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SHHHUICIDE STORIES: A CRIP CRITICAL ANALYSIS OF ATTEMPT
SURVIVORS' NARRATIONS OF SUICIDALITY

A Thesis
Presented to
the Faculty of Social Sciences
University of Denver

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

by
Emily Krebs
June 2017
Advisor: Erin K. Willer, Ph.D.

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Advisor: Erin K. Willer, Ph.D.

Degree Date: June 2017

Abstract

Estimations suggest that one person in the United States tries to take their own life every 38 seconds (Yeager & Roberts, 2015, p. 38), making suicide the 10th leading cause of death in the nation (AFSP, 2016). Despite the prevalence of this issue, communication surrounding suicidality remains scarce—as do concrete understandings of what causes the desire to die in the first place. Dominant understandings link suicidality to chemical/neurobiological issues in the brain (mental illnesses), but these claims have not yet been scientifically proven (Hjelmeland, Dieserud, Dyregrov, Knizek, & Leenaars, 2012) and, as this study suggests, biomedical aspects of suicide are only part of a much larger picture. In critically analyzing firsthand narratives of suicidality as they are shared by attempt survivors, this work blends crip theory frameworks with narrative methods to better understand how people experience suicidality, what brings them to attempt, and how treatment for survivors could be improved. Within these narratives, survivors make sense of their suicidality in hybrid forms by utilizing biomedical frameworks while also describing social causes for their attempts, notably including the ableist Othering of people deemed “mentally ill.” Through this analysis, what results is a fuller understanding of how people make sense of suicidal inclinations from an insider-perspective, as well as a set of “crip” critiques that implicate psychiatric hospitals and other biomedical care facilities as sites of oppression and abuse.

Keywords: suicide, narrative methods, crip theory, health communication, critical suicidology

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Table of Contents

Chapter One — Understanding Suicide: Medical Malady or Social Transgression?.....	1
Defining suicide.....	7
The issue of honor in self-inflicted death.....	8
Religion, law, and the criminalization of death.....	11
Decriminalization: Shifting power from God to science.....	12
Unpacking cultural politics in biomedicine	13
Biomedicine and notions of “normality”	14
Formations of fear.....	15
Biomedical histories of identity-based oppression.....	16
Gender: Hysteria, transphobia and the psychopathology of deviance.....	17
Sexuality: Queer associations and criminality.....	19
Race: Blackness and genetic inferiority.....	20
Mental health: A hidden site of biomedical oppression?.....	22
Stigma as a barrier to understanding suicide.....	24
Definitional debates and cultural politics in science: Where do we go from here?.....	27
Narrative and crip theorizing as grounding the analysis of suicide stories.....	28
Studying suicide: Shifting from empiricism to narrative.....	29
Narrative theory: Reclaiming suicidal storysharing.....	31
Storytelling as sensemaking.....	33
Narrative as dialogic.....	34
Research question.....	35
 Chapter Two — Crippling Narrative Methods	 37
Suicide attempt survivors’ stories as data.....	38
“Live Through This” data collection methods.....	40
Data analysis	44
Iterative approach	45
Narrative and crip analyses.....	46
Primary-cycle coding: Narrative sensemaking	49
Secondary-cycle coding: Crip worldmaking	51
Overarching analysis procedures	52
Validity check.....	53
Grounding the study with phronetic roots	54
 Chapter Three — Hybrid Ontologies: Biomedical and Crip Co-Minglings as Exhibiting Simultaneous Truths	 56
Utilizing biomedical epistemology.....	57
Diagnoses as tools for accessing care.....	58
“Who am I to kill myself?”: Biomedicine as a cure for narrative untellability.....	60
Hybrid modeling: Social links to biological changes	63
The [em]power[ment] of biomedical frames	66

Crippling mental illness: “Crazies” as society’s ultimate Other.....	66
Ignorance promoted by media representations of ‘psychos’	67
Internalized manifestations of stigma.....	69
Institutional policies as bases for inducing crip perspectives.....	71
Implications of crip issues	75
Honoring simultaneous truths.....	76
Chapter Four — Honoring Experiential Accounts that Describe the Oppressive Manifestations of “Crazy” Otherness in Biomedical Care	77
Crip implications for accessing care.....	80
Treatment cost	81
"Looking suicidal" versus "performing normality"	83
Barriers to care: A crip perspective	85
Compounding oppression and cultural illiteracy	86
Lack of social identity awareness during care	86
Failure to address sciocultural systems of power	90
Sociocultural illiteracy as worsening suicidal conditions.....	93
Manifestations of crip othering.....	93
Caregivers’ lack of compassion.....	94
Lack of education for biomedical practitioners and caregivers.....	96
Hospitalization as imprisonment	99
Abuse and the absence of accountability.....	102
Oppression, Otherness, and what being ‘crip’ means in biomedical practice	106
Chapter Five — Conclusions and [Un]Final Thoughts	108
Strengths: Revisiting the three goals of the study	112
Interdisciplinary and interparadigmatic approaches.....	112
Contributing methodologically and theoretically to the field of health communication.....	113
Reclaiming voice for suicidal people	114
Limitations and suggestions for future research.....	114
Emphasis on the United States	115
Data collection: Whose stories can be shared on LTT?	115
Problematizing the salience of biomedical modeling.....	116
Implications	117
Implications for the study of critical suicidology.....	118
Suggestions for healthcare policy	118
Embracing non-Western approaches to medicine and healthcare	119
Future directions	120
Narrative redirection as treatment	120
Expanding methods of study	121
Conclusion: Reflexive Engagement	122
References.....	124
Appendix A.....	144

Chapter One — Understanding Suicide: Medical Malady or Social Transgression?

Although no official count of suicide attempts is kept in the United States, estimations suggest that one person in this country tries to take their own life every 38 seconds (Yeager & Roberts, 2015, p. 38). Though only about four percent of these attempts are completed, over 44,000 Americans die by suicide each year, making it the 10th leading cause of death in the nation (AFSP, 2016). Despite the prevalence of suicide attempts and deaths, communication about these matters remains scarce. Stigma surrounding suicidality promotes a culture of silence in which people experiencing suicidal thoughts and ideations do not share their feelings outside of close relationships. More expansive, detailed stories of individuals' experiences with suicidality are rarely shared at all, making it difficult for researchers seeking to understand the phenomenon to obtain meaningful accounts of what it means to live with the will to die.

Nonetheless, researchers in numerous fields such as sociology, psychology, biomedicine, cultural studies, and religious studies have long sought to find and define the ontology of self-inflicted death. Numerous theories about the basis of suicidal behavior float through the United States' cultural sphere, but biomedical understandings of mental illness as neurological error hold the most clout in the mainstream. This is largely because "the position that suicide rises as a consequence of mental illness is often presented as an indisputable scientific and medical fact" (Marsh, 2010, p. 27). Psychiatrists make up the bulk of government advisors on suicide-related policy; as well

as the majority of leaders for [inter]national suicide prevention organizations, editors for academic journals in suicidology, and heads of suicide research centers (Marsh, 2010, p. 29). As such, millions of private and public dollars are poured into the biomedical¹ industry's research on suicide prevention each year. Even with these extraordinary efforts and claims of scientific fact linking mental illness to suicidality, however, a concrete biomedical understanding of what underlies suicidal behaviors remains elusive.

The definitive guide for providing mental healthcare to suicidal patients comes from the American Psychiatric Association's (APA's) Diagnostic and Statistical Manual of Mental Disorders (DSM). In the previous editions of this document, suicide was listed as a symptom of other psychiatric disorders (depression, bipolar disorder, etc.)—not as a condition in and of itself. Now, the current edition (DSM-V) tentatively categorizes intentional actions toward one's own death as “suicidal behavior disorder” within the section on “conditions for further study” (APA, 2013, p. 801). With this change, the APA admits a crucial glitch in medical understandings of suicidal behavior and marks it as an issue that evades current medical knowledge. In essence, what most people knew about suicide as it relates to mental health is now medically incorrect—or at least incomplete.

Based on social science literature, it is clear that biomedical understandings of this phenomenon are only one part of a much larger picture (Wexler & Gone, 2016; Fullagar & O'Brien, 2016; Bergmans, Rowe, Dineen, & Johnson, 2016; Reynolds, V.,

¹ The term “biomedical” is used over the more common use of “medical” to highlight that dominant Western understandings of medicine and medical care are not universal. Not all forms of medicine around the world define [mental] illness the same way, but the focus of this study is on the dominant forms of the medical industry in the United States—not forms deemed “alternative” in the mainstream sphere.

2016). As many scholars note, medical care, mandatory reporting, and other issues surrounding suicide are not all about science; religion and morality are heavily intertwined as well (Jamison, 2000; Marsh, 2010). Jensen (2016) explains this link between science and sociocultural norms through the rhetorical phenomenon of medicalization. According to Conrad (1992), medicalization, the process by which experiential knowledge becomes subordinate to biomedical expertise, explains how many aspects of social life have come to be labeled as medical “disease.” This medicalization process “emerges and folds according to dynamic rhetorical, material, and sociocultural encounters” (Jensen, 2016, p. 2), so medical knowledge is never truly pure or unbiased. By contrast, it is heavily intertwined with sociocultural and religious beliefs about health, illness, morality, and the sanctity of human life (Lupton, 2012). For the study of mental health, this means that the medical understandings of what it means to be “mentally ill” cannot be understood as biologically deterministic; they are closely related to sociocultural understandings of what it means to be “abnormal.” With that in mind, it is essential to acknowledge that moralizing often persists despite medicalization, thus situating its subjects as “both responsible for their health and yet inherently incapable of meeting that responsibility on their own” (Jensen, 2016, p. 4). Suicidal people are therefore trapped within a bind where they are simultaneously unavoidably ill and decidedly morally corrupt, exempt from blame and the targets of moral criticism.

This critical argument stems from the ideological underpinnings of “crip theory” (McRuer, 2006). This theoretical approach to understanding disability claims that in opposition to medical models that locate impairment and pathology within the individual,

what actually impairs a person is living in a culture and a world that does not account for their needs (Krieg, 2013, p. 44). “Essentially,” Krieg argues, “the person is not disabled, but rather it is the world that is *disabling*” (2013, p. 44 [emphasis in original]). Though crip theory’s emphasis on the sociocritical seems to strike a polar relationship with biomedical understandings of disability, the two can also be used to inform, challenge, and improve one another.

Because of this potential for more nuanced understandings, I argue that biomedical ways of defining suicide must be matched with alternative ways of knowing this experience. Epistemological variety is key because when a singular form of evidence is privileged as more “truthful” than others, much of the complexity of any given matter is lost (Holmes, Murray, Perron, & Rail, 2006). No one field may hold the key to unlocking the “Truth” behind suicide, but interdisciplinary approaches will help uncover and create alternative truths that hold important implications for the way humans care for, interact with, and live as suicidal people.

Narratology, the study of stories and how their structures affect human perception, is one of these interdisciplinary means that holds particular promise in the realm of suicidology. In contrast to biomedical ways of knowing that emphasize biochemical tests conducted in labs, narrative epistemologies honor theories of the flesh: a perspective put forth by Chicana feminist scholars Gloria Anzaldúa and Cherríe Moraga (1983) that privileges the body as a way and site of knowing. By honoring people’s own complex experiences of their situations and identities, narrative practices in this context are essentially medicalization in reverse—a sort of de-medicalization that places power

back in the hands of those experiencing suicidality instead of leaving that authority with their healthcare providers. Despite the promise of such an emphasis, the field of health communication has not addressed narrative sensemaking on the subject of suicide. No publications on the matter currently exist, and those that address suicide in other forms do so through more traditional methods that leave the person experiencing suicidality absent from the meaning-making process.

With that gap in mind, adopting narrative methods is particularly relevant to the study of suicide since most ableist cultures deem attempt survivors “insane” and do not value tellers’ stories (Bergmans, et al., 2016; Capponi, 2003). Embracing these narratives as significant sites of knowledge and understanding is one small step in reclaiming attempt survivors’ minds and lives as worthy, credible, and important. This is crucial because, as Frank asserts, “Stories do not simply describe the self; they are the self’s medium of being” (2013, p. 53). The inverse notion that “those who do not narrate do not have a self” (Shuman, 2010, p. 152) is a significant dehumanizing prospect for suicide survivors. By seeking to learn about suicide through attempt survivors’ personal narratives, the proposed study aims to [re]humanize suicide and those plagued by its ideation within academia and the broader culture at large.

To access and co-create these alternative truths, in this study I analyze attempt survivors’ suicide narratives, specifically those shared in conversation with and published by the director of the online art-activist project “Live Through This” (LTT). These stories share individuals’ backgrounds of the roots of their suicidal ideation, vivid accounts of their suicide attempts, and the social struggles of living with such taboo internal

hostilities. These first-hand accounts of suicidality shared on LTT offer a more nuanced understanding of what it means to live with the will to die from an experiential perspective—far from the sanitized versions told (or hidden) in funeral services, academic research, and other semi-public stages. This is lived-experience base key because in today’s biomedical world, suicidal people are rarely granted the ability to tell and embrace their own stories as definitional truths; they are almost always defined and classified by biomedical professionals (Capponi, 2003). Allowing people to explain and assign meaning to their own experiences is a seemingly simple idea, but it is rarely embraced in formal academic research practices.

With this objective in mind, the goal of this study is threefold: (1) to bring together, critique, and problematize numerous fields’ exiting conceptualizations of suicide; (2) to fortify the academic study of health communication by expanding its [post]positivist history into critical qualitative directions using crip theory as a lens; and (3) to embrace experiential ways of knowing in the form of suicide attempt survivors’ narratives as valid and important to acknowledge and study, not only as data but also as voices of expertise.

In order to address these three aims, I call on narrative theorizing and inquiry. Methodologically, this entails “a deliberate inclination to seek out and discern the storied elements within human depictions of life events,” and to “understand and convey inherent meanings” (Yamasaki et al., 2014, p. 101). To ground this work, a review of existing literature on the subject of suicide in social contexts is provided below. This review first explores the rhetorical and definitional issues of “suicide” as a term, matched

with critical analyses of different values placed on self-inflicted deaths in its various forms. With this criticality in mind, the cultural politics of morality historically present in biomedicine are highlighted in order to justify the necessity of bringing a critical lens to the study of contemporary suicidology. Next, the silencing impacts of stigma on people living with mental illness, particularly in terms of the mentally-ill-as-dangerous stereotype disseminated through ableist media, are examined in order to more deeply engage the primary theoretical and methodological lens for this study: critical narrative inquiry.

Defining Suicide

Before entering a critical discussion about suicide, it is key to begin by defining the term and noting that not all self-induced forms of dying are regarded in the same way (Goldsmith, Pellmar, Kleinman, & Bunney, 2002, p. 193). According to critical suicidologists White, Marsh, Kral, and Morris (2016), “suicide cannot be easily understood in singular, static, or acontextual terms. On the contrary, suicide and suicidal behaviors...are deeply embedded in particular social, political, ethical, and historical contexts” (p. 1). Different cultures regard[ed] and define[d] different sorts self-inflicted deaths in vastly disparate ways, and the term “suicide” itself has a complex and controversial history in the English-speaking world.

The *Oxford English Dictionary* points to the first use of “suicide” in the English language in 1651, then meaning “to vindicate oneself from...inevitable Calamity.” Two centuries after the term entered English vocabularies, sociologist Erving Goffman broadened this definition and made the term “applied to all cases of death resulting

directly or indirectly from a[n]...act of the victim himself, which he knows will produce this result,” regardless of external motives or intentions (1951 [1897], p. 44). This broad definition included deaths such as a mother knowingly sacrificing her own life during childbirth, a person jumping in front of a train to push a stranger from its path, or a soldier using their body to shield a civilian during an armed attack. This broad definition is the base of the one currently held by the Centers for Disease Control and Prevention (CDC); the only difference is the latter’s emphasis on intention. Specifically, the CDC designates suicide as “death caused by self-directed injurious behavior *with an intent to die* as a result of the behavior” (CDC, 2016) (emphasis mine).

This inclusion of “intent to die” is what characterizes most medical and social definitions of suicide today—including my own. However, all three of these definitions inform the history of suicide’s cultural conceptions in the English-speaking world. Though a thorough exploration of various languages and cultural terms for this phenomena is beyond the scope of this paper, a brief review of the rhetorical and definitional issues of “suicide” as it relates to the United States is provided below. This background is essential to mapping the meaning of the term as it impacts people dealing with suicidality today because as new rhetorical norms come into being, previous ones are never entirely replaced; they inexorably “linger” and impact contemporary meanings (Koerber, 2013, p. 13). The legacy of the term is therefore essential to understanding its current meanings, usage, and impacts in various forms and contexts.

The issue of honor in self-inflicted death. Marsh (2010) outlines the history of understanding suicide (in Western thought) in three main phases: lenses of (1) morality;

(2) criminality; and (3) mental illness. Many archival texts show that the first of these, morality, has been used to both support and condemn suicidal actions throughout history. Prior to the colonization of what is now the United States of America and Canada, numerous native peoples including the Eskimo and Crow accepted “altruistic suicides” amongst the sick and elderly (Bromberg & Cassel, 1983). Such practices are not unique to them; contemporary “Right to Die” supporters in the United States also use rhetorics of benevolence to support a terminally-ill patient’s right to choose their own death, often for the benefit of their caretakers and providers (Gunderson & Mayo, 1993). In all of these cases, suicide is marked as an act of selflessness that promotes the wellbeing of the broader community.

Ancient Greeks and Romans also viewed some self-inflicted deaths as symbols of honor (Jamison, 2000). Hannibal, Brutus, Cato, and numerous other famed leaders consumed poison rather than be captured, disgraced, or killed by their enemies, and all were hailed for such displays of righteousness and courage. Even in the Christian Bible, a site which many claim is anti-suicide despite the fact that no references to its condemnation exist, there are several accounts of self-induced death in the name of honor (e.g., Judges 9:50-54; Kings 16:15-20). Beyond that, radicalists in nearly all of the world’s religions (e.g., Christianity, Islam, Shinto) have historically used suicide as a means of fighting for their faiths and lands.

In all of these cases, self-inflicted deaths are not viewed as “suicides” in the typical sense of the term. A feminist perspective highlights that these sort of deaths are framed in a masculine light: deliberate acts in the name of self-sacrifice, bravery, and

duty to a greater good—thus they are acceptable and praiseworthy. There exists a deep gap between these sorts of valiant self-inflicted deaths and those framed as feminine: those associated mental illness, weakness, and irrationality. The latter shows the policing function of Marsh’s (2010) ‘morality stage’ of understanding suicide. By framing suicide as an individual failure/defect, society is able to depoliticize the actions and hide any external factors which may contribute to the suicidal situation (Reynolds, 2016; Vaid-Menon, 2014).

Puar (2007) points out that this framing gap is especially clear in the suicides of people of color—particularly when these people can be associated with Islam or immigrant statuses. She argues that in the U.S. cultural sphere, brown “terrorists” (people who take their own lives or enact violence in the name of a broader political struggles) are immediately framed as queer; they are associated with the “feminine” irrationality and weakness that runs directly opposed to hyper-masculine ideologies of American exceptionalism despite their self-sacrificial political goals (Puar, 2007). This demonstrates that the masculine/feminine divide in framing suicide does not necessarily relate to the genders of those dying by their own hand, but rather to the ways in which society views [ir]rationality through a gendered and raced lens. Considering the well-documented link between medicalization and moralization, this historical distinction between moral (masculine) and immoral (feminine) suicide cannot be ignored. Addressing this binary is particularly relevant because all current biomedical conceptions of suicide are related to mental illness; weakness and irrationality are the core—never some sort of pure masculine honor. Moreover, over time these notions of morality have

been codified into religious law in numerous nations around the world, including the United States.

Religion, law, and the criminalization of death. During 17th century, European colonists brought Christian beliefs (primarily Protestant and Catholic) to the United States. With these ideologies came the cultural prohibition of suicide long associated with the Church in post-Biblical times. This religious stance against suicide is explicitly outlined in the Catechism of the Catholic Church: “It is God who remains the sovereign Master of life... We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of” (Part 3, Section 2, Article 5, #2280). The next line explicitly states that suicide “is contrary to love for the living God” (Part 3, Section 2, Article 5, #2281). Famed philosophers such as Martin Luther (Rettersol, 1993), John Locke (Williams, 1997), and various Puritan leaders (Kushner, 1991) echoed this pious sentiment. Within most branches of Christianity suicidal actions remain forbidden, but the souls of those lost are left to the mercy of God—not the judgement of Man.

Though Man was not granted the ecclesiastical right to judge suicidal souls, humans around the world *did* create legal rights to do so (Jamison, 2000). Many of the world’s nations created laws against self-inflicted death, and it remains an unlawful act in numerous modern countries. Suicide is no longer illegal in the United States, but the penal phrase “commit suicide” remains common nomenclature for someone dying by their own hand. The term “commit” insinuates a criminal act—a term associated with murder, fraud, and other actions punishable by law (Sather & Newman, 2016). This rhetorical norm perpetuates suicide as an un unlawful act, and therefore highlights the

deep cultural condemnation of such deaths. Many activist circles focusing on suicide prevention have extricated “commit” from their vocabularies, instead using terminology like “died by suicide” to avoid adding to the stigma against those impacted by the issue (see Reynolds, 2016, p. 172). This new rhetoric also serves as a nod to the notion that suicide is not necessarily an internal issue, but rather a social one in which external factors are relevant to the production of self-destructive actions. This idea of suicide as social murder is a relatively new idea that deviates from Marsh’s (2010) third stage of Western understandings of suicide: Mental illness.

Decriminalization: Shifting power from God to science. Following Marsh’s (2010) timeline, contemporary understandings of suicide move beyond issues of morality and criminality to emphasize biomedical origins. Suicide is no longer commonly viewed a matter of spiritual demonism or unlawful rebellion, but rather an issue of chemical origins within the human brain. This ontological change mirrored a larger cultural shift in which the power of God was eclipsed by the power of Science during the Scientific Revolution (Szasz, 1997, p. 138); it marked a turn in which the world was no longer ruled by abstract faith, but rather by microscopes and human emphases on classification (i.e., Darwinism). Despite its near-ubiquitous embrace, Marsh (2010) and others argue that this jump from God to Science was somewhat arbitrary. Particularly for suicide, there was no medical discovery of pathological anatomy to support medical claims of expertise in this arena (Marsh, 2016, p. 18).

Despite this alleged ideological metamorphosis, the purity of “science” is viewed skeptically by many critical scholars, especially those who study race, gender, and

disability (e.g., Robinson, 1983; Butler, 2007; McRuer, 2006). These scholars point out that biological “science” is often used to support oppressive ideologies such as sexism, racism, and homophobia by giving people a so-called “empirical” base for their beliefs. This matter is outlined in-depth later in this paper, but for the sake of this section it is key to note that behaviors biomedically linked to “mental illnesses” in the DSM are often argued as simply deviations from the norms for sociocultural conduct; they have been pathologized by the “illness ideology” that permeates contemporary times (Maddux, 2009; Szasz, 1997; Geist & Dreyer, 1993). There remains a lack of cogent empirical findings that link suicidal behaviors to actual physical or mental pathology (Hjelmeland, Dieserud, Dyregrov, Knizek, & Leenaars, 2012). What *does* promote this link is the permeation of the United States’ “cultural politics of emotion” (term coined by Puar, 2004) within biomedical science. With this in mind, embracing a more critical view of suicide and biomedical conceptions thereof is key to fuller understandings of this phenomenon. Analyzing attempt survivors’ narratives should provide more focus on these sociocultural aspects of what it means to live with suicidality—what it means to exist in a world that sees one’s mind as not only ill, but also deemed counter to the love of God and antithetical to basic human morality. Though these ideas are social in nature, their infiltration into biomedical practices cannot be dismissed (see Lupton, 2012).

Unpacking Cultural Politics in Biomedicine

Science is, at its core, a culturally- and historically-situated storytelling process (Haraway, 1976). In the United States, however, the notion that “health services are culturally constituted—both in terms of anticipated needs and in terms of how those

needs are addressed” is consistently overlooked, if not ignored entirely (Wexler & Gone, 2016, p. 57). Mainstream healthcare’s association with biomedical “science” means that patients are typically encouraged to view their doctors as godly entities, and themselves as rightfully subservient beings awaiting a treatment or cure (Charon, 2006). This power differential has significant implications interpersonally in terms of doctor-patient relationships, as well as in broader sociocultural senses in which science is Truth and physicians are determined presenters thereof.

Biomedicine and notions of “normality”. Within Western biomedicine, social understandings of appropriate behavior and normality have been almost completely eclipsed by the so-called pathological reign (Szasz, 1997). What was once understood as mere personal, individual action is now frequently claimed pathological; many human behaviors are claimed disordered—regardless of biological evidence for bodily error—whenever they deviate from the norm (Szasz, 2007). Though there is no doubt that many important medical breakthroughs and progresses have improved human lifespans and wellbeing, many other “advancements” are often unnecessary if not entirely counterproductive. In the words of Bergmans, Rowe, Dineen, and Johnson (2016), “the whole human experience is being medicalized” (p. 135). And with it, human brains are new objects for social control.

Hayden (1993) argues that illness is defined by what is perceived to be a socially deviant state. While this is undoubtedly valid, it is less commonly recognized that deviant states are often perceived as signals of illness (Rowe, 2016). Maddux (2011) summarizes this notion:

[B]oth physical and psychological disease are inherently social constructions that serve sociocultural goals and values and, therefore, our notions of psychological normality/abnormality and health/illness are filtered by our assumptions about how people should live their lives and about what constitutes a life worth living. (p. 63)

This means that while diagnoses are often first steps in the journey toward receiving medical treatment, they're often also condemnations. Diagnoses reflect static, dehumanizing understandings of a human body in which a person no longer "has" as problem, but *is* a problem (Horn et al, 2007, p. 266). This rhetorical gap between a person "having an illness" to "being ill" forms Othering, us/them dichotomies that allow people who carry diagnostic labels to be ostracized from society (Bergmans et al., 2016, p. 138). It also promotes the Great Origin Myth of suicidology: the implicit idea that the ultimate origin of suicide lies within the individual—regardless of external stressors and precursors (Oral, 1998, p. 229).

Formations of fear. This tendency toward illness ideologies is what creates the cultural image of the American Psycho: a crazy person whose mind is so diseased that their actions are utterly irrational...and almost always violent and unpredictable. The person living with a (diagnosed or undiagnosed but assumed) mental illness thus becomes an object of fear—a monster undeserving of compassion, empathy, or attempts at understanding (Pirkis, Blood, Francis, & McCallum, 2006). This abjection is extraordinarily relevant to social understandings of suicide, as well as academic ones. Stigma lessens the ease of academic research in the area, including acquiring grant money, Institutional Review Board (IRB) approval, and other support for such projects.

Unfortunately, I argue that this fear—academic or otherwise—simultaneously stems from and induces a lack of understanding.

Puar (2007) argues that despite our rhetorical use of the term (e.g., “I’m scared!”), fear does not come from within and move outward toward an object or Other; rather, fear works to cement a relationship between these two bodies that is already culturally situated (p. 62). She further explains that fear “envelopes the bodies that feel it, as well as constructs such bodies as enveloped, as contained by it” (p. 63). It therefore works to contain certain bodies within social spaces (p. 70): sometimes symbolically as in cases of media representations of the mentally ill as villainous, sometimes quite literally in the cases of forcible-admission insane asylums. The “mentally insane” are not a unified group, however. Social identities (e.g., race, gender, sexual orientation, class) are all hugely relevant to how and whether or not mental illnesses are attributed to various bodies.

Biomedical Histories of Identity-Based Oppression

As discussed previously, science was legitimized as a source of social control in place of many overtly religious forms of power in the 19th century. With this concurrent empowerment of biomedicine came a long history of oppression in the name of “science” in which biology was simply used to legitimize existing sociocultural fears. This is easily reviewed in histories of scientism regarding gender, sexuality, and race—all of which still remain prevalent in biomedical practices, though perhaps less visibly than in previous years. It is important to review these identity-based histories for two reasons: First, because suicidal people hold many varying social identities that impact their experiences;

and second, because, echoing crip theory perspectives, the identity of “suicidal” itself may also be framed as a site of identity-based oppression—one that deserves similar scrutiny to others such as sexism, racism, homophobia, transphobia and the like. Each of these is discussed below.

Gender: Hysteria, transphobia, and the psychopathology of deviance. Many feminist scholars argue that the Scientific Revolution was simply another manifestation of patriarchy, claiming that modern science was “inherently masculine and therefore driven to conquer nature and women’s bodies simultaneously” (Cody, 2010, p. 214). This may seem like a bold claim, but even a basic glance at the history of gender-based medicine illuminates this propensity quite deftly. Nineteenth century expert medical discourses of the “hysterical female body” marked all humans with vaginas incapable of rational thought or logical action due to their tendencies toward what was deemed excess emotionality (Barky, 1988; Beechy & Donald, 1985; Foucault, 1980). Beyond just tainting all women with this propensity toward insanity in the sociocultural sphere, “hystericism” was a medically diagnosable condition which even possessed a treatment: the use of what are now called vibrators to sexually stimulate a woman—of course by a [male] physician in a medical office—in hopes of easing her high-strung mind (Maines, 2001). Consent within this “treatment” remains a foggy ethical arena in which sexual assault was likely medically-induced.

The medicalization of childbirth serves as another example of sexism in biomedicine. Despite the fact that women had been giving birth without medical intervention since the dawn of the existence of homo sapiens, the biomedical field

quickly marked women incapable of knowing their own bodies and in need of masculine help (by obstetric doctors who were almost always male). Practices such as shackling, forced cesareans, twilight sleep, Pitocin cycling and other modes of controlling the birth process all suppressed women's birthing power through matrices of masculine and heterosexual dominance (Pollock, 1999, p. 10). Though in some cases prenatal health care increases the survival rates of babies and aids high-risk pregnancies, these external controls are often placed upon pregnant women regardless of their own and their babies' situations (Lake, 2008). The issue rests within that fact, not within biomedical assistance for women and babies who actually require it to survive.

The overwhelming biological essentialism which marked women (people assigned female at birth) as inherently weak, irrational, and in constant need of care is the same ideology that promotes transphobia within the medical community. Though the DSM-V marked a shift in this, previous editions of the APA's venerated text marked being transgender as a disorder (Krieg, 2013). Having a gender identity that did not align with the sex assigned at birth was deemed a psychological disease. Because of the "treatments"—social (being forced to live as the assigned gender) and medical (conversion therapies)—that followed the diagnosis of "gender identity disorder," to this day nearly half of all trans people attempt suicide in their lifetimes (Haas, Rodgers, & Herman, 2014). This example highlights the dangers of biomedicine's sociocultural base; it shows what people fear—what is Other—can be directly harmed, if not killed, by medicalization.

These examples of hystericism “treatments,” childbirth interventions, and transphobic therapies serve to highlight links between [cis]sexism and medicine—essentially the medicalization of patriarchy. In relation to suicidality, understanding this is essential because it brings forth questions of what could be called the medicalization of morality. If women and trans people were (and oftentimes still are) “ill” because their identities did not align with society’s definitions of normality, perhaps suicidal people are similarly defined as “unwell” because their thoughts and feelings seem to run counter to most sociocultural understandings of acceptable behavior.

Sexuality: Queer associations and criminality. This medicalization of Otherness is also exemplified by the medical field’s history of “treating” queerness. Though same-sex intercourse and other sexual acts and attractions have been documented throughout world history, their condemnation by the Church, and thus Western biomedicine, quickly made same-sex romantic/sexual feelings a diagnosable condition with the rise of medical power. Although the APA removed homosexuality from the DSM in 1973, the previous edition of the document marked it as a diagnosable—and thus treatable—disorder (Krieg, 2013). Conversion or “reparative” therapies including brain surgery, electric shock therapy, chemical castration, and psychoanalytic counseling were commonly performed in medical offices (Dean, 2014). Of course, these attempts at “curing” homosexuality were more a sociocultural treatment than a medical one.

Throughout the 1950s (the height of nuclear families and conversion therapies), anti-gay public service announcements about “the homosexuals” were commonplace. One called “Boys Beware,” which was produced with and narrated by a local police

department, warns young boys of the dangers of hitch-hiking—not because of potential criminal drivers, but because they might be picked up by “a homosexual.” The PSA follows the fictional story of Jimmy: a boy who falls victim to what was described in the film as a “sick man” afflicted with “a sickness that was not visible like smallpox, but no less dangerous and contagious: a sickness of the mind...a homosexual.” In this PSA and in the cultural sphere at large, same-sex desire was a form of perversion conflated with pedophilia and bestiality (see Nicoll, 2014). When biomedicine came to charge, it is not surprising then that diagnoses and treatments would take advantage of such a deeply-carved cultural fear. Of course, there is no known biological defect or “cause” of same-sex desire and it is now known within the medical community as a “natural biological variant” in humans (Vernon, 2012). From a critical standpoint, it is possible that suicidality is similar in nature, that it is a “natural variant” in humans that frightens the majority who do not experience it.

Race: Blackness and genetic inferiority. Though perhaps less frequently cited than the history of gender- and sexuality-based oppressions within science, race is a significant category in this arena as well. Critical race scholars have documented the massive impact of “science” upon process of racialization. Much like in the previously-described cases of oppression, white supremacy existed far before biomedical science. As “white” explorers journeyed into areas where people’s skin color differed from their own, they quickly made justifications for the subservience of such “discovered” (native) people (Robinson, 1983). The larger process of colonialism required narratives of brown and black inferiority to maintain its power (Gonder, 2004), and anthropologists have long

described people of color as antiquated, uncivilized beasts (Orbe, Warren, & Cornwell, 2000).

By the time genetics became a scientific study, racial difference had become a biological concern. Miscegenation laws and other forms of segregation were justified by an alleged genetic difference between white and black people. In *Genetics and Man* (1953), C. D. Darlington argued that “equality in the physical, intellectual and cultural capacities of such [racial] groups” is “make-believe” (p. 259). Though there was no biological evidence supporting such claims, marking people of color as scientifically subordinate to white folks was common practice. Remnants of such “biomedical” claims manifest in numerous jokes in today’s United States society, including political cartoons of black leaders displayed as monkeys (playing off the “missing link” stereotype) and the increased murders of black men by police officers (assuming the men’s irrationality and bestial nature). Once again, science—the unbiased and pure lens it is purported to be—serves as a source of sociocultural control and oppression.

Taking these three examples of gender, sexuality, and race into consultation with one another, it is clear that the role of biomedicine in addressing suicide and “mental health” must be questioned more critically. Since mental illness is often framed as an identity in itself (i.e., “She is mentally ill,” or “They are psycho”), being critical of the rhetorical and sociocultural impacts of its labeling is key. Medicalization transfers what is viewed as “abnormal” into a diagnosable illness, effectively containing deviations and, in turn, *deviants* as such. This directly impacts how society comes to know people—in this case those experiencing suicidality—and their ways of being in the world. This notion

has been addressed in relation to mental health numerous times in the past (e.g., Szasz, 1984; Szasz, 1988; Szasz, 1996; Szasz, 1997), but such claims have always met staunch resistance.

Mental health: A hidden site of biomedical oppression? Thomas Szasz rocked the psychiatric world in the early 1970s with his claims that the field's medicalization of the mind was unscientific and unbased. His central text *The Myth of Psychotherapy: Mental Health as Religion, Rhetoric, and Repression* (1979) caused significant uproar with claims that mental illness simply did not exist in any medical sense. Instead, Szasz argued that mental illness was simply a metaphor for human problems in living: "The 'diseased mind' is a metaphor, a mistake, a myth" (Szasz, 2007, p. xix). He further argued that this medicalization of the Other (so-called mentally ill patient) functions to control and punish, not to treat anything that helps that person in their own rite (p. xvi).

While Szasz's positions are radical and certainly contestable, his arguments highlight the need to be increasingly critical of the often unquestioned power held by biomedical mental healthcare practices. For example, mental hospitals—places where people are oftentimes sent against their will—are structured much like prisons, echoing the criminal/immoral sentiments surrounding mental "illness" (Whitehead, 1979). Containment rather than compassion is the norm created by confinement chambers, locked doors, bars, shackles, and fences barring patients from the outside world. Patients, much like prisoners, are also forced to take medications, food, and liquids into their bodies regardless of whether or not they agree to consume them (*Sell v. United States*, 539 U.S. 166, 123 S.Ct. 2174 [2003]). Occupants of such facilities are also barred from

their typical clothing (i.e. anything with strings is taken away, including shoes), technological devices, and contact with outsiders during psychiatric holds known as “suicide watches” (Carrigan & Lynch, 2003). While this sort of containment is meant to be a treatment focused on the preservation of life, it eerily resembles the “treatment” of criminals in the penal system.

Beyond the walls of such asylums, many of the outpatient “treatments” prescribed by biomedical doctors for so-claimed mental health disorders are experimental (Insel, 2012); many of the drugs can make their consumers severely ill, and can even lead to death. Though this is not exceptionally different from medications and treatments for physical health conditions, consent marks a massive divide. Adults with physical health conditions must consent to treatment therefor. By contrast, adults with mental health conditions can be quickly deemed unfit to make such decisions, and thus can be thrust into treatment, often residential in nature, without their own approval (see U.S. Supreme Court cases *Youngberg v. Romeo*, 102 S.Ct. 2452, U.S.Pa., 1982; *Mills v. Rogers*, 102 S.Ct. 2442 U.S., 1982; *Rennie v. Klein*, 102 S.Ct. 3506 U.S., 1982).

In fact, most schools, hospitals, and elder care centers have policies that force staff members to report incidents in which people share thoughts of self-harm or suicide (Lab & Lab, 2010). In broader legal terms, if a patient or student discloses that they are planning to kill themselves and a staff member explicitly agrees to keep this plan a secret, they can be charged with assisting self-murder, and therefore may be found guilty of manslaughter in many states (e.g., Florida § 782.08). Beyond these legal liabilities, the ethics of breaking privacy expectations in the name of preserving life are well-

understood. If a person needs urgent medical care but is unwilling or unable to pursue it, they may require an outside push. It must be noted however that despite the positive aspects of this potentially life-preserving act, many people considering suicide view reporting policies as deterrents to disclosure and prefer to stay silent about their thoughts (NAMI, 2012)—often for fear of the dehumanization that comes with forced hospitalization and treatment.

Even if suicidal people do not fear medical interventions, the social ostracization associated with being “crazy” (read: mentally ill, which is assumed when a person discloses suicidal thoughts or actions) is a massive barrier to sharing one’s experiences and thoughts. The stigma surrounding these subjects makes them very difficult to study and analyze in meaningful ways. Before proposing a new method of attempting to take on such a task, the role of stigma as a barrier to current understandings of suicide is addressed below.

Stigma as a Barrier to Understanding Suicide

Though not specific to the topic of suicide, there is considerable literature surrounding issues of stigma and isolation as they relate to social abjection. The most broadly cited understanding of this comes from the work of sociological researcher Erving Goffman. He defined stigma as “the situation of the individual who is disqualified from full social acceptance” (Goffman, 1963, p. 9). In contrast to earlier works that pointed to individual abnormalities as the cause of social denial, Goffman argued that a language of relationships must be highlighted when discussing stigma because an attribute that stigmatizes one person often functions to “confirm the usualness of another”

(Goffman, 1963, p. 5). In other words, what is “normal” is constructed in relation to what is “abnormal”; the two are intimately intertwined.

Recognizing this social base is essential to understanding the communicative function of stereotyping, a specific manifestation of stigma that is crucial to work on suicidality. Stereotypes serve as sense-making devices that allow people to make assumptions about relational others based on socially-assigned meanings of [un]desirable characteristics (Goffman, 1963). However, the objective of these typecasts is “not to reflect or represent a reality but to function as a disguise, or mystification, of objective social relations” (Carby, 1987). This process can have grave consequences for people living with mental illness, who are often stereotypically marked as “dangerous, incompetent, unable to care for themselves, and childlike” (Caputo & Rouner, 2011). These labels are especially harmful for people experiencing suicidality because such tags promote a dangerous spiral of social ostracism that discourages people from speaking out about their struggles, which ultimately bars them from access to proper care...and leads to increased death counts. To address the gravity of these stereotypes, a brief review of the mentally-ill-as-dangerous typecast is provided below.

Before continuing, it must be acknowledged that not all people with mental illnesses (PWMIs) are suicidal, and (arguably) not all people who kill themselves are mentally ill. The purpose of reviewing stereotypes against PWMIs is not to cement a link between the two. Rather, it is to acknowledge how biomedical conceptions of suicide as a product of mental illness are enmeshed with sociocultural understandings of what it means to be “crazy” or “deranged.” This conflation between being “psycho” (violent and

irrational) and being suicidal (seeking to harm oneself, not others) creates a harsh barrier to accessing, receiving, and providing compassionate care—medical or social in nature. The dehumanization that follows any sort of “mentally ill” marker is exemplified in American mass media.

Under the guise of protecting society from their alleged threat, the construction of the psychotic villain normalizes an ironic culture of physical and emotional violence *against* people suffering from mental illness. This pattern is frequently exemplified by mainstream media rhetoric surrounding mass shooters (e.g., gunmen at Virginia Tech [2007], the Aurora Theater [2012], Sandy Hook Elementary School [2012]). The actions of these aggressors (typically white men, since people of color are usually deemed “terrorists”) are almost always blamed on mental illness in breaking news reports—far before accurate knowledge of their medical statuses can be ascertained (Metzl & MacLeish, 2015). In response to this assumptive trend, psychological researchers Metzl and MacLeish (2015) conducted a vast review of literature on the subject of violence and mental health. They summarized their findings with the following:

Four assumptions frequently arise in the aftermath of mass shootings in the United States: (1) that mental illness causes gun violence, (2) that psychiatric diagnosis can predict gun crime, (3) that shootings represent the deranged acts of mentally ill loners, and (4) that gun control “won’t prevent” another Newtown (Connecticut school mass shooting). Each of these statements is certainly true in particular instances. Yet, as we show, notions of *mental illness that emerge in relation to mass shootings frequently reflect larger cultural stereotypes and anxieties about matters such as race/ethnicity, social class, and politics...* [M]entally ill’ ceases to be a medical designation and becomes a sign of violent threat. (p. 240) (emphasis mine)

This shift from “mental illness” as a medical classification to a label of impending danger isolates those living under the grips of the term, regardless of their individual actions.

While indeed the behaviors of some people struggling with mental illness do align with some aspects of their stigmatized identity, in this case stereotypical violence, the American Psychological Association reported in a 2014 study that only 7.5 percent of crimes committed by people with serious mental disorders were directly related to symptoms of mental illness (Peterson et al., 2014). By contrast, people with psychiatric disabilities and illnesses are far more likely to be targets than perpetrators of violent corporeal crime (Appleby et al., 2001); they're 2.5 times more likely to be attacked, raped, or mugged than the general population (Hiday, 1999). In essence, the backlash produced by the mentally-ill-as-dangerous stereotype is largely unfounded—particularly for suicidal people who seek to harm themselves, not others. Based on this notion as well as the extensive review on the rhetorical medicalization of suicide, I review current norms for studying this phenomenon before introducing a narrative theoretical base for the proposed study aimed at disrupting the silence surrounding this suicidality.

Definitional Debates and Cultural Politics in Science: Where Do We Go from Here?

As the above literature illuminates, understanding suicide as a medical malady or a social transgression—or some combination thereof—is not a simple process. Even defining “suicide” as a term is difficult because the word brings a host of historically- and culturally-situated meanings that differ vastly depending on its context in space and time. Despite this variability, the understanding of suicide as linked to biomedical/neurological mental illness is dominant in most U.S. medical and sociocultural circles. This claim of pathological origin is not backed by extant neurological research, but this does not mean such an internal cause is impossible; rather, it means that researchers must question the

domination of such a pathological understanding. Critical suicidologists and health communication researchers alike must attend to the complex history of identity-based oppressions within the medical field as well as the stigma surrounding suicidality in order to form more nuanced understandings of such an uncertain and convoluted phenomenon.

In order to exemplify this critical turn in my own work, I embrace narrative and crip theorizing as modes for grounding the analysis of suicide stories. Such critical qualitative approaches within the health communication field remain less common and less accepted than their quantitative counterparts (Thompson, Cusella, & Southwell, 2014), so adding crip narrative methods and theories helps expand the field while simultaneously growing academic understandings of suicide as a topic. With the call for more critical approaches to studying health communication in mind, the relevance of narrative and crip theorizing to my analysis is discussed below. This review serves as a guide toward the formation of my research question, beginning with a problematization of the current research norms within the field.

Narrative and crip theorizing as grounding the analysis of suicide stories. The vast majority of published research in the field of health communication remains quantitative and post-positivist in nature (Thompson et al., 2014). It is indisputable that these studies have made significant contributions to the field (White et al., 2016) and helped improve healthcare and in many ways. For suicidology in particular, quantitative risk factor studies have helped produce tools for social workers to better predict suicide in their clients (e.g., Sánchez, 2001). Such quantitative studies also tend to be more

persuasive with policy members when it comes to making protocol and funding changes (Berman, Ford-Gilboe, & Campbell, 1998).

However, this [post]positivist work often leaves the voices of those experiencing health issues themselves silent; it keeps power in the hands of researchers and away from those directly affected by illness. It also typically fails to account for critical issues because it rarely engages with issues of power (Doucet, Letourneau, & Stoppard, 2010). This is a significant issue since, as demonstrated previously, racism, sexism, homophobia, and other means of oppression are always relevant and oftentimes central to biomedical conceptualizations of illness. The continued silence of quantitative research in this realm directly contributes to the oppressive nature of medicalization. Therefore, for the health communication field in particular, being cognizant of how researchers communicate with those they study is key and ironically often ignored.

Studying suicide: Shifting from empiricism to narrative. Though quantitative research remains the norm within health communication, many scholars in the field have begun to address this issue by embracing visual (Willer, 2012; Moletsane et al., 2009), critical qualitative (Norwood & Turner, 2013), and narrative methods (Bute, Harter, Kirby, & Thompson, 2010; Harter, Japp, & Beck, 2008; Weaver-Hightower, 2012). These scholars show particular commitment to understanding health communication from the perspective of those experiencing health issues as opposed to external assessments, prescriptions, or analyses. Unfortunately, this drive has not been extended into health communication work on suicide in particular. In fact, very few studies in the communication field address suicide at all. A handful of scholars address the topic in

terms of risk assessment (Cummins et al., 2015), media representations and reporting (Parkins, Blood, Skehan, & Dare, 2010; Pollock & Yulis, 2010; Schäfer & Quiring, 2014), physician-assisted suicide (Joslyn & Haider-Markel, 2006), and suicide bombings (Berkowitz, 2005). Only one study (Kenny, 2009) addresses suicide and narrative together, but the work is rhetorically-based and emphasizes the power of argument and credibility in public judgement of physician-assisted suicide. None of the existing publications in health communication address suicidal individuals' meaning-making through narrative means.

In the narrower field of suicidology, quantitative research reigns supreme as well. The most comprehensive (in terms of the number of articles published annually) of the three top international journals in the field is *Suicide and Life-Threatening Behavior* (*SLTB*) (Hjelmeland, 2016, p. 32). In 2011, the journal's Editor in Chief, famed suicidologist Thomas Joiner, emphasized that he would include qualitative manuscripts in the journal, but that he would prioritize quantitative studies, "without which genuine progress [in suicide prevention] is distinctly unlikely" (p. 472). Of the next 110 articles published in *SLTB*, only two contained a qualitative portion (Hjelmeland, 2016). None were exclusively or even majority qualitative in nature.

While Joiner was correct in his claims that quantitative research is important because it often directly influences lab funding and policy change, the lack of qualitative inquiry in health communication, suicidology, and the rare overlaps between these fields is important because it dismisses a great deal of valuable knowledge. Such a limiting definition of what counts as scientific rigor results in a loss of many multifaceted and

historically-contingent aspects of suicide (White, 2012, p. 48). Furthermore, it does not embrace pluralistic understandings in which multiple “truths” or realities about an issue can be held simultaneously, which I argue is a central feature of meaningful analyses.

David Webb (2010), a suicidologist and an attempt survivor himself, explains this issue of empiricism carefully:

The academic and professional discipline of suicidology strives hard to be an objective science, but...it feels as if the expert ‘suicidologists’ are looking through the wrong end of their telescope. Their remote, long-distance (objective, empirical) view of suicide transforms the subjective reality and meaning of the suicidal crisis of the self—that is, the actual suicidal person—into almost invisible pinpricks in the far distance. (p. 40)

This distance, Webb (2010) argues, misses the heart of suicidology: the experiences of those considering self-inflicted death. Alongside Webb, I argue that human-centered research should promote better living conditions for its subjects. Narrative methods hold particular promise in such a realm since stories themselves are often understood as “equipment for living” in their literary form (Burke, 1973, p. 59) due to their function as sensemaking devices (e.g., Fox, 2014).

Narrative theory: Reclaiming suicidal storysharing. As opposed to the positivist methods employed by biomedical researchers, the narrative approach embraced in this study works to reclaim people’s own experiences as valid sites of knowledge. It [re]places the power of authorship in the hands of suicide attempt survivors themselves as opposed to leaving it with physicians and clinicians. This ability to write one’s own story is key because as Harter attests, “Health care is shaped ultimately by which stories are heard and taken seriously, and what sense is made of those stories” (2009, p. 141). Since people experiencing suicidality themselves have unique perspectives on their own needs

and circumstances, this story-based method allows them to decide what is and is not relevant to their care. Furthermore, narrative practices embrace a determined effort *not* to pathologize individuals, which is central to the goals of this work (Sather & Newman, 2016, p. 115).

Narrative also rejects the silence induced by the stigmas surrounding suicide. Lorde (1984) addresses the fears associated with speaking in such a fragile environment. “We fear the visibility without which we cannot truly live,” she claims (p. 42). Though there are certainly dangers in the telling, there are also dangers in the silence. “My silences had not protected me,” she writes. “Your silence will not protect you...[W]e all share[] a war against the tyrannies of silence” (Lorde, 1984, p. 41). Though these words were initially referencing issues of misogynoir and racist oppression, when applied to the topic of suicide, Lorde’s sentiments redefine speaking about “mental illness” or thoughts of self-inflicted death as brave acts in the face of persecution. This is particularly relevant for people of color, for whom talking about suicide and mental illness is often even more highly stigmatized than it is for white people (Walker, 2017).

This shift in framing suicide stories from weak admissions of brokenness to brave assertions of empowerment helps eclipse what Tuck (2009) refers to as damage-centered research. Instead of positivistically researching people as subjects who are “depleted, ruined, and helpless” (Tuck, 2009, p. 409), a narrative approach honors their power as subjects who make sense of their own experiences and thus contribute to the body of knowledge surrounding their suicidal labeling. It also allows them to participate in their own sensemaking as an avenue toward healing.

Storytelling as sensemaking. The individual teller's involvement in the narrative process highlights storytelling as an avenue toward "consciousness, engagement, responsibility, and ethicality" (Charon, 2006, p. 131). Strength and empowerment reside in the sharing of hidden stories, particularly when such tales are highly stigmatized. Being able to construct one's own life narrative helps "enable a sense of control in the face of threat and disorder," particularly in such chaos as that presented when one experiences suicidality (Sharf, Harter, Yamasaki, & Haidet, 2011, p. 38). This sense of personal control can have life-saving implications; Jones claims that storytelling is a "*survival strategy* for people who have been historically marginalized" (2015, p. 773) (emphasis mine). The choice to use narrative methods for this research is therefore as much about the activist potential of storysharing as it is about inquiry.

Personal empowerment aside, narratives are not merely individualistic accounts of experience. Langellier (1989) explains: "All personal narratives have a political function in that they produce a certain way of seeing the world which privileges certain interests (stories and meanings) over others, regardless of whether or not they contain explicit political content" (p. 271). Self-narrations are never separate from sociocultural influence. For the means of this the proposed study in particular, instead it must be noted that personal narrative is a highly social and cultural meaning-making performance—not an isolated event. In their narrative choices of characters, plot, and setting, suicidal storytellers essentially articulate what they believe is important to study within suicidology. These narrators hold the "transformative power to assert self-definitions about who matters and what matters: the existence, worth and vitality of a person or

group as meanings not otherwise available to an audience” (Langellier, 1999, p. 134).

Forcing an external judgement on what is important to study is no longer necessary with this method; such decisions are made by the participants themselves.

Narrative as dialogic. Despite the fact that narrators have the choice to construct their stories how they see fit, narrative is not a one way-process. Stories are social constructions based upon their narrators’ interactions—both real and imagined (Honeycutt, 2014)—with external others who possess socioculturally-bound notions of what it means to be suicidal, mentally ill, or “crazy.” This does not mean the stories are fabrications, but rather that “Truth is not born nor is it to be found inside the head of an individual person; it is born *between people* collectively searching for truth, in the process of their dialogic interaction” (Bakhtin, 1984, p. 110). “Truth,” perhaps more aptly, truths, are products of social and interpersonal meaning-making.

The body of work produced by Russian literary scholar Mikhail Bakhtin, contemporarily dubbed “dialogism,” argues that all utterances are intertextual; each one is a link in a complex chain of others, all of which are formed in relation to those that precede it (Bakhtin, 1986, p. 94). This argument is based on the notion that no individual speaker is the “biblical Adam” who describes objects for the first time; rather, she builds her utterance—in this case, a narrative—within existing systems of meaning (Bakhtin, 1986, p. 93). For suicidal storytellers, this means grappling with narrative untellability, an issue put forth by Shuman (2005) who argues that some stories are tellable only if the narrator is willing to live with existing categories for interpreting their experience (p. 7). In other words, stories must be told within specific frameworks (i.e., beginning, middle,

and end) and commonly accepted truths (i.e., that suicide represents an error in morality or health) if audiences are to understand these accounts.

Narrative untellability is particularly relevant for topics not often shared in narrative form—like suicide. For example, those who do not see their suicidality as biomedically-based will have to build their arguments around that norm, knowing that their truth may not make sense in a world that sees the ontology of suicide so uniformly. Likewise, someone who believes their suicidality is the product of heterosexism and homophobia will have to form their story in such a way that addresses the fact that many audience members will not see their identities as valid sources of oppression, or even valid in their own rite at all. This narrator-audience (or assumed audience) relationship will be key to the analysis suicide stories in the proposed study.

Research Question

In bringing together, critiquing, and problematizing many fields' extant conceptualizations of suicide with particular regard to the historical links between medicalization and moralization, I aimed to articulate a clear path to how the contemporary stigma surrounding suicide came into being. Like many other socioculturally-deemed “shameful” health issues, suicide is a complex phenomenon linked to the cultural politics of many religious, legal, moral, and medical epistemologies. The overarching issue within this epistemological complexity does not lie in its multifacetedness, but rather in the fact that suicide as a phenomenon is almost entirely understood from the perspective of outsiders (historically including priests, lawyers, and philosophers). Today, biomedical physicians possess the ultimate power of defining what

it means to be suicidal, what causes suicidal ideations and attempts. Their largely-unquestioned dominance in this arena is problematic because the biomedical field has a long history of using “science” to explain and justify the oppression of societal Others—perhaps now including suicidal people who are often dehumanized as psychotic, deranged outsiders.

In this study, I seek [re]empower suicide attempt survivors as legitimate sources of knowledge in order to curb the dominance of biomedical evaluations. Analyzing first-person narratives allows me to shift the power to make sense of and define suicide away from biomedical practitioners and into the hands of those who know suicidality firsthand. In order to understand these survivors’ sensemaking processes, I pose an overarching research question that engages with biomedical conceptions of suicide while also opening opportunities for alternative ways of knowing that embrace crip theory’s conception of mentally ill people as Others:

How do attempt survivors narrate their experiences of suicidality in ways that reflect and/or deny biomedical and sociocritical/crip understandings of suicide?

This research question honors narratives shared by suicide attempt survivors and offers a crucial piece of anti-stigma activism as well as a unique opportunity to expand definitional comprehensions of suicide as a whole. This work also aims to fortify the academic study of health communication by expanding its [post]positivist history into critical qualitative directions.

Chapter Two — Crippling Narrative Methods

Because biomedical definitions of suicide reign supreme in the United States, studying what suicide might mean outside of them—for instance, what it means to attempt survivors and those experiencing it firsthand—proves difficult. Narrative methods allow me to analyze and understand how suicide attempt survivors make sense of their experiences through storytelling. However, these methods don't inherently account for systems of power that my research question aims to confront. To address that lack, I add crip theory to the mix, effectively “cripping” narrative methods. As Sandahl (2003) describes, the act of crippling exposes “the arbitrary delineation between normal and defective and the negative social ramifications of attempts to homogenize humanity” (p. 37). In other words, crippling narrative methods allows me to emphasize uniqueness over homogeneity and disrupt the notion that suicidality is inherently abnormal. This practice also brings light to the harm of creating a “single story” for what it means to be suicidal.

In this chapter, I describe the process of crippling narrative methods more in-depth as it relates to my particular study. Before doing this, I first discuss my dataset of suicide attempt survivors' narratives and describe how these stories were collected. I then explain my iterative methodological approach that blends narrative and crip analyses through primary- and secondary-cycle coding. Finally, I detail peer data conferencing as the

validity check measure that helped ensure my research methods and the findings resulting from them were sound.

Suicide attempt survivors' stories as data. Despite my seemingly simple goal of honoring suicide attempt survivors' stories as sources of legitimate knowledge, the process of actually getting access to these stories proved a difficult matter. Many times survivors willing to share their suicide stories do so in very limited formats (such as anonymous online posts), reflecting their own fears and corporeal dangers related to stigma. Most websites that host suicide attempt narratives are filled with posts by faceless users, and these stories oftentimes are not shared with activist goals of promoting understanding; they are cries for help or sites to vent when close relational others do not or cannot listen. It is true that stories often serve both of these functions at once, and I do not seek to belittle narratives shared for solely therapeutic reasons. This is a vastly important role of storysharing. However, I wanted to be sure that the stories used in this study were not cries for help that I would be exploiting in a voyeuristic, unethical way.

With that sensitivity in mind, data for this project are transcriptions of narrative interviews from "Live Through This" (LTT): an online "collection of [photographic] portraits and stories of suicide attempt survivors, as told by those survivors" (livethroughthis.org). I chose this platform as my source for data because all of the LTT storytellers pointedly participated in the site's project in order to help others better understand suicide, and they specifically sought the opportunity to share their stories publically. I believe my research project honors these narrators' goals as well as those

posed by LTT without appropriating or exploiting content that was posted/made for other means.

Furthermore, from the photographs on the site it appears that a variety of races, genders, sexualities, socioeconomic classes, and ages are likely represented by the LTT narrators. These will not be assumed or collected for demographic means in this research project, however; they will only be analyzed as they are present in and relevant to the narrators' stories and the research question. Having a wide range of identities represented in the data is important to getting a fuller picture of suicide without restricting it to dominant norms of whiteness, heterosexuality, masculinity, and the like.

Generally, the narratives on the LTT website reveal a host of different storytelling styles, political investments, and personal goals. Many of the stories begin with childhood reflections on times when the narrators first encountered the notion of suicide or understood that humans could kill themselves. Some narratives talk about the background of stresses (often abuse and trauma) leading to an attempt, or their efforts to tell others they were suffering. Several storytellers also include explicit information on choosing methods for their attempts to die and the thought processes immediately preceding these attempts. Because of this variety, the LTT narratives highlight that no singular image of a "suicide story" is possible to define.

The fact that these narratives are available publicly online and the interviews gathering them were conducted prior to this project by an outside party (described below) also allows me as a researcher with no clinical mental healthcare background to hear these stories without placing participants at risk. Though this technically removes the

potential for me as a researcher to place people in harm's way, I am still concerned with the ethicality of how the narratives were gathered prior to my analysis. I wanted to be sure that the ways in which these stories were collected were careful to minimize risk of those involved. This concern was shared by the LTT project's founder: Des'Rae L. Stage, a self-described photographer, writer, and suicide awareness activist.

“Live Through This” data collection methods. In order to sit down with a suicide survivor and record their story, Stage requires that all story-sharers be over 18 years of age (the legal age of consent for most medical procedures), be willing to use their full name and likeness (not concerned about being “exposed”), and be at least one year out from their most recent suicide attempt (less likely to be retraumatized) (LTT, 2017). Furthermore, all participants submit an online form requesting to be a part of the project, so they are the ones initiating participation in this project; survivors aren't recruited or incentivized to speak. All of these efforts help create relatively safe environments without restricting participants so much that their stories were muted or altered in order to be accepted.

In addition to these careful protocols and their efforts to minimize risk to LTT participants, Stage is also trained in various crisis intervention techniques.² These techniques provide tools for her to conduct interviews in ethical and safe ways, which was important to me because the LTT project was not approved by an Institutional Review Board or any other sort of formal ethics committee since Stage is not an

² These crisis intervention trainings include QPR Gatekeeper Training and Applied Suicide Intervention Skills Training (ASIST), per Stage's curriculum vitae (available on the LTT website).

academic or medical provider by trade. I reasoned that as the sole interviewer for LTT, Stage's background in crisis intervention as well as undergraduate and graduate work in psychology act as further safeguards for the suicide attempt survivors with whom she interacts. Stage also travels around the country to collect these narratives, and often conducts her interviews in parks and other public locations near where her interviewees live. This likely means the participants are closer to their systems of support if they should need help after telling their stories.

Beyond these external efforts to learn about suicidality and protect those with histories thereof, Stage also has a rich personal and relational history with suicide. Stage's own suicide attempt coupled with the loss of friends to suicide was the major catalyst for her to begin working on LTT. In February of 2013, she raised \$23,000 via a Kickstarter campaign to begin the project with the goal of collecting portraits and narratives of suicide attempt survival around the country. In the years since then, Stage has collected over 160 narratives, and the project has been featured in many popular media outlets such as *Newsweek*, *The New York Times*, *Associated Press*, *NPR*, and *Upworthy*—all of which praise the work for its stigma-busting potential (see Carey, 2014; Clark, 2014; Aschwanden, 2014; Crary, 2013; Mariani, 2015). She also frequently presents projects at the American Association of Suicidology's annual conferences in addition to giving invited talks on the subject of suicide prevention at various colleges and universities around the United States.

When interviewing attempt survivors for her project, Stage leaves the structure of the narratives almost entirely up to the survivors. What both parties say is audio-recorded and later transcribed verbatim. Stage describes this process:

First, the survivor [introduces themselves and] tells their story. I let them go at their own pace and include only the details they wish to share. I try not to interrupt—I prefer it to be as purely from the survivor's perspective as possible and don't want to throw it off course. I do often ask questions at the end, but it's more of a conversation than an interview. There is no structure, and the content of the questions comes from the story. Everything is recorded. (LTT, 2017)

From my own reading of the transcripts, Stage's initial prompt does not offer direction other than asking the participants to tell their stories "as they see fit to tell them." After they are finished telling the story, Stage often asks questions about the narrators' involvements with healthcare institutions, including hospitalizations, use of medications, and whether or not these things were consensual and helpful. Examples of these questions in her interviews include: "Have you ever been on meds?" (AU)³ and "What was being hospitalized like for you?" (MR). She also prompts discussions with statements in addition to questions. For example, Stage probes with prompts such as "I want to hear your thoughts on mental illness not being a disease" (AU), and "Talk to me about your view on mental illness. Does it exist? Is it relevant?" (DJ).

While Stage includes these sorts of probing questions in nearly all of the interviews, she never leads with these questions, nor does she ask them in ways that directly criticize these healthcare systems; she simply opens space for peoples' interactions with biomedicine to shine through—for better or for worse. This provides

³ Each citation from LTT is marked with the initials of the narrator. A full list of the storytellers whose narratives I included in my analysis is available in Appendix A.

particularly fertile ground for this research study because the narrative-conversations allow Stage to probe into issues of biomedicine without overtly displaying an agenda that would sway participants to share certain perspectives while hiding others.⁴ However the narrators describe their experience with biomedical institutions, Stage seems to mirror their perspectives and validate whatever stance they take. For example, one teller detailed her fears of hospitalization: “I know where I’ll be taken: I’ll end up in an emergency room, and if there’s no room in the mental hospital, I’ll sit in an emergency room for three days. And that’s the big, scary thing” (EO). The narrator expressed concern over the care she would receive based on past histories of hospitalization and poor treatment within the biomedical system. Mirroring the colloquial language of her interviewee, Stage’s response was blunt: “Something a lot of us talk about is how the system’s so fucked up that if we get into it, we get mistreated a lot of the time, and that’s if we get into it at all.” “Yeah, exactly,” continued the participant, who then proceeded to elaborate on her perspective (EO). As this exemplifies, Stage reflects the standpoints of her participants and often uses this validation as a way to probe more deeply into the perspectives—but not to alter them.

Overall, Stage’s LTT narrative interview techniques provide a solid base upon which to set a research study because of her attention to recruitment ethics, unbiased

⁴ Stage does not share political leanings or goals on the LTT website. She does, however, have a statement of activist intent for the project: “The intention of *Live Through This* is to show that everyone is susceptible to depression and suicidal thoughts by sharing portraits and stories of real attempt survivors—people who look just like you. These feelings could affect your mom, your partner, or your brother, and the fear of talking about it can be a killer” (LTT, 2017).

interaction, and probing questions. She carefully reduces the risk to her participants by setting rules about who can share their stories on her site. Following an open-ended prompt, the interactions she has with the suicide attempt survivor-storytellers mirror the perspectives of these tellers. This allows her to support the interviewees and probe into their sensemaking processes more deeply through her follow-up questions. All of this contributes not only to a mine of rich qualitative data, but also a space in which suicide survivors are valued as experts of their own experience—and of suicide more broadly. As opposed to collecting data from biomedical practitioners or chemical tests, LTT offers an activist stage that [re]empowers people dealing with suicide to define what that means and what creates such feelings for themselves.

Data Analysis

To narrow down the vastness of the data available on LTT, I began by saving all of the published narratives as PDFs on my computer. I then sorted the files by name (all were titled with the names of the storytellers) and numbered them in alphabetical order. Next, I used a random number generator to select twenty of the stories for analysis with the understanding that if theoretical saturation was not reached, I would add additional narratives to the data set. The selected narratives ranged from two to 34 pages in length, altogether resulting in 236 single-spaced pages of data. After randomly selecting these files, I printed and placed them in a binder so I could read and code them without the distractions of my computer.

To analyze the binder of LTT narratives, I embraced an iterative approach (Tracy, 2013) based on narrative sensemaking (Yamasaki, Sharf, & Harter, 2014) and crip theory

frameworks (McRuer, 2006). This allowed me to bring extant literature and personal reflexivity to my analysis process without sacrificing norms for qualitative data analysis involved in careful and thorough coding processes. After finishing primary and secondary coding, I then used peer data conferencing to validate both my analysis procedures and the findings that came through them. These processes are reviewed in greater depth in the following sections.

Iterative approach. First, I began with a data immersion phase. To submerge myself in the stories, I read and re-read the collected narratives to grasp the breadth of the data and what was included (and excluded) in the narratives. I then conducted each of the following coding steps on the narratives. I reached theoretical saturation (see Glaser & Strauss, 1967) about three-quarters of the way through the twenty narratives, but continued the coding/analysis process to ensure this saturation was solid.

To analyze the narratives, I used an iterative approach that alternated between emic/emergent readings of the data and an etic/external joining of existing theories, knowledges, and explanations (Tracy, 2013, p. 184). This meant I was able to honor what the narrators shared (what emerged from their stories) as well as what extant research and perspectives (critical theories, past studies, my personal experiences) brought to the sensemaking process. This iterative approach was crucial because I aimed to bring an etic, existing framework—crip theory—into conversation with what emerged from the data. As highlighted in my research question, I also came to this project with a defined interest in the process of medicalization and how it relates to this subject. However, I was also interested in allowing the data to speak for itself since knowledge about suicide is

rarely valued when it comes from those experiencing suicidality themselves. An iterative approach allowed me to dip in and out of these broader topics while still analyzing what was present in the data itself.

Narrative and crip analyses. Within this iterative process, one of the primary sensitizing methods employed to examine these suicide stories was narrative analysis. Yamasaki, Sharf, and Harter (2014, p. 105) suggest multiple sites of focus toward which researchers should aim their attention: *characters, setting/context, plot/arrangement and timing of events, storytelling activities and relationships, consequences of narratives, and purposes/motivations of narratives*. In terms of the actual analysis process, those authors provide a list of guiding questions for each category inspired by narrative theory. In my analysis, I used these questions (see table below) as sensitizing devices to guide my initial readings of the data:

TABLE 6.1 Questions Inspired by Narrative Theory (Yamasaki, et al., 2014, p. 105)

Characters

- How are characters and actions organized in time and space?
- What archetypal characters live in stories (heroes, antagonists)? Who is chosen? Who is barred? Who is not eligible or qualified to enact certain roles?

Setting/Context

- What is the setting(s) of the actions? What is the setting(s) of the storytelling?
- How do contexts give rise to particular stories?
- How does storytelling reveal conditions of its production?
- What sorts of actions or developments does the setting suggest and/or require?
- What recurrent patterns of human symbolizing are developed and reinforced by conditions of living?

- What narrative conventions are privileged in particular contexts?
- What stories are (re)told in particular contexts until they become taken for granted?

Plot/Arrangement and Timing of Events

- How are the past and future envisioned in light of current circumstances?
- Why is the succession of events configured in this way?
- How did the outcome come about?
- What events and actions contributed to the solution?
- Are there inconsistencies that suggest alternative narratives?
- Where are the gaps in stories? Narrative silences? The unmentioned or unmentionable? Absence of some stories altogether?

Consequences of Narratives

- What does the story accomplish?
- What are the consequences produced by particular stories?
- What social orders are maintained or disrupted through storytelling?
- What subjectivities/identities are called into being by stories?
- What new possibilities do stories introduce for being in this world?
- Under what conditions is storytelling therapeutic?
- How do stories evolve and change over time as various constituencies render their experience in alternative stories?

Storytelling Activities and Relationships

- What worldviews are reflected in stories?
- What cultural markers of concern are revealed in narratives?
- Whose interests are served (or not) by stories?
- What stories are told to justify actions? Relationships?
- What motives are assigned to characters through storytelling?

Since my goal was to understand how attempt survivors narrate their experiences in ways that reflect and/or deny mainstream understandings of suicide, these questions allowed me to focus on various ways the narrators expressed their views. The questions and categories of analysis formed by them helped me find more nuance within the stories by allowing for simultaneous and contradicting truths. For example, a narrator might frame biomedical hospitals as settings for horrific abuse, but also frame medications as catalysts for their healing. This would suggest a more complex view of biomedical care that is not easily reducible to “good” or “bad” binary conclusions.

Through this narrative approach, I aim to add depth and richness to the primarily post-positive, empirical nature of the field. Most research in the area emphasizes predicting and controlling phenomena as opposed to critically analyzing the power structures behind them (Doucet, Letourneau, & Stoppard, 2010). In terms of suicide, this often manifests in overarching prevention suggestions that are *reactive* instead of *proactive*. An interpretive or constructivist approach—commonly aligned with narrative theory—expands these efforts and makes health communication research more open to participants’ own sensemaking and getting at the “why” behind suicidality *before* it becomes a dangerous act. This value is essential to my efforts of valuing suicide attempt survivor-storytellers’ narratives as valid and important sources of knowledge to better understanding the phenomenon.

Despite these benefits, such an interpretive approach still does not fully aim the analysis toward my research question. Crip theory directs that final turn toward critical sensemaking by allowing me to see pathology within the world as opposed to suicidal

individuals. It directs attention to the power of institutions (biomedical hospitals, universities, workplaces) and ideologies (chemical origins to suicide, belief that suicide is immoral) instead, ultimately serving as a critical lens through which to read the findings as they shined through the data. By combining narrative and crip theories, I effectively “crip” narrative methods (see Sandahl, 2003) by blurring lines of what counts as [ab]normal in terms of how suicide attempt survivors make sense of their experiences. This crippled-narrative practice helps address my research question because it disrupts power that typical defines what is and is not possible, remarkable, and normal in the world.

Primary-cycle coding: Narrative sensemaking. While embracing narrative sensemaking (Cunliffe & Coupland, 2001), I began with primary-cycle coding (Tracy, 2013). This open-coding phase identified data relevant to narrative inquiry such as the presence of characters, settings/contexts, the plot and arrangement of events, and the consequences of the narratives (see Yamasaki et al., 2014). These first level codes focused solely on what was present in the data without imposing “how” or “why” analytical notions. In practice, this meant going through the printed data with various highlighters, marking narrative elements and their roles in the stories (for example, marking characters and noting whether they had positive valences [heroes] or negative valences [villains]). During this, asking myself the questions in Yamasaki et al.’s “Questions Inspired by Narrative Theory” chart (2014, p. 105) helped me focus on how each narrative element (e.g., character, setting, plot line) revealed important analytical moves.

After going through all of the narratives in this fashion, I then placed all of the primary data into a digital spreadsheet with the same categorical headings as the aforementioned chart: *characters, setting/context, plot/arrangement and timing of events, storytelling activities and relationships, consequences of narratives, and purposes/motivations of narratives* (Yamasaki et al., 2014, p. 105). As I recorded the stories' elements in this chart, I began creating subcategories for repeated sentiments. For example, beneath "Purposes/Motivations of Narratives," I created subcategories for "Social Causes Upheld" (when narrators talked about social ostracism, homophobia, sexual abuse, etc. as linking to their suicidality), "Biomed Upheld" (when narrators embraced medication or hospitalization as key elements in their healing process), and "Crip Upheld" (when narrators directly cited ableism against people with mental illnesses as detrimental to their experiences). I continued creating categories beneath each narrative theory element until all of the data fit in some sort of relevant group.

Having the data arranged in this way allowed me to see themes in narrative elements, as well as contradictions in the way various narrators viewed certain aspects common in suicide stories. For example, one of the subcategories beneath "Settings" was "Role of Hospitalization." Scrolling down the spreadsheet, which was color-coded by category as a visual aid, this column allowed me to see significant differences in the ways various suicide attempt survivors framed this context in their narratives; some found in-patient care life-saving and essential while others framed it is the most horrific part of their attempt experience. Having the spreadsheet detailed in this way rather than merely labeled in the printed narratives themselves allowed me to make comparisons directly

without having to constantly flip through the data and rely on memory to find comparable narrative elements between the stories.

Secondary-cycle coding: Crip worldmaking. With the data organized in this spreadsheet format based on narrative theory, I then engaged in secondary-cycle coding in which I began to organize and synthesize the primary codes into interpretive concepts (Tracy, 2013). This process moved beyond mere description and instead emphasized analytic moves into theory and explanation. During this phase of analysis, I also engaged in prospective conjecture (Tracy, 2013) to employ crip theory and other relevant external models and assumptions. This practice allowed me to specifically focus on my research question, which emphasized the role of biomedicine within these stories.

Crip theory was not simply embraced and forced onto the data though; it was used both positively (affirming and constructing) and negatively (complicating or disrupting). For example, as I moved through secondary coding I created a broad category entitled “Crip Approach: Mental Illness as Abject” containing discursive content that framed suicidal people as society’s abject Others or, as I’ve come to term them, *Undesirables*. This included thematic subcategories such as “Institutional” (marking attempt survivors’ exclusion from social organizations) and “Intrapersonal” (marking internal concern about being viewed as “crazy” by close and distant relational others).

During this time, I also engaged negative case analyses that challenged these extant models and theories (Tracy, 2013). This runs directly in line with my research question, which posits two seemingly opposing realities in conversation with one another: biomedical and sociocritical/crip understandings of suicide. Exemplifying this, I had one

thematic category labeled “Embrace of Biomedicine” which contained narrative elements that supported biochemical understandings of mental illness and ran directly against crip understandings of disability located within society rather than in the individual. This helped me organize how narrators were including biomedical discourses in their stories in order to better understand how this model functioned, particularly as it was positioned in relation to assumed audiences.

Overall, this secondary-coding phase helped me dial data toward the research question while also ensuring that my own personal biases were not erasing the perspectives of the narrators. This reflexivity was key because the “mind and body of a qualitative researcher literally serve as research instruments—absorbing, sifting through, and interpreting the world through observation, participation, and interviewing” (Tracy, 2013, p. 3). In essence, who I am cannot be removed from what I see during the analysis process.

Overarching analysis procedures. In review of the above procedures, I began my analysis process by narrowing the field of data from the entire LTT website to twenty randomly-selected narratives (236 single-spaced pages). I then used an iterative approach to engage narrative and crip sensemaking while simultaneously honoring the information emanating from the stories themselves. Narrative theory provided direction to my primary-cycle coding, and crip theory did the same for my secondary-cycle coding. I recorded all parts of my analysis in a digital spreadsheet which allowed me to see the data in a clear, organized fashion. Once my initial findings were finished, I prepared to share them with others for corroboration.

Validity Check

After collecting these narratives and analyzing them on my own, I checked the validity of my findings using peer data conferencing (Braithwaite, Allen, & Moore, in press). There is a lack of consensus over verification steps qualitative researchers should undertake to validate their analyses (Morse et al., 2008; Tracy, 2010), but this method matched the goals of my study by allowing me to ensure that my own personal biases did not overshadow the narrators' stories. The stories had to remain at the core of this analysis regardless of whether or not the sensemaking present within them aligned with my own—academically or experientially. As a researcher who also has a personal history of suicidality, I believe it was important to have others who know me, my story, and my political biases on the subject present in reviewing my analysis process—a notion which this validity check method wholeheartedly embraced. Moreover, this validity check procedure spurred increased self-reflexivity for me as the primary researcher, which Tracy (2013, p. 2) argues is central to qualitative research. Knowing that my peers would critique my findings while acknowledging my positionality caused me to preemptively try to predict their critiques, thus engaging in reflexivity more carefully than I would have done otherwise.

Shifting to the formal validity check itself, Braithwaite et al. (in press) offer a clear outline of the steps involved in peer data conferencing. Following their lead, I first conducted my own analysis and created a rough “methods section draft” as I did so, recording all of my analysis steps and activities (Tracy, 2013, p. 196). Then I invited a group of four scholars (including two doctoral candidates, one doctoral student, and my

thesis advisor) who were willing to engage fully by thoroughly reviewing the codes as well as challenging my assumptions, analyses, and results. Collectively, these scholars had expertise in qualitative data analysis, narrative theory and analysis, and/or critical methods. During the actual data conference (roughly 2 hours in length), I explained the “trail” of my data analysis process and detailed the justifications for my findings in relation to my research question. All of us discussed the findings, possibilities for how they should be organized and revised categorically, and how this analysis would manifest in written form. We also helped reduce the findings to separate what was relevant to this particular project, and what could be saved for later projects in order to ensure that the scope was reasonable and applicable to the study at hand.

Grounding the study with phronetic roots. Reviewing the methods used for this study, I began with a praxis-based, “phronetic” approach to this research project (Tracy, 2007). I identified a particular problem in the world—misunderstandings of suicide and the mistreatment of those experiencing it—and systematically collected (in my case, found), interpreted, and critically analyzed data in order to “open[] a path for possible social transformation” (Tracy, 2013, p. 4). After narrowing my data field to 20 suicide attempt survivors’ narratives, I employed an iterative approach to engage narrative and crip theories while simultaneously honoring what the narrators themselves found important to share. Narrative theory provided direction to my primary-cycle coding, and crip theory did the same for my secondary-cycle coding. This process ultimately resulted in three clear categories narrators used to make sense of suicidality: (1) an embrace of the biomedical model of suicide as linked to internal pathology; (2) a crip view that

highlighted mental illness as abject in U.S. society; and (3) critiques of biomedicine that combined the former two categories and used that link to criticize current norms for healthcare surrounding suicide.

Chapter Three — Hybrid Ontologies: Biomedical and Crip Co-Minglings as Exhibiting Simultaneous Truths

Based on the literature review provided in Chapter One, defining suicide as a medical malady, social transgression, and/or something else entirely is no easy feat. Over time the term “suicide” has held multiple meanings depending on its context; religion, culture, law, science, and historical time periods all affected—and continue to affect—popular definitions of suicide. Though scientific arguments that self-inflicted death stems from mental pathology are most commonly accepted in the United States today, such claims lack scientific origin. There is no known link between mental pathology and suicidality (Hjelmeland et al., 2012; Szasz, 2011). Between this fact and the biomedical field’s histories of oppressive diagnostic measures that promote social control over pathological management, I expected some, if not most, suicide attempt survivors to critique the biomedical model of mental illness. Like Szasz (2007), who argued that mental illness was simply a metaphor for human problems in living, I thought that some of the narrators would position the “mental illness” framework as something used to control and punish social difference—or to erase other systematic oppressions (homophobia, racism, classism, etc.) altogether. Due to the dominance of biomedical discourse, however, I still expected that others would embrace the traditional mental illness model as truth. My research question, then, was as follows:

How do attempt survivors narrate their experiences of suicidality in ways that reflect and/or deny biomedical and sociocritical/crip understandings of suicide?

The “both/and” nature of this question was aimed at embracing complexity in the narratives as opposed to simply making an argument for one view or another. When discussing the results of the analysis, this more nuanced view is key because it allows for multiple truths to coexist without one erasing or overpowering another.

With that complexity in mind, I discuss three key thematic results of this research—each supported by Yamasaki et al.’s (2014) narrative elements (settings, characters, plot lines, etc.)—that relate to the research question. First, I examine the narrators’ use of the biomedical model and its importance to psychological healing as well as the social tellability of suicide stories. Next, I problematize the salience of this system by acknowledging hybrid models that blend biomedical understandings with forms that simultaneously discuss social causes for suicidality. Finally, I outline a crip framework for understanding mental illness as an abject, Othered social identity in order to form a broader critical framework for understanding suicidality and the barriers to receiving help before and after suicide attempts.

Utilizing Biomedical Epistemology

Though the 20 narratives I analyzed were unique in their depictions of suicidality, almost all of them ultimately embraced a biomedical model that framed suicide as linked to chemical or neurological errors within the brain. Even if the narrators experienced significant social and/or physical trauma leading to their attempts (e.g., rape, child abuse, bullying), they cited mental illness as the end cause of their suicidality. This biomedical

framing functioned narratively in two main ways: (1) by granting suicide attempt survivors access to diagnoses, care, and/or medications for American Psychological Association-sanctioned disorders; and (2) by working as a sensemaking device for audience members of suicide stories to better understand such a stigmatized concept.

Diagnoses as tools for accessing care. From a biomedical standpoint, many narrators framed official medical diagnoses as tools to better understand the way their brains worked. These diagnostic labels were important not only to the tellers' internal wellbeing (knowing that they were not alone in their struggles, that such thoughts and behaviors were not their fault), but also to receiving biomedical treatment such as medications and hospitalization when they felt they needed it.

One attempt survivor, Erin,⁵ explained the function of her diagnosis matter-of-factly: "...I will always think about killing myself. That's part of being bipolar" (EO). She presented this statement as an indisputable fact that explained her past history of what was previously assumed to be social deviance. Erin's younger years were packed with self-harm, getting kicked out of schools, and relational troubles—all of which contributed to her eventual suicidality, but could not be explained pre-diagnosis. Having an official diagnostic label is what allowed her to find what she felt was appropriate care: regular appointments with a "shrink" (counselor) and prescriptions for psychiatric medication. Using a biomedical framework for her narrative thus allowed her to make

⁵ All of the names included in this analysis are the actual names of the suicide attempt survivor-storytellers.

sense of her personal life history on an internal level, as well as an external one since she was able to justify her actions and thoughts to others.

Beyond Erin's story, medications such as anti-depressants and anti-psychotics were positioned throughout the narratives as crucial aids to the survivors' continued mental stability. Finding the correct medication or combination of medications often presented as a significant challenge since many people react differently—often horrifically—to psychiatric drugs. Such medications can lead to severe nausea, sexual dysfunction, sleep problems, increased anxiety, and increased suicidality and attempts (National Institute of Mental Health, 2016). For some, these imagined and/or experienced harmful effects cut off efforts to seek medication altogether. However, survivors that sought and were able to find the correct medication often positioned this moment a key turning point through which they were able to heal and get back to their everyday lives. Narratively, this meant that biomedical care was framed in a positive light. Furthermore, biomedical ontologies of suicide as an issue of chemical error in the brain was understood as something treatable through medication, even though finding proper medications could be difficult.

Despite this potential for medication-based recuperation, psychiatric drugs hold a harsh stigma in the United States' dominant cultural sphere. Shayda, an attempt survivor and longtime medication user exemplified how use of the biomedical model can eclipse such a stigma:

It's not like, "You're doing well now, you don't need your medication." It's actually like, "I'm doing well now *because* I have my medication." You wouldn't

tell someone who has diabetes, “You know what? You’re doing great, right? You can stop taking your insulin.” We just wouldn’t have that conversation with someone. (SK) (emphasis mine)

By putting psychiatric medications in conversation with those used to treat diabetes, Shayda challenged outside others who positioned her medication as unimportant. She earlier expressed undergoing significant pressure to stop taking these medications now that she is no longer suicidal, which, as she argued, would never happen in the case of a physical illness. In her case, the biomedical model functions positively as a metaphor to absolve suicide attempt survivors of some of the stigma that comes with receiving long term medical care. Biomedical discourse allows her story to make sense in the minds of those who may not understand, which makes receiving care (medications) for her mind much easier.

“Who am I to kill myself?”: Biomedicine as a cure for narrative untellability.

In addition to helping suicide attempt survivors find what they believed to be proper healthcare, calling on the dominant worldview of suicidality as inherently attached mental illness—something biochemical or neurological in origin—helped those without a history of trauma to convey their experiences of suicide to broader audiences. Many of the LTT narrators assumed that people would only accept, and thus understand, their suicide stories if the conditions leading up to the attempt were significantly horrific (e.g., hostage situations, repeated sexual abuse, starvation, etc.). By contrast, if the narrators lived relatively trauma-free, “normal” lives, their suicide narratives would not be

accepted; they would be unfairly judged or deemed utterly incoherent because they did not align with audience expectations.

For these narrators without seemingly “sufficient” traumatic pasts, a biomedical diagnosis of mental illness serves as a bridge across what would otherwise be an instance of narrative untellability: a gap in which the rising action (lack of trauma) of the stories wouldn’t seem to lead to the climax (suicide attempt). Shuman (2005) explains this phenomenon of untellability, noting that some stories are tellable “only if the teller is willing to live with existing categories for interpreting experience” (p. 7), in this case, if they could categorize their pre-attempt life as appropriately horrific, *or* if they were living with a mental illness that clouded their perceptions of reality.

The issue of pre-diagnosis untellability was expressed directly by many narrators. “Who am I to ask for help?” Matt explained, describing his past thinking patterns as shrouded in guilt. “Nothing bad happened to me. I grew up in a nice house with nice friends and family, so who the hell am I to kill myself?” (MF). This notion of lacking a justifiable cause for suicidality induced high levels of shame for this attempt survivor, and it was not until a physician designated his darkened mental state as biological in origin that he came to terms with his own thoughts. The biomedical model therefore helped Matt bridge the logical gap in his story by explaining his seemingly irrational thoughts as easily attributable to chemical imbalance. This understanding led to a sense of recovery in which suicide is “no longer an option” for him.

Internal dialogues concerning the ability to justify the desire to die were not simply personal issues, however; these fears of narrative untellability were often based in

past lived conversations with relational others. Lyndee revealed this issue in discussing her mental health prior to being suicidal:

A lot of people would say things like, “What do you have to be depressed about?” Which is silly because depression doesn’t need a reason; it just is. For the most part, my life wasn’t totally screwed up. I didn’t come from a bad background. I just didn’t have the reasons that people wanted. It just was. (LM)

As Lyndee explained, she lacked “the reasons that people wanted” (traumatic experiences) for being suicidal. This untellability isolated her because others simply could not understand *why* she felt the way she did. Beyond troubling the storytelling process, this untellability directly manifested in both Matt and Lyndee’s narratives as a deterrent for seeking social or medical help. The inability to form a socially “suitable” backstory around their suicidality directly prevented people from accessing care throughout the LTT narratives.

While a matter of faulty narration may seem minor, the impacts of untellability in a human society of storytellers (*homonarrans*) are extensive (Shuman, 2005). Narrative tellability functions here not simply in a social manner, but also as a crucial part of accessing life-saving care; it opens the doors for people to receive medications, hospitalizations, and other medical treatments. This access to care directly stemmed from narrators utilizing the biomedical model of mental illness. This biomedical framework allowed their narratives to make sense in a world that does not often find compassion or understanding in listening to accounts of self-inflicted death (or attempts thereof). Furthermore, the biomedical model also removes blame from the narrator, a key issue

since many people who die by or attempt suicide are deemed selfish and/or immoral (Reynolds, 2016).

Hybrid modeling: Social links to biological changes. While nearly all of the narrators used the biomedical master narrative of mental illness as the cause of suicidality to substantiate their stories, the vast majority blended these claims with others more social in origin. They created hybrid ontologies for their suicidal inclinations by arguing that mental health is both biological *and* affected by social circumstance. This finding substantiates the fields of epigenetics and trauma biology in their assertions that social horrors can, in fact, alter human biochemistry. With or without scientific backing, however, it is well-documented that the social contexts of suicide are extraordinarily relevant to people's decisions to attempt. As Reynolds (2016) explains, defining a person's suicide as solely internal in nature blurs the contexts of their struggles which, by extension, "obscures violence" committed against those who eventually die at their own hand (p. 175).

Within the LTT narratives, the importance of social contexts for suicide was expressed through metaphor. For example, when discussing whether or not he believed in the concept of mental illness following a lengthy conversation about his suicidality being linked to his perceived failings as a Mormon man to support his family financially, Dave explained, "I think, to a degree, all of us have [mental illnesses]. We always talk about baggage of life—that we all have baggage—and to a certain extent, I believe that mental illness is baggage that we carry with us: how we were raised, moments in our life" (DJ). Though this narrator also directly claimed that he believed in biological mental illness

and has seen it “up front,” he also suggested that the origin of such illnesses might not be purely chemical. This aligned with many other narratives whose tellers included histories of physical and emotional abuse, sexual assault, homophobic bullying, racism, and chronic physical illness.

Following the pattern of suicide stories including histories of abuse and suffering, another narrator more fully parses out this issue of trauma: “Well, mental illness, for many people, usually comes after a lot of trauma... So, it’s curious that we spend millions of dollars on looking at genetic causes when, instead, we could be looking at reaching trauma” (AU). The U.S. Department of Health and Human Services (2014) corroborates this assertion. Though they explain that trauma biology is still a developing area of research, it is already established that “exposure to trauma leads to a cascade of biological changes and stress responses” such as changes in the limbic system functioning, neurotransmitter-related dysregulation, and hypothalamic-pituitary-adrenal axis activity changes (USDHHS, 2014, p. 65). This means that traumatic experiences can and do, in fact, change human biology. Furthermore, they do so in ways that impact mental health in particular (e.g., Southwick et al., 1999).

Issues typically associated with horrific experiences like post-traumatic stress disorder (PTSD) are well-known to have psychosocial implications (avoiding certain spaces or situations, lashing out against loved ones). However, internal biological changes are rarely brought to conversation outside medical circles. Related to this issue, Oral (1998) remarks on the ‘great origin myth’ in suicidology: the implicit notion that “the ultimate origin of suicide, whatever the stressful precursors, lies within the person”

(p. 229). The trauma biology and epigenetics perspectives dismantle this assertion of the myth of internal causation as partial fable, and further highlight that social and biological perspectives on suicidality may not be so distant from one another. In fact, social issues may *cause* biological changes (neurological illnesses) that precipitate suicidal thoughts and actions. Though it is beyond the scope of this paper, more research on this matter could bridge many conflicting theories on the ontology of suicide. Instead of looking for an “ultimate cause” of suicide in this pursuit, I argue that researchers must hold space for multiple, likely simultaneous, truths.

Another suicide attempt survivor, Vyronika, explained through metaphor her worldview on the matter of social and biological comorbidities:

When one person in the community is sick, it's because the community itself is sick. [The sick person is] the canary. In the early mining days, they would take a canary down into the mineshaft and if the canary didn't sing, it's because there were gasses down there that were toxic and the canary had died...I think that people with illness of any sort are a canary for our community...Time and time again, it's proven itself true. People with mental illness were lacking on some sort of resource in their community, some sort of ability to meet their needs, because I think that that patterning in the brain happens as a coping mechanism. Their brain does something to make something happen. (VVM)

This metaphor presents a sophisticated scientific idea in a more accessible form by alluding to historical practices. In doing so, this counter narrative also frames people with mental illness as societal victims—not as aggressors as they are often framed in news

reports (shooters) (Metzl & MacLeish, 2015) and mainstream movies (psychological killers) (e.g., Michael Myers in *Halloween*, 1978; Buffalo Bill in *Silence of the Lambs*, 1991; Norman Bates in *Psycho*, 1960). Overall, this shift in framing alters the focus toward a more critical view of people with mental illness as “crazies” who are directly oppressed by their place as Others in the United States’ mainstream sociocultural sphere.

The [em]power[ment] of biomedical frames. Though all of the narratives I analyzed in this study depicted suicide in different lights, almost all of them utilized the biomedical model that frames suicide as linked to biochemical errors within the brain. “Mental illness” was repeatedly cited as the ultimate cause for the tellers’ suicidality, even if they experienced significant trauma leading to their attempts. Using this biomedical framing functioned narratively in two main ways: first, by granting suicide attempt survivors access to diagnoses, care, and/or medications; and second, by working as a sensemaking device for audience members of suicide stories to better understand such a stigmatized concept. Regardless of whether such a framework was included intentionally to meet these goals or simply what came naturally to the narrators, biomedical framings directly benefited suicide attempt survivors in their attempts to tell the stories of their experiences.

Crippling Mental Illness: “Crazies” as Society’s Ultimate Other

While the biomedical model was often used to aid attempt survivors in easing their own guilt for being suicidal seemingly without a justifiable traumatic cause, such pathological framings also had negative effects in the form of discrimination. Because the psychiatric view locates blame and illness within the individual—not the society—people

are often Othered as incurable deviants. Suicidal people within this lens become society's "Undesirables": people who cannot function "normally" and must be carefully monitored, controlled, and isolated from the rest of society. Suicidality in this sense is often framed as a contagion (i.e., the Werther Effect in which one person's suicide makes others more susceptible to copycat suicides) at best, and a danger (i.e., those who attack others before killing themselves) at worst. In all cases, suicidal people are framed as a selfish danger to society as opposed to people in need of help and compassion (see Batterham, Calear, & Christensen, 2013). This issue of stigma manifested in the narratives through three main channels: (1) media representations of monstrous "psychos"; (2) internalized intrapersonal messages about what it means to be "crazy"; and (3) institutional discrimination such as religious excommunication or employment termination.

Ignorance promoted by media representations of 'psychos'. Echoing the crip perspective, stigma evolving from media representations of the monstrously ill Other was a central part of the setting of nearly all of the LTT narratives. In the United States' most popular horror films, fictional characters with alleged mental illnesses are often portrayed as mass murderers, monsters, or similarly horrific beings unable to grasp normative, civilized life (e.g., Michael Myers in *Halloween*, 1978; Buffalo Bill in *Silence of the Lambs*, 1991; Norman Bates in *Psycho*, 1960). Mainstream news broadcasts often similarly attribute mental illnesses to criminals like school shooters without knowledge of any sort of biomedical diagnostic information for these aggressors (Metzl & MacLeish, 2015). This means that the "mental illness" label has effectively become a marker of

social abnormality as opposed to a confirmed pathological disorder, making media representations all the more important to analyze.

The permeation of media is significant in the realm of mental illness because for many people, media representations are not matched with somatically-gained knowledge (Ott & Mack, 2009). In other words, many people come to know mental illness and suicidality solely through media channels and representation—not interpersonal, direct interactions with those experiencing these issues. The narrators of LTT were well-aware of this phenomenon, and cited it numerous times as a barrier to receiving help. “Every single college shooting, all of this other stuff, you’ve got this anti-mental illness thing going on,” explained Erin. “At CNN, they do active shooter drills and people are afraid of people with mental illness. There’s no understanding of what mental illness is... We have such an ignorance” (EO). Erin’s assertion directly promotes a crip understanding of mental illness in which the issue lies not within the individual, but within the culture surrounding them. In this narrative, dealing with mental illness is framed as a manageable project in biomedical means (medication, therapy, etc.). However, reaching access to such care is hugely difficult in a world full of stigma and anti-“psycho” sentiments.

Further explaining this crip perspective on mental illness, Sarah, another attempt survivor with experience in mental health activism, emphasized this problem:

People have this view of what it means to have a mental health issue... what it means to be suicidal, and they then discriminate and they’re prejudiced against that. And it’s fear based, right? I get that. Most prejudice is, and it just permeates. It permeates everything about our culture. (SC)

Sarah's explanation affirms social science academic research on stigma. It is well documented that labeling someone as mentally ill is positively correlated with the belief of that person as dangerous (e.g., Angermeyer & Matschinger, 2003). This perception of danger directly leads to a desire for "greater social distance" from the person beneath the "mentally ill" label (Angermeyer & Matschinger, 2003, p. 308), a phenomenon that was frequently cited as a social concern amongst suicide attempt survivors' narrations. Matt, another of these survivors, similarly explained these fears of social ostracism: "I was afraid that someone was going to think I was fucking crazy...I was afraid of what people would think of what was going on inside of my head, that I was some kind of psycho, Columbine, some type of mass murderer, which I'm not" (MF). For him, identifying as mentally ill directly characterized him as "some type of mass murderer" in the eyes of those around him. This directly formed a barrier to him seeking any form of social or medical care—even in the most desperate of times. In his narrative and many others', media representations of people with mental illness as "psychos" were assumed to leak into the psyches of interpersonal others around him.

Internalized manifestations of stigma. Media representations of the monstrous mentally ill patient caused significant intra- and inter-personal struggles for suicide attempt survivors who were afraid that being diagnosed or deemed "ill" would mean that they were also "crazy." This conundrum surfaced throughout the narratives, particularly when the storytellers described themselves as characters. Melanie explained the trouble of seeking counseling, even when she knew she wanted and needed it: "I was ashamed of that, 'cause going to a therapist—I thought that meant I was crazy...I didn't want people

to think that I was crazy or weak or selfish” (MD). Even though this narrator believed attending therapy would help her wellbeing, her sense of self was harmed by internalized stigma that labeled her “weak” and “selfish” for seeking help—or even considering it.

Another attempt survivor, Misha, struggled with this issue in university settings. “Pure stigma was the one thing that really prevented me [from getting the help I needed]” he explained (MK). The silencing effect of stigma has grave consequences for U.S. college students in particular, for whom suicide is the leading cause of death (Schwartz, 2006). An estimated 73 percent of college students living with a mental health condition will experience a mental health crisis while on campus (NAMI, 2012), but 35 percent say that their school will know nothing about it (NAMI, 2012). Like Misha, many students shy away from seeking help due to fear of what sort of interpersonal backlash lies in the future.

In contrast to the harm induced by being called “crazy,” being able to describe themselves as “normal” was restorative for many narrators and typically served as a catalyst for an upward narrative arc. This un-labeling, or perhaps more accurately, label-replacement process gave people freedom to view themselves not as disordered, but as individuals experiencing a normative variant of human life. One survivor described this freedom found through reading a book in which the author, who was diagnosed with a mental illness herself, asserted the normalcy in being bipolar or depressed:

I didn’t realize at that point that other people have suicidal ideations all the time too, and that it was completely normal. [The author] told me I was normal for

what I had, and it was the most amazing [feeling]...I can't even tell you how awesome that was for me, to be like, 'You're normal.' (EO)

This excerpt reveals the power of counter-narrations which reclaim suicidality from biomedical views of disorder and abnormality. In doing so, its author reflects a crip understanding of mental illness that locates impairment within an ableist culture as opposed to an ill mind. In other words, the author expresses that what disabled her is societal notions of what it means to be mentally ill (insane, degenerate, etc.)—not her actual illnesses themselves. When she could redefine herself as “normal,” she was able to recover much more quickly and is now less bothered when her mind drifts to suicidal thoughts. Unfortunately, such a simultaneous view of diagnosed mental illness and “normalcy” existing together is not commonly held. The direct opposite view causes many issues for suicidal people dealing with institutions such as schools, workplaces, and religious establishments.

Institutional policies as bases for inducing crip perspectives. Suicide survivors' narratives aligned with crip perspectives most closely when they described being excluded from large social institutions based on stigmatized understandings of mental illness. In these locations, typically universities, workplaces, and sites of worship, being framed as sinful liabilities was particularly isolating because these institutions played central roles in the narrators' lives. One woman talked about Christian faith throughout her narrative, and her relationship with God was crucial to her post-attempt recovery. However, her experience with the church as an institution was not so positive:

There was a lack of understanding in the church. There were people who thought, “You just need to have more faith. Your lack of faith is what has led to your depression”...I've been very involved with my church for a very long time, and so I just expected more [support]. (LM)

The failing of this narrator's church to support her in this time of need was particularly salient to her story because she was raised believing that the church was a place for the Broken to find support. The fact that such an all-welcoming institution regarded her as too damaged to help was a huge blow to her psyche. In her narrative, therefore, the disabling nature of mental illness did not reside in her brain; it was upheld by religious, institutional views that reflected broader societal stigmas.

This experience of a religious institution as a site of harm is not unique to this narrators' story. “Self-murderers” (people who die by suicide) were often—and in some places continue to be—denied Christian burials (MacDonald & Murphy, 1990, p. 15). This practice stems from a long-running history of religious framings of suicide as a sin that challenges the authority of God as sovereign—a transgression that required punishment that was visible and served as an example to others (Marsh, 2010, p. 88). Such burial refusal policies were only recently changed in the Church of England, which until 2015 embraced ecclesiastical laws that prohibited people who died by suicide from receiving traditional burial rites (Doughty, 2015). Policies forbidding the burial of “self-murderers” remain in many other Christian factions.

Mirroring religious institutions' lack of compassion for suicide survivors (or non-survivors), educational systems also hold problematic policies therefor. Narrators that

cited troubles with universities held these schools as central locations for their being, and were crushed by the potential of being permanently marked as dysfunctional. Misha explained:

I was terrified that my university was gonna put some big black mark on my record because I had a suicide attempt, and that I would never get hired where I wanted to go...I was terrified that if I went and got psychological help, they would write me off for good...because who the fuck would want a crazy? That is the most damaging perception because it prevented me from fully seeking help.

(MK)

Though Misha was more concerned about his future career than collegiate inclusion itself, his reference to the school marking him as Other represents a common—and justified—concern. Some universities force students receiving mental health care to withdraw from the school, and many don't guarantee readmission even after the treatment is finished (Scelfo, 2015). This means that students who require medical care can be barred from participation in the academy entirely, even after a known-temporary crisis is resolved. This exclusion likely damages students twofold: first by increasing [oftentimes already-high] levels of anxiety and depression, and second by serving as a deterrent to seeking proper care.

Administrative powers aside, universities are legally required to manage students with mental illnesses according to the Americans with Disabilities Act (ADA) guidelines. This legislation explicitly states that “reasonable accommodations” must be made for students living with “impairments,” including mental illness (American with Disabilities

Act of 1990, § 12112). Under the ADA, universities may not exclude students because of their mental health needs unless they fail to meet the university's scholastic and behavioral standards even after receiving medical treatment and social assistance. However, many universities fail to live up to these legal standards. They frequently force students out of university housing, classes, athletics—sometimes fully ejecting from the university as a whole despite the clear dangers of this ostracism (Scelfo, 2015). These institutional policies rarely benefit students struggling with mental illness; they instead serve university interests regarding liability and the financial implications of providing special services for students.

Churches' and universities' failings to accept and care for suicidal people commonly extend to other institutions; it is common for workplaces of all kinds to fire or mistreat employees struggling with mental illnesses (Brohan & Thornicroft, 2010). Unemployment is alarmingly high for people with mental illnesses as well, sometimes as much as nine times higher than in the general population (Satorius & Schulze, 2005). This issue is exemplified by Kelechi, a suicide survivor and mental health consultant, who described reaching out to her boss about mental and emotional struggles in relation to her rapist's continued attempts to contact her, only to be fired due to the stigma of such an admission: "I told [my boss] my whole story. She sat with me and she listened and she looked at me empathetically and cared. The next day, I overheard her say to someone, 'Oh, we gotta get rid of Kelechi. She's crazy'" (KM). As other suicide survivors avoided telling others about their thoughts for fear social ostracization, this story affirms that such

hiding actions were justified; the stigma surrounding mental illness holds very real social and economic consequences.

Implications of crip issues. Nearly all of the survivors who shared their stories with LTT demonstrated the impact of stigma on their experiences with suicide. Whether noting this at mainstream media, intrapersonal, or institutional levels, the narrators consistently noted that suicidal people are framed as society's undesirable Others—perhaps even the ultimate Others. Regardless of the narrators' other oppressed identities (race, gender, sexuality, class, etc.), being deemed “mentally ill” offered a sort of supreme, final straw of Otherness. That said, this does not mean that other identities do not matter when discussing suicidality. An intersectional perspective (Crenshaw, 1989; 1991) highlights a sort of compounding Otherness in which other oppressed identities combine with mental illness to create an even more nuanced and difficult situation for those experiencing suicidality. This is not surprising due to the history of the biomedical oppression of people of color, queer folks, women, and those of low socioeconomic status, but it is often erased in academic suicidology circles and in broader whitewashed activism on the subject (Wexler & Gone, 2016; Fullagar & O'Brien, 2016; Reynolds, 2016).

Oftentimes this erasure is justified by claims that pain caused by suicide should not be ranked as more or less extreme based on social identities. In other words, a white straight woman and a black trans and pansexual person, when attempting suicide, are in the same level of pain—the amount required to make them want to die. This notion is, at its core, true. Oppression cannot be ranked or made numerical “arithmetically” (May,

2015), nor can human psych-ache be quantified. However, this perspective also erases key factors in how other oppressive systems such as racism and homophobia form a matrix of domination (Collins, 2009) with ableist ideologies in ways that directly impact how people experience social and medical care for suicidality and suicide attempts.

Honoring Simultaneous Truths

The suicide attempt survivor-storytellers included in this study were not unified in their definitions of the origins of suicidality. Most utilized biomedical ontologies that linked suicidality to neurological or chemical errors within their brains. This biological framework allowed them to eclipse issues of narrative untellability, as well as gaining access to the care (medications, hospitalizations) that they believed they needed. Other narrators problematized this biomedical perspective with personal histories of trauma (e.g., rape, abuse, homophobia) as forces contributing to their suicidal leanings, as well as highlighting the stigma of being called “mentally ill” as a harmful force in their lives. Despite these ontological conversations and findings, I reiterate that the goal of this study is not to locate some sort of ultimate Truth about the core of suicide as biological or social in origin. Rather, it is to honor multiple, simultaneous truths and analyze how they relate to the way humans care for, interact with, and live as suicidal people.

Chapter Four — Honoring Experiential Accounts of the Oppressive Manifestations of “Crazy” Otherness in Biomedical Care

In preparation for this study, I reviewed extensive literature on the history of the biomedical field. While God (or the men who claimed to represent His⁶ ideals) was the main source of social control in the Western world prior to the 19th century, science (and those who wrote it) became the new arbiter of social control through the Scientific Revolution. This newfound scientific power brought with it a substantial history of oppression in which biology was simply used to legitimize existing sociocultural fears through the process of medicalization. Identity-based oppression against women, trans people, queer folks, people of color, and others were effectively sanctioned by “science” and biomedicine.

With this history of oppression in mind, I came to this study expecting narrators to reject biomedical understandings of mental illness. Following the biomedical field’s history of medicalizing other oppressed identities, I was highly critical of any claims that suicide was simply attributable to some sort of illness. By contrast, I aligned with Szasz in his arguments that mental illness was simply a metaphor for human problems in living, that the “‘diseased mind’ is a metaphor, a mistake, a myth” (2007, p. xix). In other words,

⁶ “His” is capitalized in reference to the Christian God, who was and is the primary figure of holiness in the Western World.

mental illness was often used as a disguise to hide contextual issues of social and bodily trauma (sexual abuse, racism, homophobia, etc.). Particularly because there remains a lack of empirical findings that solidly link suicidal behaviors to actual physical or mental pathology (Hjelmeland et al., 2012; Szasz, 2011), I was initially concerned that the LTT narrators were somehow duped by biomedical institutions and the discourses of science that underlie them.

Though it initially seemed as if the understandings of biomedicine as an oppressor were irrelevant to these narrators' stories of suicidality, the survivors' accounts of the biomedical care they received following their attempts revealed a different story. While still embracing the biomedical mental illness model, the vast majority of the LTT narratives aligned with Szasz's critical perspective in another way. Though they did not agree that mental healthcare was fruitless or that mental illness was a metaphor, the narrators did echo Szasz's argument that medicalization, at least in part, functions to control and punish those labeled "mentally ill" (Szasz, 2007, p. xvi). This was particularly relevant to the parts of their stories that took place in biomedical hospitals and psychiatric wards.

This medical, institutional location is key because while most of the LTT narrators embrace the biomedical model that poses deficits within their brains as the cause of their disability, they also pointed to oppressive practices and policies in mental healthcare systems as further disabling forces. This crip understanding highlights that while the narrators believed that their problems were in some way internal, their

hardships were compounded by external structures that unnecessarily prevented them from participating as full members of society.

Though numerous other academics and legal sources have reported issues within psychiatric treatment centers that align with this perspective (Department of Public Health, 2014; Campbell & King, 2009) the set of critiques in this chapter comes directly from the suicide attempt survivors themselves. I use outside sources to further explain their narratives, but the core of each critique remains rooted deeply in the stories told by those experiencing issues with biomedical mental healthcare firsthand. On a boarder level, my efforts to honor what narrators described as relevant epistemologically honors theories of the flesh: a perspective that privileges the body as a way and site of knowing (Anzaldúa & Moraga, 1983). This is important because suicide attempt survivors are rarely allowed to define their own experiences and almost never considered credible when they articulate their personal histories. My methods therefore offer a power shift that values individuals living with suicidality as experts of their own experience, which by extension challenges the authority of their healthcare providers and external others who oversee biomedical care such as government officials or attorneys.

The LTT narrators' main critiques of biomedical care are rooted in oppressive manifestations of Otherness—essentially healthcare providers seeing patients as “psychos” or monstrous Others. Because the world was not built to handle these Undesirables, the biomedical system has little pressure or motivation to improve; it reflects the original bias of people with mental illness as Others *and* perpetuates it. In this chapter, I discuss four categories of critiques put forth by LTT suicide survivors in their

accounts of [not] receiving medical care.⁷ First, I outline the difficulties of accessing mental healthcare as they relate to crip understandings of mental illness as abject. Next, I work through compounding oppressions and cultural illiteracy as they impact people's experiences—particularly as they relate to race—while receiving out-patient care. Finally, I talk about the manifestations of crip othering within in-patient institutions and how stigma directly impacts human bodies and lives as they exist in such facilities or, as they are often claimed in metaphor, “prisons for the mentally ill.”

Crip Implications for Accessing Care

For people experiencing suicidality, the manifestations of stigma impact their medical care even before they receive it. As outlined in Chapter Three, media-based, intrapersonal, and institutional oppressions based in stigma intertwine to co-form suicide attempt survivors as abject Others in the broader sociocultural sphere. Beyond initially coming to understand the social implications of being viewed as Undesirables, suicide attempt survivors cited two main barriers to receiving care: (1) cost of treatment; and (2) not being taken seriously enough to receive care despite requests therefor. Both of these reflected crip understandings of suicidality within the narrators, meaning that these survivor-storytellers viewed the disability of being suicidal as rooted in the external world as opposed to their internal minds/selves. It was the biomedical care they received

⁷ I separated these critiques from the analysis section because I viewed them as the narrators' discussions of why understanding how suicide gets defined is important. Beyond analyzing how suicide is explained ontologically, these critiques of biomedicine discuss care-based manifestations of power dynamics between biomedical and other less pervasive perspectives on the subject.

that was disabling—not their suicidal minds which could, by contrast, be treated and potentially cured were it not for these barriers.

Treatment cost. Because the United States currently runs a system of privatized healthcare in which individuals pay for all of their own care and insurance, obtaining desired biomedical or otherwise therapeutic services for mental illnesses (including suicidality, whether or not it is linked to neurological pathology) is hugely cost prohibitive and restrictive. Narrators framed cost as a direct barrier to the progress of their healing because they could not afford access to such care, even with private insurance because these policies rarely covered mental healthcare. One of the attempt survivors, Erin, exemplified this issue of classism as a barrier to care:

There are some amazing programs out there, but they're for people who have money. I cannot tell you how many times I have wished and prayed to God that somebody would send me to Sierra Tucson⁸ so I could take time to focus and get back to me, but I don't have \$30,000 to spend a month there. I don't. They're all over the place, these nice, private hospitals, and they don't take insurance, so you end up in places like here. (EO)

As Erin alluded to “places like here,” she contrasted private residential care centers with her own: one that she said did not use medical imaging or other tests to better understand what was happening in her brain, and was staffed with low-paid, uninterested clinicians. I argue that the overarching lack of affordable and proper healthcare for people with

⁸ Sierra Tucson is an internationally-renowned residential campus for the treatment of mental health disorders. Though the website does not include information on cost (it's different for all patients), online sources estimate the monthly price at ~\$45,000.

diagnosed mental illnesses—as described by Erin and many other narrators—largely stems from the fact that such people are viewed as Others: subhuman, non-members of society who do not deserve the community’s attention or resources. This perspective is similarly adopted by Vyronika, who noted (in her previously discussed metaphor of a suicidal person in society as the canary in the mineshaft) that the lack of care is a systemic, community-wide issue.

With that community-wide context in mind, this care gap as it relates to socioeconomic status is increasingly discussed in the United States’ political sphere, particularly with partisan conflicts between the Affordable Care Act (“Obamacare”) and the recently-failed GOP replacement plan (Collinson et al., 2017). According to the U.S. Department of Health and Human Services (2017), the Affordable Care Act (ACA) prevents insurance plans from denying coverage or increasing its cost based on pre-existing health conditions, including mental illnesses. However, the ACA is being challenged by republican majorities across the House of Representatives and the Senate, as well as the White House. Even if it were to survive the recent conservative push in Congress, the ACA does not necessarily provide patients with access to private hospitals like Sierra Tucson as LTT narrator Erin seeks. The wealthy still have access to levels of care that lower class individuals simply cannot access—insurance/ACA coverage or not.

Narrators in the present study that *could* afford private residential care (likely indicating high levels of class privilege) were much less critical of the care they received. For example, Megan described her experience as much more positive than the majority of the other LTT narrators:

I decided I was going to go into a women’s program at a hospital in Rhode Island...I got to come home that night and sleep in my own bed, which was real nice, and then I would be there all day learning skills: how to deal with things, talking to therapists, getting medications fixed, and stuff like that. That was literally the best thing that has happened to me. (MR)

This narrative’s description of healthcare facilities as positive settings was far from the majority of the others’ experiences (detailed in later sections of this chapter). The class divide which seems to split these experiences is not likely to change within the United States’ capitalist system, so this issue of cost-based barriers to care must be addressed in future healthcare policies.

“Looking suicidal” versus “performing normality”. Mirroring many other “invisible illnesses” (Arrol & Dancy, 2014; Selak & Overman, 2012), recognizing a person as suicidal through external means is difficult. Many crisis intervention centers offer ways to recognize people at risk for suicide. Such “signs” include as loss of interest in usual hobbies, sleeping too much or too little, and stressful life events such as job loss or divorce (American Foundation for Suicide Prevention, 2017). However, the vast majority of people exhibiting these signs and circumstances never consider or attempt suicide, and many people who do attempt seem “normal” based on outsider evaluations. This seeming “normal” issue is particularly relevant for suicidal people who do not align with the stereotypical image of what a person planning a suicide looks like (distracted, distanced, etc.). Many LTT narrators brought up this issue in their own experiences of seeking care.

When characterizing themselves within their narratives, many suicide attempt survivors noted that their social functionality (relative to the assumption that suicidal people cannot engage in typical life tasks) meant that they were not taken seriously by biomedical care providers. If the narrators did not properly perform “mentally ill” or “suicidal”—meaning they were visibly distraught or “psychotic”—when seeking help, clinicians often assumed they were faking it or otherwise deemed these people unworthy of attention. Sarah explained her experience with this: “I went to a school counselor and asked for help, and they told me that I didn’t really need help: ‘You don’t have problems. You get really good grades and you have friends. Everything’s okay’” (SC). Being denied care based on performance is particularly problematic for teens and young adults. The group’s increased investment in social relationships frequently manifests itself in excessive concern about the possibility of being disliked by others, and as a result, individuals within it often place high value on performing in ways designed to please those around them (Robins & Block, 1988). This means that they are likely to perform “normality” (in Sarah’s case, “get really good grades”) and hide any sorts of behavior that may identify them as “crazy” or otherwise abnormal, even during times of significant psyche-ache or emotional trauma.

Such hiding also has protective effects in a world that harms people with mental illnesses. As stated previously, people with mental illnesses (diagnosed or assumed) are 2.5 times more likely to be attacked, raped, or mugged than the general population (Hiday, 1999), and are frequently subject to institutional discrimination (Brohan & Thornicroft, 2010; Scelfo, 2015). This means that people experiencing suicidality are

likely to hide their thoughts and outward signals thereof. Despite this propensity to fake “being okay,” biomedical care providers continue to reject patients who do not seem adequately distressed and therefore believably suicidal.

Kelechi, another narrator who struggled to receive care based on outward evaluations of her abilities, expressed outright mocking of her requests for medical care:

At the hospital, they laughed at me. They were like, “You’re so high functioning! You’re fine!”...I was like, you know, “I want to die.” Doesn’t mean that I can’t tell you that I want to die, just because I use good words...Because I can eloquently tell you I want to die, you’re like, “Oh you’re healthy. You’re fine.”

(KM)

Though it is clear that many people who are suicidal can still function in school, workplaces, and the like, the dominant cultural image of “psychos” hides this reality from outside eyes—including healthcare providers. This issue may initially seem practical, as though the providers are simply trying to determine who needs and does not need care so they can be most efficient. However, the clinicians’ laughter included in Kelechi’s story suggests that efficiency is not the sole result of such practices; impact and intent are not necessarily aligned. Efforts to visibly determine who is “truly” suicidal can function to further marginalize those who seek care, reflecting broader oppressive views of biomedical clinicians as the sole arbiters of defining who is sick and what sort of care they need.

Barriers to care: A cripper perspective. As expressed above, the manifestations of stigma impact suicidal people’s medical care at a base level by acting as gatekeepers.

Attempt survivors cited two main barriers to receiving care for suicidality: (1) cost and lack of insurance coverage; and (2) not being taken seriously enough to receive care despite requests therefor. I argue that these issues reflect crip understandings of suicidality within the narrators. Mirroring the tenants of crip theory, these survivor-storytellers viewed the disability of being suicidal as rooted in the external world (insurance companies, privatized healthcare, biomedical care providers) as opposed to their internal minds/selves. It was the biomedical care they received that was disabling—not their suicidal brains.

Compounding Oppression and Cultural Illiteracy

When looking at suicide narratives, it is essential to note that the tellers are not simply “suicidal” people. They hold a myriad of other social identities such as race, gender, class, sexual orientation, age, nationality, and ability. Taking an intersectional approach (that embraces these various social identities) to analyzing the failings of biomedical care allows for deeper and more nuanced analysis that favors critical views over generalizable ones (May, 2015). This perspective illuminated two main critiques of biomedical care in the LTT narratives: (1) a lack of social identity awareness during care; and (2) failure to address social issues and oppression beyond mental health. These two themes are closely interrelated, but the former refers to how patient care is conducted, while the latter focuses on the causes of suicidality in the first place.

Lacking social identity awareness during care. Survivor-storytellers often cast those providing medical care as villain characters who contributed to their trauma instead of easing it. Most often, this was due to the fact that these clinicians—knowingly or

not—contributed to systems of oppression already at play because they did not recognize the importance of the sociocultural identities held by their patients. In other words, they perpetuated racist, homophobic, or otherwise oppressive ideologies through their words and actions. Angela, a black woman who dealt with suicidality from a young age, explained the impact of racism on the care she was given:

I was put on Seroquel.⁹ About 800mg, which is absolutely horrible, since the standard dose is 300. African Americans, unfortunately, are usually dosed much more highly than whites. I fell over in the streets and the doctor decided to lower it to 600mg...[Physicians] saw African Americans as being more aggressive and more dangerous, even if the symptoms presented by a white person were the same, and they tended to dose [African Americans] higher. (AU)

Angela's claims are not without backing. Clinicians in emergency rooms prescribe more and higher doses of antipsychotic medications to African Americans than to whites (Segel et al, 1996), as do other physicians and nurses working in in-patient wards (Chung, Mahler, & Kakuma, 1995). Though some argue that this is because black people's metabolisms biologically require more medications for the drugs to be effective, the opposite is presented in biomedical research. A greater amount of African Americans than whites are said to metabolize various psychiatric medications more slowly, and they are more sensitive to them overall (Ziegler & Biggs, 1977; Bradford et al., 1998). This means they should be dosed at lower levels, not higher ones.

⁹ Seroquel is a brand-name form of quetiapine, an antipsychotic medication used for the treatment of schizophrenia, bipolar disorder, and major depressive disorder.

While race-based science is clouded in histories of oppression (Robinson, 1983), the fact that these studies are regarded by the Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity (2001) as Truth means that they should be taken seriously by the medical community. The fact that African Americans receive larger doses of medications despite this is hugely problematic, and reflects stereotypical views of the black body as a site of danger (see Orbe et al., 2000). This racist oppression combines with views of the mentally ill as menacing to society in order to form a sort of compounding oppression for people of color experiencing suicidality.

This assemblage of identity-based oppression is also found in people who have a history of other mental illnesses. Cleo, a combat veteran with severe PTSD, highlighted this when she described her experience of calling a suicide hotline. Instead of sending help, a police officer called her and asked if she had any weapons in the house. When she said she had a gun that was unloaded and locked in a case, the officer asked her to step outside. She continued:

I open my door and I step outside and there's a SWAT team out there. I mean, I'm talking the van, the SWAT van, eight patrol cars and they got shotguns and M-16s and pistols pointed at me and they're screaming, "Get down, get down, get down, get down!"...And like four officers, you know, one on my neck, one my hip, they're cuffing me and I'm like, "What the fuck is going on?" (CDL)

Cleo explained that the local police knew her history of military service and did not want to take any risks regarding her potential for violent reactions. While this concern may seem valid, it does not take into account the narrator's PTSD—which was also well-

known by the small town police force. Cleo explained that her therapist (notably *not* part of a biomedical care team) eloquently described the problematic nature of law enforcement's reaction to Cleo's call while on the phone with the arresting party the next day: "What the fuck are you guys doing, pulling M-16s and shotguns on a PTSD combat vet? What's wrong with you people?" (CDL). By showing up to Cleo's house with SWAT forces, the local police force could have actually induced a PTSD episode or made her suicidality worse (which it seems to have done according to the narrative). Though the decision to show up with such force was framed by the police as for the safety of Cleo and the officers, it actually reflects an oppressive view of suicidal people as inherently "insane" and violent. This, once again, relates to media fascinations with depicting people with mental illness as murderers and villains far more than it does reality since people with mental illnesses are far more likely to be targets than perpetrators of violent corporeal crime (Appleby et al., 2001). It also highlights a lack of effort to help Cleo in ways that account for her psychiatric disability. This reflects an ableist view in which suicidal people are deemed burdens to society as opposed to human beings in need of care.

In both Cleo's account of local law enforcement (as directed by a suicide hotline) disregarding her status as a combat veteran with PTSD and Angela's story of being overdosed with medication due to assumptions about her race, a lack of social identity awareness during care for suicidal people led to significant problems. Neither person was able to receive adequate medical care because their providers did not account for nuances of their identities. While in both cases providers were aware of the narrators oppressed

identities (Cleo, PTSD status; Angela, being black), they did not address these identities in meaningful ways. Beyond serving as a barrier to proper care, this negligence directly harmed both narrators by furthering the intensity of the race- and ability-based oppressions they already face.

Failure to address sociocultural systems of power. The lack of sociocultural identity awareness in caring for suicidal people displayed above also manifested in the contexts that gave rise to suicidality in the first place. In describing the settings in which their suicidal thoughts originated, many narrators talked about issues allegedly-unrelated¹⁰ to biological mental illness such as sexual abuse, emotional abuse, homophobia, racism, or failure in school or familial life. These social traumas were rarely if ever addressed by biomedical care providers, which narrators positioned as huge barriers to their healing.

One narrator, Kelechi, describes the social situations that gave rise to her suicidality as just as important to her story as biomedical illnesses:

My mom, because the education system in Georgia is what it is—which is not great—she had me to go majority white schools, and so I was there. I wasn't fitting in. There was a lot of racism happening. I just didn't understand who I was supposed to be. I wanted to be close to the other kids in my neighborhood, who were black, but they didn't really accept me because they thought I wasn't like them—because I spoke well, or I read too many books, which actually was a sign

¹⁰ Trauma biology and epigenetics perspectives would argue that these experiences likely *are* related to physical pathology and/or mental illness.

of not-blackness. There was a lot of Otherness, so I was just Othered to death. I frequently thought about how I could leave. I always had a plan B. (KM)

The “in between” space Kelechi describes based on the dissonance between her black racial identity and “white” performance represents what Turner (1932) defines as a liminal space. Kelechi’s racially-liminal location reflects Turner’s broader conceptualizations of liminal spaces as settings in which people’s feelings of entrapment often cause remarkable distress that sets the “scene of disease, despair, death, [and] suicide” (1932, p. 46). In this case, it was not necessarily a biological pathology that required treatment, but rather social changes to promote a more comfortable and livable space for the narrator that could have helped. Transferring to a different school or receiving critical support for what it means to exist in a racially-liminal space could have prevented the teller’s experience of being “Othered to death.” These sorts of solutions are often addressed by therapists and social workers, but rarely by biomedical physicians in psychiatric wards where suicide survivors are sent post-attempt.

The same narrator also addressed broader cultural trauma faced by the black community in the United States, and how this impacts her mental health. “No one should have to be a hashtag,” she explained, referencing various social media campaigns that sought to bring attention murders of black people by white police officers. “We’re just humans, and if we’re not even treated like humans, how do you think that would impact someone’s mental health? It’s horribly traumatic” (KM). In referencing the very brutal, corporeal manifestations of white supremacy in police homicides, Kelechi calls into

question the value placed on her life by dominant society—whether or not she was truly meant to survive in the first place.

From this narrator’s perspective, oppressive systems—in this case, white supremacy—that define some lives as more valuable than others can, by extension, effectively murder those who fall beneath the dominant group. This echoes the notion of “social murder” put forth in philosophy of Engels, who notes that “when society places hundreds of proletarians in such a position that they inevitably meet a too early and an unnatural death...when it places them under conditions in which they cannot live...its deed is murder just as surely as the deed of the single individual” (1845 [1967, p. 126]). In other words, oppressive forces that make life harder for certain groups of people essentially slowly kill individuals within these marginalized groups. While those benefiting from and perpetuating this oppression are not often directly linked to the deaths of these people, they cannot be absolved of blame.

This social murder philosophical perspective is shared by many critical suicidologists (e.g., Reynolds, 2016) and LTT suicide attempt survivors. Despite its prominence, the social murder view is largely if not entirely dismissed by biomedical mental healthcare providers. The erasure of such oppressions plays into Othering of suicidal identities themselves, and perpetuates an erasure of personal experience within patients deemed mentally ill. By failing to address sociocultural systems of power, caregivers erase many experiences that lead people toward suicidality, as well as implicate how these patients might best receive care.

Sociocultural illiteracy as worsening suicidal conditions. As the LTT narrators illuminate, biomedical care providers rarely address social identities and the power systems surrounding them when providing care to suicidal patients. This often results in care that is not well-suited to those receiving it because this care reflects a generalizable population—in other words, majority identities (white, heterosexual, cisgender, male, etc.). When patients’ experiences do not align with these privileged experiences, the treatments they receive oftentimes compound their experiences of psych-ache and suicidal pain, and effectively worsen their conditions of living.

Manifestations of Crip Othering

After outlining the extreme impacts of social Othering as in the case of social murder, the direct manifestations of this crip Othering within biomedical care for suicidal patients can be explored more critically. To review, a crip understanding of suicidality states that disability does not rest within the individual (as in the case of mental illness and dominant conceptions of neurology), but rather it is the external world that is disabling (institutions and relationships that were not built for and do not accommodate suicidal people). Stigma is a significant part of this crip framework because it represents both a manifestation of and a mode for perpetuating the Otherness associated with suicide.

There were three main ways this stigmatized view of the mentally ill Other (“psycho”) showed up in the LTT narratives. First, attempt survivors cited caregivers’ apparent lack of compassion as shown by poor bedside manner as dehumanizing and disheartening. Second, for narrators who were trained in mental healthcare fields

themselves, medical education systems were highlighted as sites of failure that preceded and promoted the providers' negative care practices. These initial two themes ultimately resulted in the third category of patient abuse, which many narrators noted was not addressed due to the absence of proper accountability measures in the biomedical mental healthcare field.

Caregivers' lack of compassion. For the suicide survivor-narrators, the most obvious symptom of the stigma surrounding suicidality within biomedical hospitals was the bedside manner exhibited by caregivers. Their nurses' and physicians' [anti]social behavior was hugely important to how the narrators perceived their time spent in psychiatric hospitalization, and was often one of the first things explained when these narrators described their hospital stays. Only a few of the narrators—those at private residential or private university facilities—reported positive bedside manner that contributed to beneficial care. The rest were highly critical of how their clinicians interacted with them.

Many of the narrators characterized their healthcare providers as villains because they seemed to lack compassion for their patients—likely due to their view of suicidal people as Others. Anita, a survivor and clinician, described this issue when she started working at the same hospital and intensive care unit where she was treated after her first suicide attempt:

Some of the nurses I worked with would make comments about some of the patients that we got in who were suicide attempts. They'd say, "Why don't we just let them die?" and stuff like that... They just think that a person who attempts

suicide is not worth the time to take care of...It was disturbing to see someone who is supposed to be a medical professional make comments like that. (AE)

Anita attributed this issue of poor bedside manner and “hidden” speak to ignorance. “Either they don’t really care to know, or they were just not informed about mental health and mental illness,” she explained (AE). None of these coworkers knew that Anita had just attempted suicide for the second time, so their comments were unfiltered. Their lack of compassion was not cited as a cause for Anita’s third attempt, but it is possible that such a dehumanizing view could have contributed to low self-worth for her preceding it.

Another survivor-narrator, Lyndee, paralleled this experience, showing that poor bedside manner is a widespread issue. Her parents took her to the emergency room after she told them that she “took a bunch of pills” one evening in an attempt to die. “The hospital was pretty rough. People are mean and really lack a lot of understanding,” she recalled. “That was hard, and that was the general attitude I got from everyone. [The doctor] kind of snickered at me and shook his head. Most of the nurses were pretty rude. It was just awful” (LM). Being mistreated and belittled in medical spaces, like in Lyndee’s narrative, is hugely detrimental since most people dealing with suicidality already see their lives as unworthy of living. Furthermore, as discussed at the start of this chapter, accessing biomedical care for mental illness is difficult and traumatic in and of itself without being exacerbated by poor treatment once entrance is gained.

A crip perspective helps make sense of this lack of compassion on the part of biomedical clinicians and its relevance to suicidal people. While both Lyndee and Anita express distaste for the bedside manner they witnessed/received in mental hospitals, a

critical lens notes that this behavior was not simply an issue of impoliteness. The lack of attention to compassionate communication reflects broader systems of oppression that frame people with mental illness as subhuman entities undeserving of respect or attention. Furthermore, this lack of compassion or attention to bedside manner highlights the fact that the disability associated with suicidality often lies within the outside world—stigma and resulting mistreatment of suicidal people—as opposed to being located within suicidal individuals’ minds.

Lack of education for biomedical practitioners and caregivers. Narrators who were themselves educated in mental healthcare fields shared similar experiences with uncompassionate care providers as expressed by those without such insider knowledge. Those with personal biomedical expertise frequently cited poor bedside manner and disrespectful interactions with their healthcare providers during hospitalizations. However, these narrators did not locate the locus of failure in the providers as people; they argued that it was the education systems that failed to prepare these clinicians for work with suicidal patients. Sarah explained:

Social work grad school was hell because you see how the people who work in the mental health system are trained, and you understand differently. It’s not a personal thing. These people aren’t necessarily bad, but we are trained through our institutions to systematically dehumanize the Other, and I was the Other. (SC)

In this excerpt, Sarah directly referenced crip notions of abject Otherness in relation to being mentally ill. She further located the root of this Othering within institutional

practice; dehumanized views of people with mental illness as subhuman were taught as acceptable and encouraged techniques for serving patients better care.

Dehumanizing patients in this manner is a highly controversial but commonplace practice in the medical field. Many times, subconscious and unintentional dehumanization of patients occurs as a byproduct of the way human minds evolve to interact with the functional requirements of performing procedures (oftentimes painful or gruesome in nature) on multiple patients and functioning in hospital settings (Haque & Waytz, 2012, p. 178). Many hospital policies, such as not allowing surgeons to operate on their family members, function to de-individuate the patient in order to give physicians greater objectivity in their decision-making processes (Anyanwu, Abedi, & Onohwakpor, 2014). In most cases, such dehumanizing practices are seen as essential to providing high quality care because they allow physicians to focus on treating illnesses as opposed to dealing with multifaceted, complex people. It also allows doctors to distance themselves from patients to avoid being so empathetic that they cannot conduct higher level medical problem solving (Haque & Waytz, 2012).

These dehumanization patterns are magnified when patients are labeled *as* their illnesses. For example, labeling a person as “schizophrenic” rather than “a person with schizophrenia,” increases objectification because it eclipses the human being altogether and suggests that *the disorder is who they are* (Hall, 2002; Sass, 2007). This is particularly relevant for patients with mental illnesses, who are already framed as subhuman and incapable of rational thought or human behavior. As revealed in Sarah’s narrative, this dehumanization can lead clinicians to believe that suicidal patients are

altogether unworthy of care or attention. The practice does not seem to benefit their care whatsoever.

Normative efforts to dehumanize patients, however positive in intention, are amplified for patients of color. Because white supremacist norms are linked to the assumed heterogeneity of members of nonwhite groups, this allows physicians to further de-individuate these patients (Anthony, Copper, & Mullen, 1992; Ostrom & Sedikides, 1992). This can have grave effects for people of color who attempt suicide or present as patients assumed mental illnesses, such as the overdosing of African American patients discussed in earlier in this chapter. As one of the LTT narrators who is now in nursing school attests, “Psych, as far as education, is only—in my program—a seven and a half week course” (AE). If nurses are given less than two months to learn about all types of mental illnesses, is it unlikely that they are also educated about the nuances of dehumanization and its impacts on varying identity groups during this time. Such reflexivity and social awareness takes far longer to develop than any one course, and further presents a lifelong commitment for those who seek such critical reflection in their thoughts and actions.

Though a few of the narrators in this study attempted to determine whether biomedical mental healthcare providers lacked compassion for their patients due to personal, educational, or structural issues, it is fair to assume that all three of these factors are relevant to this issue of dehumanization. Such stigmatized beliefs, ideologies, and policies cannot be neatly separated from one another and therefore must be addressed as an assemblage. Though conducting a thorough analysis of this assemblage is beyond the

sphere of this paper, what is important to recognize is the knowledge shared by LTT narrators repeatedly: that internal Othering manifests in very real harm for suicide attempt survivors—particularly during inpatient care.

Hospitalization as imprisonment. Beyond understanding mental hospitalization as a site for dehumanization based on uncompassionate and apathetic communication from care providers, many LTT narrators regarded psychiatric wards as prisons. These institutions were framed as sites of mistreatment, isolation, and punishment—not recovery or health. Because of this hospital-as-jail characterization, being committed to an inpatient mental hospital was a site of constant fear for many narrators. Many of these storysharers saw hospitalization as a form of imprisonment that would, much like jailing, result in poor treatment and increased stigma around their minds. Even if they were able to endure their time physically restrained to the hospital, their reputations as “crazies” who were locked up like criminals would carry on long after their release.

Leanne’s view of hospitalization as imprisonment directly prevented her from seeking medical care. After attempting suicide by slitting her arm, her initial thought was to seek medical treatment. “Perhaps I should get stitches,” she began in an internal dialogue. “But [I stopped] in instant defense mode, because you don’t want to get put into a mental institution where they basically lock you up and it’s like a jail, essentially” (LK). Another narrator echoed this sentiment in her own time of desperation: “I was so tired and scared and I just didn’t want to be sent to a facility. It’s a scary thing when you’re [hospitalized] and you don’t have a say in it anymore” (LM). Both of these attempt survivors framed hospital settings as barriers to—not sites for—receiving help. Such

fears are not without base; it is common practice for suicide attempt survivors to be forcibly hospitalized after their actions regardless of their own desires for treatment.

In the state of California, for example, a person who is deemed suicidal by a medical professional can be “involuntarily contained” and locked in a psychiatric unit for three days (Bonn, 2010). After this initial period, the hospital can extend this hold for an additional 14 days, barring a hearing in which the patient is able to convince a judge without any sort of medical training that such an extension is unnecessary. Though these hearings are available, biomedical expertise is seldom challenged and the 14-day hold is rarely overturned (Los Angeles Superior Court, n.d.). This highlights the core issue of biomedical dominance within suicide: the fact that its power often reigns unquestioned.

For the LTT narrators, unquestioned/forced hospitalization was not solely a representation of decreased freedom; it also reflected an American history of defining suicide as a literal criminal act. Thomas Szasz, 50 years after he rocked the psychiatric world with “The Myth of Psychotherapy,” came back to reassert his initial claims:

My offense—if it be so deemed—was calling public attention to the linguistic pretensions of psychiatry and its pre-emptive rhetoric. Who can be against ‘helping suffering patients’ or ‘providing patients with life-saving treatment’? Rejecting that jargon, I insisted that mental hospitals are like prisons not hospitals, that involuntary mental hospitalisation is a type of imprisonment not medical care, and that coercive psychiatrists function as judges and jailers not physicians and healers. (Szasz, 2011, p. 180)

These bold claims confront the biomedical model head-on, but not without base. Many practices common within inpatient psychiatric wards mirror those in prisons:

straightjacketing, placing patients/prisoners in isolation rooms, forcing them to take

medications, confining them in locked chambers, and restricting and monitoring their contact with the outside world.

Kelechi, describes little detail of her time in inpatient care. Instead, she simply stated that the hospital was “very scary.” She explained the impact of her time there succinctly: “What I learned from being in the hospital was now to never be in a hospital again, which wasn’t a good thing to learn, because the main thing I learned was to never tell anyone the truth” (KM). Though she did not describe what she experienced while hospitalized, she did point out that her admission was not consensual, and her time there directly prohibited her from seeking medical care in the future. For her, being locked up was a punishment—not a treatment.

Famed sociologist Erving Goffman (1961) reflected Kelechi’s framing when he categorized mental hospitals in the same group as prisons, concentration camps, and orphanages. Each of these, he argued, are “total institutions,” meaning that they are places of residence where a large amount of similarly-situated people are kept together and cut off from the wider community. These closed institutions are highly structured and, in the case of mental asylums, socialize people into the role of a good patient: someone “‘dull, harmless and inconspicuous,’ which in turn reinforce[s] notions of chronicity in severe mental illness” (Lester & Gask, 2006; citing Goffman, 1961). This “good patient” does not reject their treatment within the psychiatric hospital; they accept it without question. This is not necessarily the case in reality. Patients frequently resist treatment during inpatient care. Unfortunately, this resistance has little impact on the

greater structures of oppression within mental hospitals—most notably, the abuse that occurs within their walls.

Overall, the notion of hospitalization as imprisonment represents a significant manifestation of “crazy” Otherness in biomedical care. From a crip perspective, the unquestioned power of mental institutions is problematic because external sources of oppression—as opposed to internal pathologies—are what disable people experiencing suicidality. In the attempt survivors’ stories, being hospitalized reflected their roles as societal Others in need of containment. Forced hospitalization also quite literally disabled the narrators by removing their agency. Once institutionalized, people with [assumed] mental illnesses are unable to make decisions for themselves about when and what to eat, when to sleep, what to wear, and even what sorts of medications they will consume. This alters their abilities far beyond the restrictions formed by being suicidal in the first place.

Abuse and the absence of accountability. The core of involuntary containment (forced hospitalization) policies rests in the biomedical model’s assumption that physicians as the true “knowers” of experiences related to illness; patient experiences and utterances are untrustworthy. The issue with the overarching reach of biomedical power does not solely reside in the fact that it forces people into medical care; the issue lies within the lack of checks and balances therefor. Leaving mental health clinicians with the ultimate power to define a person’s treatment and experience sets the stage for abuse within psychiatric wards because they tend to be less transparent, and therefore, less accountable to mistreatments therein.

Because of the dominant worldview of people with mental illness as insane and unreliable, patients' accounts of such abusive events are easily refuted. This makes peer-reviewed research on the subject difficult to conduct, and leaves many accounts of abuse to the margins of rumors, cultural myths, and unauthorized online documentaries. This study emphasizes shifting the power to "know" these experiences from external researchers to those with lived histories of such abuses. The survivor-narrators who told their stories to LTT disclosed several abuses to which they were subjected while in psychiatric wards, and it is likely that others hid these experiences for fear of backlash or further stigmatization.

Sarah explained that while she was in the hospital, she fell off a chair and broke her foot while hanging posters with positive quotes on the walls. The doctors refused to give her pain medication (ibuprofen) or x-ray the bones. "They had essentially pathologized my broken foot as a mental illness...So in my medical records, what it looked like was that I was unstable and totally crazy and just wanted attention, and yet my foot was broken" (SC). The physicians eventually x-rayed her ankle, "so then they had all this ammo to say that [she] was lying." Sarah explained that the break was in her foot, not her ankle, and it took three days for doctors to honor her need for further imaging tests—which confirmed the broken foot—and resulting treatment. In this case, she was forced to suffer the untreated pain of a broken foot as well as to live without any sort of care (such as splinting or casting) therefor simply because her outcries were attributed to psychosis. Viewing her as an insane Other essentially enabled biomedical clinicians to dismiss her claims of orthopedic fracture as simply a failure to connect with

reality. This assumption led to abuse that, arguably, would not occur beyond the walls of locked psychiatric wards.

Other accounts of abuse stemmed from what is perhaps the most controversial treatment available for patients with mental illness in contemporary times: Electroconvulsive therapy (ECT). Previously known as electro-shock therapy and conducted on homosexuals¹¹ while they viewed same-sex erotic images, this treatment was initially used as “aversion for sexual deviations” (see Feldman, 1966). The treatment is presently “established” and deemed “highly effective” for patients experiencing suicidality (Prudic & Sackeim, 1999), and involves the passing of electric currents through the brain to trigger brief seizures. According to the Mayo Clinic (2017), ECT seems to cause changes in brain chemistry that can “quickly reverse symptoms of certain mental illnesses.” The positivity of such reports, however, are not shared by the survivor-narrators in this study.

One narrator explained that despite claims of needing further help after being discharged from the hospital, her doctors would only let her back to their care facility if she agreed to undergo ECT:

We call that coercion, and from what I know now, obviously, it happens all the time in the mental health system, but I didn't know that then. I agreed to do the first one, and it was horrible, and it was as traumatic and violating as one would expect it to be when they knock you out and they shock your brain and you wake

¹¹ I use term “homosexuals” intentionally over “gay” or “queer” people because it reflects the pathological orientation of the term, which originated as a biomedical diagnosis for same-sex attraction.

up in complete and total pain and confusion. And then they deny that... They told me I was such a 'quick cure' because, after the first one, I was so terrified of it that I knew I had to do whatever I could to get out of the system. (SC)

While proper procedure for ECT involves anesthesia, most descriptions of the therapy fail to mention post-procedural pain. In addition, facilities vary considerably in many aspects of ECT practice, oftentimes evidently departing from the standards for safety and comfort set by the field (Prudic, Olfson, & Sackeim, 2001). Many ECT practitioners also fail to recognize the impacts of its problematic history of use in conversion therapies and how this might impact the mental and emotional wellbeing of LGBTQ patients, among others whose predecessors were abused by such "treatments" for non-pathological identities.

Like Sarah, Cleo's description of ECT was similarly dismal. "So they shocked my brain three times a week for six months," she explained. "I've had 180 shock treatments to my brain and all it really succeeded in doing is shredding my memory. It didn't work. It made me more paranoid" (CDL). Long-term risks for ECT, which increase in likelihood and severity with concurrent cardiovascular and other medical illnesses, include spontaneous seizures, memory loss (retrograde amnesia), severe and persistent cognitive deficits, and death (Weiner, 1994; Mayo Clinic, 2017). While many other medical procedures have similar risks, what divides ECT for suicidal patients from other circumstances is consent. Adults with physical health conditions must consent to treatment for their bodies. By contrast, adults with mental health conditions can be quickly deemed unfit to make such decisions, and thus can be thrust into treatment

without their own approval (see U.S. Supreme Court cases *Youngberg v. Romeo*, 102 S.Ct. 2452, U.S.Pa., 1982; *Mills v. Rogers*, 102 S.Ct. 2442 U.S., 1982; *Rennie v. Klein*, 102 S.Ct. 3506 U.S., 1982). In these cases, the risks of procedures such as ECT may not be adequately understood by patients—if shared with them at all. This lack of consent further dehumanizes suicide attempt survivors and people with mental illnesses by marking them incapable of making decisions, particularly those like ECT that have the potential to cause severe disabilities and alterations to their lives.

Oppression, Otherness, and What Being “Crip” Means in Biomedical Practice

In summary, while most of the LTT narrators utilized the biomedical mental illness model as a framework for their stories, the vast majority of these suicide attempt survivors also aligned with a critical perspective of biomedical care. Most argued, at least in part, that biomedicine functions to control and punish those labeled “mentally ill” (Szasz, 2007, p. xvi). This was particularly relevant to the parts of their stories that took place in biomedical hospitals. This institutional location was key because the narrators pointed to oppressive practices and policies within these psychiatric hospitals as disabling forces that worsened their quality of life. This crip understanding of external forces (as opposed to internal pathologies) as the core of disability highlights that while the narrators believed that their problems were in some way internal, these hardships were compounded by external structures that unnecessarily prevented them from participating as full members of society.

In this chapter, I discussed four categories of critiques put forth by LTT suicide survivors in their accounts of failing to receive proper medical care. First, I reviewed crip

implications for accessing mental healthcare based on cost prohibitions and issues of “looking suicidal” versus “performing normality.” These discussions were followed by analyses of instances of compounding oppressions in which social identities (race, gender, veteran status, etc.) and sociocultural systems of power (racism, ableism, homophobia, etc.) were ignored to due cultural illiteracy and a lack of reflexivity on behalf of the biomedical care providers. All of this ultimately led to three main manifestations of crip Othering: lack of compassion from caregivers and lack of education therefor, hospitalization as imprisonment, and abuse within psychiatric wards.

Chapter Five — Conclusions and [Un]Final Thoughts

Estimations suggest that one person in the United States attempts suicide every 38 seconds (Yeager & Roberts, 2015, p. 38). Though only about four percent of these attempts are completed, over 44,000 Americans die by suicide each year (AFSP, 2016). Despite this being the 10th leading cause of death in the nation, communication about suicide remains uncommon. Stigma surrounding the matter promotes a culture of silence in which individuals' stories of suicidal experiences are rarely shared, making it difficult for researchers to understand what it means to live with the desire to die.

In spite of the difficulty surrounding data collection on the subject of suicide, researchers in numerous fields such as sociology, psychology, biomedicine, cultural studies, and religious studies have long sought to find and define the ontology of self-inflicted death. In recent times, the “position that suicide rises as a consequence of mental illness is often presented as an indisputable scientific and medical fact” (Marsh, 2010, p. 27). However, a concrete biomedical understanding of what underlies suicidal behaviors remains elusive. The American Psychiatric Association’s “Diagnostic and Statistical Manual of Mental Disorders” (DSM) recently shifted suicide from a symptom of other psychiatric disorders to a condition in and of itself (APA, 2013, p. 801). This relocation is tentative however, and suicide now resides in section on “conditions for further study.” By admitting this provisional nature, the APA shows a crucial glitch in medical

understandings of suicidal behavior and marks it as an issue that evades current medical knowledge. In essence, what most people “knew” about suicide as it relates to mental health is now up for debate in medical communities.

In this study, I used the fracture in contemporary biomedical understandings of suicide as a call to action. The medical field’s admission that suicide may not truly be a pathological/internal issue related to mental illness opened space for alternative ways of knowing to gain significant ground, which I saw as an opportunity for more critical perspectives on suicidality to be centralized. I used a narrative approach to studying the topic because I wanted to see what people experiencing suicidality directly had to say about their condition. Analyzing first-person narratives allowed me to do this while also shifting definitional power from biomedical researchers to their patients. In essence, I embraced theories of the flesh: an approach to knowledge that privileges the body as a way and site of knowing (Anzaldúa & Moraga, 1983). This runs directly against dominant frameworks of what knowledge “counts” as Truth and who gets to define this information as such.

To add a critical lens to traditional narrative theory and method, I introduced crip theory—for the first time in health communication studies of suicidality—as an overarching framework. Crip theory (McRuer, 2006) approaches the study of disability in opposition to medical models that locate impairment and pathology within the individual. According to this lens, what actually impairs a person is living in a culture and a world that does not account for their needs. “Essentially,” Krieg explains, “the person is not disabled, but rather it is the world that is *disabling*” (2013, p. 44 [emphasis in original]).

While this may seem entirely contradictory to biomedical models of suicide as the product of internal pathology (mental illness), I sought to research how this crip perspective might add to contemporary understandings of suicidality, and furthermore how it might positively impact healthcare practices.

Though crip theory's emphasis on the sociocritical seems to strike a polar relationship with biomedical understandings of disability, I argued that the two can also be used to inform, challenge, and improve one another. With that potential in mind I began my study with the following research question:

How do attempt survivors narrate their experiences of suicidality in ways that reflect and/or deny biomedical and sociocritical/crip understandings of suicide?

In my analysis, I found that the vast majority of suicide attempt survivor-storytellers utilized biomedical models of mental illness as the cause of suicidality. They claimed that official diagnoses and oftentimes the treatments and medications that followed were essential to their healing processes post-attempt.

At the same time, these narrators also problematized the biomedical model by noting the stigma that comes with being labeled "mentally ill." This notion of "crazies" (people with mental illnesses) as society's ultimate Other directly harmed attempt survivors and left them ostracized from their peers, subjects of institutional discrimination, and more distant from potential treatments for their low states of wellbeing. In essence, the disability associated with being suicidal or mentally ill was located in the external world (ableist ideologies, institutions, and policies) as opposed to

the minds of individuals experiencing suicidality. This understanding mirrors crip theory perspectives and holds significant implications for biomedical care.

The discussion based on my analysis was centered around honoring experiential accounts that describe the oppressive manifestations of “crazy” Otherness within biomedical care. The narrators noted that people with mental illnesses and those experiencing suicidality are subhuman in the eyes of many healthcare providers. This meant that their care was subpar and in many cases abusive. In discussing the experiences shared by the narrators, I discussed various issues with biomedical healthcare practices. Treatments within this field are costly (and thus unattainable by many), often denied to people who do not appear “properly” suicidal (openly distraught or “crazy”). Clinicians also lack social identity awareness and cultural literacy, making it more difficult for patients experiencing interlocking systems of oppression such as ableism, racism, and gender-based violence simultaneously to receive proper care that accounts for these circumstances. All of this Othering eventually manifests in caregivers’ lack of compassion for patients post-suicide attempt. The resulting dehumanization of suicidal people results in many of them viewing hospitals as prisons and sites for rampant abuse based on the lack of accountability therefor.

To summarize this research, I will discuss the strengths of my project based on the three goals I set at the beginning of the work. I will then consider the limitations of this study and suggestions for future research before fleshing out the implications of this work for future academic studies in health communication and critical suicidology, as well as for healthcare policy. Finally, I will end with future directions for my own work.

Strengths: Revisiting the Three Goals of the Study

Related to the academic and activist implications of this study, the goals of this project were threefold: (1) to bring together, critique, and problematize numerous fields' existing conceptualizations of suicide; (2) to fortify the academic study of health communication by expanding its [post]positivist history into critical qualitative directions using crip theory as a lens; and (3) to embrace experiential ways of knowing in the form of suicide attempt survivors' narratives as valid and important to acknowledge and study, not only as data but also as voices of expertise. All three of these goals were met throughout the project.

Interdisciplinary and interparadigmatic approaches. In both the literature review and the methods, I purposefully brought together numerous fields' conceptualizations of suicide. This was important because suicidology spans many large disciplines such as psychology, biology, sociology, religious studies, and philosophy. Focusing on any one in particular would have unnecessarily excluded important ways of understanding suicide, and furthermore would not have provided a broad enough platform on which to rest the suicide attempt survivors' narratives as data that speak for themselves. Having a broad, interdisciplinary approach opened doors for multiple ways of meaning-making to emanate from the data.

From a paradigmatic perspective, numerous scholars have cited the importance of moving beyond traditional silos of research paradigms in organizational communication

(Deetz, 2001), family communication (Droser, 2017), and health communication (Lupton, 1994). This study extends these efforts and serves as an example of such a destabilizing move in terms of the history of clearly delineated paradigmatic approaches within suicidology and health communication. In addition to shedding light on the benefits of interdisciplinary scholarship, this interparadigmatic approach highlights the power of conducting research as relevant to the data, research question, and problem being addressed as opposed to appealing to normative structures and frames of what research “should” look like according to academic traditions.

Contributing methodologically and theoretically to the field of health communication. In line with transgressing disciplinary and paradigmatic lines, through this study I also sought to fortify the academic field of health communication by expanding its [post]positivist history into critical qualitative directions. Narrative inquiry was already a well-established part of this field, but this study was the first to combine narrative sensemaking with crip theory (“cripping” narrative methods). It was also the first to address suicidality from a narrative perspective. Overall, this crip-narrative sensemaking combination expanded narrative inquiry topically as well as methodologically.

One of this study’s main strengths was its innovative method, or perhaps more accurately, theory-method assemblage. Most narrative inquiry is interpretive in nature and does not engage with critical theories; it emphasizes letting people’s stories speak for themselves. Narrative theory can certainly be critical in nature if the researcher employing it chooses, but deliberately adding a critical theory to narrative social science

methods is a unique turn. This bringing-together of critical and interpretive paradigms is important from the other direction as well; crip theory is typically applied to rhetorical methods (e.g., McRuer, 2006), not social scientific ones like narrative sensemaking. With these separations in mind, bringing narrative and crip theorizing together in an iterative approach marked a significant move for health communication studies that opens doors for further methodological and theoretical blendings in the future.

Reclaiming voice for suicidal people. In terms of critical suicidology, this study also answers the call of Webb (2010) who argues that the greatest failing of contemporary research on suicide is the failure to include and embrace the lived experiences of those considering self-inflicted deaths. With an iterative analytical approach, this study offers an example of the power of intertwining attempt survivors' narratives with extant research in ways that better direct academic studies by allowing attempt survivors themselves to direct researchers to areas most relevant to their experiences. This approach embraced experiential ways of knowing in the form of suicide attempt survivors' narratives as valid and important to acknowledge and study, not only as data but also as voices of expertise that deserve and require proper recognition.

Limitations and Suggestions for Future Research

Despite the various strengths of this study, the work also holds significant limitations. First of all, it emphasized United States contexts and did not account for other locational settings that embrace biomedical approaches to healthcare. In addition, the fact that data were collected through LTT posed limitations on whose stories could be

included in this study. Furthermore, the relevance of the salience of biomedical frameworks within the narrators' stories is debatable.

Emphasis on the United States. All of the narratives analyzed for this study were collected within the United States. This is relevant because all of the narratives shared were situated within a specific form of Western biomedical care that is not universal. This is locational aspect important because, for example, different countries have highly variant policies on forced hospitalization even when they share biomedical models for mental illness as the core of suicidality. Varying nations also have different systems of paying for healthcare such as socialized medicine in which individuals are less likely to encounter cost-based barriers to their care. Future studies should address this by extending work on the power of biomedical discourse within suicidality to other locations around the world. This context-based limitation is compounded by the limiting standards present in the data collection method.

Data collection: Whose stories can be shared on LTT? All of the narratives used in this study were shared publically on the Live Through This website. The stories were accompanied by photographic portraits and the full names of their tellers. This restricts the data to people who were willing and able to tell their stories without fear of family, friends, or employers finding out. This likely means that the tellers were "out" about their suicide attempts and at least somewhat well-rehearsed and comfortable in sharing their experiences with others prior to telling having their stories transcribed through LTT. People whose suicide attempts were comparatively kept secret due to personal, relational, or institutional limitations could not be collected in the dataset. This

limitation likely precludes attempt survivors in political positions, those presently working in biomedical fields, and others for whom public storysharing could prove detrimental to their employment or familial lives.

The LTT requirements for participation set by the site's founder also reduced the field of who was able to share their stories. All narrators had to be over the age of 18, which limited access to pediatric suicidal patients—those who likely would have endured increased oppression and dehumanization based on ageist assumptions about their sensemaking abilities. In addition to being legal adults, participants also had to be one year out from their most recent suicide attempt, so the stories were largely retrospective. This time restraint takes away from the power of hearing from those currently going through biomedical hospitalization post-attempt. Rawer accounts may have different perspectives on what causes and cures (or at least treats) suicidality.

Problematizing the salience of biomedical modeling. As a final limitation, I seek to problematize the presence of biomedical frameworks within the narrators' stories. While it is clear that the narrators' reliance upon biomedical modeling had many benefits in terms of helping suicidal people and those around them come to terms with suicidality, its ubiquity in these narratives must be questioned. Because the "suicide as a product of mental illness" notion is dominant in the United States' sociocultural sphere, the fact that the narrators included it as their worldview does not necessarily define it as *their* Truth. It may alternatively be a model that the narrators internalized due to hegemonic forces and, thus, narrative tellability as opposed to something their own lived experience birthed into understanding. In other words, they may have attributed their suicidality to neurological

or chemical issues in their brains not because they believed this was true, but because it would help others hear their stories more readily.

Of course, this is speculation; I cannot know the narrators' intentions behind setting their narrative worldviews as such—particularly because I was not the one interviewing the study's narrators. It is certainly possible that chemical/neuro-biological issues lead to suicidality in some people, even though it has not yet been scientifically proven that such a link exists (Hjelmeland et al., 2012; Szasz, 2011). My concern in addressing this limitation is not to argue whether or not the narrators were “correct” about the roots of their suicidality; rather, it is to highlight that their responses, like the biomedical care they received, could not be free of external/sociocultural systems of meaning.

Implications

Despite the limitations addressed above, this study holds significant implications for the field of suicidology as well as for healthcare policy. Both are important to my aims as a scholar conducting “phronetic” research that is rooted in praxis-based change (Tracy, 2007). Before forming this study, I identified a specific problem in the world—misunderstandings of suicide and the mistreatment of those experiencing it—and systematically conducted a study in order to “open[] a path for possible social transformation” (Tracy, 2013, p. 4). Social transformation at the forefront, my findings are relevant to the academic study of critical suicidology as well as to healthcare policy activism far beyond the walls of the Ivory Tower.

Implications for the study of critical suicidology. Though attention to stigma is ubiquitous throughout critical conversations surrounding suicide (see examples in White et al., 2016), crip theory more specifically has not yet been applied to this concept. The theory is only a decade old at this time, but it follows longstanding cultural studies traditions that question the naturalized order of things by considering how phenomena are embedded in complex economic, social, institutional, ideological, and cultural relations. These roots make crip theory a natural fit for critical suicidology, and my hope is that this study serves as a jumping-off point for myself and others to use the lens in more inclusive ways because this work implies that such a pursuit is both possible and beneficial to critical projects.

Despite this positive potential for furthering critical thought, crip theory (much like its queer theoretical parent) is often critiqued as a whitewashed entity that focuses on a single axis of identity ([dis]ability for crip theory, sexuality for queer theory) and erases the others (race, gender, age, nationality, etc.) by extension. With this study I highlighted that such erasure is not inherent to crip theory; the power to embrace or reject intersectionality lies within the researcher employing it. By directly engaging with issues of race amongst other social identities in addition to “mentally ill” and “suicidal” labels, I suggest that future research within the realm of critical suicidology will similarly embrace these intersectional inclusions as central to their analysis—not some sort of sidebar or footnote.

Suggestions for healthcare policy. In addition to the academic implications of this study, the project also calls for significant work in healthcare policy and activism

therefor. Because the study's narrators revealed numerous experiences of abuse while patients within mental health institutions—notably when they were forced into these hospitals—it is essential that policy changes increase transparency of such facilities. Making these facilities less closed and opaque would increase accountability for biomedical clinicians while also allowing for more checks and balances to be set in place.

As some of the study's narrators who were themselves trained in biomedical practices noted, much of the mistreatment in mental health facilities is related to the lack of education for practitioners. Adding mandatory education policies surrounding compassionate communication, the role of stigma in Othering people with mental illnesses, sociocultural elements of suicidality, as well as biomedical histories of identity-based oppression would better prepare clinicians to care for suicidal people. This mandatory education should also include aspects of self-reflexivity that encourage care providers to be critical of their own biases, privileges, and experiences as they relate to their work.

Embracing non-Western approaches to medicine and healthcare. This study also calls into question the overarching power of biomedicine within the United States. Other cultures' medical practices—commonly known as “Eastern” medicine and encompassing practices like homeopathy, acupuncture, Ayurveda, osteopathic medicine, massage, and yoga—have long recognized the connection between sociocultural experiences and health. Recent biomedical pursuits such as those present in trauma biology research are slow to join this claim, and are only just beginning to do so as they gain “empirical” support for this argument. The fact that the narrators in this study made

it clear that their health and suicidality were directly linked to social experiences suggests that others struggling in this arena might find better support in “nontraditional” medical practices that are more understanding of this mind-body link.

Future Directions

Personally, this study served as one of many in what I hope will be a critical line of work on suicide and health communication. In the future, I hope to expand narrative work on the subject, specifically as it was suggested as a form of treatment by narrators in this study. I also aim to approach the topic from critical participatory action research, media studies, and arts-based methods.

Narrative redirection as treatment. Many of the narrators reflected Frank’s (2013) notion of the “narrative wreck” in their stories. They positioned significant illnesses—in this case suicide attempts—as roadblocks that crushed the narratives they imagined their lives would follow. The ensuing narrative chaos caused significant distress in which attempt survivors could not imagine life following their suicidal actions.

Creating new narratives is what allowed people to move forward. Craig explained:

I had to take note of where I stood before I felt like I could move on. I looked really deeply at the things that I was hanging onto, the molestation and the bullying and broken home and all the other shit that went along with it. I had to make sense of it for me...I had to find hope, not only in my future, but I had to find that hope in my past. (CM)

For this narrator, narratively making sense of his experience was the key to creating a new future. A handful of other attempt survivors echoed this circumstance of the

narrative wreck as one of significant distress, but also an issue that, when resolved, could have massive implications for increased wellbeing.

In the future, I would like to work with psychologists and social workers to explore the possibility of introducing a sort of “narrative therapy” (similar to White and Epston’s [1990] method) into care facilities for suicide attempt survivors. As Jones asserts, storytelling is a “*survival strategy* for people who have been historically marginalized” (2015, p. 773). The implication of reclaiming this storytelling/meaning-making process *within* settings that cause marginalization in the first place could hold critical potential for conscientization and activism in the arena. I would also be interested in pursuing this sort of narrative therapy through community/arts-based means since it is traditionally employed in solo, talk-therapy settings. Based on my own history of working with narrative/art sensemaking and activism on the subject of baby loss through The Scraps of the Heart Project (2015), I believe community and arts-based research holds significant promise within suicidology.

Expanding methods of study. Regardless of method, I hope future studies will continue this project’s efforts toward honoring firsthand accounts of suicidality as valuable crucial sites of knowing. Studies using critical participatory action research (CPAR) (Cahill, 2007) to directly involve attempt survivors in the entire formation and conduction of a project would offer significant promise in this arena. This CPAR methodology could be matched with the above discussed narrative/art-based sensemaking to directly involve people experiencing suicidality in research and activism for ethical treatment of themselves and others in similar situations. Furthermore, participatory

methods would allow attempt survivors to not only engage in these efforts, but to *lead* them in conjunction with other researchers.

In addition to these nontraditional forms of academic research, I also intend to extend my work on crip theory and suicide within the more established discipline of media studies. Though this would not necessarily honor survivor narratives to the degree that this thesis project did, I believe media studies on suicide are a worthwhile pursuit due to the audience this work reaches. Critical media projects are often more accessed by broader audiences—including undergraduate students—than critical health communication studies, so the former holds significant potential for social change.

Conclusion: Reflexive Engagement

As mentioned briefly in Chapter Two, I did not come to this study solely as an outsider or casually interested researcher; I have a longstanding personal history of suicidality. I was just 10 years old when the thought of suicide first entered my mind. I made my first plan to attempt at age 18, but never actually began the process, nor have I ever engaged in any sort of physical self-harm. Today, almost five years after that initial (and final) plan, I consider myself an activist for increased compassion surrounding issues of suicide and those affected by it.

Because of my personal history and activist orientation, reflexivity was a central part of conducting this study. Engaging in critical self-reflection is essential to all health communication research regardless of method, but it is particularly relevant for critical narrative work. This is because just as storytellers make sense of their experiences in the telling, audiences (or researchers) also make sense of stories as they hear them. Who we

are as listeners cannot be removed from what we hear in other people's stories.

Therefore, though it is not the norm for social science research, in future work with crippled or otherwise critical narrative methods, I will emphasize my reflexivity process within the writing itself. Reflexivity should be centralized during these projects, not left to the margins of private conversations or personal journals.

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Appendix A

“Live Through This” narrators included in this study:

- Angela Usery
- Dave Jenkins
- Erin Oliver
- Kelechi Marie
- Christina Gleason
- Matt Fried
- Leanne Klocke
- Megan Rotatori
- Natalie Medina
- Sarah Couch
- Shayda Kafai
- Melanie Demoree
- Cleo DeLoner
- Vyronika Van Meter
- Lyndee McKinley
- Misha Kessler
- Brenda Hughes
- Craig Miller
- Jack Park
- Anita Estrada