This Thesis Entitled:

Queering Suicide: Complicated Discourses, Compiled Deviances, and Communal Directives Surrounding LGBTQIA+ Intentional Self-Initiated Death

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find that both the content and the form meet acceptable presentation standards
of scholarly work in the above-mentioned discipline.

Abstract

Queering Suicide is a work based upon an embodied research initiative that explores the prominence of suicide in the LGBTQIA+ community while confronting the structural and institutional mechanisms that drive individual bodies into deviance, depression, mental-illness, and self-violent ideation.

Grounded in critical autoethnographic and of-depth qualitative narratives, this research explores the embodied and personally emotive understandings of marginalized queer identity, deviance designation, multiple oppressions, and systematic erasure as they relate to suicidality. However, suicide act as both a queer experience, and a *queered* concept, which provides insight into the social facts that designate, and have been designated by, the historical, political, economic, and cultural ideologies around death, productivity, sociality, and health for LGBTQIA+ individuals.

Thus, in critique of the overly simplified social understandings of queer suicide and inappropriately stigmatized *death-driven* identities, participants and researcher come together to create an embodied perspective and researched work. This connective and dialogically-based method imbues the notion of suicide with a profound sense of queerness in deeply felt, wild, and emotively complex community-based approaches to resilience and creativity.

Acknowledgements

To all of the participants who offered me their time and trust in talking on a subject that is deeply raw, prolifically vulnerable, and intricately complex—I am deeply moved by your stories

To my committee members and mentors—for your guidance, patience, reassurance and support.

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To Katie, for making dinner on the difficult nights and talking with me through the complex and theoretical renderings, painful perspectives, and wildly unintelligible rantings.

And to all of our friends and loved ones who have died by suicide, thank you for your lives, for your unspoken experiences, wisdoms, and multitudes of offerings from beyond. We miss you.

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Artwork by Marcel, September 2018

Glossary[1]

AFAB/AMAB: Assigned Female at Birth/Assigned Male at Birth

Ally: A person who advocates for and supports a community beyond their own and does so by acting in support (as this is an action-based classification).

Binary: the classification of gender and sexuality into two main forms of masculine/male/man and feminine/female/woman which are socialized as the only forms of gender and sexuality that are legitimate, and thus, are privileged.

Cisgender: A term for when an individual identifies as their sex assigned at birth. This does not indicate biology, gender expression, or sexual orientation[2]

Gender: The culturally imbued constructs of man and woman that describe and dictate an individual's actions and expressions based in their assigned sex at birth.

> Example: Woman have, historically, been socially policed into submissive categories of behavior and action based in their gender, and are often expected to perform a variety of delineated tasks like child rearing, cleaning, and home-making. Due to these expectations, women in the work force are deemed less productive and capable and are paid at much lower wages, statistically, than men (Jonung et al. 1998, 173)

Gender Queer/Non-Binary: Broad "umbrella" terms used to express identities that are beyond the masculine/man and the feminine/woman, as those which also fall outside of cisnormativity or the gender binary. Genderqueer or non-binary people can also identify as non-gendered or more than one gender, or as fluid and between genders, or as "other-gendered"[2]

Gender Dysphoria: Anxiety, depression, or discomfort with one's sex assigned at birth

Heteronormativity: is the social and personal belief that heterosexuality and gendered binarism are the default; this can also be seen as a field of power; a historical mode of personality; and a political orientation[3]

Heterosexism: Often based in institutionalized rhetorics, heterosexism assumes that individuals should be and are heterosexual and that heterosexuality is "normal, natural, and right"[4]

Homophobia: The wide-range of negative attitudes, feelings, fears, or mistrust of people who are LGBTQIA+; can take on many forms such as prejudice, violence, exclusion, faith belief systems, and personal internalization[4]

LGBTQQIAA+: A collection of identities short for Lesbian, Gay, Bisexual, Trans, Queer, Questioning, Intersex, Asexual, A-romantic and is often abbreviated LGBT, LGBTQ+ ("Ally" is not included in this acronym). For this work, I will use the abbreviation LGBTQIA+

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[1] Many terms have been derived from Trans Student Educational Resources' (TRES) *LGBTQ+ Definitions*

[2] Usher (2007) *North American Lexicon of Transgender Terms*

[3] Warner (1991) *Introduction: Fear of a Queer Planet*

[4] Girshick (2008) *Homophobia*

Personal Gender Pronouns (PGP): Also known as preferred pronouns, these are Identified by an individual as the pronouns with which they choose to identify themselves

Multiple Pronouns: Individuals may use multiple pronouns as their identifiers due to gender-fluidity, trans-fluidity, or a multitude of other reasons. Using multiple pronouns for a singular individual in this work will look like this…

> Example: Sam (he/they) is a trans masculine person and loves to play basketball. He/they practice four days a week on a gender inclusive team.

> - **Gender Neutral Pronouns**: These are pronouns that do not specify the "gender" of an individual[5]
> - **They/Them/Theirs**: A non-binary singular pronoun

Pronouns:	In a sentence:
she/her/hers	She wants you to use her pronouns.
he/him/his	He wants you to use his pronouns.
ze/hir	Ze wants you to use hir pronouns.
they/ them/ theirs	They want you to use their pronouns.
co/cos	Co wants you to use cos pronouns.
No pronoun/name (use the person's name instead of a pronoun)	_____(name) wants you to use _____(name) pronouns.
xe/xem/xyr	Xe wants you to use xyr pronouns.
hy/hym/hys	Hy wants you to use hys pronouns.

Pronoun Template Courtesy of: Lowry's (2017) *A Guide To Non-binary Pronouns And Why They Matter*

Sex: A set of culturally and biologically ascribed characteristics that assign a person to the categories of "male" and "female"

> Example: Taylor's (they/them) sex assigned at birth was female, and they identify as femme but non-binary.

Sexual Minorities: Individuals and communities who differ from the classical notion of racial and ethnic marginalization as typically "self-identified" and not always "easily identifiable by others"[6]

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[5] Forsey (2018) *Gender Neutral Pronouns: What They Are & How to Use Them*
[6] Gross (1991, 20) *Out of the Mainstream: Sexual Minorities and the Mass Media*

Trans/Transgender: A term used for and by people whose gender identity is different from the sex that they were assigned at birth. This term is not indicative of sexual orientation, gender expression, physical or hormonal makeup.

> **Transwoman**: Someone assigned male at birth who identifies as a woman (M2F – Male to Female, transfeminine)

> **Transman**: Someone assigned female at birth who identifies as a man (F2M – Female to Male, transmasculine)

Transition/Transitioning: An individual's process of moving into and developing a gender expression that matches their gender identity. Transition can (but does not have to) include coming out to one's community; changing one's name and/or sex on legal and governmental documents; hormone therapy; surgery.

T: Short for the hormone *testosterone*, which is used by many to transition

Transphobia: The systematic violence against trans/transgender people, is often associated with attitudes of disgust, discomfort, and distrust.

Queer: A term used for people of marginalized or "deviant" gender identities and sexual orientations beyond heterosexuality.

Synonyms for Suicide used in this work: Self-directed violence, intentional-self harm, intentional self-death, volitional self-death, self-annihilation

Suicide: All cases of death resulting as directly or indirectly from a positive or negative act of the victim…which [they] know will produce this result"[7]

> **Ideation:** Thinking about, ruminating on, or planning to die by suicide

> **Attempt:** The act of trying to die by suicide but surviving

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[7] Durkheim (1966, 44) *On Suicide*

INTRODUCTION

It was a bright, August morning in 2017 and I was just sitting down to breakfast when my friend called wanting to know if I had heard the news. As I listened to them describe the suicide of a queer friend whom we both knew, I could feel the dread well up in my throat, making it hard to speak. I hung up in a daze and pushed away my food. This was the third death by suicide in our community that summer, and we had yet to make it to September.

As I stared in to the swirling heat of my tea, racking my brain for any "warning signs" or strange interactions that I might have had with the person before they died, something began creeping up in my psyche. *How was it that the phenomenon of depression and suicidality were such prominent conversations between my friends and I in the queer community? Why was it that so many of us spoke to the difficulty, personal pain, and often overwhelming darkness of day-to-day living?*

The phenomenon and ideas were rapidly surfacing, bringing with them raw and deep emotionality as I began contemplating that suicidality amongst my people, the queer community, might be higher, more prominent, and more visceral. I sat there, looking out the window for quite some time. My food was cooling down but I was getting warmer, fiery even, in realizing that maybe these deaths and my own experiences were not a "simple" matter of "adolescent angst", difficult life transitions, or a sad statistical coincidence. Maybe there was something more, something that we have yet to understand; a pulsating, subconscious experience that, for queer individuals, creates mental episodes and permanent states of death-driven depression, disassociation, and dark demeanors.

This is how it all began, amidst those morning ponderings and grief imbued realizations that suicide is not just a social phenomenon, but a lens into the communal feelings of marginalized, oppressed, and erased experiences of many LGBTQIA+ individuals.

Suicide and the Social

As one of the few classical subjects in sociology, the theoretical treatments of suicide are imbued with a historical lineage in framework and understanding (Douglas 2015). Probing into the silence of personal despair, *On Suicide* (1966)—originally published in 1897—the groundbreaking work of French Sociologist, Emile Durkheim, has remained a vital foundation

for modern studies and their categorical frameworks on suicide (Tomasi 1993; Chandler and Tsai 1993; Pickering and Walford 2000; Kushner and Sterk 2005; Aliverdinia and Pridemore 2009). In this lineage, suicide is understood as a **social fact** that can be explored and understood through sociological methodologies.

However, amidst a long history of literature on suicide, the cultural realities underlying suicide in the queer community have been relatively neglected in academia and scholarship. Even with growing recognition and work on the issue (Remafedi et al. 1998; Fergusson et al. 1999; Bagley and D'Augelli 2000; Haas et al. 2010; Zhao et al. 2010; Puar 2011; Coviello 2012; Cover 2012a; Goltz 2013; Grzanka and Mann 2014; Bauer 2017; Barnett et al. 2019) there is still little consensus on the understandings of social and psychological distress in the LGBTQIA+ community as related to ideation. Also, too narrow is the conclusive data that often erases other kinds of oppression and multiple jeopardies experienced by many sexual minorities (Collins 2000; Erwin 1993).

Amidst these gaps in understanding and perspectivity, this research offers a framework for interacting with suicide through a lens of sociological theory and social fact. Yet, it also offers a *Queering of Suicide* by agitating and critiquing the pre-conceived notions of suicidality and its space in the LGBTQIA+ community. Through this embodied work based in the dialogical practices of storytelling, identity is perceived both as performance and as a window into the invisible lives of personal narrative (Ellingson 2017; Riessman 2005; Chang et al. 2012).

In this light, my research is both socially and sociologically significant in that it seeks, not for solutions, but for a queer offering of space where narratives are heard, and growth is based off of communal rhetorics and participatory action. Rooted in autoethnographic and qualitative narratives, this work is imbued with a profound sense of community which infuses the often analytic and, dare I say, emotionless perceptions of academic inquiry with tactile, storied breadth.

Going Forward

Less a researcher, and more a holder of narratives, I will delve into the social facts and structural issues that construct suicidality amidst concepts of *deviance*, *social normalcy,* and *shame*. These understandings will provide insight into ideation's affective role in the social

reading, emotional-political discourses, grief orientations, and outward expressions of personally narrated experiences in the LGBTQIA+ community. In a multitude of directions to and from there, this work will, then, provide a non-linear discussion of the structuralized, historicized, medicalized, and institutionalized provocations into suicidality and queerness.

Full and rich with embodied perspectives, my research is as untidy and exploratory as the bodies with which it interacts, providing fluid and collaborative notions of suicidality that question mainstream, western norms and rhetorics around mental illness, depression, and intentional self-death. These concepts and discussions are meant to intersect and build upon each other as communal conversations and fluid understandings that grow and develop through the eyes of, you, as the readership, myself, as the researcher and experiencer, and the participants, as the feelers and storytellers.

Hence, this work is founded upon the questions and gaps in literature surrounding suicide in the queer community. It is also based in the premise and exploration around what is means to *Queer Suicide* as a reorientation towards perspectives of intentional self-death in volitional and inherently fleshy experiences.

Statistical Evidence

In 2017, 47,173 people died by suicide in the United States. Studies are unable to demarcate how many of those deaths were queer/LGBTQIA+ related. What can be assessed, however, is that queer people experience much higher rates suicidal ideation and attempt than the general population (Schimanski and Treharne 2019).

Reliable reporting of suicides amongst LGBTQIA+ people is often murky and unofficial as death records rarely report the deceased's sexual orientation and gender expression (Haas et al. 2010, 16). However, many studies have now shown that LGBTQIA+ adults and youth experience elevated rates of personal-distress, mental-illness, self-harm, substance-abuse, and suicidal ideation and attempt (Meyer 2003; King, McKeown, et al. 2003; Bagley and D'Augelli 2000; King, Semlyen, et al. 2008; Mathy 2002). Queer youth are 3 times as likely to contemplate suicide as heterosexual youth (Kann et al. 2016;), and are 8.4 times as likely to attempt suicide if outwardly rejected by family (Ryan et al. 2009).

Isolation from family and peers (Ryan et al. 2009), on-going mental-health issues (King, Semlyen, et al. 2008), substance abuse (Senreich 2010), and hate-crime or victimization (Paterson et al. 2019; Barnett et al. 2019) all act as motivators for suicidality in queer individuals (Fergusson et al. 1999; *Suicide Risk and Prevention for LGBTQ People* 2018). Too, persons with **Intersecting Identities,** or the compounding "of many and varied aspects of identity" amidst race, class, ethnicity, sexuality, and regionality (Régis et al. 2013; Butler 1990) are more likely to experience "self-directed violence" and depression (Lytle et al. 2014).

Can We Talk About It?

Studies suggest that talking about suicidality with "at-risk" populations does not increase the prevalence of attempt (Wu et al. 2012; Dazzi et al. 2014). Omerov et al. (2014) found that discussing suicidality with patients in medical care had positive effects on their psyche and wellbeing, and Cedereke et al. (2002) found that talking-interventions had positive lasting impacts on people after a failed-attempt. Westerlund (2013) suggests that the opportunity to meet and talk with others who have experienced ideation and attempt, and who neither condemn nor lecture on the matter, offers a deeply connective and positive opportunity.

Open suicidal discourse, then, is that which creates a social dialogue surrounding the concepts and experiences of suicide and offers insight as to "why and how people communicate about suicide" which are incredibly important when creating strategies and implementing resources for support and wellbeing (Fordham 2017). While conversations like those of this research create emotional spaces, they also offer many individuals an outlet to work through experiences that are often limited by social taboos; "conversations can break down barriers, allowing people to share their concerns and offer support to each other" (Fordham 2017) in ways that can save-lives (Fitchett 2016).

A REVIEW OF THE LITERATURE

Unfortunately, the majority of discourse from academic and institutional review on queer suicide is pronouncedly demure and static, while broader mainstream media and culture over simplify the "unthinkable" subject by predominantly spotlighting singularities of suicidality as stemming from sexual and gender deviance (Erwin 1993). This outlook often generalizes deeply complex and institutional experiences as that which are *of* and *from* the individual and must be "fixed" at the personal level. Moving forward, this work will dive into the theoretical understandings of suicide and queerness so as to better grasp these cultural rhetorics of sexuality, deviance, and suicide.

Theoretical Perspectives

It Gets Better? The Stitching Together of Queerness, Suicide, and Taboo

The reality of mainstream social rhetoric around queer suicide is based, not in discussions rooted in embodied corporeal *ecologies of sensation* (Puar 2011, 157)*,* but in the statistical reporting of "deviance" and "difference", and the sensationalized *personality stories* of non-heteronormativity and sexual minorities (Cover 2012b, 1175). Ideating, queer individuals, considered sexual minorities (Gross 1991), are pushed to the volitional "fringe" of society in both the representations of their gender and sexualities, as well as in their suicidality.

Modern media, like the *It Gets Better*[8] campaign, thus, create visibility around queer suicidality in a manner that reflects the biases and interests of a singular, elite group (Gross 1991, 21), and of which are based in anti-suicide *futurity* rhetorics that are remarkably lacking in diversity and perspective (Majkowski 2011; Montague-Asp 2012; Goltz 2013).

On Suicide and Durkheim

As a fringe identity, queer suicidality ties into Durkheim's (1966) concept of *anomie,* as a vital approach towards grasping the theoretical and social basis of marginalization for many members of the LGBTQIA+ community. And, while much of classical sociology can feel "hopelessly mired in the antiquated Enlightenment subject"(Green 2007, 26), the pervasive and

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[8] The It Gets Better campaign is an internet-based non-profit which was created in 2010 as a social response to the chillingly high rate of queer youth suicides (ItGetsBetter.org)

compounding issues that lead to anomie, or an individualistic and listless declining of social integration and self-security (Graeff and Mehlkop 2007, 522) will direct this work in a variety of ways towards better grasping queer self-annihilation.

As a classically trained sociologist, Durkheim's 1897 work sought to expose "the causal impact of social group cohesion" (Condorelli 2016:2) by both broadening the lens of suicidality and highlighting the group dynamics that factor into an individual's self-destructive impulses. Defining **Suicide** as "all cases of death resulting as directly or indirectly from a positive or negative act of the victim…which [they] know will produce this result**"**, Durkheim (1966) created various typologies for suicidality due to its "many different ends" (43-44) and basis in social structure.

Social Structure, then, according to the sociologist, sits at the intersection of the integrating and regulating principles in a society (291). Based in this concept, Bearman's comprehensive work, *The Social Structure of Suicide* (1991) defines **Integration**, further, "as the extent of social relations binding a person or a group to others such that they are exposed to the moral demands of the group" and **Regulation** "as the normative or moral demands placed on the individual that come with membership in a group"(503). Abnormalities in the balance of both these cohesive concepts creates an environment for suicidality to emerge. Utilizing, thus, the framework of integration and regulation allows for further comparative analysis within Durkheim's egoistic and anomic typologies.

Egoistic

Egoistic Suicide orients towards society's lack of depth, presence, and integration in individual lives. This is what Durkheim (1966) deemed as "excessive Individuation" (258) and is often due to one's loss of congruency in religious, domestic, or political societies (208). For an individual experiencing egoistic ideation, no longer do they find a "basis for existence in life" (258), having loss the tethering of social support and group connectivity that was once a pertinent intimacy. Providing support for the egoistic typology, Breault and Barkey (1982) show both a preliminary relationship between religious and political integration as "exponential in shape", and that of "family integration and suicide [as] linear" (330).

Anomic

While egoistic suicide is met with high individualization and little social support or cohesive membership, ***Anomic Suicide*** is based in an unraveling of social norms; a social-deregulation that confuses and blurs cultural characteristics as an unsettling lack of values. Often leading to deviant behaviors, anomic suicide differs from other typologies "in its dependence, not on the way in which individuals are attached to society, but on how it regulates them" (Durkheim, 1966, 258).

As a primary concept for Durkheim, anomie functions in consequence of collapsing norms, values, and cultural customs without the replacement or re-building of new ideals and social ethics. Individuals struggling under the social pressure of anomie often consult the limits of their ambitions and social placements as indicative of aspiring to "nothing beyond" (Durkheim 1966, 250) which leads to emptiness, and lack of purpose (Johnson and Duberley 2011, 564).

Anomie, as it is understood in this work, is connected to Marx's theory of labor, materialism, and perceptions of bourgeoisie ideologies (Kovel 1986, 180) and as an experience that is driven by institutional "subjugation of bodies" as a concept of biopower (Foucault 1990; 2003). Durkheim (1966) wrote on the "dogma of economic materialism" (255) as that which creates the social knowledge that subordinates the secondary qualities of the mind like consciousness, will, attention and desire. By relegating "all spiritual entities" to a second-class existence (Kovel 1986:179), the external nature of materialism and neo-liberal productivity deny personhood and create anomic structures of individualism.

Queering Durkheim and Classical Sociology

It is important to note before moving forward that, while Durkheim's (1966) typologies provide insight and understandings for this work, even a foundational text like *On Suicide* is not without its critiques. Pickering and Walford (2000) argue that Durkheim, and many of his successors, provide a eurocentric point of view which often limit global perspectives on suicidality. By focusing my lens away from Eurocentricity with its classical notions of simplistic theorization, this work will provide a queer, expansive, and dynamic view of cultural and social

understandings that radicalize Durkheim's typologies by agitating the stable notions of linear identities and suicidality.

Fleshy Existences and Unlivable Lives

Moraga and Anzaldúa (2015) offer a queer of color critique called the *theory of the flesh,* in which, by exploring queer convictions (xvi) in the "physical realities of…lives—skin color, the land or concrete grown up on, [and] sexual longings", the authors move away from the *easy* explanations of existence and collective cultural history (19). This work, however, will not be using Moraga and Anzaldúa's work as a theoretical approach for fear of appropriating their critique into a primarily white queer scholarship. However, giving distinction to their foundational work offers this research a space to root in the concepts of fleshed embodiment and experiential corporeality.

Embodiment and the notion of identity (Anzaldúa 1991, 260) as that which is "fleshed out" and based on the terrestrial plain, is grounded both in the corporeal and the individual experiences of the self. As a ***praxis of reflexivity,*** then, this work seeks to meld the performative and embodied experiences of the self in day-to-day life, with the dynamics of qualitative field research (Gore 2018). Reflexivity, as a departure from the linear approaches of interviewer-interviewee relations, is a process through which qualitative work is imbued with the "activity of storytelling" and the experiences of the researcher and the participants (Steier 1991; Gore 2018).

As a researcher, I am, thus, both "embedded" and "embodied" in my work, as are the participants that have shared their narratives and experiences in such profound and personal ways. *Queering Suicide,* then, becomes a reflexive, "flesh and blood" approach surrounding the human beings of the LGBTQIA+ community and of this research.

Queer Youth Suicide

In *Queer Youth Suicide, Culture and Identity: Unlivable Lives,* Cover (2012a) delves into issues surrounding queer youth suicide (abbreviated further as QYS) by critiquing hegemonic assumptions of vulnerability and universal risk.

Promoting a re-figuration of causality away from the queer identity itself and onto the social factors at play in communal knowledge dissemination (3), the author suggests that cultural

grasping of QYS pathologize *queerness,* deem it the main issue and, thus, often reduce all members of the community to suicidal intention (4-5). Erwin (1993) terms this the *gay myth of suicide* which refers to the still popular social belief that "gay people" have an inherent "psychopathology" that makes them suicidal (473). Unfortunately, instead of grasping the fleshy, personal experiences of queer individuals, cultural perceptions objectify queer identity, commodify the community, and "reinforce the broad, existing cultural knowledge that associates non-normative sexualities with self-harm and suicide" (Cover 2012a, 20).

Queer Suicide as a Social Fact

Like the normalized experiences of gendered hierarchies and economic social structures, sexuality-related suicide is a **social fact**[9] (Cover 2012b, 38). Being, then, that notions of queer suicide are so deeply intrenched in socio-cultural dynamics, mainstream reasonings for queer suicide are, as the Cover (2012b) identifies, based in four main assumptions. The first is that homophobia is the primary causal factor of suicidality (40), an oversimplifying of a complex issue. The second is that isolation and invisibility are also risk factors (42) and, third, that coming-out elevates the isolation and is a positive and vital part of self-empowerment (47). The fourth assumption is that sexualities are fixed and timeless (52).

The social fact of queer suicidality, then, is based upon these false communal assumptions that drastically change the way self-death is understood in the queer community. May it be known, as well, that a critique of these social facts does not invalidate the real issues of isolation and homophobia many queer individuals encounter daily, nor does it depreciate the "coming-out" narrative that is often an empowering and positive step for people. However, this work does spotlight the overly simplified thinking patterns that surround suicide in the queer community, especially for youths, in academic writing and popular media (Cover 2012a, 55).

Naturalizing Heterosexism, Reifying Queer Vulnerability

Aspects of cultural-normalization around the social facts of queer suicide are deeply inter-connected within neoliberalism and the economic sphere. The materialistic dogma that is professed in western political structures is problematic in its subjugation and commodification of

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[9] According to Durkheim (1966), a **social fact** is a phenomenon with the power of external coercion of which it "exercises…over individuals", and, therefore, has a profound effect on social sanctioning and the resistance offered to individual wills (10).

bodies. In grasping the deeply complex and pervasive interconnections of "economy, queer [community] and heteronormativity" it is important to also acknowledge the institutionalized hetero-sexual practices of social construction and repetition in "naturalized gender, sexuality and…family" patterns (Garwood 2016, 7).

Thus, the incentivization of hope and homogeny, like in campaigns such as *It Gets Better*, reaffirm stereotypes of vulnerability and *inherent minority status* in the queer community (Cover 2012a, 68-69). In confirming the susceptibility of queer people, neoliberal idealizations of futurity and better tomorrows both individualize queer suicidality, reify resilience as a personal problem, and then blame those who cannot cope (Cover 2012a, 71-73). This suggests, subtly, that queer persons are defenseless to suicidal ideation and yet are "responsible for developing their own manners of coping" (73).

Anomie, Slow Death, and Dehumanized Biopowers

Neoliberal ideas of queer vulnerability are, and have been, historically reified by campaigns and organizations that promote self-empowerment in the "coming out" narrative as motivators of "productive citizenship". However, amidst these incentivizations of hope and hegemony are the subversive, yet subconsciously destructive notions of cultural policing and normalizing of which Berlant (2007) terms ***Slow Death.***

Slow death performs in anomic circumstances devoid of solidarity, and/or personal agency and is based in the physio-emotional "wearing out of a population" and the deterioration of its people, which often act as the defining condition of their modern and historical experiences (754). This often occurs amidst the neoliberal logics of ***biopower,*** a *Foucauldian* concept founded upon the transformation of human life into a task or a project for governance (Foucault 2003).

Individuals and communities experience slow death when they fail to meet norms and roles expected of the *capital subject,* and thus are policed, shamed, and zoned by institutional structures that figure bodies, not as identities or people, but "as data" or numbers with which to give and take life (Puar 2011, 153). In these structures, there are very few individuals or communities who are able to "maintain an independent integrity" (Gross 1991, 20) amidst the automated, dehumanized, cultural rhetorics of individualized productivity.

Isolation in Shame and Self-Shedding

In slow death, queer bodies are forced to constancy re-orient and re-create self-identities for the neoliberal subject as a mechanism of survival, an experience that creates deep personal shame. As Lester (1997) points out, shame is different from guilt in its ability to encompass "the whole of ourselves", prompting desires "to hide, disappear, or die"(352). Sudnow's (1967) *social death* acts as a death of the self-amidst shame and social isolation, and parallels Charmaz's (1991) *symbolic death,* in which, as circumstances of interactions, "valued aspects of the self are invalidated, violated, or otherwise negated"(80).

Lester (1997) brings to light the **cultural syndromes** of slow, social death as the perpetuated norms of self-abasement, inadequacy, and self-withdrawal (356). These internalizations of deviance and lack-of-worth lead to anomic experiences for queer individuals, and often necessitate *cyclonic self-shedding* (Coviello 2012). This a method of rigorous self-reformation undertaken "in anxious proximity to imagined futures" and yet only adds to an individual's fear and process of "immobilizing identity" (74). What constant re-identification does, in this case, is "speed up" the process of slow death, leaving no room for individual empowerment or worldly realism.

Identity as Performative – Social Naming

The performativity o(Butler 1993)—or thwarted renditions of performance—in queer identity constructions and cyclonic self-shedding orientations are often *shame-avoidance strategies* around negotiating homophobic policing (McDermott et al. 2008). Thus, for many queer individuals, the foundations of self-hood never truly feel "safe", as they are, instead, rendered into problematic, shameful and—often—elitist social expectations.

The process of **self-naming** often builds upon social-opposition, however that of which is procured in resistance to societal norms deteriorates as an identity the moment it is verbalized (Butler 1993). Queer identity, in this way, is often built in the vast evolution of "laying claim" (20) to terms that have been politically disjointed (21) and of which are invariably stigmatized.

Utterance, Historicity, and Selfdom

Self-naming as a **Performative Utterance**[10] can offer a multitude of opportunities to self-identify. This is often based in the "coming out" story *as a confessional practice* (Parsons 1964; Cover 2011), which reflects the bodily claims of memory as central to one's identity formation and personal categorization. However, this public naming may be received by the community as shameful which "introduces the subject into the social world" (417) through stigma and *historicized*[11] misconceptions (Holmes 2015, 417).

Emotive Politics and the Social Structuring of Bodies

Recognizing that the "invocations of memory presuppose identity" in claiming selfdom (International Studies Association, 2007, 86) is a vital perspective to this work as much of my research is based in the social narratives and memory invocations of personal pasts amidst systematic structures of oppression and slow death.

In the considerations of performative utterances and queer selfhood as a minority status (Butler 2006; Cover 2012a), Ahmed (2004) argues that queer realities are founded upon "claiming [one's] identity through shame" (101). Cultural perceptions of marginality and risk act as observed emotive-signifiers, whether validated or not, in the rainbow community.

Thus, queer outward displays of expression create, what Ahmed terms as the **outside-in model.** This is where emotions, personal understandings, and verbalized identifiers are absorbed or "taken in" by the individual through social networking, and, thus, *shaped* in the **sociality of emotions** as processes of "naming" feelings and bringing them into significance, and thus into political and social power. This out-side-in model is one that I will refer to as **Internalized Deviance** for this work, as the embodiment of socially—and inappropriately—named aspects of queer subjectivity that further de-empower individuals and communities.

Heterosexualized *affective economies* circulate misconceptions and inappropriate assumptions of queer suicide. What both Cover (2012a) and Ahmed (2004) push to expose, then, is the lack of legitimized and emotionally supportive spaces for queer identity formation, suicidal

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[10] **Performative Utterance** is the verbal act of a binding, authoritative identification (Butler 2006)

[11] **Historicity** acts as the antiquated norms and discourses that cling to a name or a performance of identity (Butler 2013) and is necessary to understanding how history creates the junctures of modern experience (Butler 2006).

tenets, and compounded grief. *Queer Losses* are excluded from the public cultures of grief (Ahmed 2004, 46) as they do not represent the "ideal" or normative structures (44). The reoccurring concept of lacking space and belonging, or the personal sense of "out-of-place-ness" and disorientation that queer individuals may feel in hetero-centric spaces is much like being "cast out from the domain of the livable" (Ahmed 2004, 48,55).

Further on, I will explore the notions of "casting in" and "casting out" that Ahmed (2004) writes about, though within the contexts of social norms and deviance, the racial critiques of suicide and queerness, and the historical renderings that have informed our current western perspectives on homosexuality. With an understanding of the theoretical approaches to shame, suicide, and identity, this work will then move onto the concepts of medicalization and pharmaceuticalization that acquaint us, the researcher and readers of this work, with current perspectives of suicidality, mental illness, and depression in modern-day health-care intuitions.

Norms and Deviance

According to Williams (2011) *Norms* are the "laws, conventions, morals, mores, folkways, customs, and rules" that, as guiding assumptions, are taken for granted in normal life (169). Norms, also, are first and foremost, descriptive polarities, where ***prescriptive norms*** encourage behaviors that people should or must do, and ***proscriptive norms*** indicate behaviors one should not engage in (Jasso and Opp 1997;Williams 2011).

Proper adherence (or lack thereof) to social norms is established by rewards and sanctions (Williams 2011, 170). Socialization, as the "learning, training, and absorption of norms, values, skills" (172) is either formal and deliberate (like in schools) or indirect (like with peers) (172). ***Regimes of Domination***, defined by Gordon (2007) as the "impersonal sets of rules regulating relationships between people", are the defining features of social relationships in norm prescribing. These regimes cannot be *opted-out* of as they act in totality, in the same way that Foucault (1990) recognizes sexual "analytics of power" (82) as being "everywhere", "repetitious" and "self-producing" (93). These regimes of power and domination reproduce in the social and physical interactions of day-to-day life, creating what Perlman (2002) terms the ***tribe mentality.***

Deviance, then, spurs from the disobeying the tribe's norms, and—as many norms are based in hierarchies, also acts as a subversion of hierarchical power. Deviance as a *relation* is, thus, informed by social interactions (Love 2015, 78) as a concretization of norms, rather than traits inherent in the individual (81). In the logics of *sexual deviance,* as have been historically designated in the medicalized pathologizing of "unusual sexual behavior" (De Block and Adriaens 2013) norm policing is done by strategized enforcers (Mollborn 2017, 210).

In adolescent lives, norm enforcers are often the authoritative adults, like parents, teachers, and religious figures, that use "scare" and threat tactics to demand regulation (Mollborn 2017,118). When adults deviate, however, enforcement is based in institutional regimes that root in social interactions, and of which often create a reoccurring patterns of *internalized deviance* as the norms of, not only action, but *feeling*. Hochschild (1979) terms these the *feeling rules* (563) or the social guidelines of prescribed "rights and duties applied directly" to emotions (564). This concept that traces back to Ahmed's (2004) outside-in-model of cultural absorption, where the intensity of feelings signifies to the individual that they have "transgressed" a social border (27).

Racial Perspectives

Racism in the Queer Community

While the primary focus of my research is not on racism in the queer community, this is a large and outstanding issue which, for participants of color, is imperative to speak to amidst suicidality and mental-health.

No matter how much inclusion is professed in queer space, transgression from others based on "whiteness and middle-to-high-income identities" often creates marginalizing barriers for people of color (Harris 2016). Queer *urban spaces,* therefore, become places of "contained and constrained existence" while appearing, easily, as "mirages of free existence, movement, and visibility" (147).

White Queer perspectives have gained much political and economic power since the Gay Liberation Movement of the 1990's, "shoring up pre-existing racialized politically and economically conservative processes of profit-accumulation" (Nast 2002, 877). Hegemonic racism has benefited from the *patriarchal fatherhood* of stereotypical gay virility in "white

hetero-cowboys and frontiersmen of Manifest Destiny" (Nast 2002, 887). Morgensen (2011) terms this *U.S. exceptionalism* as a "white ascendency" into homonationalism (105).

The bio-political stance of *colonial necropolitics* have deemed Black, Indigenous People of Color (BIPOC) primitive amidst sexual modernity and the *repressive hypothesis* where "exotic" individualities are "marked for death" (Morgensen 2011, 106; Foucault 2003). Queer Modernities, then, are regulated and based in the "new colonial moral order" (Morgenson 2011, 108) where freedom is equated with wealth, and social viability with controlled visibility (Brown 2018, 582).

In order to be queer and socially "received", one must provide their body as means of *consumer citizenship*, and prescribe to "the neoliberal projects" of homonormative *urban entrepreneurialism* (Bell and Binnie 2004). The consumer citizen and the *pink economy* (Rao 2015) of commodified gay places erase "the most vulnerable and disenfranchised by cleaning up spaces and populations deemed dirty and wasteful" (Vargas 2014).

Society seeks "to tame" the incongruent, *wild* bodies of color by enforcing *gay-subject making*, bringing to light or "outing" the dark subjectivities and dark bodies from closets and communities (Halberstam 2014, 142) in order to provide bridled and cultivated identities of civilization and modernity. This control has, also, at its roots the science of racism as the culturally imbued "reading of bodies" by subjective scientific methodologies (Somerville 1994). These understandings were brought about to justify the strategic political and economic subjugation of "various racial groups within the systems of slavery and colonialism" (250).

Queer homonormativity, thus, has in its politics of scientific racism, created colonialized structures around the *territorializing of intimacy* (White 2013) or the regulating of "gay" eligibility around notions of citizenship, class, ethnicity, and wealth. These utopic versions of civilization are based in the *politics of respectability* (Brown 2018, 582) where marginalized groups are expected to uphold dominant cultural rhetorics. Unfortunately, as individual experiences and perspectives "push the envelopes" of hegemonic principles and norms, violence and strategic oppression increase in severity. From the politics of respectability, Harris (2016) explains that…

"Race, ethnicity, visible identifiers of religious affiliation, sexuality, and gender play a heavy role in the types of violence a person can encounter and become far more prevalent, as these identities intersect the expectations for stereotype alignment and capitulation to the presence of dominance." (139)

Termed **the matrix of domination**, sociologist and author Patricia Hill Collins (2000) argues that this intersection of marginalized and oppressed identities overlap and interconnect, especially for black women or people of color with diverse sexualities (230). The matrix, as a social paradigm, is based in the globalized decent of U.S. Nationalism (233) and is organized amidst four distinct domains of power: structural, disciplinary, hegemonic, and interpersonal (276). **Multiple jeopardy** is the burdened experience amidst the four domains, and is interpreted by King (1988) as the "multiplicative relationships" among oppressions where each marginal identity multiplies the next; "the equivalent formulation is racism multiplied by sexism multiplied by classism" (47).

Erased Suicidalities

Amidst the multiple jeopardies at play in the matrix of domination, there is a lack of understanding and research around the suicidality of African-American, Latinx, and American Indian population (Spates 2015; Dennis 2018). Due to the misclassification of ethnicity after suicide, and racialized data-disparities in collection methodologies (Rockett et al. 2006), the political, cultural, and historical invisibilities faced by many people of color (Purdie-Vaughns and Eibach 2008) have deemed "suicide a white people thing" (Dennis 2018). Academic scholarship and scientific research are just now beginning to study and interrogate suicidality amongst non-white communities in the US (Joe 2006).

For African American comminutes, trends in suicidality show a higher rate for individuals under the age of 35 (Willis et al. 2003) and there has been a recent spike in black-youth suicide starting in 2015 (Center for Disease Control 2017; O'Donnell and Saker 2018). People of color—more broadly—between the ages of 20-34, are highly likely to die by suicide, and that increases with "intersecting" diverse gender and sexual identities (Center for Disease Control 2017; Lytle, Silenzio, et al. 2018). Trans people of color face devastatingly high levels of abuse and discrimination, and are nearly 33 times likelier to attempt suicide than the general population (Grant et al. 2011). Anti-transgender bias and structural racism, then, create an

experience of *cumulative discrimination,* and multiple jeopardies for LGBTQIA+ people of color, which result in the "additive effects" directly linked to people's increase in mental illnesses and ideation (Sutter et al. 2016).

Racism manifests at all levels of interaction, and must be addressed in and out of the queer community (Lanzerotti et al. 2002). By negotiating the construction of historical, political, economic, and social privileges in "whiteness", this work seeks to propose further study and orientation into anti-racist and justice-oriented perspectives in queer academic and non-academic communities. This discussion has evolved from the compelling narratives of participants of color in this work, and their experiences of multiple jeopardies in various and complex ways. Feeling unwelcome in the white queer community to due racial prejudice and differences has created lasting schisms and isolation for many individuals.

Historical Perspectives

As this work has explored deeply, social, political, economic, and cultural ideologies inform the personal identities and collective narratives of various communities in drastic ways. Going forward, I will discuss the historical and cultural approaches to queer identity and mental-illness that have led to current-day logics of medicalization, suicide-prevention, deviance medicating, and recovery logics.

Homosexuality as a Disorder- Church and State

In 1952 the American Psychiatric Association (APA) released its first Diagnostic and Statistical Manual of Mental Disorders publication, which, at the time, categorized *homosexuality* as a sexual deviation and thus "an instance of 'sociopathic personality disturbance'" (Schneider 2015, 10). This diagnosis was rooted in western *antihomosexual bias* which has considered queer sexual orientation an abomination for "much of the past two thousand years" (Bayer 1987, 15). From criminal deviance as "heinous crimes…against nature" (Foucault 1990, 30), to psychiatric illnesses, most theories based in the typologies of sexual deviance were symptomatically imbued with judgements of pathology and immaturity.

By the mid-1900's, *A-typical gender behaviors* had become medicalized and were presented as "symptoms of…disease or disorder to which mental health professionals [were] to attend" (Drescher 2015, 566). In this light, language around sexuality has always been coded,

and its speakers qualified (Foucault 1990, 29), making it so that "medical diagnosis [of homosexual or queer individuals] was little more than a professional reiteration of a popular and pernicious prejudice" (Schneider 2015, 12). Much medicalized discourse also viewed "mental distress and suicidality as manifestations of homosexual pathology" (Erwin 1993, 441).

Religiosity and Bigotry

As moral-religious traditions have historically informed medical perspectives, the condemnation of homosexual and deviant desire was felt to uphold the "Devine Plan" of the Judeo-Christian god, as is detailed in both the new and old testaments of the bible (Bayer 1987). Still to this day there is a great deal of prejudice in religious orthodoxies against LGBTQIA+ identities (Fisher et al. 1994; Krull 2017).

It has been found that "religious-fundamentalism, religious service attendance, orthodoxy, self-rated religiosity, and intrinsic orientation" all correlate with hate-based, or negative views of LGBTQ+ people (Whitley 2009, 29).Thus, predicted bias in religious fundamentalism, or the belief that one's religion contains fundamental truths (Gilad and Stepanova 2015), is linked to anti-gay perspectives and sexual prejudices; (Rowatt et al. 2006; Mellinger and Levant 2014), perspectives that have persuaded medical discussions for hundreds of years.

"Mental Illness and Spiritual Malaise"[12]

Christian religious contexts have had a profound impact on how western society grasps role infractions and social deviance (Parsons 1964, 272). In Institutionalizing the concept of *original sin* as an aspect that exudes from *within* the individual, the church created a "social responsibility for law observance" that reflects in modern society's deference to authority and psychosomatic here-say.

Grounded in religio-ethics, the institutional values of society have slowly evolved from the "cure of souls" into what Parson's (1946) terms the "new religions" of modern health institutions (292-293). Medical and psychiatric professionals now function as the "trustees of the

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[12] Parsons (1946, 292) *Social Structure and Personality*

religious interests of the individual" (316), where the doctor's office acts as the confessional, and the diagnosis as their "saving grace".

These "confessional" based production of truths around sex have merged with *scientific regularity* to create clinical codices of diffused causalities (Foucault 1990, 65), creating an "economy" of discourse in medicine (68). In the perspective of *biopower* as the "subjugation of bodies and control of populations" (40), institutional powers, whether religious, political, or medical, have in the past and continue presently to control sex and sexuality by establishing a unified, systematic set of rules around orientation and expression.

<u>New Debates</u>

The American Psychological Association removed homosexuality from the list of mental illnesses in 1973 (Kozuch 2017), marking the beginning of modern and drastic shifts away from medical categorization, and into moral and political debate around sexuality and gender (Drescher 2015, 571). There is, now in the United States, a lack of "scientific rationalization for discrimination" (572), however, homophobia and transphobia remain sunken yet subversive in many political, social, and medical institutions today (Barr 2018).

Medical Perspectives

<u>Medicalization and Ideology</u>

Medicalization (or medicalisation as it is sometimes spelled) is the process through which human conditions and experiences come to be characterized as medical issues and are therefore subjected to categorization, study, treatment, and medical perspectives (Maturo 2012). Considered a social process by which medical knowledge is applied to social expression and behavior that is not discernably physiological (White 2016), medicalization offers a link in understanding both "deviance and the sociology of science and science studies" (Schneider 2015, 24-25). For the use of this work, I will interact with medicalization as a mover in and creator of conversation and reaction to suicide, on both the personal and societal levels.

Medical Ideology, as defined by Weitzer (2002), is "a type of [medicalized] social control that involves defining a behavior or condition as an illness primarily because of the social and ideological benefits accrued by conceptualizing it in medical terms" (197). The author speaks to

the benefits and costs of defining illness and disease in ways that support central social institutions. Health has become a coded means of referring to "individually, socially, and cosmically ideal states of affairs" (Fox 1977, 15).

Based in the medicalized ideologies of mental illness and pharmaceuticalization of social issues, this work will continue to interrogate the costs and benefits of interacting with the health-care system as individuals of queer, ideating, and/or deviant identities.

Categorizing Deviance and Mental Illness

Systematic categorization of mental illness is a "socially organized process" (Blum 1970, 31) and, thus, based in inherent judgement. When a "mental illness" diagnosis, decision or judgement is placed on an individual (or individuals), it is rooted in a socially prescribed "model of naming" and language (36) which is used to methodically recognize and categorize deviant behavior. This manner of judgement, then, is inherently ridged and continuously uses the same body of knowledge and prescription to reproduce and recategorize (38) the same effects on complexly different individuals.

Broad-based categorization in this affinity is what Skene (2002) terms as *Social Normativism,* or the systematically based language inferences in psychopathology that infer value judgements and bias (114). "Subjective and inferential", *disorder-type classification* cannot distinguish between theory and value (117), which leads to the conclusion that "psychiatry is a form of social control which represses socially undesirable behaviors" (115).

For medical ideologies, mental health and illness act as "states of the personality", and are defined by how an individual does or does not "perform institutionalized roles[13]" (Parsons 1964, 259). These roles act as the primary bridges of interpretation between social systems and individual personalities (261) where "the very state of uniformity conforms to commonsense beliefs regarding the nature and features of medical illnesses."(Rossol 2001)

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[13] For our terms in this work, role is distinguished as the "organized system of participation of an individual in a social system" (Parsons 1964, 261)

What is Normal?

Imposing belief systems around the categorization of mental illness requires a systematic distinguishing of what is deemed "normal" *cultural competence,* a process that classifies "the parameters of adequate membership" (Blum 1970, 44) in society. "The notion of [the] `normal human being'" may have as its source the medical approach to humanity as one that treats "all members in some respects as equal." (Goffman 1986, 17) Such *normative* regulations are grounded in physical and phycological characteristics that create "inference and action" (45), and, as such, must meet prescribed "routine, practical accomplishments" (56). *Mental Health*, then, is fundamentally concerned with the notion of "capacity" as it infers to the ability to enter into social relationships and fulfill the expectations of those memberships (Parsons 1964, 258)

Pharmaceuticalization

Pharmaceuticalization refers to the medicalized process through which "human conditions" are turned into issues or illnesses "requiring treatment or enhancement with pharmaceuticals" (Bell and Figert 2012,778). In Pills, Power, People Joan Busfield (2006) speaks to the social underpinnings of the now global pharmaceutical industry. Expenditure in pharmaceutical preparations and medicines has increased by 60 percent in the last decade (National Audit Office 2007; Busfield 2010, 934), an advancement in correlation with the influx of *malady profiles* and hundreds of new symptomologies provided in current additions of the DSM.

Lane (2007) links this increasing lot of mental-conditions and malady profiles with the large-scale investiture of the pharma-industry, describing the intersection as an economically prosperous *pathologizing of emotions* (39). "Profit more than health need" acts as the "guiding principle in the development and marketing of pills (Busfield 2010,936), as drug companies are eager to tap into the "vast new markets" of mental ailments and conditions, with full support from media and advertising firms (Lane 2007, 43).

Outwardly affective and mental a-typical personalities are de-valued aspects of the person, and frequently mistaken and diagnosed as disordered conditions (Chriss 2013, 170) then heavily treated with pharmaceuticals. Holt (2004) touches on this concern amidst the burgeoning new sciences of ***medicating-to-normal***. Floating with the question as to if *prescribed* happiness

and normalcy are positive and socially ideal, the author detangles notions of happiness as it is understood in mainstream western approach and after psychiatric diagnosis. In both queries the author contends with the expected feelings of happiness as looking quite similar to feelings of complacency, apathy, and contentment. Lane (2007, 209) speaks to this phenomenon of regulation in pharmaceuticalization as "the willingness to risk drug dependence and side effects in order to be 'up' and 'on' around the clock", as a medicating away from the "full range" of human emotions.

Addressing the overuse and capitalistic methods of pharmaceuticalization is vital to interacting with the mis-diagnosis and over-prescribing of "medicines to treat conditions for which they are not effective" (Busfield 2015). The risks and safety-concerns of psychiatric drugs are often over looked or misrepresented in the "language of an adversarial legal system"(Maris and Healy 2015, 11). Devising critical methodologies for prescribing and promoting medication for suicidal or self-harming ideations and depression would allow for a critical elimination of those with frequent suicidogenic and personally-destructive side-effects (37).

The Bright Side of Medicalization

Pharmaceutical drugs are a vital part of western medicine and have the potential to create a process of mutual-construction and wellness with consumers (Rose 2007). However, over use and problematic medical-regimes "can only occur within a political economy of subjectification" (702) and the day-to-day refortifying of destructive and biased pedagogies based on concepts of medical forms of wellness and life.

Thus, as an agent of social control, the institution of medicine has many sides and faces, not all of them capitalist. Weitzer (2002) offers a variety of benefits and positive qualities around the medicalization and pharmaceuticalization in the global west. The humanitarian trend of conceptualizing deviance no longer treats patients as inherently evil or morally corrupt, but instead treats socially abnormal behavior as a disease (198) where the patient is considered in need, and physicians are deemed "beneficent and honorable" (200). With pharmaceuticalization, medicine is not inherently bad. If prescription medications can be fully integrated and engaged with in day-to-day life, beyond neoliberal, industrialized rhetorics, then they should bear little critique (Rose 2007, 702).

The Sick Role

The medical profession acts as the conclusive designator of the *sick role,* a term, originally formulated by Parsons (1951), which removes blame and condemnation from individual patients and defines particular forms of deviance as illness (Weitzer 2002, 196, 197). The "sick" person is deemed "helpless and in need of aid" (Parsons 1951, 296) and withdrawals into dependency on the institution (193) as a mechanism of social control and deviance remedy (321). The sick role, thus, offers a "shield" against social reproach, permitting the patient to take space away from various role obligations and expectations (Weitzer 2002, 196; Lane 2007, 205; Parsons 1964, 274).

Mental Illness, in the sick role, is defined—not in the notion of deviant culpability allotted to those deemed "criminal" or "sinful"—but as individually undesirable and in need of active reparation (Fox 1977,15; Weitzer 2002, 199). However, and as will be expanded upon further, the sick role is only valid as a socially "acceptable" form of deviance when the individual or patient accepts the "inherent undesirability" of their "condition" and acquiesces to the care of the medical institutions at play (Weitzer 2002, 199). The "hope", then, of individual wellness is rooted in medicalized therapeutic ideologies which assert that illness or deviance can be overcome if only the "correct" treatment is administered (199).

Recovery and It Gets Better

> "The stigmatized individual can also attempt to correct [their] condition indirectly by devoting much private effort to the mastery of areas of activity ordinarily felt to be closed on incidental and physical grounds to one with [their] shortcoming. This is illustrated by the lame person who learns or re-learns to swim, ride, play tennis, or fly an airplane, or the blind person who becomes expert at skiing and mountain climbing" (Goffman 1986, 19)

Pulling from Goffman's (1986) perception, it is clear that rhetoric around the sick role in the United States is based upon the conditional legitimization of deviance at the "price" of recovering as "expeditiously as possible" (Parson 1964, 276). Not only does communal membership require a socially-based determination to avoid illness—and deviance—at all costs, but the individual in the sick role is obliged "to cooperate fully with the therapeutic agency" and show great motivation to achieve their own recovery (284).

Medical ideology is based upon "an implied or explicit call for resistance" (Schneider 2015, 8) against deviance and is often vested in facilities and or institutional settings "established to care for persons felt to be both incapable of looking after themselves and a threat to the community" (Goffman 1990, 4). "Mutual trust", then, between patient and their medicalized institution is vested in the belief that the physician is trying their best to aid the patient in their recovery, and that the patient is cooperative "to the best of their ability" (Parsons 1951, 312). In this sense, the patient is "responsible" to their physician (312).

Queer and Suicidal Contagion

In tow with the IGB perspectives of mandated recovery, a primary function of western philosophy's health-illness role typologies are that of *insulation,* or the separating of the "sick" individual from normally functioning social spaces; a *quarantine* of deviance that is considered *contagious* to the rest of the population (Parsons 1964, 275). Pulling from Fritsch and McGuire (2018), queer lives are often based in cultural "narratives, practices, and temporalities of contagion" (vii). The *bio-social* perspective, rooted in sites of queer sex and *queer blood,* drive both the historical and modern orientations of isolation and segregation seen in current medicalized perspectives of separation for the ideating and mentally unwell queer individual (Bennett 2015, 4-5).

These imperial practices of hygiene, cultural and biological, are based in the response to the concept of *social contagion* or the fear that social contact and collaboration leads to the transmission of socio-cultural artifacts or states (Wald 2007; Marsden 1998; Ugander et al. 2012). As a morally contagious phenomenon that "erodes the very basis of society" (Wald 2007, 115), deviance and suicide, or the fear of, acts as the basis for the ejection of ideating patients from normative social spaces. Rooted much less in an ethic of care for the individual, and more so in limiting the "spreading" of the issue to other civilians, the ousting of mentally-ill patients strategically parallels the ousting of other forms of social deviance in American society—like crime and political communism (Parsons 1964, 275).

These notions of isolation, queer-phobic, and medicalized perspectives were brought to the public's eye in 2015 when Tyler Prescott, a transgender teen living in San Diego, CA, died by suicide after enduring a traumatizing 72-hour hold in the emergency wing of Rady Children's Hospital San Diego. Facing isolating and brutalizing treatment, the teen was accosted by

"repeated misgendering" as hospital staff blatantly declined to "affirm his male gender and his gender dysphoria" (Bever 2016). By hiding deviant mentalities, "the sick person is prevented from setting an example which others might be tempted to follow" (Parsons 1964, 276) and treated, thus, in an admonished manner. This is an experience that, in the case of Tyler Prescott, can prove fatal.

As there is a growing doubt regarding the legitimacy, feasibility, and effectiveness of standardized suicide prevention procedures (Morgan and Evans 1994; Holland Barnes 2014), this work argues for a radical reconsideration of both the ejective response taken by many medicalized institutions when confronted with ideation or self-harm, as well as for the creation of more humanized, community based programs that restructure individualized prevention into empathetic communal perspectives.

Moving On: Queer Suicide and Grief as Resistance

Queering suicide is the act of dissolving all social conventions related to normative ideologies. Disidentifying with the notion of suicide is just as vital as disidentifying with the prescribed (often heteronormative) notions of life. Muñoz (1999) points to the power and poignancy of "crisscrossed identificatory and desiring circuits" (15) where disidentifying opens people to the freedom from ideology and assimilation (18).

To "queer" something is to, as Seidman (1997) describes, place doubt in foundational assumptions in order to open up "new possibilities for critical social analysis" and political change (xi). Resisting the taboo orientations surrounding intentional self-death, Coviello (2012) writes…

> "I want to wonder what happens if we begin to think of suicide as…a different kind of action, one that like other kinds of action…is better understood as the expression of a search for motive, of an effort to concretize impulses that otherwise remain obdurately illegible and incoherent to the self in which they unfold." (Coviello 2012: 66)

Perhaps the antithesis to violence and aggressive normative rhetoric is the escape that suicide offers for many queer folk each year (Cover 2012b)? Perhaps the notions of self-harming ideations are more than just simply "wrong", perverse, or inconceivable?

Moving forward, or side-ward as is queer, this work will take the notions of anomie, slow-death, the performative nature of (dis)identification, and the affective economies of social-emotive experiences, and use them to reassess the medicalized and normalized rhetorics of institutional structures—like the church, the hospital, and the home.

The foundational literature above is provided in order for this work to interact with a multitude of theoretical perspectives as a basis of allyship and understanding. It is not my prerogative to link all methodologies and findings back to the reviewed works. Instead, what a basis in literature does, here, is offer a historical perspective on the compounding issues affecting queer individuals who experience ideation and depression. This is done through a lens of communal depletion, and psycho-social frameworks of mental illness and identity-confusion, where the authors mentioned above act as allies in recognizing the hugely problematic force that systematic and institutional policing creates for marginalized, queer identities.

In this case, a non-traditional approach and a lack of linking back to the broader literature act to strengthen the argument that this work offers, which stems from the issues of academicizing queer suicide in general. More deeply, the lack of personal narratives in the rather sterile basis for sociological and scholarly writing creates a gap in researched literature, so, while the theoretical perspectives above are important jumping points for my research, there is still a large schism between the work I am trying to promote and the current peer-reviewed writings.

Queering Suicide acts as a bridge itself, without needing a direct correlation to the review literature. As such this research will continue to provide a window into the compounding nature of communal shame, the intersectional futures of grief and forgiveness, and both the community and individualized identities of death that demarcate queer identity and queer pain.

METHODS

In broad exploration, this study grew amidst the pressing question of the heightened vulnerability to—and prevalence of—suicide and self-harm in the LGBTQ2IA+ community (Robinson and Espelage 2012; Delaney M. Skerrett et al. 2015; Delaney Michael Skerrett et al. 2016; Medicine Institute Staff et al. 2011). Simmering for 9 months, I began with a contested and rather difficult review process which took a multitube of revisions before finally being accepted by the Institutional Review Board (IRB) in the summer of 2018.

From there, I began a 4-month window of data collection and further analysis. As such, much of my interactions with participants took place in September, October, and November of 2018. This primary qualitative research was based in of-depth interviewing, with the in-person research taking place in both the Denver and Boulder metropolitan areas. There were a select few interviews done over web-based platforms in order to accommodate participants who were traveling and/or living out of Colorado. The final sample of interviewees was 17 people in total, each person participating fully and sharing in deeply vulnerable and touching narratives, all of which I am overwhelmingly grateful to have witnessed.

The Person Behind the Interview

There are valid critiques of *of*-depth interviewing such as *inter-coder reliability* and the appropriation of subject voicings—especially in methodologies founded upon post-modernist sensibilities (Borer and Fontana 2014, 4; Campbell et al. 2013; Van Maanen 2011). However, as a facet of qualitative research, *of-depth* interviewing offers an integrative and personal experience for both the interviewer and participant(s). Of-depth methodologies are based in the belief that "the real-life members of, or participants in some everyday activity, event, or place" hold the deep understandings, through which the interviewer takes on the role of *student* to learn about and grasp more intersubjectively (Johnson and Rowlands 2012, 6).

Thus, interpersonal interviews are based upon the interviewee themselves, which offer insight into personal epistemologies, where the constructions and manifestations of knowledge are based in the subject's representations of reality and culture (Rivas and Gibson-Light 2016, 319). Shining light into cognitive processes of meaning-making amidst abstract and complex mental entities (320), *of*-depth interviewing also offers insight into what Geertz (1973) terms the

symbolic culture(s), of which are based in the mind's organizing of action and experiences (57). Too, as has been previously discussed, understanding the mind's actions offers an understanding of *meaning, motivation, and discourse* as based in the *lingual mechanisms,* or the conceptual "springs of action" that Mills (1940) argues create the social contexts for an individual (904-905). Thus, verbalization, or utterance, as an *act* and a *performance* (Austin 1962; Butler 2006) create individualized social realities, into which the cultural dimensions of of-depth interviewing offer access and understanding (Rivas and Gibson-Light 2016, 323).

Away from the neopostivist empiricism that creates impartial dichotomies between object and subject (England 1994, 242), talking deeply with participants also creates important and integrative space for speech acts, shared-knowledge acquisition, and personal meaning-making in this work. Addressing the pursuit of diverse understandings in the qualitative of-depth interviews is also a process of addressing my personal bias towards human-based research in the graspings of "complex, dynamic, sociocultural, psychological, and biological processes" of individual bodies and perceptions. (Dionigi 2006, 376). Sociology, is, after all, a human-based approach to recognition of broader populace and culture.

Acknowledging the problems around research that used in exploitative means to "collect stories of pain and humiliation in the lives of those being researched for commodification" (Tuck and Yang 2014, 2), this study accesses *of*-depth interviewing to create personal connection and community between interviewees and interviewer. Person-based research, with its complex biases, intimate accounts, and cultural renderings is, in such a way, vital to a decolonized, non-traditionalist rendering of narrative and personhood.

Moving away from the *politics of recognition*[14] rampant in traditional and post-modern social research, this work has centered interviewing methodologies, not in *damaged-focused* narratives, but in the *desire-based research.* This approach offers person-based expectations of which delve into the *"*process of becoming more fully human"(Blackburn 2014, 2) through dialogic interaction with intent for action (14). By building on human desire, then, this research becomes a *methodology of reparation*, an approach Tuck (2010) understands as that which links desire to one's personal narratives of the past and the future (644-645).

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[14] *Politics of Recognition* create a victimization of participants that legitimizes the power of the researcher and not of the subject in traditional qualitative methodologies (Tuck and Yang 2014, 7).

Desire-sharing in research, then, is an action which is embedded in the personal story-telling and dialogical practices of this work, where of-depth interviewing is based in the participant's empowerment as well as my own. Seeking reciprocal relationships and shared-meanings amidst myself and participants, I have created a body of work that is not just a product, but a *process* of personal and communal evolution. (England 1994, 243-244). **Reflexivity**—as the "self-critical sympathetic introspection and the self-conscious analytical scrutiny of the self as researcher"—as well as **Intersubjectivity**—the creation of shared meanings and dialogical knowledge frameworks (244), have been and will continue to be vital components of this work's methodological foundations.

Autoethnographical Expansions

Autoethnographical Research (AR) offers a move to of-depth*,* humanized research by "systematically analyzing personal experience" in order to better grasp social phenomenon away from cumulation-based academic research orientations (Ellis et al. 2011, 1; Kuhn 1962). However, the ethical dilemmas of AR are based both in the implications of stereotyping when works are handled by various institutions and readership (Boylorn 2017, 9), as well as in what Gingrich-Philbrook (2005) calls the "wanting of daddy's approval". Both these issues stem from the frequency of autoethnographic renderings being situated in patriarchal ideals and academic mindsets that have "a penchant for accounts of oppression"(Tuck and Yang 2014, 10). *Logics of Pain,* as "the teleological trajectory of… brokenness, repair, or irreparability" (10-11) upon which social research often hyper focuses and thus appropriates, can imbue autoethnographic research with a sense of hierarchical power and inauthentic reporting.

Boylorn (2017) expresses the need to protect researched communities from academic appropriation, where "pain is documented in order to be erased, often by eradicating the communities that are supposedly injured and supplanting them with hopeful stories of progress into a better, whiter, world" (Tuck and Yang 2014, 11). This is not to say that acknowledging pain and accessing communal suffering is inappropriate, in fact such bringing to light is vital to reparative work. However, qualitative, of-depth AR should be based in personal, rooted and *desire-based frameworks* (11), with desire stemming from the collective longing, hope, and the textures of personal experiences, not just in collections of pain-narratives that superimpose academic understandings onto individual, feeling bodies.

Narrative and *critical autoethnographic methodologies*[15] will allow this work to create a new type of relationship between myself, my participants, and you—the readership (Ellis et al. 2011, 2). Through these approaches, I am less a researcher and more of a storyteller (Bochner and Ellis 2016, 76) who expands upon the "borders of legitimate scholarship" in order to "humanize" my participants and challenge the "one dimensional representations of them" (Boylorn 2017) by expanding upon connective, and emotional experiences of importance "to human well-being" (Bochner and Ellis 2016, 80).

Autoethnography, as the critical and narrative confluences of "autobiography" and "ethnography" (Ellis et al. 2011; Chang et al. 2012; Choi 2016), imbues person-based essences and fluid-perspectives into collaborative approaches and intuitive workings (Chang et al. 2012). As a *reflexive ideal of conscience*[16] and beyond the rational objectivity in hierarchical social research methods, *storytelling* offers the "self as a window" which, as a holistic interpretation, can more readily be tapped into for social dialogue (Chang et al. 2012, 21).

The value of autoethnography is based in the credibility of personal accounts reflecting individual experiences of culture. Writing as a mode of inquiry and a "way of knowing" (Ellis et al. 2011, 6) offers space for a "witnessing" and or "showing and telling" that incorporates personal validations into pain and experiences, while tying into the interpersonal *relational ethics* crucial to the inquiring dimensions of social research (Ellis et al. 2011; Bochner and Ellis 2016; Witkin 2014).

Institutional Review

Attaining research participants began only after approval from the University of Colorado, Boulder's Institutional Review Board (IRB)—a process which took an upwards of nine months and multiple re-writings of protocol and drafting. Problems faced in the wake of the necessary and yet often stagnant process of institutional approval brought with them the realization of both the institutionalized and culturally insidious fear of death and suicide in the

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[15] **Narrative Autoethnography** are the "texts presented in the form of stories that incorporate the ethnographer's experiences into the ethnographic descriptions and analysis of others" (Ellis et al. 2011, 4). **Critical Autoethnography** is a an epistemic rupturing and recreation of language and logics that is human and connective, and based in personal justice orientations at the intersection of identity and ethical responsibility (Boylorn et al. 2013, 15; Kuhn 1962; Kvasz 2014)

[16] **The Reflexive Ideal of Conscience** is a qualitative methodology that "exposes rather than protects the speaker through a medium that can bring author and reader closer together" (82).

global west. Death-denial creates extensive social dread and anxiety surrounding personal mortality and volition self-death, and thus, the foreboding topic of suicide proved dubious for IRB.

The central concern for the review board was whether discourse around the topic of suicide might spur collective or individual action, thought, or attempt based in ideation and self-death. As I have discussed at length, and as Westerlund (2013) proports, discourse around ideation and depression can create space for connectivity that is often absent in the isolation and taboo around suicide narratives. While there is evidence that shows some problematic qualities of mass media representations of suicide (Niederkrotenthaler 2013), de-stigmatizing conversation and offering space for discourse takes away the stigma of intentional self-death, and recognizes "suicide [as] an action, not an illness" (Cutcliffe 2003, 93).

I understand that the IRB review process is obliged to protect the "rights and welfare of human subjects", however the regulations and outdated processes create restricting mechanisms of control which seem less oriented towards the ethics of humanized research and more geared towards meeting federal regulations (Keane 2008; Menikoff 2010; Bozeman and Hirsch 2005). Finding the balance between institutional legitimacy, and ethical, human-based interactions created limitation for my research. With the basis of mandatory reporting as the bane of intimacy, and IRB's stifling of more radical perspectives around ideation and attempt, I did struggle to create supportive, confidential spaces with interviewees that deeply affected the "places" conversations could travel and the comfortability that participants felt in my presence.

Sampling and Collection Procedures

Criteria for communal accession[17] and participation required that subjects identify with, or be an ally of, the various genders, sexualities, presentations—or lack thereof—in the LGBTQ2IA+ or *Queer* communities[18]. Participants were required to be of age 18 years or older[19]

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[17] *Accession* will be used instead of *Selection*, a term that Paris (2011) defines as colonial in its granting of "unilateral power of the researcher to select" participants (140).

[18] It was not an expectation that interview participants be "out" in any ways to their families, friends, or larger communities about their or other's identities.

[19] I opted to forgo implementing an upper age-limit as—for many Queer affiliated individuals (regardless of generation)—youth *and* adulthood prove deeply influential in the evolution of self-identities, personal growth, and communal experiences. Creating ageist expectations bars vital multi-generational experience and narrative.

and have personal experiences with their own or *close others* ideation, attempts, or accomplishment of suicide.

Methods for garnering support and participation were based in *convenience sampling*, through which proximity and time-availability acted to promote participant, and researcher, accessibility (Etikan et al. 2015). By posting flyers on various university campuses, as well as in education-based resource centers, and online through social media platforms, I was able to use acquaintance networking to access participants in the various social circles of the Denver and Boulder metropolitan LGBTQIA+ communities[20]. *Snowball sampling*, as a subset of convenience sampling, allowed for my created participant networks to promote through word-of mouth recommendation, where subjects both volunteered for interviews as well as endorsed my work help increase involvement. As such, the majority of interview participation that I received came from the *snowballing* recruitment producers that were primarily based in my personal social circles, acquaintanceships, or "friend of friends" groupings.

Interestingly, the difficulty in data collection came, not in creating and sustaining interview appointments, in which participants were punctual and consistently reliable, but from anonymous public scrutiny of the work. After I would post flyers, it would seem that reactive measures were taken, especially on the University of Colorado, Boulder's campus, to hide or destroy the promotional materials. Perhaps coincidence, or the effect of a culturally situated death-denial and fear, finding that the flyers were constantly missing, covered, taken-down, or damaged proved disconcerting. At points it even felt as if a nameless and formless type of social policing was breathing down my back, forcing the queer conversations around suicide back "into the closet" through the destruction of my promotional material.

However, the resilience of this work parallels the resilience of the bodies whose narratives it speaks. Even amidst the issues around IRB approval and promotional advertising, the narratives and stories have come together to create a foundational research project and initiative. By creatively handling the pre-data collection hiccups, such as finding more internal and "safe" places to post flyers and working to be flexible with the university mandates of

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[20] *Random sampling* operations were left out in my procedures as this research does not require randomized data from the various LGBTQ2IA+ Denver and Boulder communities.

review, this research has become more pliable and less complacent in its queer perspectives and fluid characteristics.

Dialogical Space, Dialogical Conversation

Fielding initial responses from either the flyers or by word-of-mouth through email, I began to receive more inquiries about the study as time went on and as more people interviewed. Many who emailed proved reliable and only a few inquiries, especially those from persons hoping for monetary compensation—of which there was none—stopped communicating after a few messages sent back and forth.

Jumping into field work, I organized interviews with participants of whom either I knew closely, was acquainted with through various groups and relationships, or of whom were complete strangers. Creating "relationships of dignity and care and glimpsing insider understanding across multiple borders of difference" (Paris 2011, 140) became of primary concern. In interacting and interviewing with close-friends or acquaintances, it was vital that they feel completely volitional, unpressured, and impelled by the research. For subjects with whom I was unacquainted at the beginning, offering safety, space, and humanizing conversation amidst the foreign experience of suicide discourse and this research became an act of community building.

Before each interview, participants were asked to read over and sign a consent and confidentiality form. This brief moment offered time to both process the coming dialogue, ask questions, and/or express any comments or concerns participants might have had. *Humanizing through research*, a continual objective in this work, began with the creation of environments that "help provide a collective affirmation of identity, and allow for self-definition and self-exploration" (England 1994, 245). If interviewees felt ambivalent about space or preferred that I chose where to meet, I would reserve private rooms at either an on-campus library or at a public library in Boulder or Denver. Allowing participants to choose spaces in which they felt at-ease, asking only for them to be in public areas if we were unacquainted, offered a volitional and empowered interaction that countered the initial stabilizing of power relationships that "studying-down" on vulnerable peoples fortifies in traditional methodologies (Plesner 2011).

Along with the consent and confidentiality form, interview participants were given the option to fill-out a *face sheet,* which allowed for the quick and non-intrusive collection of demographic and less of-depth information, such as religious backgrounds, knowledge of resources, age, and ethnicity. Negotiating conversations that come from a methodology that creates "situations of inauthenticity, dissimilitude, and potential, perhaps inevitable betrayal" (Stacey 1988, 23), I struggled to find space for a breadth of narrative while also holding the responsibility, based in CU's Constitutional and cultural fear of death and suicide, as a *mandatory reporter* (MR).

The Down Side to Mandatory Reporting

Prior to each interview, I was constitutionally bound to confess my role as mandatory reporter, a system in place with positive intentions yet deeply disastrous effects. Not only did the IRB regulations pose significant barriers in conversation, but such disclosing creates a crack in the agreement of confidentiality, subverting the already marginal Interviewer-Interviewee trust, and re-creating power hierarchies of the subordinated-subject (Bartolome 1994, 180).

As Stacey (1988) claims, "fieldwork represents an intrusion and intervention into a system of relationships, a system that "the researcher is far freer than the researched to leave" (23). As a mandatory "outing" of an individual's deeply complex and multi-faceted grasp on suicide, ideation, self-harm, and depression, the act of compulsory informing pathologizes, even more extensively, the stigma and queer notions of dark mental headspaces. Creating *pedagogies of shame,* the performative role of reporting an individual for their "deviant behaviors" de-empowers the individual in their choice to either stay silent, seek help, or profess more publicly (Werry and O'Gorman 2007; Witzig 2015). If participants cannot trust that the researcher offers confidential, safe space, they are less likely to engage in communal, dialogical discourse (Morton and Oravecz 2009, 180), a hugely limiting aspect of institutionally backed research.

Many participants chose to craft a narrative or method of expression that kept themselves and/or others completely anonymous. Though, even amidst finding ways to evade mandatory reporting, the institutional grip upon this research was hugely restrictive. However, being that many participants were friends or members of my same social circles, if not in collective solidarity within the queer overhead, conversations during the interview-process were deeply impactful. The dialogic nature that aids in the circumventing of traditional, authoritative method-

stances allowed me to become more fully human amidst the of-depths responses. Resisting the notion that sharing of the interviewer creates less authentic, and more leading response (Paris 2011, 142), offering my own personal vulnerabilities gave participants the space to feel empowered in holding communal reciprocation and genuine dialogue (140).

Creating Genuine Conversation Space

The length of interviews ranged anywhere from thirty minutes to two hours, averaging at about one hour each. As I became more comfortable with asking questions, reading the situations, and finding space for reflection in each conversation, the shape and face of the data collection began to evolve. At about the eighth and ninth interviews, the middle marks of collection, I noticed a more frequent and growing comfort in corresponding and expressing from personal antidotes with participants. This dialogical progression became a balancing act between connecting and sharing with interviewees and not trying to persuade them of my personal opinions and views. Many participants stayed after interviews concluded to speak off-the-record, and talk more intimately about their feelings and orientations at the intersections of queer identity, suicide narratives, and personal evolutions.

Too, when given the choice, many participants also opted to find a space outside, orienting towards shady, grassy areas. More than not, both the participant and I came away with stains on our clothing from sitting or lying amongst wet grass and vegetation. *Queer Ecologies,* or the notion of nature as a relationality in the decolonization and de-exploitation of human bodies and land bodies (Barad 2011, 126-133), acts as a more-than-human ally for many queer or socially-marginalized individuals. *Nature,* or the notion of what is right, prescribed, and normal, has historically been used as a social Darwinist critique of "homosexuals…women, people of color, and indigenous peoples" (Morgensen 2011, 51). However, in this research an interesting perspective of the natural setting and plant-based beings arose, orienting towards green, out-of-door spaces as wild, physical allies, and raw supportive environments.

The only issues that arose with most of the interviews held outdoors was the lack of predictability that came with environmental distractions. Some interviews were moved once or twice to accommodate the nearing leaf-blowers and lawn equipment, others to reinforce confidentiality and privacy as others drew closer to the interviewing areas.

Embodied Research

In conventional research methodologies, and as I have discussed previously, there is a clear hierarchy of mind-over-body that privileges thought over physical feeling. This concept is deeply engrained in western culture (Ellingson 2017) and promotes scientific study and research that is completely void of personal perspective. Left out of our orderly research reports and sterile interview environments are the embodied experiences of the researcher and the participants. Standardized expectations of writing "circumscribe the types of bodies that produce and are produced by" qualitative research (172), which seek to build normalized, formidable body rhetorics that erases the disordered and unruly nature of physical life.

As an alternative, albeit still power-imbued approach, I have sought to embrace embodiment as a set of fluid, unbounded "practices—cognitive, emotional, physical, reflexive, [and] engaged" (Ellingson 2017, 6) that (***De)composes bodies*** in research. Based in queer and crip composition theory, the decomposition of bodies is a term that McRuer (2004) uses for the di-institutionalizing and de-arranging of understandings and perspectives around how academics interact with their participants.

Current western research methodologies often write about and compose straightness, normalcy, able-bodiedness and biological perspectives around identity (McRuer 2004, 53) into large qualitative works. However—by centralizing the body—fleshly experiences and physical perspectives imbue qualitative research with *queer* methodologies by moving away from the central paradigms of mind-over-body. Instead, they orient towards the ill, disabled, mixed-race, transgressive, "out-of-gender", and "out-of-bounds experiences" of real people with physical experiences. (53).

This embodied work of autoethnographic and qualitative approach does not offer structuralist and oversimplified "solutions" to suicidality. Instead it orients towards queer experiences for better grasping the actually physical lives of individuals who experience suicide, depression, mental illness, and oppression, through a wrestling and learning with the semantics of creative and complex bodies (Ellingson 2012).

Data Analysis

A combination of analytical techniques helped inform and sort through the qualitative data of this work. Based in *grounded theory* with its "epistemological roots in positivism, pragmatism and symbolic interactionism" (Thornberg and Charmaz 2014, 154), the construction of this research is founded upon the inductive, continual, and fluid construction of theoretical understandings amidst the gathering and processing of data (Charmaz 2006). I have, thus, oriented towards analysis as rooted in "actions and processes" rather than motifs and structures of participant narratives (Thornberg and Charmaz 2014).

Interviews were transcribed at length by an accredited service, and, while the transcribers offered quality work and quick turn-around, they certainly lacked the context for interpreting the complex data accurately[21] (Saldaña and Omasta 2018). However, I was able to mitigate any losses in context by listening into each interview while reading though the transcripts, during the first round of coding, and inserting or noting aspects of the interactions that seemed pertinent, such as laughter, sarcasm, pauses, or crying. This offered a reassessment and refortification of accuracy within the data.

Too, being that each interaction was transcribed after the initial recording, I was able to go through the written documents and code prior to my next interview. In the grounded theory process, this allowed for a comparative analysis of my data as I was collecting it, helping to generate more inductive and fluid concepts that I could further explore in my future conversations with participants.

The transcriptions, themselves, where analyzed based in Riessman's (2005) method of narrative analysis as the systematic "study [of] personal narratives of experience" (5). Based in the *performance* of "storytelling [as] what we do with our research materials and what informants do with us" (Riessman 1993, 1), this process of analysis focuses in on bridging the gap between standard research methodologies and "naturally occurring conversation" (Mishler 1986).

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[21] By "accurately" I mean that transcriptions encompass the holistic understanding and contexts of the situations in which interviews were held. This includes grasping non-verbal intonations and expressions, as well as personal vibrancies of character like sarcasm and voice changes, discomfort and confusion.

Storytelling and story-receiving are a relational activity, a fluid and collaborative process, and an iterative means of learning (Riessman 2012, 368). Thus, using a more person-oriented approach that blurs the lines between myself, as researcher, and my participants, as interviewees, generated the possibilities of discussion and comprehension beyond traditional approaches (Mishler 1986, 67). *Performative analysis,* then, is an extending of interactional approaches, to understanding interview narratives as a "doing" rather than a just a telling (Riessman 2005). In this sense, narrative is grasped as *praxis* in an embodied approach of involving and moving the audience through language and gesture (5), a collaborative construction of meaning (4).

Coding

The first round of coding was based in **sensitizing concepts** (Van den Hoonaard 1997), or as Given (2008) terms them "the constructs" that are derived from interactions with the participants, and the distinctive, "natural terms" used within a population, that help inform the interviewer of "possible lines of inquiry" (812). These concepts offer general themes and senses of orientation for the researcher, especially amidst semi-structured interviews. By color-coding my broad senses of thematic referencing, I was able to grasp more foundational thoughts and topics for deeper analysis to come.

The second layer of examination for this work was based in the more finessed and strategic coding of my *initial structural framework* built upon sensitizing concepts (Bowen 2006). Using **the constant comparative method** of grounded theory (Glaser and Strauss 1967), I took the general color-coding of themes in my transcripts and broke them down into specific categories, so as to create a thematic-web that structured the emerging themes into a more concrete and palatable format. Based in grounded theory, the "essential feature" of the constant comparative model is founded in the method of comparing each unit of data with the "previously collected and analyzed data" so as to create variations and understandings "that exhaust all angels of the topic" (Mathison 2005). Focusing on the subjective and personal encounters with the participants, I was able to create what Tracy (2013) terms a *systematic codebook,* or "a data display that lists key codes, definitions, and examples" to be used in my analysis. Using suggestive symbols for each new concept under the broad thematic points, I built a "legend" for my analysis to come.

In the third round of investigation, I used a brief "primary-cycle" of coding to help fortify the thematic concepts and narrative quotes that I found pertinent. Then from there I utilized my codebook and transcriptions to compile an in-depth database of *exemplars,* which are the "embodiments" of themes and concepts that help the reader integrate better into the qualitative research processes and findings (Tracy 2013). Doing this allowed me to go back through the interviews an interrogate how each theme and concept appeared and was expressed, illustrated, and uniquely understood.

Valid, Consistent, and Quality Data

Based in the above-mentioned data and analysis methodologies, this research has produced rigorous, reliable results and has prompted new discussion on the topic of suicide in the queer community. ***Procedural validation***, as the research design and analysis "that inherently improves the fit between the reality studied and the theory generated" (Walther et al. 2017), has been built by producing enough data to support the research and delving into and analyzing the data with great attention to reliability and multi-faceted approaches (Patton 1999). Thus, any social scientist familiar with these qualitative techniques might interrogate the producers and patterns in this research and see the data as rich, strong and, viable.

This work's high level of reliability is based in multiple methodologies for coding and analysis as an approach of ***crystalization*** (Ellingson 2009) where each method reveals different aspects of empirical reality (Patton 1999, 1192). By combining different techniques and "multiple lenses" and forms of representation for each level of coding and analysis, I was able to garner a more impressive grasp of the thematic and conceptual motifs that arose through each interview (Tracy 2013; Ellingson 2009).

A "continuum approach", like crystallization, resists dichotomies and polarities in research and creates a fluidity that produces rich, complex, embodied interpretations of data with a high amount of reflexivity for myself, as researcher, and as participant (Ellingson 2009, 10). This work, then, is structurally sound and scientifically valid in its bodily, affective strategic coding and analytic techniques. By understanding the implications of working with bodies in written analysis, I have been able to more deeply access and initiate person-oriented perspectives and (de)compose normative westernized subjections and rhetorics of the body. *Queering Suicide* offers a de-structuralizing of international self-death and depression by negotiating the

corporeality of myself and my participants every step of the way by embodying perspectives and destabilizing the mind-body hierarchies.

FINDINGS AND DISCUSSION

Communal Experiences

Homosexuality as a Disorder: Outsider status

> "I hated myself so much, I remember waking up every morning and feeling my heart beating so fast because I didn't want [the feeling of being gay] to be true" (Payton 6).

Social norms, as the conventions, customs, beliefs, and rules prescribed by society (Williams 2011), are constituted, for many, both privately and publicly. These conventions are often based in religio-moral etiquette especially around sexual deviance and create *prescriptive expectations* or the aspects of engagement from which one is to refrain (169). As he is not out to his family about his queer, homoromantic identity, Blaine (he/him) uses she/her in public. When writing in Spanish, however, he uses male pronouns, but keeps that aspect of his life hidden. When talking about his family, he refers to their behavior—which is common in the Latinx community—as "don't ask, don't tell". "They'd rather not know" he says and is closeted to his sisters with whom he lives because "*la chisme* gets around quick".

Growing up and being educated catholic, Blaine recalls homosexuality being taught "as an inherent disorder, attached to original sin" and hides his experiences because homophobia is "violently enforced" in the Latinx community. As a kid, his family often fought him on what he wanted to wear and how he wanted to express, though now, out of the house, he feels more seen and understood by them. Finley (they/them) who is non-binary and asexual, was also exposed to scare-tactics and *strategized enforcement* (Mollborn 2017, 210) of homophobia at their catholic school in Plano, Illinois. "There was definitely a mentality of 'being gay is bad', 'being sexual is bad'" they pointed out, reflecting on the homophobic rhetorics they heard frequently.

From a young age, Gray (she/hers), a white, queer, gay woman who grew up in rural Colorado, was also taught by her evangelical church that homosexuality was sinful. "If you're gay you go to hell" she said simply, recalling the "parameters" of membership (Blum 1970)

imposed upon her where "a woman's job is to marry a man, have kids, start and family, and raise them in church".

As such, when she came out as a lesbian in college, Gray was chastised and sanctioned from afar for not adhering to the norms in which she was raised (Williams 2011). With community comments on her clothing choices and personal expression like "not dressed your best today, pretty girl?", she faced an immediate squelching by family members who were afraid of the loss of status in their church and town. Slowly, Gray became estranged from her family, "choosing to protect [her]self" from their judgements by "avoiding [the town] as a whole". Kai (she/her), a queer bi-racial woman, experienced a similar sanctioning and policing, though was immediately disowned by her mother when she came out. She has also raised in a church that both believed "people of different ethnicities weren't supposed to mix" and that homosexuality was a sin, and so experienced the *slow death* (Berlant 2007) of internalized self-hate and lack of belonging her whole life.

Amidst Christian religious contexts, Parsons (1964) notes that sexual deviance is seen as extending from *within* the individual, and thus deference to the institution and religious authorities is deemed critical for one's "escape" from sin. In their childhood Baptist church, Halle, (they/them), a non-binary, gender-queer individual from Denver, was taught that if one experiences any sort of homosexual desire or suicidal ideation, they "should just pray it away…or start going to church [and] talking to the pastor more". Homosexuality was condemned in their church and, if ever they were feeling "sad", there was no other rhetoric of support besides "go to god".

<u>Silenced and Misunderstood</u>

There is often a notion of silencing from familial and church authorities when people experience deviance or if there are "rumors" of *queer* events that have happened in the community. Sid, (she/her-they/them) a queer woman, was raised in the bible belt of Georgia, where "some Baptist churches preach hell fire for queer individuals". She/they grew up amidst intolerance, though her/their church was relatively hushed on the matter of homosexuality. It "wasn't called out" but when she/they started to feel sexually deviant, "one of the first things that [she/they] felt was guilt". In recalling the experience, Sid remembers thinking "I can't tell people because I know, in some way, that it's not okay". Finley also spoke about embodying or

internalizing of deviance from childhood onward, saying "I've been raised in this idea that [sexual deviance] is not something that's normal. It's not something I should be telling people".

However, for many participants, the broad, overarching experience of deviance is often hard to put one's finger on; feeling "wrong" and "different" comes from deep historical and cultural norms around the *repression* of sexuality (Foucault 1990), and are particularly poignant for myself, as both a researcher and a queer individual. In growing up Catholic, I came out as "confused" around the age of 18 years and was condemned to hell the first time I ever told my mother that I might not be "straight". Around that time, especially in that I was discerning nun-hood, I was also told by my religious organization's head priest that there was "help" for me, and that gay conversion therapy would make it so that I was able to function "normally" in my religious roles.

The effect of *Hate the Sin, Love the Sinner* as a mediator of aggression and religious perspective—and something that Krull (2017) writes on amply—was a foundational perspective in my orientation of homosexuality when growing up. It was socialized at home and at church that "radical" loving was accepting all people and seeing their sins as deviance beyond their humanness. However, much of the rhetoric I was socialized in as a young child was a process of normalizing blame-shifting, where sin was the issue, not the sinner, deviance was the issue, not the queer. These rhetorics acted as a religious priming for the neoliberal perspectives of "saving" myself by "choosing" not to be gay that I continue to unravel daily.

Misconstrued, Mistaken, and Mixed Up—Generational and Social Gaps in Understanding

Unraveling socialized and internalized homophobia is a deeply painful and often ostracizing thing for myself and many participants in this work. There is a deep experience of being deemed "sinful" and "wrong" by familial and religious authorities in childhood, through which many people experience a deep loss of connection and understanding amidst their kin and blood relatives later on.

Coming from the physical and emotional spaces of university life, when Halle visits home, they "feel erased" as a non-binary person, where hiding their pronouns and full identity is a "security thing". Because deviance acts as a *relation* and is informed by social interactions (Love 2015), Halle obscures their identity, especially around the reactivity of their mother and

sister who "[would] just freak out and be like 'you were born with a vagina! You're a GIRL'". Finley feels similarly misunderstood, saying that, when they opened up to their mother about gender-fluidity and asexuality, "she didn't say anything" then wrote their experiences off as a "phase" and changed the subject.

Many participants remarked feeling like their parents and families could not quite grasp their gender and sexual identities, which led to divisional feelings and disconnect in the family. Plummer (2010) offers insight into this lack of understanding arguing that "sexuality is always locatable in social worlds" (169) and "all knowledge is shaped by and dwells within generational structures" (171). Thus, *generational sexualities,* as the socialized norms of sex and gender for a generation, create substantial disconnect between individuals of different ages and generations, especially for people born in the millennial generation who are often trying to reconcile their identities with their baby-boomer parents and guardians.

Many queer individuals, in such a way, feel completely lost to their parent's and guardian's perspectives. Kacey (they/them) expressed discomfort to me when on the topic of "coming out" to their parents, saying that "gender stuff" is too "out there" for them, a sentiment Houston (they/them), a gender non-binary individual, said about their parents who have been "limited in understanding", especially their father who "understands wanting to be a man" and "understands wanting to be a woman" but cannot conceptualize "not wanting to be either". Blithe (they/them), who is also gender-queer, spoke about hearing their mother outwardly express transphobic sentiment and who "won't acknowledge" their pronouns, making them feel vulnerable and unsafe when they visit her.

Beyond the socio-religious contexts of homophobia, many parents and guardians, often based in the baby boomer and Generation X cohorts, struggle to parent individuals in the younger millennial and Generation Z cohorts. The majority of folx over the current age of 45 were socialized within the historically demarcated "parameters of heterosexual[ity]" (Rowntree 2015) and find difficulty in the interacting with and comprehending of more modern radical expressions and understandings of queerness, sex, gender and deviance.

Social Perspectives on Suicide

Amidst the many interviews for this work came stories, too, of experiences with church and family reactions and discourse around, not just queerness, but suicide as well. In her church, Gray remembers the rhetorics of "if you're depressed, you're crazy" and of suicide being thought of as "ungodly". Founded in the teachings of condemnation, death was centered around salvation and the belief that "if you commit suicide, you're going to going to hell". Gray recalls that "when someone committed suicide, it was a huge shame on that family, and families were often embarrassed, which explained her own family's reaction to her first attempt as a junior in high school. "My parents were disgusted by me…so disappointed", everything was very "hush hush" and they told her not to tell anyone in order to kept things "very quiet".

In Halle's church, too, "there was a very negative connotation towards suicide". They look back saying, "we didn't talk about [a community member's death by suicide], we would just say that they had some sort of illness or they died of a stroke or something… or some people would just say they would die of unknown causes". Both Gray and Halle experienced the "impersonal sets of rules and regulations" that their communities, especially at church, created around the defining prescribers of norms on death and suicide (Gordon 2007). Religious rhetorics, thus, became the social analytics that drove the taboo topics and experiences into secrecy.

Suicide is often understood in medical and religious institutions as embarrassing and shameful for all persons involved. Skye (He/Him) recalls his mother attempting suicide when he was 9 years old and, as "she wasn't honest about it" and lied about her wrist wounds, it became "something to be ashamed of or stigmatized". He remembers feeling "like she shouldn't be experiencing mental illness as she was, and she shouldn't be coping in the ways that she was". Skye's experience offers the perspective of a young person and the stigma that is socialized around suicide and depression, from a young age, as wrong, bad, and, in many ways, immoral.

Personal Note: this work is by no means motivated to singularly critique religious and medical institutions. Faith and spirituality, specifically, are often vital to recovery and act as support-mechanisms for persons struggling with ideation, mental-health conditions, and depression (Medlock 2015) and, thus, can prove critical for queer wellness amidst high levels of self-hate and self-injury related behaviors (Stroud et al. 2015). However, what this work does

critique is the bigoted, hate-based reactions to suicidality and queerness in religious and familial structures that have gravely affected the narratives for many participants in this research.

Medical Experiences

Mental Illness as Deviance

Many participants in my research verbalized feeling pathologized in their experiences with medical staff at various hospitals and institutions. Skene's (2002) notion of *social normativism* is present in the stigmatizing of individuals with *abnormal* or *a-typical* personality traits and experiences. As a non-binary, transmasculine *boy,* Skye spoke a lot about the issues with institutionalized perspectives on recovery, feeling that queer and marginalized groups are often dehumanized and subjected to *disorder-type* classification (Skene 2002, 117), the dominant solutions of which are, according to him, "super-oppressive and fucked" (Skye).

The internalizing of shame in being deemed "damaged" or "sick" created personal feelings of stigma for those participants who had direct experiences with metal-health interventions especially. For Gray, being forcefully hospitalized and deemed "a danger to herself and…others" created deep experiences of humiliation and self-disgust. Pescosolido (2015) speaks on these experiences of humiliation and shame as the "social phycological ramifications of being diagnosed with mental illness" (273).

Olive (she/her) a queer woman grappling amidst the suicide of Cameron (they/them), her younger sibling, saw her parents immediately medicalize and blame the intentional self-death on mental illness. Their rhetoric was that "Cam was bipolar or something", while Olive feels, as Cameron was "really sensitive" and never quite resonated with their assigned sex, that "there [was] just a lot of feeling out of place" which should not and cannot be blamed strictly on mental illness.

Normalizing Rhetorics

Normalcy, then, or the institutionally based designations of *competence,* has at its root the pathologizing of emotions. Hayden (she/hers), in relating to her alcoholism and depression as a queer black woman, narrated the experiences of wanting to make herself "more normal", saying

"I've always just felt like an outcast…ostracized and different, and that I don't fit in and that I don't adhere to the social norms". Payton (she/hers) also talked about experiencing shame similarly, both through her own moments with depression, anxiety, and self-hate, as well as in watching her close friend Micah (he/him), a trans-man and a person of color, die by suicide.

Micah's death came as a shock to Payton and her community, as "he never talked about it" and denied being depressed. Clearly, this internalized *fear of deviance* that is placed on queer and marginalized bodies by medical and political institutions is substantive. Social misgiving around "the social devaluing of identities marked as *damaged"* (Goffman 1986) is a shared experience in the western world. Of the estimated 6.2 million adults that will experience major depression in the United States this year, 37% of them will go without help (Ahrnsbrak et al. 2017; Singh 2016) for fear of being deemed "sick", or problematic.

Understanding internalized deviance in queer communities, thus, necessitates grappling with the ways in which "scientific research and theories are shaped by historical, political, social, and cultural processes" (Erwin 1993, 449). For Houston, especially in working as a Resident's Assistant at their university, the fear of stigma around discussing suicide and mental illness is unmistakable. They told me that "I have friends who have expressed to me their…anxiety [around] discussing suicide with other people because of its taboo", a social uneasiness which is rational amidst prescribed and policed normalcy in medicalized, large-scale, bureaucratic organizations (Goffman 1986) like public universities.

Describing their frustration with normalizing rhetorics around how individuals should "be" in society, Houston also noted the expectation productivity from students as a vital part of "adequate [social] membership" (Blum 1970). In order to be a viable part of day-to-day life, people are required to have "normal" c*ultural competencies* (44) or the capacities to fulfill membership "requirements" and expectations (Parsons 1964). Noticing students outside the window of the small dorm office in which we were talking, Houston looked on and explained with great frustration that "if you're not productive for many reasons including mental health, then you are not [welcome]" on campus, or in normal-day-to-day social interactions.

In many of Houston's work settings and experiences with young adults, the medicalized categorizing of deviance as mental illness emerges as immediate reactivity on part of the education administration. Forcefully removing students and faculty from on-campus experiences,

or mandating treatment and therapeutic services, lacks empathy and accommodation for the individual as a human, acting more as a function of "fixing" rather than a supporting of the person.

Membership into Deviance

The term "mental health" is concerned with one's *ability* to fill social expectations of membership (Parsons 1964). The reactivity that Houston and other participants have witnessed on their university campuses not only parallels much of the immediate action to suicide, depression, and mental illness taken in western society, but also spotlights the issue of membership as denounced by mainstream rhetorics.

For Sid, growing up "privileged" in the South around much intolerance led to internalized self-depreciating rhetorics when, at 16 her/their depression began manifesting in notable ways. Using self-harm, like cutting or banging her/their head against the wall, Sid hoped to manifest the deviance she/they had internalized. Her/their mental experiences depicted the chaos and personal pain of feeling abnormal or like a member of a deviant community. In telling herself things like "you're wrong, you're stupid, you did all of this [it's] your fault", "self-punishment" became her/their reaction to feeling stigmatized, "sick" and pressured "to figure [her/their] shit out".

As Marsh and Shanks (2014) have discussed at length, membership into mental illness is a "slippery slope" in which "emulating dysfunctional behavior" can feel like "the first step toward being a member of a disorder category" (1022). In Sid's case, and with other participants, the *labeling* of oneself generates feelings of "wrongness", abnormality, and deviance (Scheff 1999). Experiencing oneself as a *member* of a deviant community can socially and personally propel an individual's internalized stigma and questionings of worth.

As non-binary, Kacey began experiencing themself as (sexually) different in middle school, and, in high-school, fell into depression and ideating episodes. "I'd just be so exhausted all the time, I never wanted to shower or anything", and they struggled to remain active at school, "losing interest" and staying home often. With the concern of their parents, Kacey sought medicalized labels, admitting that "for a while I thought I had bipolar [disorder]", a concern for which they later got tested. In this vein, Individuals are often encouraged, through medicalized

approaches, to seek answers and exemption for their deviant experiences in the *sick role;* this both deems the person helpless and dependent on the institution (Parsons 1951), yet removes the blame and condemnation by medicalizing deviance as mental illness.

Medical communities and membership can confer "essentialist identities" onto individuals by informing and distorting the nature of who belongs and who doesn't (Ballard 2016, 79), a categorization that offers broad based institutions the "sociological and ideological" benefits of control (Weitzer 2002, 197). Membership into medical categorization, for many participants, was based upon their internalizing of and fear around being categorized as deviant. This intra-personal manifestation of social stigma around suicide, ideation, depression, and queer identities encouraged people to diminish themselves amidst medical perspectives. Too, the sick role, while offering an individual some reprieve from social roles and expectations, is only valid if people acknowledge and accept the "inherent undesirability" of their conditioned deviance and, thus, acquiesce to the care of the medical institutions, working to *get better* and overcome their personal issues (Weitzer 2002).

Getting Better and Getting Better Fast

> "Either you have a transactional relationship where you receive the therapy you need to get better or [you] don't. And if you didn't do that, you failed" (Skye)

In the sick role, the "stigmatized individual" *must* attempt to correct their condition by private effort and devotion (Goffman 1986) as "expeditiously as possible" (Parsons 1964). This is a function of "cooperative" recovery that what I will term the *It Gets Better* (IGB) complex in medicalization and pharmaceuticalization. Forcing "hope" and normalizing rhetorics onto deviant bodies, this work bases the complex off of a broad critique of the *It Gets Better* campaign's "straight temporalities", linear futures, and *passive generativity* (Goltz 2013, 140) into the collective "sick role" placed on queer, ideating individuals.

Kai had three suicide attempts in 4 days, the last of which proved successful. She was institutionalized after the first, removed from her solitary hotel room and placed onto a 72 hour hold at the community ER. In being hospitalized, "she felt like a caged animal" and, having attempted and been institutionalized before, was then rejected from many correctional facilities and transitional homes. She would not cooperate or consent to care, going on food fasts as

protest, and, while in therapy, had been passed from provider to provider, which contributed to her feeling "dumped" and hopeless.

Paxton, Kai's partner at the time, reflects on how frustrating it was to try and prevent the suicide attempts, talking with law enforcement, various social workers, and medical staff to find long term treatment where, in the past, Kai had responded promisingly…

> *"They were saying, well you know, if none of these places take her, we're just going to have to hold her for 72 hours in the ER, and then just release her. That's all we can do"* (Paxton).

After her last time being hospitalized, the ER did release Kai and she died by suicide hours later, retreating into the mountains away from institutional grasp and social expectation. In the IGB medicalized complex, Kai pushed against notions of physician and medicinal-based recovery and refused the "hope" discourse situated in psychiatric "therapeutic agencies".

Without speculating and condemning the medical institutions that saw and "treated" Kai over the years of her attempts, I would like to make it clear that she slowly lost favor of those designating membership in the "sick role", and as such, was lost to the "regenerative" forces of medicalization (Parsons 1951, 211). Medicalized perspectives—while offering benefits to individuals willing to accommodate the academy—may also seek social control in a way that optimizes erasure and displacement of individuals thought to be "overly" deviant and socially immedicable.

Refusing to Get Better

Constructed as both a medicalized and social issue (Dumit 2004; Grzanka and Mann 2014), suicide of queer individuals fits at the intersections of neoliberalist rhetoric and the reduction of "merely cultural" economic and political categorization (Butler 1997, 267; Garwood 2016). Thus, the medicalization of IGB produces notions about suicide as a "production" of weakness on the individual's part, promoting their inability to "withstand the realities of the social (world)" (Grzanka and Mann 2014, 377) without the aid of therapeutic forces.

Kai, in many senses, refused the psycho-analytic renderings of queer trauma (Cover 2012b) and therefore negated the *cultural politics* (Ahmed 2014) of mental health. Moving beyond the medicalized, affective economies and rejecting the fantastical futurity of homo-

normative "recovery", she went *wild,* a term Halberstam (2014) describes as the "space…beyond current logics of rule" (138). In her *wildness,* Kai shows us "an alternative logic of being and doing" (145) that leads us away from the IGB politics of medicalized neoliberalism and into a radical alternative of self-control.

"The Creature doesn't ever go away"

For many participants, suicidal ideation and stigma based on queer identities are not things that can just "get better" and go away. Sid expressed ideation as something that she/they always carries with her/them: "I can't put it down…It's a beautiful and hurtful and wonderful thing that's a part of me". Halle, in this vein, likened ideation to a *creature* that sits on their shoulder and gets either more or less difficult to carry based on "how bad society is" amdist the exhaustion of daily events and social interactions. In these difficult moments of depression, Halle spoke about the creature (ideation and darkness) as getting "bigger and bigger", and "heavier and heavier, and you just want to stop walking, or stop going, or stop doing things". Acknowledging that this creature-esque experience "won't ever go away" is a radical perspective for both Sid and Halle, amidst the IGB medical-frameworks expecting full and, often immediate recovery.

Kacey, too, had this experience after going into outpatient care for ideation and depression, noting that, after a while, they "just started to go back down", feeling more like a burden and becoming increasingly jealous of other's who died by suicide "because they were dead "and attempting suicide would have", amidst the internalized deviance, "validated" their personal pain more than the medical institutions had. Hayden has also continually experienced depressive and ideating states, both before and after her medicalization and time in the 72-hour hold. "I don't know if they're really spurred, they're just kind of always there and I just sink in and out of them" she said calmly, speaking to her experiences as normal, day-to-day events.

Pharmaceuticalization

Pharmaceuticalization, as a response to the mandatory IGB rhetorics in mental illness and ideation, is often based in the de-valuing of outwardly affective and a-typical mental and personal experiences, which are frequently diagnosed as disordered conditions and then treated with medication (Chriss 2013). *Prescribing-for-normalcy,* as Holt (2004) has offered it, is based

in the mainstream rhetorics of *normal* as fully-functional, beyond and away from the "full range of human emotions" (Lane 2007).

Grey mentions a conversation with her therapist after her second 72-hour hold, which centered around her fear of medication and the somewhat forced "zombie-like" experience she had had in the ER. Her psychiatrist's reaction was…

> "Gray, it's not your fault that you have a chemical imbalance in your brain. That's not something that's wrong with you. That's something that we're going to help you get through" (Gray).

However, diagnosing the individual as deviant and blaming brain chemistry is not always a productive and person-based approach. Grey recalls, after that conversation with her therapist, being put on the anti-depression and anti-anxiety medication Zoloft and being unable to cry for 7 months.

Olive, who has experienced severe ideation and also lost her queer sibling to suicide, expressed to me the pain of both being involuntarily *outed* as suicidal after a college roommate read her journal, and being required to see a therapist who immediately put her on anti-depressants.

> "I just don't really believe in anti-depressants, I'm pretty anti after being on them and reflecting on my own experiences with them. This was a social problem, not a problem with my brain. I didn't have any social support or network, and humans are social creatures, even the most solitary and introverted of us" (Olive)

Olive's experience of needing social support but instead being considered deviant and, thus, immediately medicated is, unfortunately, quite common. The issues with the "physical withdrawal symptoms" and strange mental states "were a lot to handle", which—later on— pushed her to find other resources. "Having done the drugs and [feeling like] that's not the answer", many participants realized what Lane (2007) and Busfield (2010) have deemed the profit-oriented lack of care in the pharmaceutical industry.

Over-dose as an Enabler of Suicide

Some participants also noted "stock-piling" or easily assessing medications—theirs or others—to attempt to or successfully die by suicide. Kai's body was found in proximity to pill

and alcohol bottles, and both Halle and Hayden mentioned attempts based in overdosing on pills. In their most recent report, The Substance Abuse and Mental Health Services Administration found that, in 2011, there were over 200,000 Emergency Room visits resulting from "drug-related suicide attempts", 94.7% of those involved prescription or over-the counter medication (SAMHSA 2013, 10, 59). More recently, The Center for Disease Control reported that, in 2016, there were an estimated 5,086 suicides by drug overdose (CDCP 2018, 66) and SAMHSA (2015) reported an estimated 39% of emergency room visits are based on drug-related suicide attempts, many of which often include alcohol.

Acknowledging the huge role of western culture's methods in over-prescribing as related to suicidality, queer experience, and the rhetoric of "acting normal", allows this work to better access mainstream medical and social rhetorics of deviance and productive normalization. Pharmaceuticalization often then, at the beck and call of medicalized rhetorics, "treats" emotional symptomologies as illnesses, which, at best is ineffective, and worst can lead to the misuse of medicines in suicide (Busfield 2015; Bohnert and Ilgen 2019).

Benefits R Us—The Bright Side of Medicalization

As a researcher and a participant, medical and pharmaceutical anti-suicide politics have created, in myself, experiences of "sickness" and deviance. I, like many interviewees, have experienced the debilitating effects of anti-depressants and pharmaceuticals prescribed to me for ideation. Yet, it is important to note that this work is not founded upon the vilifying of medical and pharmaceutical institutions, in fact, as Rose (2007) argues, medicine provides a unique and vital role in western civilization, and, when used appropriately and rationally (Esher and Coutinho 2017), can change lives.

From personal experiences, as well as community narratives, I believe there is space for medicalized processes in the complex and deeply human experiences of queer suicide ideation, and mental illness in general. Marcel (she/hers), a trans-woman who moved to Boulder in hopes of a safer place to transition, said that she's highly medicated and deeply reliant on her emergency anxiety prescription to simply making it through the day. However, she feels like the mix between psychiatric support and her incredible "trans, non-binary" therapist "who loves folx in trauma" has helped keep her afloat amidst the eb and flow of daily depression and ideation.

As medicalized therapeutic services function, many participants, like Marcel, have reported feeling supported though their counseling services. Paxton, in looking back on times when her partner Kai was slipping into deep depressive episodes and ideations, comments that therapy "was the only thing sort of keeping me sane". Hayden too has said that therapy was transformative (before she lost health care coverage), and even her diagnosis and prescriptions got her "through some darker times" by "numbing the pain". In these experiences, Weitzer's (2002) *bright side of medicalization* is at play, where patients in depression or other mental spaces, are not considered evil or morally corrupt, but treated as persons with a disease and in need of medical professionals who are deemed "beneficent and honorable" (200).

However, amidst the sprawling pharmaceutical industry and mainstream rhetorics based in the normalizing of "deviant" mentalities, pharmaceuticalization and medicalization can become dangerous and drastically effective. Not only is mental illness and ideation considered deviant, "dying voluntarily [due to suicide] is ostensibly illegal" and attempts are "routinely punished by incarceration in a psychiatric institutions" (Szasz 2011).

Mental Contagion and Social Ejection

> "I can't imagine anyone going in [to the prevention facilities] and being like 'oh I feel better now'" (Gray)

In many of this work's personal accounts around suicide, the notion and question of suicidality as "spreadable" came into light around how individuals felt stigmatized or *quarantined* due to their experiences. Caleb, who like Marcel, also moved to Boulder for the transition-friendly insurance and community initiatives, was very adamant in his remarks on suicidality. He experienced suicidal ideation after transitioning but felt like it was his responsibility to the trans-community to not act because "suicide is contagious" and "one of the biggest predicators of suicide is knowing somebody who has committed suicide".

While there is some thought that *suicide-as-imitation* is a media-based contagion indicator for copy-cat type action in various communities (Romer et al. 2006; Yıldız et al. 2018; Mueller and Abrutyn 2015), there is much bias and lack of clarity as to how media and televised portrayal of suicide effects large groups (Ferguson 2018; Cheng et al. 2014; Stack 2000).

The fear around suicidality spreading is a visceral and painful experience for communities who have members with high rates of ideation. While treating self-harm and mental illness as a contagion is very common in institutionalized medical practices, for communities who have lost individual members, suicide can feel like a pandora's box opening. Sea discusses this in the wake of losing her dear friend, Kade, to suicide, an experience she likens to a bomb going off in her queer community.

> "It just feels to me fundamentally pretty unfair that [Kade's self-death] has created—in a more vivid and accessible way—suicide as a choice for others who will follow in their footsteps in this community" (Sea)

However, suicide as a contagion promotes fear discourses in many communities and individuals alike, though, this work is based in the *queering* of suicide, which acts to highlight the personal experience and alternative approach to intentional self-death, ideation, depression, mental illness, and those relations to queer livelihoods. Looking at how institutionalized fear of suicide has created immediate and retroactive action-based rhetorics in medicalized spaces will tie together the issues of membership, sick-role-making, and deviance-as-illness classification in personal, dialogic experiences. In our talk together, Houston mentioned that their sister, who is a queer trans-woman, has expressed…

> "a fear of being institutionalized. Not explicitly because of suicidal thoughts but because mental health is something that requires your removal from society –Like, if your mental health is something that doesn't allow you to function in our capitalist society…then you need to be removed from it. Be that forcefully, at your expense, [or] at the expense of your life" (Houston).

The discursive constraints placed on queer bodies deemed *damaged* and impure—flaunting the failures of normativity—become stigmatized "civic identities" (Bennett 2015, 5). Mental illness, as a form of embodiment in the queer individual, furthers neoliberal and neo-colonial logics of "disability-as-threat", moving the *queer/crip contagion* out of the "vital fold" and into social and medical isolation (Fritsch and McGuire 2018, ix).

Insulation, then, as a basis of western medicalized approaches, forcefully ejects individuals who are seen as deviant (Szasz 2011). The fear of "catching" mental illness or suicidality in the same way as one might contract a physical cold or flu, is an evident social

belief (Marsh and Shanks 2014, 1023) and is one that requires immediate separation of *the sick* from *the healthy* (i.e. normal) (Parsons 1964).

Many interviewees expressed feeling completely dehumanized in the reactions they received to their expressed ideations. Gray, after also being "outed" as suicidal, was forcefully removed from her apartment in handcuffs and placed on a 72-hour hold. Her account of the facilities and treatment are harrowing, an experience of being "treated like an inmate" in holding, and one that she has been subjected to multiple times.

> I was closed and medicated in this cement room on this cot to just sit…It was like a punishment for what I had felt. There were no locks on the doors [and] there were no windows. There's a tiny TV behind glass. There are no sheets because you could hang yourself…There are no locks on the bathroom doors [and there were] windows so they could watch you. There was no mirror for you to break and hurt yourself. It was just so cold and isolating. (Grey).

While suicide has been majorly decriminalized in the United States—with the exception of a few states filing it under "common law crimes" (Mendelson and Freckelton 2013)—the historical stigma of ideation and self-harm "spread[ing] like germs" is still sub-culturally propagated (Wald 2007,137). Not only have participants in this research been forced out of day-to-day social interaction, they have been pushed into spaces where they are "treated like criminals", handcuffed and "taken in the backs of cop cars", given little attention, and "shut into a cement room".

Destigmatizing Rhetorics

Erwin (1993) argues that the "gay myths" in society are both that queer individuals have an "inherent psychopathology" that makes them suicidal as well as that social isolation and internalization of negative stereotypes" lead to ideation (437). Amidst these mythic, medicalized discourses of ejection, insulation, and rehabilitation, however, many participants sought to normalize what is stigmatized, taboo, and erased. For many, the prospect of *Queering Suicide* roots in the logic of critiquing neoliberal social institutions for LGBTQIA+ suicides and ideation, rather than criticizing the individuals themselves.

For Blithe, who has worked in various resource centers for LGBTQIA+ individuals and People of Color, taking away the stigma for individuals who have died by suicide, attempted, or

experienced ideation is a process of recognizing such events as "a societal harm done onto the person [or a] violence being enacted upon that person, rather than that person being the enactor of violence". Olive parallels this view, wishing that "people just understood that you're not a bad person for having those thoughts… especially suicidal ideation [which] is, for some reason, a natural response to emotional pain".

Jae (he/him) a gay man who lovingly skyped me all the way from Berlin to talk, also remarked that he though suicide was natural in the context of current-day society, something that, for Skye, reveals that the "white, hetero-patriarchal, colonialist…system doesn't work for anyone". Finley also remarked in our conversation that suicidal ideation is much more rational than people think it is and that "being sad and being angry at yourself and being insecure…and wanting to end your life is normal".

Sid, on looking back on her/their younger years wishes someone had taught her/them that "this [ideation] is an okay thing" and that "this is happening to lots of other people…which is a really hard thing to reconcile when you're young". Halle echoed this in saying "I think it's good to know that people go through [ideation], whether it's communal…or it's individual…it does happen" as a group commonality.

Normalizing suicide is not a creation of pro-suicide logics, but instead, is a process of building destigmatized discourse so that ideating and attempting individuals do not feel the need to hide and isolate in their experiences. Normalization is based in queering logics of taboo and stigma so that we, as communities and as academic groups, may gain more insight into how the effects of suicide and ideation ripple throughout individual and community logics (Pitman et al. 2017)

As we were ending our talk, Gray stood up and looked around and, after pausing looked at me and said "there's no face of suicide or suicidal ideation; it's not a lifestyle that you choose to live. It's something that you learn how to hide from because of societal pressures and because of taboo". She wanted to reiterate, for this work, that "the complex feelings" of the self-hate and lack of worth are valid, that *people are always valid in their experiences.*

Sociological Perspectives

The Rationality of Suicide

In this validity of personal narrative, Barry (1994), reevaluates a multitude of longstanding, critical western values like forgiveness and embedded freedom. In this reassessing of culturally imbued biases around intentional self-death in social lore and representation, the author argues that suicide—as a response to large and oppressive structural issues—can be *rational.*

In this perspective, then, of rationality, participants, demonstrated not only their grasp of sociological perspectives, but their personal understandings around the structural factors at play in queer, ideating identities. Skye put it well when we talked, saying "I don't think that [suicide] needs to happen on the level that it is or that it needs to happen at all. But given the context of our society, it just makes a lot of sense to me". Noting that he does not "believe that shaming the person who chooses to end their life is the direction that responses need to be pointed", Skye spoke on suicide, for many, as not necessarily feeling like a choice, but, amidst a lack of other options, "they might be making the only choice they have".

From this perspective, Blithe, too, commented on suicide as being directly corelated with communal experiences through "broader social systems that are highly destructive forces inflicting trauma upon marginalized groups…including queer and trans people". Sea also negotiated these notions when we talked, speaking to the trauma around aspects of current social experiences, like "[the] patriarchy…environmental destruction and sexual violence" and how, as these collective traumas are dealt with in complexly different and individual ways, "that doesn't mean a person who ends their life should be blamed".

Houston argued that "oppression is something that is intangible" yet "ever present" and Marcel tied into this around her personal experiences, verbalizing that suicide is really "the feeling that things are hopeless, that they won't change" and "because [suicide] seems like the only option when things just aren't going to get better", sometimes "it's all just loosing".

Suicidality, then, acts as the right to end one's suffering, where the personal experiences of pain, emotion and physical, exceed the threshold of the individual (Motto 1972). When suffering is a product of institutional biopower (Foucault 1990, 2003) and deep, historically

based erasure, suicide amidst the lack of autonomy (Onkay Ho 2014) and institutional factors of trauma, lack of access to care, and racism, takes on a rational and queer perspective (Barry 1994).

Trauma

Self-harm, suicidal ideation and attempt are often extreme ways of coping with traumatic experiences (Baek et al. 2018) and, in the narratives of this work, trauma has been a significant focal point for many participants.

Childhood trauma is directly related to an individual's suicidality later on in life (Zatti et al. 2017). Skye grew up with a father addicted to meth for 15 years and a mother who has had many, repeated suicide attempts. He was exposed to drugs and alcohol early in life and, amidst everything, took on the obligation as a primary care-taker for his younger sibling—aspects that forced adulthood and responsibility onto the nine-year old Skye in traumatic ways. Skye's depression and *passive suicidality,* then, grew amidst his unreliable, unpredictable home structure and the intense feelings of being left by his parents to cope with life alone.

Hayden narrates her childhood upbringing as one filled with pain and isolation as well. "I never really got what I needed growing up, as far as nurturing or any positive support" she said, "it was just like 'here's some boxed food. Get out of my room. Don't talk to me". Hayden also experienced "a lot of bullying" in and out of the home and was both sexually and verbally abused by her older sister. She remembers her self-worth being completely reliant upon sexual expression and that being "really the only thing [she] felt [she] had value in". Sex, then became a form of coping (Howard 2007) amidst the familial trauma, and "generally not feeling loved or having any sense of worth".

Sexual abuse and assault were also prominent experiences for other participants, a form of trauma that is often overlooked or erased for many individuals, especially female-bodied people (Murphy et al. 2011). Marcel, like Hayden, was sexually abused as a child by her stepfather and first began experiencing suicidal ideation amidst the PTSD, where her tactile flashbacks felt like she was being "haunted by a ghost". Gray was assaulted by an elder at her church and when it was reported to the police, the church condemned her for lying, saying "we

need justice for him". People assumed, too, that Gray "chose to be queer" because she was assaulted and would discredit her identity as a response to trauma.

Hayden, Halle, and Finley were all assaulted one or more times in various romantic relationships, and other participants noted their friends and community members experiencing rape or assault, often without justice (Lonsway and Archambault 2012; Temkin and Krahé 2008). As sexual assault and abuse are significantly associated with "emotional distress", belonginess, self-worth, and suicidal ideation (Bryan et al. 2013) many interviewees expressed self-hating identity questioning amidst processing the caustic events.

Lacking the Access to Health Services

Systemic injustices and health-inequalities are no new experiences to queer people, who are often used to lacking health resources, being denied health-care, and erased—completely—in the medical institutions (Rubin 2015). Hayden spoke to the difficulties she has had getting through the "sort of bureaucracy of low-income health services that are so limited" and where "they make it so hard for people to find…and access [support] and get what they need". When we talked, she was currently without health care and unable to seek therapeutic services, which she had found much support through in the past. Skye, also, openly critiqued these systems, speaking to the options of "treatment centers…mental health facilities, [and] behavioral health" as all being "astronomically expensive" and not "accepting most insurances", as well as being "gender segregated" and catered to "almost only white, wealthy people".

Kai, Marcel, and Hayden have all been forced to interact with the debt of medicalization and ambulance trips around suicide attempts and ideation, a huge cost for many Americans each year (Wiltshire et al. 2016) and which has caused significant stressors on each individual. With her insurance covering only half of all of her medical costs during her *required* 72-hour hold, Marcel told me that she has given up and "just kind of stopped paying" the bills and the debt. Paxton remembers her partner, Kai, feeling similarly, living in this "hopelessness of all the material stuff" that was "never going to get fixed", especially the student loan debt and her "medical bills from being hospitalized on and off so many times over the years".

I have also experienced the erasure of my identity in seeking medical care, as well as the inability to afford the hugely problematic monthly costs of health-insurance. Myself and the

participants of this research are not alone, over 47 million Americans express financial hardship around the lack of affordable insurance each year, and even more struggle to pay for health coverage with insurance (US Committee on the Judiciary 2009,7). The out-of-pockets costs for households and individuals who seek medical aid often lead to high rates of debt and borrowing (Patrick et al. 2018) which create suffocating financial hardships in which many people feel pushed to ideation and attempt (Coope et al. 2015).

Racism

Medical debt has also been shown to disproportionately affect African American communities in the United States (Wiltshire et al. 2016), a racialized issue that hits only the tip of the metaphorical ice-burg for Queer and Trans People of Color (QTPOC). For many of this work's participants of color, marginalization based on race is something that that they experience in both the queer community and in larger society (Erwin 1993,446; Collins 2000). There is also academic research connecting higher rates of depression and suicidality with marginalized groups of color, the *cumulative discrimination* of multiple jeopardies (King 1988; Sutter et al. 2016) amidst color-based lines drawn around medical resources, mental health and psychiatric services (Walker et al. 2014; Abe et al. 2006; Crosby and Molock 2006).

Erasure in White Queer Spaces

Many participants of color felt isolated, marginalized, and unwelcome in white, queer spaces. Blaine expressed realizing that he connects more with people of color based in comfortability and the solidarity around feeling oppressed and erased in large society. He also noted that he almost always prefers to go to out with people of color—"even if it's a straight club"—because he feels more comfortable.

Jae, as a man of color, expressed a similar sentiment around queer community, stating that "white queers act in an entitled, privileged way, where people of color are constantly unafforded an identity". He also explained not feeling "accepted" by white, cis, gay men, and, in that, understands suicide and self-harm as mechanisms of escape from both racism and toxic masculinity in his own communities.

In my interviews with participants of color there was also much sentiment around feeling "in between" communities and not quite being accepted in either. This is an experience Harris

(2016) speaks to where the "queer transnational body of color" is rejected by western, hegemonic society and seeks out " a sense of belonging or community within their own cultural subgroup" (148). However, that sense of belonging in communities of color is often found at the erasure of an individual's queer experiences.

Halle speaks to this divide, pulling upon memories from high school where they had "no support system" and felt like they "didn't want to be black and…didn't want to be queer" because they were bullied heavily. Stating that they could never pick one community "because they will always pick at the other identity", Halle felt isolated and alone, which generated feelings like "I don't belong here, even on this earth" and "no one really cares about me". Currently at their university, Halle "doesn't feel erased" like they did in high school, though they do feel "safer in the black community" there. They said that "when it comes to whiteness, I feel like that is something that challenges all of my identities at the same time…like being black, and fem, and queer, and trans" because "white hegemonic society…has so much power over everything".

Paxton, in speaking about her former partner[22], told me about the racism that Kai, as a bi-racial person, grew up around. Kai's mother, as a white woman, was extremely racist towards her child and would take Kai to a church that did not believe in the mixing of races. Paxton recalls that Kai "had a very deep, deep seated self-hatred", feeling torn between "wanting to be white" and being perceived as black, where she would never "let her hair be natural in any kind of way [because] it was hugely triggering for her". Paxton also notes that, amidst the racial and sexual prejudice Kai faced at home and in society throughout her life, she had really mentally and physically "packed up" a long time before her suicide.

Suicide as Escape

Amidst the structural issues related above, suicide and self-harm provide methods for *escape* for many individuals who experience multi-oppressions and double jeopardies (Baumeister 1990; King 1998; Davis 2009; Clarke et al. 2016), in and beyond the white community. In the contexts of working with participants, self-harm took on many different

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[22] Paxton is a white woman inferring about Kai's experiences as a queer, mixed-race person because Kai is unable to tell her story herself. While there may be some biases in Paxton's recalling, there is validity in the reflections around community and personal identity rifts.

expressions, cutting and biting, hitting one's head and body against the wall or ground, not-eating or throwing up, using substances until incoherent, scratching or slapping one's face or hands, and intentionally limiting one's interactions with others.

Expressing to me the that it has been "hard to find queer people who want to do things other than drink all the time" Blithe feels like the "queer community is very oriented towards self-destructive behaviors" in trying to cope and escape from the "collective trauma" of homophobia, transphobia, and a multitude of other "systems of oppression". Many people that they are close to "binge drink in response to trauma", a recurrent escapism for many participants in this work.

For Blaine, in using self-harm as a coping mechanism amidst the constant erasure and vulnerability in white, heteronormative society, alcohol has been "an easier" escape than other forms of self-harm…

> In Catholicism, you're not allowed to kill yourself or commit suicide. In a way, blacking out all the time was a way of dying and the coming back to life later. It was my way of dying over and over again, feeling the shadow of death over me all the time." (Blaine)

Partying hard and "letting loose in a bad way" throughout his college career offered Blaine an "escape from[his] own mind". He explained that "realizing I was queer fucked me up…it's when I stopped taking care of myself", using his "dedication" and "obsession" with getting drunk as an escape from "the root of his behavior" that he "thought [he] couldn't deal with". Jae also spoke on escape in this light, saying "I want to be away from my own thoughts for a little but, not for the rest of my life".

Skye looks back on his experiences as a younger person and frames "alcoholism as the way [he] understands [his] own suicidality". Feeling out of control with alcohol and "not caring" whether he "lived or died" was an act of *passive suicidality* and detachment from living. "I also really desperately wanted to care and wanted to be engaged" he remembers, yet drugs and alcohol acted as a "justification" and his "god-given right to not care about shit" amidst the abuse and addiction in his childhood home. Drinking, Skye said, "gave me less sense of control, which kind of made an illusion of freedom. But it wasn't. I was pretty chained to alcohol."

Escape drinking (Dickter et al. 2014) and insulated alienation (Goffman 1986, 16) are methods of self-harm that many participants used as escapisms from daily life. Hayden spoke about alcohol and isolation as being both "comfortable and destructive" coping mechanisms. For her, in feeling like a burden and processing much family and societal trauma, depression is a dark experience of heaviness that she likens to the feeling of "wet ropes in the mud". In this, Hayden explained seeing suicide as "a tempting and reasonable exit strategy", the "best solution" or an escape for "alleviating other people and [herself] of the burden of wondering about [her] and the pain of just living".

For Sid, escaping life manifests in a multitude of different ways, sometimes like body-burning, or slamming her/their head against the wall, and other times it exhibits itself in over-working her/their self and pushing to always be moving or constantly doing things. In many moments, Sid notes that "self-harm…is literally relieving" because "I still feel like I need to get away from these feelings" and will often use over-productivity as a form of withdrawal from her/their self. "I love being an active person. But at the same time, sometimes that's a mechanism of not confronting myself about whatever it is that's coming up for me", an experience for Sid that many other participants also expressed—the need to keep moving in order to run from themselves and the daily, systematic mechanisms that tell them they are wrong, deviant, and "sick".

FURTHER ON: A COLLECTIVE APPROACH TO PERSON BASED CHANGES

Wilber (2000) warns against the disassociation of the mind and body in current day-academic research. This section seeks to remedy and reconcile the schism between body and mind, as well as between social research and community integration.

Wisdom of the People

This is the part of my work that I rely upon daily to help myself and, hopefully, my community work through the societal oppression and collective traumas of heteronormative, capitalistic, colonial cultures and histories. Here, and going forward, this work becomes a fluid and growing space where collective understandings, personal experiences, current scholarship, and a relied upon resilience weave together in order to create a deep and growing body of support. With a foundation in the sociological and academically theoretical lenses, these ideals and perspectives now take on person-based orientations, beyond *it gets better* and mainstream suicide prevention ideals, for thinking about and beyond suicide.

Spirituality

There is much literature on the intersections of queer identities and religious spiritualities (Kelly 2018; Stobie 2014; Weiman-Kelman 2018; Blackmore 2016; Rodriguez 2009; Shallenberger 1998; Rodriguez and Follins 2012), and I think it quite important to negotiate *Spirituality*—as the direct engagement with the sacred (Miller and Thoresen 2003)—when interacting with person-based approaches to wellness and revival for queer individuals. The process of experiencing *the spiritual* and *sacred* can often be "associated with a movement, a journey, or even a pilgrimage" (Browne et al. 2010, 8) as a fluid and ever changing personal growth. Thus, the aspects of spiritual understandings that propel queer resilience and recovery offer fascinating opportunities to *queer* mainstream perspectives of religiosity into deeply complex personal rituals of growth.

In this work, the notion of *the sacred* refers to the experience of the spiritual, something beyond ourselves, as well as the experiences of the sublime, deep cherishing, reverent dedication, or preciousness (Hanson 2013). However, a sociological work around the sacred and spiritual would not be complete without introducing Durkheim's (1964) understandings. The sociologist grasped the sacred as that which goes beyond the *profane,* day-to-day experiences

(84) and provides a unification and collective belief system for groups. Religion, then, is the maintaining of difference between the two realms, where the sacred is held in separated awe through the totem, the sacred's character and symbol (157).

Thus, **Sacred Queer Spiritualties** manifest as the mechanisms of belief that bring meaning into life, offering support and understanding in times of deep loss, pain, crisis, or darkness. For Skye, "having some structure around spiritual practice" has helped and informed him through his recovery from suicidal ideation and alcoholism. Meeting at our local library, he and I covered many topics on depression and personal evolution, though I was quite taken by the wisdom and meditative approaches in many of his perspectives. Surrounding the experience that Skye has had around community and family members ideating, he expressed a significant notion of love and forgiveness in detachment from loss…

> "I have to just trust [that] folx who may choose to end their lives or who have had attempts…are acting in extreme versions of self-harm that might accidently lead to [suicide]. In order for me to be okay, I need to be able to trust that those people's love for me can remain consistent regardless of if they choose to end their life" (Skye)

Trusting in people and their love, even if they have died by suicide, is a great act of spiritual orientation and belief in the human connection beyond trauma and mental conditions of pain. In this vein, Skye also noted that, amidst his grabbling with the grief and fear of losing his loved ones, he has sought forgiveness for himself and for those people who experience depression and ideation. **Self-forgiveness** and **community forgiveness** offer a spiritually based detachment that helps to lessen emotional distress and personal bereavement (Bryan et al. 2015). *Letting go* has offered Skye an option to self-care and better understand the trauma that often leads suicide and depression in himself and others.

Sacred, Queer Beliefs and Spaces

In trusting in the spiritual connection of queer spaces, and the deep salve that forgiveness offers amidst the grief and loss of suicide, finding the sacred in accessing higher deities and mechanisms of belief also provides deep care and growth for individuals.

Halle spoke about "believing in a higher deity and/or God" because their grandmother was very involved with the church and was the first person who they came out to. Their

grandmother said that "she didn't care" and kept on loving and caring for Halle. At our interview, Finley, too, told me, amidst trauma from their father's death and the pain of losing themself in ideation and self-harm, that there have been "a lot of things that have proven to [them] that there is a God". Browne et al. (2010) notes that queer spiritual space cannot be universalized and must remain "dynamic, fluid, and messy" (21), the capacities of which are personal and endless. For Halle, spiritual space is rooted in their grandmother's care for them beyond identity and into the personal. For Finley, queer spiritual space has grown from a need for answers around self-pain and the fear of death, finding friends and community that offer "someone to relate too…someone to understand".

Queer spiritual spaces, then, are the capricious, whimsical, and erratic ways of meaning-making, often based in communion with others, and in places of safety and embodied growth (Browne et al. 2010, 25). Creating these sacred spaces for ourselves and one another offer resilience in meaning making and chaos (Chéry 2017) that rejects contemporary rhetoric based in the schism between sexuality and spirit (Stobie 2014). Browne et al. (2010) speak to sacred spaces as those which are rooted in…

> Touching others, touching ourselves, these seem to be the basic desires of queer spiritualities, so that queer spiritual spaces can become simultaneously eerie and comforting, alienating and accepting, enabling and constraining (25).

Rooted in *Integral spirituality* as that which embraces all person-based understandings and perceptions, the "necessarily slippery", "strategic and negotiable" embodiments of queer sacred spaces act as an integrating framework for all different experiences of embodiment, and can manifest anywhere and everywhere (Browne et al. 2010, 25; Maxwell 2003, 266).

Houston mentioned that they "don't feel a part of a community" and, thus, are not able to provide support and love, care and orientation for other queer people. "There is a need", they said, for queer community, and I would go even further to say this need is one for sacred space and togetherness. From these theoretical conceptualizations, creating queer spaces takes on a new and evolved basis of reworking, as one that can grow from any person and any circumstance.

Further, I will explore notions of space-creation in all of its messy and fleshed-out orientations, that have helped myself and participants in this work negotiate the often perilous and murky waters of ideation, depression, and personal love.

<u>Sacred Community</u>

"Yes, we're looking at things that are very challenging systematically and to the individual, but because we have each other at the end of the day we're going to be okay and we're going to keep doing this and we're going to stay alive and we're going to keep each other moving forward and keep each other's spirit's strong enough to keep being alive and keep doing this" (Sea)

Community is a vital foundation for wellness of individuals, and as Saul (2013) puts it, "collective trauma requires collective responses" (183). As has been discussed at depth in this work, suicide and depression for queer individuals are not personal but structural issues that require broad based reworkings. However, communities amidst these oppressive structures find themselves grappling with difficult, daily oppression and stigma that can be life-threatening for many people personally coping. ***Collective Recovery*** in the queering of suicide looks much like the reintegration of people and the sacred into social spaces with empathy and love.

Payton expressed to me that, for her, most of her actions are rooted in the principle of "I want to be accepted by other people". Admitting that "I guess every action I take is like 'I want this other person to love me, to care about me'" she concluded that that was "probably the main reason why I started self-harming , so that, in kind of a messed up [way] I'd feel like people cared about me". For many participants who long for the care and support of community—myself included—*queer sacred spaces* often look like group and collective formations which are extremely helpful to in recovery and processing.

Creative and improvisational approaches to community making offer a "multi-systematic approach to collective recovery" (Saul 2013) and these queer spiritual spaces often manifest as the sacred in day-to-day happenings, spontaneously and in conjunction with a need for support. Blithe remembers lying in bed, reading with one of their partners, Sam, when they came about a triggering passage on self-harm. In that moment, Sam, who has a long history of self-harm, stopped and looked at them and began the conversation around stigma and stereotypes of mental

illness. For Blithe, they recall that as a sacred, special space which opened up to unpack a multitude of perceptions around depression and ideation.

Queer, sacred space is a destigmatized space. It can manifest in bed late at night, when scuba-diving for the first time, at the club with friends, or in the classroom with a professor who facilitates a personal conversation. Sid spoke about needing space to talk to people "because I need someone to make sure I'm okay. I need these support systems. I need to make it real for myself, otherwise I'm going to be alone, going to be isolated". Payton, too, spoke about the effects of having a close community where "self-acceptance is easier with communal acceptance", and guidance comes from those with whom she is closest. Creating communal recovery spaces, then, are based in openness and conversation beyond reactivity, immediate action, or mandatory reporting.

I would like to note that this communitarian perspective is based in the life-supportive aspects of social sharing and supportive networks. However, community-based perspectives can often be limited in grasping the deeply complex and painful experiences of depression and suicidality. Community cannot help everyone because not everyone wants or needs to be helped. Sometimes, the most viable aspect of self-care that an individual can take looks like retreat and isolation. And sometimes, offering them that volition, rather than pushing for more "productive" means of wellness, is vital for respecting and orienting towards their personal self-hood.

Reconsidering Mandatory Reporting

De-institutionalizing wellness is vital to creating communities situated in the sacred and spiritual, though, as I have touched on previously, mandatory reporting obliterates rapport and trust between people. The system of reporting is in place as a security mechanism and protection for people and providers, and is beneficial for medical and social service practitioners when there is suspected neglect, maltreatment, and abuse of children, elderly, or other vulnerable, susceptible populations (Koch 1990; Cross and Casanueva 2009; Kuruppu et al. 2018).

However, as Melton (2005) has recognized, the policies in place guiding mandatory reporting are largely based on "erroneous assumption" and bias. Reporting, then, on intrinsically complex issues of ideation and self-harm is based on the perceptions of institutional professionals who deem a situation or person either safe or unsafe (Barnhorst et al. 2018). This

proves a difficult task for physicians and care-providers, as it breaches both the trust and confidentiality created in health-based settings (Witzig 2015).

Payton acknowledges the need to talk openly about suicidal thoughts and ideation though feels that mandatory reporting "is toxic" in its preemptive reactivity. The last time she went into the counseling services provided by her university, she felt the need to lie about her experiences with ideation because, as she said, "If I put down anything else [on the ranking intake sheet] they [health services] are going to push a button and put me in an ambulance". Houston, as a mandatory reporter themself, said that the whole mandate is "removed from people's experiences and I don't think it supports them".

Mandatory reporting can also lead to socially and financially costly results—especially when people are forcefully taken into a 72-hour hold or transported in ambulances from and to different care centers. Gray, Marcel, Kai, and Hayden all experienced this burden and many other participants have spoken to the issues of inability to afford society's reactive perspectives on mental health and ideation. People want and need to be cared for in community spaces and, in facilitation of those experiences, offering care without the attached fear of reactivity is imperative. Finding mentors, role models and supportive loved ones that offer guidance and understanding in trauma and pain processing acts as a sacred part of community recovery as well.

Role Models

Touching upon her own support structures, Hayden told me that "I definitely think that I'm grateful for the people who I met that understood sort of the anxiety and depression and PTSD and the different forms that it can take" and of whom "would give me tips to get through [it all]". The foundation of queer sacred spaces is based in reconnecting with the self—an orientation that community mentors and elders often help to actuate. In a majority of social communities and organizations in the west, from surgical to religious dogmas, girl-scouts of America to emerging music education, mentorship or role-models are a primary part of growth and evolution for community members (Poorthuis et al. 2003; Scoggins et al. 2018; Poole 2014; McWhirter 2017).

Mentors serve as advocates and teachers (Moed 2012)—an aspect of queer community that is greatly lacking. Halle mentioned to me feeling isolated and without a support system in high school, where they longed for and needed "a black, queer mentor". Cultural and personal validation is vital in mentoring relationships, especially when working with individuals who experience multiple-jeopardies (Castellanos et al. 2016). Simmons, in their essay *I'm black and queer. We need more role models* (2016) expresses much of what many participants of colors have had issue with in queer community—the lack of visibility and support, role-models, and leadership for life "in-between" communities. Halle, at their current university, expresses having a much better support structure and two "awesome queer women of color" that they can look up to, however, the sentiment is still strong—role models create space for growth that is hard to conceive of on one's own.

We need more spiritual, sacred community space, and we need more role models. Finley remarks that their junior year of high school was "one of the better parts" of their life because they were open to themselves, creative, and "had a lot of positive role models". Sea and Grey also expressed seeing themselves as positive, supporting role models for others, a task that is often indicative of immense self-worth and a desire to care for others in the way they have hoped for themselves to be cared for all along (Kettle 2008, 138).

Caleb revealed the role he's taken on as a trans man, working through his own suicidal ideation by reiterating that his identity "is something to be proud of". He wants his life "to be notable in the sense that [he] invested in [himself]" as a trans man and wants to portray his life "as worth living and worth choosing", beyond "the negative narrative" of trans people as less happy. Caleb also said he feels "like it's his responsibility to [his] community not to [commit suicide]" and "not to contribute to that narrative" even amidst deep pain and difficulty, because he wants to offer himself as a role model and a picture of resilience for others like him.

Trauma-Informed Leadership

Role models and community elders for queer and marginalized identities act as personal support structures and facilitators of compassion, guidance and advocacy in the larger field of the community. In suicide and depression support and guidance, it is important that queer and marginalized communities are offered the tools to interact with and facilitate communicative, support spaces for people that need them. Communities can learn and grow within themselves in

order to better offer **trauma stewardship** (Lipsky and Burk 2009), an expertise that each community and space will integrate and orient towards differently. There is no universal way for trauma-informed leaders (Manderscheid 2009) to implement their care, it is completely based on their cultural and social perspectives and the community's needs.

Having both a culture of role models and elder support, as well as trained community resource personally to help aid and support in trauma, ideation, loss, and grief are important ways of promoting sacred, communal networks and spiritually-based personal orientations.

Spiritual Creativity

This void of solitude/Makes me insane/Existence now
Becomes my bane/A heart without blood/A clock without gears
Hallow and empty/I lose all my fear/The end is now nigh
No fear of death/The darkness fades/With my final breathe
(A poem by Marcel, December 2017)

As McRuer (2004) argues, resistance to normativity is "not purely negative or reactive or destructive" but can also be dynamic, and positive, and creative. Thus, for queer communities, learning into resilience and growth can be done through creative exploration, in thought and physical expression. Meyers (2016) also writes on the link between great creative feats, and the depression and ideation of creators. In queer spiritual spaces, there is a collective creativity that stems from and expresses the deep pain and experiences people go through on a day-to-day basis. Creativity, in such a way, has become a totem of the sacred for many queer individuals.

Marcel and I met over social media where, as we have community connections, I was exposed to her poetry around ideation and depression. After reading her work, I reached out for an interview. When we met, she told me that painting, poetry, and dance are her main outlets for expression around the darkness she feels, and I have included some of her painting and poetry in this work. Other participants also spoke out about how creative expression has offered them support and outlets for the pain and isolation: Finley remembers "doing music, and art, and…writing" as ways of "opening to the world" when they were struggling in high school; Hayden finds space to express in her writing; Sid uses dance and journaling to communicate with her/themself around ideation and depression. Creative expression, thus, offers a sense of

communing with the sacred, and creates queer spiritual spaces through the affective and personal offerings of self, an experience to which Browne et al. (2010) write…

> Art and literature provide a symbolic conduit for the reorientation of high emotional states [and] the intensification of existing emotions. The movement from one affective condition to another is what characterizes the very process of aesthetic consumption. Indeed, it is the function of works of art to induce sensation. Emotions seem to 'lock on' to the spectator, and artworks can be understood as interpellations that rhetoricise sets of feelings"

Creativity and Wildness

Creativity, in all of its forms and expressions, extends beyond contemporary creative pursuits. Many folx in my research expressed becoming more aware, oriented, and creative about coping and moving through their depression, ideations, and mental conditions. As an experience of the corporeal, creativity, thus, crosses all domains of life (Kaufman et al. 2017) and can be used as a method if resilience amidst systematic oppression. In this sense, creativity is *wild,* unkept, and divergent. It acts as the healer of experiences ravaged by white, heteronormative, colonial barbarities and offers a space for chaos to flutter as a confounder of life and death and darkness and light together.

Creative wildness offers a queer form of survivorship (Lin 2016), as the boundaryless holding of both "utopian dimensions of queer possibility" and queer failure in its bleaker aspects of enormous "loss, social injury, and grief" (Takemoto 2016, 87). Wild creativity cultivates and is cultivated by queer spiritual spaces, and can "embody a traumatic loss and its mourning" (Dreifuss-Kattan 2016, 16) by finding the corporeal and the person, together, ravaged, and renewing.

Corporeal Creativity

By embodying wildness, creativity becomes erotic, beyond sexuality and pleasure, and into power of the body and sensation. Reintegrating with the fleshy corporeal existences in which we live, the "erotic embodies transcendence and subsequently an epistemology for engaging with life" (Chávez 2008, 11). As we were sitting outside on the warm August grass, Sid stretched as she told me that self-harm and self-wellness are all "about the body…and the corporeal experience". For her/them, self-harm is based in taking back control of the body and

releasing and relieving pain. Self-harm, in this sense, takes on a creative expression, and parallels the wild and chaotically creative release that artistic pursuits offer.

While this work is not, in that light, pro-self-violence, it is pro-embodiment as an aspect of moving and living that encompass self-hood in evolving, fluid and, regenerative ways. As acts of "re-solidifying the cohesion of the self" (Dreifuss-Kattan 2016, 16-18), awareness and finesse into our bodies offers "sublimation and idealization" as methods of awakening into and reimagining unknown futures. By exploring and creating landscapes at the club, in the bathtub, alone at the bowling alley, or wherever else queer sacred space leads us, we learn and grow into ourselves in deep and affective ways—the nuances of which offer a perspective for change and hope that requires creative embodiment to thrive.

Person-Based Recovery and Support

Hope, as a creativity-based perspective offers spiritual space in vying and longing for sacred queer utopias. These utopic visions can be expressed in a multitude and vibrancy of ways. For this work, hope looks like a radical deinstitutionalized and person-based care perspective, where erasing the stigma and shock of mental illness, depression, and ideation creates an openness to these conditions so as to learn from the people who experience them. For Sid, taking thought processes and self-understandings out of institutional mindsets means reframing day-to-day beliefs as fluid and resilient, as she/they put it, "I don't view my mental health as weakness any more".

Sid also explains that, when she/they were younger and experiencing ideation, there was only one mentality and that was "the only way to deal with this is to kill myself, so that I don't continue feeling like this". She/they paused after saying this and then, looking up at the trees said "now I see it so much more as this is just a part of me. I will manage it till the day I die. I don't hate it about myself, it's just something I experience." The process of deinstitutionalizing, or *queering,* care and recovery around mental illness and ideation is a process of seeing the people and their lives in context, not as deviant, but as emotional beings.

Recognizing people as knowledge creators is also accepting them as volitional and valid, and *beyond control.* This was an experience that Sea verbally worked through in our interview, realizing—amidst the pain and grief of losing her close friend to suicide—that "you can't tell

other people what's good for them. Maybe they just need to have more honest ways and formats in which to explore [depression, ideation, mental illness]". She added that "maybe exploring can create more will to live, just being able to honestly explore it, rather than keep it canned and hidden away".

Offering spaces for people to feel shameless and safe to explore life and death in ways that are not immediately activating of institutionalized mechanisms, creates a post-humanist[23], "vital and pulsing" wildness and discovery (Nyong'o 2015, 258). This unbound creativity and exploration is vital to reorienting and questioning social perspectives on suicide—pushing up against mainstream conceptions in order to explore human oriented—not clinic oriented—approaches.

Decolonialized and Deinstitutionalized Medical Domains

Amidst explorative opportunities, de-institutionalized[24] spaces also build a culture "committed to deconstructing colonial thinking[25] and colonial ways of orienting towards each other". Skye finds this aspect of evolved-recovery spaces important and contends that deconstructing the "many rules around how we care for each other" is a major step in creating spaces for people to heal beyond political and social domains.

Marya (2018) uses the notion of a *paternalistic approach* to define current institutions and the colonized-basis of medicine "where the doctor is bigger, smarter and knows more, and you are the little patient". In this clinical perspective, the health professional makes the decisions as to one's health and wellbeing, and often, the patient is left in the dark or unaware of the magnitude of their diagnosis, medications, or procedures.

In vying for the person as the knowledge creator and holder, de-colonizing and de-institutionalizing medical care and recovery share in a communal effort away from the

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[23] Humanism is not necessarily a negative nor toxic philosophy, though, in queering suicide, the humanist beliefs of rational scientific approach and secular political stances on liberty (American Humanist Association) offer no space to speculate in wildness and chaos

[24] Deinstitutionalization, in this work, is a process of removing clinical, stigmatized, and medical-based perspectives from issues such as suicide, depression, and mental illness. In its physical processes, deinstitutionalizing acts as the removing of people considered "deviant" or "ill" from large scale institutional complexes and services, offering smaller, person-based recovery and care spaces (Enbar et al. 2004).

[25] Decolonization in *Queering Suicide* builds upon, and away, from homonationalism, and concepts of civility and western processes of entitlement to land, space, and beliefs as a hierarchical and humanistic (Eyers 2017).

hierarchies of power. Changing how relationships are built between the person and their doctor means facing what access to health care and resources looks like, changing how it is understood by both parties, and confronting the large social and personal contexts that play into the patient's experiences (Marya 2018). These approaches offer a rationalization and a space for people to be *unwell* amidst trauma, lack of access, and the multiple other oppressions and social issues that queer and marginalized identities face daily.

A Sacred Place to Go

> "I long for an inpatient center that doesn't require some extreme episode to be admitted to it. Like maybe it's just too hard out here for a queer to have to work and maintain and pay and survive, and just somewhere to where I don't have to do that… Maybe there should be a garden, or just some place to go when you just want to give up, but you don't have access to enough pills or the right razor or the right poisonous plant or some volcano to jump into." (Hayden)

Hayden expressed the above intention with a quietude that has yet to leave me. Needing a recuperative, spiritually-oriented space that creates a sacred experience in recovery and care is almost utopic. Almost. Deinstitutionalizing design, in the physical sense, offers a new way of building spaces that support people, not clinical and medical mandates; offering therapeutic spaces for growth and person-based care (Doherty 2011). These spaces, as deinstitutionalized and decolonized, "consent to care", as Skye mentioned, where there is a communal willingness and support structure based off of medical-care that is the beyond hospitalization against one's will.

It is the hope of this work to see, someday, as a *queer futurity* (Muñoz 2009), the re-centering of the patient and the individual as a knowledge creator, as well as the offering of creative spaces that allow for the positive chaos of trauma care and recovery to stem beyond clinical assumptions of people and contexts. I hope one day that, as Hayden expressed, we can find ways of caring for people in depression, mental illness, and ideation that provides a retreat in the wildness and the flourishing of communal perspectives, because, sometimes all one really needs is support from afar and to "be left alone, maybe in the garden" (Hayden).

Anti-Racism

Anti-racism as both a communal and personal orientation, is a process of recognizing racism and actively challenging it. By taking on anti-racist frameworks in academia and in the white queer community, we can challenge policies and practices that mask racialized power and exploitation, behind the neoliberal guise of individualism (Blewett, n.d.). While this work's main premise and motivation is not based in a critique of racism as it manifests in LGBTQIA+ spaces, the people of color who graciously took time to interview and participate in this work brought up large-scale and insidious notions of racism and toxicity in the queer community. Their acknowledgments around the accumulation orientations of white homonationalism and the post-industrial queer modernities that profit off of privilege accumulation (Nast 2002) are vital to interacting with large-scale systematic thinking and structures.

Yet, I am under no assumption that speaking to these issues, however briefly, "necessarily equals emancipation" or acts as a "remedy for injustice (Douglas et al. 2011, 113). Thus, this work is limited in perspective without that of a broad and ranging anti-racist critique for which I have not the knowledge, currently, to interrogate in full. It is my hope, going forward, to consistently acknowledge these pressing issues and offer critiques in future work that negotiate the structural and social dismantling of racism in all of queer communal and private spaces (Giwa and Greensmith 2012). Ethically, it is important, as well, for myself and my colleagues in academia to wholly support authors who, as people of color and members of the queer community, constantly work to destabilize and interrogate these issues of westernized racism, colonial death-drives, and oppression.

LIMITATIONS

This work has been fundamentally exploratory, and thus, experiences certain limitations based in qualitative analysis. As much of my sampling and interviewing was done and based around the University of Colorado, Boulder, many of my interviewees were either affiliated or directly linked to the university. As institutionalized settings for academia are entrenched in classical racial discrimination (Arday and Mirza 2018), on CU Boulder's campus it was difficult to integrate a diversity of perspectives without tokenizing individuals. Thus, 68% of my respondents were white.

Lack of age diversity also limited perspectives in my interviews as a majority of participants fell between the ages of 20 and 30 years. This was due, impart to the fact that I was only able to advertise and flyer in a few strategic locals in Boulder and Denver, many of those being centered around universities or educational institutions. Also, the-snow ball sampling procedures utilized were based in various queer and co-op communities, many of which have a lesser amount of age and racial diversity than the broader communities of Boulder and Denver. Lucas (2014) refers to this collective homogeneity in participant communities as "lumpiness" in the "concentrations of entities and sparse locales" that provide "constellations of characteristics" (391).

Time-availability, also, to spend 1 to 2 hours interviewing and often in the middle of the day, mitigated away from the perspectives of participants who had full-time jobs. Many people who expressed interest, could not meet at certain times when I had spaces scheduled for interviews. Thus, a majority of participants, with the exception of a certain few, had student or part-time work schedules.

My research, then, includes the perspectives of mainly white, educated, queer folk who could take time out of their day to interview. A majority of people come from families and origins practicing in Christian affiliated denominations and, of the all my participants, most were middle to upper class. All these observations are signals that, for research like this in the future, *a larger participant base is vital*. This is because, while I was learning and gaining insight throughout each individual interview, saturation was not met on many thematic and conceptual levels. Too, a wider diversity in perspectives would offer broader insights and more frameworks for changing public perception and social orientation towards suicide.

A smaller participant base also makes more obvious my subjective analysis as both a researcher and a participant. Because this is partly an autoethnographic work, my biases play into interview analyzing more overtly with a smaller body of data, whereas, when there is a larger body of research and perspectives, themes are more likely to condense without the researcher projecting expectations onto certain parts of the work. However, autoethnographic researcher-bias can be minimized in participatory-action research, a method I will speak to further on. I also believe that the limitations in generalizability of findings to the greater participant population would be better suited to a mixed methods approach where data and research is based on a variety of subjects and subject matter (O'Dwyer and Bernauer 2014)

FURTHER RESEARCH

From the beginning, this research has been envisioned as a "launching pad" for further work and studies in this arena. It is my hope, then, that further on, more work and discussion will focus on, not only the issue of suicide as a prominent experience in the queer community, but a queer critique of suicide norms of understanding and regulation. Because of my autoethnographic perspectives, this endeavor is one that is exploratory, coming at the research from a personal basis rather than a strictly academic approach. Thus, I strongly suggest, for further studies, the method of Participatory Action Research (PAR), rather than strictly qualitative or quantitative methodologies around work on *Queering Suicide.*

The method of PAR is an approach based on community engagement in research, and is used "to describe and understand, rather than to predict and control" (MacDonald 2012). Breaking from positivist and empiricist scientific methods of research, Participatory Action Research is "multidisciplinary and multiform" (Bradbury and Reason 2008, 31) and emphasizes collective inquiry and communal reflection to determine further action (Baum et al. 2006).

PAR must be done *with* and *of* the people, not *for* the people, imbuing research with propensities for life experiences that come from a "service of practice[ing]" in the tradition of community perspective (Bradbury and Reason 2008, 21). *Queering Suicide* cannot be done without the people who experience depression, ideation, and mental illness daily. Approaches, thus, must be formulated within and of the queer and other marginalized communities who, in

their day-to-day livings, inoculate the theoretical concepts of academic work with a rugged and realistic life force of experience.

CONCLUSION

This work is only the very tip of the very large and complex metaphorical ice-burg of *Queering Suicide.* It does not act as comprehensive review for all the work around suicide in the queer community and beyond, but, instead, has sought to provide an exploratory framework that begins to unravel the social and institutional basis of personal ideation, depression, and mental experiences. Nor does this work make use of the expansive material derived from each of-depth interview, there is certainly much more to be said and worked through from each narrative provided by participants.

My work, however, does fill in the gaps of personal experience amidst the broad base of literature regarding suicide in the queer community. Findings from this research are suggestive of a great need to re-evaluate the community and social responses around ideation and depression in the western medicalized institutions, as well as in faith-based communities and familial structures.

Beyond the notions of homosexuality and queerness as a *disorder,* many queer folx feel and grapple daily with their *outsider status* in rhetorics of *normalcy* around health and wellbeing. The medical and political structuring of deviance is a huge propeller for people feeling "wrong", "bad", or "abnormal" in their queerness and mental conditions. This experience of deviancies backed by approaches to socialization in the home and church whose rhetorics endure with individuals into adulthood and beyond. Many participants have expressed frequently feeling misunderstood and like an outsider within their families and amidst mainstream social spaces, like on campus, in the classroom, and in medical settings.

Medicalization and pharmaceuticalization, while offering forward moving and adaptive processes for health, are often based in "the sick role" as one that, while offering individuals some reprieve from normal social roles and daily expectations, also classifies depression, ideation, and mental health as personal problems when, many times, such conditions are consequences of larger social forces. There is also the medicalized rhetoric that permeates social understandings of suicide as *contagious,* and therefore, those experiencing attempt or ideation

must be quarantined and removed from normal social interactions. Forceful ejection and mandatory reporting act as methods of policing individuals into the "it gets better" phenomenon of sick role saliency. One can be unwell for a shot amount of time, yet long-term mental conditions and depression are seen as aberrant and, in the case of Kia, can be ostracized from continuing health-services and support.

In this research, suicide, from a sociological basis, can appear rational and valid amidst, not only social and medicalized oppression and deviance, but amidst other institutional factors weighing on individual bodies. My findings have shown that not only are medicalized perspectives dangerous to the mentalities of queer individuals and those experiencing ideation or attempt, but that medical institutions are often out-of-reach for many folx who lack insurance or health coverage, not to mention that a lot of people hold personal fear and discomfort with accessing healthcare, most of which is not trans or queer friendly.

Racial biases and inequalities also play a large role in people struggling to find supportive queer communities and access LGBTQIA+ friendly medical services. Many participants noted feeling like the queer community is extremely racist and entitled, an issue rising amidst the neo-colonial notions of the gay, male patriarch and homonationalist pride discourses. Equity and openness are lacking from the rainbow community, which excludes members of color and non-white cultures from feeling supported and welcome.

Suicide as an escape, then, stems from the intersections of social and institutional oppression that many folx face as a routine part of their daily experiences. Substance abuse and *escape drinking¸* self-harm and lack of self-care, act as methods for individuals to withdraw from their personal pain and depression, offering a "destructive yet comfortable" reprieve from the isolation, stigma, and policing of their internal worlds and personal identities. These findings will act as the foundation for further research on the project of queering western discourse around suicide.

CONTRIBUTIONS

The most viable contribution of this work lies in the methods and hopes provided by participants around changing the current mainstream discourses on suicide and ideation. Queer

spiritual spaces are the mechanisms of survivorship that allow queer folx to engage and evolve amidst the deep pain and difficulty of life. These spaces, as Durkheim (1964) noted, offer the *extraordinary* beyond the day-to-day mundane, and act as opportunities for people to access what they deem sacred, precious, and life-giving. Queer spirituality is a concept of meaning-making that offer access to the personal sacred and wildness that supports queer life and queer endeavors.

Spirituality allows the rainbow person a reconnection of the erotic body and mind into the *sodomitical sublime,* which in Browne et al.'s (2010) terms, is a "symbol of diffuse desires, mysterious delight and inchoate feelings, with a potential for uncanniness, and a counter-normative capacity to transgress and subvert" (8). This sublime experience is one of potentiality and desiring, as well as of the body-mind connectivity that produces embedded resilience and coping methodologies for growth.

Community can offer spaces and endeavors into creating the sodomitical sublime and spiritual spaces for its members. Thus, sacred queer community is something that many interviewees touched on as a vital part of their experiences and resourcing amidst the darkness and pain of depression and ideation. Trauma-oriented and supported leadership and role-models are vital to this community and act as the foundations for participants to feel support and the positive orientation of queer futurity.

Too creative expression is a notion of self-care and sacred spirituality that offers hope in the making of meaning. Creativity can move beyond forms of artistic definition into day-to-day approaches to wellness and survivorship that are based in the experience of the body. When Halle and Sid described learning how to acknowledge and sit with depression and ideation as a *creature*, or a beautiful part of one's personality, they imbued change and understanding with creativity. Many other participants of this work have expressed similarly inventive and resilient ways of processing pain and working through dark-internal worlds.

Offering people spaces to access and sit in the spiritual and wild creativity of resilience, and/or the communal networks and connective processes of growth are all processes of deinstitutionalizing and decolonizing health care and social definitions of wellness and suicide. Findings in this research suggest that providing physical centers for queer people and other marginalized identities to receive care, support, and understanding amidst depression, mental

illness, and ideation would have drastic and positive effects. Deinstitutionalizing health care is a difficult and slow process, yet, by creating spiritual communal spaces, not only could the likelihood of attempted suicides lessen, but could people also learn the tools to work through trauma and pain, while receiving the lifelong support to grow and evolve in and with mental illness and depression.

Queer, for this research then, acts as "a methodology of critical thinking" (Domínguez Ruvalcaba 2017) that goes beyond gender and sexuality as a process of deconstructing the social norms that create the foundations of medical and social institutions. Thus, *Queering Suicide* provides both discourse on destabilization amidst institutional and cultural experiences, as well as idea-making around regeneration-based perspectives.

Hope can only be created if there is space to interact and reflect on the processes of trauma and oppression that lead marginalized individuals into a collective need for escape and relief. This work is based in this anticipation of a queer future, one where collaboration centers around collective goals, the art of the oppressed, the intentional-self *life* of resilience, and, possibly, the solitary walks around sacred, wild gardens.

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Appendix A – Demographic Breakdown

Name	Age	Race	Family Religion	Current Spiritual Practice	Education/Degree	First Generation College Student?
Blithe	22	White	Lutheran/Catholic	Witchcraft	Bachelor's degree	
Gray	21	White	Christian/Methodist/ Lutheran	None	Bachelor's Student	
Olive	28	White	Protestant	None	Bachelor's degree	
Blaine	24	Mexican	Catholic	None	Master's degree	Yes
Jae	22	Multi-Racial/Mixed	Catholic	None	Bachelor's Degree	
Skye	24	White	Christian	Unitarian/ Spiritual	Bachelor's Degree	Yes
Halle	21	Black	Baptist	Agnostic	Bachelor's Student	
Finley	19	White	Catholic	Some Catholicism	Bachelor's Student	
Sid	21	White	Presbyterian/Christian	None	Bachelor's Student	
Paxton	29	White	Lutheran/Agnostic	Pagan	Bachelor's Student	
Kacey	18	White	Lutheran	None	Bachelor's Student	
Sea	40	White	Episcopalian/Greek Orthodox	Naturalism	Doctoral Candidate	Yes
Caleb	32	White	None	None	Bachelor's Degree	
Houston	22	White	Protestant	None	Bachelor's Student	
Payton	20	White/Mixed/ Middle Eastern	Jewish	Judaism	Bachelor's Student	
Marcel	34	White	Catholic	None	Bachelor's Degree	Yes
Hayden	31	Black	None	Earth Based, Plant Based	Some College	