Clayton Jarrard: Welcome to New Books Network. My name is Clayton Gerrard. My pronouns are he/him, and today I am here with Dr. Alexandre Baril, author of Undoing Suicidism: a Trans, Queer, Crip Approach to Rethinking (Assisted) Suicide.

In Undoing Suicidism, Alexandre Baril argues that suicidal people are oppressed by what he calls structural suicidism, a hidden oppression that until now has been unnamed and under theorized. Each year suicidism and its preventionist script and strategies reproduce violence and cause additional harm and death among suicidal people through forms of criminalization, incarceration, discrimination, stigmatization and pathologization. This is particularly true for marginalized groups experiencing multiple oppressions, including queer, trans, disabled, or mad people. Undoing Suicidism questions the belief that the best way to help suicidal people is through the logic of prevention, offering a new queer-crit model of (assisted) suicide. Alexandre Baril invites us to imagine what could happen if we started thinking about (assisted) suicide from an anti-suicidist and intersectional framework.

So, thank you so much for being here with me today, Dr. Baril. To begin the interview, I was wondering if you could tell us a little bit about yourself.

Alexandre Baril: Yeah, thank you so much for the invitation. So I'm an Associate Professor at the University of Ottawa, and my work is situated at the crossroads of gender, queer, trans, disability, crip and mad studies. I do a little bit as well in critical gerontology, and of course, critical suicidology. So this--those are the main fields of specialization. I am really passionate about marginalized communities and how suicide and assisted suicide specifically impact those marginalized communities

Clayton Jarrard: Awesome. Thank you so much for that introduction. I'm really excited to talk with you about Undoing Suicidism. This kind of book--I've been looking to find one of these books for a while now, and it brings such insightful and thought provoking perspectives into the discussion about suicide and prevention, especially drawing on, like you mentioned, queer, trans, disability, and mad studies. So I'm super excited for our conversation. To begin talking about your book, Undoing Suicidism, could you tell us a little bit about how this book came about for you.

Alexandre Baril: Yeah, for sure. So the the idea for this book project first emerged when during my post doctoral fellowships in the United States in 2014, at the City University of New York, or CUNY for those who know this institution. So at that time, it was a very different project, focused on various kinds of crucial but unconventional decision people making about their body, including those made by transgender people, but also trans-abled people. That is, people who voluntarily want to acquire a disability, such as becoming deaf, blind, paraplegic, or amputee, people who want to voluntarily acquire HIV, also called ìbug chasers,î as well as people who want to to die. So, however, the book was not, as it is now, focused on suicide and assisted suicide. Only the second part of my book at that time was dedicated to those topics.

Alexandre Baril: For various reasons, I've never completed the writing of this previous book, and my initial interest to write about suicide and assisted suicide made its way into multiple articles and book chapters I published between 2016 and now, as well as in my current book, of course; and I believe that my book my new book is therefore anchored in many ways in that former book project.

So in 2020, my partner, who is also an academic, had a Sabbatical year, and we spent 6 months in a cabin in the woods without Internet. That was wonderful. And it was a kickstarter in the process of writing this book. So at that time I began working on suicide and assisted suicide by mobilizing the conceptual tools and theoretical frameworks. I have been using since I began graduate studies back in 2003, so feminist and gender theory, queer theory, trans, disability, crip, and mad theory. And I noticed that scholars in those fields of study were barely engaging with the topic of suicide and assisted suicide, and when doing so they were discussing suicide from a very negative stance in which suicidality is seen as the ultimate result of structural violence and must be eradicated. Simultaneously, I was reading very interesting work in the field of critical sociology that was complexifying discourses surrounding suicidality, such as the work of Ian Marsh, Jennifer White, Katrina Jaworski, Scott Fitzpatrick, Amy Chandler, or Isabelle Perreault. And I thought it would--it would be very interesting to cross pollinate those critical reflections on suicide with with the field of gender, queer, trans, and disability, crip, and mad studies.

So I would say that my desire to write a book on suicide and assisted suicide comes from both a personal and an academic interest. I've been a suicidal person since the age of 12, and even though there are periods in my life such as currently when I'm feeling better, suicidality never really disappears from my life, and much of my work, such as my work in trans, disability, crip, and mad studies is anchored in my various marginalized identities as a trans person, as a disabled person, as a mad person. So my writing and research help me to better understand my lived experience and to connect it to broader social, political, and legal contexts. So I guess that my interest in suicide comes from this needs to understand my my own subjective experience of suicidality and to situate it in a larger social, political context. And in terms of my academic interest, I've been driven in my career to try to understand how various social movements and their related fields of study often, despite their best intentions, reproduce forms of marginalization, discrimination, and oppression towards certain people. So in this case, I was interested in how social movements, who are very keen to put forth the voices of the first people concerned, nevertheless quickly dismiss the voices, ideas, and claims of suicidal people, and even reproduce oppression towards them.

Also, I was astonished to learn that no concept existed to name the oppression of suicidal people until I coined the term ìsuicidism.î So my hope is that my book provides the tools to help us, suicidal people, to name our oppression, to connect with other suicidal people, and also build solidarities with other social movements.

Clayton Jarrard: Thank you for going over that. I love hearing about how books come about for people and the motivation and inspiration behind, you know, what we actually can hold in our

hands. So to follow along with what you just ended on, can you describe this oppression that suicidal people experience, what you've called ìsuicidismî? Why is it important to give this experience of impress--of oppression a name, and how does it intersect with other regimes of oppression, like racism, colonialism, ableism, sanism, and so on.

Alexandre Baril: Yes, so suicidism refers to an oppressive system that functions at the normative, medical, legal, social, political, economic, and epistemic levels; a system in which suicidal people experience multiple forms of injustice and violence such as--you mentioned it earlier--discrimination, stigmatization, exclusion, pathologization and even forms of incarceration. Our society is replete with horrific stories of suicidal individuals facing inhuman treatment after expressing their suicidal ideations in order to save their lives at all costs, from being hospitalized and drugged against their will, to being handcuffed and shot by police, to losing their jobs, to having their parental rights revoked to even being kicked off university campuses. So because of these negative consequences, suicidal people remain silent and complete their suicides without reaching out for help to anyone. As I always say, every single suicide completed suicide is the proof that what we are doing doing currently is not working, because each of those people did not call for help before completing their suicide in the few days before, in the few hours before. So these stories illustrate that, despite the support of discourses surrounding suicidality, suicidal people who call for help do not find the promised support. And worse. I argue in the book that suicide prevention services do more harm than good. Simply put, suicide prevention often increases deaths by suicide rather than prevents them. So it's quite paradoxical. And this is especially true as you mentioned in the introduction for marginalized suicidal people, such as indigenous, racialized, poor, queer, trans disabled, neurodivergent and mad individuals for whom suicide intervention often increases the racist, colonialist, classist, sexist, heterosexist, cisgenderist, ableist, and sanist violence they experience.

To give only a few examples, emergency services and police officers won't react the same way if they are called for a suicide crisis if the person involved is a white woman living in a wealthy neighborhood versus if the person is a black man living in a poor neighborhood, or a neurodivergent person who, in the midst of the intervention, panics and start kicking and screaming. So many researchers, including Susan Stefan, have shown that ìsuicide by cops,î or what we can literally call murders by cops, happens when police is called to respond to suicide crisis scenes, and particularly when it comes to marginalized communities. In other words, suicidism is interlocked with classism and the racism, colonialism, heterosexism, ableism, and other forms of oppression.

Some community organizations such as Trans Lifeline, hotline in the US and in Canada where I'm from, who work with trans and non-binary people argue, as I do in my work, that nonconsensual rescue of suicidal people intensify suicidality due to the inhuman, harmful, and violent treatment imposed on marginalized subjects by the police, healthcare providers, and other parties. In short, rather than finding the comfort, support, and care that they are looking for. A majority of marginalized people experience discrimination, micro aggressions, trauma, and incarceration, by reaching out for help, which seems counterproductive and completely unacceptable. So the thesis I put forth is that suicidal people are oppressed by suicidism, and

that the oppression they experience remains under-theorized, including in our social movements and in queer, trans, disability, mad studies and critical suicidology.

And regarding your question about why is it important to give this oppression a name, the response is quite simple. Naming the structural violence we experience as a group, in this case as suicidal people, collectivizing and politicizing our common experience of violence, micro aggression, pathologization, and criminalization allow us, as is the case with all other marginalized groups, to denounce the systemic oppression we are experiencing on a daily level in all spheres of our lives, and to stop seeing them as individual experiences or individuals to solve through cures. As I explained in the book, with the help of frameworks, such as epistemic injustices as coined by Miranda Fricker, not having terms and concept with which to name our oppression in daily struggles constitutes a form of hermeneutical injustice. Our oppression as suicidal people starts with this epistemic scarcity surrounding suicidism to the point of not even having a term with which to denounce it, to politicize it. So suicidism is the word I sought for years until I coined it in 2016, and it is the concept many of us have been searching for as evidence by texts written now by self-identified scholars. In the response to my work on suicidism, I'm thinking here, for example, of Lore/tta LeMaster or Emily Krebs, who mobilize in their PhD theses, my theoretical framework on suicidism, and say that although the suppression is not new, giving it a specific name, suicidism is very important, since it permits us to rally around the cause and and fighting against the oppression suicidal people face.

The necessity for this concept is also evidenced by the numerous emails I have received over the years from suicidal people, telling me that they had been thinking about the oppression suicidal people face, but did not have a term to name it. Many suicidal individuals have written to me to express their gratitude for the fact that my work has provided them with theories and concepts and tools that make sense of their harsh experiences in the world. So since the publication of my book, those emails keeps multiplying, as you can imagine, and they testify, I believe, to this deep need we have as a community of people to create multiple theoretical tools and concepts such as those I propose in the book to help combat suicidism and its destructive consequences on suicidal people.

Clayton Jarrard: Great. Thank you for going over that with us. It's such a huge deal, like you mentioned, to name these kinds of things, and that's only the foundation of where the book goes. One of the key concepts that you talk about is kind of this idea of ìcompulsory aliveness,î which you talk about in the introduction and some of the first few chapters. You say, ìUnder compulsory aliveness, suicidal peopleís experiences of incarceration are disguised and justified as care.î And you alluded to some of the negative experiences people have when they can seek help when they're in those dire and distressing situations, if they are suicidal. But can you share about how compulsory aliveness shows up in our current preventionist scripts, and how it often masks harm in the name of care?

Alexandre Baril: Yeah, that's a very good question. So I think, in order to answer these questions, I first need to describe a little bit what I mean by compulsory aliveness. So inspired by the notion of compulsory heterosexuality theorized by Adriane Rich and Judith Butler, or the

notion of compulsory able-bodiness or able-mindedness theorized by disability, crip, and mad scholars, such as Robert McRuer or Alison Kafer--the theoretical framework on suicidism, I propose, allows for a rethinking of what I called in one of my earlier essays, published in the Disability Studies Quarterly in the 2020, compulsory aliveness. So I argue that compulsory aliveness represents the normative component of suicidism and includes various injunctions, or what we could-or what could be seen as moral imperatives, including what I've called in the last few years, in various articles and chapters, the injunction to live and to futurity. So compulsory aliveness as an apparatus function through a wide array of tools and mechanisms, such as laws, regulations, attitudes, discourses, and so on, and it translates into what I call in the book the ìsuicide preventionist script,î which represents the dominant response to suicidality, and that could be summarized as follow: Very simply, suicide is never an option, particularly not for suicidal people.

As a dominant system of intelligibility within a suicidal regime, compulsory aliveness mask its own historicity and mechanism of apparition, which give life an apparently stable and natural character. Yet this stability, and this naturalness stem from performative statements about the desire to live. So by modeling Judith Butler's thesis on gender as performative, I see the desire to live as performative as well. Indeed, institutions, social policies, laws, practices, intervention, theories, and discourses shape the desire to live and present it in a similar way to how we present gender as if it were a natural, stable, unchangeable desire. Whereas, in fact, it results from norms, discourses, pressures, and practices that remain invisible within the suicidal regime. And reversely, the desire to die is seen as abnormal and pathological, regardless of whether this pathology is identified in the individual, or if in the social, political structures of society. In the spirit of Sarah Ahmedís suspension of the presumption that happiness is necessarily a good thing, I wonder in the book what kind of new relationship to suicidality and suicidal people could emerge if we let go of the injunction to live and to futurity and suspend our adherence to compulsory aliveness, as Ahmed does in relation to happiness.

I'm interested in tracking the effects of the presence of compulsory aliveness on marginalized groups, including suicidal people, and this is important to do, because the injunction to live and to futurity, like the injunction to happiness, is used to justify the oppression of the most marginalized groups. And in my book, I ask the question, what does it mean in this context to have not only a happiness duty, but also a life duty implemented through a vast array of mechanisms and carceral institutions in the name of care? As you were asking in the question, so, as I mentioned earlier in the name of protecting vulnerable people from themselves and saving their lives at all costs, we imposed upon them inhuman treatments, such as involuntary institutionalization and and incarceration, enforced pharmaceutical or behavioral treatments.

As I argue in the book as well as in a forthcoming chapter on this topic, suicide prevention and its goal of eradicating suicidality in suicidal subjects could be compared, to some extent, to conversion therapies for queer and trans subjects. Conversion therapies are designed to realign misalign subjects into normative sexual and gender identities, and in a similar way, suicide prevention aims to fix suicidal people and to reorient them toward a good life most of the time without asking them what they really want and need. So the problem and solution has been

identified without consulting the first people concerned, suicidal people, and the intervention plans are applied regardless of whether suicidal people feel it is helpful or harmful. In the same way that scholar scholars, activists in disability and mad studies asked us to look at the care we offer to disabled and mad people from a new lens, in my book I invite us to transform our vision about the support and care we offer to suicidal people in suicidal society.

So compulsory aliveness and its injunction to live and to futurity in a suicidal regime is materialized through what I call suicide prevention violence, and it could be conceptualized alongside what Eunjung Kim has called ìcurative violence.î That is a cure that aims to be a remedy, but that simultaneously harms. As curative violence, suicide prevention violence conceptualizes suicidality as nothing more than a problem to fix and cure. So suicide prevention is presented as a solution. But this remedy is simultaneously deadly for suicidal people, because it prevents them from reaching out for help, for fear of experiencing suicidal violence and discrimination. Suicide prevention refuses to leave any room for suicidality in the life of suicidal people, and therefore justifies physical, material, and epistemic violence towards suicidal people in the name of cure.

In sum, while it appears that our society and social movements care about suicidal people, I reveal in the book that through a preventionist script we are, in fact, exercising systemic violence, discrimination, and pathologization against suicidal people, and the preventionist scripts fueled by suicidism, compulsory aliveness and its injunction to live and to futurity forces us to take unaccountable and uncompassionate approach towards suicidal people. But sadly, this creative logic of prevention is not helpful for suicidal people.

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Clayton Jarrard: Yeah, thank you for speaking to that. It's such a complex issue, but I appreciate you talking through all those different points. And I'd love to follow along this thread of the injunction to live and to futurity. It's such a core concept throughout your book. Can you speak to the ways this concept surfaces in issues of suicidism as well as its deeper negative impacts in more general ways on marginalized groups?

Alexandre Baril: Yes, for sure. So the concept of the- the injunction to live and to futurity has been a core concept in my work, I would say, since 2016 and a key concept of my book. And I have been inspired by many authors, but two authors in particular: So Ann Cvetkovich and Zoreh Bayatrizi. And even though none of those authors proposes the notion of the injunction to live and to futurity per se, Cvetkovich discusses the moral imperatives to stay alive in her book, Depression, and Bayatrizi mentions the idea of a ìlife sentenceî in the title of her book. So in my book, I explain how this injunction to live and to futurity is part of a larger normative system, compulsory aliveness. Simply put, the injunction to live and to futurity aims to impose life and a future to everyone, except those cast by dominant ageist, ableist, and sanist norms as unproductive or unsalvageable subjects in our neoliberal economy. So if you are young, otherwise physically healthy, and specifically, if you attempt to end your life, emergency personel will save you even against your will. In fact, all discourses, institutions, practices, and

interventions are anchored in this injunction to live and to futurity in order to prevent all suicides from happening.

Unsurprisingly, many marginalized groups are overrepresented in statistics of suicidality which includes suicide ideations, suicide attempts, and in some case, completed suicides. So, for example, some studies show that trans and non-binary people have between 8 and 20 times more chances than the rest of the population to experience suicidality. What it means is that many marginalized groups have crucial needs to help them cope with the distress they experience, but their support needs remain unmet through current suicide prevention services, as is generally also the case for suicidal people. As I have shown in my work, the majority of current prevention services fails to reach suicidal people, especially those who are the most determined to die, or who belong to marginalized groups, such as trans people. Many suicidal people belonging to racialized, queer, trans, disabled, mad or or neurodiverse communities testify that they learn literally to shut up about wanting to die to avoid negative consequences associated with revealing their suicidality. This is supported by a great deal of research demonstrating that suicidal people, particularly those from marginalized groups and those very determined to die, do not feel safe to ask for help.

The horrific experiences that some people go through as a result of disclosing their suicidal ideations are so difficult that many say, as is the case in Radford and colleaguesí study of trans people, that they would prefer to die than to seek help and deal with negative consequences. In other words, suicide, prevention measures that aims to save lives at all costs, and that are guided by this injunction to live and to futurity have huge costs in the lives of marginalized suicidal individuals.

Following some observations made by Trans Lifeline, to use this example among many others, I identify a series of negative consequences associated with nonconsensual rescues based on this injunction to live and that affect trans communities. For example, non-consensual rescues often ìoutî trans people to their relatives and families, and such forms of outing can lead to further rejection, expulsion from the home, and violence. Those rescues often involve fees, ambulance, hospitalization, and so on for trans people, who are already overrepresented in statistics on poverty. Additionally, involuntary hospitalization and histories of mental health tissues, particularly suicide, may negatively impact access to trans affirmative health care by delaying or blocking care.

Furthermore, interactions with the healthcare system and social services often include stigmatization and violence, as we know, and finally, those rescues break the trust of potential hotline callers who may fear that the operators will initiate a non-consensual active rescues. And therefore, in other words, a hotline that supports coercive suicide prevention measures, which is the case with 99% of hotlines in Canada and in the US, does not elicit trust or confidence. In sum, in addition to their suicidalities, suicidal people, particularly those who belong to marginalized groups, experience more distress often in their interaction with prevention services. So paradoxically, the injunction to live and to futurity imposed on suicidal subjects increases suicidality instead of reducing it.

Clayton Jarrard: Awesome. Thank you for talking through that. So to continue along, you discuss in Chapter 1 the four theoretical frameworks of conceptualizing suicide that are in the literature and the research so far, which is the best overview of the various models that I've come across, so thank you for that, you know, research and explaining all those different theoretical models. But could you briefly describe those four frameworks and also talk about how your intervention is unique?

Alexandre Baril: Yes, for sure. So indeed, it took a lot of research to to gather all the information about those four frameworks and to build my own framework. That is a a fifth model. So in in my book, I propose a this typology of four models of suicidality. So the medical and psychological, social, public health, and social justice. So I will go over each of one.

First, the the medical model focuses not only on physiological pathologies coming from genetics or neurobiology, but also on pathologies of the mind and heart, that is, you know, mental and emotional health issues. In the medical model, the problem of suicidality is situated totally or partially in the body or in the mind of the person.

So influenced by the work of sociologists, the social model of suicide, instead of situating the problem of suicidality solely or primarily in the individual, identifies society and its dysfunction as the culprits. So the social model aims to identify patterns, recurrences, and tendencies between suicidality and social factors, such as economic crisis wars, social values, marginalized identities or cultural representations to understand and prevent suicidality.

Third, falling between the two previous models--the public health model, also known sometimes as the biopsychosocial model of suicidality, is anchored in public health, epidemiological approaches and frameworks, evidence-based research, and statistical data. This model bridges, individualistic and social approaches to promote population health, adopted by many healthcare professionals and even the the World Health Organization. Currently, this model informs international suicide prevention, guidelines, and strategies.

Fourth, the social justice model of suicide has been put forward by critical suicidologists in the last decade or so in opposition to a psychocentric and individualist approach to suicidality. This model focuses on the collective, structural and systemic, social, cultural, political factors that influence suicidality. It's a model that goes beyond the social model and the public health model by not only taking into consideration environmental and social factors that impact suicidality, but also by being politically engaged and committed to social justice. Many scholars who adopt this model are working at the intersection of other anti-oppressive fields of studies, such as critical race studies, queer studies, trans studies, and so on.

What I want to show--what I show in my work is that, despite numerous differences, these models arrive at the same conclusion: Suicide is not a good option for suicidal people. As a result, not only do these models fail to recognize the suicidal oppression faced by suicidal people, but they also perpetuate it through a suicidal preventionist script, as I discussed earlier.

And one of the most perverse perverse effects of the preventionist script is the silencing of suicidal people. Indeed, they are encouraged to share their suicidal ideations but are discouraged from pursuing suicide as a valid option. In other words, suicidal ideation can be explored, but suicide itself remains completely taboo. What quantitative studies show is that suicide statistics, however, remain relatively stable, and they have not improved significantly over the past decades. So, despite multiple strategies and billions of dollars invested in outreach initiatives, studies show that the those most determined to die carry out their societal plans without reaching out for help. In sum, our prevention strategies based on those various models do not work. So just to be clear, I'm not saying that current discourses, policies, intervention, suicide prevention programs or suicide hotlines based on this suicidal preventionist script never help anyone. Neither am I condemning suicidal people who search for cures cures, be they medical or social as a suicidal person. I know myself how we struggle a lot of the time, and we want to feel better. But I I want simply to highlight here how all these models, incurred in compulsory aliveness, cannot imagine anything other than prevention to help suicidal people.

Indeed, in the various models of suicidality as well as in the views of the right to die activists who promote assisted death for older, sick, and disabled people, suicidal people must be kept alive in all those models. So in all these contradictory but complementary interpretations, suicidality needs to be eradicated to help suicidal people. And in the cases where suicide is not seen as a negative action to be absolutely avoided--suicide is presented as a negative right, that is as a personal decision with which we should not interfere, but not as a positive right that should be supported by the State and society.

In my queercrip model of suicide, the fifth model in this typology, I propose that suicide become a positive right. And I can come back to this idea of suicide as a positive right later. But I contend that, as surprising as it sounds, allowing assisted suicide for suicidal people might be the only way to reestablish the confidence and trust of suicidal people and to break the silence they experience. And while the primary goal of my queercrip model of (assisted) suicide is to provide a more humane, respectful, and compassionate support for suicidal people rather than save lives at all cost, one of my hypotheses--and that's very important--is that my approach, a suicide affirmative approach that supports assisted suicide for suicidal people, might actually save more lives than current prevention strategies do. And this is what makes my framework and approach so unique. In consulting more than 2,000 sources while writing this book and not so long after, I've not found anyone who has ever, to my knowledge, in French and English proposed what I suggest in my book. That is an explicit support of assisted suicide for suicidal people.

Clayton Jarrard: Yeah, thank you for speaking to that. That's a lot of information, and I appreciate that you've kind of broken it down in ways that are digestible. And I definitely agree with what you're saying. So I'd love to continue thinking about this. But first I do want to discuss kind of some of the discussion around assisted suicide. So in Chapter 3 you rethink mad and disabled suicide. Would you be able to speak more about the exceptionalism of suicidal people in mad and disability studies and communities? What are some of the tensions at play here? And how are some forms of death and suicide legitimized while others are delegitimized?

Alexandre Baril: Yes, for sure. And it's a very hot topic and contentious debate, and there are a lot of fraught discussions surrounding those those questions. So the exceptionalism regarding the suicidality of disabled, sick, ill people in comparison with those regarded as able-bodied, healthy, insane as framed in the binary position between suicide and physician-assisted that, or what is sometimes called assisted, that assisted suicide or voluntary euthanasia. And this exceptionalism has long been critiqued by disability activists and scholars. For example, Carol J. Gill dedicated several papers to what she calls selective suicide intervention that marginalizes disabled people based on the devaluation of their lives. Gill points out double standards about suicidality based on disability status, which exist in society and among healthcare practitioners and professionals. When an able bodied individual expresses a wish to die, they are characterized as suicidal and targeted by suicide prevention, intervention, and the injunction to live and to futurity, as I discussed earlier. But when this individual is disabled, the desire to die is recast as rational.

In my book, I show how suicidism is therefore linked to ableism and sanism--that is, the oppression towards people considered ìinsane.î Quote unquote. I argue that suicidism makes some people's desire for that a normal and inconceivable. In contrast, we legitimize assisted suicide for those cast as quote unquote, ìunproductiveî and ìundesirableî based on dominant norms such as dis, such as disabled sick, ill, or old people in their case. Specifically, their desire for death is considered normal and rebranded as medical assistance in dying or physician-assisted debt. However, suicidal people's desire for that is cast as crazy, irrational, mad, insane, alienated, and they are stripped of their decision-making capacity. In other words, from an ableist, sanist, ageist, and capitalist perspective, people who are seen as unproductive, or quote unquote ìa burdenî in our society are supported to die through medical assistance in dying and forms of assisted death, while suicidal people, who are seen as having productive futures, are excluded from these laws and forced to stay alive. In other words, the physician assisted death ontology. That is what assisted death is, founded in Ableism and Sanism, among many other oppressive systems, and on the systemic dismissal of the quality of life of disabled, sick, and ill people creates.

As I discuss this in an early article I published on the topic in a 2017. It was in a journal called Somatechnics. I was saying that it creates two classes of suicidal subjects by considering physically disabled or ill people as legitimate subjects who should receive assistance in dying and suicidal people as illegitimate subject who must be kept alive. My work asks the following question, and this is very central to my to my book: Why are we offering assistance in dying to disabled sick, ill, old people, who, in the vast majority of cases don't want to die, but ask for better living conditions, and are driven to despair by the lack of help while those who do want to die, such as suicidal people, are denied any assistance and forced to die alone in atrocious conditions.

It's important to mention, however, that in all national contexts that allow some forms of medical assistance in dying or physician assisted death or suicide. Suicidal people are excluded. Only people who are physically or sometimes mentally ill can have access to those procedures, and these laws specify that no suicidal person should ever be supported in their desire to die.

And so, even though I mentioned earlier the possibility of offering assistance, suicide for suicidal people through the notion of positive rights, I want to make it clear that my approach is radically distinct from that of offering medical assistance in dying for people for whom mental illness is the sole condition of their requests. In my work I advocate for the abolition of these discriminatory laws on medical assistance and dying, that allow assistance, suicide only for quote, unquote ìspecial populationsî based on dominant norms of who should live or die. And I would like to see the creation of new laws and policies surrounding assisted suicide for all adults who have a stable desire to die, including suicidal people. In other words, my approach is not based on a physical or mental illness or disability diagnosis as the criterion for allowing assisted suicide.

Clayton Jarrard: Awesome. Yeah, I appreciate how you tease out the nuance and all these different issues throughout the book. It's very important, and it's a very complicated topic, so you did an amazing job talking through that and writing through that in the book. In Part 2 of your book you speak specifically to assisted suicide, and you really walk through your suicide affirmative approach, which is also very complex. You say, quote, ìI believe that queering, transing, cripping, and maddening assisted suicide involve working toward the creation of real accessibility to assisted suicide for suicidal people, such as through suicide affirmative health care.î Can you speak to how this is based on your anti oppressive approach and what it means to be suicide affirmative by accompanying suicidal people through their journeys?

Alexandre Baril: Yes, first, I want to say that--and it's very important--that while my approach to suicide and assisted suicide is radically different, it's not intended to encourage suicide. On the contrary, I'm hopeful it will reduce suicide rates.

And we will put, if it's possible some hotline numbers and crisis number for the the podcast today. So it's really important to understand that. Second, I would like to explain what I mean by using the verb--the verbs--queering and transing before going forward with the the rest of my response. So for me, queering and transing suicidality means allowing suicidal people to change the normative discourses on suicidality based on their own perspectives, needs, and goals. Queering and transing suicidality blurs the the boundaries between good and bad decisions about health, life, and death, between the rationality and irrationality of certain actions, between positive and negative affects, and it also means questioning the useful usefulness of these binary categories altogether. To queer and to trans suicidality makes possible to resignify the negative meanings automatically attributed to it, to allow different narratives to emerge. Queering and transing suicide allow to unpack the idea that the best way to help suicidal people is through prevention, and additionally, cripping and maddening assisted suicide allow me to conceptualize forms of assisted suicide or a physician-assisted death that is not based on forms of ableism, sanism, ageism, and so many other -isms, as is currently the case.

So, as you mentioned in your your question, one of the most radical ideas of my book, and probably one of the most controversial, is indeed to theorize suicide as a positive right that would involve supporting suicidal people in their quest for that through assisted suicide. My queercrip model of assisted suicide is meant to complement, not supersede, the fight against

systemic oppressions that influence suicidality in marginalized groups. The support offered to suicidal people would be delivered through a suicide affirmative approach, and suicide affirmative health care.

My suicide affirmative approach is inspired by trans affirmative approaches to rethink the care offered to trans people not based on forms of control and gatekeeping, but based on supporting their autonomy. My approach is anchored in anti-oppressive values, intersectionality, self-determination and informed consent and harm reduction. A suicide affirmative approach does not mean pushing suicidal people to suicide just as the goal of the trans affirmative approach is not to push a person to transition, right? So rather, it means that instead of trying to cure trans people of their transness or suicidal people of their suicidality, we develop safer spaces in which we can examine their suicidality with them and discuss a variety of options.

My approach proposes to shift from a preventionist and creative logic to a logic of accompaniment, to empower suicidal people to help them to make the best informed decisions about life and death, informed of support that could be both life-affirming and death affirming. And this shift from prevention to accompaniment is very similar to trans affirmative approach, because the the suicide affirmative approach offers care and support through informed consent. An informed consent model that is, taking for granted that the expert in the decision to transition, and in this case, from life to death, is the person making the decision. In that sense, I work toward a real accessibility to assisted suicide, and not
accessed, based on exclusive criteria that are also, as I mentioned, ablist, sanist, and ageist. In other words, I propose to replace the logic of prevention with a logic of accompaniment to empower the suicidal person in my approach. And this is very important. The priority is the suicidal person, not life itself.

I often say that we are regarding the theorization of suicidism and the rights and recognition of suicidal people where trans people were regarding trans rights and recognition in the 1930s. Indeed, everything needs to be imagined theorized and transformed, as was the case for trans people when transitioning was not even an option. So my work constitutes a first step, baby step, we can say in this direction. It allows us to open our hearts, our imaginations when it comes to the possibility of envisioning suicide, and assisted suicide from a different point of view from this standpoint of suicidal people. As I mentioned in the book my queercrip model of assisted suicide is meant to open up our imagined to our imaginations, to what our discourses our practices might look like if we begin to think about assisted suicide within an anti-suicidist, intersectional, and transformative justice framework.

And my hypothesis is that a suicide affirmative approach, despite this greater accessibility to assisted suicide, might actually save more lives than current prevention strategies. Indeed, rather than being forced to die in secrecy by completing their suicide without consulting anyone due to fear of experiencing suicidal consequences, suicidal people in my non-stigmatizing approach would have the chance to speak freely and to benefit from an accompaniment process to reach an informed decisions about their desire to live or die.

So numerous suicidal people I've written to tell me that they totally agree with my argument. Maybe one last thing I would like to say is that at first people might think that my book, which discusses a politics of that a suicide affirmative approach and the possibility to assist the suicide of suicidal people constitutes a form of banalization of death that would be characterized by pessimism and hopelessness. However, people who take the time to read my arguments actually discover a book filled with hope and passion to build a better world for all marginalized groups, including suicidal people.

So, despite the fact that I'm critiquing--following authors such as Sarah Ahmed, Jack Halberstam, the notion of hope itself, the toxic positivity, the injunction to happiness, and the idea behind a successful life--the book is not all about darkness. I truly believe that my approach has the potential to reduce rates of suicidality, particularly among marginalized groups by opening the channels of communication with people who are currently too afraid to reach out for help. And even for the small minority of people who would go ahead with an assisted suicide, my book aims to offer them a less lonely and violent death and a relational process of dying that would also be less traumatic for family and friends than current completed suicide.

So the approach I have in mind opens not only a space in which death, by assisted suicide may occur, but also a space in which to openly discuss what it means to live with a desire to die. And in that sense, the politics of death I propose is a politics not only for suicidal people, but for all people interested in fighting for social justice when it comes to death, suicide, and assisted suicide. And in that sense, it represents, I believe, an ethics of living with suicidal people.

Clayton Jarrard: Yeah, I definitely agree. Your book casts a vision that's, you know, a lot more relational and less lonely. And this is epitomized just in how you talk about this approach being person-centered instead of valuing life above everything else. So I would definitely echo those sentiments. So as we're wrapping up, you close the book, talking about more practical steps and more practical interventions to be made not only to be anti or anti suicidism, but also to be more relational in those capacities, and to be more or--to accompany people throughout this process. You say, quote, ìSimply studying and describing suicidism is not enough. We must also work to eliminate it. Undoing Suicidism is my call for action and collective mobilization through a politics of death.î

What was this process like doing so much theoretical work in the book, yet also making sure that it can be practical for people's every day, lives especially for such a charged issue?

Alexandre Baril: Yeah, while writing the book I had 3 key messages that I wanted to deliver that are also linked to my desire, despite the theoretical aspect of my work, to articulate ideas that could have practical implications for people's everyday lives. And the first, I would say concrete takeaways on Undoing Suicidism is that if we are really committed to helping suicidal people, particularly those the most determined to die and who currently complete their suicide, we need to first acknowledge that we do almost everything wrong. As simple as that.

The second takeaway is that suicidal people have important messages to convey, and the general public, decision makers, researchers, and practitioners should start paying attention to what suicidal people have to say and consider them as experts of what they experience and what they need.

And the last takeaway is that, despite a multiplicity of prevention, strategies, as I discuss, that have been implemented in various countries decade after decade, despite a few ebbs and flows in the statistics of suicide, we don't see a significant decrease of suicide rates. So again, what this indicates is that what we have been doing so far doesn't work and that it might be time to try solutions completely outside the box, such as the one I'm proposing in this book.

And despite being, first and foremost, a philosophical contribution, my book Undoing Suicidism is written with a desire to blur the lines between those inside and outside academia. I propose following Jay Dolmage that using simple and plain language is one way to deconstruct this insider outsider perspective and to strike back against academic ableism. It's in the same spirit of accessibility, including for those who are socio-economically disadvantaged, that I decided to make this book freely available through open access on the Internet.

In addition to making this book accessible for everyone, I've I also have many hopes now that my book is out in the world and is circulating. First, I hope to offer reflection that could nurture the emergence of a new social movement, the anti-suicidist movement, a movement by and for suicidal people. And I start seeing the emergence of that again. I hope that readers will discover that the suicide affirmative approach I propose will cause no further harm to suicidal people. Quite the contrary. In addition to potentially saving more lives, the gradual passage from prevention to accompaniment would contribute to better interactions with suicidal people and better care for them. Third, I hope that the theoretical framework I offer, which remains necessarily incomplete on so many levels will be picked up by others. Other people who may point out the embrocation that suicidism has with colonialism, racism, classism, ageism and other forms of violence. And I see this book as a starting point for those very concrete conversations.

I just got funding for a research project to analyze how suicidism is interlocked with all those other forms of violence, and despite the theoretical core of my book, I can already see how it touches people's hearts and minds. The emails I received from people all around the world give me hope that. And the feeling that some things are starting to shift these include emails from suicidal people telling me that my book provides words concept theories to what they have been experiencing for years.

In my book I decided if if people buy it or download it on the Internet will, they will see--I decided to be more vocal about my own suicidality. And while I was scared to integrate those personal experiences, at first I thought it was necessary to do so, since I'm calling for the creation of an anti-suicitis movement. And I believe that this personal tone in my book elicits trust from other suicidal people. I also receive emails from physicians, psychiatrists, psychologists, social workers and activists, saying that my work resonates with their vision

values, philosophies, experience, and practice. In fact, I am currently a consultant for a few local and national organizations to help them to implement an anti-suicidist approach in their suicide intervention plans and guidelines.

And there are already some community organizations such as Autisme Soutien--so it's a peer help group by and for autistic people that have decided to embrace my anti-suicidist approach in the online support they offer to autistic people in the stress. I finally think that the more the book will circulate, the more we will see concrete applications of the framework I and approach. I propose the dissemination of my framework on suicidism has already started in various medium, such as students using it as a theoretical framework in their thesis, or people discussing in non academic ways. What suicid suicid ism means on blogs and social media. I saw some posts on Instagram about it. So this is not my thing, but I'm happy that people talk about it on Instagram. I also recently gave an interview to a playwright who is doing documentary theater, a form of theater that integrates documentary materials, interviews, and so on into a play. And this person, whose father died by suicide, fell in love with the ideas I'm proposing, and wants to educate the general public through the art form, about the necessity to change our perceptions, discourses, and interventions regarding suicide, and assisted suicide to better support, not only suicidal people themselves, but also their families like her and her brother, who were, you know, touch ed and impacted by the death of their father. So in a year or two from now, some excerpts from that interview will make their way into the play, and an actor will play my role. So this is the first time that my academic ideas and concepts will be transformed into an artistic project, and, to be honest, I'm quite excited at the prospect of seeing, display, and hearing comments from the public, because I believe that this project will touch the audience, different kinds of audience in a way that the the book cannot. So yeah.

Clayton Jarrard: Awesome. That's great to hear about. I'm so excited to hear about the reach that this book is having. So Dr. Baril, I've really appreciated this conversation, and thank you so much for taking the time to talk with me before we wrap up. I wanted to just give you the floor in case there was anything that we missed that you would like to go over, or any other work that you're doing, that you are excited about sharing. I just wanted to make sure you have this space to do so.

Alexandre Baril: Well, maybe one last thing I would like to say is that if you are experiencing suicidality, if you feel lonely, if you feel isolated, it's important to reach out. It's important to talk about it, and there are safer, safer spaces to do so. And it's possible to connect with other people who are sharing the same kind of perspectives and values. So please don't hesitate to use those resources and connect with other people.

Clayton Jarrard: Awesome. Thank you for speaking to that. We can be sure to include any resources you would like in the show notes for the podcast episode as well as a link to the open access book. So with that being said again, thank you so much, Dr. Baril, for joining me to day and having this beautiful conversation. I've really appreciated the chance to read your book and getting into this work that you've spent so much time and energy on, so I just want to say thank you for sharing it with us in the world.

Alexandre Baril: Thank you so much, Clayton.