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ORIGINAL ARTICLE

Rethinking Suicidality in the Context of Suicide-Affirmative Healthcare: A Survivor's Perspective

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Abstract
In this paper, I examine Alexandre Baril's notion of "suicidism" which accounts for the ways suicidal persons are uniquely marginalized. Using my personal experiences as a suicide survivor, as well as research in suicidology and testimony from other survivors, I argue that coping with suicidality is rendered nearly impossible in a world where the dominant narratives of suicidality are written by persons with no lived experience *being suicidal.* Suicidal persons are epistemically and affectively harmed by suicidism and ironically, those services that are intended to help often serve to increase suicidality by sending mixed messages or by outright silencing of suicidal persons. I argue that we should adopt many of the tenets of Baril's "suicide-affirmative healthcare" model instead and allow space for suicidal persons to speak, and most importantly, to exist.

Keywords
Suicide, Suicidology, Epistemic Justice, Harm Reduction

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1. Situating Suicidality: personal, political, philosophical

I start with my personal narrative to situate myself within the context of this paper. In 2016, after the birth of my first child, I was actively suicidal. I have struggled with suicidality since I was a teenager, so I knew it was possible and even likely that my mental health would be impacted by pregnancy and the postpartum period. Despite scaffolding myself with a support network and various other positive coping strategies, after a prolonged labor that lasted three days and ended in an emergency C-section, I found myself utterly exhausted, which was met with more exhaustion, now that I had a newborn to care for, and I began to crumble. The pain medication, the sleeplessness, the perpetually crying infant, the hormones, and a history of anorexia, anxiety, and suicidality was the perfect storm that nearly killed me. I developed postpartum psychosis with hallucinations. I wrote a note to my newborn son, explaining that I was more harmful to him alive than dead, and that all I wanted was for him to grow up knowing happiness, which I truly believed would only happen without me in his life. Fortunately, my partner gently urged me to seek emergency

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care, and I agreed. Even more fortunate was that the care I received did not further harm me. My psychiatrist did not shame me. She helped me wean off the medications as I improved and supported my autonomous decision-making. Not once did she suggest that my child might be better off in the care of someone else, or that I was a danger to him. I had not even considered this as a possibility.

When I was no longer in crisis, I returned to the blog I had been writing about pregnancy, mental health, and eating disorders. I wrote about the horrors of postpartum depression. My aim in writing this entry was to let other new parents know they are not alone, despite how lonely postpartum depression can feel. It was a dark and scary post because it detailed what happened during my psychosis and my active efforts to end my life. But it was raw and honest, and ultimately had a positive ending, insofar as I was on the other side of it, having received the care I needed. I wanted to add to the growing chorus of attempts to destigmatize postpartum depression, and I hoped that my words would comfort anyone out there thinking they were a failure for feeling anything other than happiness immediately following the birth of their child.

However, instead, two days after publishing this blog post, Child Protective Services (CPS) appeared at my door. I was subjected to 45 days of intrusive investigation, the fear of losing my child looming over the whole ordeal. Once it was finally established that I posed no threat and my case was dropped, I requested the report and when it was mailed to me, I was surprised to see a "reference" listed of someone I did not know. I had provided my own references – coworkers, doctors, etc. – but this person was not one of them. She was a social worker who worked in the same office as my sister-in-law, who is a clinical psychologist. My sister-in-law had been one of a small group of people I shared my blog with and had never once reached out to me to see if I needed support. Instead, she had set in motion a chain of events that led to my family being traumatized. This was re-traumatizing for us, as we had just recovered from the initial pain of my active suicidality and postpartum psychosis.

The way my sister-in-law mishandled my suicidality is a prime example of what Alexandre Baril (2023; 2020) has dubbed "suicidism", which is a unique form of marginalization and discrimination to which suicidal persons are subjected. I will discuss his framework in what follows, as well as the ways suicidism intersects with carceral and punitive systems such as Child Protective Services. These 'protection' and 'welfare' agencies have been seen as policing institutions steeped in racism and classism, and inextricably tied to the "mental healthcare industrial complex" (Greene 2023; Roberts 2022, 2012; Segrest 2020). I discuss these intersections and show how they are also suffused with ableism and sanism. Likewise, I will explain how responses to suicidal persons are often examples of both *epistemic* and *affective* injustice. Finally, I return to Baril's discussion of suicidism and one of his proposed means of dismantling it, namely, "suicide affirmative healthcare." I explore this framework, noting some of its strengths, as well as the challenges it faces, and then return to my story to imagine how things might have unfolded differently in a world not marked by suicidism.

2. Suicidism: Definitions, Examples, Intersections

As I noted in the introduction, there have been times in my life when I have been *actively* suicidal, but those times are thankfully few and far between. I do, however, still consider myself to be passively suicidal a majority of the time and I therefore identify as a suicidal person. In short, much like Anna Borges describes it, I live most of my life in the "nebulous gray space between fleeting thought and attempt" (Borges 2019). Identifying as a suicidal person is intentional. For one, I hope to lessen the stigma attached to the label by showing how I and many others live and cope with suicidality, and that rather than being something to be ashamed of, it is something suicidal people ought to be able to share openly and honestly. Another related reason for my identifying as suicidal is that I see it as an act of political resistance or pushback against the prevailing suicidist ideologies which I will discuss.

Despite their well-intentioned efforts, non-suicidal persons often impose a dichotomy onto suicidal persons: we are either victims of our suicidality and hence, dead, or we are cured, and thus no longer suicidal. Suicidal persons, therefore, ought not to exist, or at least, that is the ideal that most suicide prevention campaigns strive toward. In turn, there is a paucity of information about suicide written from the first-person, namely, the suicidal person's perspective. What little writing can be found authored by suicidal people is almost always written in the past tense. They are 'better' now. They are a 'good patient' who has been in therapy, taken the medications, listened to the doctors, and no longer wishes to die, and hence, these pieces are, paradoxically, *not* written by suicidal persons.[1]

I do not identify with these 'model survivors' because in truth, it is rare for a day to pass where I don't experience at least momentary speculations about ending my life, or what are often called 'suicidal ideations.' It would be irresponsible of me to write publicly about my struggles with suicidality entirely in the past tense, even though I have not experienced active suicidality in many years. Being suicidal is part of the mosaic of my personhood, and it is inextricably linked to other foundational aspects of my identity. I am also an adopted person, someone who has struggled with anorexia, a mother, an athlete, and many other things, but these components are inextricably tied to my suicidality and more importantly, how I cope with it.

One more note about terminology before I proceed: I think 'suicide survivor' is also an appropriate label for me, given that I have survived the attempts I've made to end my life. I

[1] For instance, note the books recommended on this site, the majority of which are written by those impacted by suicide loss, not attempt survivors, https://www.sscc.edu/services/assets/recommended-books-for-survivors-after-suicide.pdf. Another prominent speaker/writer's messaging is centered on 'healing': https://livethroughthis.org/. Clancy Martin, a survivor who is more open to admitting he presently struggles with suicidality, still titles his book "How Not to Kill Yourself", see story here: https://www.npr.org/2023/04/05/1168104827/how-not-to-kill-yourself-suicide-clancy-martin

mention this because a subtle way in which suicidal persons are marginalized is in the conscripting of the term 'survivor' to apply to non-suicidal persons who are mourning the loss of a loved one who died by suicide. As Baril (2023) argues, the term "survivor" ought to belong solely to those who have actually survived a suicide attempt. As he notes, in many communities, 'survivor' denotes someone who has endured violence, bodily violation, or police brutality, and hence to use it to describe a person left in the wake of a loved one's suicide is to subtly imply that the person, in dying by suicide, committed violence against others. In reality, the victim of a suicide is the person who died. The persons left behind are indeed in need of care and grief support, but they are not victims of a crime.

I've provided these details about my suicidality and choices regarding how I identify because it highlights many of the key aspects of what Baril (2023, 2020) calls "suicidism." It is because suicidal persons are discriminated against and marginalized in specific ways that Baril proposes a framework to understand how this occurs. Suicidism intersects with ableism and sanism (see e.g., Perlin 1992, 2013; Ahrend 2022; Baril 2022) and, as I have recently argued (Merritt 2024), it also dovetails with the way adopted persons are often marginalized, what I have termed 'adoptism.' In an ableist society, able-bodied and able-minded persons are unreflectively seen as the default setting of humanity and hence, life is situated around this assumption. Likewise, in a sanist society, being sane is the default and even preferred status. Hence, anyone seen as 'insane' or 'mad,' is inherently seen as unwell, abnormal, sick, and in need of curing. Those critical of the mental healthcare establishment, and movements such as Mad Pride, have pushed back against sanism over the years and questioned the validity of psychiatric diagnosis (see, e.g. Curtis et al 2011; Jeppsson 2022)

Most suicidal people are deemed 'mentally unwell,' despite research indicating that while mental illness is a risk factor, other precipitating causes, such as Adverse Childhood Experiences (ACEs), psychological abuse, and marginalized status play equally important roles (Yeh et al. 2019; Ports et al. 2017). Thus, dismantling sanism, Baril argues, is not sufficient to addressing suicidism, because not all suicidal persons are mentally unwell, and moreover, as we just discussed, being 'mad,' much like being deaf, might not be something that inherently needs to be cured.

Nevertheless, the overwhelming societal assumption regarding suicidal persons is that they are mentally unwell. Even those who rightly note that we ought to address the social inequities and disparities at the root of mental illness still tend to pathologize suicidality in a way that suggests, above all, the goal should be to erase it. When one considers that the Mad Pride movement is often marked by acceptance of and even embracing at least some facets of 'madness,' it reveals just how marginalized suicidal persons can be, given that even among these circles, suicidism is prevalent.

Another way to see how suicidality is stigmatized is to examine how suicides are discussed after they occur. Postmortem speculations about what led a person to suicide often pathologize victims. The person was 'out of their mind' or must have been mentally unwell

to do such a thing. As many advocates have argued, this is harmful, because it assumes no person could rationally contemplate dying: no 'sane' person chooses to die, their 'mental illness' did that to them (Bradshaw 2014). These sorts of statements subtly imply a suicidal person is a *patient* rather than an *agent* and thus is incapable of authorship over their actions.

Besides being pathologized, suicidal persons are often criminalized. Saying someone 'committed' suicide, for example, implies they perpetrated a crime which is why this phrasing is increasingly discouraged by suicidologists (see, e.g., Beaton et al. 2013). Despite seeking to de-criminalize suicide, many suicide prevention workers still manage to treat suicidal persons like criminals, insofar as involuntary hospitalization, medication, and even police involvement, are seen as necessary to keep suicidal people alive. Police involvement is more likely if a suicidal person is multiply marginalized (see, e.g., Kindy 2020), and, as many studies indicate, if you are Black in the United States, your chances of surviving a police intervention are already lower than the statistical average (Lamanna et al. 2019; Edwards et al. 2019; Nix et al. 2021). Thus, with an intersectional lens on the issue of criminalizing suicidality, the question of whether institutions designed to prevent suicides actually help suicidal people is a difficult one to answer.

Perhaps one of the most insidious ways that suicidism operates in society is in campaigns and messaging that place the burden of survival on the suicidal person. Pleas for folks to 'save themselves' and to reach out without fear of shame or discrimination completely ignore how *unsafe* it can be to do so. The irony is that reaching out is often responded to with punitive measures. Suicidologists have warned against simplistic 'solutions', such as the 988 hotline (the national United States suicide and crisis line) (Pattani 2022), and have noted the likelihood of police intervention when contacting these services (Way 2022). These hotlines often report directly to the police or lead the person in crisis to being involuntarily hospitalized and drugged. For those who are hospitalized against their consent, chances of dying by suicide after being released increase dramatically (Chung et al. 2016; Chung et al. 2017; Swaraj et al. 2019). In sum, many of the current intervention strategies deployed are violence disguised as help and are steeped in suicidism.

I noted earlier that suicidism also intersects with *adoptism,* a term I coined to capture the ways adopted persons are subjected to a myriad of injustices, such as silencing and the imperative to be grateful. The overriding script of plenary adoption – by which I mean the type of adoption that permanently and irrevocably severs all ties between a child and their genetic family (Ouellette 2003) – is a narrative of rescue, of a 'better life,' a 'win-win,' and ultimately, something an adoptee/adopted person ought to be grateful for. When an adopted person attempts to interrogate this narrative in any way, they are often met with varying forms of epistemic and affective injustice, such as being told they are 'bitter,' 'ungrateful,' or 'insane.' One of the most common questions we often receive is "well, would you rather have been aborted?"

As it turns out, adopted people are at a greater risk for suicidality than non-adopted persons (Campo-Arias et al. 2020; Keyes et al. 2013; Slap et al. 2001). I never knew this growing up. I also never knew that suicidality was rampant in my genetic family. I often ponder whether my struggles with suicidality for all these years is genetic or if it stems from the traumatic nature of family separation. There are no definitive answers to this question, but the fact that adopted people are as much as four times more likely to attempt suicide in their lifetimes should not be ignored. Regardless of the specific cause of my suicidality, knowing that it runs in my genetic family might have provided me with tools to cope with it earlier on. This reveals another way that adopted people are marginalization and discrimination against. In closed adoptions in particular, we are prevented from knowing genetic information that might help us make informed decisions about our physiological and mental health care, not to mention being kept from our genetic kin with whom we might choose to have familial ties. This is an example of what Calder (2021) refers to as "testimonial throttling" which is the purposeful withholding of information that might otherwise strengthen or support a person's testimony. In the case of suicidality, knowing that multiple relatives had died by suicide, or suicide-adjacent deaths from addiction and overdose, would have allowed me to better prepare for and understand the active suicidality I experienced after the birth of my first child.

Considering adoptism, and the way adopted persons can be marginalized by a system ostensibly designed to protect them, we are now in a better position to think about how suicidal persons are analogously subjected to the same paradoxical treatment. Baril (2023), whose notion of the "injunction to live and to futurity," inspired my choice to similarly refer to the "injunction to gratitude" to which adopted persons are subjected, argues that suicidal persons violate one of the most basic assumptions made by non-suicidal persons, namely, that everyone *wants* to live. Likewise, an adoptee who says they are unhappy being adopted violates the default premise that everyone who was adopted will be grateful they were 'rescued' or 'given a better life.' In the next section, I will discuss how these injunctions are also instances of epistemic and affective injustice. However, first, I want to examine how suicidism underscores the way mental healthcare often places the burden of care on those same persons it is supposed to be caring for.

Baril argues that current models of suicide prevention are suicidist, and often operate with similarly carceral logic to systems such as the family policing industrial complex, or what is euphemistically referred to as 'Child Welfare.' There are also important overlaps between Baril's work and those who critique psychology and psychiatry more generally, by noting overly reductive approaches that attempt to locate all mental illness squarely within the brain (see e.g., Davies 2013; Cohen 2016; Garson 2022). Assuming a suicidal person has something wrong with their brain locates the 'problem' of suicide inside the individual, a result of a defect in their neural wiring. Alternatively, social models of suicide, like social models of mental illness, locate the causes of these afflictions in the social world (Mueller et al. 2021). Poverty, relationship stress, job loss, bullying, and so forth are the more likely

precipitating factors, so seeking to redress these issues is where the real preventative work should focus.

Social justice models of suicide prevention go a step further and examine the *systems* underpinning the inequities that are responsible for the fastest growing population of victims of suicide being teenage Black males, or LGBTQ persons being disproportionately affected by suicide (Hightower et al., 2023; Button, 2016). Because so much of suicidality is rooted in social inequity, redressing systemic racism, homophobia, transphobia, and economic inequality would lead to genuine suicide prevention. Social justice models therefore argue that rather than simply focusing on individuals or even how those individuals interact with one another, we must go a step further and dismantle the unjust systems that give rise to the desire to die in so many vulnerable populations.

However, while the social justice model of suicide prevention represents a step in the right direction toward decriminalizing and depathologizing suicidal persons, it remains fundamentally suicidist. As Baril argues, what marks almost all suicide prevention programs is the assumption that the desire to live is the healthy/sane/normal or default setting of humanity, and thus the desire to die is unhealthy, insane, and to be avoided at all costs. While the social justice model pays lip service to the idea that the desire to die is a reasonable reaction to unreasonable circumstances, the background assumption that we ought to erase this desire remains. The injunction to live, in other words, is operative even if the social justice model recognizes that suicide prevention is fundamentally a social justice issue. Hence, the desire is still pathologized, albeit subtly. This can be seen clearly when we consider that the pathologization only tends to occur when the person desiring to die is otherwise healthy, capable of working and contributing to society, and able-bodied. When a person is facing a terminal illness or is otherwise not valuable in a capitalist society, and they desire to die, we don't call it suicide, but something more like 'medical assistance in dying' (MAiD). In other words, these persons are not subjected to the injunction to live and to futurity (see, e.g., Stefan 2016). Indeed some proponents of MAiD want to include things like chronic depression or even "terminal anorexia" as reasons to be allowed to seek medical assistance in dying (Bayliss 2022; Gaudiani et al. 2022). There are all sorts of problems with these suggestions, not least of which is they treat people suffering with mental illness as not worthy of saving, or perhaps as too expensive to save, as is the case with anorexia patients (Roff 2024). I will gloss over all these issues here and just note again that there are plenty of suicidal persons who are not chronically depressed nor have any diagnosable mental disorder. And yet, there is reason to believe their desire to die ought not be pathologized. This is the point Baril makes in his work and it's one I will keep in mind in the following section.

3. The Epistemic and Affective Harms of Suicidism

Returning to my encounter with Child Protective Services besides it being a clear example of suicidism, there were also epistemic and affective harms to which I was subjected. Baril

notes that suicidal persons often suffer various forms of what feminist scholars have described as "being harmed specifically in one's capacity as a knower" (Fricker 2007, 1). In other words, if someone is attempting to provide testimony or to otherwise contribute to the knowledge pool about a given subject, and their input is devalued on the grounds that they are a woman, disabled, Black, or 'mad,' this is epistemic injustice, specifically what Fricker calls testimonial injustice. Prior to and the condition for epistemic injustice is what she calls hermeneutical injustice. Due to systemic identity biases that stem from racism, classism, sexism, ableism, and sanism, the lived experiences of entire groups of people are often precluded from the collective understanding surrounding an issue (see also Fricker and Jenkins 2017).

Again, we can look at adoption as an example of hermeneutical injustice (see, e.g., Merritt 2024). Conspicuously absent in discussions of adoption are the voices of adopted persons who do not uphold the "gratitude imperative" (see also Gustafsson and Merritt 2024). Much like how Baril's injunction to life and to futurity marks suicidism, the injunction to gratitude marks adoptism. Likewise, suicidal people are *hermeneutically marginalized*, insofar as they under-contribute to the knowledge pool on suicide, and likewise, adoptees are deemed irrational or insane if they are not grateful for being adopted. Hence, their lived experiential knowledge is erased and ignored.

I've mentioned adoption again because there are some obvious parallels between the ways adoptees and suicidal persons are subjected to epistemic injustice. Also, as I live at the intersection of these two identities, I am aware of the overlap between being adopted and being suicidal. Another form of epistemic injustice falls under the umbrella of what Kristie Dotson (2011) has termed *epistemic violence* which includes what she calls *testimonial smothering*. Testimonial smothering is when a speaker truncates, softens, or otherwise silences *themselves* because they know they will be unheard and dismissed, or worse, they know that their testimony could result in physical harm, carceral treatment, or other violence. Speaking about adoption, I have never feared for my physical safety, though I know that some adopted persons have received death threats due to their activism. I have, however, smothered my testimony to protect my mental health. I often judge that it's simply not worth the cost of being repeatedly gaslit or dismissed when talking about adoption with certain folks.

On the other hand, when I first began openly discussing my suicidality, I did not smother my testimony, and I was severely punished for speaking out. That was eight years ago and I still fear talking about my experiences. When I am struggling with suicidal thoughts or impulses, I no longer blog about it, nor do I confide in many people, as I do not wish to be terrorized by Child Protective Services again. Lately, I have found the courage to write more about it, in part because I discovered Baril's work and found a community that reminds me that I'm not alone. Ironically, it is this community of folks who desire to die that has helped me find the courage to live and to tell my story. This ability to cope with being suicidal is, I argue, crucial to preventing suicide. And yet, it is not something that current prevention regimes stress.

Indeed, one might say it is actively discouraged that we build community with one another, much the same way mental health inpatients are discouraged from staying in touch with one another upon discharge (Vanasco 2017).

Preventing marginalized persons from building community is a well-recognized tool of oppression. This is not to say that those who work in suicide prevention are purposefully aiming to oppress suicidal persons. However, refusing to validate the desire to die as an acceptable feeling, upholds the assumption that there ought not to be any communities of suicidal persons, because there ought not to be any suicidal persons in the first place. This is why Baril argues that most suicide prevention campaigns are suicidist. The injunction to live is the vehicle by which this suicidist ideology is driven along. Baril (2023) introduces the idea of "suicide affirmative healthcare" (see pp. 217-224) to counter suicidist prevention strategies, and I will discuss this in the final section. First, I want to recognize that pathologizing the desire to die to the point that suicidal persons feel shame for even possessing that desire is an example of *affective injustice.*

There is currently a lot of debate about understandings of affective injustice (add reference here). For simplicity's sake, I will use a definition that combines elements from several scholars on the topic: Affective injustice can be understood as being harmed specifically in one's capacity to attain 'affective goods,' such as access to communities of care and empathy, or to simply be able to be in touch with one's own feelings and to be able to express those feelings, as well as to expect their interlocutor to receive those expressed feelings in an empathic and understanding manner. (Stockdale, 2024; Gallegos, 2022; Srnivasan, 2018).

Clearly, being incapacitated in terms of community building is an example of an affective injustice suicidal persons often face. I would also argue that a more insidious form of this injustice occurs when we shame ourselves for having the desire to die in the first place. Similar to testimonial smothering, we might call this form of affective injustice *emotional smothering*. An example of this would be a suicidal person trying to extinguish a sudden and powerful urge to die by negative self-talk like "*that's a stupid thought", "that's just your anxiety lying to you" or "you cannot actually desire that!",* effectively sweeping the desire under the rug. To be clear, there might be times when such cognitive strategies are useful for some people, at least in my experience, dismissing and shaming myself does not make the desire disappear. I just push it away only to have it rear its head even more forcefully at a later date. Furthermore, keeping in mind that shame is an inherently a social emotion, to feel this about your own feelings means there is likely an externalizing factor at play, some kind of social script that has been internalized.

In the case of suicide discourse, being able to express one's feelings and expect to be heard by one's audience is foreclosed by many of the dominant prevention narratives. One of the most salient examples of this I have seen is the slogan, which varies depending on how it's

written, “Stay for them,” implying that though you might have the desire to die, others don’t want you to, so you ought to stick around so they can be emotionally fulfilled by your presence. Although the creators of this slogan presumably intended to prevent, not cause, harm, it can effectively to dismiss the suicidal person’s own suffering and force them to live, despite wanting to die, in order to prevent the suffering of others. In other words, I should stay alive because my primary purpose is to make others happy, even if it means me being miserable. This message is powerful and I think it contributes to suicidal persons often feel great shame and not even wanting to admit they are suicidal. It’s not as if suicidal people are all cold and lacking in sensitivity. If anything, I would suggest that many of us are probably hypersensitive to hurting others and we know that even telling a loved one you want to die can make that person very sad. Moreover, many suicidal persons believe that their existence is precisely what makes others miserable and that their family and friends would be better without the burden of them (Webb 2010).

To summarise, the affective lives of suicidal persons are often dismissed, smothered, gaslit, and invalidated by those persons invested in preventing suicidal suffering. This affective injustice is often taken to extremes, such as when Child Protective Services invades a suicidal person’s life, or the police show up and a suicidal person is involuntarily hospitalized. The pervading ideology is the same, namely, that the ‘healthy’ or default setting of humanity is the desire to live, and thus, anyone who does not feel that way violates normality, and is reducible to a body to be disciplined.

What if, however, wanting to live was not seen as the default setting, thereby deeming those who desire to die as abnormal, insane, pathological, and thus in need of saving? This is the premise of Baril’s suicide affirmative healthcare, a model that necessarily involves dismantling suicidism. In the final section, I examine what this sort of healthcare might look like, adding to his account what I term the ‘burden of comfort’ and why we must shift this burden away from suicidal persons and onto those who do not experience suicidality.

4. Affirming the Desire to Die, Coping with Suicidality, and Prevention without Intervention

In considering any supposed right to die, we often imagine *negative rights*, such as situations in which persons are terminally ill and seek assistance to die with dignity. In other words, you have a right *not* to suffer. Baril has a more radical notion of a *positive* right to die, by assisted suicide. According to Baril (2023, 2020) the core of the medical assistance in dying discourse is a capitalist ideology that treats certain persons as inherently disposable – the elderly, the sick, the disabled, and so forth – because they are not productive. Medical (physician) assistance to die is not about granting these groups any positive rights because they are not seen as autonomous in the first place. Baril’s framework, however, treats

suicidal people as rational *agents,* who are authors of their own actions, and capable of making informed decisions about their care. As he says:

> The suicide affirmative approach insists on the importance of an affective and relational turn regarding suicidal people. It takes into consideration suicidal people's subjective experiences of suffering, regardless of the source(s) of suffering. It opens up the possibility of exploring suicidality without shame and guilt. It allows us to explore with them crucial questions: What appeals to you about the option of assisted suicide? What kind of support or help do you need to go through this difficult period of your life or to end your life? Did you inform your relatives and friends about your wish to end your life, and do they support you in this process? Did you consider other options? Did you consider all the implications of this decision? Did you plan your end of life, death, and post-death? Similar to a trans-affirmative approach, the suicide affirmative approach offers care, compassion, 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.
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> Baril 2023, 219.

This line of gentle questioning encapsulates Baril's Suicide Affirmative Healthcare proposal. In his book, he lists the following tenets of such an approach, which are as follows:

1. Anti-Suicidist Framework
2. Endorsing an Intersectional Lens
3. Understanding Suicidality as a Complex Phenomenon
4. Embracing a Nonjudgmental Attitude
5. Encouraging Initiatives by and for Suicidal People
6. Promoting Peer and Community Support
7. Refusing Nonconsensual and Coercive Interventions
8. Valorizing Autonomy and Self-Determination
9. Adopting a Harm-Reduction Approach
10. Supporting Assisted Suicide Through Informed Consent

I have discussed several of these tenets already and will focus on the last one, because it is arguably his most radical suggestion. Baril is careful to note that his approach should not *encourage* suicide, but rather that it would open up a space to consider dying as a right just like any other bodily right we bestow upon humans. Learning to treat suicide this way satisfies several criteria of his suicide affirmative approach and echoes what Saartje Tack (2019) says about the "readability" of suicide. The desire to live is, again, the default setting of humans, or what Tack 2019: 57) describes as the "originary characteristic of bodies" and hence what we all ought to be naturally oriented toward: "The choice of death thus comes to constitute a choice against the natural and renders those who choose it unintelligible". It remains to be seen whether learning to read suicide as a natural and normal choice would reduce suicide deaths, but that's part of the radicalness of the proposal. At the heart of abolitionist movements that seek to dismantle unjust systems is the idea that we *don't know* what it will look like on the other side. What we do know, however, is that the current system is not working. To reiterate, suicide rates, at least in the United States, are on the rise (Garnett and Curtin 2023)[2] and not even the social justice model of suicide seems to be able to alter this trend. We could also look to analogous cases where destigmatization and normalization have taken place, such as with safe drug use and how this leads to fewer overdoses. Of course, as Baril notes, even within a suicide-affirmative approach, suicides might still occur. If they did, however, he argues that they would be far less traumatic for everyone involved, with folks determined to die able to freely discuss and plan it, say proper goodbyes, and to die surrounded by loved ones in a peaceful manner, rather than violently and alone, the way most suicides occur today.

Marsh and co-authors (2022) argue, however, that approaches such as Baril's would not:

> fully escape the forms of power that constitutes and produces suicides according to a pernicious social logic (Button 2016; Marsh 2019). The interactions between social structures, hierarchies, and moral economies of human worth, the psychic and emotional life of people caught up in such regimes, and deaths by suicide are unlikely to cease to function.
>
> Marsh et al, 2022, p.21

Whilst this may be true, as I see it, this is all the more reason to adopt the tenets Baril lays out. Dismantling suicidism is crucial to destigmatizing the desire to die, which would thereby normalize talking about that desire, freeing it from judgment and carceral treatment. When I think about my own story, well before I had read any of this literature, I was trying to do just that. My story highlights precisely how suicidism operates and is hidden within systems that are ostensibly designed to help. My sister-in-law should have been a safe person to confide in, but instead, she was made so uncomfortable by my pain, she saw that I was punished for it. She should have been someone I trusted with my vulnerable information,

[2] See also: https://www.kff.org/mental-health/issue-brief/a-look-at-the-latest-suicide-data-and-change-over-the-last-decade/

but instead, she taught me to be distrustful of mental healthcare professionals. I have since learned that my sister-in-law is no anomaly. After reading Baril's work, and many other critiques of psychiatry from service users, it is evident to me that my distrust is not paranoia, and that becoming more private about what I share and with whom is unfortunately a necessary defense mechanism. The irony of this is that I am afraid of the profession that is supposed to keep me safe, a profession that supposedly wants me to stay alive.

Imagine, instead, if my sister-in-law had been the safe person I needed back then. Imagine the lives that might be saved if we took Baril's suggestions seriously. Baril says that suicide prevention is not the main intent behind his work, and I am inclined to agree with him, because putting the goal of reducing suicide deaths at the forefront of suicide prevention has the unfortunate effect of dehumanizing the very people these efforts are supposed to be saving. Instead, focusing on the way we treat suicidal people, both when they are alive *and* after they have died, is key. Then it is likely that suicide rates will decline as a result.

Thus, I want to add to Baril's list of tenets the idea of *postvention* (Schneidman 1973), which is the idea that the aftermath of a suicide is crucial to preventing suicide. This means that the way we talk about the loss, and how we characterize the person who took their own life, can actually impact suicide rates. Folks who advocate for postvention are less concerned with prevention, recognizing, as Marsh and others do, that the social inequities and harsh material realities that constitute unlivable conditions for so many are not going to just magically disappear. In the wake of a suicide, postventionists argue that our words are crucial, especially to suicidal persons (see, e.g., Abbate et al. 2024). Again, drawing on my own experiences I concur. Whenever a suicide occurs, it is hard for me to hear all the suicidist interpellations, specifically what Marsh has termed the "compulsory ontology of pathology" (2010, 43) that marks so much post-suicide discussion.

In contrast, suicide affirmative healthcare would open up a space for suicidal persons to speak openly and safely about their pain. Coping with suicidality will look different for each suicidal person, but adhering to Baril's framework, especially "embracing a nonjudgmental attitude, encouraging initiatives by and for suicidal people, and promoting peer and community support," are crucial for all of us to overcome the stigma, along with the epistemic and affective injustices we face when grappling with telling our stories. For me, besides my typical coping strategies of exercising and practicing mindfulness, one of the most life-affirming things has been the community I've found. Much like with the adopted people I've met over the years who validate my feelings about adoption, finding other suicidal people, ironically, has saved my life. I emailed Alexandre Baril one day just to tell him how much his work had impacted me, and we've struck up a friendship that I cherish. The people I trust the most in this world right now are people who have experienced suicidality. If I'm ever in a really dark place, they are the ones I will lean on. Because I believe they will not subject me to suicidist violence. Therefore, despite some of its challenges, I think Baril's approach is a step in the right direction because, before we

proclaim to know how to end suicide, we need to sit with suicidal people and take their desires seriously, rather than turn our heads in disgust and fear.

Finally, I want to relate this discussion to the notion of "Madpeople's coping mechanisms" (the focus of this special issue of the journal). We often think of 'coping' as similar to, if not synonymous with, self-care, but what I've described here is about as far from self-care as one could get. Being a part of a community – a community that truly cares for you and your wellbeing – is a collective effort. Although many suicide preventionist models nod towards community care, at the end of the day, the overarching ideology remains suicidist primarily because the underlying message is that to be suicidal is bad and is something to be eradicated from this world, and hence suicidal people must be eliminated. This is paradoxical, given that the supposed aims of suicide prevention is to 'save' us. Instead, I suggest that in the context of suicide, we rethink coping entirely, such that the coping strategies are those that the *non-suicidal* persons develop and employ. As I have stated throughout the paper, suicidal persons exist and many of us live fulfilling lives while also being suicidal. We are already coping just fine. It's the non-suicidal persons that need to sit with discomfort of this fact and interrogate their suicidist assumptions about us.

Being suicidal is part of who I am, much like being eating-disordered. To be sure, my anorexia is in remission, but I know better than to assume there is no life event or emotional upheaval that might awaken those maladaptive thoughts and behaviors. The same is true of my suicidal thoughts and behaviors. I echo Anna Borges who says, she'd like to not always be swimming in this ocean of apathy toward being alive. I'm here, however, and I'm afloat, and most days, I enjoy swimming. Some days, however, I just feel like letting it drown me, because I'm tired, and lonely, and world-weary. This is how I've been most of my life and I highly doubt self-care can do anything about that. What truly helps, when I feel like the waves are going to wash over me and I won't have the strength to dive into them and emerge on the surface once they've subsided, are the people who love me and recognize when I am drowning, not the ones who say things like "you have so many reasons to live" or "we love you and want you here." It's the folks who just sit with me in that moment, the way Baril suggests we ought to care for suicidal persons, namely, with curiosity, compassion, and the full recognition of their autonomy.

Nothing I have said here implies that suicidal persons are absolved of any responsibility to care for themselves, but it is important to emphasise again that caring for oneself is impossible to do in a world that is constantly trying to erase you. It is not possible to care for yourself if the social supports that ought to be in place for you to do so are absent, or worse, hostile toward the type of suffering you are experiencing. And it's hard to develop healthy coping strategies when everywhere you turn, the message is "please tell the truth about your suicidality but also, if you tell the truth, we will lock you up, drug you and take your children away from you."

Suicide prevention is steeped in non-suicidal bias, the supposed default setting of humanity. I think this bias manifests most apparently as an 'incitement to comfort.' What I mean by this is that suicide makes people uncomfortable. People want to be comfortable so preventing suicide is the obvious route to take. However, this argument is sustained entirely from a non-suicidal, and therefore suicidist, perspective. The burden of comfort, in other words, is placed squarely on suicidal people to stop making everyone else uncomfortable. The effect of this is that we either suffer in silence and many of us die because of this, or we are cured and turn into one of *them* – non-suicidal, happy, sane, and *normal* people. But that's not reality. I live suicidal. That's a paradox that makes people uncomfortable. I should not exist, and yet, here I am.

The burden of comfort is not to be placed squarely on the shoulders of suicidal people. If we truly cared about suicidal people, we would accept this uncomfortable truth and learn to be comfortable with the discomfort. Non-suicidal people need to learn to cope with the existence of suicidal people and practice community care, far more than suicidal people need to learn to just reach out and stay alive at all costs. Being in community with someone means having difficult, but often transformative, conversations. We do not build solidarity by subjecting one another to carceral treatment or by suppressing those voices we do not fully understand.

5. Concluding Thoughts

I am suggesting that we start thinking of coping with suicidality as a collective responsibility, rather than as an individual burden. Furthermore, I would urge non-suicidal people to resist the impulse to throw life preservers toward every person they perceive to be drowning. I empathize with this impulse. I have children, including one I rescued from actual drowning once. But she was helpless, and I didn't throw a life preserver because that would have been pointless. I dived into the water and held her in my arms until she was safe. Many of us suicidal people are not drowning, but we are struggling to find the desire to keep swimming. Our choice to live or die is ultimately ours to make. Non-suicidal people often say this when trying to make sense of that which they are incapable of understanding. They will say "there is nothing I could have done" or "even a phone call would not have stopped him." Rather than disagree with the logic of these claims, I will grant the non-suicidal person the truth of these statements that, at least for some of us, there is nothing to be done. It is hard to cope with that fact. But in their effort to remove the discomfort of suicide from their lives, non-suicidal persons are sending the message that they would prefer suicidal persons to be removed from their lives. What if, instead, they dived into the water and floated alongside us? What if they learned to cope with the fact that we exist and always will? The ocean of apathy toward living can be a scary place, but if non-suicidal persons would like to understand how we manage to navigate this, listening to suicidal persons with care and compassion is a good place to start. It would be a lot less lonely and terrifying if there were more humans and fewer life preservers.

Integrity statement: I declare that this manuscript is my original work, has not been published before and is not currently being considered for publication elsewhere

Conflict of Interest statement: I declare that I have no known competing financial or personal relationships that could be viewed as influencing the work reported in this paper

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