracy is indifferent to persons and the personal. The policeman talks to the young Inuk man as a police officer to a criminal, thereby administering justice and keeping the peace.² But how does this mesh with the idea, disseminated in *The Book of Wisdom*, that the RCMP are the Eskimos' friends? What is friendship if not a willingness to act in an interested way on a friend's behalf?

Acting as a "professional," the RCMP agent that knocked on the young "criminal's" door appeared disinterested—unbiased by personal interest, to be sure—but also perhaps "unbrotherly" in Weber's sense. There is nothing friendly—in the sense of being motivated by personal interest—about such a bureaucratic way of proceeding. As Quvianaqtuq put it, "Sometimes we [the Inuit and the Qallunaat] do not understand each other." In this case, the line between friend and professional describes a scene of violence, flatteringly known as justice.

In Nunavut today, the situation is both very different and very much the same as when Joannasie's friend committed suicide. Although the line between friend and professional still describes a scene of violence, suicide is, tragically, no longer an unusual event. As one youth put it to me, "Sometimes we hear, 'So-and-so committed suicide or tried to commit suicide.' I find that sometimes I try to really hear it, and understand it, but I find it's just in one ear and out the other. Just because it's something that happened so often."

In 2003, for the first time since the creation of the territory in 1999, the Nunavut legislature tabled the question of suicide (Nunavut Legislative Assembly 2003: 2347–77). Beyond all the statistics, the legislators agreed that every citizen of Nunavut had been affected by suicide—that is, every citizen had experienced the death of a family member or friend. The minister of health declared suicide "probably the number 1 health care crisis in Nunavut" (2351). Another member suggested, "Every single Nunavummiut has thought at one time or another that their child is possibly suicidal" (2354). To form a comprehensive strategy each and every department of the fledgling Nunavut government was expected to come up with strategies to "suicide-proof" their organization and the territory. Everyone was at risk and everyone was implicated. By 2007, when the Nunavut government (GN) came out with its suicide intervention and prevention strategy, it suggested that there should be "frequent exchange of information among all GN employees regarding suicide in Nunavut" (Government of Nunavut 2007: 16). In reading the Hansard transcripts along with the territory's 2007 suicide intervention and prevention strategy, it becomes clear that the new territory is somehow steeped in suicide, that the desire to die and the desire to stem that desire has become part of its identity. In such a context, the claim that one has "made a difference" in the lives of Inuit youth is literally contested territory.³

The life of a suicidal Inuit youth today is vetted by agents too numerous to count. Performing "the most suicide interventions in Canada" has become a point of ambivalent pride for a counselor who prefaces her speeches with this fact. Everyone—all Inuit, that is—has become potentially suicidal and in need of counseling. As a suicide prevention pamphlet released by the Nunavut Department of Education in 2005 warns, you should trust your instincts: if you think someone is suicidal, he or she probably is. In a parallel fashion, every activity is potentially a suicide prevention strategy: soccer, hunting, day care, field trips, drum dancing, eating country food—all can be fashioned as life preserving.

Anniruktut, Nunavut's Suicide Intervention and Prevention Strategy, lists among its measures to combat suicide "math and science awareness programs" and "tobacco reduction initiatives" (Government of Nunavut 2007: 20–21). The brochures instruct readers never to leave a high-risk person alone. Signs that a person may be at high risk for suicide include coming from a broken home, drug and alcohol abuse, and physical, sexual, and verbal abuse. A pamphlet from the Northwest Territories suggests, "People who talk about suicide do it. Four out of five people who kill themselves have given out definite signals or talked to someone about it" (Tli Cho Suicide Prevention Team 2004).

Of course, viewed within such a framework, most of the youth in Iqaluit are at high risk of suicide. As the member of legislature suggests, there isn't a parent in Nunavut who hasn't at some point suspected his or her child was suicidal. In such a context, care quickly becomes linked to surveillance. In fact, the director of a youth center admitted to me that for her, the most important suicide prevention programming would be having someone available twenty-four hours a day to whom she could hand off suicidal kids once the youth center was closed. She hated having to go home wondering what was going to happen.

Ian Marsh writes in a very lucid way about the "compulsory ontology of pathology" that has governed thinking about suicide since the nineteenth century. By this Marsh means that since the nineteenth century suicide has been pathologized as mental illness (understood to have biological causes), and all other ways of thinking about suicide have come to be seen as somehow "ethically indefensible" (2013: 749).⁴ According to Marsh, this "compulsory ontology of pathology" has the effect of both individualizing suicide (as mental illness, suicide belongs properly to the body of the suicidal person) and removing responsibility for the act from the individual and placing it with the caretaker. In Marsh's own experience working in the field of mental health, "Suicidal individuals themselves are positioned within this discourse of pathology as mentally unwell, and thus not fully responsible for their actions; instead, clinicians are taken to be the responsible, accountable, and possibly culpable agents in relation to their 'suicidal patients.' Suicide prevention training and planning comes to be largely about the identification and treatment of mental illness within 'at risk' populations" (2013: 749). Although the discourse in aboriginal communities focuses less on mental illness per se than on issues of trauma and abuse (Aboriginal Healing Foundation 2004; Elias et al. 2012), Marsh's insights about the identification and treatment of "at risk" individuals

hold true, as do his insights into the thorny question of clinician responsibility.⁵

Suicide prevention programs, along with their attempts to reduce the risk of self-harm, generally strive to ensure that practitioners cannot be implicated in the death of their charges. One aspect of suicide intervention that makes it so complicated is that the caregiver, whether a doctor, teacher, or school counselor, is constantly faced with the brute fact of the agency of another human being. In simple terms, "disease" is marked here primarily by the intention to carry out a particular *action* rather than by an organic imbalance or deviation from a norm (although both the organic imbalance and deviation from a norm may be presumed to exist). One way to manage the uncertainty of such an encounter, where health is defined negatively as the absence of an action or its desire, is to have a set of procedures ready to carry out that will in some sense absolve the practitioner of any "responsibility" for the patient's future actions. For instance, the Northwest Territories Mental Health Act, to which Nunavut adheres, stipulates that individuals must be admitted to the hospital if they are at risk of harming themselves or others (Northwest Territories 2009). It is clear that once an individual is under constant surveillance, the risk of him or her committing suicide is radically reduced.⁶ Of course, the possibilities of life are also reduced. The authors of an article arguing for the necessity of a protocol for early suicide intervention in First Nations communities argue, "The development of an effective suicide risk management tool is essential not only to *capture* Aboriginal clients at risk before they commit suicide, but also to provide an opportunity for early intervention by supplying culturally-based support from members within their own community" (MacNeil and Guilmette 2004; emphasis added).

Capturing at risk aboriginal clients may reduce the number of suicides. It is also one way to ensure that one is not held responsible for missing the warning signs. By turning people who are suffering into "clients" who become objects of suicide risk management tools, the counselor no longer has to cope with the existential anxiety that is raised by suicide and the specificity of the suffering one is witnessing. The proliferation of suicide protocols [as an important aspect of the professionalization of suicide prevention] is an example of what Charles Taylor (1994) calls the "bureaucratic ways of proceeding" that are characteristic of modern state forms (see chapter 2). These bureaucratic ways of proceeding, which lift the burden of decision or responsibility from us, are generally designed to mitigate the failure of the state or its agents and to ensure prompt and professional action.

The Nunavut Suicide Response Protocol, written in 2001, opens with the following paragraph:

In Nunavut suicide is an all too common occurrence. This protocol is going to address the devastation that results in communities, and schools in particular, when a student or staff member kills him or herself. Communities and the schools within these communities need to know what to do. There needs to be a plan to help ease the pain of those affected by the suicide and to help enable the grief to be expressed and the healing to begin. (Nunavut Department of Education 2001: 1)

I am interested here in the fact that it is only through having “a plan” that grief will be expressed and healing will begin. The protocol that schools are instructed to follow involves eight main “actions” to be taken after a suicide occurs, each divided into multiple bulleted sub-headings. If a practitioner follows the protocol, there is, in a certain sense, “nothing more that could have been done.” No pointing of fingers. The actions to be taken include confirming and providing information about the suicide to the RCMP and the family, as well as setting up grieving rooms and sending condolence letters. Another crucial step is to identify “at risk” students and staff and provide a list of those persons to “H&SS personnel so that they can apply their Suicide Response Postvention protocol.” The circularity of the protocol is remarkable. That anyone could resist “capture” seems unlikely.

A different kind of protocol, originally developed by the Kitikmeot Health and Social Services in 1999, establishes a procedure to follow in the event that one of its staff: 1) encounters someone with suicidal ideas; 2) witnesses or is informed of a suicide attempt; or 3) has to cope with the aftermath of a completed suicide.⁷ The importance of doing things within the proper time frame is emphasized: there are things to do immediately, things to do within two hours, and things to do within twenty-four hours. After a suicide attempt, for example, one must immediately contact the “on-call Social Worker and the on-call Nurse and Mental Health/Addiction Counselor” (Northwest Territories Health and Social Services 2005: 5). Once the location of the suicide is deemed safe from firearms or other weapons, “front line staff will access the client directly/in person, for the purposes of a Mental Status Exam and Suicide Risk Assessment,” which are provided in the appendix. Within two hours, “any high risk family members and/or friends who self identify or are identified by the client or any other persons/professional in the community, must be interviewed by the Team to establish their level of risk/need at the time of the incident” (6). And within twenty-four

hours, “the *Suicide Completions and Attempts* form will be completed and faxed to the Clinical Supervisor” (7).

For most front-line youth workers, the fear of someone dying on their watch (or just after) is understandably terrifying. And I want to make one thing very clear: the individuals involved in suicide prevention very often do make a difference and do provide indispensable care to people who are in pain. They are generally dedicated, thoughtful, and self-reflective people—exactly the kind of people I would want to talk to in a moment of acute distress. And in fact, I count myself as having been, for a short time during fieldwork, among those who were trying to help. I spent several months volunteering on the hotline and experienced the strange terror that hearing the phone ring elicits. One night I received a call from a woman in tears about a relationship. We made a connection, and by the end of the conversation I think she felt a little better.

But the discourse of suicide has a time—and we might even say a “life”—of its own. As Foucault reminded us, “Discourse is not life, its time is not your time” (1991: 71). Crucially, it is precisely the distinction between “your life” and the “discourse” on that life that threatens to disappear in contemporary suicide prevention efforts in Nunavut. That is, the suicide apparatus in Nunavut functions as a powerful discursive machine that seeks to frame what it means to be in life and in time. To care properly one must care according to the protocols—in their time. Such protocols may at times function as what Cora Diamond (2008) calls a “deflection” from the wounded body, a way of treating the body as a fact that prevents caregivers (perhaps understandably, but still unfortunately) from recognizing the ontological uncertainty of whether or not someone will actually try to kill him or herself, as well as from dealing with the specificity of the person before them. After twenty-four hours the person who attempted suicide has become yet another name on the “Suicide Completion and Attempts” form.⁸

EXPECTING DEATH

The “regime of life” I have been describing vis-à-vis the tuberculosis epidemic began to attach itself, starting in the 1970s and '80s, to this new problem of Inuit youth suicide. Today suicide is portrayed as a massive public health problem, one that, it is hoped, will be responsive to reeducation campaigns set up by the territorial government.⁹ This is, when one thinks about it, a startling formulation. How can I presume

to use the word "reeducation" in conjunction with a suicide prevention campaign? Because there is something about the way experts try to get Inuit to stay alive that is reminiscent of the way experts tried to make them clean. We teach cleanliness but expect filth. We teach life as the ultimate value but expect death.¹⁰

The idea of "expecting" Inuit to commit suicide is tied up with what the minister of health, in that early discussion on suicide in the Nunavut legislature, called the normalization of suicide: "Suicide has become so normal within our culture, within our society, within our territory, we are not shocked by suicides anymore" (Nunavut Legislative Assembly 2003: 2349).¹¹ But that's not all it is. To expect suicide of the Inuit has everything to do with the vestiges of our colonial desires that mean we are secretly fascinated by, drawn to, Inuit filth and, in a parallel manner, Inuit death.

One manifestation of what I am calling "reeducation" campaigns, beyond all the conferences and workshops that take place, appears in the prolife slogans that appear on posters around the community reminiscent of those extolling the virtues of quitting smoking and saying "no" to drugs.¹² The baldness of their messages is striking: one that was distributed by the Nunavut government read, "Inuit Pride, Stay Alive, Inuit Survive." Such posters, like the RCMP agent as well as Coetzee's doctor (described in chapter 2), spread their message of cooperation indifferently. It matters not who you are, but that you, the reader of the poster, stay alive.

I am arguing here that the indifference to the identity of the individual who must live is the implicit structure of suicide prevention in Nunavut, just as it was in the assault on tuberculosis and the imposition of the disc list system that I discussed in chapter 1. Care becomes, as Joannasie pointed out, "too professional," or, as I would like to put it, care becomes "anonymous."

When life becomes an indifferent value it no longer matters *who* you are, only that you cooperate in the project of staying alive. Remember the bureaucrat who imagines having a dead "Eskimo" on his hands (chapter 1) and the way "Eskimos are also statistics" (chapter 1) but also the way that the doctor in Coetzee's novel keeps tripping over Michael's name (chapter 2): in Coetzee's novel the doctor cares for his patient because he is a doctor, not because of who Michael is or what the story of his name might reveal. For the RCMP agent, of course, it mattered not who the criminal was but only that he was punished. We have to ask ourselves whether anything has changed: is there also some-

thing punitive/punishing about making Inuit live while expecting them to die?¹³

PROFESSIONAL AND FRIEND

The shifting relationship between professional and friend, indifference and concern, the bureaucratic and the intimate, is central to an understanding of suicide prevention in Nunavut. In fact, we could say that it is this tension between professional and friend that structures suicide prevention work. The longest-standing suicide prevention initiative in Nunavut is the Kamatsiaqtut "help line" that began as an anonymous suicide hotline in 1989. Although it has shifted its mandate (and name) over the years to address other related forms of distress (coming to be officially called a crisis line and a help line), it is still known locally as the "suicide hotline," and youth in Iqaluit are quick to rhyme off its phone number, sometimes taunting each other, "Why don't you just call -3333?"

The tension between indifference and concern, professional and friend, is central to how the hotline works. A brochure advertising the hotline informs the reader that the word "*kamatsiaqtut*" can be translated as "thoughtful people who care" and that the help line is designed to provide a "discreet and anonymous service" for *anyone* experiencing emotional distress.¹⁴ It doesn't matter who you are (again, the volunteers are in this sense "indifferent" to your identity): you will be cared for.

The hotline is generally open from 9 p.m. to midnight every night, even on Christmas. At any given time there are approximately fifty volunteers on the roster, and almost all of them are professionals, such as teachers, social workers, and nurses. At the time I was doing research, only four of the fifty were Inuit. The volunteers field calls from all of the twenty-eight communities in Nunavut, as well as from Nunavik, the Inuit settlement area of Northern Quebec. The people who call the line, save for the occasional caller from Southern Ontario, are mostly Inuit.

During the time I spent volunteering on the line, I became curious about what it meant to be able to care for others, especially Inuit others, without knowing who they were—to care indiscriminately, professionally, and anonymously. To care anonymously requires being able to care intransitively, to be able to say, "I care" without specifying for whom. As one volunteer explained to me, even if you recognize the voice on the other end of the phone, you treat that person as if you didn't; you even

come to believe on a certain level that you don't know that person. This also describes the scene of the RCMP officer at the teenager's door. When the RCMP officer approached the teenager who had committed a "break and enter," he affected what appeared to be a sudden shift—from a concerned friend to a disinterested and theoretically impersonal professional. He seemed not to know the teenager. The officer who stood at the door, calling the teenager out, was performing anonymous care.

One result of this on the hotline is that the suffering of the person on the other end of the line is circumscribed by anonymous relations in such a way that no claims are made on the volunteer nor the caller after she hangs up. One of the volunteers described the caring that occurs on the hotline as

more an abstract caring. It's not the same as caring for someone I know. It's like—if I was driving along a highway and I saw an accident, I would stop even though I don't know the person, because as a human being I would care that there is somebody who is hurt. You get affected by some of the calls you get and you hear how hurt the person is. Sure, I don't care about them personally, but I do care as a human being.

Or, as another volunteer responded when I asked exactly for *whom* she was caring when she went on the line, "You're doing something for Nunavut. You're doing something for your community. You're doing something for society at large . . . And any time you do something to help someone help themselves and to make some good choices, you are doing something for the community, for society, for your families. So it's not something that's just a one-on-one thing—whatsoever!"¹⁵ When I asked another woman why she volunteered, she said, "For me it's just to help in general. I'm happy to help in any way!"

For many of the volunteers who reflected on their experience, there seemed to be no direct object of care, except, perhaps, for the class of anonymous individuals that comprises the category of "community," "society," or "the human." One comes to experience oneself as a caring person, caring such that it matters not for whom. In this way, a call to the help line forges no lasting bonds, entails no responsibility, leaves no lasting connection between the individuals on the phone. Volunteers are charged with temporarily ameliorating the caller's mood—making them "feel better"—and helping the caller to develop strategies to address his or her problems. But there is no long-term association, no relationship or friendship developed during the call. The volunteer is supposed to be as interested in one caller as the next but never to make a personal con-

nection beyond the call. In fact, in anonymous forms of care, personal connections are supposed to be suppressed.

That anonymity and confidentiality are social goods is a culturally and historically specific idea.¹⁶ Peter Kulchyski points to the structural impossibility of anonymity in many small Inuit communities, which allows for a different kind of social responsibility:

Saving face as a cultural practice remains critical in contemporary Pangnirtung: one is not going to move on and teach in a different (better?) department leaving behind all those one has publicly "dissed." In Pangnirtung, one has the embodied sense that one's great great great to the nth degree grandchildren will very likely be interacting with the great great great to the nth degree grandchildren of one's neighbor. Best to ensure, even when one has something "up" on them, that they save face. (Kulchyski 2006: 160)

As one Inuit elder put it at a conference for traditional healers that I attended, "As Inuit we hear about confidentiality. There is no such thing for Inuit. We live like a book. Our life is like an open book." When I asked a friend in his forties why, in the end, so few Inuit youth call the hotline, he said, "I think people just need to talk to someone, but at the one-to-one level. One time my cousin called me up. Had a gun in his hand. Said he's gonna kill himself. I went over there, I confronted him, and I was there with him. Everything is so anonymous in Western society."

Still, it doesn't surprise me that, according to the founders of Kamatsiaqtut, when the idea for an anonymous hotline was put forward, "the concepts of confidentiality and anonymity, although foreign to traditional cultural beliefs, were viewed as a bonus by the Inuit who worked with us" (Levy and Fletcher 1998: 355–56). I do think anonymity may sometimes come as a great relief when living in a small community. I also think a significant amount of social stigma can be avoided through the professional dictates of confidentiality. But the point I am making here lies elsewhere. To recognize confidentiality and anonymity as appropriate in particular contexts is different from identifying the way care has become anonymous—the way that anonymity actually comes to structure our very definition of what it is to care.

In this chapter I turn to the suicide hotline, not only to understand specific ways of caring in the Canadian Arctic, but also as a concrete form (something like Foucault's panopticon in *Discipline and Punish* [1977]) that illuminates a more general mode of engagement with the world—a mode I have been calling "anonymous care." Paul Rabinow calls these concrete forms "strategic exemplars" (1989: 12). Through the strategic example of a suicide hotline a whole mode of care becomes visible.

But let me be very clear on one point. I am not saying that anonymous care is the only form of care operant in Nunavut today. The number of suicide prevention programs and initiatives in Nunavut is astonishing, and this book is not an attempt to survey their methods or to adjudicate their effectiveness.¹⁷ Instead I am attempting to convey, through a series of concrete and empirical examples from the colonial and the contemporary ethnographic record, a surprisingly ubiquitous and powerful form of attending to the life and death of an other—anonymous care.

A suicide hotline, because it holds the specific details of a life in abeyance, makes the texture and specificity of a particular life irrelevant, or relevant only insofar as the survival of the other is ensured. As a larger mode of relating in the world, anonymous care transforms our relationships to others and changes the ethical landscape of our social programs. Although anonymous care can reinforce an abstract sense of community, caring anonymously means that no individual bonds are established, no specific links between people strengthened.

The possibility of caring anonymously can be related to the emergence of imaginary communities or “publics” in which one might say that the very category of “friend” is enlarged—through technologies such as the printing press, map making, and, later, newspapers and television—to include people one will never encounter (Anderson 1991). In the context of a suicide hotline, personal biography is relevant only insofar as it can keep someone alive. The way such biographies or lives might intersect and form a “web of human relationships” (Arendt 1958: 183) is usually irrelevant.

What is fascinating about anonymous care, however, is that it becomes a privileged mode of care even in situations where one does or might have face-to-face relations with the other. Anonymous care for suicidal people becomes the prototype of modern care, perhaps its purest—most sublime—form.

Anonymous care for suicidal people reaches toward the sublime in two directions. In his book *On Suicide Bombing* (2007), Talal Asad unpacks the relationship between horror and the sublime in an attempt to understand why people in the West express horror at suicide bombing while they remain complacent about other more extensive and more commonplace forms of killing. In a difficult but thoughtful analysis of horror, Asad observes that horror is not only linked to the dissolution of the self or the transgression of boundaries (especially those that lie between the dead and the living),¹⁸ but also to a kind of delight. This

feeling of delight, although often difficult to acknowledge, is directly connected to an experience of the sublime. Asad draws on Edmund Burke to argue that such delight “draws us in horrified fascination to catastrophes” (2007: 73).

I want to suggest that the suicide hotline enables the volunteer to experience the sublime without letting go of his or her biopolitical principles. That is, when working on a suicide hotline, as when participating in any other suicide intervention, one can listen to the grim details of a suicide plan, a plan whose goal is to bring about the dissolution of the self, and experience a kind of horror (linked to a kind of delight or “horrified fascination”) at the details of the plan, and the possibility of the dissolution of the self, while simultaneously confirming one’s own moral vigor and strength by censuring such desires.

However, the exaltation of fellow feeling that one attains specifically through caring anonymously also entails a “sublimated” or second-order version of the sublime—for there is a dissolution of the self involved for the hotline operator too. Stripped of all attributes, the person on the receiving end of the call experiences him- or herself as a member of humanity, relating, above all, to another human being. The concept of humanity involves a certain kind of sublime dissolution of self.

HISTORY OF THE SUICIDE HOTLINE

The history of the suicide hotline is shot through with expressions of such exalted feeling. In 1953, when the first suicide hotline was set up in London, England, suicide was described as a “cry of distress,” and answering that cry was considered a way of bringing about a “new order of life”—and not just for the suicidal. Suicide prevention was alternately a “humanitarian effort” (1969), a “fight” (Dublin 1963), a “mission” (Soubrier 2002), a “tremendous resurgence of practical Christianity” (Fox 1962), and a social “movement” (McCord and Packwood 1973; Varah 1985). The fervor with which people involved in these early hotlines described their participation is remarkable. How the hotline itself emerged as an exalted way to care for suicidal others—a form of care that is anonymous, occurs at a distance, and requires no particular qualifications except that one is a caring human being—is the question that interests me here.

In 1953, Chad Varah, an Anglican priest and counselor specializing in “sexual problems,” read that there were three suicides a day in London

(Varah 1985: 17). Disturbed by the fact that there wasn't an emergency telephone number for suicides—as there was for fire or police—Varah decided to initiate what he called a “999 for the suicidal.” Varah based his new service on the biblical parable of the Good Samaritan in which a stranger tends to an injured person on the roadside (Fox 1962: 1103) and hoped that he could find a phone number for the hotline that would reflect the fact that suicide was a “*human* emergency for thousands” (Varah 1985: 21; emphasis added).¹⁹

Varah was very clear about the objectives of the Samaritans. In spite of early research that found that 99.5 percent of Samaritan clients were not actually going to take their lives (Barracough and Shea 1970: 870), Varah would argue vehemently that the organization's success or failure should be measured solely by the reduction of the number of suicides—not merely the diminishing of human misery:

The success or otherwise of our work is to be judged solely on whether it does or does not reduce the number of suicides in the areas in which we operate. If we are not saving lives, we are failing; and it is no good giving us pats on the back for doing something else. To decrease human misery is undoubtedly a worthy endeavour, and we may be thankful for the activities in this regard of such diverse professions as comedian, restaurateur, prostitute, hairdresser, and health visitor, but *our* task is to decrease human misery in those who might, unless this were achieved, be more likely to die by their own hands. (1985: 50)

The Samaritans, as an organization, were emphatically dedicated to keeping people alive. Anything else was failure. By contrast, the “worthy” endeavors of people such as prostitutes, hairdressers, and comedians, who decrease human misery, amount to a transposition of the Samaritans' means and ends. For a Samaritan, decreasing human misery was merely a means to the end of preventing people from killing themselves. (This will become very important in the contemporary Arctic, where virtually everything seems to have become a means to the end of preventing suicide and not an end in itself.) Whether or not the Samaritans saved lives, Varah's sense of the moral imperative of caring for the lives of the suicidal rapidly took hold around the world. In less than ten years the Samaritans had become an international organization boasting twenty-six branches.²⁰

Even in the earliest discussions of suicide hotlines, when anonymity was still optional, the abstraction of the caller and the listener was emphasized.²¹ As we saw earlier, Varah underlines the fact that suicide is a “human emergency” and also describes the sympathy of the volunteers as “human

sympathy” (1985: 24). Likewise, in 1965, in a report describing the inauguration of a new hotline in a psychiatric emergency room, the authors (two psychiatrists) reflect on the merits of the line. They note, “It has also become apparent that there are many lonely isolated human beings in the community who have used this telephone as a means of establishing contact with another human being” (Waltzer and Hankoff 1965: 314).

To be recognized *a priori* as “human” means to lose all manner of distinctions. Thinking about the hotline in terms of one human being caring for another meant that *who* you were as a volunteer (even insofar as you were a doctor, a psychiatrist, a social worker, etc.) became irrelevant. One's basic or fundamental humanity was what mattered,²² and from there it was one small step to seeing even one's name as superfluous. *A-nonymous* care.

In 1968, reflecting on the developments of suicidology, and in particular the growth of the Samaritans, Louis I. Dublin concluded that the lay volunteer “was probably the most important single discovery in the fifty-year history of suicide prevention. Little progress was made until he came into the picture. The lay volunteer had the time and the qualities of character to prove that he cared” (1969: 45).²³

Or, as Chad Varah put it, “The person you turned to did not need to be someone with qualifications or diplomas so long as he or she *cared*” (1985: 37; emphasis in original). Caring turns out to be more important than any qualifications or diplomas, and caring is understood as what one human being, any human being, can (and should) do for another.

This idea that the “care” of one human being for another could help prevent suicide was so convincing that it didn't seem to matter that there was little empirical evidence of the effectiveness of the proliferating suicide hotlines. Researchers involved with the hotline movement were primed to assume that an adequate measure of the hotline's effectiveness had simply yet to be developed.²⁴ The question I am asking is *why* a hotline makes so much sense to people, especially to those on the receiving end of the line? Why is a suicide hotline such a compelling intervention *for the volunteers*—then as well as today?

In 1965, Edwin S. Shneidman and Norman L. Farberow, two directors of the path-breaking Suicide Prevention Centre in Los Angeles, who would go on to have distinguished careers as suicidologists, published an article in the *American Journal of Public Health* advertising the success of their center and their methods. They conclude their article with a rousing cry to readers to join the “vocal” corps of people across America mobilizing to prevent suicide. They write:

Justice Benjamin Cardozo, in 1923, stated: "A cry of distress is a summons to rescue." This ringing statement can stand as the credo of an enlightened democratic society, whose keystone lies in its heightened evaluation of each human life.

We believe that there is a new and vocal group in America: it includes all of us who are passionate about the need and the feasibility of effectively reducing the unnecessary present suicide rates. The place for each of us to do this is in *our* community. The time is *now*. (1965: 26; emphasis in original)

The assertions Schneidman and Farberow make in this concluding paragraph are instructive: 1) a "heightened evaluation of each human life" is posited as "keystone" of both enlightenment and democracy; 2) it follows that suicide and suicidality are seen as a cry of distress to which we cannot fail to respond without losing our moral and social standing; 3) but, in addition, working in suicide prevention (in *our* communities, right *now*) places one at the vanguard of such enlightened democratic societies. Suicide prevention is no longer (if it ever was) only about the person on the other end of the line. It is about enlightenment, democracy, and a new social order.

In fact, by 1981 two community psychologists, Echterling and Wylie, would suggest that suicide prevention is actually a social movement seeking to establish a "new order of life" (Echterling and Wylie 1981: 342). The psychologists argue that, like all social movements, this one "begin[s] in a condition of unrest, with dissatisfaction with the current form of life and hopes for a new system of living" (1981: 342)—a new order of life that revolves around *how* we care for the other.²⁵ In an anonymous suicide hotline the caregiver is witness to someone else's desire for the dissolution of the self but also experiences the dissolution of one's own self into the category of humanity.

The emergence in the 1950s and 1960s of suicide hotlines as a form of care dovetailed not only with the biopolitical emphasis on preserving life itself, but also with a kind of "humanitarian reason" (Fassin 2012). Through the exalted feeling that a notion of humanity encouraged, such care became sublime. Answering the "cry of distress" at a certain remove—over the telephone—where caller and called can remain anonymous, enables discrete individuals to be easily rendered abstract at the same time as it heightens the sense that one is working for a higher good, something beyond one's own self-interest or community. It is not simply the value of human life that Schneidman and Farberow are celebrating but its "*heightened* evaluation," and suicide prevention is a work to be done "passionately" and with a kind of urgency. "The time is *now*."²⁶

The "time" of suicide prevention is still now; it's still urgent. In an article describing the crisis line, the founders of Nunavut's Kamatsiaqtut hotline argued, "The foremost responsibility of any society is to nurture and protect its citizens[,] especially its children. In the Canadian North today, one of the most serious threats to the health and well-being of its citizens, especially its young people, is suicide" (Levy and Fletcher 1998: 353). And, like earlier advocates of hotlines, they also emphasize that it is almost impossible to assess the effectiveness of their work. Yet, in spite of the lack of evidence, they also argue, "We see the creation and continuing existence of the line as a symbol that the community can and will take charge of its own problems and solutions, and that the community is sending out a signal to those most in need of its service that it does care" (365).

As the volunteers at Kamatsiaqtut explained to me, although many nights can go by without a phone call of any sort, there is always the possibility and hope of making a connection, helping someone in pain. And when I pressed a volunteer about the distance anonymity creates, he insisted, "But you still are a voice. And you still are an individual that they are actually talking to." When the encounter happens, when you make a connection, the reasons you are doing it, the success rate of the program cease to matter quite so much. As one volunteer put it, if you think about call volume, the sense that you are doing something important disappears. The positive effect of all those nights waiting for the phone to ring is not something that can be measured. The number of calls the hotline receives becomes irrelevant because "every single life is worth saving. Absolutely."

And you never know how good you are or whether you will save anybody's life, but the fact is that the opportunity is there. We will probably never know. But I've been at meetings and people have thanked us for being on the line and said how much we have helped them over the years. You don't know what good this line is doing because you can't measure it. You're not building a building; you can't literally see what you're doing.

Another longtime volunteer added, "The line itself is a drop in the bucket. It is a drop though. And every drop counts."

Here again, empirical measures of the effectiveness of the help line are downplayed: "You never know . . . whether you will save anybody's life, but the fact is the opportunity is there." A recent study on caller characteristics and call content of the Nunavut Kamatsiaqtut help line from 1991 to 2001 concludes that younger callers (those most at risk

for suicide) tend to use the line only to make prank calls (Tan et al. 2012). The majority of the users were adult females calling to discuss relationships and issues of loneliness or boredom. Hotlines make sense, despite a lack of evidence of their effectiveness in preventing suicide, because their goal—to save any life whatsoever, not particular lives of particular people—has become a kind of unquestioned “secular sacred” (see Murray 2006). The anonymity of such hotlines ensures that the moral value of saving the life of a stranger is not tainted by any kind of self-interest or social obligation.

OF CONFERENCES AND CRUISE SHIPS

When the Kamatsiaqtut help line hosted the Canadian Association for Suicide Prevention's Annual Meeting in 2005, people from all over Canada converged on Iqaluit. Preparations for the conference were feverish. The high school was shut down for two days. Inuit elders, youth, and social workers from all over Nunavut were flown in. Several smaller preconferences were organized to take place just before the main event. Government departments and NGOs began to compete for bodies to participate in their suicide prevention projects and workshops. Bobby was invited to participate in three separate workshops held over the same time period. He chose a workshop taking place in a neighboring community so that he would be paid a per diem for his efforts. As the time for the main conference drew nearer, a Nunavut Department of Health employee, a Qallunaaq only peripherally involved in the preparations, remarked to me sheepishly, “I’m not trying to make light of it, but it feels like a suicide cruise ship, just cruising through town.”

Her image of a suicide cruise ship, unsettling to government employees as well as to anyone I have described it to, is nonetheless resonant. It resonates with my friend Miali's statement that she would never volunteer for Nunavut's hotline. For her, the hotline is a Qallunaaq “social club.” One of the volunteers on the hotline said something very similar. She was reflecting on the way many newcomers to Iqaluit, people “right off the boat,” would sign up to volunteer for the hotline. “I think they come to the community and . . . they want to volunteer, and probably [some people] from the help line are the very first people to get to them. If they'd met somebody from the yoga club they'd probably be in yoga, but we got to them first.” And the people who work on the line do form an extended social network. They have dinner at each other's houses. They see each other at the Elks' meetings, at school, at the hockey arena.

One volunteer said thoughtfully, “I guess I do believe, also, that you're caring for yourself when you are doing this type of thing because you are feeding your own soul because you're doing something that, if you believe in it, . . . you feel is worthwhile. And that's good for you. I mean, you're making new friends, you're making new contacts, you're feeling that you're making a contribution to your community.”

The contrast between the intense sociality of the people on the line and the anonymity that is maintained toward the callers is striking. The image of a suicide cruise ship also calls forth images of the doctors on board the *C.D. Howe* in the 1950s and '60s, heading north to treat the “Eskimos” for tuberculosis. In fact, the chief medical officer on the 1955 Eastern Arctic Patrol, in a note to his superior, writes that although on the whole he is satisfied with his medical party, “there is a tendency for some of them to forget that they are not on a cruise to Hawaii, feeling that they should be given shore leave at every port” (Willis 1955). Another doctor, traveling north on one of the last voyages of the *C.D. Howe* to treat tubercular Inuit, reported to a journalist en route that so far he had seen two whales, two polar bears, and a narwhal and got pictures of it all. “The vastness of it all,” he said, made “this trip, the ride itself, worth somewhere between \$4000 and \$8000” (Arctic Hospital Ship 1968).

EXPECTING SUICIDE

The fervor of people within the contemporary suicide apparatus can also be experienced as alienating to youth who are identified by that very apparatus as “at risk.”²⁷ Take Monica, a fourteen-year-old girl whose mother is an Inuk and father is a Qallunaaq. Her best friend committed suicide a few months ago, shortly after they had separated for the night. When they were kids they spent every minute together. Monica dreams about Annie a lot. In one dream Annie is sitting in a chair at a restaurant, not making eye contact with Monica, who is sitting across from her. Finally she looks at her and says, “Trade spots?”

At the moment Monica lives at her cousin's place. It's in “White Row,” a series of identical row houses with white plastic siding. In the front of the house is a bedroom window where the light is always on. You can see people inside playing cards, smoking at the window, talking. Every now and then a figure approaches the window from outside, talks to the people inside a moment, pockets a baggie, and walks away.

Inside, Monica's grandfather sleeps on the couch in the living room. He eats only country food and speaks only Inuktitut. She speaks only

English. She tells me she wants to do more “Inuit” things. Her grandfather has a drinking problem, but he usually just falls asleep after drinking; he doesn’t get violent. He likes having the dealer live there because he helps out with the bills and keeps him supplied with pot. The dealer, a good friend of Monica’s, tells her that when he gets his own apartment she can live with him. He is a gregarious guy, always saying that he has quit dealing for good. For now Monica has her own room with a bed and a dresser. She usually goes to bed around 1 A.M. If she eats, she cooks the food herself.

Her mother comes by occasionally, but they argue a lot. Friday night she came by drunk and they got into an argument about whether Monica’s sister should have dropped out of school. Then her mother tells her that she wants to “rat” on the drug dealers in the other room. She picks up the phone to call the RCMP. Monica tries to stop her.

“No, don’t rat him out. You fuckin’ bitch.” They struggle, and Monica’s mother throws the phone at Monica’s head, causing a small torrent of blood. Later the others tell her they could hear the phone hitting her head from the other room.

Monica cries, not from the pain but from the fact her mother hit her. She punches her mother on the shoulder.

“I never wanted to hit my mom,” she tells me later. Monica dials her father’s pager. He’s out at the Legion, drinking. When the phone rings again, it’s his girlfriend calling back.

“What do you want?”

When her father finally comes to pick her up, Monica screams at him, “You care more about your fucking bitch girlfriend than me.” Her father is silent. He drives really fast and it scares her.

“Do you want to kill us?” Her father doesn’t answer. He drops her off at his apartment and goes back to the Legion. Hours later Monica hears her father and his girlfriend come in, but she pretends to be asleep so she doesn’t have to argue. She tells me, “It’s not that I’m suicidal, but sometimes I don’t want to live any more.”

What does it mean to Monica to be “suicidal”? In Iqaluit, suicide has become one of those teenage behaviors, like smoking, having sex, and taking drugs, that are discussed in health education classes, high school assemblies, and public service announcements on television. It is not unusual to see an antismoking poster depicting a woman with a severely deformed face and blackened gums beside one that says, “Stay Alive. Suicide is not the Inuit Way. Survive your problems.” The implication is that real Inuit don’t commit suicide, just as another poster suggests that

Inuit men who care about their babies don’t let their wives smoke. Staying alive is the take-home message.

Once I asked Monica how she felt about her smoking habit. Her answer was quick and assured. “It’s no good, it’s very bad for you . . . but it’s addictive.” There was no apology in her voice. The fact that it was addictive, a fact often emphasized to scare youth from taking up smoking, had convinced her that there wasn’t anything to be done about it. Inuit youth get the message that they shouldn’t smoke, but also the message that it’s so addictive that it’s almost impossible to stop. Something similar happens with respect to suicide. There is a sense of inevitability about Inuit suicide. Inuit youth feel it, and sometimes they resist, asking for their pain to be recognized in a different register. Sometimes, tragically, they play along.²⁸

The anticipation of Inuit suicide—coupled with its prohibition—is evident in the remarks of a filmmaker in the Canadian Arctic town of Igloolik: “According to Igloolik’s yearly suicide rate there are at least five or six young people walking around town today who will probably be dead by next Christmas. This is a horrible thought. We don’t know who they are. . . . Our goal is to keep some of them—hopefully all of them—alive at this time next year” (Cousineau 1999). The goal is to keep Inuit alive, but the truth of the yearly suicide rates makes their death inevitable. Inuit are tentatively imagined as the walking dead, and yet even that thought is proscribed: It is a “horrible thought.”

That suicide causes no surprise is significant. It does not mean there is an absence of pain, almost unbearable pain. Suicide is at once prohibited and awaited. Suicide, as a counterfactual—something that hasn’t but might happen—evokes ambivalence. Future suicides are imagined and the thoughts then suppressed. Suicide, too awful to think about, is a possibility that is articulated and then denied.

Statistics play an important role in making suicide real.²⁹ The statistics about Inuit suicide are cited endlessly. The possibility that any Inuit youth will commit suicide is tabulated, that person’s death thereby measured. However, as S. Lochlann Jain points out in the context of cancer prognosis, the *you* who either will or will not die and the *you* who has a 5 percent chance of survival are not seamlessly aligned. She describes the experience of living this misalignment phenomenologically as “living in prognosis” (Jain 2007: 78). All young Inuit live in prognosis, all live the misalignment between statistical probabilities of their death and the existential fact of their life or death.

When Monica says, "It's not that I'm suicidal, but sometimes I don't want to live anymore," we have to remember that she has lived her whole life within a postcolonial state that simultaneously bans and anticipates her death, a state that wants her death—if she is going to die—so that it can tabulate rates and predict future deaths. How does such an anticipation of death (on the part of the state and its agents) enter youthful imaginaries? The colonial commandment not to commit suicide effects an uncanny doubling in which the postcolonial state both does and does not want Inuit youth dead, just as the RCMP's public health efforts to kill dogs are reinterpreted as having murderous designs (see chapter 2). My friend, who sometimes wants to die, is holding at bay that whole suicidal apparatus by saying, in effect, "Although I want to die, I am not suicidal. I do not belong to your calculations. I want at least to own my own death, and my pain." She is trying to escape her life lived in prognosis, in which her death is never a surprise to anyone, least of all herself.

As Michel Foucault suggests, within a biopolitical regime death itself "is outside the power relationship. Death is beyond the reach of power, and power has a grip on it only in general, overall or statistical terms. Power has no control over death, but it can control mortality" (2003: 248). There is definitely a sense in which the bureaucrats "have" the dead Eskimo in statistical terms—whether in the context of tuberculosis or suicide—and their power is a power over death rates, as Foucault suggests. But to leave the analysis there renders us deaf to the overtones of the bureaucrats' voice, the way that "having" speaks of something beyond a diffuse regulatory power of which bureaucrats are merely mouthpieces. It speaks to the way that, as Frantz Fanon (1967) suggested, colonialism works on and through the psyche, in the way the colonial imagination infuses everyday relationships.³⁰ It speaks to what I have been calling the "psychic life" of biopolitics.

To better hear these overtones, we have to ask what happens when attention to the welfare of populations is combined with a colonial imagination and desire.³¹ What happens when staying alive (the secular sacred) and being a good, deserving Inuk become one? What happens when staying alive becomes not only a normative injunction but also, like every other colonial norm, one that you, as an Inuk, can only ever be expected to imperfectly live up to? Do we, in our policies, programs, and exhortations, ask Inuit to live while also expecting them to die? In the case of Inuit suicide, coming to terms with the ambivalent command "Do not kill yourself, but, of course, you will" requires that biopolitics and colonial psychology be thought together.

In my conversation with Monica she distinguishes between being suicidal—a closely regulated behavior—and not wanting to live anymore. One of the things teenagers recognize is that confessing to being suicidal in Iqaluit has a long series of entailments, including trips to the hospital (and possibly even being sent down South for psychiatric evaluation), visits with the school counselor, and persistent questions from friends and family. It is clear that youth sometimes talk about suicide precisely in order to garner some of that attention. Counselors warn of kids who just want a "trip out" of the community and so play up their suicide ideation. And the youth know all the signs of suicidality and can list them off verbatim. One youth, hoping for a reaction, told me that he had just "cleaned up his whole bedroom, thrown out a whole lot of clothes."

Without suggesting that it should be otherwise, I simply want to point out the intense and often anonymous policing of the suicidal body. Monica's distinction between being suicidal and not wanting to live is a subtle one, but it is one that removes her, if only temporarily, from the suicide apparatus and allows her to acknowledge the ways in which her young life is marked by pain, anger, and injustice. *It's just that I don't want to live anymore.* I agree that, ultimately, to prevent the possibility of suicide, many Inuit youth should never be left alone. But living, as opposed to staying alive, seems to require both pain and the taking of risks. It seems to require risking the possibility that one will not stay alive.

In my experience with Inuit youth, suicidality has much to do with excess and repetition, and the crisis it represents usually occurs after the procedures and protocols have long since been followed, once the nurses and doctors have already been seen. How to proceed is terrifyingly uncertain. That is, even when in desperation I insisted my young friends visit a doctor, to relieve me of some of the responsibility I felt, things didn't always go the way I anticipated.

STATE OF BEING

By way of conclusion I want to recount the evening I spent with my friend Bobby. I was talking to him on the phone and he said, "If I tell you something, will you promise not to tell the others?"

"Yeah, what?"

"I just tried to commit suicide."

"What do you mean? Why?"

He then tells me more specifically that he tried to hang himself. Twice. The rope broke both times. He is telling me that he won't go to the

training the next day because of the marks around his neck. His back and arm are bruised from falling. His left side is numb and he can't see properly out of his left eye.

"Can I call an ambulance?"

"No. I don't want to go there. They're going to know what I did."

"I'm coming to get you."

"Okay."

When I get there he is waiting for me at the door. I don't even have to honk. I try to hug him when I see him, but it's awkward. We don't usually hug. Without saying much, we drive around. We go to Apex, then toward the dump, but it's too dark, so we go out Federal Road, around the Road to Nowhere. I ask, "What were you thinking?"

"I wasn't thinking. I wasn't thinking anything."

At some point his mood starts to shift and he starts talking about girls, some of whom I know and some I don't. His voice is shiny, almost metallic; it matches the warehouses and barking dogs we are driving by. He keeps talking about girls, about the size of their boobs and the ways he flirts with them. I am disgusted and yet I let him go on talking. This is somehow about desire after all. Then I change the subject.

The next day, as we walked together to a friend's house for caribou stew, he told me about the dreams he was having of the angel of death. The angel of death appeared in his dreams every night telling him that he, Bobby, was next. As he spoke I looked up at the fingernail moon and the stars.

"Every time I closed my eyes I could see him. Whether it was just because my head was playing mind tricks or whatever, I realized that if I died I wouldn't have *anything*. I wouldn't even have family, I wouldn't have my deceased family. I wouldn't have anything. Nothing. Except death. That's the only thing I would have. And that's where he came from. Because I didn't think I would have anything if I died."

We were taking the shortcut to Tundra Valley through the cemetery. The white crosses looked bluish in the night. As we walked up the hill from the cemetery he told me that this was his favorite place to come and sit and think. He pointed out a huge swath of northern lights that looked like a snowmobile trail.

At that moment a small plane banked before going in for a landing at the airstrip. It caught us in its lights. We stopped, unable to see anything except the plane heading toward us. At what seemed like the last minute, it banked left against the cliff.

It was very cold—minus fifty with the wind chill—and Bobby told me he could feel his nose and ears getting frostbitten.

"It don't matter. It happens all the time. I just feel a little tingling."

"Don't they swell up?"

"Sometimes, but it's okay." So we kept walking, the granular snow blowing like sand, creating eddies of snow. We didn't say anything. Later he drew the angel of death on a small piece of paper. A man with no feet, carrying a scythe and wearing a hooded dress. "It wasn't just a voice in my head. It was someone telling me something. You know what I mean? Maybe that sounds crazy."

Later that evening I convinced him to go to the emergency room with me. A small television hung from the ceiling, its volume muted. Faces of Michael Jackson were spinning past, black hair against a pasty whiteness of skin. Beside me was his sister, thirteen, a headband pulling her hair back tightly. Beside her was her brother. She had pleaded with him not to leave her, not to commit suicide, and had insisted on coming to the hospital with us. Behind a counter two male staff in scrubs were standing hunched over a computer, talking in the languid cadence that marks an after-hours shift—waiting only for the time to pass between emergencies.

Even as they talked, however, they were observing us with their blank glances, deftly preserving the required sense of distance and disinterest while simultaneously consuming our pain, assessing, cataloging, and ranking it. But for all the distress collected in our bodies—the one asking to die, his younger sister pulling him back, and me, wanting a reprieve from responsibility—we were not an emergency. Months later, looking back on that time, Bobby would say, "Everything was going wrong with me. Everything. I wanted to die. I told everybody, 'I don't care, I wanna die, I wanna die, I wanna die, I wanna die.'"

"And do you think you really did?"

"I think I really did. I think I *really, really* wanted to die."

Bobby knew what to tell the doctor. He knew that if he said he wanted to kill himself—if he told them about the angel of death—that he would end up confined to a hospital bed. He had been admitted to the hospital before and had already regaled me with the story of how he had overpowered a guard to get some drugs from a hospital medicine cabinet. His stomach had to be pumped after he ingested a fistful of the pills he found there—but only after another fight with the guards who had been called in for reinforcement. The bravado of the story seemed to erase any shame.

He didn't want to spend the night in the hospital again, so he had to pull himself together, make a lighthearted joke to the doctor, focus on

his lack of sleep (if only he could get enough, things would be okay), on his girlfriend leaving him (it really made him feel like shit), on the predictability of his emotional turmoil.

Of course, anyone would feel like that in your shoes. What about some pills to help you sleep?

Yeah. That sounds good. How many do I take?

Two tonight, and I'll give you enough for three more nights. That should do the trick. Come back if you're still feeling bad.

Yeah. Okay.

Before I knew it we were walking back down the hill that we had climbed expectantly, just an hour before, six pills in a package tucked into Bobby's inner pocket. I think about how after a suicide people say things like, "Oh, I wish we had known. I wish he had said something." But usually it isn't that he never said anything but that he was always saying it, and that the saying turned into a drone, which had no meaning except exhaustion, which became the background of life. It's not that we never knew, it's that we always knew, and so it didn't seem important.

There we were. The irrepressible Bobby, alternately dreaming and then nightmaring. The absurdly hopeful fieldworker, who could no longer say why she was there. A young girl, who was supposed to be at school the next morning, going with her brother to the hospital.

After accompanying Bobby to the hospital, I still could not be certain he wouldn't commit suicide. In the place of hope there was something else. We had spent ourselves, and in that there was a solidarity. A going and a coming that had not had any describable effect. But each of us knew the other was willing somehow, and that we could be together in the face of another night, with thin northern lights and dry powdered snow, dogs barking and snowmobiles revving. Late at night, without any emergency except as a state of being.³²