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# Suicidism: A new theoretical framework to conceptualize suicide from an anti-oppressive perspective [1]

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**Abstract**

*Anchored in queer and crip perspectives, this essay proposes the neologism "suicidism" as a new theoretical framework to conceptualize the oppressive system in which suicidal people experience forms of injustice and violence. The thesis proposed here is that suicidal people suffer both individually and collectively from suicidist violence, an oppression that remains unproblematized in all current interpretations of suicide, including those taken up by anti-oppressive scholars and activists. I pursue three interrelated objectives: 1) interrogate dominant ideas and perspectives on suicidality; 2) make visible and denounce the power relations between suicidal and non-suicidal people; 3) enrich intersectional analyses by naming and problematizing an oppression that has been neglected. In sum, this essay proposes to analyze suicidality by asking the following epistemological questions: What and who is missing from current conceptualizations of suicide? What can we learn from these absences? How might new understandings of suicide, from queer and crip perspectives, help anti-oppressive scholars and activists avoid reproducing forms of oppression toward suicidal people? This essay is divided into two parts. The first part reviews some of the predominant models of suicide to illustrate how they all arrive at the same conclusion—that suicide is never an option—and how this results in a silencing of suicidal subjects. In so doing, I also demonstrate how suicidism is intertwined in forms of ableism/sanism. I conclude this first part by mobilizing the notion of epistemic injustice to*

*theorize both the testimonial and hermeneutical injustices experienced by suicidal subjects. In the second part, I explore additional interpretations of suicide that contrast with the dominant "negative" conceptualizations that seek to prevent it in all circumstances. I demonstrate how even "positive" perspectives of suicidality (e.g. the libertarian position) are founded in forms of ableism/sanism, and that even though they may critique the marginalization of suicidal subjects, they don't conceptualize their oppression as systemic, nor address it from an anti-oppressive perspective. Critiquing the "positive" conceptualizations of suicide allows me to delineate an alternative conceptualization of suicide rooted in queer and crip perspectives. Mobilizing a queer perspective to study suicide doesn't mean offering only analyses that take queer theories as a starting point or queer communities as the objects of the study. The intention is rather to queer suicide in a more holistic sense, that is, by applying queering and cripping methods, theories, epistemologies and prevention strategies to the topic of suicidality. Based on a harm-reduction and a non-coercive suicide approach, I suggest that assisted suicide should be a possibility for suicidal people, a position that relies on an ethics of living and a responsibility toward suicidal people.*

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## Theorizing suicidism: A "suicidal manifesto" [2]

> "Sometimes I worry that's what people around me would do if I were honest with someone […] about this lack of attachment to life and the sometimes-desire to be rid of it. After they know my default state, will I be self-conscious? Will I regret it? Will they ever forget it, or will it shadow my every move and our every conversation? Will they become too aware, watch me too closely? But then I think: Isn't there middle ground between hypervigilance and complete secrecy? […] If people talked about feeling suicidal […] as much as they talked about feeling depressed or anxious, would we finally be forced to see how common it is and start creating space for these conversations? Would it be the worst thing in the world if we started talking about not wanting to be alive, and what might help keep us here?" (Borges, 2019)

Anna Borges, mental health advocate and writer for a number of media outlets, [3] "came out" recently as someone who experiences "passive suicidality," that is, a person who has suicidal ideations without actively attempting suicide. In addition to the strength, determination and courage required for such a public coming out–knowing that suicidal people suffer significant stigmatization, exclusion, marginalization and pathologization–Borges's online essay is noteworthy in that she identifies some of the pervasive worries, fears, norms, and consequences that surround suicidality [4] and that lead to the silencing of suicidal people, such as surveillance and stigma. This widespread but unspoken phenomenon that isolates suicidal people has not yet been analyzed. It is a "problem that has no name," to paraphrase Betty Friedan (1963) who was trying to theorize women's oppression at a time when feminist conceptual tools were still under-developed. In this era of intersectional analyses, in which long lists of oppressions have been theorized and denounced, including sexism, racism, colonialism, classism, ageism, cisgenderism (or transphobia), heterosexism, sizeism, ableism and sanism, to name but a few (Combahee River Collective, 1997/1977; Crenshaw, 1989; Hill Collins, 2000; Hill Collins and Bilge, 2016), one form of oppression remains absent from such lists: the oppression of suicidal people. Although anti-oppressive activists and scholars [5] address suicide, they do so in the hope of preventing suicides rather than with the goal of theorizing the oppression endured by suicidal people. The absence of this kind of oppression from discussions of suicidality is so profound that the oppression has yet to be named. By borrowing from terms such as sexism and ableism, I coined the neologism "suicidism" in 2017 (Baril, 2018). Though the Webster dictionary has included the term "suicidism" since 1913, its definition differs radically from mine. While the dictionary definition refers to "the quality or state of being suicidal" (Webster dictionary, 1913), a term that is nowadays not

widely used, [6] my use of the term "suicidism" refers to "[…] an oppressive system (stemming from non-suicidal perspectives) functioning at the normative, discursive, medical, legal, social, political, economic, and epistemic levels in which suicidal people experience multiple forms of injustice and violence […]" (my translation, Baril, 2018: 193). As I demonstrate below, suicidist violence is pernicious in the way it is taken up by anti-oppressive activists and scholars within discourses of protecting vulnerable people from themselves. In that sense, suicidism is deeply intertwined with ableism and sanism (or mental ableism/mentalism) because it mobilizes arguments about "mental stability/capacity" to revoke people's voices and agency. However, suicidism should not be reduced to ableism and sanism since, as I show later, suicidist norms and structures are at work regardless of whether ableist and sanist perspectives are deployed to oppress suicidal subjects. [7] The thesis defended here is simple but radical: suicidal people suffer both individually and collectively from suicidist oppression, and this oppression, suicidism, remains unproblematized in all current interpretations of suicide, including those from an anti-oppressive perspectives.

Let me be clear: suicidality is a topic that has been, and remains, problematized. From biomedical, biopsychosocial, or social/political models of suicide that attempt to understand, explain and prevent suicides, to media discussions, cultural productions or suicide prevention campaigns, suicide is a "hot topic" that we hear or read about regularly (Beattie and Devitt, 2015; Bering, 2018). What is left unaddressed, however, is suicidism. The systemic oppression experienced by suicidal people is left unexamined, as is the need for a liberation project that so often accompanies the theorization and denunciation of forms of violence experienced by marginalized groups. This essay fills that gap in the current literature on suicidality by providing a first theoretical framework, *suicidism*, that conceptualizes and calls into question the oppression of suicidal people from queer and crip perspectives. [8] This essay not only mobilizes queer theories as a starting point to analyse suicidality or queer communities' suicides as an object of study; it also aims at queering and cripping methods, theories, epistemologies and prevention strategies on suicidality or, in other words, aims at questioning norms in the literature on suicidality. I pursue three intertwined objectives throughout this text: 1) interrogate dominant ideas and perspectives on suicidality; 2) make visible and denounce the power relations that exist between two porous but distinct categories, i.e. suicidal and non-suicidal people; 3) enrich intersectional analyses by naming and problematizing an oppression that has been neglected, or worse, dismissed. In sum, this essay proposes to analyze suicidality by asking the following questions: What and who is missing from current conceptualizations of suicidality? What and how can we learn from these absences? How might new conceptualizations of suicidality, from queer and crip perspectives, help anti-oppressive activists and scholars (including queer and crip activists/scholars) avoid perpetuating forms of oppression toward suicidal people? In the spirit of Ian March's (2016: 16) questions: "How is suicide most commonly talked about? What are constructed as the truths of suicide? […] Who gets to speak the truth of suicide? What happens to people identified as being at risk of suicide?," this essay raises crucial epistemological questions in relation to dominant conceptualizations

and discourses on suicidality. This essay does not pretend to provide clear answers and solutions to the problem(s) I am identifying; rather, I am offering critiques and questions as food for thought and as a starting point for theorizing suicidal people's oppression. From this viewpoint, this essay could be read as a first "suicidal manifesto."

The "radicality" of the thesis defended here calls for four important precautions. The first is that by destigmatizing suicidality, I am in no way encouraging suicide. The second is that I fully support suicide prevention. In fact, I believe that critiquing the oppression suffered by suicidal people and talking more openly about suicidality might lead to more respectful and effective prevention strategies. However, I do believe that developing more accountability toward suicidal people includes listening to their voices, concerns, and discourses, and deploying alternative non-coercive approaches to suicidality that could involve supporting some people's decision to die. The third point I would like to specify is that, following Eli Clare (2017: 27) who says that he is "[…] less interested in the rightness or wrongness of these choices [or perspectives] by themselves than in the distinct pattern they create when placed side by side, exposing the systemic desire to erase a whole group of people," I am less interested in critiquing each model of suicidality and its proponents' arguments, a task that I have done elsewhere (Baril, 2017; 2018; 2020a). My goal is to highlight "the pattern they create when placed side by side" and that has the effect of erasing suicidal people's voices. The last precaution is that, in the spirit of queer and crip perspectives that respectively interrogate and deconstruct binary categories that oppose heterosexuality/queerness and ability/disability (Kafer, 2013; McRuer, 2006; 2018), I do not believe that opposing suicidal versus non-suicidal people represents the complexity of what and who "counts" as suicidal. Indeed, depending on one's interpretation of what constitutes suicidal ideations, attempts or completed suicides, the category of the "suicidal subject" will include more or fewer people (in addition to life changes that result in people entering and exiting those categories). The limited space in this article prevents me from addressing this specific question. [9] I do, however, believe in the value of mobilizing these binary categories of suicidal versus non-suicidal people for two reasons. First, even though it is crucial to question and deconstruct identity categories, these categories need to first be named in order that the oppression faced by marginalized groups be denounced. For example, the first critiques of ableism historically involved mobilizing categories of able-bodied versus disabled people. Deconstructing this binary opposition was possible only later in critical disability/crip studies, once people started to understand the oppression experienced by disabled people (Longmore, 2003; McRuer, 2006; Kafer, 2013; Shakespeare, 2006; Siebers, 2008). Second, naming a group and differentiating it from another, in this case suicidal versus non-suicidal people, makes visible the power relations between them, even if the boundaries between the two groups are not hermetic.

This essay is divided into two main parts, each comprised of sub-sections. The first part briefly reviews some of the predominant models of suicidality to illustrate how they all arrive at the same conclusion−*suicide is never an option*−and how this

results in a silencing of suicidal subjects and a dismissal of the oppression they experience. I thus demonstrate how suicidism is intertwined in forms of ableism and sanism and how these interconnected oppressions function within the larger apparatus of biopower that deploys an injunction to live for subjects deemed "redeemable." In other words, if a person is considered "salvageable," i.e. non-disabled from an ableist point of view, all efforts should be taken to save their life, even if such efforts involve forms of coercion (e.g. forced treatments and institutionalization). I conclude that first part by mobilizing the notion of epistemic injustice coined by Miranda Fricker (2007) in order to theorize both the testimonial and hermeneutical injustices experienced by suicidal subjects and that dismiss the legitimacy of their voices and their knowledge on the topic of suicidality. In the second part, I briefly explore some additional interpretations of suicidality that differ from the dominant "negative" conceptualizations. I demonstrate how even "positive" perspectives of suicidality (e.g. the radical libertarian position) are founded in forms of ableism and sanism and that, though critiquing to some extent the marginalization of suicidal subjects, don't ultimately conceptualize their oppression as systemic, nor do they address it from an anti-oppressive perspective. Critiquing the liberal/individualist "positive" conceptualizations of suicide allows me to delineate an alternative conceptualization of suicide rooted in queer and crip perspectives. Based on a harm-reduction, non-coercive approach to suicide, I suggest that assisted suicide should be an option for suicidal people, a position that relies on an ethics of responsability toward suicidal people. In the short conclusion to this essay, I reiterate why it is important to theorize suicidism and to develop accountability toward suicidal people and how taking into consideration their oppression would enrich and expand intersectional analyses.

## 1. A ghost in the theorizations of suicidality: Suicidism

### 1.1. Dominant Models Of Suicidality

There are several models to conceptualize suicidality in the fields of suicidology, the study of suicidality from medical, psychiatric or psychological perspectives that focus on mental illness, as well as in critical suicidology, the study of suicidality from a critical stance that insists on its social dimensions (Marsh, 2015; White et al., 2016: 1-2). Before discussing these models, however, it is important to situate them in a historical context. Prior to being conceptualized as a form of mental illness or as a response to social problems, suicide was perceived as a sin and a crime (Bayatrizi, 2008; March, 2016; Perreault et al., 2016; Szasz, 1999; Taylor, 2015). It was only in the 18$^{th}$ century, through the emergence of biopower (Foucault, 1976; 1997) that the "suicidal person," like the "homosexual person," made its appearance. One could say that, throughout history, suicide followed a trajectory similar to that of same-sex sexual practices; it went from being perceived as both a sin against God and an illegal act to being perceived as a psychiatric and psychological condition (Taylor, 2015: 198-201). In so doing, the medicalization and psychiatrization of suicide eliminated suicidal people's agency and autonomy. As Zohreh Bayatrizi (2008: 97) explains: "What characterizes this new domain

of analysis is that it is stripped of free will the author of the suicidal act… The individual may have gained the right to kill himself, but in the process, he lost the status of author of his own acts."

### 1.1.1. The Medical Model Of Suicidality

The medical/psychiatric model of suicidality conceptualizes suicidality as an individual pathology to be cured with drugs or various therapies (Bayatrizi, 2008; Joiner, 2005; Marsh, 2016; Usborne, 2017). Thomas Szasz (1999: 31) characterizes this process as "transforming badness into madness" and shows that this pathological model is founded on three beliefs: "[…] (1) such a disease is the 'cause' of the unwanted acts or feelings of the subject–who now becomes the patient; (2) the 'patient' has no responsibility for his acts or feelings–now called 'symptoms'; and (3) psychiatrists are authorized, perhaps even obligated, to treat the patient's disease with or without the patient's permission" (Szasz, 1999: 18). [10] Emerging in the late 18th century, a specific power apparatus intended to maximize the life of the population, biopower (Foucault, 1976; 1997), created conditions under which suicidal ideations and acts became identities and were recast as specific forms of madness. These conditions allowed biopolitics (or politics centered on the life of the population) to flourish through the deployment of demography, statistics, and other tools used by early sociologists, among others. This simultaneously facilitated the emergence of a competing discourse on suicidality, which I discuss below.

### 1.1.2. The Social Model Of Suicidality

A competing discourse on suicidality is the social model, which focuses less on individual pathology and more on the social and political pathologies that lead to suicide, as illustrated in the work of Emile Durkheim (1867). I argue that contemporary anti-oppressive activists/scholars, such as feminist, queer, trans, disability or mad activists/scholars, have inherited part of their reflections on suicidality from these early sociological analyses of suicide. Far from being homogeneous, these anti-oppressive activists/scholars demonstrate a variety of positions and interpretations of suicidality (e.g. Bauer et al., 2015; Button, 2016; Chrisjohn et al., 2017; Cover, 2012; Dorais and Lajeunesse, 2004; Hjelmeland and Knizek, 2020; McDermott and Roen, 2016; Mills, 2018; Pyne, 2015; Reynolds, 2016; Roen et al., 2008; Taylor, 2015; White et al., 2016). However, according to my previous analyses (Baril, 2017; 2018; 2020a; 2020b), a surprising "consensus" emerges from these different interpretations of suicide. Indeed, from a social and political perspective that conceptualizes suicidality as the result of heterosexism, cisgenderism, ableism, colonialism, capitalism or other systemic factors, anti-oppressive activists/scholars promote sociopolitical change as a means of eradicating the oppressive

practices believed to cause suicidality. In sum, the social model believes in the social roots of suicidality and calls for a structural remedy. As Bayatrizi (2008: 102) contends:

> […] [T]he medical camp insists that suicide is a result of mental maladies, while the sociological camp stresses social and cultural malaise. Suicide is a disease either of the individual or of civilization; its pathology afflicts either the individual body or the body politic. What was not put in question is the assumption that suicide is, indeed, pathological and nothing more.

We could say, therefore, that the social model of suicidality is founded on two assumptions: 1) that suicidality does not result from mental illness, and 2) that suicidality is a social and structural issue (Bauer et al., 2015; Chrisjohn et al., 2017; Cover, 2012; Longmore, 2003; Mäkinen, 2016; McDermott et Roen, 2016; Mills, 2018; Roen et al., 2008; White et al., 2016). In opposition to the medical/psychiatric model, the social model suggests a "historicization and politicization" (Taylor 2015: 206) of suicidality by pointing out norms and structures that push marginalized groups to want to die. [11] Proponents of the social model argue that "hate kills" suicidal people (Reynold 2016; Dorais and Lajeunesse, 2004) and that oppressive systems are the causes of those deaths (Chrisjohn et al., 2017). For example, Mills (2018: 317), in an analysis of suicides under austerity measures in the UK, argues that austerity provokes slow deaths and ultimately kills: "Put another way, people are killing themselves because austerity is killing them. Austerity suicides may be read as the ultimate outcome of the internalisation of eugenic and market logic underlying welfare reform driven by austerity. Such deaths make visible the slow death endemic to austerity." While I believe that the social model undoubtedly has positive impacts, and while I agree with anti-oppressive activists/scholars that we must examine the factors influencing high rates of suicidality in marginalized communities (I am particularly sensitive to these type of analyses since I myself identify as a transgender, bisexual and disabled man), I believe that the social model nonetheless perpetuates a similar pathologization found in the medical model, even though in this case the pathology is situated in the sociopolitical realm. [12]

### 1.1.3. The Biopsychosocial Model Of Suicidality

Between these two oppositional perspectives, a third important approach has emerged in the past decades: the biopsychosocial model of suicidality (Beattie and Devitt 2015: 46-49; Webb, 2011: 97). Adopted by many healthcare professionals, it is the model underlying the international guidelines and strategies regarding suicide prevention. It can be found, for example, in documents produced by the World Health Organization (WHO). In a recent publication, the WHO (2018: 2) states

that "Research, for instance, has shown the importance of the interplay between biological, psychological, social, environmental and cultural factors in determining suicidal behaviours," calling for a "multisectoral national prevention strategy" (WHO, 2018: 5). It is possible to describe this third model of suicidality as an integrated approach that tries to mobilize the strengths and contributions of both the medical and social models. [13] However, this model is not without flaws, and some authors have pointed out some of its limitations, as well as its depoliticising and biologizing effects. For example, from a critical suicidology lens, Mills (2018: 309; 315) argues that this model remains based upon a "psychocentric approach" that tends to dismiss the importance of structural factors in suicidality, such as austerity, and to overemphasize the pathological self, notwithstanding the "lip-service" discourse that acknowledges the complex factors of suicide.

Despite significant differences, these three dominant conceptualizations of suicidality nevertheless all theorize suicidality as a "problem" in need of fixing (Bayatrizi, 2008). They all support prevention campaigns stating that "suicide is never a good option," as suicide is considered an irrational or too radical an answer to mental or social suffering. In their unanimous condemnation of suicide, these models only acknowledge suicidal people's discourses in relation to surveillance, regulation and prevention in order to help identify those "at risk" and to convince them to opt for solutions other than suicide (Baril, 2017; 2018; 2020a; 2020b). In so doing, not only do these models fail to recognize the oppression faced by suicidal people, but they also unintentionally perpetuate it. Indeed, I believe that one of the most perverse effects of all these models and their prevention strategies, despite their good intentions, is the silencing of suicidal people. I contend that despite these models' willingness to listen to suicidal people, their unilateral negative perception of suicidality prevents suicidal people from reaching out and talking about their suicidal ideations. I argue, therefore, that the voices of suicidal people are mostly absent from these models and that these absences prevent solidarity. One could say that suicidism is like the ghost of suicidality's theorizations−ubiquitous and pervasive, but simultaneously never fully visible, named or recognized.

## 1.2. Silence = Death

### 1.2.1. A Deadly Silence

In lesbian, gay, bisexual and queer (LGBQ) circles, a famous logo depicting a pink triangle against a black background with the mention "Silence=Death" was used in the 1980s by activists groups, such as ACT-UP, to denounce the silence surrounding the HIV/AIDS epidemic and the fact that government inaction was leading to more deaths each week (Fung and McCaskell, 2012). In a similar fashion, we often hear in public discourses on suicidality that there is an "epidemy" of suicides

(Chrisjohn et al., 2017; Beattie and Devitt, 2015; Bering, 2018, Usborne, 2017). With 800 000 completed suicides each year at the international level, and likely many more suicidal ideations and suicide attempts (WHO, 2018), the phenomenon touches almost everyone directly or indirectly. In stark contrast to the indifference shown in the early years of the HIV/AIDS crisis, we are constantly talking about suicidality, but not in a way that invites suicidal people to "break the silence." The slogan "silence = death" could thus be resignified and redeployed for suicidality. Indeed, despite the billions of dollars invested in prevention campaigns that summon suicidal people to reach out and speak out, they remain silent. [14] David Webb discusses openly his own past suicidal experience as a suicidology scholar. He explains why so many suicidal people linger in silence:

> In the current environment […] talking about your suicidal feelings runs the very real risk of finding yourself being judged, locked up and drugged. Suicidal people know this and […] will do their best to prevent it happening to them. We hide our feelings from others, go underground. And the deadly cycle of silence, taboo and prejudice is reinforced. […] There is a fundamental flaw at the core of contemporary thinking about suicide; which is the failure to understand suicidality as it is lived by those who experience it (Webb 2011: 5). [15]

The taboos, stigmatization, and even criminalization that surround suicidality–including prison sentences for not dissuading someone from ending their life or for helping them to do so (Davey, 2010; Gandsman, 2018), or insurance policies that offer no coverage to families of people who take their own lives–reduce suicidal people to silence (Bergmans et al., 2016; Bayatrizi, 2008; Stefan, 2016; Szasz, 1999). What is evident in diverse testimonials, including those from David Webb and Anna Borges quoted in the introduction, [16] is that suicidal people feel unsafe to discuss their suicidal ideations. As Webb reminds us, safer spaces are the key to eliciting open conversations, testimonials and thoughts: "In order to tell our stories, with all-of-me [*sic*] fully present, we need a space that is *safe*. […] All of me cannot be present when the biggest issue on my mind at the time, my suicidal thoughts, are denied, rejected, or avoided" (Webb, 2011: 59). Susan Stefan, who interviewed a large number of suicidal subjects, concludes that suicidal people will not reveal their wishes to anyone when they are determined to achieve their goal:

> [The experiences] of most of the people I interviewed, and abundant case law, is that many people who kill themselves often plan their suicides carefully and conceal those plans with great success from the people who know them best,

> including friends and family. The people I interviewed were unanimous in saying that the more determined they were to kill themselves, the more they concealed their intentions from the people in their lives" (Stefan, 2016: 107-108).

Statistics confirm this reality: suicidal people hide in order to end their lives (Beattie and Devitt, 2015; WHO, 2014; Peck, 2003). My argument is that they do not speak because they fear the negative consequences of doing so in a suicidist environment. Indeed, as empirical research shows, suicidal people, as is often the case for those considered "mad" and "crazy," are institutionalized and drugged against their will, are excluded from insurance programs, are either not hired for new jobs or fired from their current jobs, are expelled from university campuses, have their parenting rights revoked, are seen as incapable of sound judgment and of consenting or not to healthcare, and are subjected to other unfair treatments (Beattie and Devitt, 2015; Hewitt, 2010; 2013; Joiner, 2005; Stefan, 2016; Szasz, 1999; Webb, 2011).

### 1.2.2. Breaking The Silence: Safer Spaces Needed

However, suicidal people have key messages to deliver and crucial expertise on suicidality (including on suicide-prevention strategies) that are simply not taken into consideration (Bergsman et al., 2016; Webb, 2011). [17] Indeed, when Stefan questioned the suicidal people she interviewed about the most important messages that they would like to convey regarding suicidality, there was consensus among them about the need to be listened to, *for real*:

> I asked, "If you could tell suicide prevention policymakers and mental health professionals three things, what would they be?" There was one message that was by far the most common […] "DON'T […] treat them as if they are annoying and difficult, and pump them full of drugs. LISTEN for God's sake" [Survey 40]. "Don't come from a place of preventing—come from a place of connecting […]" [Survey 75]. "Listen, listen, listen. Listen with your whole being." [Survey 93] "Be kind. Be understanding. Listen with your heart" [Survey 209]. (Stefan, 2016: xxvi).

A few researchers have begun to appreciate the importance of suicidal people's discourses and voices and have started to examine the notes left behind by those who ended their life (Furqan et al., 2018; Gratton and Genest, 2008; Perreault et al., 2016). This groundbreaking approach is necessary and provides, I believe, key information about suicidality from an "insider perspective." What surprises me, however, is why suicidal people don't seem to be perceived as reliable experts, contrary to all other marginalized groups who are regarded, from an anti-oppressive perspective, as having an expertise due to their situated

viewpoint and their lived experience. Even in critical suicidology in which "insider perspectives" are valorized, we hear from experts, family, friends or *ex-suicidal people* (Bering, 2018; Rowe, 2016), but the voices of *current* suicidal people remain erased, as is the case in White et al.'s (2016) edited volume. [18] It would seem beneficial to take into consideration these voices and to try to understand them *while they are still alive, not only once they are dead*. In order to do that, we need to create safer spaces for suicidal people to express themselves, and one of the most important features of a safer space is an acknowledgment of the systemic oppression experienced by a specific group and of the microaggressions they face (Baines, 2017). Without the recognition of an oppression, a safer space is moot. Just as "safer spaces" for disabled people that do not recognize the existence of ableism cannot be considered "safer spaces," "safer spaces" for suicidal people that do not recognize suicidism are not spaces that invite suicidal people to openly and safely discuss their experiences.

### 1.3. Suicidism, Sanism And The Injunction To Live: A Complex Web Of Norms

Two distinct but interlocking systems of oppression, suicidism and sanism, function concurrently to harm suicidal people. [19] I argue that suicidal people live at the intersection of suicidism and sanism, which condemn them to a life of silence for two main reasons. First, their need to die is perceived as irrational from a sanist perspective (Burstow, 2016; Hewitt, 2010, 2013) that assumes that suicidal people suffer from a mental illness that clouds their judgment and invalidates their competence to consent to a voluntary death (Cholbi, 2011; Joiner, 2005). In other words, suicidal people are considered "insane" and "crazy" to choose death over life. While anti-oppressive activists/scholars are usually averse to pathological individualistic explanations, they tend to redeploy them with regard to suicidal individuals (Roen, Scourfield et McDermott, 2008; Shakespeare, 2006). [20] While empowerment and agency are encouraged for other groups (LGBTQ people, disabled people, etc.), with political agendas centered around the voices of those who experience marginalization, they are denied when it comes to suicidal people. Indeed, although suicidal people are not always necessarily depicted by anti-oppressive activists/scholars as "mad" or "crazy," their agency is often invalidated and their judgment considered biased by oppressive systems. Second, the desire to die is delegitimized because suicide is seen as an illegitimate response to social and political suffering (Dorais and Lajeunesse, 2004; McDermott and Roen, 2016; Reynolds, 2016). In other words, suicide should not be a valid option in the face of oppression; only political struggle should be. Individuals should not have to end their life due to systemic violence and discrimination, but should be relieved from social oppression through suicide prevention strategies focused on social justice and political change. For these two reasons, suicidal discourses are not listened to or understood. To be intelligible, these discourses must follow the prevention

scripts, recognizing that suicide is a flawed and radical "solution" that should never be an option. Indeed, suicidal people are encouraged to share their emotions and suicidal ideations with healthcare professionals but are quickly discouraged from pursuing any reflection that would legitimize suicide as a valid option to solve their problems. As Stefan (2016) notes, the question of liability for those professionals is central for harboring this attitude–hence, for instance, the "life contract" that suicidal people are asked to sign, to name but one example. In other words, their thoughts on suicide are elicited only in order to more effectively prevent and eradicate them as unilateraly negative, invalid and illegitimate.

As a result, suicidal people must live and die in secrecy; revealing their intent to die by suicide, whether to relatives, friends, or healthcare professionals, will almost certainly thwart their plans due to a plethora of security measures intended to prevent suicide, including forced institutionalization (see, for example, Joiner, 2005 or Cholbi, 2011 as proponents of institutionalization). Furthermore, whatever explanations they may provide to justify their wish to die are deemed irrational or illegitimate and cast as wishes that must be eradicated through medical, psychological or sociopolitical remedies. As Graeme Bayliss expressed, suicidal people are always in a lose-lose situation regarding their self-determination and competence to make decisions regarding their life and death: "I don't want to live, but the very fact that I don't want to live means I can't possibly consent to die" (Bayliss, 2016).

In sum, it is possible to see the silencing of suicidal people as deriving from two distinct but intertwined systems of oppression: suicidism and sanism. These oppressions are anchored more generally in biopower and its various mechanisms, including what I call an "injunction to live and to futurity" (Baril, 2017; 2018). As Bayatrizi (2008: 128) notes, in this kind of context "[…] life finds the seat of its unequivocal sanctity solely within the individual body and death becomes the ultimate profanation of life. Any sign of life, however trivial, must now be protected and its continuation must be ensured almost at any cost and by any means." [21] This injunction to live and to futurity underlies the discourses of both suicidology and critical suicidology and is based on the presumption that life should be preserved at almost "any cost," except, I would add, when the subjects are deemed unproductive and irrecuperable from a neoliberal, capitalist, ageist and ableist point of view (Fritsch, 2016; Kafer, 2013; McRuer, 2018). In those cases, suicide is rebranded as medical assistance in dying and is considered legitimate for people who are disabled and/or ill. [22] This leads, as I noted in my previous work, to the creation of "two classes of suicidal subjects by considering physically disabled or ill people as legitimate subjects who should receive assistance in dying and suicidal people as illegitimate subjects who must be kept alive" (Baril, 2017: 201).

I contend that it would be important to theorize the injunction to live and to futurity as a dominant system of intelligibility, similar to the injunction to able-bodiedness or able-mindedness that makes able-bodyminds the only normal,

desirable option in our society. Systems of intelligibility comprise a vast array of ideologies, conceptualizations, social representations, norms, structures and institutions that cast some subjects (e.g. members of dominant groups) and practices (e.g. heterosexuality) as normal and reward them with privileges; conversely, other subjects and practices are deemed abnormal, regulated, controlled, punished, eradicated or assimilated, such as those of disabled people. Systems of intelligibility often conceal their own historical construction and discursive and material components, meaning that they tend to frame the construction of binary categories such as normal/abnormal, good/bad, as if they were natural and ahistorical. Therefore, it is important to make visible the social construction of these categories and the delegitimation and pathologization of some identities and practices, along with the oppressions to which they lead (ableism, sanism, suicidism, etc.). I argue that the injunction to live and to futurity, as a system of intelligibility, in combination with suicidism and sanism, forces us into an unaccountable and uncompassionate approach to suicidality. Anti-oppressive activists/scholars who value social justice should be sensitive to this occultation of marginalized individuals who feel so unsupported that they prefer to die alone in difficult conditions instead of facing the stigma and negative consequences that so often accompany the "revelation" of suicidal ideations.

## 1.4. Suicidism As Epistemic Injustice

### 1.4.1. Suicidal Subjects, Testimonial And Hermeneutical Injustices

Based on the arguments I put forward in the previous sections, I contend that suicidal people are subjected to forms of "epistemic injustice" that deny their legitimacy as knowing subjects. In other words, suicidal subjects are not seen as knowledgeable on the topic of suicidality, but are more often perceived as mere victims of suicidality. Miranda Fricker (2007: 1) identifies two types of epistemic injustices: "testimonial injustice" and "hermeneutical injustice." While the former refers to the fact that some people's voices are less credible in the eyes of dominant groups simply because they belong to marginalized groups, the later refers to the idea that marginalized individuals do not have easy access to the theoretical tools needed to understand and explain their oppression.

> "Testimonial injustice occurs when prejudice causes a hearer to give a deflated level of credibility to a speaker's word; hermeneutical injustice occurs at a prior stage, when a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences. An example of the first might be that the police do not believe you because you are black; an example of the second might be that you suffer sexual

> harassment in a culture that still lacks that critical concept" (Fricker, 2007: 1).

In a subsequent piece published with Katharine Jenkins, Fricker discusses an earlier notion theorized in her work: "hermeneutical marginalization," conceptualized as a precondition to hermeneutical injustice (Fricker and Jenkins, 2017: 268). Fricker and Jenkins explain that "[h]ermeneutical injustice is the injustice of being frustrated in an attempt to render a significant social experience intelligible […] where hermeneutical marginalization is a significant causal factor in that failure. Someone counts as hermeneutically marginalized insofar as they belong to a social group that under-contributes to the common pool of concepts and social meanings" (Fricker and Jenkins, 2017: 268). In other words, hermeneutical marginalization happens when someone, for example a disabled person, doesn't have the same equality of opportunity to build knowledge regarding disability and ableism because they are excluded (or their opinion and ideas are less valued) from certain forms of employment and knowledge building communities such as academic milieus, decision-making processes, public policy development, etc.

I contend that suicidal people experience both types of epistemic injustice, as well as hermeneutical marginalization. I argue that testimonial injustice is produced by interlocking sanist, suicidist and paternalist views that regard the judgment of suicidal people as irrational, incompetent, illegitimate or alienated and which destroy the suicidal subject's credibility. In that sense, suicidal people's voices are invalidated. Furthermore, as a group, suicidal people lack the conceptual tools necessary to understand their experiences outside the mainstream curative and preventative frameworks and to make them intelligible to others. As we saw above, no matter what model one uses to theorize suicidality, suicide is not considered a valid option and hence is not rendered intelligible or rational. **23** This doesn't mean that suicidal people are not able to develop those analytical tools and don't have the capacity or agency to do so, but simply that there is a scarcity of theories, notions and concepts to help them conceptualize their experience as part of a larger system of oppression rather than an individual problem. To give an example, the fact that a suicidal person finds it difficult to reach out due to a multitude of reasons−fear of negative consequences and stigma, guilt at the idea of leaving their loved ones or "depriving" them from life insurance that doesn't apply in the case of suicide, the conviction they are being selfish or cowardly−demonstrates that it is difficult for suicidal people to conceptualize their personal experience as part of a larger oppressive system that produces violence and discrimination toward suicidal subjects. In addition, this hermeneutical injustice is partly founded on the fact that suicidal subjects experience hermeneutical marginalization.

As demonstrated earlier, suicidal people are not (or very rarely) invited to contribute to knowledge construction on suicidality by either the fields of suicidology or critical suicidology. This makes the theorizing of suicidist oppression incredibly challenging for suicidal people, since no existing suicide-related discourses allow one to conceive this form of oppression. Similar to women trying to make sense of their experiences of conjugal sexual violence in historical or geographical contexts in which sexual assault is not recognized between married partners (Fricker, 2007), or similar to mad people trying to make sense of their experiences of trauma-related psychiatrization in societies in which madness is seen as an objective fact and in which sanism is not recognized (Nicki, 2001), suicidal people do not have easy access to the conceptual tools to interpret suicidism as a form of oppression and violence.

### 1.4.2. Suicidal Subjects, Pre-Emptive Testimonial Injustice And Testimonial Smothering

Fricker and Jenkins also expand on a notion developed by Fricker (2007: 130-131) ten years earlier: the "pre-emptive form of testimonial injustice," defined as "[…] an advance credibility deficit sufficient to ensure that your word is not even solicited" (Fricker and Jenkins, 2017: 272-273) and add that "such pre-emptive testimonial injustice functions to maintain ignorance regarding trans experiences [or other marginalized experiences] and identities by ensuring that only a narrow subset of those experiences and identities reach a wider audience" (273). In the case of disabled people, for example, the media often solicit disabled people only to confirm ableist scripts and narratives that depict disabled people as either having a tragic life or as supercrips overcoming their disabilities (Kafer, 2013; McRuer, 2006; 2018). In a similar fashion, suicidal people experience pre-emptive testimonial injustice when, instead of their voices being dismissed entirely, their testimonials are solicited only to present a tragic/overcoming narrative. As a result, we are exposed only to a "narrow subset" of suicidal experiences (Fitzpatrick, 2016), comprised mainly of those of *ex-suicidal* people (as, for example, in the edited volume of White et al., 2016), adopting a script that aims to show that once they obtain the help they need, be it chemical, psychological, social, political or otherwise, suicidal people reevaluate their wish to die. In sum, there is a scarcity of suicidal people's discourses in the public sphere and the priority is usually given to *ex-suicidal* people's discourses in order to give hope to those who might contemplate suicide.

A wide variety of suicidal narratives are further shut down by "testimonial smothering," a phenomenon coined by Dotson (2011) and also discussed by Fricker and Jenkins. When marginalized groups testify publicly about their experiences, testimonial smothering

encourages them to voluntarily conceal parts of their testimonials or to transform their messages in order to make them more palatable to a certain audience (Fricker and Jenkins, 2017: 273). For example, some disabled people might be tempted to soften their critiques of ableism in the media in order to convince an audience about the importance of universal accessibility. In the case of suicidal discourses, it is not surprising that most testimonials are narrated in the *past tense*, such as the one of Webb (2011), or as what Borges (2019) calls *passive* suicidal ideations, as if revealing *current and active* suicidal ideations is so menacing and threatening to the injunction to live and to futurity and comes with so many damaging consequences that is it not even an option for current and active suicidal subjects. In that sense, I wonder if some testimonials have been smothered in order to make a difficult topic palatable. [24] I can certainly confirm that testimonial smothering is at work in my case. While I generally use an auto-ethnographic methodology in most of my work on disability and trans issues, mobilizing personal experiences to theorize social and political issues, I didn't automatically turn to subjective experience in my work on suicide. Despite having published four previous texts on the topic, in this article it is the first time I have decided to "come out" (in a footnote and this paragraph only) as a suicidal person, after being questioned about my position/situatedness as an author by one of the peer reviewers of this article. For so many reasons impossible to unpack in the limited space here, I voluntarily concealed, in my past publications, as well as in the tone of this one, some information about me and about my experience of suicidality in order to make my thesis and arguments more palatable and credible to my audience. In sum, it is possible to see how pre-emptive testimonial injustice and testimonial smothering contribute to ignorance regarding suicidal people's experiences, because their voices remain relatively absent from the public sphere or are transformed or adapted to be more "acceptable", in turn fostering hermeneutical injustice and leading to greater difficulty in theorizing suicidist oppression–and hence perpetuating the deadly silencing circle of epistemic violence.

## 2. (Re)thinking suicidality from an anti-oppressive perspective

### 2.1. "Positive" Conceptualizations Of Suicidality

One could object that the arguments I have presented thus far do not do justice to the diversity of positions on suicide. Indeed, all the models of suicidality presented in the first part of this essay adopt a "negative" point of view about suicide, aiming to prevent it. In this second part, I depict other conceptualizations of suicide that can be characterized as "positive" without necessarily succumbing to the glorification of suicide. The history of philosophy is replete with examples of philosophers (Plato, Aristotle, Hume, Camus or Sartre, to name but a few) for whom suicide was a possibility under

specific circumstances and contexts, or philosophical schools of thought, such libertarian or existentialist, that defended the liberty of completing suicide (Cholbi, 2011; 2017; March, 2016). It is worth mentioning that none of these philosophers or philosophical stances, even the libertarian defense of the right to die by suicide, have theorized suicidism. It is also important to note, as Michael Cholbi (2011; 2017) reminds us, that except for the libertarians, all other positions on suicide suggest intervening, at least minimally, with suicidal people in order to prevent suicide. While some of these positions propose non-coercive intervention methods, such as trying to encourage suicidal people to change their minds, others are strongly coercive.

A few authors quoted in this essay, such as Szasz (1999) and Stefan (2016), vehemently critique the "terror" (a term employed by Szasz) that suicidal people experience in our Western societies through coercive prevention measures. Their important and groundbreaking work aims to highlight the stigmatization, as well as the psychiatrization, institutionalization and even criminalization, that suicidal people experience. In order to better understand what distinguishes my thesis from other authors who critique the unfair treatment reserved for suicidal people, it is useful to review briefly both Szasz and Stefan's positions. [25] Philosopher and psychiatrist Thomas Szasz (1999) believes that suicidal people are discriminated against by society, psychiatry, the law and the State. He develops a thesis similar to mine, but from a libertarian point of view. He sustains that individuals should have the *liberty to end their life without interference*. He is, however, strongly opposed to any state or medical interventions that would provide assisted suicide, as these measures would be considered an interference in individual liberty and would give too much power to physicians, psychiatrists and the State. Based on a liberal conception of choice, liberty and autonomy, Szasz supports a strong division between the private and public spheres and only approves of suicide when it is a "private" affair. He goes as far as saying that we should even criminalize and punish suicidal people who end their life in the public sphere because they are causing trouble for society, for example by disrupting traffic as a result of jumping in front of a train or from a bridge (Szasz, 1999: 130). In sum, Szasz denounces coercive treatments forced upon suicidal people but doesn't approve any forms of support that could be provided to help suicidal people accomplish their goal. In philosophical terms, it is the difference between a positive and a negative right, as he explains in the following passage:

> The difference between a positive right and a negative right is briefly this: A positive right is a claim on someone else's goods or services; in other words, it is a euphemism for an entitlement. Because the notion of a *right to suicide* (or physician-assisted suicide) entails an obligation by others to fulfill the reciprocal *duties* it entails, I reject the notion of a "right to suicide." However, I believe we have – and ought to be accorded–a "natural right" to be left alone to commit suicide (Szasz, 1999: 108). [26]

In sum, while a positive right involves obligations from others and/or from the State to provide services or measures to help people exercise that right, a negative right only entails that others and/or the State don't interfere to prevent that right from being exercised. Before critiquing Szasz's position, I would like to present Stefan's position.

Susan Stefan (2016) expresses a sincere desire to listen to and to understand, from an open-minded perspective, the suicidal subjects she interviewed. She demonstrates, through legal cases, how suicidal people are stigmatized, delegitimized and treated as irrational. Despite her innovative approach and the arguments she deploys to show that suicidal people represent a discriminated group, she does not frame this discrimation a a form of suicidist oppression and she does not pursue a positive right to suicide. Instead of supporting suicidal people in their quest, she claims that it is not the duty of society to help them to die. Like Szasz, she contends that if they want to do it, they should be allowed to do so without interference (Stefan, 2016: 474-475, 486). The ultimate goal of Stefan is to critique the current ineffective and damaging coercive prevention strategies and to develop a "public health approach" (Stefan, 2016: 468) comprised of diverse social policies and multisectoral prevention strategies to prevent as many suicides as possible. In the "unified field theory of suicide" that she offers in the conclusion to her book (Stefan, 2016: 495-498), she shows that people should be helped to live and not to die (and that assistance in dying or completing suicide should be illegal):

> People are suicidal in part because of larger systemic issues of child abuse, domestic violence, bullying, and trauma at home and overseas. They are suicidal in part because they have biological conditions that do not get the attention or care that medical conditions do. They are suicidal in part because of things that society can do nothing about: the death of a parent, the breakup of a marriage, infidelity, and terminal illness. People should have their own decisions about life and death respected, but they should get help, too—not help to die, but help to change their lives into lives worth living. For the most part, they know what they need: to stay in school, to get support taking care of their children, to be taught a new perspective to frame their problems and solve them, to get a bit of a break and some rest, and to have a community that sticks by them for the long, long haul, to have someone listen. They know what they don't need: involuntary hospitalization, getting shot by police, moralizing judgments by people who don't have a clue what they've been through, and to never be permitted to actually articulate how terribly they are feeling without having their drug dosage increased (Stefan, 2016: 495).

A few positions that allow suicidal people to speak more freely, such as those of Bergmans et al. (2016), Werth (1998) and Webb (2011) presented earlier, adopt a stance similar to that of Stefan: destigmatizing suicidality ultimately

saves more lives and leads to better suicide-prevention strategies. I contend that these positions, while offering an important first step, are incomplete. While providing a solid and documented critique of how suicidal people are stigmatized in our Western societies, they do not articulate the suicidist oppression faced by suicidal people and do not suggest the adoption of any positive rights for suicidal people that would involve an obligation or a duty to support them. [27]

### 2.2. What Is Missing From "Positive" Conceptualizations Of Suicidality?

My goal in this section is not to provide a detailed critique of Szasz and Stefan's positions, a goal that would go beyond the scope of this essay. My objective, rather, is to insist on what is absent in their "positive" theorizations of suicidality and to address the consequences of those absences. While these two authors have offered some of the most radical reflections to theorize the hurdles, mistreatments and discrimination that suicidal subjects experience, their theories are not founded in anti-oppressive perspectives and do not offer the conceptual tools or political agendas mobilized by anti-oppressive activists/scholars when denouncing the violence faced by other marginalized groups. My argument, contrary to Szasz's and Stefan's position, is that like other marginalized groups, *suicidal people are entitled to receive support and assistance*.

Some of the positions discussed above, such as those of Webb (2011) and Stefan (2016), [28] don't question the injunction to live and to futurity that underlies the suicide-prevention strategies they seek to reform. Furthermore, some of those "positive" conceptualizations of suicidality, such as those of Stefan (2016) and Szasz (1999), argue for a negative, not a positive, right to suicide. In other words, they want to stop the violence that suicidal people face and promote non-interference with regards to suicide attempts, but neither author states that suicidal people should be supported by society and its institutions. Both Stefan and Szasz make analogies between abortion and assisted suicide. Perhaps unsurprisingly, both of them, in their critique of the medical system, err on the side of a demedicalization and disengagement of the State when it comes to abortion (Stefan even affirms that "demedicalizing abortion is an explicit goal of feminists […]" (2016: 85).

I would like to pursue their analogy about abortion. My goal is not to infer that abortion and suicide are comparable practices but rather to assert that any rights, such as reproductive rights, are ineffective without concrete measures and policies to implement them. Indeed, from my perspective, decriminalizing abortion, in other words, giving a "negative right" to abort, does not support reproductive rights or reproductive justice unless accompanied by strong measures, social policies, forms of support, and institutional services that *really* give access to abortion to everyone. I believe it should be an obligation and a duty of the State to do everything possible to facilitate access to such services, while simultaneously providing people with relevant sexual education

and contraceptive measures. In a similar fashion, I believe that decriminalizing and depathologizing suicide, reducing stigmatization, and requesting that the State and its medical and legal institutions stop imposing dehumanizing treatments is not enough to support suicidal people's rights or social justice toward this marginalized group. As a feminist, trans, disability and queer activist, I adhere to the same logic for all marginalized groups. I believe that working toward strong and effective equity for marginalized groups, including suicidal people, is not limited to preventing State control or direct forms of violence but includes creating the conditions in which these marginalized groups have access to the same opportunities and resources, and also receive the same social, cultural, political, and legal recognition as other people (Kafer, 2013; McRuer, 2006; 2018). For example, decriminalizing, depathologizing and destigmatizing trans identities could certainly help trans and nonbinary people, but those measures alone are almost useless unless positive rights are given to trans and nonbinary people and social policies, measures, and strong trans-affirmative healthcare are provided and implemented in a free and accessible manner (Bauer et al., 2015; Clare, 2017).

The same should be true for suicidal people. Without encouraging suicide or offering a non-reflexive and acritical quick way to help to end their life, I argue that the State should offer assisted suicide as one among several potential options, carefully guiding and counselling those who are contemplating this possibility. In this respect, my thesis differs radically from the positions of Szasz or Stefan; the notion of suicidism I develop here from an anti-oppressive perspective aims not only to critique and denounce the oppression suicidal people face, but also to end their oppression through structural remedies and sociopolitical, legal, medical, economic and epistemic transformations. As I elaborate below, this new theoretical framework aims to contribute to epistemic change as a first step toward ending the violence suicidal people endure. Inspired by a harm-reduction approach developed for drug users, sex workers, and other groups (Marlatt et al., 2012), I call for an ethics of suicide based on compassion, responsibility, and accountability, designed to support suicidal people in their need to end their life. This harm-reduction approach aims to complement, not replace, the fight against systemic oppressions that contribute to the over-representation of marginalized groups in suicide rates (Baril, 2017; 2018; 2020a). Having its roots in an anti-ableist, anti-sanist and anti-suicidist perspectives, this approach to "cripping" and "queering" suicide seeks to move beyond the limits of the medical, social and biopsychosocial models of suicidality, as well as those of the more "positive" conceptualizations of suicidality that still leave suicidal subjects to fend for themselves. This "noncoercive suicide prevention" approach, which Szasz (1999: 46) mentions in his book but does not develop, would provide compassion and support to people who express a desire to end their lives but who might change their minds during the accompaniment process, as well as to those who want to pursue their suicide. [29] This non-coercive suicide approach is developed below.

## 2.3. A Non-Coercive Suicide Approach

### 2.3.1. Cripping And Queering Suicide

In a seminal text at the intersection of queer and critical disability studies, Carrie Sandahl (2003) proposed to use both the terms queer and crip as verbs. [30] Sandahl writes:

> Queers and cripples often experience profound isolation while growing up, since they are rarely born into queer or crip families, much less communities. To cope with this isolation, and to resist the negative interpellations of being queer or crippled (not to mention queer *and* crippled), members of both groups have developed a wry critique of hegemonic norms. In queer communities, the application of this critique has been given its own verb: *to queer*. Queering describes the practices of putting a spin on mainstream representations to reveal latent queer subtexts; of appropriating a representation for one's own purposes, forcing it to signify differently; or of deconstructing a representation's heterosexism. Similarly, some disabled people practice "cripping." Cripping spins mainstream representations or practices to reveal able-bodied assumptions and exclusionary effects. Both queering and cripping expose the arbitrary delineation between normal and defective and the negative social ramifications of attempts to homogenize humanity, and both disarm what is painful with wicked humor, including camp (Sandahl 2003: 137).

It is in the spirit of queer epistemologies and "cripistemologies" (McRuer and Johnson, 2014) that I would like to situate the epistemological reflections on suicidality offered in this essay. "Queering" is not limited to focusing on sexual and gender minorities, or even positioning them at the heart of our analyses and actions. Queering is about refusing norms, assimilation and the judgment of what is (ab)normal. Queering is reappropriating, recoding and resignifying certain realities. To queer is to question, to blur boundaries, and to refute binary categories (Edelman, 2004; Halberstam, 2008; 2011; Halperin, 2003; Kafer, 2013; McRuer, 2006; 2018). Unlike the work of some scholars who claim to queer suicide (Cover, 2012; Marsh, 2010; McDermott and Roen, 2016) yet offer only analyses that take queer theories as a starting point or queer communities as the objects of their study, this essay intends to queer suicide in a more holistic sense, that is, by queering methods, theories, epistemologies and prevention strategies on the topic of suicidality. Cripping and queering suicidality means allowing suicidal people to reclaim and redeploy discourses on suicidality based on their perspectives, needs and goals. Cripping and queering suicidality blurs

the boundaries between "good" and "bad" decisions about life and death, between the "rationality" and "irrationality" of certain actions, between "positive" and "negative" affects, and the binaries of these categories (Baril, 2020b: 325-326). To crip and queer suicidality makes it possible to resignify the negative and abnormal meaning automatically given to it in order to allow different narratives to emerge; the fact that positions like the one adopted in this essay are not presented in *any* of the literature consulted on the topic of suicidality (regardless of their approach) reveals that such different narratives do not exist or are censored (or "smothered" to reuse Dotson's term) from the public space. As with other complex phenomena, there should be a variety of interpretations, theorizations and *positions* about suicidality. While a wide range of theorizations exist, it seems astounding that almost all of them arrive at the same position/conclusion: "don't do it." It is fruitful to consider this conclusion as an injunction to live and to futurity that is part of what I would call a "compulsory liveness" in a suicidist system, similar to compulsory heterosexuality or compulsory able-bodiedness (McRuer, 2006). The compulsory liveness aims to impose on everyone a will to live and makes the desire/need for death of some people abnormal, unconceivable and inintelligible, like suicidal subjects themselves.

Robert McRuer (2006), in the introduction to his seminal book at the origin of crip theory, denounces the constant interrogation that able-bodied people direct toward disabled people, asking about their supposed desire to be "normal:" "The culture asking such questions assumes in advance that we all agree: able-bodied perspectives are preferable and are what we are collectively seeking. A system of compulsory able-bodiedness repeatedly demands that people with disabilities embody for others an affirmative answer to the unspoken question, "Yes, but in the end, wouldn't you rather be more like me?" (McRuer, 2006: 9). A similar compulsory mechanism (compulsory liveness) is at play regarding suicidality: non-suicidal people are constantly wondering *why* suicidal people are suicidal and what can be changed (in them or in society) so that they may conform to the non-suicidal norm. [31] Through the injunction to live and to futurity, non-suicidal people implicitly ask the same question to suicidal people: "Yes, but in the end, wouldn't you rather be more like me, that is someone who wants to live a long life and enjoy living it?" Some, if not a majority, of suicidal people might answer positively to this question and should therefore be supported to arrive at solutions to help them abandon their suicidal state. However, it seems problematic to take for granted that all suicidal people would have an affirmative answer to this question, or to "assume in advance that we all agree" about the correct answer to this question, to reuse McRuer's words. Furthermore, it is simply unintelligible from a suicidist (and sanist) perspective that someone could answer the following: "No thanks, I don't want to be cured, I don't

want to be fixed, or I don't want to wait to see the social revolution that will eradicate the oppression that makes me suffer… I just want to die now; I have lived enough. I don't care if my life is over; this is what I want." Like Deaf, disabled and crip people who told us, in the past decades, that they don't want the "ideal solution" that mainstream societies offer them (e.g. cochlear implants, cures, etc.) but instead want their voices, perspectives, needs and claims respected and supported (Clare, 2017; Fritsch, 2016; Kafer, 2013), suicidal people should not have imposed on them pre-conceived solutions devised by the majority of people who don't experience their reality but who nevertheless believe that they have the best solutions to offer.

In my work, I am less interested by a politics of negativity, antisociality, antifuturity or failure, along the lines of Edelman (2004) or Halberstam (2008; 2011), [32] that could position suicide as the queer act *par excellence* to thwart heteronormative and reproductive futurism. Rather, I argue that we should conceptualize the passage from life to death as a social and relational passage, and that this relationality and sociality should be denied to no one, regardless of how they die. The cripping and queering approach to suicidality proposed here aims to take into consideration suicidal people's subjective experiences of suffering. It is a non-coercive approach that insists on the importance of an affective and relational turn (Cvetkovitch, 2012) regarding suicidal people. The approach proposed here opens up the possibility of exploring suicidality without shame, guilt, or negativity with those who contemplate suicide as a way to end their suffering. It allows us to explore with them some crucial questions: What attracts you to the option of suicide? What kind of support or help would you like to have to go through this difficult period or to end your life? Did you inform your relatives and friends about your idea of ending your life, and do they support you in this period or process? Did you consider other options? Did you consider all the implications of that potential decision, for yourself and for your loved ones? Did you plan carefully your end of life, death and post-death? In a similar fashion to trans-affirmative healthcare, the "suicide-affirmative" healthcare model I propose here would offer care and support through an informed-consent model, taking for granted that the expert in the decision to transition, in this case from life to death, is the person making the decision. [33] It goes without saying that before implementing this approach, it would be important to engage in extensive critical reflection regarding the conditions, regulations, safeguards, and type of accompaniment, as well as the simultaneous sociopolitical changes necessary, to reduce suicidal ideations. These concrete aspects of a harm-reduction approach would have to be determined primarily *by and for* suicidal people and their allies, mobilizing their expertise on suicidality.

### 2.3.2. "Suicide-Affirmative" Healthcare: An Ethics Of "Living With" Suicidal People

By applying a cripping and queering approach to suicidality, it is possible to develop critical social analyses of the oppressive structures that may increase marginalized people's suicidal ideations and suicide attempts, while at the same time formulating accountable responses to these people's subjective experiences of suffering through "suicide-affirmative" healthcare. My approach seeks to create safer spaces in which the voices of suicidal people can be listened to, legitimized and desubjugated, to paraphrase Foucault (1976; 1997). These safer spaces must be as free as possible from forms of judgment, stigmatization, paternalism and oppression and must foster a welcoming environment so that suicidal people can freely express their lived experiences, thoughts and demands without fear of reprisals and negative consequences. This approach recognizes the pain and suffering that social oppression and/or mental and psychological disabilities can cause (Clare, 2017; Kafer, 2013; Nicki, 2001), without using suicidal people's mental and psychological condition to invalidate their agency (Burstow, 2016). It suggests that we work on multiple levels simultaneously. While it is necessary that we tirelessly tackle the sociopolitical oppressions that can create or intensify suicidal ideations, we must also acknowledge that suicidal peoples' experience of suffering is real and respect their need to end their life after careful consideration in a very supportive process of accompaniment that also offers, along the way, a wide variety of other potential solutions.

Attempting to destigmatize suicide and to recognize it as one viable option among others–albeit one that requires considerable critical reflection with the support of relatives, friends, and healthcare professionals–may help a majority of suicidal people find solutions other than suicide along their exploratory journey of life and death. [34] Simultaneously, the harm-reduction approach I suggest here may allow a small number of suicidal people who are determined to die to be accompanied while preparing their death. They would have the opportunity to explore other solutions with professionals in order to determine if suicide is still, after much consideration, their preferred option, to carefully plan their death several weeks or months in advance, to say goodbye to their loved ones and to leave this world using less lonely and violent means than those usually employed in completed suicides. This would also be less traumatic for the relatives and friends, despite the mourning that accompanies all forms of death. Either way, my approach insists on building relations with suicidal people, on caring for them and supporting them throughout their journey. In some cases, the support of others can awaken in a suicidal person the will to live. In a compelling short documentary entitled *24 & Ready to Die*, Emily, a 24 year old physically healthy Belgian woman

suffering from psychological distress, recounts that it was through the support of her friends and family and the preparation of her own assisted suicide that she found the desire to continue to live, at least for a while. She says: "Without the option of euthanasia, years of suffering would have been compounded by a gruesome, lonely death. I would have killed myself" (*The Economist*, 2015). She is not alone in testifying that being able to name her need to die and being listened to and respected in that wish ultimately helped her to go on living. This is also the case, to some extent, with the artist Vivek Shraya who, in a short film entitled *I Want to Kill Myself*, recounts how, by breaking the silence, she managed to survive her desire to die. She says: "Saying *I want to kill myself* kept me alive" (Shraya, 2017).

The non-coercive suicide approach I outline in this essay could possibly save more lives than current suicidality models and their prevention strategies that are clearly failing suicidal people, as many authors cited in this essay have demonstrated. In the few countries that have decided to include in their assisted-suicide legislation people whose requests are based on psychological/emotional suffering (Appel, 2007; Stefan, 2016; *The Economist*, 2015), several candidates changed their minds along the way; preparing for their death was a cathartic process that made some of them want to live. Above all, this process allowed them to talk openly with their relatives and professionals, thus preventing them from lingering in silence and completing suicide without exploring other avenues. In other words, unlike suicides currently performed in isolation, assisted suicide processes would be characterized by support, accompaniment and relationality. Although it has some resemblance with medical assistance in dying, my approach differs radically in its foundation and application. Indeed, while in medical assistance in dying suicidal subjects are explicitly excluded and distinguished from ill/disabled subjects that should be helped to die (from an ableist perspective), the primary goal of the approach sketched here is to offer assistance to suicidal subjects from an anti-suicidist/anti-ableist/anti-sanist perspective. **35** In sum, this approach proposes an ethics of "living with" suicidal people while they are making their ultimate decision.

## Final words

Nelly Arcan, a Quebec author who took her own life in 2009 and who discussed suicidality abundantly in her fiction, semi-fiction and non-fiction work, **36** wrote (Arcan, 2008: 1, my translation): "If there is one subject that needs to be addressed with a good thickness of white gloves, held on a leash by an indescribable political rectitude, it is suicide. Something to do with an aura of contagion. Maybe one of the problems is that we think we have understood everything about it. […] We [must] start thinking about suicide in its intense and painful complexity." This essay, I hope, was able to delve into the "intense and painful complexity" of suicidality with

both sensitivity and audacity, in the spirit of queer and crip theories. By providing alternative narratives about suicidality and proposing suicidism as a new theoretical framework to conceptualize suicidal people's oppression, as well as a new non-coercive approach to intervene with suicidal people based on harm reduction, I hope the arguments provided here convinced some readers about the importance and urgency of thinking outside the box about a topic so crucial that it is a matter of life and death.

As intersectional analyses have taught us, it is imperative that discourses on marginalized groups and strategies to eliminate oppression avoid reproducing violence (Combahee River Collective, 1997/1977; Crenshaw, 1989; Hill Collins, 2000; Hill Collins and Bilge, 2016). The arguments proposed here have shown how suicidal people experience several forms of violence, including epistemic injustices. While in the early years of intersectional thinking the focus was primarily on the canonical trio of sex, class and race, the past few decades have taught anti-oppressive activists/scholars that there are many more axes of identities and oppressions to take into consideration, not only because including these other groups and oppressions is crucial, but mostly because diverse identities and oppressions are interlocked and connected. This essay only touched on suicidism and its connections to ableism and sanism, but there would be many more reflections to unfold regarding the intersections of suicidism, colonialism, racism, capitalism, ageism, and so on. From an intersectional lens, I contend that analyzing sanism, ableism, capitalism or ageism without suicidism could provide only one incomplete and partial vision of how these systems work together. Therefore, theorizing the oppression experienced by suicidal people holds promise because it shines light into the hidden corners of intersectional analyses. This essay is, in sum, an invitation to listen to suicidal people's voices and perspectives, to expand on the current limited interpretations of suicidality and to enrich intersectional analyses.

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## Endnotes

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2. Manifestos have been used by marginalized groups to be heard. While I am not using a first-person voice in the body of this essay, I am writing this essay/manifesto from the situated perspective of someone who has been suicidal since the age of twelve.
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3. This biographical information is taken from Anna Borges's website: https://www.annaborgeswrites.com/.
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4. In this essay, suicidality is understood as a broad term encompassing suicidal ideations, suicidal attempts and completed suicides.
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5. The expression "anti-oppressive activists and scholars" in this essay refers to people involved in social movements, such as women's, trans, disability rights movements, to name but a few, and their related fields of study, such as feminist, trans and disability studies. On anti-oppressive perspectives, see Baines (2017).
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6. There are a few exceptions, but a Google search for "suicidism" demonstrates that this term doesn't circulate widely and has not been used in the sense described here. Given the limited circulation of this term, its resignification is less risky than reclaiming other terms, such as "crip" and "queer."
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7. As I demonstrate later, proponents of the social model of suicide, who reject medical/psychiatric explanations of suicidality, could reconduct suicidism without ableist and sanist perspectives. Therefore, suicidism is distinct from, though interlocked with, other systems of oppression.
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8. While I will discuss later in this essay how I understand queer and crip perspectives, the limited space in this article prevents me from providing extensive definitions of these perspectives. For those unfamiliar with these perspectives, the following references might be helpful: Clare (2017), Edelman (2004), Fritsch (2016), Halberstam (2011), Halperin (2003), Kafer (2013), McRuer (2006; 2018), McRuer and Johnson (2014) and Sandahl (2003).
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9. For readers interested in the question of what counts as suicidal, see Bayatrizi (2008), Cholbi (2011), Marsh (2016), Stefan (2016), Werth (1996) and White et al. (2016).
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10. See also Marsh (2016) and Bayatrizi (2008) for a critical analysis of the assumptions underlying the medical model.
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11. Button (2016: 270), for example, aims to develop a "political approach to suicide" centered on social justice, as is often the case in the field of critical suicidology (Marsh, 2015; White et al., 2016). While the social model, by adopting anti-oppressive perspectives, presents a lot of similarities with the approach I adopt, the radical difference is that the anti-oppressive perspectives in that model are not used to analyze *the oppression of suicidal people*.
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12. For a more detailed explanation of my concerns about the limitations of the social model, see Baril (2017; 2018; 2020a). While I have been the only author, to my knowledge, to critique the limitations of the social model of suicide from an anti-oppressive perspective (and hence from a socio-political perspective), several existing critiques of the social model of disability have inspired my work on suicide, such as those proposed by Clare (2017), Kafer (2013), McRuer (2006; 2018), Nicki (2001) and Siebers (2008). There are similarities between the social models of suicide and of disability, but those models should not be conflated.
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13. Similar to the biopsychosocial model, the "interpersonal theory of suicide," adopted for example by Joiner (2005) and critiqued by others (Hjelmeland and Knizek, 2020), mobilizes biological, psychological, social and environmental factors to explain suicidality and "posits that suicide can be explained by the simultaneous presence of three risk factors only, namely acquired capability for suicide, thwarted belongingness, and perceived burdensomeness" (Hjelmeland and Knizek, 2020: 168).
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14. Stefan (2016) shows that despite massive financial investments in multiple kinds of suicide prevention campaigns, suicide rates have remained stable. Other authors demonstrate similar patterns (Peck, 2003).
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15. Webb (2011: 24) adds: "As I studied the […] discipline known as 'suicidology,' what first jumped out of me was the almost complete absence of the actual suicidal person. […] [Y]ou never heard directly from the suicidal person in their own words. The first-person voice of those who had actually lived the experience of suicidal feelings was apparently not on the agenda of suicidology."
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16. A few people have discussed their desire to die or their suicidal ideations publicly in the past few years, for example the former managing editor of the *Walrus Magazine*, Graeme Bayliss (2016), or the artist Vivek Shraya (2017).
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17. Some researchers believe that suicidal people cannot be seen as "experts" on their reality because they might have a "distorted view" of it (Bantjes and Swartz, 2019). See also Bering (2018), Cholbi (2011) and Joiner (2005).
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18. The chapter written by Bergmans et al. (2016) insists on the importance of listening to the voices of suicidal people to achieve more effective suicide intervention but doesn't include *current* suicidal people voices.
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19. Ableism, intertwined with sanism, is also part of this dynamic. Limited space here prevents me from elaborating on this, but I discuss it in other publications (Baril, 2017; 2018; 2020a).
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20. The literature has shown that there exist forms of sanism among disability scholars and activists (Burstow et al., 2014; Clare, 2017; Gorman and LeFrançois, 2017; LeFrançois et al., 2013; Lewis, 2010; Nicki, 2001). In this context, it is not surprising to notice that suicidality is often perceived through a sanist lense as a "mental illness" to be "fixed." To give only one example, well-known disability activist Tom Shakespeare (2006), while justifying assisted suicide for people with terminal illnesses, insists on the fact that people with mental illnesses who want to die should be prevented from doing so. Shakespeare (2006: 124) writes: "For example, depression and other mental illness could cloud judgement and may prevent a person with terminal illness making a competent decision to request death." It is also interesting to note that most texts in the field of mad studies do not address the question of suicide. For example, in the edited volume *Psychiatry Disrupted* (Burstow's et al., 2014), the authors specify that what is left unexamined in a book is often as revealing as what is examined and note seven groups (e.g. trans people, Indigenous people, older adults, etc.) who are not extensively discussed in their book (Burstow and LeFrançois, 2014: 10-13). Despite the fact that

suicidal people experience high rates of psychiatrization, pathologization, forced institutionalization and treatments, they are not mentioned among the under-analyzed groups in the book.
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21. Bayatrizi (2008: 10) refers to a "life sentence" in the title of her book as a form of biopower and healthism promoted through contemporary biopolitics, but doesn't analyze it as a mechanism that hurts people labelled as "mentally ill" or "suicidal" and doesn't theorize the ableism and sanism involved in this phenomenon.
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22. While I would like to engage more deeply with debates surrounding disability and assisted suicide, space limitations prevent me to do so. I invite readers to consult Baril (2017) for a deeper reflection on that topic. Readers could also consult the following documents: Bayatrizi (2008), Burstow (2016), Gandsman (2018), Hewitt (2010; 2013); Longmore (2003) and Stefan (2016).
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23. The different authors who argue in favor of what is called "rational suicide" often defend suicide based on ageist, ableist and sanist presumptions; if someone is at the end of their life due to age or illness, or is living with disabilities, it seems like the right/rational thing to do for themselves and/or for their relatives to end their life (Ogien, 2009; McInerney, 2000; Werth, 1996; 1998). Suicide is recast here as a logical and rational response to a "tragic situation." I would also add that most authors in favor of "rational suicide" adhere by default to sanist perspectives, since rational suicide is seen as an act accomplished by a *rational* subject competent to decide, usually defined in opposition to people labelled as having intellectual, cognitive, mental, and psychological disabilities or illnesses.
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24. On the framing of personal narratives surrounding suicidality in the public sphere, see Fitzpatrick (2016) and Bantjes and Swartz (2019). See also the testimonials from suicidal people in Stefan's book (2016) regarding self-censoring and lying about current and active suicidal ideations.
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25. Space limitations prevent me from developing other positions in favor of suicide, such as the right-to-die position usually framed as an individual right for those with disabilities or terminal illnesses and denied most of the time to people with mental illnesses, a position that I consider ableist and sanist (Baril, 2017). See also on the right-to-die movement: Gandsman (2018) and McInerney (2000). Several people have argued for extending the right-to-die position to people with mental illnesses, but their arguments are often (though

not always) developed either from an individualistic or medical/psychological perspective and not from an anti-oppressive perspective (Appel, 2007; Bayliss, 2016; Hewitt, 2010; 2013; Maier Clayton, 2016; Tappolet, 2003). In addition, none of these positions recognize suicidism. The only position I have encountered thus far from an anti-oppressive perspective is that of Burstow (2016), who denounces how people labeled with mental illness are discriminated against when they are excluded from medical assistance in dying. Burstow was a well-known anti-psychiatry activist/scholar but didn't develop further her reflections on the topic of suicide.
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26. Other philosophers, such as Ogien (2009), have defended similar positions, distinguishing between a liberty and a right to suicide.
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27. On the notion of "duty," see Cholbi (2011; 2017).
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28. See also Werth (1998) and Bergmans et al. (2016) on the advantages of allowing suicidal people to speak more freely in order to save more lives. This kind of position is also well illustrated in the work of Roen et al. (2008: 2096): "Ideally, this would mean working with the discursive tension to reduce the perception of suicide as a viable 'option', but to simultaneously challenge the fears that lead to the ostracism and Othering of young people who have attempted suicide."
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29. A majority of suicidal people interviewed by Stefan (2016: 508) are in favour of providing assisted suicide to depressed and suicidal people, at least in certain circumstances.
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30. For definitions and explanations of the usage of queer and crip as verbs, see Chandler (2012); McRuer and Johnson (2014) and Fritsch (2016). As Chandler (2012) mentions, "To crip is to open up desire for what disability disrupts." McRuer (2018: 24) adds: "Cripping always attends to how spaces, issues or discussions get 'straightened.' The critical act of cripping, I argue, resists 'straightening' in a rather more expansive sense that we might think of straightening at the moment, in queer studies, activism, or art."
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31. This is also the case in the dominant narratives of ex-suicidal people, such as Jesse Bering in his book *Suicidal: Why we kill ourselves?* (2018) or Rowe

(2016).
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32. Even in that stream of queer scholarship, the death drive often remains figurative, and suicidality is neither discussed nor questioned from the angle proposed here (see, for example, Halberstam, 2010; Puar, 2012).
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33. One of the anonymous reviewers of this article, whom I thank for their invaluable feedback, raised the ethical responsibilities of suicidal subjects, asking, for example, what shall be done if the suicidal person is a caregiver or a parent of a minor. Some philosophers such as Cholbi (2011) address those issues. While this is certainly a topic I will address in my future work, space limitations prevent me from developing my thoughts on the topic here. I think, however, that some of the questions I sketched in the proposed suicide-affirmative healthcare model would help to solve some of those difficult questions. In my future work, I will concretely address how the theoretical approach suggested here could work, how it differs from the current laws on medical assistance on dying (on that topic, see also Baril, 2017) and how it addresses some of the concerns raised by disability rights activists regarding medical assistance in dying.
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34. Although some authors (Bergmans et al., 2016; Stefan, 2016; Szasz, 1999; Webb, 2011; Werth, 1996) have suggested that an open-minded approach that allows suicidal subjects to speak freely could be an effective method of prevention, they do not adopt the second component of the approach proposed here, which consists of accompanying suicidal people in their suicide process using a harm-reduction approach.
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35. See Baril (2017) on my critique of medical assistance in dying.
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36. For analyses of suicide in Arcan's work, see Baril (2020b) and Taylor (2015).
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