

**Care with Aloha: Preventing Suicide in Oahu, Hawaii**

by

**Lauren Sealy Krishnamurti**

B.A. Chatham College, 2008

M.A. Carnegie Mellon University, 2009

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This dissertation was presented

by

**Lauren Sealy Krishnamurti**

It was defended on

November 8, 2019

and approved by

Lisa D. Brush, Professor., Department of Sociology

Gabriella Lukacs, Associate Professor, Department of Anthropology

Kathleen Musante, Professor, Department of Anthropology

Dissertation Director: Tomas Matza, Assistant Professor, Department of Anthropology

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Lauren Sealy Krishnamurti, PhD

University of Pittsburgh, 2020

This dissertation examines iterations of care in preventing suicide in Oahu, Hawaii. Rates of suicidal ideation among young people in Hawaii have been high over the past decade, peaking in 2009 at nearly double the U.S. average for this age demographic. My fieldwork (2014—2019) follows the efforts of prevention workers in Honolulu, Hawaii and shows that a majority of those involved in (predominantly unpaid) prevention work share affective connections to the cause of prevention, with many having personally lost someone to suicide. In this dissertation, I position suicide prevention workers' care with *aloha* as an alternative to depersonalizing approaches of Western suicide prevention efforts, which rely on protocol. I examine *aloha*'s many contested meanings and (mis)uses in and beyond Hawaii and draw on ethnographic examples to reveal how care workers in Hawaii describe a type of “watchful” (Garcia 2010) care and explicitly aim to personalize their interactions with *aloha*. And yet, my ethnography reveals that there are troubling inconsistencies when putting this type of care into practice.

In this dissertation, I ask whether care as the primary tool of suicide prevention workers in the United States must be viewed as being either helpful or harmful, productive or nonproductive. Through examining suicide care in Hawaii, I ask whether these dualistic concepts might be better evaluated as coexisting rather than competing. Regarding the forms of care that are produced in prevention work in Hawaii, care seems to be simultaneously loaded with and empty of meaning—a statement that, my dissertation reveals, shares similarities with the word and concept of *aloha*—and is complicatedly both effective and ineffective, regulated and unregulated. In this ethnography,

I understand care as a practice, an ethics of the self, an action, a form of (exploitable) labor, a (bio)political endeavor that produces and reinforces inequalities—but fundamentally, I view care as something that is relational, that is produced out of a desire to relate with others. This dissertation suggests that rather than relying on these dualities, we might instead view care as a kind of open-ended concept: as something on a flexible spectrum, open to possibility.

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## Preface

Suicide has long been a focal point of the social sciences. Since Socrates and Herodotus, it has confounded philosophers and remains a divisive issue across disciplines. It has been viewed as a form of political resistance (Abufarha 2009; Zhang, Kleinman, and Tu 2011; Billaud 2012), analyzed in countless psychological case studies, and was the central subject of Durkheim’s monumental contribution to the field of sociology (Durkheim 1897). Even with ongoing debates surrounding its medicalization, suicide is widely considered to be a major public health concern around the world. And yet despite this longstanding history, and despite the immense weight of suffering that remains for those left behind, there has been very little anthropological interest in attending to what Camus once wrote is the “only question that matters” (Camus *MS* 1955:3): “Deciding whether or not life is worth living amounts to answering the fundamental question of philosophy. All the rest follows from that” (*MS* 3).

Suicide feels more like an answer than a question—an action or a reaction, perhaps, to the Durkheimian explanation of social isolation or *anomie*. Suicide certainly presents a problem: the World Health Organization shows that the social and economic impact of suicide within affected families and communities is universally devastating, and suicide prevention programs remain one of the foremost mental health initiatives<sup>1</sup> in contemporary global psychiatry (WHO 2019). For

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<sup>1</sup> In 2014, the World Health Organization released a global prevention plan for suicide, the first of its kind, called “Preventing Suicide: A Global Imperative.” One year previously, the 66th World Health Assembly added the first ever WHO Mental Health Action Plan, naming suicide prevention “an integral part of the

Camus, suicide is a rather predictable response to the underlying absurdity and meaninglessness of life: those who kill themselves do so because they can see no meaning in their lives. But is not knowing the meaning of life enough of a reason not to live it? Camus says no: life is worth living, even though it is meaninglessness—we simply find ways of coping with this absurdity.

His is not the most hopeful of explanations, but this sentiment has always motivated my interest in studying suicide anthropologically: what makes life worth living? How do different people conceive of life's value? What is it that makes us assume that life *is* valuable? These kinds of deeply existential questions get at core concepts related to human experience and consciousness. What does it mean to decide to die? And how is it that all people, in all societies, have this choice? Suicide is something that is so rare in its universality, and yet it still remains elusive in a field that defines itself by its concern for the human experience. As anthropology's focus is to generalize cultural forms in "regular and quotidian" life, suicide persists as something "exceptional and contingent" (Broz & Münster 2015:4). Ethnographies of suicide are considered ethnographies of the exception, not of the everyday—but is that accurate? With so many people attempting or dying by suicide throughout the world each year, is suicide not in fact part of "the everyday"?

In a 2012 preface to a special issue of *Culture, Medicine, and Psychiatry*, anthropologists James Staples and Tom Widger write that the challenge for the field in studying suicide is to move beyond the normative approaches of the *psy* disciplines. They remind us that, on the one hand, the phenomenological position of sociology sheds light on important external forces that can affect the individual in society. As Durkheim claimed, suicide renders social deficiencies visible: it can

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plan, with the goal of reducing the rate of suicide in countries by 10% by 2020" (WHO 2014:1). The WHO's approach fundamentally stresses suicide's preventability as a cause of death.

provide a lens through which we are able to analyze the interplay between social cohesion and individual mental resilience. On the other hand, the psychological autopsy method of psychiatry privileges a view of individual mentality that phenomenological approaches overlook altogether. In moving beyond these dominant approaches, anthropologists might attempt to “engage in [their] informants’ own points of view—and in so doing cast the problem in a new light and new terms” (2012:185). The question I posed to myself, at the beginning of this project and in response to this challenge, was: who are informants in studies of suicide? And what are the “new terms” of suicide to look like? What alternative narrative on suicide can anthropologists—can I—contribute?

Suicide is not only a deeply challenging issue to study anthropologically, it is also difficult to study pragmatically: it is simultaneously a singular as well as a social phenomenon. By virtue of its subject, suicide presents a tremendous logistical challenge to intersubjectivity. The reality in any academic engagement with suicide is that those who might possess intimate knowledge of it are gone—they are beyond our ethnographic reach. I therefore steered away, in part by chance of my project’s trajectory, from centering on suicide as the object of focus. I chose instead, as other social scientists have been forced to do, to work around suicide. In trying to articulate a definition of suicide within this project, I take the position that suicide is an *action*: it is an event and perhaps a way of behaving, but it is not a diagnosis. As such, I have steered away from engaging with theoretical paradigms that cast suicide from an illness perspective, as I find them unproductive. In my view, the future of an anthropological view of suicide centers instead on complex themes of human agency, freedom, biopolitics, and ethics—anthropology, it seems, has a lot to offer.

In studying suicide ethnographically, we might shape more thorough understandings of how death, whether self-inflicted or not, speaks back to human life. How does living with death, or living *through* death, shape our forward perceptions of the living world? How do we ascribe

value to our own lives, and how do we extend that value to others? In the conclusion to this dissertation, I return to some of these themes—agency, biopolitics, freedom—as a way of closing this philosophical circle. But I spend the majority of this dissertation attending to a discussion of care—its possibilities and its limits—in relation to suicide. I made the connections to care somewhat late in this project, in part because suicide itself has proved such a difficult thing to study, but also because care is the backbone of suicide prevention in the United States, and nowhere is this more apparent than in Hawaii, where prevention efforts seemed to appear overnight across the state in response to a need. In the end, I aimed to produce an ethnography in Hawaii that might at least help to reconfigure suicide as something that is more dynamic than previous characterizations claim it to be: I focused on those who live in its proximity, those who work to stop it from happening, those who want to help others from falling into the dark. In searching for these people, I found that what tied them all together was care—not simply as a theoretical framework, but a kind of fundamental care for life itself.

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Thank you to the University of Pittsburgh for supporting me financially during my time here. I realize that it is a privilege to pursue academic work like this, and so I never felt that I was “owed” anything—still, I would encourage the university to pay attention to its student workers. Students deserve a quality of life wherein, for example, their health insurance premiums—in many cases, for entire families—are not over seventy percent of their monthly incomes. Additionally, new mothers like myself need a period of time to recover that does not impact their time-to-degree completion. I succeeded at this institution through the strength of my own determination and with the support of understanding advisors and a caring, working partner. There is a better way.

Thank you to the Department of Anthropology for their support and trust. Having had no previous background in anthropology, this was not a smooth ride for me. In fact, after my first couple semesters in this program, I was actively looking for an exit—I felt extremely lost. Having Professor Gabriella Lukacs as my initial advisor made me stay, in part, because of her kindness, her generosity, her blunt humor, and her willingness to support and listen to me, even when she had no time to do so. It was and is encouraging to know that she was on my side. Thank you to Professor Kathleen Musante, whose course on medical anthropology inspired me to go this route and not another. I am extremely grateful for her guidance and for her kindness. Thank you to Professor Nicole Constable for her inspiration and insights over the years. Thank you to Professor Gabby Yearwood for sharing so much of his wisdom with me, for playing with my son in his office while I went to meetings, and for believing in me as I worked through this dissertation, even when it meant I wasn’t as present in my other work.

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On a personal note, I owe so much to my family for helping me become the person that I am: my parents, Michael and Debra Sealy, are loving and hard-working people and I come to see this more clearly every day. My siblings, and especially my sisters Karen and Christine, with their hearts of gold. My aunt, Janice Poletti. My mother and father-in-law, Oonagh and Ramesh



Krishnamurti, who have walked me through so much of life that it's strange to think they didn't raise me, too. My sister-in-law, Tamar Krishnamurti Glass, and her spectacular boys. To my friends both old and new, peripheral and close: I thank them all for their love, kindness, and support over these years. My dog Barley and my old lady cat Tumble have (literally) been at my side as I wrote this, and I love them both to pieces for it.

Most of all, Jules Krishnamurti, my best friend and partner in all things: thank you for loving me completely. Thank you for supporting our family in so many ways—I know that this project wasn't easy for you, either. Through it all, you've continued to define love and friendship for me and I would not be here without you.

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## 1.0 Trouble in Paradise

*No man is an island entire of itself; every man  
is a piece of the continent, a part of the main  
—John Donne*

### 1.1 “An Island in the Pacific”

In September 2015 I attended a community awareness walk for suicide prevention at Ala Moana Beach Park in downtown Honolulu. It was my final week of fieldwork that summer and I was preparing to head back home, when three different people from three different local mental health organizations invited me to participate in this event which they said was part of a national campaign for suicide prevention. Like other local chapters in other states, I was told that we would be walking into the community with signs and t-shirts. Each shirt would be a different color, each color representing a unique personal connection to the cause—purple for survivor, orange for educator—creating, appropriately, a rainbow of support. When I asked if I could help out in any way, I was told simply to “show up and pick a shirt.” I selected the color that best represented my position: green, advocate.

It was late morning on a Saturday as I walked through the steadily gathering crowd. Already, pop-up tents were set up with various activities: at one, a healing circle. At another, add a deceased loved one’s photograph to a “Memory Quilt.” At another, paint a stone with the name of someone lost to suicide; place the stone onto a growing pile. At yet another, string healing beads together to honor a suicide victim.

Underneath a central tent, speakers addressed the crowd. Among them was Iolani, a mother who had lost her son to suicide and a self-proclaimed “suicide activist” in Hawaii. Iolani and I met several times over the course of my fieldwork, and our conversations continue throughout this ethnography, but the exchange we had at this event would be our first. I quickly introduced myself; she told me she was glad I could make it all the way from Pittsburgh.

As the speeches wrapped up, the crowd was instructed to begin walking along the designated march route, which was to go the length of the beach park and, I had expected, into Waikiki, Honolulu’s most lively shopping, dining, and entertainment area. It is famously packed with people night and day, locals and tourists alike; I could think of no more public a place to take this community awareness walk than straight through its central strip. I followed along with the crowd as we began walking the route. We slowly went the length of Ala Moana park, about a half a mile of beach which owes its popularity, in part, to its proximity with Waikiki, and we continued in a circle around a place known colloquially as Magic Island, a small human-made peninsula of white sand that stretches out from the park into the ocean. We walked the length of Magic Island and then looped back along an oceanfront boulevard to the front of the park again. The march was not headed into Waikiki at all.

In this moment, the isolation I briefly perceived in this public march with no audience felt evocative of the isolation, both literally and symbolically, of Hawaii as a place itself. As we moved unnoticed around this artificial island, it seemed that any sign of “trouble” in Hawaii quickly disappeared, erased by its ubiquitous characterization as “paradise,” as if it were something of a fictional place unaffected by time, space or the outside world. As one of my informants would later tell me, “Hawaii *isn’t a real place.*” For many others, Hawaii (as Jeff Sessions once

notoriously dismissed it) is just “an island in the Pacific.” An island in the middle of nowhere. An island where problems like suicide aren’t thought to exist at all.

As we turned the first bend of Magic Island, people raised signs above their heads with the names, ages, and faces of lost loved ones and phrases of support for those struggling. I couldn’t help but feel confused at what I was witnessing. For an event that was meant to bring public attention to the problem of suicide among Hawaii’s communities, the couple hundred people in attendance were walking in almost total isolation from the public. Rather than being seen or heard, their messages of hope and tragedy faced the uncaring waters of the ocean, not a soul in sight to receive them.



**Figure 1 Honolulu, HI - “Memory Quilt,” 2016**

## **1.2 Suicide Care**

Throughout the course of my fieldwork, this vignette has somehow stood out. Over time, I came to realize what this scene revealed and why it has always felt so important. As I watched this “public” march unfold, I first perceived the work of suicide prevention in Hawaii to be somewhat

isolated, perhaps by design, from a wider community response. Even if intentional, this wouldn't be too unexpected: as so much of Hawaii's economy depends upon year-round tourism, calling attention to the issue of suicide on one of the state's most heavily trafficked boulevards could be viewed as a little counterproductive. The concept of isolation also evoked, at the time, the very literal remoteness of Hawaii: a group of tiny islands in the middle of an ocean, a five hour plane ride to the nearest continent on either side. The illustrative metaphor of a remote island also spoke to the type of isolation that is so often connected with suicidality. "No man is an island," reads the famous first line of John Donne's literary declaration of humanity's need for connectivity. But what the scene at Ala Moana Beach Park highlights is that suicide as a phenomenon is anything but individual. It involves prevention, loved ones, those who nearly lost, or finally did lose, someone. Suicide, in other words, encompasses a variety of other social processes—including, especially, suicide prevention work.

But how should we approach the study of suicide's social dimensions? In this dissertation, I examine suicide prevention work as a form of care. And I show that suicide prevention, which so often rests on abstract configurations of caregiving, can in fact be something tangible: the quilt, the healing beads, the different color t-shirts were crafted, held within and made from people's hands with purpose and intent. These types of events, though they sometimes felt trivial, became such a central part of my fieldwork—and they were designed to prevent suicide through these seemingly small but meaningful, and often physical, acts of care.

Care and isolation emerged as central themes in this ethnography of suicide and its prevention in Oahu, Hawaii. And it would seem fitting, too, as this dissertation follows in the social science tradition laid out by Durkheim and his monumental 1897 work on the subject, *Suicide*. It was Durkheim who theorized that suicide as a social phenomenon is nearly always linked with

isolation, whether it be from society, from one's own morality, from a sense of direction, or from a governing body. Durkheim's work is both dated and problematic in its methodological approach: he attempted to explain the phenomena of suicide using aggregate data of death rates as recorded within populations, which contradicts the individualistic reality of suicide as a form of death. Nevertheless, while more recent anthropological studies of suicide aim to distance themselves from Durkheim's functionalism, they have often shown suicide in a similar framework as being linked in some way with a form of isolation—whether it be social, economic, cultural or political. In this project, I aim to distance myself from these others in attempting to view suicide as something more dynamic and more relational than in previous iterations.

These topics come together in a striking way in one of the most geographically isolated places in the world: the archipelago of Hawaii, where concern surrounding increasing rates of suicide and suicide attempts has grown over the past decade. Yet people nearly always react to the issue of suicide in Hawaii with shock and confusion and variations on the phrase: "Why would someone want to kill themselves *there*?" This response and the many iterations of it was something I heard countless times throughout this project. I have since come to realize that the apparent simplicity of this reaction masks a greater complexity: the very notion of something so final and so purposeful as self-death in a beautiful place evokes a kind of paradox, a contrast that feels counterintuitive.

The particular branding of the beauty of Hawaii is indeed pervasive: it has become heavily romanticized and embedded into the Orientalizing global and popular imagination since it was first discovered by Western explorers. Like most of its neighboring islands in the Pacific, Hawaii's image is, to borrow from Baudrillard, a hyperreal one: that is to say, the particular image of Hawaii that has been exported via sight and sound and word is an exaggeration of its reality and has

become, for Americans especially, more real in its hyperbole than the actual reality of Hawaii (Baudrillard 1994). It exists as a sort of breathing postcard, everything an advertisement of the archetype of itself. The persistence of this hyperreal image is evident even among those who have known no other place as home. For many of those I spoke with throughout this project, Hawaii is a place they consider themselves “lucky to live in,” because of nothing other than its characterization as an island paradise, even if the immediate fruits of such a paradise are inaccessible—or altogether prohibitive—to them.

Certainly, framing suicide in Hawaii as a paradox can be theoretically useful. The branding of Hawaii has become embedded for many, including scholars and historians; the rhetoric of “paradise” and the notion of being lucky to live within it become critical concepts in discussing suicide as an issue among Hawaii’s residents. In fact, it often seemed to be the case that the inability to separate the realities of life in Hawaii from this imaginary was at the speculative core of discontentment for many people with whom I spoke. Here again is another variation on the theme of isolation: the hyperreality of Hawaii-as-place maintains a relationship of isolation between those whose lives are anything but, and the fiction that Hawaii *is*, a paradise.

The reality of the “problem” of suicide in Hawaii, however, is far more complex. Although suicide has been consistently highlighted as one of the most significant public health challenges in the state, and suicide prevention a leading concern of the Department of Health for more than a decade, suicide is not unusually high in Hawaii. In fact, in comparison with the rest of the United States, the rate of death by suicide is actually relatively low, ranking 35<sup>th</sup> in the country with approximately 12.1 suicide deaths per 100,000<sup>2</sup> people in 2017 (CDC 2019). The present public

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<sup>2</sup> The U.S. state average hovers around 13, with the highest rate of 26 per 100,000 reported in Montana.

health urgency that is given to suicide prevention in Hawaii might, then, seem somewhat misplaced; however, several important factors help elucidate the need for a focus on suicide *prevention* and the strength of the response to addressing suicide in the state. The problem Hawaii faces is suicidality. Rates of suicidality—which refers to suicidal ideation and/or a plan to commit suicide—and suicide attempt rates among young people (typically aged between 14 and 24, but highest within the 20 to 29-year-old demographic) are among the highest reported in the U.S., reportedly doubling in Hawaii between 2007 and 2012.

The issue of suicidality, I was told early on in my fieldwork, was one of the most important concerns that the mental health community in Hawaii was facing. Because growing numbers of (particularly young) people were considering or attempting suicide, the means of addressing this problem statewide was through suicide *prevention* efforts: in other words, mitigating a crisis before it becomes a crisis through preventative strategies to lower attempt rates. This project began as an examination of this high rate of youth suicidality and of what I observed to be a proliferation of community responses to mitigating suicide across multiple levels of expertise and intervention. To clarify, my interest has been on the *possibility* of a suicide epidemic in Hawaii. My focus has never been on suicide itself; unlike other anthropological studies of suicide, this has never been an account of a suicide epidemic. Rather, I am interested in the specific modalities of care at work in preventing suicide as a response to the increase in suicide attempts in the state.

As an anthropologist, working on the subject of suicide is isolating in its own right. At the time that I set out on this project, there were only two contemporary ethnographies focused on suicide in different parts of the world: Lisa Stevenson's work on the suicide epidemic affecting the Nunavut in Northern Arctic Canada (2014, 2016) and Jocelyn Lim Chua's work on suicide among aspiring youth in Kerala, South India (2014). Others, like Angela Garcia (2011), have



woven suicide into ethnography in ways that complicate it productively as something that is lived rather than suspended in place and time. I consider myself to be in close conversation with these writers most directly throughout this ethnography, not simply because their research also broaches suicide, but also because of how they have advanced and opened up particular modes of theorizing suicide and writing about it as it operates in daily life. In particular, I dialogue with Stevenson's conceptualization of "anonymous care" and what she calls the "suicide apparatus" of prevention. I similarly frame Hawaii's models of prevention (and the United States' writ large) within the framework of policing life itself (2014)—in other words, suicide prevention is fundamentally a biopolitical enterprise in its concern with preventing death. I also follow Chua's discussion of suicide and "problems of aspiration" in my discussion of Hawaii's upwardly (im)mobile young people, and Garcia's work on the caring acts of those living up close to physical and spiritual grief, pain, and suffering.

I diverge from these authors' treatment of suicide in several key ways, and that is where this first chapter begins. One difference is with my usage of the concept of isolation. In each of these other ethnographic cases, suicide is understood as an epidemic that seems to be contained within a community that is by nature somewhat isolated: for Stevenson, the homology of her subject/object is that the Nunavut community exists within a small and traceable geography, culture, and history. Likewise, Chua focuses on one city in a globalizing South India. These instances of suicide the authors describe correspond to a particular, containable, cultural (and literal) place. In contrast, I understand isolation both as it is experienced as a physical reality for those living in Hawaii, and in regards to the phenomenology of suicide and of what I might call "suicide communities." That is not to say that these other case studies focus too narrowly on instances of suicide in "small places" (Widger 2015); they do go beyond their cases in very

important ways, but their anthropological interventions remain stringently tied to their place and to the centrality of suicide as an epidemic. My project, in contrast, does not approach suicide with the intensity that these ethnographies must devote to something that pervasively impacts a community in very consequential ways. Instead, I focus on forms of sociality and communal care in the remediation of *risk* in suicide from the standpoint of prevention work/ers.

Of course, suicide in Hawaii *can* be neatly defined in the same way as these other ethnographies—there have certainly been many occasions where I have wondered if my research would benefit from being “isolated,” that is to say limited, to one affected group in Hawaii. I have been encouraged, on more than one occasion, to link the problem of risk and suicide with culture, which in the context of Hawaii, almost implicitly refers to indigeneity. My continuing issue with this has not been whether it *can be* defined in such a way, but whether or not suicide in Hawaii *should* be. I contend that this is the wrong presentation of the issue for several reasons. Most significantly, I find such framings to be outdated and racist in the way they default to attributing risk and negative health to cultural and ethnic minorities. Certainly, in rural parts of Hawaii and within the smaller Neighboring Islands especially, localized and demographically indigenous communities are at a greater statistical risk for suicide, just as they are at a greater risk of unemployment, lack of healthcare access, and so on. This risk is not, however, reflective of a biological predisposition or to the *potential* for health and wellness among these populations. Nor is this risk explainable in terms of a culture. Rural communities and those on the smaller Islands in Hawaii are more likely to be isolated from *all* resources because they *are* more isolated, whether by choice or by colonialist design—there is no inherent predisposition to ill health beyond the naturalizing of structural inequalities that cut off certain populations. Despite this, and although these communities visibly lack the metropolitan infrastructure of Honolulu county, they do not

escape the ideologies and needs brought by capitalism and its many (dis)contents throughout the now-state of Hawaii. And, as tends to be the case in places with a history of dispossession and land displacement, these communities are also, by virtue of their location within the geography and ideology of the contemporary Hawaiian economy, more likely to be *Kānaka Maoli*—Native Hawaiian.

This discussion of the racializing implications of how suicide is spatialized as “isolated” also bears on the theoretical concept of care. One significant way that care functions as potentially harmful not simply *in* Hawaii, but in scholarship *on* Hawaii, is through this persistent highlighting of Native Hawaiian populations as being at the greatest risk for all negative health and social conditions. Prevalent public health discourses in the U.S. emphasize the disproportionate adverse health conditions (physical, mental) among Native Hawaiians and Pacific Islanders. These presentations of health, though they are indeed statistically rooted, are too often ignorant of the social and structural violence that has set many of these communities up to fail in very tangible ways, ways that are perpetuated by the same state apparatuses that also decry these negative health conditions. In other words, in my view, the perceived poor physical and mental health of *Kānaka Maoli* is yet another enforced casualty of colonialism. And the care that springs from such framings of risk must also therefore be interrogated.

One of the positions that I take at the outset of this project is intentionally to counter these public health discourses that set ethnic groups up to fail. Despite the propensity of higher risk of suicide among Native Hawaiians, my research has revealed that this is a misleading, incomplete way to frame suicidality in Hawaii. As it does in other U.S. states, suicide and suicidality impacts many groups across a variety of demographics; the preventative strategies that I focus on in Hawaii take this into account. Part of the reason for the diversity among the “at-risk demographic” in

Hawaii is also reflective of a certain fluidity and ambiguity in demographic categorization in the state (Osorio 2014). Specifically, who counts as a “local” or as a Hawaiian versus who is considered *Kānaka Maoli*, or Native Hawaiian, have become flexible categories. For some, claiming any amount of *Kānaka Maoli* ancestry is enough to be Native Hawaiian. For others whose heritages are from the broader Pacific Islands or East Asia, “Hawaiianness” is not as important or as dominant as, for example, being Japanese or being Tongan. As such, I too approach demographics in Hawaii as most people with whom I spoke do, which is by referring to all those who identify as being from Hawaii as being Hawaiian.

Another important reason for why suicide and suicidality in Hawaii must be viewed across demographic (especially ethnic) groups is that suicide itself is a complex social and individual phenomenon that does not lend itself well to a reductionist, culture-based analysis. Suicide is not containable or isolatable. It does not typically occur neatly in spaces. Nunavut or Kerala seem to me to be “exceptional” examples (Staples & Widger 2015) of suicide among groups that experts might call high-risk and under pressure, epidemically affecting those living within particularly precarious social circumstances. The more unexceptional picture of suicide as a human condition, and what I intend to show through Hawaii as an example, is that suicide affects all people across the board for a multitude of reasons that are not so easily broken down demographically, spatially, culturally, or phenomenologically. One of the realities of suicide as a human behavior is that it is, for lack of a better word, something universal to the human experience. Suicide occurs in all parts of the world, it impacts all sorts of people—it is, as a physical action against oneself, a possibility regardless of culture, language, race, or socioeconomic status. Suicide is a radical human choice that remains available even when all other choices are taken away.

And yet, as anthropologists have approached talking about suicide, it seems the conversations have frequently been drawn away from asking some of the questions that I feel are the most pertinent to understanding it as part of the human experience. I wonder if part of the problem in discussing causality in suicide comes from a fear of stepping beyond the perceived limits of what anthropology is allowed to do, particularly as suicide has been categorized and medicalized as belonging to the *psy* disciplines. As Jocelyn Chua writes in the introduction to her ethnography, she is not so much interested in suicide's causality at the individual level: she does not discuss the pathologies of most of the suicide deaths that she addresses, nor is she aligned with the Durkheimian view of suicide as a social barometer. Rather, she is interested in the sociality that suicide creates/produces in spaces and how suicide has been construed by residents and mental health experts in Kerala as "the fallout of false or failed aspiration, a social pathology symptomatic of the lofty dreams and blighted hopes" of its suicidal youth (Chua 2014:8). This is an anthropological way of framing things, and aligns with the approach that interests me. Yet it seems to me that, in her ethnography, causality and societal distress remain front and center nevertheless: a surplus of unemployment, the weight of financial strain, the misery of desperate, overeducated youth and their burden of aspiration in a dwindling economy leaves her demographic with the favorable option of suicide. Is that not a view of suicide as something that is caused by social dysfunction?

At the same time, it is important to avoid broadly psychoanalyzing social and individual causality in suicide. Indeed, it would certainly be impossible to understand all of the instances in a single person's life, no matter what attention is given to physical or mental health histories, that contribute to an individual suicide. And to focus too narrowly there not only does a disservice to that person's life, but it also gives an unfair amount of power to their chosen method of death as

retrospectively overshadowing a life lived. I encountered this perspective often among those I spoke with who had lost a loved one: they asserted that a person who died by suicide was and is not defined by their suicide. Similarly, to look only at causality in suicide among specific social groups runs the risk of essentializing them in a functionalist manner, as Durkheim has done.

Articulating suicide in Hawaii (its causes, its characteristics) is troublesome in that the whole of Hawaii can be defined by an almost constant culture of change: the landscape, its population, their identities, ethnicities, even indigeneity in Hawaii is something that is continuously in flux. Amongst a diverse population in the largest city in Hawaii, it would be inaccurate to portray suicide, as Chua can in Kerala, as a problem of aspiration or as a problem of Native Hawaiian health, or even as a problem of the dispossession of Western colonialism (as Stevenson characterizes it as “murderous” to the Canadian Inuit) without ignoring these characteristics that underscore Hawaii’s identity. Again, suicide and suicidality in Hawaii, much like suicide in the rest of the United States, simply does not disproportionately affect any one particular group. It is itself very much a messy thing as it cuts across ages, incomes, ethnicities, and life experiences. In this sense, outlining the problem of suicide in Hawaii, and by extension in the United States, must be decoupled from place.

The reason for making this argument is more than just an academic one. My broader aim is to call out the “management” of suicide within U.S. mental health care. This, in my view, can be tied to a form of carelessness that has emerged in the context of the privatization of health care. Health care in the United States favors depersonalizing therapeutic languages and liabilities in providing care, rather than focusing on the needs of those seeking care. The format of mental health systems in the U.S. have allocated “care” as a service that is the responsibility of those in need to seek out, as a consumer to a product. Within this exchange, the suicidal subject seems to disappear

as a real person in need of real help—they become “anonymous” rather than acknowledged by a system that claims to care (Stevenson 2014).

This brings me to the second and most significant way that this project diverges from, or perhaps more accurately, builds upon other ethnographies of suicide, which is in the way that it situates care in relation to suicide—what I refer to throughout this project as *suicide care*. Care has become something of a catch-all term, particularly ubiquitous in anthropological conversations about health. It is embedded into the very names of the public systems designed to treat our many bodily, moral, and mental ailments. In the context of institutions, care has been discussed as a process of exclusion, specifically in how care is or is not distributed to certain groups or individuals (Biehl 2005). Anthropologists have predominantly followed Foucault’s notion of the biopolitical in situating care at the level of populations, particularly in terms of analyzing how inequalities of care operate in everyday life (Giordano 2014; Stevenson 2014; Tiktin 2011). Care has also been viewed as a practice and as a commodity; in these instances, the social action of caring becomes something exploitable, even when intentions might remain benevolent (Adams 2013; Muehlebach 2012). In the therapeutic encounter, care has been articulated as a potentially reciprocal exchange between provider and patient, and/or an ethical practice (Carr 2011; Garcia 2011; Matza 2018; Mol 2008; Myers 2015). The vulnerabilities that are exposed and the socialities that are produced in these two-way therapeutic encounters are threaded throughout my discussions of suicide care.

Before entering this dialogue on care, it is important to first outline its role within suicide prevention as opposed to other kinds of psychiatric work, as it differs from other modes of treatment in several key ways. First, the mechanism at work in suicide care is *prevention*—literally, stopping the event of suicide from occurring. Suicide prevention therefore functions primarily as a language, a rhetorical form of care whose attempts to elevate the value of life is the only tool by

which it keeps death away. Care's focus in instances of suicide is about *preserving* life (Stevenson 2014); in Hawaii specifically, "sustaining life" or "passing life forward." In suicide prevention, the value of life "becomes the ground upon which all forms of caring stem" (Stevenson 2014:7). But as Stevenson outlines in her discussion of "anonymous care," in promoting life as being collectively valuable across at risk populations, there emerges a crisis of treatment in individual suicide care. The vernacular of prevention speaks out to an unknown audience while assuming and assigning a value to that audience's existence. With nothing else to grab onto, prevention needs to make those at risk see the value of their lives—but it does this in an indifferent way, in what Stevenson talks about as "anonymous care" (2014): that care is administered "without it mattering for whom" (2014:5).

This kind of "anonymous" care is not limited to outreach or awareness campaigns, but is also present, and arguably even more so, in suicide interventions. In interventional encounters that are one-on-one between care providers and those seeking help, organizational protocols disallow personalized connections. In the U.S., these methods of caring are already somewhat spatially disconnected, as in the typical format of crisis hotline or chat support encounter. Workers here are bound by institutional liabilities in responding to those seeking care, following scripts and deflecting information that is too personal or borders on relationship-building. This leaves open the possibility that care in therapeutic encounters of suicide can be harmful, or even dangerous (cf. Matza 2018). As Stevenson has argued, indifferently declaring life "as the ultimate good" may well be as harmful as negating it altogether (2014:10). In writing about a suicide hotline in the Canadian Arctic, Stevenson says: "There is no long-term association, no relationship or friendship developed during the call. The volunteer is supposed to be as interested in one caller as the next but never to make a personal connection beyond the call. In fact, in anonymous forms of care,



personal connections are supposed to be suppressed” (Stevenson 2014:84-85). I would emphasize also that this inherent care-lessness, the literal detachment of a meaningful connection, further distances those who are seeking care in suicide.

Second, workers in suicide prevention (and intervention) are largely non-professionals; that is to say, those who operate at the frontlines of suicide care are often volunteers with no formal medical training in psychiatric intervention. Aside from completing crisis training programs, which are often run at the community level by other non-medical experts, those administering care in the actual encounter of suicide are not, by design, professionals. In the actual encounter of suicide, these non-professionals simply follow scripts that prompt them to relay an individual on to the next care provider. This can be doubly isolating, as those seeking care become thrust into a system that feels particularly uncaring, while workers, worked under protocols, are disengaged from creating any connections beyond the intervention. There is no possibility for either to “flip the scripts,” even in situations of life and death (Carr 2011; Stevenson 2014). As Matza writes, referring more generally to psychotherapeutic work, care “can either align with or diverge from biopolitical norms. In one instant, help can become harm. Care is precarious” (2018:9). This is particularly true with the urgency of suicide care. In the actual event of suicide prevention—an identifiable moment where the suicidal individual is facing imminent harm—the indifference of anonymously administering care, and the (in)ability of those to adequately perform this care work, can become particularly precarious and its potential to harm particularly dire. When those providing care in suicide rely upon scripts that do not align with the immediate needs of those seeking care, the distance created in that encounter can leave the suicidal individual feeling more isolated than before. The fundamental flaw in relying upon depersonalizing scripts and protocols is that individual needs are rendered obsolete: the immediate voice of those seeking care goes

unheard when their words do not correspond with a scripted action. In these encounters of life and death, care must learn to function more effectively.

So who and what cares about suicide? What does it mean, both to care about suicide and to take up the responsibility of engaging in its care? As Stevenson writes, professionalized care in our time has been forced to fall into shifts—literally, we function in a world where caring occurs between 9 and 5. Implicit in this system of care “is that the object of care must learn to mime the caregiver’s attitudes to time and to care. If you—the patient, the distressed, the sick—care enough you will seek out psychologists, social workers, and counselors for your family, and you will be on time to your appointments and not stay overlong” (2014:134). For the suicidal individual, seeking out care falls on that person to “ask for help” as much as it does on the caregiver to provide adequate care in response to “noticing the warning signs of suicide.” For those whose stories I tell in this ethnography, suicide care is not relegated to 9-to-5 shifts, but rather has become, to use Garcia’s conceptualization, “a way of life” (Garcia 2010).

Suicide *care*, not suicide on its own, is what underscores the work that my informants do and have done—even in those instances when it is not, in fact, their job. I view this kind of care here along Liisa Malkki’s (2015) notion of the transformative nature of physically engaging in humanitarian work as a form of self-care—care in the context of impossible situations. I am similarly interested in the intangible something that calls individuals not only to care, but to take up the responsibility of care well beyond, and sometimes even surpassing, their own limitations as distributors of a type of care that I imagine as balancing professionalism with compassion; a form of care *with aloha* that I read along Garcia’s notion of what it means to be “watchful” in instances of suicide prevention (2010:181). This concept of *aloha*, as I will explain throughout my discussions on care in the following chapters, allows not only for this idea of watchfulness in

suicide, it promotes the idea that watchfulness is a necessary (inter)personal and cultural responsibility that manifests in the work of suicide care in Hawaii.

Within the many layers of care at work in suicide prevention in Hawaii, I highlight the relational aspects of a type of therapeutic care that I view as being necessary to exchanges between those providing and those seeking care in suicide. Moreover, as those who come to care about and work in suicide prevention in Hawaii are often intimately connected to the issue—survivors of an attempt or of a suicide loss—the type of care present in these affectively-influenced encounters is more intersubjective than typical doctor/patient exchanges in mental health interventions. This, as my informants’ work illustrates, opens the possibility for a more compassionate approach to suicide prevention than institutional models of protocol-informed care in the United States allow. In focusing on the interpersonal narratives of suicide care in Hawaii, I am implicitly critical of the ubiquity of these dominant and seemingly care-less institutional suicide prevention strategies in the U.S. I point instead to how those working to prevent suicide in Hawaii illustrate that effective, interpersonal interventions in suicide are possible and exist outside of dichotomous models of “cold” institutional and “warm” familiar care (Thelen 2007). Suicide care in Hawaii bridges both of these approaches through its articulated relationship as care with *aloha*, which is itself a complicated cultural and historical concept, loaded with instabilities and contradictions that I interrogate throughout the following chapters.

This dissertation therefore examines the varieties or iterations of care in relation to suicide and its prevention in Oahu, Hawaii. While care is something that has been discussed at length in the social sciences, it is still somewhat difficult to pin down its clear conceptual definition, despite these many inquiries and explanations. In this ethnography, I understand care as being all of the above—a practice, an ethics of the self, an action, a form of (exploitable) labor, a (bio)political

endeavor that produces and reinforces inequalities—but fundamentally, I view care as something that is relational, that is produced out of a desire to relate with others. Care, in my view, is about love, concern, attention, the “inescapable” notion of human interdependency (Butler 2004, cf. Berlant 2011). The inherent responsibility of care is recognizing the needs of others in our own selves and responding to that need *in spite of* ourselves. This ethnography comes at a time in U.S. history where public systems of care have become entangled within a professionalized social ambivalence to life and death, as enacted through our governments and their policies, and infiltrating into sectors that were designed solely to care for our bodies (health care), our minds (mental health care), our children (public education), and our neighbors (immigration “reform”). In my view, the further privatization and commercialization of these systems of care in the United States, the shift toward preventive/preventative health, and the focus on neoliberal self-responsibility in care-seeking results in a fragmentation of these other inexplicables—love, concern, attention, empathy for others—within those systems that are built solely for purposes of caring in these very ways. The dominant medical systems that intervene in suicide therefore appear ambivalent to the outcomes of those seeking care: they are more bound to liabilities than to patients, more to protocols than to people. And yet, because we operate in a system that preferences professional authority, there still exists the potentiality of harm caused by unregulated care in treating the suicidal.

Must care, as the primary tool of suicide prevention workers, be viewed as being either helpful or harmful, productive or nonproductive? Through examining suicide care within the context of care/work in Hawaii, I ask whether these dualistic concepts might coexist rather than compete. Regarding the forms of care that are produced in prevention work in Hawaii, care seems to be simultaneously loaded with and empty of meaning—a statement that shares similarities with

the word and concept of *aloha*—and is often shown to be both effective and ineffective, regulated and unregulated. In this ethnography, I suggest that rather than relying on these dualities, we might instead view care as a kind of open-ended concept—as something on a flexible spectrum, open to possibility. Indeed, perhaps limiting a definition of care to one-or-the-other simply reinforces an overreliance on a value system that marks forms of care as either/or: benevolent or bad, effective or failing, cold or embracing. Suicide care in Hawaii disrupts this duality. My informants show how it is both at the same time, that unregulated care is not inherently harmful in its detachment from protocol- or expertise-informed care, and that care itself is social, transformative, and ultimately deeply (inter)personal. As Thelen writes, shifting our perspective from a limited dichotomous view of care allows us to articulate it as something changeable and “open, giving shape to ever-shifting forms of social organization” (Thelen 2007:509). In my ethnographic case, both care and *aloha* exist as changeable concepts.

Care with *aloha* is not either/or but is rather both/and: good *and* bad, cold *and* warm, public *and* private. Caring with *aloha*, though the word itself means something different to almost everyone I spoke with, shares a common goal of providing unbiased, nonjudgmental, limitless generosity of concern for another person’s needs. And yet at the very same time, those working hardest in suicide prevention in Hawaii are not “typical” authorities in suicide (or mental health) care beyond their own connections and experiences—there still exists, within this structure, an unpredictable potential for this type of “unregulated” care to be unstable, to be inadequate, or to contradict its own purpose. I grapple with this perspective throughout these chapters, and I argue that the caring actions of those in this ethnography can, at the very least, open the possibility for a more compassionate form of semi-professionalized care that bridges these divides in clinical, experiential, and affective forms of expertise in order to adequately support those in desperation.

I present these narratives of care in order to ask whether we might benefit not simply from valuing more holistic, subjectively-informed approaches to caring for the suicidal, but whether it might become possible, within mental health care systems more broadly, to care non-reciprocally, without bias, and with a greater urgency—with *aloha*.



**Figure 2 North Shore, Oahu, HI - “Pass With Care” Road Sign, September 2015**

### **1.3 Suicide Prevention in the United States**

In order to fully situate suicide care in Hawaii, it is important to outline three things that have fundamentally shaped the way that suicide prevention operates within contemporary models of mental health care in the United States: diagnosis, deinstitutionalization and the biomedical organization of prevention. First and most significant is suicide’s tenuous placement within psychiatry due to its unclear epidemiology: suicide has historically been understood as a behavior, not an illness, even within *psy* discourse. Following its inclusion as a psychiatric concern, suicide still occupies a unique position within mental health care as something that is neither chronic nor

independently diagnoseable (Decker 2013). Second, as the deinstitutionalization of psychiatry in the mid-twentieth century shifted the healthcare landscape from centralized state hospitals to community clinics, medical intervention in suicide has treated suicide according to its urgency: that is to say that, literally, the site of treatment in suicide is viewed as something temporal, represented by a moment of crisis that is determined by a perceived threat of harm. It is a process of triaging based on need, a “prioritizing of those who should be rescued” and the values assigned to them within a “pragmatic assemblage<sup>3</sup> of procedures and technologies” (Nguyen 2010:109). In the encounter, those at a perceived greatest risk of immediate harm are treated by emergency medicine or by crisis intervention specialists, whereas those experiencing thoughts of suicide with no *immediate* threat of self-harm are funneled through outpatient clinics, where the focus shifts to therapeutic interventions and preventative support. This sorting has the effect of flattening different subjectivities and experiences in suicidality along a continuum that places a somewhat arbitrary value assessment on what is considered “a crisis.”

Finally, suicide prevention strategies, while aiming to provide alternative forms of care for those at risk, are dependent on the definitions and deficiencies of biomedical psychiatry’s treatment of suicide. Some of these deficiencies include the unclear diagnostic assessment of suicidality: if something cannot be diagnosed, then it seems to escape the need for treatment (cf. Luhrmann 2000). Another deficiency is in the kind of passing over suicidal patients because of the ubiquity of emergency medicine in crisis models. Suicidal individuals thought to be experiencing a crisis are routinely moved through an E.R. and discharged once the temporal moment of “crisis”

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<sup>3</sup> What Vinh-Kim Nguyen calls “life boat ethics” in triaging based on perceived need, in his case, among HIV/AIDS patients in West Africa (2010:109-110).

has been resolved—not accounting for the residual or preceding events that may be part of the crisis. The work of preventing suicide, then, is more about managing the potentiality of suicide through affective forms of support, which are far more social than they are biomedical. Such support can involve promoting the value of life, offering hope or positive coping strategies, community building, and so on. Prevention relies on intersubjectivity and draws from an affectively-engaged economy/workforce of caregivers (Adams 2013; Ahmed 2004). This section provides background that will briefly explain the process of deinstitutionalization in the United States in order to situate suicide and suicide prevention, from both an epidemiological and a functional perspective, within the complex system of mental health care in America.

### **1.3.1 *The Epidemiology of Suicide/Prevention***

The unclear etiology of suicide has historically presented a challenge to its inclusion within psychiatric diagnostic manuals. Despite being recognized as having a pathological component, suicide has never been defined as an independent mental disorder. Rather, it has been viewed somewhat straightforwardly as an action of willful self-destruction. The National Institute of Health broadly defines suicide as “death caused by self-directed injurious behavior with any intent to die as a result of the behavior” (NIH 2018). Even Freud had little to say about suicide: he simply viewed self-harming behavior as a form of violence similar to that of homicide (Litman 1970; Hamilton 2002; Briggs 2006). In the United States, the transition from viewing suicide as a behavior to its medicalization within psychiatry followed from the diagnostic acceptance of clinical depression, which itself developed out of a long tradition of literature on *melancholia* and mood (Kleinman 1988; Freud 2005; Martin 2007). That is, the inclusion of clinical depression as



a DSM diagnosis within biomedical psychiatry in the mid-twentieth century U.S. transformed suicide from a socially stigmatized behavior into a mental health concern requiring standardized measures for identification and treatment. The relationship between depression and suicide is hard to ignore: health research continually illustrates that a majority of suicides are linked with depression, to the point where it is difficult to untangle one from the other.

While the treatment of depression is approached more holistically, the treatment of suicide presents a unique challenge to biomedical psychiatry. Unlike a mental illness whose symptoms are managed over time via a combined regimen of psychotherapy and psychoactive drugs, suicide's treatment rests entirely on two types of support: prevention and intervention. The distinguishing characteristic of these approaches is a temporal one: prevention efforts aim to predict and dissuade at-risk groups from attempting suicide, while intervention aims to intervene in an actual encounter of suicide. With the inception of suicide prevention programs in the U.S., psychiatry began taking a positivist approach to identifying the causes, characteristics, and motivations considered universal to suicidal behavior. One of the defining characteristics of suicide is that it is, as a form of death, thought to be entirely preventable. Psychiatrists working in the field of suicidology, a micro-focused branch of psychiatry dedicated to the field of suicide, aim to identify an etiology of suicide that recognizes its warning signs as symptoms that can be addressed and treated (Shneidman 1993). However, contrary to the perspectives of those who consider suicide to be a clinical concern with a distinctive characteristics, signs, and symptoms is the fact that not all those who commit suicide have a diagnosed mental illness (Fitzpatrick et al 2014), and that the symptoms outlined as suicide's defining criteria rely on fundamentally subjective understandings of behavior.

It is important to emphasize these inconsistencies, even just within *psy* discourse, in the classification of suicide as a clinical issue. When psychiatrists refer to its medicalization, they refer to its symptomatic correlation with mental disorders because diagnostically, suicide and suicidal ideation are not disorders in and of themselves.<sup>4</sup> As Thomas Szasz writes, for the victim, suicide is simply “an action. Psychiatrists, however, maintain that suicide is a happening, the result of a disease: as coronary arteriosclerosis causes myocardial infarction, so clinical depression causes suicide” (1999:41). Except, of course, when it doesn’t: although suicide has been explicitly linked to depressive disorders, it can also occur with no preceding diagnosis. In other words, suicide can and does happen with no history or symptoms of mental illness. Taking this fact at face value, however, presents a problem in two ways that are worth mentioning. First, the idea that suicide can occur without a history of mental diagnosis suggests that those of sound mind sometimes choose to end their life. This not only destabilizes the authority of biomedical psychiatry in attempting to prescribe an anticipatory model of care for suicide, it also presents a second issue connected with agency and rationality: if suicide is a possibility for all—and by extension, even those with a “healthy” mind—then one must also consider the place of agency and self-freedom in suicide. Such perspectives on human action are largely incompatible with psychiatric models of health care (Decker 2013).

Similar to the WHO framing of suicide, public health literature on suicide in the United States overwhelmingly considers it a significant, preventable public and mental health concern (CDC 2019). Somewhat counterintuitively, though, national strategies from the NIMH to the Surgeon General’s report directly place the responsibility for suicide prevention—and

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<sup>4</sup> Still as of the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-V 2013).

increasingly, its intervention—on the lay community, declaring suicide to be “everyone’s business” and implying it is within everyone’s purview to be a potential caregiver. The WHO and U.S. public health emphasis on the wider community’s role and responsibility in preventing suicide follows the aftereffects of deinstitutionalization, which saw a complete shift to community-based care in the U.S. mental health care system. Lay and otherwise non-professional workers and volunteers are frequently the ones tasked with “treating” the suicidal, whether through a phone call, chat, or walk-in encounter in a crisis center. The leading centers for intervention in suicide in the United States, including the National Suicide Prevention Lifeline’s crisis hotline and chat support, are widely publicized as the first step for those seeking help across the country (SAMHSA 2006). A kaleidoscope of workers, from psychiatrists to clinicians to hotline volunteers, work within the individual crisis centers that make up the constellation of Lifeline services. Although this method of community-based care has become a norm and can be an effective model of treatment for mental health in the U.S., the lack of standardization in programming and the ubiquity of mental health services provided by minimally trained volunteers is most certainly at odds with the aforementioned institutional discourse that highlights the public health burden, the clinical nature of suicide, and the standard protocols of response.

### ***1.3.2 A Brief History of U.S. Mental Health Care and its Effects in Hawaii***

The primary difference between past and contemporary models of mental health care in the United States is who is (or should be) responsible for providing care. The gradual switch from institutional to community care shifted the responsibility of day-to-day care to clinicians rather than doctors and to volunteers rather than licensed nurses. The history of psychiatric care in the

United States, and by extension in Hawaii, has long been defined by an underlying sense of social and moral responsibility to care for the mentally ill, however defined (Menninger & Nemiah 2000; Scull 2018). It has also been characterized by a persistent debate regarding the benefits of confinement versus public integration of those with severe mental illnesses (Luhmann 2000). Articulated in contemporary terms as inpatient versus outpatient care, the present model of mental health in the United States is a fragmented result of the decentralization of public mental health facilities in favor of smaller community clinics. A history of institutional instabilities in providing effective long-term treatment for chronic mental illnesses has had a lasting and severe impact on this country: increased incarceration rates, substance abuse, and urban homelessness are some of the continued aftereffects of deinstitutionalization in the United States—unsurprisingly, these conditions frequently co-occur with instances of suicide (Menninger & Nemiah 2000; Scull 2018).

Foucault once argued that the notion of “madness” was reshaped through institutionalized psychiatry: the institution, he said, liberated the mad by humanizing their condition and legitimizing their suffering, and they became perceived as mentally ill as opposed to criminals and deviants (Foucault 1988). At its early stage, American psychiatry lacked Foucault’s “asylums” as those needing care generally remained within the home or were taken in by churches as charity cases. Early American psychiatry was founded on a principle of humanization and the moral responsibility to provide benevolent care for the mentally ill. Only later did psychiatric institutions develop, alongside the demands of population growth and urbanization, as well as with scientific and medical discoveries which led to the development of formal psychiatric facilities and practices (Caplan 2001). Historically, many of these facilities do not have positive reputations: early American psychiatric institutions were known for experimenting with medical treatments, most of which focused on physical interventions—these would influence commonly acceptable treatments,

like electroconvulsive therapy—which were thought to be inhumane (Goffman 1961). During this early period, the mental patient as a subject in American discourse, within medicine, policy, and public sentiment, was largely viewed as a danger to themselves, as incapable of managing their own hygiene, medical decision-making, and overall welfare. Even within steadily more progressive facilities, and under the care of more benevolent medicine, confinement of the mentally ill, the cognitively disabled, and the suicidal was regarded as a moral and ethical necessity, an incentive to protect both citizens and patients from themselves (Decker 2013).

By the turn of the twentieth century, efforts to house and care for the mentally ill were overwhelmed as many institutions were overcrowded, understaffed, and underfunded. Despite this, organizations like the American Psychological Association emerged and gained support: by World War II, the majority of the APA was employed in state institutions. Larger public organizations like the National Institute of Mental Health and private organizations like Mental Health America were also founded in the immediate post-war years. This and an increase in federal support for psychiatric research in the post-war U.S. prompted the first publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in the early 1950s, the bible of mental classification, diagnosis, and taxonomy in the United States, which continues to be updated roughly every five years (Clegg 2012; Decker 2013). Following the implementation of the DSM was the passing of the Mental Health Act, a legislation that allocated federal support towards psychiatric research and treatment, and which placed mental illness at the forefront of public discourse on ethical care. The reputation of psychiatric institutions by this time had prompted growing public concern regarding the efficacy of treatment methods, as reports regarding poor living conditions caused many to question the necessity of inpatient confinement for seemingly indefinite lengths of time. Inspired further by dialogues on Civil Rights, public support for deinstitutionalization in the mid-twentieth

century argued a number of points: first, the efficacy of prescription drugs in outpatient programs could allow individuals to transition back into society. Second, individuals within institutions had been stripped of their agency and ability to make decisions regarding their own care. Under the Kennedy administration, government initiatives began investigating public facilities, initiating a plan to gradually shift the model towards community outpatient psychiatry. Federal policy changes allocated more funds to private care facilities, removing the financial burden from states and by the mid-1970s, deinstitutionalization of psychiatry was more or less complete (Decker 2013).

These national shifts were also implicated in Hawaii: its history of mental health care largely mirrors national trends, even before Hawaii became a part of the United States. Hawaii was first annexed by the U.S. government in 1898, but the presence and influence of Western biomedicine had earlier roots. Until 1866, mental illness was criminalized: the mentally ill were considered dangerous and were remanded to Oahu Prison. Towards the end of the 19th century, as global sentiment changed regarding the need for care as opposed to incarceration, an insane asylum was built in Kapalama, Hawaii—not far from Honolulu. Here, those with mental illness were treated by physicians and discharged when “cured” (CSHSH 2018). At the turn of the century, just following annexation, the institution had 130 residents—over the next two decades, the patient count would more than double and the asylum became overburdened (2018). In the 1920s, plans were underway to construct a Territorial Hospital complex to house a greater number of patients with funding from the Territorial Department of Public Works. By 1930, the initial Kapalama hospital had been expanded and renamed the Territorial Hospital and a second site was added in Kaneohe, on the Northeastern part of Oahu, called the New Territorial Hospital. Some sad details from the 2018 report on this document how 541 individuals were moved to the Kaneohe site “by a convoy of thirty three trucks and drivers donated for the occasion by the U.S. Army” (2018:11):

“Several patients were transported in strait jackets. [...] There were no escapes, but there were several cases of car sickness by patients who had never ridden in a vehicle” (11). Some of these details are made more distressing upon the report’s admission that the patient demographic has long been slanted “to those of mixed Hawaiian ancestry and the poorer strata of society in Hawaii” (2018:17).

As it did in the mainland during wartime, conditions during the war lead to continuing issues for the Territorial Hospitals during the post-war period: facilities were overcrowded, understaffed, and underfunded while patient admissions rose (among younger residents and veterans in particular) following the war. In addition, the Territorial Hospitals had accommodated the U.S. Navy following Japanese attacks in the Islands, one which happened very nearby on the Kaneohe Naval Air Station. Despite the difficulties faced during wartime, the Kaneohe hospital was advanced in offering new and innovative treatments, including electroencephalography, electric shock treatment (ECT), and lobotomy—it was widely considered to be a “world class facility” for mental health treatment (2018:17). As in the rest of the United States, though, the effects of federal deinstitutionalization were widely felt in Hawaii’s hospitals. By 1959, Hawaii had become the 50th U.S. state; by 1960, the Territorial Hospitals became the Hawaii State Hospital. Seven community mental health clinics opened throughout the state, reflecting the switch from inpatient to outpatient care that dominated the U.S. mental health care landscape at the time. With the passing of the Community Mental Health Act by Kennedy in 1963, these smaller community clinics received federal funding to assist patients on a local level rather than housing them at the state level. While this produced some positive outcomes, specifically for preventative care, it also caused problems regarding what to do with those truly in need of inpatient care. In Hawaii, the demands of deinstitutionalization pressed the already-overtaxed Hawaii State Hospital

into accommodating more with less, creating a ripple effect of problems both in and outside of the institution itself. Between the 1990s until the present, the hospital has been the site of multiple violent incidents, on-campus deaths, and escapes of violent patients.<sup>5</sup>

With the cost shifting to community outpatient mental health facilities and widespread closures of state hospitals, deinstitutionalization produced lasting effects in the United States that are evident across the disciplines. Beyond anthropology, scholars in social and political science, public health and community psychiatry, have all written on some of the immediate fallouts as evidenced by increased rates of incarceration and co-occurrence of mental illness and substance abuse among expanding homeless populations throughout the country. Major anthropological studies emerged regarding some of these issues of addiction, failed rehabilitative programs, and the lapsed systems for housing the homeless mentally ill (Agar 1973; Carr 2011; Desjarlais 1995; Rhodes 1991, 2004). Several other direct critiques of deinstitutionalization focused on the collapse of emergency care clinics in tandem with increased incarceration rates. Lorna Rhodes's ethnography of an emergency psychiatric unit in particular showed how patients became shuffled from one unit to the next, as the structural pressure of "emptying beds" became a managerial task for nurses to discharge patients quickly and often at their own expense. Rhodes illustrated the inefficiencies of the mental health system by focusing not only on their time "in the system," but on how individuals navigate, often in abject poverty, the "outside" of psychiatry (1995). More contemporary anthropological studies have also focused on the financial burdens of community

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<sup>5</sup> In 2017, a patient who had been found not guilty by reason of insanity for having stabbed a woman to death in a Honolulu mall parking lot, escaped the State Hospital after not returning from his curfew.



psychiatry in providing service treatment in the face of collapsed funding and limited programming (Brodwin 2013; Myers 2015). Myers in particular shows how the recovering mentally ill are motivated through workfare-type programs to work in community mental health, with a limited amount of training and expertise in professional intervention beyond their own.

### ***1.3.3 Suicide Prevention in the United States: A Grassroots Effort***

Implemented not long before deinstitutionalization in the U.S. took place, the first suicide prevention center in the country was opened in Los Angeles in 1958, headed by clinical psychologist Dr. Edwin Shneidman. Shneidman was a pioneer in outlining suicidal motivation and has become known for creating new terminology to explain suicidal ideation, including the term “psychache,” which he offered as a more encompassing expression of the subjective complaint of individual psychological pain (Shneidman 1993). In 1966, the Center for Studies of Suicide Prevention was established under the National Institute of Mental Health (NIMH), marking the first time suicide occupied its own category within institutional U.S. mental health. In 1968, Shneidman and his colleagues went on to found the American Association of Suicidology, which remains the only field in the U.S. dedicated to the scientific study of suicide and its prevention. Since its inception, the field of suicidology has taken a positivist approach to identifying causes, characteristics, and motivations considered endemic to suicidal behavior. Their goal is not simply to understand suicide, but to outline its warning signs in order to prevent it from occurring. As such, suicidologists widely consider suicide as a clinical concern with distinctive signs and symptoms, despite the contradictory fact that many of those who commit suicide have no diagnosed mental illness (Fitzpatrick et al 2014).

What has been referred to as suicide prevention in the United States was, up until the mid-1980s, operating primarily as an interventional rather than as the implied preventative model. Prevention typically occurred within crisis intervention centers, following the opening of Shneidman's L.A. center, but these places were largely concerned with attending to those in need of immediate assistance, not addressing other co-occurring factors that might contribute to suicidality. While the intent of these centers was to treat the suicidal, crisis centers in the U.S. have overwhelmingly become resources for other mental health and lifestyle crises, such as addiction recovery, domestic abuse, homelessness, untreated mental illness, poverty, and so on. In 1983, the Centers for Disease Control and Prevention (CDC) created a violence prevention unit to investigate such crises. In this report, it was revealed that there was an alarming rise in youth suicide rates across the country. Following this revelation, the Secretary of the U.S. Department of Health and Human Services established the first ever Task Force on youth suicide, as part of the violence prevention unit of the CDC, which was designed to allocate resources and research to preventing suicide among young people. The Task Force model is now the contemporary model that all U.S. states adopt via their respective Departments of Health. In Hawaii, the Task Force model represents the whole of state efforts to prevent suicide and is the organizational model under which all other community programs fall.

Suicide became centralized in the public<sup>6</sup> during the mid-1990s, when survivors of suicide loss appealed to the U.S. Congress demanding the development of a national strategy for

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<sup>6</sup> Taken from the *National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention*, released by the Education Development Center (et al) in 2012.

prevention. This citizen-initiated movement, largely created by those who had lost family and friends to suicide, followed the United Nations guidelines for implementing national strategies in their push for legislation. The result was the passing of two Congressional Resolutions which recognize suicide as a national problem and place prevention as a public health priority in the country, thereby allocating funds towards these causes within various State Departments of Health. In this sense, the push for a national strategy for suicide prevention in the U.S. has been and continues to be the result of grassroots, volunteer-motivated efforts—which is reflected in the contemporary reality of prevention’s workforce in U.S. community mental health care. In Hawaii, as in the U.S. model outlined above, suicide prevention efforts are almost entirely the result of community provocation and the tireless efforts of volunteers.

#### **1.4 Methodology: Shaping Ethnographic Research on Suicide**

The task of reproducing convincing intersubjective views on suicide as felt by those in close proximity to it a complicated task. Anthropologists aim to look within a community or population for those voices with the knowledge and experience of something. But in the case of suicide, those immediately impacted by it are either logistically or ethically beyond the reach of study. Because of this, one of this project’s primary methodological challenges was having to always work around, rather than with, the suicidal subject: the interviews I conducted were with people who had experience and intimate knowledge of suicide from many perspectives, but none were suicidal themselves. This was not only a practical choice but an ethical one, as the intention of any anthropological study should unequivocally be to do no harm. I certainly knew the limits

of my (in)ability to adequately engage with an individual experiencing a suicidal crisis, despite the many certifications and trainings I received throughout this research.

The second and perhaps most impactful methodological challenge that this project faced was a lack of funding to support an uninterrupted length of time spent in the field. While there are some methodological drawbacks to what scholars refer to as the back-and-forth vs. the extended stay approach, it is also increasingly becoming a relied-upon avenue for ethnographic research (Brković & Hodges 2015). In many ways, Hawaii being a part of the United States, where I am from, lessens the need for an extended stay approach—there are few functional differences between Hawaii and Pennsylvania<sup>7</sup> as U.S. states. It is important, however, to emphasize the complexity of doing research in a place like Hawaii, which though considered a “domestic” U.S. territory, has a rich and complicated heritage that is at once deeply rooted in Polynesian language and culture, yet also intermixed with a legacy of continual outsider migration and mobility. Hawaii is constantly undergoing cultural change, in very tangible ways affecting all of its resident, local, and indigenous populations as well as its revolving tourist traffic. My research on suicide has also been shaped by the pervasive characterization of Hawaii as a type of non-place in regards to the lack of funding sources for domestic anthropological projects. My dissertation research has therefore occurred over four fragmented fieldwork trips between the summer of 2014 and April of 2019, all but one supported through small grants, primarily from the Department of Anthropology and generously through the Asian Studies Center.

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<sup>7</sup> Prior to this project, I had been to several different parts of Hawaii. Half of my family is from California, where I also grew up for a time, so I had been there a few times even before I was an adult.

### **1.4.1 *Research Objectives***

I did not set out to study care; it emerged as the center of this research gradually. My initial framework for this project was on the nature of community labor in suicide prevention in Hawaii; I was interested in the nature of labor within mental health care work. In order to understand how work functions within the lives and within the encounters of those invested in suicide prevention work, I followed two primary areas of inquiry in my initial research objectives. First, (1) what are the pathways through which workers and volunteers in prevention come to perform this type of suicide care? Specifically, what particular “expertise” and experience do they bring to their positions within this particular niche of community mental health? Within the political economy of prevention as a form of labor, I sought to examine the histories and motivations of those who became service providers in suicide, whether they work in high-risk encounters, in low-risk prevention trainings, take up professional or unpaid positions. Especially in the case of crisis encounters with the suicidal, the anonymity of workers presents a still-significant ethnographic question: as a type of vulnerable consumer, what are the motivations of those to whom others in crisis are reaching out to? Are those working to prevent suicide paid clinicians and counselors, are they working towards career advancement? Are they volunteers, interns, parents of a child lost to suicide, the recovering mentally ill or suicidal? How do the differences in these subjective narratives and histories inform their motivations within the work of preventing suicide in both a direct and indirect encounter? Are they, as I hypothesized, primarily motivated through a personal history or the suicide of a loved one, for professional reasons, or does something else entirely bring individuals to this cause? How does gender figure into their recruitment?

Establishing a narrative baseline of workers’ motivations to care about their work in order to perform these tasks revealed how so many become mobilized through personal incentives to

care and to provide such emotionally high-stakes services. Throughout my research, I made a distinction between the motivations of paid workers and volunteers and focused my attention on the different socialities created through volunteering itself. Following the works of anthropologists (Adams 2013; Allahyari 2000; Malkki 2015; Muehlebach 2011; Myers 2015) I examined how volunteers in high-stakes interventions such as those in suicide create meaning and reshape understandings of their own social usefulness, responsible citizenship, and productivity beyond waged labor. One key difference in this project was that the services performed by workers and volunteers in suicide prevention are effectively replacing insufficient (or inefficient) public programs for mental health care regarding suicide intervention. I hypothesized here that the narratives of workers would provide insight into the potentially exploitative labor practices of institutional mental health care in the U.S. and its ironic shifting of responsibility through this manipulation. I investigated whether workers and volunteers identify as being called to “give back” in some way, whether motivated by their own histories of suicide and suicide loss, or whether their work is part of a broader discourse on citizenship and social responsibility.

Second, in order to ask questions about the value and role of (personal, professional) expertise in suicide prevention workers’ encounters, I asked (2) how do workers narrate their work experiences and how do they see their own expertise being valued within them? As a majority of those working in suicide prevention lack comprehensive *medical* training beyond following simple scripts, this objective investigated how authority in suicide prevention becomes passed from the institution to the community and ultimately to the individual, whether a paid employee or an un(der)trained volunteer. Within this objective, I asked questions such as: how do workers define their “successes” in their encounters? How do their interpretations of concepts, such as defining a “crisis” in suicide, differ from institutional renderings? Through these worker narratives, I

analyzed the scripts that were used in their encounters, specifically: who writes this protocol and how is it being broken or enforced by the worker in the encounter? While institutional scripts represent a formal “expert” discourse, here I focused also on the public health discourse surrounding suicide in order to challenge the relevance of its medicalization if the model for care is increasingly community-based and non-professionally staffed. Following the works of anthropologists critiquing the approaches of institutional and community mental health in the U.S. (Brodwin 2013; Carr 2011; Luhrmann 2000; Martin 2007; Myers 2015), I interrogated the language on suicide in order to understand what is meant by terms such as “crisis” and “prevention.” How do the institutional models purport the treatment of those “in crisis” if not as a type of consumer? How do community models of intervention differ in their treatment of these “clients” in crisis? In linking this objective with the personal narratives of workers, what *subjective* knowledge of suicide are workers bringing to the encounter, and is this expertise being valued or ignored by the psychiatric community? This project therefore set out to contribute to studies of workers within community mental health care from the perspective of expertise and labor, rather than care.

#### **1.4.2 Pilot Research**

Prior to beginning this project, I spent four years working as a data analyst for research psychiatrists at the Western Psychiatric Institute & Clinic of the University of Pittsburgh Medical Center in Pittsburgh, PA. Starting in 2010, I absorbed a great deal of knowledge surrounding the institutional policies, health insurance practices, psychiatric diagnostic criteria, and the local networks and operations of multiple rehabilitative centers, including community-based mental

health, crisis counseling, and substance abuse treatment centers and providers throughout the Pittsburgh area and neighboring counties. Throughout my time in this position, which overlapped with the start of my doctoral career, I became very familiar with what community mental health care, including suicide prevention, looks like in a “typical” U.S. city.

During pilot research specifically for a project on suicide prevention workers that was done as part of my graduate coursework in 2014, I connected with the National Suicide Prevention Lifeline and the American Foundation of Suicide Prevention (further abbreviated throughout as AFSP). At that time, I conducted several telephone and in-person interviews with Lifeline and AFSP administrators, programming staff, and volunteers regarding suicide prevention strategies in the United States more broadly. In collecting this data, I established an early hypothesis that volunteers are the most common liaisons—throughout the entire United States—between those experiencing a suicide crisis, whether callers or walk-ins, and access to care for suicide intervention. These volunteers are not only on the frontlines as has been suggested, but they are themselves handling much of the “dirty work” of prevention, whether this be putting in longer hours or handling particularly complex encounters. This preliminary data informed my later hypothesis that many of those working (and particularly those volunteering) in suicide prevention have a personal connection to suicide loss that informs their work and care in suicide.

My preliminary research in Hawaii, funded by the Department of Anthropology, began in May of 2014. With their support, I was able to participate in multiple public awareness events for suicide prevention in Oahu. I also conducted interviews with directors of suicide prevention programs at the National Alliance on Mental Illness, Mental Health America, and volunteer organizers from the AFSP in Honolulu over the two subsequent summers. All of the data collected and contacts established during this early period of pilot research served as the baseline for the



proposed fieldwork I then conducted in Hawaii up through April of 2019. Over time, and across a total of four fieldwork trips spanning from a few days to two months at a time, I was able to gather the data that I present here in this dissertation.

### **1.4.3 Project Design**

This dissertation research is an ethnography of care and work in community suicide prevention in Honolulu county on the island of Oahu, Hawaii. Over a total of six months of nonconsecutive field research beginning in May 2014 and ending in April 2019, this project engages with how care workers in suicide prevention balance their own personal histories and authority in their work in suicide prevention, and how expertise in “suicide care” becomes transformed within and beyond these encounters. The concepts of suicide care and caring with *aloha* are applicable concepts beyond the region in which this research project takes place, but recognizing how these local networks of prevention shape and transform personal, individual narratives of care in suicide as something that is *lived* is what this ethnography centers on in Hawaii. In order to understand the many and multiple iterations of care in suicide prevention, this project included participant observation and semi-structured interviews with 70 participants across different field sites within Honolulu county’s suicide prevention network.

#### **1.4.4 *Research Sites***

All field research for this project took place in Honolulu county on the island of Oahu in Hawaii. This location was selected above all others in the state because it is the most populated (over 90% of the entire state's residents live on Oahu) and also the most diverse area, both ethnically and economically. It is also the only metropolitan area in Hawaii with a significant, sophisticated social infrastructure where it made sense to conduct an analysis of health care systems with implications beyond their case, as these organizations are headquartered here and in other similar U.S. cities. As a study of suicide prevention work and workers, the field sites included in my observation were varied. I very quickly learned that little happens in an administrative office over the course of four or so hours. Instead, my observation occurred primarily at public suicide prevention events, organizational-affiliated or other accredited prevention trainings, statewide health conferences, community awareness walks, and other mostly public—or at the very least, made public to me—places where people within the prevention community came together to exchange information or ideas, where I could also participate in this exchange. It was through attending these events that I came to meet almost all of my informants. Interviews with selected informants occurred in a variety of places: some happened on the spot, some occurred later in offices, cafes, or parks. When invited, I was also able to meet with individuals in their homes and private businesses. Throughout my field research, I never gained access to observe or collect data within any institutional medical center in Hawaii. All of my fieldwork stayed within the level of community mental health care in and around the city of Honolulu.

### 1.4.5 *Sampling Strategy*

Participants for this project ( $n=70$ )<sup>8</sup> were contacted based on referral sampling through initial contacts made during preliminary research. Additional sampling occurred through contacts<sup>9</sup> established during participant observation and interviewing. From the outset of my fieldwork, I outlined four different categories from which I then sampled for participants, in order to capture the perspectives of those who contribute to/shape how care functions within suicide prevention work in the state of Hawaii. The categories, which changed somewhat during the course of my fieldwork, were as follows:

Experts ( $n=10$ ): This sample included medical professionals and experts on the subject of suicide and its prevention. These individuals were predominantly psychiatrists, research faculty, executive program directors, and leading mental health professionals in Hawaii, and some of them had national affiliations as well. I did not use criteria, such as age or gender, to stratify this sample; rather, the criteria for inclusion here was limited to those who occupy positions of institutionally-recognized authority on suicide/prevention in prominent positions in Hawaii (i.e. the State Department of Health) or in leading national networks (i.e. the AFSP).

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<sup>8</sup> All of these numbers have been adjusted to reflect my post-fieldwork totals. My anticipation of and subsequent lack of funding for this project dramatically shaped my time spent in Hawaii, and therefore is reflected in my adjustment. I had initially intended a sample size of 100 but since had to lower this total number to 70.

<sup>9</sup> Prior to participation in the research, all potential participants were provided with verbal consent forms in which the project and their contribution(s), including any potential risks and benefits, were explained and elaborated.

Administrators ( $n=10$ ): This group consisted of middle to upper-level administrative staff and management workers, including program coordinators, staff recruiters, and center or program supervisors. The interviews within this sample were primarily interested in learning about the work practices and experiences in prevention from a functional standpoint: literally, how the day-to-day operations work and what they look like in Hawaii. Criteria for inclusion in this sample was mostly based on job title and organizational affiliation, not on other more subjective factors such as the length of time at the job. There was no demographic basis for inclusion within this sample. Those with whom I spoke therefore represent, to the best of my understanding, an accurate demographic regarding those who work as administrators in suicide prevention in Hawaii.

Volunteers/workers ( $n=30$ ): This was the largest group to be included in the ethnographic component of this project. Criteria for this sample were limited to those in unpaid positions. I was predominantly interested in those who volunteer in providing direct services in suicide prevention. In this sample, I attempted to adjust inclusion to include a fairly even number of perspectives, which I identified at the outset as primarily being the length of time in their position. In my recruitment, I attempted to include an evenly distributed sample of newer and more seasoned volunteers, which I was mostly able to reflect. At the outset, this sample was also intended to include a wide scope of perspectives and, I hoped, would be adjusted as needed to include an equal distribution of demographic difference, specifically in regards to gender. Instead, I found a problem including enough male volunteers in my sample: most of those I spoke with throughout this project were female, including and almost especially within the volunteer community. This is reflective of the nature of care work itself which is so often seen as “women’s work.” The gendered

nature of care work is something I only briefly interrogate throughout my ethnography, as my intention was more to focus on care itself within prevention work.

Miscellaneous ( $n=20$ ): This category was not initially included during my research objectives, but evolved as a necessary category. It includes those who are not in any way affiliated with suicide prevention work in Hawaii. It became clear over the course of my fieldwork trips that many people with whom I interacted in Hawaii had a wealth of perspectives, not simply regarding my interest in the state, but simply regarding life in the state in general. I had countless conversations with cab drivers, store clerks, passers-by on beaches and on the street, several homeless individuals, hotel hosts/hostesses, and so on. Their insights were ultimately incredibly helpful and I am only now in hindsight realizing this project's expressed need for including this category of subject. These individuals were integral to my understanding of the broader context of the cultural, political, and social climate of Hawaii, within which suicide and prevention is simply one factor.

#### **1.4.6 *Data Collection and Analysis***

The data for this research was collected using three primary techniques: (1) participant observation, (2) semi-structured interviews, and (3) literature analysis. Interviews<sup>10</sup> were

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<sup>10</sup> All interviews, when consented by the interviewee, were digitally recorded and replicated for safekeeping. Identifiable information was removed and codes were assigned to participants to protect their identity and to ensure the confidentiality of their responses. All participants were guaranteed confidentiality

transcribed and entered into qualitative research software for analyzing and interpreting. Field notes from participant observation were typed and analyzed throughout the duration of fieldwork.

Elaboration on these study methods is as follows:

(1) *Observation* was conducted within readily accessible areas of organizational locations, as deemed appropriate by their review boards and on-site staff. Activities included observing daily activities and the interactions of their administrative staff, medical professionals, workers, and volunteers. The bulk of my activities therefore included attending private and public events, such as meetings, trainings, and other workshops for volunteers. I had hoped that, with expressed written consent from all participating parties, I would be able to observe several encounters between “clients” seeking help for suicide and staff, when possible. I was never able to achieve this and do not disagree with the reasons for that prohibition. Instead, I focused my observation on attending public organizational-affiliated events, such as community awareness events and public outreach programs. Among these were suicide prevention walks for awareness, community gatherings to remember those lost to suicide, meetings about prevention strategies, and so on. I observed and attended several conferences, training sessions in schools, hotel conference rooms, and medical centers throughout the research project.

(2) *Interviews* for this ethnography were semi-structured while adhering to particular question prompts that were designed to elicit narratives of experience from the various sampled groups. In all cases, these questions were open-ended so that participants could comfortably provide information on their own terms. Repeat interviews with some of the same participants

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and told that in any potential publications, names and sites would be described in general terms and given pseudonyms to prevent unintended repercussions.

occurred several times—so much so, in fact, that this informed my analysis and subsequent decision to follow an amalgam “case study” approach to presenting my repeat informants’ narratives. All interviews were conducted in English and, unless consent was declined, audio recorded. When Hawaiian language terms or phrases were used in individual interviews, they were almost always explained or defined in to me in English simultaneously. The audio recordings were coded for anonymity and stored on a protected external flash drive.

(3) An in-depth *literature analysis* of all materials collected during research included materials such as advertisements, pamphlets, policy documents, guide/handbooks, training manuals, counseling scripts, websites, and lecture notes. The focus of the analysis was content-driven with a focus on key themes and phrases, including places where either expertise or care is a central part of the discussion. Some themes that I anticipated would be on particular rhetoric that promotes collective responsibility. The analysis also focused on the institutional texts that directly inform how community workers implement prevention protocols, including literature from the NIMH, SAMHSA, and the AFSP.

#### **1.4.7 A Note on Anonymity and Composites**

One thing I have always been mindful of throughout this project was that the networks of suicide prevention in Hawaii are very small and intimately close. Moreover, individuals’ stories and personal histories were, by nature of what we discussed, often very detailed and specific, to the point where the sharing of particular information on my part would all but reveal an individual’s full name. In an effort to preserve the anonymity of those with whom I spoke, and to treat the memories of deceased individuals with respect, I decided to present the narratives in this

project as amalgams of several different individuals within one particular sampling category: in most cases throughout these chapters, the “characters” are composites of multiple people who each correspond to a category within my sample or another category that emerged during my analysis. For example, the character of Iolani is based on a real individual and is written as a singular person, but some of the details of her story are in fact constructed from similar stories of multiple people, all of whom worked in similar positions and all of whom were also survivors of loss. I repeated this strategy with the majority of those I interviewed in this project. I felt this was an important strategy not only in preserving confidentiality, but also as a way of avoiding what sometimes reads as sensationalism when reporting on or talking about suicide. Only in instances where specific details were already made public or were “more “neutral” did I report the details more directly.

## 1.5 Chapter Outline

This first chapter has laid out the overarching theoretical framework of this project: taking the idea that *care* is the operative in suicide prevention, that care is fundamentally relational, that care is not bound to either/or (either helpful or harmful) but is can be, rather, both/and (both helpful and harmful). This framing places care as the central point of focus in understanding how suicide prevention work manifests in various ways—and in various people—in Hawaii. Following this, chapter two sets the stage for understanding the full scope of this project and it does this by presenting a number of important threads. First, it reveals that the “problem” of suicide in Hawaii is not with suicide itself, but with suicide attempts—prevention in Hawaii is truly *preventative*



work. In mapping out the problem of suicide, chapter two also maps out the networks of suicide care in Hawaii and situates them both in the context of the state's unique geography as well as within the broader U.S. context of suicide prevention. As this chapter attempts to “map” out the issue of suicide/suicidality in Hawaii, I take the opportunity here to address some issues of causality—specifically, I provide some dialogue surrounding *why* suicide might be an issue in Hawaii. I bring Jocelyn Chua's work on suicide in Kerala into conversation with my own ethnography's tackling of the causality. Without lending too much credit to speculation, I explain how a consistent theme of “desperation” was threaded through many of my conversations over the years of my fieldwork. I present these narratives, which I present in a section referring to the political economy of desperation, not as an explanation of suicide but as an interrogation of some of the perceived “costs of living” in Hawaii, as felt by people who live there.

Chapter three, *Becoming Subjects of Suicide Care*, focuses on the subjectification of care as (in)forming how those in this ethnography find themselves becoming involved, in visible and in less visible ways, with suicide care in Hawaii. In this chapter, I place the work of those in suicide prevention within a larger framework of care and care worker motivations. Through outlining the ways in which different people became activated to care in suicide prevention work, I show how their different forms of (affective, informal, and professionalized) care are transformed into something productive, both for workers themselves and for others—in other words, how they became both subjects and providers of care. Care worker motivations are a widely subjective range that includes personal experience with suicide, feelings of collective responsibility, and the notion of “giving back” to a community in need. This chapter explains how a majority of people with whom I spoke in Hawaii are brought to suicide prevention through their own subjective connections—emotional, experiential, moral—which they see as informing and directing their

implementation of suicide care. As these individuals show throughout this chapter, caring about suicide/prevention often develops out of subjective, personal experiences with suicide, although this is not always the case. I end this chapter with a look at an alternative approach to subjectification in suicide prevention vis-à-vis an institutional training known as QPR. Here, I show how inorganic being “trained to care” in suicide seems in contrast to the affective care of those throughout the chapter. This training is important in also setting the stakes for how care with aloha deviates from institutional approaches.

This fourth and final ethnographic chapter presents and explains *aloha* as a form of care that many of those working in suicide prevention explain as central to their work. It begins with a critical history of the term itself, focusing not just on its colonial history, but also on its cooption by non-Hawaiians and its usage among *Kānaka Maoli* in the present. Following this, I articulate what the term *aloha* means to those who work in suicide prevention and how it is used as part of their work. Here, I envision how the idea of *aloha* is an example of Angela Garcia’s (2010) vision of the healing potential of a “watchful” type of care. The third section of this chapter illustrates how the concepts of *aloha* are put into practice as part of suicide prevention work. I describe this in terms of offering an alternative to Lisa Stevenson’s (2014) description of the “anonymous care” of suicide prevention, as care in Hawaii appears to be anything but depersonalizing. But, as the final part of this chapter reveals, some of the instabilities present in *aloha* care may in fact be just as precarious.

## 2.0 The Cost of Living: Mapping Care and Concern in Hawaii

### 2.1 “The Big Picture”

This chapter provides pieces of information that are essential to understanding the context of this project. First and most importantly, it reveals how suicide prevention in Hawaii is truly *preventative* work: its impetus has long been to counteract the growing trend of suicidality among its most precious age demographic before more suicides are realized. This sets prevention work in Hawaii as something different than in other anthropological contexts where suicide has already become an epidemic affecting a community (Chua 2014; Stevenson 2014). Sonya, who I introduce below, describes the work of prevention in Hawaii as taking a “big picture” approach to addressing suicide. Following Sonya’s cue, this chapter maps out the big picture of suicide in Hawaii by first explaining the issue—what it is, who it most impacts—and then how local networks of care have emerged to address the problem. In taking this big picture approach, I illustrate how these networks of care operate in the context of the state’s unique island geography and suicide prevention work in the United States more broadly.

In addition, although perhaps somewhat out of sequence, because this chapter is concerned with explaining the problem of suicide and mapping prevention networks, it also contends with issues of causality. As Jocelyn Chua writes in her ethnography of suicide in Kerala, there is some intellectual resistance in anthropological scholarship to simply asking, “what happened?” And, as I will argue later in this chapter, while Chua offers substantive reasons for turning away from a full interrogation of suicide’s causes, I want to give it some space and ask: *why* is suicide an issue in Hawaii? How do those working in prevention make sense of causality within their own

communities? What do those closest to suicide imagine is responsible for its emergence in Hawaii, specifically among younger people?

As this chapter will explain, although suicide deaths are low overall in the state, the attempt rates are either climbing or already disproportionately high. Many of those with whom I spoke repeatedly expressed concerns about a distressing rise in young people in Hawaii facing, in their own words, a kind of “desperation.” Whether or not these narratives of desperation are linked, in a concrete way, to suicidality is not my point here: rather, through offering my informants’ own interpretations and ruminations on questions of causality, I shed light on broader “costs of living” in Hawaii as felt by the people who live there. I understand “cost” here in more than just economic terms. The “cost of living” framework that people drew on included themes of social decay and desperation linked to homelessness and unhappiness, even in contexts of wealth.

This chapter begins with a section dedicated to mapping out suicide “by the numbers” in Hawaii. In this first section, I introduce Sonya and Gary, both professional public health workers with different but data-informed insights into the problem of youth suicidality. Here, I use the tools that public health officials most reference in order to provide a statistical complement to the anecdotal evidence. Together this brings the “big picture” of suicide in Hawaii into clear focus. The section that follows describes the shape that suicide prevention takes in most U.S. contexts and introduces the Prevent Suicide Hawaii Task Force, which I explain is the locus of care in preventing suicide in Hawaii’s communities. Section four considers the topic of desperation in the land of *aloha*, bringing Jocelyn Chua’s work into dialogue with questions of causality that emerged in my own ethnography. Following a discussion of Chua, I present narratives about what I refer to as the political economy of desperation. Within these individual sub-sections are the various perspectives and experiences of literal and sometimes figurative “costs of living” in contemporary

Hawaii. These narratives, split into three parts, each link back to recurring themes from my conversations with informants regarding issues of youth mobility, economic strain, homelessness and housing, and the clash that exists between Hawaii’s “postcard image” and the reality of some of its domestic issues, many of which are hidden in plain sight.



**Figure 3 Honolulu Viewed From Diamond Head Crater, May 2014**

## **2.2 Suicide by the Numbers in Hawaii**

Honolulu sits right along the coastline of Oahu’s south shore. Visually, the city looks somewhat precarious there on the edge of an ocean: a concentration of towering buildings clustered together right where the Pacific meets land appears impressive but also fragile, as if they could topple right into the sea. The city itself is an eclectic mixture of old and new architecture, with concrete buildings in gradient shades of greys and whites jutting up from sea level to as high as 46 stories. Much of the city’s residential areas are intermixed with business districts, and passing through the city, it’s difficult to distinguish hotels from condos or office buildings. Within the city, though, are two distinct areas nearly opposite from one another. Waikiki (beach and district) is a famous and popular center for dining, entertainment, and shopping. The streets of Waikiki are

nearly always crowded with people bustling through the multitude of mainstream U.S. retail stores that line its main boulevard. Armed guards stand at the entrances to designer stores—Chanel, Gucci, Tiffany & Co.—which draw wealthy customers from all over the world, but primarily from China and Japan. If shopping is not your thing, the beaches at Waikiki boast some of the calmest waters on the island and are one of the most sought-after beach hangouts and oceanfront hotel resort destinations in the world.

Chinatown, on the other hand, has a very different aesthetic. A sixteen-block section of Honolulu, Chinatown is dotted with dim sum and noodle restaurants, clusters of dive bars, food stands, and Asian grocery stores. It contains some of the city's oldest buildings and has become, in more recent years, a central location for Hawaii's independent art and music scene. While the Honolulu Police Department has enacted efforts to clear Waikiki of homeless residents, this is not as much the case in Chinatown. The high rate of petty crime and vagrancy in downtown Honolulu's Chinatown district has therefore made it a less frequented area for tourism. Several parking lots appear abandoned but have in reality been taken over by homeless camps, seabirds fighting over pieces of garbage left out in the hot sun. It is not uncommon to have to walk in the middle of the streets to avoid disturbing those living in makeshift homes built on city sidewalks. This is not an uncommon scene for much of Honolulu, though it is particularly noticeable, and the volatility of the homeless crisis a little more urgent, in Chinatown.

On this particular day, I was to meet with Sonya, the director of Mental Health America's Hawaii chapter, in her office near Chinatown. I had circled the block several times, no doubt confusing the same homeless man whom I'd passed three or four times already, before I finally decided to phone Sonya's secretary for directions. To my embarrassment, I had been standing in front of the correct door for almost ten minutes. The building was so run-down that I initially

thought I had the wrong address. Her secretary buzzed me in and instructed me up a steep set of stairs covered in a stained navy carpet. Posters for various resources and hotlines covered the walls of the stairwell: toll-free numbers, a community events board, a family in an embrace, a picture of a stressed young woman holding her head in her hands, under the word “Suicidal?” Underneath the image was the number to call if, presumably, the answer to the question was yes.

Sonya’s secretary, a woman in her mid 50s, greeted me at the top of the stairs and we went through the only door in the hallway into their office. The office was one open room shared by three office administrators, all of them women, plus Sonya in a separate room demarcated only by a thin false wall with no door. Though the space itself was open, it felt cramped and disorganized, with papers and unmarked banker boxes covering most every surface in sight. Their desks seemed to float in the middle of it all with no real reason for their particular placement. The windows were open as wide as they could go, despite the midday heat and the noise of downtown traffic and construction droning through. Their fans weren’t working, I was told. I hadn’t expected much from a non-profit administrative office, especially in community mental health care, but this seemed to be in poor shape even by those standards.

I first contacted Mental Health America (hereafter MHA) because of its role in suicide prevention programming not just in Hawaii, but throughout the country. MHA is one of the largest community-based nonprofits in the United States dedicated to the preventative needs of the mentally ill, making them a clear first stop for me early on<sup>11</sup> during my fieldwork. Following the format of most major nonprofit organizations in the U.S., local state chapters of MHA function as

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<sup>11</sup> I first made contact with Mental Health America of Hawaii in May 2014, and continued follow-up with them until late 2018. This particular interview occurred in late 2015.

a combination of both national and grassroots affiliates; there are more than 200 such chapters in 41 states. While local chapters are independently managed, they work with the oversight and support of a central administration, which provides literature, shares best practices, and distributes need-based funding. The offices are typically staffed by paid workers, but the majority of the work that MHA does within communities relies heavily on volunteer support, with volunteers outnumbering staff nationally by about 2 to 1. Though most mainland states have multiple offices in different regional areas, Hawaii only has one location on Oahu, the most densely populated island, and one small branch office in Maui. The main office where I met Sonya in Chinatown serves, by extension of its volunteer network and affiliations with other local and state sponsored mental health care teams, the entire state of Hawaii. Two toll free numbers are set up to connect all the islands to crisis services, the bulk of which are also physically based in Honolulu, though they provide and connect individuals on the Neighboring Islands to services of all kinds.

Sonya was well connected and well liked within the prevention community—she referred to working with them as “being with my people.” And it was easy to see why: she was warm, friendly, and engaged in talking about what I’d anticipated may have been difficult to discuss in a first meeting. She was very laid back, almost to the point where I wondered whether her leadership role was something she had fallen into naturally. But she assured me, as others had too, that much of work culture in Hawaii was casual. There was a small sign carved out of wood, painted in a happy blue color sitting on top of her desk that said “RELAX.” Before I arrived to her office that morning, Sonya had printed out several papers for me to reference, each with various statistics on suicide in Hawaii, broken down by age and other risk factors. She was eager to help me understand “whatever it was” I had come there to ask her. I explained that I wanted to know more about the depth of the concern surrounding suicide in Hawaii. Sonya quickly clarified things:



Well, it's not a high rate of suicide we're dealing with. What we really have here is very high rates of young people with suicidal ideation. Three years ago, we were the top of the nation. That rate had been steadily increasing, but it tripled over the past three years based on in-school surveys that we distribute each year. In terms of actual suicides, we're not really in the high range in the state or even in the country, though suicide is still the (she tapped her desk at every other word when she spoke) *leading cause of death among those aged 15-24* in the state of Hawaii. More than car accidents, more than drugs—more than anything else.

Compared with the national average, for a state as small as Hawaii and among such a young age demographic, the information Sonya shared did not immediately stand out to me as something that was unexpected or even all that unusual. In fact, the CDC has shown suicide as one of the top ten causes of death among those aged 15-24 nationwide: in 2016, during the height of my fieldwork, it was in tenth place following unintentional injury and a number of chronic fatal illnesses. To situate this in the context of the United States as a whole, approximately 44,000 people die by suicide per year, averaging at around 15 per 100,000 nationally. This number varies dramatically from state to state, from a high of 28 in Wyoming to 7 (per 100,000) in New York in 2017.

Although Hawaii has routinely been ranked on the lower end of suicide rates across the country (15 per 100,000 in 2017), Sonya felt that the potential success of Hawaii's prevention efforts was in its emphasis on "the big picture." It wasn't just about getting the rates down, she said, but rather creating a situation where they would never go up again. This was important because, as she then explained to me, the significant outlying factor in Hawaii, and the driving motivation of the prevention community, is their youth suicide attempt rate. Among young people

in particular, suicidality has steadily been one of the highest rates in the nation. The in-school survey Sonya had referenced in this first meeting is called the Youth Behavior Risk Survey, which has been distributed among Hawaii's high school students annually since 2010. During its first year of circulation, the survey results shocked local mental health workers in Hawaii as it reported one of the highest rates ever recorded in the country of youth who reported actively considering suicide (19% compared to a nationwide average of 15%) and of those who had actually *attempted* suicide (13% compare to a national average of 8%) in the United States. Around this time, suicide also appeared to peak in Hawaii as the annual number of suicide deaths jumped from 170 to 200 per year, marking a 30-year high (in 2010) since data has been recorded in the state.

Relaying this to me in her office that day, Sonya remarked that most people find this information shocking. "We're supposed to be the land of *aloha*, of sun and surfing and all of that, but the truth is that some people here are really desperate." In pairing despair as being in conflict with the sunny, "land of *aloha*" image of Hawaii, I started to wonder more specifically about how Sonya and others quantified what she had termed to be "desperation." Thinking, also, of the Youth Behavior Risk Survey that she had mentioned, how does individual suffering become quantifiable statistically?

As a categorizable form of death, suicide has always been subject to codification through death rate reporting. From state to state in the U.S., rates of death by suicide—or even more subjectively, rates of suicide attempts—are subject to laws that provide explicit criteria for determining the cause and method of a recordable death. While laws dictate types of death, the reporting is ultimately a consensus-based collaboration among individuals who analyze, interpret, and conclude when a death may have been intentionally self-inflicted. Statistical death reporting is therefore not capable of providing the full story in most cases of suicide. Yet, many individuals

I spoke with found clarity (and perhaps even some comfort) in the statistical evidence on suicide death rates that was put before them. As Sonya phrased it, being the “top in the nation” for suicide attempts was, in effect, a negative thing to report, but there was an almost enthusiastic intensity in her stating something of such significance—an irony that extends into ethnography as well. The high reported numbers—especially in comparison with other places and with Hawaii’s own past—made the issue of suicide prevention somehow more pressing, and her job perhaps that much more purposeful.

The very notion of suicide as a form of death was conceived in the seventeenth century as a term taking its roots from the Latin for “oneself” and “murder” (Minois 1999). To afflict death on the self was, at that time and for centuries afterwards, seen as an affront to God and to nature. For many years throughout Europe and in most Western contexts, suicide, or “self-murder,” was widely criminalized, oddly even after death. Those belonging to the socially deficient, “mad” classes—the poor, the mentally ill, victims of suicide or suicide attempt—were regarded as criminals and cast into the prison system and later, the sanatorium (Foucault 1988). With the social classification of types of death in the nineteenth century, suicide was delineated as a distinct category of death; however, as continues to be the case today, no consistent criteria existed for determining when a death was in fact self-inflicted (Hacking 1995). As Foucault and Hacking have both argued, the intense policing<sup>12</sup> of suicide as a statistical cause of death has fundamentally shaped social perspectives on how society draws boundaries around what is (and what isn’t) a

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<sup>12</sup> As Tierney argues, there has historically been a separate body of literature in Europe that looks specifically on the legality of suicide and the policing of suicide death by the state, specifically in Germany pre-WWII (Tierney 2010).

“death by suicide,” even still (Tierney 2010). Policing categories of death and placing suicide’s urgency as a ranked death within a particular community relies on the reporting of death rates. These numbers and statistics are determined by commonly obtained, publicly accessible data on violent death reporting: county coroner reports, police reports, EMT reports, autopsy records, and so on. Public health workers like Sonya rely on these numbers and are bound—even financially, in terms of the support allocated by federal programming based on need—to the legitimization that such concrete data seems to provide their industry.

In Hawaii’s case, data reporting on suicide death as impacting the state has never revealed a grave risk in any particular demographic. After meeting with Sonya at MHA, I then met with Gary, an epidemiologist for Hawaii’s State Department of Health’s Injury Prevention section. Gary was familiar with all that the data could tell about death and violence in Hawaii. He explained that he had spent the past ten years as “the data guy” for the State Department, and that he’d developed a bit of a dark sense of humor regarding the work he did. “I think about death all day long,” he joked. “I guess I’ll be well prepared for it.” Gary told me that for many years, the leading cause of death in Hawaii was death by poisoning. As the state defined it, this category of death referred to drugs or other substance use resulting in fatal overdose. This was an incomplete and complicated category, Gary felt, considering that a lot of drug overdoses were often intentional<sup>13</sup> rather than accidental. But barring any evidence such as a note there was no way to predict how the coroner might interpret the cause of death. In terms of suicide, “even when there is a note, it doesn’t always work out that a suicide is actually counted *as* a suicide.” From having worked in this industry over

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<sup>13</sup> It has certainly been shown in some cases, within particularly afflicted communities, that chronic drug abuse reflects something of a lifestyle of suicide (Garcia 2010).

many years in Hawaii, it was Gary’s feeling that because of the interpretive flexibility in categories of death reporting, the rate of suicide in Hawaii was potentially a lot higher than the data from the county coroner’s office suggested. Speaking to me in late 2017, Gary remarked that “right now, we have the 15th lowest rate among the 50 states—but I think it could be even higher<sup>14</sup> if we consider possible suicides or deaths of indeterminate origin.”

In addition, Gary pointed out that any rise in suicide rates in the state may also be the result of the overall suicide rate increasing throughout the entire *country* over the past few years, by around 33% since the mid-1990s. Statistically, Hawaii was likely following this trajectory. Even within the context of a gradually rising population and higher than normal increases nationwide, Gary said that the suicide rate in Hawaii is “doing pretty good, if you can say that,” though there was still a slight upward trend<sup>15</sup> in overall deaths. As of the time we spoke, in 2017, there were 190 recorded deaths by suicide in Hawaii each year. In terms of suicide risk, the more isolated communities on the Neighboring Islands were typically at higher risk for suicide. This was not unique to Hawaii, he explained, but followed the U.S. risk model at large: states with large rural populations and high geographical isolation show the highest risk for suicide, with Montana, Alaska, Wyoming, and New Mexico at the very top for both categories. The real data trend in Hawaii that Gary confirmed with me was exactly as Sonya had explained about suicidality. Each year, over 900 patients were treated for non-fatal self-inflicted injuries in Hawaii’s hospitals. There

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<sup>14</sup> Gary also shared his opinion that the state’s conservative gun laws played a serious role in curbing suicide deaths. Indeed, states with liberal access to guns have some of the highest suicide death rates (Montana, Alaska, Wyoming, New Mexico, Utah, Idaho, Nevada).

<sup>15</sup> Even into 2019, this remains the case.

was roughly an equal number of calls to Hawaii crisis hotlines for poison control regarding non-fatal intentional overdoses every year. Suicide attempts in Hawaii were the problem.

Among young people between 14 and 24, rates of suicidality were the most alarming. The Youth Risk Behavior Survey that Sonya had mentioned to me was first distributed in 2005, having subsequently been collected every two years within Hawaii's high schools. Gary was familiar with this survey from a few different angles: first, he helped integrate it into the State Department's health reporting system. Second, his daughter was in a public high school and had taken the survey herself. "It basically asks four questions," he explained. "Have you considered attempting suicide? Have you made a plan? Have you actually attempted suicide? Have you been treated for an attempt?" Going back to its first distribution in 2005, and "for the longest time since," Hawaii was "by far the highest self-report for suicidality among youth in the country," Gary continued. Within the last two surveys, the rates of self-report had moved closer to the national average and were even trending to drop below what is typical. "It's a really encouraging sign," Gary said. "Those who are working with our youth, they're clearly making a difference."

Through my conversations with Gary and Sonya, it became clear that the "big picture" of suicide in Hawaii was *not* that the state was affected by a high rate of suicide deaths. The real issue was with suicidality, and increasingly among a younger age demographic. Learning this early on in my fieldwork helped me to make better decisions about who and how to approach mapping out prevention networks in Hawaii. Moreover, rather than reflecting a response to a statistically exceptional problem, the work of suicide care in Hawaii has been truly preventative. This, too, impacted my research approach: rather than focusing on those intervening in active suicide crises, I turned to prevention networks exclusively. The bulk of this work has been motivated from within those communities that have been the most personally affected by suicide itself, often prominently

featuring survivors of loss. This has also historically reflected the larger U.S. model of grassroots engagement in community mental health care as being the result of volunteer and survivor efforts (discussed in section 1.x). In the following section, I introduce and situate Hawaii’s primary venue for preventative suicide care: the Task Force model.



**Figure 4 Old Taxi Sign, Chinatown, Honolulu HI, September 2015**

**Figure 5 King Kamehameha Graffiti, September 2015**

### **2.3 The Prevent Suicide Hawaii Task Force**

In the United States, suicide prevention is something of an umbrella term that refers to organizational aims to reduce suicide death among at-risk populations. Operationally, suicide prevention relies on the daily and collective efforts of various levels of state, public, and private organizations intervening in suicide across multiple levels of engagement and experience. Just as community mental health care in the United States is fragmented, there is similarly no central

institution or organization<sup>16</sup> for the prevention of suicide. Outside of the crisis intervention model, prevention aims to broadly and preemptively address conditions that are thought to be inherent to suicidality. In this way, most prevention programs function by simply reinforcing positive coping strategies for those struggling with depression or other mental illnesses where suicidality is thought to be co-occurring. Broadly defined, prevention strategies may also include efforts to alleviate social conditions that are linked with higher instances of suicide within communities, such as addiction, homelessness, and chronic poverty. Typical prevention strategies follow an affective approach to providing hope and support, frequently mobilizing rhetoric that feels simultaneously inclusive and caring, but also somewhat cool and detached—what Stevenson refers to as “anonymous care” (2014).

As it does throughout the United States, understanding suicide rates and mapping networks of prevention in Hawaii is fairly straightforward in that all programming and information starts with and leads back to the State Department of Health. Hawaii’s state suicide prevention plan falls under their EMS and Injury Prevention section, meaning that all efforts to reduce suicide, from the perspective of public health authorities in Hawaii, define it as a fatal injury and are primarily concerned with its relationship and treatment within emergency medical services. Moreover, the seemingly disorganized, fragmented network of prevention that I sought to untangle in mapping out Hawaii’s prevention network is interdependent by design: the overlaps between those

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<sup>16</sup> This is true, although clinics do exist for crisis intervention. As mentioned in Chapter 1, the first such dedicated suicide prevention center in the United States, a crisis clinic, was opened in Los Angeles in 1958. These places are routinely the first referred step for someone seeking immediate help in suicide intervention.



providing care in suicide, whether from the standpoint of inpatient psychiatric care to support groups in church basements run by private citizens, were intended to be linked across many different layers of care. At first glance, this might seem an unstable model of care; but in fact, these overlaps may well strengthen what is ultimately a holistic and communal approach to prevention. This model, I learned, is truly a community effort in its reality as well as in its organizational structure. This is not unique to Hawaii, but rather reflects what has become a typical U.S. model of community-based mental health care post-deinstitutionalization—that is to say, most communities are similarly (dis)organized, with many professional overlaps between organizations and affiliates.

As I mentioned in this chapter's earlier vignette in Sonya's office, suicide prevention efforts in Hawaii reflect the geographic layout of the state, with most resources centralized in Honolulu on the island of Oahu. Oahu is one of the smallest islands in terms of its total landmass, but it is in fact home to around 95% of the Hawaii's residents. Honolulu is also the only metropolitan area in the state, representing both the largest city and largest county. The city itself houses about 400,000 people, nearly half of the entire population of the island of Oahu (a total of 953,207 in 2010). Honolulu is the largest city of its kind in the Pacific and the most isolated city of its size in the world. One can really get a sense of this, too, as flying to Honolulu from the coast of California (San Francisco or Los Angeles, most commonly) takes almost 6 hours—about the same amount of time it takes to fly coast to coast. The actual county of Honolulu is even larger than the city, with a total of nearly one million residents—a significant percentage considering that the entire state is home to a total of 1.4 million. The island is also highest in population density: the entire landmass of the Islands accounts for 10,931 square miles—with a population of 1.4

million, the population density is about 223 people per square mile, which puts Hawaii as the 13th most densely populated state in the United States.

Honolulu is not only where the State Department of Health is located, but also where all of the local chapters of national prevention nonprofits, such as the American Foundation for Suicide Prevention (AFSP), Mental Health America (MHA), the National Alliance on Mental Illness (NAMI), and the Substance Abuse and Mental Health Services Administration (SAMHSA) have their offices. Despite their affiliations by name, these national organizations function locally and independently and identify themselves as being grassroots groups. This is true in the sense that local chapters of national organizations are requested, generally by a group of individuals who perceive a need for their presence, and later become accredited as part of attaining the national “branded” affiliation. Though they receive some federal subsidization and adhere to models of accreditation, each branch in every U.S. state is unique and run at the local level.

The fragmented nature of care in the model of suicide prevention makes it difficult to locate a single trajectory at the center of suicide prevention strategies in Hawaii—or really, anywhere in the United States. This becomes doubly challenging when each organization and each chapter within it is made up of a host of people from varied backgrounds, who unite simply to the cause of wanting to help in preventing suicide. Following fairly basic programming, these individuals, identified in the Hawaii Task Force’s own materials as “families and friends who have lost someone to suicide, vulnerable individuals, mental health professionals, clergy, educators, students, community and business leaders” and others, join together to focus on eliminating suicide primarily through outreach work. This work typically takes the form of delivering innovative prevention programs (to schools, church groups, neighborhoods), educating the public about risk factors and warning signs, raising funds for suicide research and programs, and reaching out to

those individuals in the community who have lost someone to suicide. The complexities in this fragmented model are apparent, too, for those seeking care: because the nature of prevention work is dynamic, this can present a problem<sup>17</sup> for suicidal individuals and their families when searching for help in a crisis.

The banner under which all of the many splintered prevention groups converge in Hawaii is called the Prevent Suicide Hawaii Task Force (PSHTF), an organization that developed directly out of the work and engagement of volunteers and survivors of suicide loss in Hawaii—and specifically, in Honolulu county. The Task Force, once I located it, quickly became what (and who) I was always instructed to refer to if I had any questions or was seeking to contact anyone in Hawaii’s suicide prevention network. Developed from the CDC’s national suicide prevention Task Force model, the PSHTF operates as a partnership of state, public, and private agencies, as well as local community groups working in collaboration to “provide leadership, develop strategies, coordinate activities, and monitor progress of prevention efforts.” Within the PSHTF are individual Island Task Forces that coordinate, among other things, culturally appropriate prevention outreach to Hawaii’s Neighboring Islands, identified broadly as West Hawaii, East Hawaii, Maui, and Kauai. Together, all of these Task Forces serve as points of contact for suicide prevention statewide. How this broadly works is that the individual Task Forces routinely communicate with one another regarding their own local strategies. In addition, they arrange events within the network, including an annual statewide prevention conference one weekend every year, and the annual event-filled National Suicide Prevention Week, which happens every

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<sup>17</sup> As it presented a problem for me as an ethnographer, I can only extrapolate what this might look like for someone in need of immediate help.

September throughout the United States. Day-to-day operations take the form of implementing training programs and materials for community leadership, updating language, material, and suicide prevention protocols in schools, in the police force, in the military bases, and so on.

The PSHTF’s Oahu Task Force, located in Honolulu county with members across the island, is where I ultimately began this project. I soon learned that Iolani Santiago, the woman whom I first met briefly at the suicide awareness walk at Ala Moana Beach Park in 2015, was the very reason behind Hawaii ever getting a Task Force at all. Iolani, who had lived her entire life on Oahu with her family, lost her son Kaleo to suicide when he was only 16. After his death, she began mobilizing those around her to do more about preventing suicide. The importance of having a Task Force in Hawaii was, for Iolani, because she knew that suicide was preventable<sup>18</sup> if only the public were more informed. The PSHTF was founded in 2005 as the result of people like Iolani’s continued efforts in legislating for funding for such a chapter to have a presence in the Islands. Anyone was welcome to join the Task Force—there were no requirements beyond an interest in helping. At the opening of a statewide suicide prevention conference in April of 2019, Iolani remarked on these beginnings: “All of these people,” she said, pointing to the other members of the Island Task Forces sitting behind her, “have been instrumental in getting this work out into the community. We started in 2005, and it took us a long time to get here, but to this very day we now have a Task Force on every island. These people here, they are champions, they continue to do this work—and I should mention they are all volunteers—with the Task Forces. They continue to do this work every single day, every month, every year, from 2005 to this very day.”

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<sup>18</sup> I briefly mentioned this prevention discourse earlier in this dissertation, at the beginning of the first chapter.

These “champions” that Iolani was cheering on here are the heart and soul of prevention efforts in Hawaii, and they collectively make up many of my informants in this ethnography. With few exceptions, most people whom I name or include have either served or currently serve on one of the Task Forces. Iolani, addressing the room at a statewide conference in 2019, was visibly impressed with the commitment that prevention workers showed to their cause. Waxing nostalgic, she remembered how “back then, I used to be the one who would gather everyone together, and just, give them the opportunity to volunteer, but then if they didn’t, we would do what I call the *volun-told*—we’d tell them what to do. But the *kupunas*<sup>19</sup> in this Task Force, we can now sit back and watch them do the telling.” Facing her colleagues at this large, statewide conference, Iolani was looking at the fruits of many years’ worth of “passing life forward” to others. The networks of care that I have introduced here tackle suicide with great energy and with a lot of hard work, even though much of it is unpaid. Iolani’s introductory story here mirrors as well the history of community-based suicide prevention in the United States in that the successes of prevention work rely on the efforts of volunteers and those with deep personal connections to/with the cause: often, these are the same people.

As this chapter will also show, understanding the problem of suicide in Hawaii requires looking beyond death rate reporting: as Gary says in the section that follows, “there’s always more to the story” than the data can show. In addition, because the issue is suicidality—the potential of suicide—prevention workers somehow have to contend with all of the many possible reasons and rationales that may play a role in causation. This seems an insurmountable task. I wondered, how do those working in prevention make sense of causality? What do they feel are issues that they

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<sup>19</sup> In Hawaiian, *kupuna* means “elder.”

need to help address through their prevention work? In mapping out these networks of care, I now turn to how the prevention network perceives of causality in suicide—specifically, having asked the question that Jocelyn Chua, evoking Veena Das, hesitates to ask herself: “what happened?” In order to do their job effectively, prevention workers need to ask this. In attending to this question, the following section discusses some of the opinions and reasons that a variety of people gave me in various positions and proximities within and outside of prevention work, for the higher rate of suicidality in Hawaii. They described a kind of “desperation” in Hawaii and speculated its relationship to increased suicide attempts among younger, and to use Chua’s articulation, aspirational individuals in particular. I offer these narratives below within what I am calling the “costs of living” within a political economy of desperation. This framework exists to provide a space for some of the concerns that exist in relation to the issue of suicidality in Hawaii, as felt by residents.

#### **2.4 Costs of Living: Desperation in Hawaii**

As I have mentioned, Hawaii is not facing a suicide epidemic. Suicidality in Hawaii, as an expression of a *potential* crisis, requires a different set of questions than are applicable in other contexts, such as Chua’s South India or Stevenson’s Canadian Arctic. And yet, precisely because the event of suicide has not occurred in Hawaii, there is a possibility to actually ask what is going on—Chua’s question of “what happened?” For Chua, in her study of the epidemic plaguing young and otherwise successful individuals in Kerala, suicide is rather straightforwardly revealed as a problem of political economy, borne out of unmet aspiration mixed with economic decline. Using Foucault’s method, Chua problematizes the suicide crisis in Kerala—which is already an issue of

deep social concern—within the context that the local discourse surrounding suicide explains it *as* a “problem of aspiration” (2014:56). Not only does this constitute a particular method of framing suicide as a social concern within a political economy of desperation, but as a result of the pervasiveness of the failed aspiration discourse, Chua writes that suicide in Kerala “necessitates forms of subjectivity, management, and intervention as life-and-death necessity among the living” (56). The underlying argument that emerges is that suicide is itself a type of sociality that, rather than being fixed on death, is a way to inscribe meaning and a way to impart knowledge about life itself. Though it’s not very clear in her theoretical explication of suicide, particularly as she is discussing how suicide is rendered in Kerala as linked to these concrete societal failures (and *anomie*, though she doesn’t actually say it), Chua attempts a departure from Durkheim and other contemporary sociological understandings of suicide as being a sign of social cohesion, or rather of its disintegration (201).

Departing from Durkheim is the intent that Chua has in her ethnography, and it is not altogether misguided. Durkheim’s functionalist approach of suggesting correlation and causation in suicide as the tendency of humans to require social integration (or else seek their own destruction) is reductionist, overly deterministic, and largely ignores individual agency, experience, pathology, and preference. Still, Chua’s ethnography explains the social pathology of suicide in similar terms as Durkheimian *anomie*. She writes that the increasing problem of suicide in Kerala is continually acknowledged—by media, by psychiatrists, by affected residents—as an action/reaction to the failure of globalization to provide sufficient opportunities to an aspiring class that she characterizes as reaching much too far, yet unable to aspire to anything less. Underlying much of Chua’s ethnography is the notion of a double-edged sword of success and failure, each with their own potentially fatal ends. Much of her ethnography talks about suicide as the

embodiment of Kerala's collective struggle and social precarity in the face of its unpredictable future. It is difficult, from my perspective, to read her explanation as a departure from Durkheim; to the contrary, it only seems to substantiate his notion that suicide is the result of societal distress.

Because the issue of suicidality in Hawaii is one of *potentiality*, it was possible for me to ask my informants, "why might this be happening?" And frequently, rather than relying on data from the Department of Health or self-reports from the Youth Behavior Risk Survey, people shared their unprompted opinions regarding the question that was in the back of everyone's mind: *why* is suicidality a problem in Hawaii? Recall how Gary, who trusted statistical reporting as part of his job, felt there was a contradiction between neat statistical representations and something as multidimensional as suicide. Working in public health, he explained, he looked at explanations as a whole in a community, "for disparities, for broad risk [...] but with something like suicide, most people have a totally different experience with it that doesn't fit the big picture profile." He shared with me an example of what he termed "cognitive dissonance" in balancing sentiment and statistic, that "there's always more to the story." He told me of the recent death of a young male exchange student at his daughter's high school:

This kid was young, younger than my daughter. She said he was quiet, but not awkward. You know, she knows what suicide is, what it looks like, you know... she's probably more aware because of what I do. But the school had a really hard time wrapping their heads around talking about this kid. They wanted to express sympathy but they also didn't want to stir up the other students. But my daughter, she wanted to know *how* he did it. *Why* he did it. It's hard, because that's a real person. And I can't tell her why. Who could?

Through Gary's example, I understood what he was trying to emphasize in balancing sentiment with statistic. This resonated even more so as most of those I spoke with either had themselves or



knew others who had suffered catastrophic personal losses: that loss was someone's child, or mother, or best friend.

In asking *why* or seeking an explanation for suicide or suicidality, it is important not to lose sight of the real people within these stories. It is arguably even more important not to pretend that there exists a one-size-fits-all explanation, and in that regard, not to give too much authority to opinion. In this section I explore some of the concerns that those either close to the problem of suicide or close to youth in Hawaii shared with me. I attempt here not to provide a reason but rather to shed light on several recurring themes that emerged during my fieldwork. The most consistent theme, across many different categories, was one of *desperation*, which was linked to a variety of ways of perceiving the *cost of living* in Hawaii: from the lack of resources in campus counseling centers to the pervasiveness of the “paradise” discourse, to the housing and homeless crisis in the state. All of these were suggested to me as variants on a theme of social desperation, which many seemed to attribute to an overall rise in suicidality. These sections present, in three parts, some of these literal and figurative “costs” of living in Hawaii not as an explanation, but as a common thread of an expressed desperation across the years of my fieldwork.

#### **2.4.1 *Desperation Narrative #1: Living the #HILife***

An office worker I encountered a few times at Mental Health America's Honolulu office once handed me a pamphlet that outlined a list of warning signs to look for in suicide. Among these were attitudes suggesting feelings of loss, withdrawal, and malaise. Examples included lack of interest in social activities, being reclusive and avoiding loved ones, expressing aloud thoughts about one's perceived uselessness, and so on. These criteria, though designed to be helpful in

assessing a suicidal risk, rely upon assumptions about what behaviors are considered normal. Even further, they require a level of subjective interpretation in evaluating these “signs” within others—what might be status quo to one person could potentially be an expression of suicidality to another.

When I first met with Sonya at Mental Health America, she had mentioned that the Youth Behavior Risk Survey (discussed above) was the metric used to determine youth suicidality. The survey, distributed every two years in Hawaii’s public elementary and high schools, collected only self-reported information. Beyond suicidality, the overall picture that it painted was distressing. Not only were students reporting negative mental health conditions, they also reported issues of bullying, domestic violence, sexual abuse and assault, food scarcity and homelessness. In general, the report revealed the very stressful and traumatic situations that young people were purportedly facing. Anecdotally, Sonya confided that the youngest student to report having attempted suicide via the self-report was only nine years old. Other stories I heard from various individuals confirmed this and shared their concerns about the growing youth trauma. Indeed, the stories that came out of the survey and the information that it revealed were alarming—and yet, I was still somewhat concerned about the validity of the answers, particularly as this data was all self-reported.

While I was quietly concerned about the inherent unreliability of the survey, Sonya expressed no doubt as to the validity of these self-reports. Moreover, she did not view the criteria that was measured as something subjective. Sonya’s interpretation of what she read in these reports was informed largely by her own experiences, she told me. She explained that she herself had intimate knowledge of these issues as someone who had once been deeply desperate herself. Sonya, who had studied social work in graduate school and worked in a women’s homeless shelter in Chicago prior to becoming the director of Mental Health America, had a long personal history of chronic mental illness and trauma. Not only had she survived a suicide attempt, she had endured

multiple hospitalizations for psychotic episodes that had occurred “as a result of decades of untreated bipolar disorder.” She explained that she had become an advocate for the mentally ill only as an extension of her becoming an advocate for her *own* self, and she felt her authority as a care provider was rooted in her experiences on the other end of the encounter.

This was not a revelation of her character by any means: in fact, Sonya frequently shared her past as part of her identity—a personal victory in transitioning from patient to provider—with the public community around her. Even prior to our first meeting, I was already aware of her mental health history and advocacy, largely due to her public persona and outspokenness about her experiences. Not only did Sonya believe that her experiences had informed her view of mental health care in general, but she also extended her critiques of care to the resources that she felt Hawaii lacked, having gone through them herself. In one interview she had done with a public panel on mental health care in Hawaii, she discussed having been hospitalized in another state for a suicide attempt. She spoke at length about her dissatisfaction with the treatment she experienced for her initial bipolar diagnosis but made a point to say that she was at the very least, mandated to be hospitalized in California. In Hawaii, long-term care for the mentally ill was minimal at best. “There’s no place for people here. I mean, if you need to be hospitalized, there’s nothing for you,” she said.

The only state hospital<sup>20</sup> (in Oahu) was frequently over-full, so most people experiencing an acute mental health crisis ended up receiving short term E.R. treatment and being released immediately due to lack of space or lack of insurance. “Now that’s bad,” she said. She also leveraged a critique at what she perceived to be an intentional public invisibility of the mentally

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<sup>20</sup> See section 1.3.1 for history and description of Hawaii State Hospital.

ill, the homeless, and the suicidal in Hawaii. From her experiences, she said this wasn't uncommon or unique to Hawaii: there is a longstanding stigmatization of these groups, she explained. On this note, Sonya connected me with Karen, whom she thought might have better insights into the situations impacting youth due to her job as a college professor. Sonya in fact used the word "agitator" when she first told me about Karen—not by name, but by description. The way she phrased it, there was a faculty member at a nearby university whom she said had been "agitating on campus, stirring things up" following several "incidents" that had happened to young people on their campus earlier in the year. I asked if by incidents she meant suicides: there had been several, she told me. She asked me how I hadn't known about them, since I had shared with her that I was living on the campus during that time. I told her that I hadn't heard a word, and she was unsurprised.

Earlier this year, a young man fell to his death. It was clear that it was suicide, later they reported it to be substance abuse. Anyway, there was no communication about it happening. So some kids knew about it, some kids didn't. The administration maybe told the professors who had the boy in class. So, there were rumors and, well, no one knew about the counseling center on campus—they are very poorly advertised.

She told me about another instance wherein a boy was attempting suicide and another died trying to stop him. It had happened a couple months before, on the same campus before the academic year began. People were just now finding out about it by reading the local newspaper. It was a tremendous tragedy, she said, and deeply frustrating that the administration had been so quiet about what had occurred.

"There's always been stigma, but there's a lot of secrecy surrounding suicides on that campus," she told me. "There've been quite a few of them there."

Karen, a faculty member at a university in Hawaii, was trying to stop that. As Sonya phrased it, Karen had somewhat inadvertently become involved in bringing visibility to suicide prevention efforts when she noticed that a student of hers was visibly upset in her class. It turned out that he had been outside when the young man, whom Sonya had mentioned to me, jumped to his death from one of the towers.

“I mean, the body landed right next to him,” Sonya shook her head as she recounted this.

Karen’s side of this story was somewhat different. I met her at a coffee shop in Mānoa one afternoon, having been referred to her as “the faculty agitator” by Sonya. Karen found this characterization funny and assured me that she’d since “amped it up.” She called herself the “agitator-in-chief, though not to be confused with the one currently occupying the presidency of this country.” According to Sonya, Karen had been the person to start pushing for communication about suicide deaths on campus because of the several that had occurred, many of them in public locations, within a short period of time. Earlier that academic year, in addition to the two suicides that Sonya already told me about in our first meeting, there were two female graduate students who had taken their lives in campus buildings, one fatal moped accident in the center of campus, and another fatal hit-and-run involving a pedestrian at the same intersection only a week afterwards. In each of these cases, Karen would later tell me in more detail, the university administration felt it best not to share any information, let alone any details, about these events—not even in the form of an internal acknowledgement.

“I get it,” Karen said. “No one likes talking about death, especially here.” She gestured at the space around us. We were outside at a campus café, the air dense and sweet, and my view entirely filled with lush green and brightly colored flowering plants. I could see how ruminating on death was perhaps a little counterintuitive in this environment.

“But for some reason, this is just, it’s like pulling teeth. Like, why can’t you just say something nice about [the student], and maybe say there’s a counseling center? How hard would that be?”

Karen and I shared an agreement that these were real people, not problems, and that they should be memorialized in some way, but Karen said it was as though the university “doesn’t care about its suffering students.” Karen told me about a makeshift shrine that several students had made for a student who, years ago, had fallen down the stairs of a campus building and suffered fatal injuries. At the foot of the stairs were flowers, pictures, letters of remembrance from friends. She added, “Students built that memorial. It was beautiful, it was there for about a year before the administration took it down.”

From Karen’s perspective, student suicide was not a shock. Overwhelmingly, she told me, her students and the students of her colleagues were facing increasingly desperate situations. These challenges took many forms, but from what Karen had experienced in her recent and close proximity to youth distress, a lot of what she witnessed among her students had to do with the burden of living in a place like Hawaii. Not only did it seem that nothing was affordable or accessible, it also seemed that everything—even the bad stuff—was somehow meant to be enjoyed. If you were from Hawaii, you were “spoiled” if you didn’t find yourself lucky to live in paradise. Social media hashtags drive this point home, with popular phrases like #luckywelveHI and #livingtheHIlife. The sometimes-invasive presence of tourists in your own home made a nuisance out of everyday life. It was a place where the contrasts between rich and poor felt dramatically disproportionate, where achievement didn’t always lead to success. This perspective was something Karen had somewhat cynically come to believe over the years. Her evidence of this was in the stories that her students told her. During one semester, she told me:

I have a young woman with a mother out of state, dying from pancreatic cancer—the student wants to drop out and go take care of her, but her mother wants her to stay in school. Her neighbor in class, she just lost a friend to suicide and her father keeps threatening it. Another student is only just coming to classes after suffering terrible PTSD and finding no one at the counseling center, which has a long waiting list. Another student wrote me about his meds, tells me he can't afford them and his rent so he has to move. He's not sure if he'll stay enrolled. Another young woman is missing classes because her father is detoxing at home and she's the only one who can be there to care for him. Some students are homeless. Some can't afford to eat dinner—I bring snacks to class most evenings now. This is all just in one class of about 30 students.

At the time of our meeting, the university featured a banner prominently outside of its front campus entrance, featuring a photograph of a student, tanned and blonde and smiling underneath the quote: “Why go anywhere else? I get to study in paradise!” This “postcard image,” as Karen referred to it, was a far cry from the reality of her students' struggles.

The “postcard image” of Hawaii as a carefree tropical paradise sits in stark contrast with the reality of many of those, including a lot of young people, working to maintain this image. One example of this is apparent in a relevant and now-widely critiqued Saturday Night Live routine, featuring one of Hawaii's own. From a pristine oceanfront view, the scene opens up inside a themed bar where couples sit huddled at small tables, sipping on cocktails served out of novelty glasses with colorful umbrellas poking out of the top. Two men dance into the room wearing grass skirts and garishly printed shirts. One of them strums a ukulele as they both sing in something that sounds like Hawaiian but turns out to be gibberish. The two men, played by Fred Armisen and Dwayne “The Rock” Johnson, who lived in Hawaii through high school, proceed to antagonize

every couple in the restaurant. One couple, gushing about being on their honeymoon, are mocked for being “so original.” They remark that it “must be fun” working in this place, to which Armisen responds sarcastically: “Oh, it’s great. They make us wear grass skirts and play the same song over and over. We make \$7 an hour. It’s a dream job.”

But Hawaii is “such a beautiful place to live,” one woman says. “You should’ve seen it before it was covered in hotels,” Armisen replies. “Yeah, it’s a fun fact about Hawaii. Our biggest export is coffee and our biggest import is fat white tourists,” says Johnson. The audience laughs, as the men somewhat painfully move on to the next table.

This sketch aired on *Saturday Night Live* in March 2009 to some protest in the state of Hawaii. The lieutenant governor at the time, James “Duke” Aiona, publicly expressed concerns that the sketch’s portrayal of disgruntled Hawaiian service workers would deter tourism to the state during an already bad year. But in general, most people in Hawaii responded positively to the short routine, and not for its humor—it wasn’t particularly funny—but rather for its accuracy. “It’s everything we think but never say,” one person told me, referencing the popular clip years later. It certainly seemed to me that the pervasiveness of tourism was something that many Hawaiian residents felt more negatively than positively about. Things like longer lines, longer travel times, and the overcrowding of public spaces were the grievances I heard most frequently. As a friend of mine said when recommending a particular hike near Kailua one morning: “If you don’t leave early, you won’t be able to enjoy it. There won’t be any room.” This is true for many of the island’s public parks and recreation areas. Parking lots to places like Hanauma Bay and other state parks are filled only hours after they open most mornings. So it was somewhat surprising to me how frequently I was encouraged by Hawaiian residents to visit all of these places, despite their own



frustration with the crowds, traffic, and parking. It was as if they were reciting travel pamphlets and internet lists of “Oahu’s top places to visit” as part of daily life.

“Sure, it’s frustrating,” a beach-goer told me, as I stood next to him on Laniakea Beach on the island’s popular North Shore. Several dozen camera-wielding tourists flooded an area where a group of hundred-pound sea turtles were basking on rocks in the sun. But one perk to being from Hawaii is “knowing all the secret spots,” he said. He gestured halfway down the beach where it was nearly deserted of people. It was where the turtles swam to get here, he told me. “You can stand over there waiting to snap a picture, or you can get in that water and actually swim with them.” He conceded that it was only a matter of time before these spots were discovered too. “You’d think you’d be able to find seclusion on an island, but none of that lasts for very long around here,” he said, suggesting that the “isolation” of living in Hawaii was something of an illusion. A charter bus with the words *Aloha Tours* written on the side pulled up behind us as another group of tourists spilled out onto the sand.

These images of non-Hawaiian tourism fueled by mass-marketed adventure-seeking tours and slogans appropriating basic Hawaiian terminology (*aloha*, *mahalo*, *e komo mai*, etc.) are so pervasive in Hawaii that they’ve become, as the *SNL* skit implies, a caricature. Words like *aloha*, which, contrary to the popular songs of the American 1950s, does not mean “hello and goodbye” as they might suggest, have been stripped of their dense meanings and used as marketing ploys, sometimes on t-shirts and tiny wooden surfboards and sometimes in popular local songs. This construction of a certain type of Hawaii, using language and meaning taken from Hawaii, is what Cristina Bacchilega writes is part of the discursive formation she calls “*legendary Hawaii*,” which she intentionally underscores in italics as representing the fictitious qualities of such a non-existent place (2007). *Legendary Hawaii* is “a space constructed for non-Hawaiians (and especially for

Americans) to experience, via Hawaiian legends, a Hawaii that is exotic and primitive while beautiful and welcoming” (2007:5); a curated image of a land illegally taken and continually manufactured into the idealized version of itself that is more real than its actual reality (Baudrillard 1994). For Bacchilega, the development of *legendary Hawaii* followed its illegal annexation by the United States. As this “constructed space,” *legendary Hawaii* exists somewhere between the ideology of the annexation and the colonialist impetus of Pacific tourism. It is based on the words of Hawaiian legends but spun in such a way as to become accessible to, if not altogether embracing of, outsiders. Tourism, she argues, is the “economic and ideological motor” of the production of *legendary Hawaii* while sight and sound—literally, as her analysis focuses on photographs and narratives—is the modus operandi of its cultural production (2007:6).

In the *Saturday Night Live* sketch, which is quite a perceptive, if inadvertent, commentary on Bacchilega’s idea, an awkward vacationer remarks how “peaceful” it is in Hawaii. “You must love living here,” she says to Dwayne Johnson’s service worker character. She is of course responding to the popular images that she has digested as *legendary Hawaii*, the Hawaii that she experiences and consumes as an outsider. He replies that the tranquility most people come to enjoy is limited to the oceanfront resorts, that his home is 15 miles inland, his house a “rusty pickup truck with weeds growing out of it.” In order to get there, he says, “first go through the shantytown, make a right at the meth lab. You’ll see a 15-year-old girl who got pregnant by an out of town businessman. Ask for her brother. That’s me.”

Though the scene attempts at bleak humor, it points to another difficult subject in Hawaii: while tourism is at the center of their economy, its success is contingent upon Native Hawaiians’ acceptance of the appropriation of their ethnicity. As their terms, imagery, and even individuals are used to market aspects of “everyday Hawaiian” life, the result feels very much like a forcible

fragmentation of concepts that are deeply valued by some—for one, the spiritual significance of the term *aloha* and what it means to the Hawaiian people—and their popular, incorrectly implemented counterparts.

One employee I spoke with at the Office of Hawaiian Affairs told me it's "unacceptable" to exploit Hawaiian culture in these ways. "People don't know what these words mean, let alone what they mean to Hawaiians, but they're used all the time. You see it everywhere." This same individual, in his critique of the overuse of the term *aloha*, also recommended that I visit the Polynesian Cultural Center. The PCC is a 42-acre cultural theme park on the North Shore owned and operated by the Church of Latter Day Saints. Approximately 70% of the center's 1,300 employees are students at the nearby Mormon-owned Brigham-Young University, and though most belong to the LDS church, the center claims it is not "a requirement" of employment. The park draws huge crowds daily and promotes itself as offering a chance to explore the "tropical splendor" of "all of Polynesia in one place." Visitors can wander through "authentic villages and mingle with natives," dine like royalty and be entertained with fire and hula dancers at evening's end. It is a bizarre Disneyfication of Polynesian culture situated in a place where that culture has, by design and by brutal history, been stripped of much of its meaning, owned and managed by those who ideologically colonized the very ground on which it stands.

Even Sonya, who proclaimed she was painfully aware of the disenfranchisement of the Hawaiian people, used some Hawaiian terms frequently and often out of context. Many of my other informants did so too, in their naming of things. Neither Sonya nor these other individuals were Hawaiian. They were not even considered "locals," a term used to mean a non-Hawaiian or white person (*haole*) who has lived in or grown up in Hawaii for an unspecified but long enough amount of time to be considered "one of us." But most of them viewed Hawaii as a land of

contrasts, a “playground” for some—particularly for those wealthy seasonal “snowbird” tourists—and a hell for others.

Sonya told me that *her* version of Hawaii was an odd juxtaposition of sentiment with reality. “We’re supposed to be the land of *aloha*, of sun and surfing and all of that, but the truth is that some people here are really desperate.” She elaborated, “I think part of the problem here is with the place. My thought is that if you’re living in a really happy place, if you’re struggling, you can feel really isolated—or worse. You know, it’s a funny thing: no one kills themselves in New Jersey.”

We shared a brief laugh at the expense of New Jersey, but I soon saw that it was a serious point that Sonya was trying to make. She felt that living in a place where a cultivated brand of often out-of-reach happiness “is forced down your throat,” as she might say, must be challenging, particularly to those more emotionally vulnerable. I recalled being at the picturesque beach of Lanikai where I found myself sitting near a group of young women who were loudly expressing their annoyance over a wedding being photographed a few yards away from us. “This is the third one today,” one of them complained. It was true, and it was not uncommon either to watch multiple events like this unfold within one afternoon in the same place. At one point I had witnessed two bridal photo-shoots happening simultaneously, each trying carefully not to capture the other in their pictures.

“When everything around you is a little bit shitty, people are more accepting of their unhappiness,” Sonya thought. New Jersey, and places like it, tend to have lower rates of suicide, she surmised, because there was a sense of camaraderie around this kind of misery. Continuing this narrative of paradise-induced desperation, she felt you could function better as a depressed

person in Jersey knowing everyone else around you was perhaps a little miserable, too. This, she thought, had the opposite effect in Hawaii.

“I think that here, you’re not allowed to be unhappy. You are bombarded with other people’s happiness. No one here wants to be the person at home on the couch watching Netflix in the middle of the day, while everyone else is out there.” She gestured to her open window, implying everything beyond it. But beyond the pervasive “happiness” that Sonya mentioned, she also felt that there were very real pressures for Hawaii’s young people, particularly those in college. It is no wonder, she expressed to me, as I shared with her some of Karen’s students’ concerns, that there would be higher rates of suicidality among these kids who “can barely afford to make it work” as it is. What kind of life is it, Sonya asked, when you have to work one or two jobs just to stay in school? How could you be expected to ever finish college, she questioned, let alone pay for it, when you’re under that much stress?

Sonya, like many upwardly mobile middle-class residents of Hawaii, was still operating at a deficit. Despite having a full-time job and a working partner with a salary, Sonya told me they still struggled to keep up with mortgage payments. Living in their own (“tiny,” she assured me) slice of paradise as income tax and property taxes rose annually and salaries remained the same was demoralizing, Sonya admitted. She said she couldn’t imagine being at the beginning of her career in a place like this. Young people were overwhelmingly facing the consequences of an overburdened tourist economy, a lack of public infrastructure, and a scarcity of affordable housing in the state—most working several jobs, she said. The cost of living in Hawaii, in Sonya’s opinion, was too high to be able to afford stopping and thinking about the future.



**Figure 6 Grand Piano in Abandoned Old Estate, outside of Kailua, September 2015**

#### **2.4.2 *Desperation Narrative #2: Gloria’s Story***

Even as a comfortably wealthy person in Hawaii, the cost of living is sometimes still an issue—beyond that of the financial burden. Strained relationships, absent family members, substance abuse, and racism were evident through several conversations that I had with Gloria from Kapolei, introduced below, and several others like her. Just over twenty miles west from downtown Honolulu is the neighborhood city of Kapolei, buffered by about five miles on either side between the windward edge of Oahu and Pearl Harbor. Kapolei is a planned community, which if you didn’t know it, is pretty easily evidenced by its predictable gridded landscape of similarly shaped beige and terracotta condos with identically paved driveways, smoothly winding cul-de-sacs, and a centrally located shopping plaza with a Whole Foods as its centerpiece. There are six golf courses, numerous spas, and a Disney resort.

Other than passing through, I hadn’t planned on spending much time in this part of Oahu. But when my housing near the university fell through for a night, I needed to find a room for a

quick stopover. Gloria's house in Kapolei was highly reviewed and affordable for a student in a last-minute situation like mine.

The reason I'd never intended to visit Kapolei was that there was nothing remarkable about it, except perhaps that it was unremarkable. In fact, driving through it felt indistinguishable from any other planned community in California, maybe even Florida. Each home was a "new build," something common to the development in suburbified parts of Hawaii. These homes were priced in the multi-millions, taxes were high, schools were primarily white; it is a rich suburb like any other in the United States. It just happens to be on a tropical island.

When I showed up to Gloria's house, she wasn't home—out with some friends at a concert and then showing them around the North Shore, she told me. The keys were in a locked box and she texted me the code. I slept better there than I had in weeks, an industrial size air conditioner humming behind me all night. It seemed appropriate to me that in a suburb nearly indistinguishable from any other in the mainland United States, this would be the only time I would ever sleep in an air-conditioned room in Hawaii; everywhere else I had ever stayed made expert use of open windows and the occasional ceiling fan. Strategic architecture is often the case, but this is due in no small part to the fact that energy—electricity, specifically—is incredibly expensive in Hawaii. In the suburbs of Kapolei, every home had a unit.

I made my way to the kitchen the next morning to meet and thank my host, who was up early making coffee. Gloria was tall, thin, and tanned except for two sharp white tan lines like stripes on both of her shoulders. She greeted me with a mug in one hand, "almond or coconut milk?" I took neither. She wore no makeup and was dressed in expensive athletic wear. A large golden cross on a delicate chain hung around her neck. She was eager to chat with me, despite the early hour, and I was eager to listen to her, despite having not yet had my coffee.

Gloria began by apologizing that her husband and children weren't around for me to meet. Her daughter was away at college in California, her husband was working one of his two full-time jobs and her son was staying with friends for the summer on another part of the island. "That's why I do this," she said, gesturing to the large, empty house around us. "No one is ever here anymore. But it's good, I make a little extra this way."

Looking around, I wondered why Gloria might need extra money at all. The house was incredibly spacious and well furnished with a perfectly manicured lawn, an elaborately tiled pool, and an air-conditioned pool house that she also rented out by the month. Her husband worked two jobs and they were able to send at least one of their children to college on the mainland. Her comment left me curious about their financial situation, but I didn't want to overextend my inquiry.

"What does your husband do?" I asked. He was a contractor, she said, and worked on his projects full time Friday through Monday. He worked in a contracting office the rest of the week, she told me. "9 to 5. But it takes him longer to get there and back so he leaves here before 7 every morning to beat the traffic." The H1 artery near the suburbs of Kapolei is notoriously congested with commuters to and from Honolulu during rush hour, which is usually more like two or three hours. "Usually he gets home after 7 too." I asked if he worked every weekend as well. Gloria threw me a mixed look of acceptance and disappointment.

"That's what we have to do to live in this place, you know? That's what most people have to do in order to be able to live here. And we are so blessed to live here."

For Gloria, moving to Hawaii had been a dream for as long as she could remember, and one that she didn't think would ever happen. She spent most of her twenties on pills in Arizona where she grew up, she told me. She'd met her husband right out of college. They got married



young and had two kids, her daughter who was now 20 and her son, 17. She told me that she was clean when she got pregnant but went back on pills following their births.

“I was always in pain,” she told me. Judging by the look on her face, I thought that by “always,” she meant long before her children or anything else—truly always. “The pain pills just normalized me.”

Although she wouldn’t confirm with me how long this habit lasted, she seemed to suggest that moving from Arizona to Hawaii nearly five years ago was what had brought her to recovery. That and her faith in Jesus Christ, she told me, clutching the golden cross hanging from her neck. At one point she remarked that her journey from the desert to the tropics was as much literal as it was spiritual.

“That’s one of my biggest problems with this place,” she said. Seeking her own recovery in Hawaii, Gloria hadn’t considered the animosity and the growing dissatisfaction of locals in Hawaii to the influx of rich white landowners buying and building new properties on which to blast their air conditioners and chill their pools.

For Gloria, the cultural and historical significance of this animosity was instead interpreted and characterized by her opinion that Hawaiians simply weren’t good Christians. I asked if she could elaborate on what she meant by this, remarking that I’d driven past over a dozen different Christian churches on my way to Kapolei from Mānoa. It was how “they act,” she said: she kept emphasizing *they* as though I knew to whom she was referring. “They” are unfriendly and un-Christian, despite belonging to the church. She said there were “a lot of them” at her parish, and that she had even done some outreach in their communities, but that they rarely if ever seemed grateful—they didn’t even smile at her, she told me. It became more clear to me that by “they,” she meant the Native Hawaiian people.

While the majority of those living in Honolulu county report to be secular, approximately 30% of the island's population claims to be some Christian denomination. In reality, in part due to the successes of Christian missionaries' colonization of Native Hawaiian society in the nineteenth and twentieth centuries, Christianity remains a popular religion among Pacific Islanders and Hawaiians. And yet, Gloria had decided that her limited experiences with Native Hawaiians who felt aggrieved over their colonial past meant that they didn't practice Christianity in "the right way." Not only did she blame them for chastising her socially, she also claimed that they had corrupted her son, introduced him to drugs, and were a bad influence on his life.

She had no evidence of this beyond what her prayers had told her about his apparent fall from grace—this, and searching through his room, was how she knew about his drug use. "I pray for him, all the time. I'm sure he'll come around. But you know, none of those kids are from good families. Our church—my church—has programs, like what you're looking at," she said. We had spoken about why I was in Hawaii, studying suicide prevention. (She was glad that I was doing "God's work.") "We reach out to some of those communities too, but they are very unwelcoming to us. Very unwelcoming."

The programs to which Gloria was referring were church-based groups that primarily served to evangelize through outreach. In these models of religious-based approaches to suicide prevention, there is no affiliation with anyone outside of the network of the church. It is entirely unregulated, and the programming itself generally presents the tenets of faith as something compatible with prevention strategies. These are essentially rogue models of prevention which are as interested in gaining parishioners as they are on saving lives from suicide, though their strategies often rely on the hopeless individuals' return to a faith-based sense of meaning in life.

“I sometimes wonder if it’s me, you know? Some days the only person I get to talk to is the cashier at the grocery store. I’ll try and make conversation, you know, talk about something like the weather or whatever, and they won’t even *look* at me.”

It became apparent through Gloria’s apparent anger towards Hawaiians for not providing her the responses she desired that she expected a particular affect: a smile, a conversation, a positive exchange with her, the *haole* resident. It seemed that she thought of them as a part of the landscape, something that should be responding to her, welcoming her efforts at outreach, at evangelization. But it also struck me that part of Gloria’s anger seemed to stem from her literal isolation—from her family, from potentially meaningful connections in her daily interactions, which she imparted were mostly solitary. Gloria seemed isolated, too, whether by chance or by choice, from the narrative of Hawaii’s history of colonization at the hands of Christian missionaries, of which her own church may well have been included. She was unable to reflect on her own positionality and its contribution to that legacy of disenfranchisement, as she both expected and demanded that Hawaiians be more like the version of themselves that she was hoping to see—the version of Hawaii that she sought out and was paying for. Gloria had come to *this* version of Hawaii, a version that existed for her own self-care, a version that she felt should bend to suit her needs.

We were soon joined by two other guests whom I was told were relatives of Gloria’s family, though it wasn’t entirely clear their relation to her. They were newly married and expecting a baby and had come to Hawaii for a sort of honeymoon vacation. I got the sense that Gloria hardly knew them, but she seemed more than happy to let them stay with her for free. I later found out that it was a common occurrence that Gloria hosted acquaintances who came to stay in her

Hawaiian guest house. It was almost as if she'd won the lottery and peripheral relatives and long-lost friends were appearing out of the woodwork, trying to collect some small part of her winnings.

“Gloria’s going to take us up to the Disney resort later today,” the male guest told me. He was referring to the Aulani spa at Ko’olina, a few miles up the coast from Kapolei. “Apparently you can swim in the lagoons there even if you’re not staying at the hotel.”

“That’s right,” Gloria clapped her hands. “That’s because all the beaches in Hawaii are free and public. The land here belongs to everyone.”



**Figure 7 Feral Cat Shelter Parking Lot, Near Kualoa, May 2014**

### **2.4.3 *Desperation Narrative #3: Costs of Living***

Gloria’s story is important in revealing how monetary wealth and “having it all” does not necessarily lend itself to happiness, even in Hawaii. But Gloria’s situation did not seem to be the norm among most people I spoke with. Most people had a much different financial experience, as this last narrative shows.

I was sitting in the back of a hot taxi early on a Monday morning in the spring of 2019. We were cutting across town to a small coffee shop in Mānoa, only about 3 miles from where I was staying in downtown Honolulu. Traffic during the work week is almost always bad in the city, but today it was taking much longer than usual to make a trip that would otherwise take less than ten minutes. My driver, a heavily tattooed Hawaiian man in his mid-40s, jokingly asked me why I wanted to go to this coffee shop anyway. “Why not just go to a Starbucks?” He laughed as we had passed two on the way. I explained that it was a nicer, quieter place where I used to go to get work done—a bit quieter than Starbucks, and with really great coffee. He told me he didn’t drink coffee, but he remarked that he routinely took Japanese tourists to this coffee shop so they could get out and take a selfie. He asked if I knew what that was all about—I didn’t know, but we got to talking about the absurdities of tourism and its impact on his career. Sitting in unmoving traffic, he said that he had quit his long-term career in construction work to take a full-time job driving with Uber.

“Because of tourists like you, I make more now than I ever did before. So I can finally afford to live in paradise,” he laughed, “although I never get to see it—I’m always working!”

Hawaii has certainly not had any trouble earning its reputation as one of the most expensive places to live—not just in the United States, but in the world. Editorials frequently place the high cost of living in context with anecdotal claims about how four rolls of toilet paper cost a ridiculous \$6 and a gallon of milk nearly \$8. And it’s not only goods that are expensive, but the price of utilities like electricity run twice as high as they do in Alaska, the second most expensive state for energy in the country (Census Bureau (U.S.) 2010). Locals rely on these metrics as well in their daily life: the “\$10 gallon of milk” and “\$5 gallon of gas” are frequent complaints, however accurate. In some ways these complaints have themselves become part of the culture of Hawaiian living. There is almost a sense of camaraderie about the high prices, as everyone at the gas pump

or in the checkout line at Safeway is sharing the same small burden of consciously overpaying for goods that are being imported, either by sea or by plane. This overpayment registers to most as one of the inevitable “costs of living” in such a beautiful place, and in the checkout aisle, it is not immediately possible to know the financial status of the person in front of or behind you. Beyond these spaces, however, glaring financial disparities between demographics mark a huge divide throughout the state and specifically in the metropolitan area of Honolulu.

While Hawaii’s inflated cost of living is in a very large part driven by a need for importation, it is also dependent on housing costs, which have soared in recent years to record numbers. As a quick example of this, the average price for a 900-square-foot apartment in Honolulu, a city housing approximately 350,000 of Oahu’s total population of 950,000, sat around \$2,000 in 2017 (Census Bureau (U.S.) 2010). Lawrence Boyd, an economist at the University of Hawaii’s Center for Labor Education Research, was quoted by *Hawaii News Now* as saying that Hawaii has become “a preferred place for the international 1 percent to buy property.” In April 2018, the Department of Housing and Urban Development published the results of its income limitations report. Since 2013, HUD programs for public assistance for housing in Hawaii have increased consistently, in some areas jumping by more than 10% from one year to the next, as the cost of living climbs. According to the HUD report in 2018, a salary in the \$65,000 range is considered to be a low-income salary for a single person living in Honolulu. This number had increased by \$7,000 from a figure of \$58,000 only one year prior in 2017. Startlingly, a family of four earning in the mid ninety-thousands is, as of 2018, now considered a low-income family in Honolulu and eligible for public assistance. Although the Islands have a higher than average median salary compared to the mainland U.S., the average cost of living remains up to two thirds higher than the rest of the country, compounded in addition by one of the highest tax rates in the

United States. Contrary to what might be expected, unemployment in Hawaii is also approaching a record low, which many would see as a good thing if those employed were able to earn enough to pay rent. In fact, news media in Hawaii routinely comments on how “Hawaii is no paradise for college graduates” who, despite finding success in looking for jobs, need to work two or more just to be able to live independently. This has been true for nearly every college-aged individual I’ve met in Hawaii who wasn’t still living with their family, some well into their thirties.

Others are not so lucky. In October 2015, Governor David Ige declared a state of emergency on homelessness in Hawaii. At that time, the rate of homelessness was just under 500 per 100,000 people, the highest per capita rate the state has seen thus far, a rate which had sharply increased since 2010 and has only recently begun to decline in the past two years. Many factors are at play in Hawaii’s homeless crisis, but one of the key concerns for the state is that the cost of living combined with a lack of affordable housing has left those who were until recently living middle class lives, working multiple full time jobs, on the streets alongside the chronically poor, lifetime drug addicts, and the homeless mentally ill.

I met one such individual on a beach along Oahu’s South Shore in 2014. We had spoken briefly, his name was Martin, and he’d been living on the beach for about two years. We met while out swimming just beyond some stark black rocks, and incidentally walked back to the shore at the same time, striking up a brief but friendly conversation. He told me he’d worked in an area hospital years ago. He said he didn’t have family in the area anymore, that after he lost his job he couldn’t afford a place on his own, so he ended up here on this beach—he gestured over to a beach chair, a cooler, and a stained blue tarp tied to two branches of low vine—his “camp,” he called it.

Between my fieldwork during 2014 and 2019, similar setups could be seen throughout all of downtown Honolulu, makeshift homeless camps crowding public parks, sometimes overtaking

sidewalks and all-but-abandoned parking lots. In Honolulu, these camps routinely housed entire families, many of them with multiple small children piled up on blankets laid underneath wooden picnic tables. In 2014, Honolulu City Council introduced a “sit-lie” ban, which its supporters have characterized as a “compassionate disruption.” The idea behind the ban, a supporter told a local news agency, is that if a homeless person is disrupted, “maybe they will be uncomfortable and will rethink their decisions and perhaps accept the help and resources being offered to them.” Waikiki was the first place to enact the ban, mainly as the result of hotels complaining that the nearby homeless were scaring away their clientele. During the sweeps of these areas, people’s homes would be torn down while the occupants were away, their possessions carted off in HAZMAT dumpsters.

Many critics of the sit-lie ban, including local law enforcement, argue that it criminalizes the homeless. One police officer expressed to me that “it’s not against the law to be homeless. You can’t go arresting people for no reason.” Taking issue with the sweeps, he said that forcing people out of these camps, the only places they call home, felt like just that. “Some of these kids living with their families, most of them are going to school. The other kids know they’re homeless. That’s bad enough. Where are they supposed to sleep at night?” In contrast, residents of Hawaii Kai, Hawaii’s second wealthiest neighborhood, shared support for the ban on an online message group led by a local volunteer. According to the website, many residents feared that the homeless population would move into their area following sweeps of downtown. Sherri, a resident, called on her neighbors “to contact the police as soon as you see one tent go up, because soon there will be two or three and then you’ll be outnumbered.” Another resident, not a native to Hawaii, was worried about property values declining in Hawaii Kai because of the homeless. Another expressed fears that the homeless camps may cause damage or set fire to “the million-dollar homes in this



community.” Many of those on this message board felt that homelessness was a lifestyle choice. “These people get a one-way ticket from the mainland,” one user wrote, “they are coming here on purpose and choosing this lifestyle and that’s not fair to keep taking from us all like that.”

In addition to finding a housing solution for those who are displaced, the state faces a much graver concern with the cost of medically treating its homeless population. Though Martin was in his early sixties, was athletic and in good health except for the wear on his skin following years of sun exposure, the overall life expectancy is only around age 50 for Hawaii’s homeless. A physician with the Institute for Homeless Services medical outreach team in downtown Honolulu told me that the health of Hawaii’s homeless has been largely ignored until politicians noticed that “the system was crashing”; and indeed, the medical cost of treatment has become exponential. Just 13,000 people are said to consume more than one billion dollars of the state’s annual Medicaid budget, and the majority of those who repeatedly return for emergency treatment are homeless. A former practicing ER doctor, Hawaii Senator Josh Green sought a radical solution to addressing the grave health risks of homelessness. Part of his proposed solution was to treat homelessness as a medical condition and allow physicians to prescribe housing, paid for by federal medical funds, as a legitimate treatment plan. His hope was to get people into homes and save medical dollars. Green’s plan has indeed helped some find homes, but critics of the strategy argue it isn’t cost-effective. Knowing much of this already, when I met Martin, I didn’t want to bother him too much with questions, but I returned to the beach frequently in the hopes that I’d run into him again and have a conversation occur organically.

It didn’t, at least not again that summer. On a very warm evening the following year, I was revisiting Sandy Beach in an attempt to locate Martin again. I knew he had been living there for some time, as I myself had seen him there two years in a row to this point. When I got there this

time, I didn't see his chair; the surrounding beach vine was empty also. I found myself instead in the large parking lot of Sandy Beach park, scanning the now-gathering crowd for any familiar faces. Sandy Beach is a favorite spot for locals and tourists alike—it is right in the middle of a strip of heavily visited scenic areas and gentle hiking spots—and is a place where, no matter what day or time, groups of locals can be found hanging out. It is colloquially known as broke-neck beach, as more people are injured there than on any other beach in Oahu, due to the heavy but low, and therefore misleading, waves which make it a favorite spot for bodysurfers. More informally, though, Sandy Beach is known to attract a fairly low-key crowd who spend their off days (and nights) barbecuing, drinking, and smoking weed in the parking lot or out in the tide pools.

As I made my way past a pick-up truck with music pouring out of it, I unintentionally caught two large Hawaiian men, leaning against the truck's hood, off guard. They quickly turned to me suspiciously and hid their hands down low, concealing what was clearly a joint, which spilled smoke upward from behind their backs. They looked at me as though I was about to ask them what they were doing, but instead I asked if they'd seen "that one homeless man with the blue beach chair" recently. Was he still around? Relieved at my question, one of the men nodded. They told me they'd seen him, but "nobody lives here now." When I asked where those who had been living here might have gone, they told me that a lot of homeless had moved back into the hills where they wouldn't be harassed.

"You mean by tourists?" I asked.

"No, by cops," they explained.

Because of the homeless sweeps that had been happening in public areas, those who had lived on this beach for years had begun to move out of sight. It was easier to hide your belongings in the forest, much of which was inaccessible by car, they told me. It was also less likely that

tourists would stumble across a homeless camp in the woods than on a crowded beach. “It’s too risky to be out here. You go out to do your business in the ocean, you come back and your stuff’s being hauled away.” With the constant interest of the state to maintain tourism, Sandy Beach needed to uphold its reputation as a hang-out destination, not as a “homeless beach.” But just like the sweeps in downtown Waikiki, it was all about visually concealing a problem. There was no solution, the men told me: no one cares if you’re homeless, as long as you can’t be seen. It was true that no one seemed to be paying much attention out beyond these public spaces. In a sense, the cost of living homeless in Hawaii seemed to be what you could get away with hiding in plain sight.



**Figure 8 View of Sandy Beach (Where I Met Martin) (2015)**



**Figure 9 Homeless in Honolulu From A Taxi Window (April 2019)**

## 2.5 Conclusion: “More to the Story”

Just as Jocelyn Chua has done, this chapter problematizes suicide as a “hovering possibility” (2014:5) in Hawaii. It has used Foucault’s notion of problematization in order to look at the “organization of meaning, discourse, practice, and institutions for defining and acting upon an issue of social concern” (Foucault *M&C* 1965:6). In doing so, this chapter reveals what Gary at the Department of Health expressed to me at the beginning: that there is “more to the story” than the initial concern surrounding the “problem” of suicide in Hawaii. In mapping out some of the issues in Hawaii, it was increasingly important to pay attention to what those I encountered expressed about suicidality as being, in their minds, linked to a wide range of issues including low wages, expensive housing, belonging and displacement, and a sense of lack of possibility. I termed this larger complex the “cost of living” in Hawaii.

Several paradoxes emerged through this chapter: first, the idea that the problem of suicide in Hawaii is not, in fact, a problem at all but rather is a *potential* problem. This immediate shift in problematizing suicide in Hawaii as one thing versus another dramatically shifted the focus of this ethnography away from suicide itself and to the prevention work that is being taken up in the community. Second is this recurrent idea of the paradox of paradise: as Sonya surmised, there is a clash of affect in Hawaii between a persistent “postcard image” and the lived reality of many residents’ tangible struggles. In problematizing hers and other observations further, it becomes evident that there is an inherent subjectivity within the notion of “paradise” itself: what does that mean, from one person to the next? As Gloria’s and Martin’s stories show, these can take very different forms in the politico-economic climate of Hawaii.

This chapter has paid necessary attention to some of the different dimensions of suicidality as they are felt by many of those living in Hawaii. The chapters that follow turn to the stories of

those explicitly providing support or otherwise working in suicide prevention—how people become involved in care—in chapter three.

### **3.0 Becoming Subjects of Suicide Care**

#### **3.1 “Life Is Hell Sometimes”**

It was late May 2016, the last week of finals for university students in Hawaii, and people were starting to clear out for the summer. I was walking over to pick up my car from the behemoth parking garage on the other side of campus, where I’d left it the night before. Parking anywhere in Honolulu, and specifically on an urban college campus so close to the city center, is expensive and limited, so those without a parking pass routinely park for free in the garage overnight. The downside to this arrangement is waking up at dawn to move your car to another free location before the towing crew arrives. Because of this, I spent many early mornings walking from my dorm to the garage across campus, often accompanied by the same handful of people—usually visiting faculty or students like myself—in similar circumstances. Though I took to this grudgingly at first, this early morning routine eventually became one of my favorite parts of the day.

On one of these morning walks, I was looking down at my feet when I noticed a message written in the concrete sidewalk that I’d never noticed before, despite having walked this same way every morning for a month. In between two slabs of concrete pavers, in front of the white stone steps of the campus art museum, someone had carved out the words, “life is hell sometimes.” It struck me as such an odd juxtaposition: under the canopies of tropical trees, their trunks reaching out over a flower-dotted sidewalk that lined the shaded pathway from one beautiful building to another, this dark, hidden phrase.

I had been shocked to hear from Sonya, during our first meeting in 2015, that not far from this sidewalk a young male college student had jumped to his death from a dorm room window. I

was only able to gather a few details about this young man, but I later learned that his name was Steven and that he was only 23 years old. On the day he committed suicide, his body had landed near a group of students who were walking back from classes. One of those students was in Karen's class, she later told me. Karen, the university professor who had become active in prevention efforts, was baffled. Despite having worked on campus for almost 15 years, she only found out about the suicide through her visibly distressed student; there had been no communication about the suicide from the administration.

Later that same year during the summer, and just a few weeks before the start of the fall semester, two young men fell from the 14<sup>th</sup> floor of the Hale Kealoha dormitory. The towering building typically houses about 600 students during the school year, but only a few dozen were living in the property over the summer during the incident. The young men were attending a party hosted by a student living in the dorms, though neither of the attendees were students themselves. They didn't know each other, and no one that I met throughout my research in Hawaii knew either one of them. The local media reported that the anonymous suicidal 19-year-old went alone to an open window. Ryan, 24, saw this happening and confronted the young man on the ledge. According to witnesses at the party, Ryan began talking the boy down from the window. He jumped anyway. Both fell, with Ryan breaking the fall of the one who intended to die. It was Ryan who died instead as the other sat in intensive care at Queens hospital for months following the incident. He has never spoken publicly about the aftermath of his attempt or the death of the stranger who tried to save him.

"Can you believe that?" Karen said to me. "The other guy was threatening to jump and the Good Samaritan dies instead, not even a year after the guy who fell on purpose. And these are just the ones *you've* heard about."

She told me about the others: There were two student suicides in the Biology Department within the past three years. There was a student who was an Iraqi war vet, in his mid-20s, found with methamphetamines on him at the bottom of a campus stairwell. Another young woman on campus, a postdoc, killed herself in a residence hall a year and a half earlier.

“I have students who, to this day, won’t even set foot in that building. This is all just through word of mouth, by the way, that I know any of this. Did you know that a Chinese student committed suicide in your dorm?”

I shook my head. No, I didn’t know that.

“I have brought this up with the administration, trying to get some response from them, and I get these suspicious looks that say, ‘You’re not supposed to know about that.’ But the fact is, I do. People tell me things. I’ve built up a reputation for myself as someone who cares, for whatever reason,” she paused, looking around the café where we were sitting. Karen’s teenage daughter, who was sitting with us, kicked her feet at something under the table. “I’m not always sure if it’s a good thing I know the things I do,” she added.

The incident with the Good Samaritan at the dorm towers caught the attention of the local media in part because of its tragic dimensions, but also because the university had remained strikingly quiet about it, releasing no public or even internal statement, although it had happened on their campus. The administration’s silence—and by contrast, the commotion made by others near to the events, like Karen—became a focal point of my conversations with Karen. Despite the immediate flutter of the community’s interest in the tower deaths, there had been no public comments made by anyone, media or otherwise, about any of the other suicides that had reportedly, through word of mouth from students and others who knew the deceased, occurred on this campus over the past few years. As I learned through Sonya and Karen both, these other deaths had



occurred on different parts of campus within the same academic year. All of the discoveries had been public, but the university never acknowledged or named the deceased. If these stories were true, I thought, then it appeared that life *was* hell sometimes, even here—or perhaps especially here—for some on this campus.

But as Karen’s and others’ stories indicate, there were several Good Samaritans at work in undoing the university administration’s uncaring response to these losses of life. The narratives in this chapter show how individuals like Karen become mobilized not just to provide care, but to produce real labor value in suicide prevention. This kind of impulse to provide care has, in the narratives presented here, largely evolved through a personal proximity to suicide. In this chapter, I discuss how suicide prevention in Hawaii relies on these personal connections: the caring labors of the “Good Samaritans” like Karen; the victims of suicide loss like Iolani; the patients-turned-providers like Sonya. Each embodies volunteering discourses that position “private virtue as public good” (Muehlebach 2012:111), particularly with regard to aiding vulnerable populations. This volunteerist dimension is ironic given public health literature on suicide. That is, suicide is highlighted as one of the most serious and preventable health concerns, yet paradoxically mental health care remains reliant on volunteers to learn and provide suicide care to the at-risk. As a majority of those working directly in suicide prevention lack comprehensive skills beyond their own experiences, it becomes important to understand who is tasked with administering suicide care, how that care is learned and, later, how it is, in my informants’ words, “passed forward” to others. This chapter focuses on how those I met in Hawaii learned to care about suicide in different ways and how their care was transformed into something productive, beginning with and for themselves and then for others—in other words, how they became subjects and providers of care.

In tracking these stories this chapter contributes to a rich body of anthropological work on the experiences of unpaid care and volunteer workers in advanced capitalist societies (Adams 2013; Boris & Parreñas 2010; Nakano Glenn 2012; Malkki 2015; Muehlebach 2012). It also opens up a critique of how state-funded mental health agencies tend to lean on the unpaid labors of care workers and capitalize on the healing arc of personal loss and trauma in relation to those who have lost someone to or are survivors of suicide. In these instances, care worker subjectivities become entangled within the everyday moral discourses of “saving” the potentially suicidal, which for them, functions as both a form of personal healing and preventative type of care. In this sense, the care provided by suicide prevention workers can be read as a practice of self-care *and* an imperfect but reliable product which stands in for the state’s (in)ability to care effectively in most formulations of community mental health in the United States. Looking beyond the tangible services that care workers provide, affective connections to causes—losing a loved one to suicide or struggling personally with mental illness—become powerful motivators for volunteers to feel “a need to help” and an incentive towards community responsibility (Adams 2013; Malkki 2015; Muehlebach 2012). At the same time, this also seems to allow them to view their work as a therapeutic encounter itself (Myers 2015), that is a form of self-care that may offer transformative possibilities (Malkki 2015).

As Sonya’s story shows through this and the previous chapter, caring about suicide in Hawaii developed out of her own personal history. Though Sonya’s care emerged from her experiences, it became legitimized through her professional role as the director of Mental Health America, a role she felt her subjective experiences had prepared her to embrace fully. Possessing the intimate knowledge of suicide that she did and thus better equipped to care publicly for others facing similar crises, Sonya felt she had a moral responsibility. Karen, on the other hand, claimed

to have fallen into suicide prevention “by accident.” She was a history teacher, a nature enthusiast, a conspiracy theorist (only a hobby, she assured me) and a mother of three teenagers. She never expressed any personal connection with or even strong attitudes towards suicide prior to our meetings. Nor did she do so during our meetings. Instead, she became involved by reacting to what she perceived to be a blatant lack of care—an indifferent response to the lives of those she was in close proximity to—in suicide’s aftermath. Her desire to help and the trajectory that her care followed aimed at a more compassionate form of caring and the acknowledgement of those affected by suicide. The way Karen eventually transformed this into an informal organization of her own was, for her, deeply rooted in a sense of moral responsibility and a kind of “ethical citizenship,” to use Muehlebach’s articulation (2012).

In contrast, though Iolani’s was an unimaginable entry into a reality where suicide took a central role, her care became something tangible and productive, both for her as a subject in need of care, and also well into the public sphere with her role in the prevention community. Losing her son to suicide forced Iolani into a position where she was unable *not to* care—for her, suicide became an unavoidable object of her attention. How Iolani chose to respond with action in the form of caring for others in the wake of her son’s death not only shows that care extends far beyond death, but that care in instances of surviving a suicide loss can be transformed into something active. Losing someone to death does not mark the end of our care for them; likewise, surviving a suicide loss does not limit our ability to care only in a passive sense. For Iolani, *doing something* with this loss became *doing something* in caring for others; which was also a way of caring for herself. In doing something, Iolani also succeeded in transforming her status as a victim of suicide to a highly visible figure with real authority in suicide care.

Iolani and Karen’s roles in suicide prevention show how care can be balanced as both

personal and professional, as something that is both deeply affective while also serving a real public utility. And yet, there are clear distinctions between Karen’s informal form of care and Iolani’s care-through-affiliation with institutional modes of suicide prevention. This chapter examines how these forms of care were differently legitimized through their proximities to professionalization and how this serves to either elevate or limit their efficacy and visibility as caregivers in the community. Through the narratives presented in this chapter, I explain how each of these women learned to care in ways that transform suicide for and beyond themselves; how they collectively participate in a type of care where suicide becomes, as Garcia has written, a “form of life” (2010:153); or “passing life forward,” as my informants would say.

The transformative nature of the forms of care presented in this chapter and developed in those that follow helps to articulate the idea of “watchfulness” in suicide, as developed briefly by Angela Garcia in relation to care in the context of prevention. Watchfulness, Garcia writes, is a practice “that opens up the possibility of being-together which is, in the end, the very heart of social commensurability” (2010:182). Caring with *aloha* is, I argue in the following chapter, a real example of this kind of hypothetical watchfulness in practice. The concept of the Good Samaritan is particularly useful in this chapter as those I discuss engage in relational forms of care that put others’ needs first, even in the midst of their own limitations as subjects and distributors of imperfect and nuanced forms of care. I understand this form of relational care in the terms laid out by feminist scholars who view care as something positioned between ourselves and others, something that exposes vulnerabilities and (inter)dependencies between those on both sides of the exchange of care (Butler 2004; Hanrahan 2018; Tronto 1993).

In the example at the beginning of this chapter, Ryan—the “Good Samaritan,” as Karen had called him—exemplifies the ultimate instance of this form of relational care: he stepped in and

sacrificed his life in an attempt to prevent the death of a complete stranger. His care in relation to and for others was exceptional and extended beyond that of his own self. But this form of “exceptional” care—giving one’s life for another—is not realistic in everyday caring. In this chapter, I focus instead on how people become subjects of (suicide) care, and how their care transforms within and beyond themselves into labor that is considered productive, despite its entanglements within inadequate structures of U.S. mental health care.

I begin with a brief review of important feminist theorizations on care and care work that help in grounding the ethnographic pieces that follow. I then introduce the case study of Karen, someone who was brought into caring about suicide with no affective connections motivating her labor beyond wanting an acknowledgement in response to public suicides. Following Karen’s story, I turn to survivors of suicide loss in section four. These individuals, as shown mostly through Iolani’s narrative, take on a tremendous amount of work in preventing suicide almost solely because of a direct personal loss. As Iolani describes the work of prevention as “passing life forward,” the final section of this chapter details an example of how workers become trained, via semi-professionalized workshops, in suicide care. I use this example to highlight some of the complexities at work in the somewhat inorganic process of teaching others to become caregivers. I conclude by returning to Sonya, whom we met in the previous chapter, who balances several types of care in her professional but also affectively-informed role in suicide prevention.

I also want to stress throughout this chapter the notion that care, as I am writing about it, does not need to align with one-or-the-other value in the dichotomous model of good or bad, effective or ineffective, professional or nonprofessional. Rather, care can be both at the same time: in the case of those who I introduce below, care is sometimes professionalized and it is sometimes not. Likewise, it is sometimes driven by personal experience, but sometimes it is arrived upon

without any affective ties at all—and sometimes it's both of these things together. Moreover, the associations scholars frequently make between being a volunteer and/or having an affective reason to care do not automatically establish care work as something that is also not legitimized. As those in this chapter illustrate, being a subject and provider of care frequently blurs the space between paid and volunteer work, personal experience and professionalization. Perhaps this blurring is what makes narratives of care worker experiences so powerful and their care so consequential.



**Figure 10 "Life Is Hell Sometimes," Campus Sidewalk, May 2014**

### **3.2 Becoming Caring Subjects/Workers**

This section provides important theoretical context regarding care and its relationship with labor and subjectification. As I have stated earlier (see: section 1.2), there is no single operational definition of care, as its meaning is continually shaped through context, but scholars have articulated several components of care that are particularly useful in describing the type(s) of care

that emerge in suicide prevention work in Hawaii. Among the points that are most relevant for my discussion is that care is itself a kind of labor and that care is fundamentally relational, although such relationships are often defined by inequality. Care has also been described as a practice, an activity that we do in order to “maintain and repair our worlds” so that we might live optimally within them (Tronto 1993). In the context of suicide care the possibility of “living optimally” implies an intimate form of self-governance which is dependent on connectedness to and with others. While this emphasizes the relational nature of care, those I spoke with in Hawaii who care about suicide produce real labor value through their work in suicide prevention. They are, for my purposes, care workers distributing a particular form of care in preventing (or aiming to prevent) suicide. Central to this discussion of care work in suicide prevention is differentiating between productive/formal and unproductive/informal types of care-as-work. As the narratives presented in this chapter explain, there is a marked social difference between legitimized (via institutional certifications and trainings) and the grassroots, “compassionate” or volunteer form of suicide care. This section theorizes on whether there might be room, in both scholarship and even in mental health policymaking, for understanding a type of care work that is both legitimate and compassionate.

Care work and care workers have become a critical focus for analyses of care that go beyond simply underscoring a feminist Marxist critique of its relationship to productivity and emotion work. Though emotions are central to understanding care, scholars and ethnographers have shown the many contexts in which care work is enmeshed in larger social, political, and economic inequalities (Constable 2007; Ehrenreich & Hochschild 2003). Studies of care in the United States have focused in particular on waged labor within particularly “caring” disciplines—framed as “women’s work” and characterized by their proximity to private spaces and the

domestic. The undercurrent of these studies is that a steady weakening of social welfare programs in the U.S. perpetuates an overwhelming reliance on care workers to meet the basic needs of a growing number of citizens. At the same time, the overall devaluation of care for its inherent associations with women and unproductive labor has created a widening disparity between those who purchase care and those who perform it. The persistent “care crisis” in the United States is evidence enough that care work and care worker experiences are deeply entangled in relations of inequality and social injustice.

Care work has also been articulated as a form of labor in which caring is both the source of value and the product exchanged. Feminist scholars have written extensively about the devaluation of care as work, referring to the public/private split in how U.S. society conceptualizes labors of care in terms of their visibility—these works highlight the visible forms of care as in medicine, and those less visible, private forms of care like domestic work (Green & Lawson 2011). As these scholars suggest, in the U.S., an internalized and “naturalized” form of care has emerged which places gendered, hierarchical values on care work and its functions in society. This division between productive and unproductive labor characterizes the commoditization of care in the U.S. With the marketization of industrial capitalism transforming the household from self-reliance to one dependent on waged labor outside the home, women were historically alienated from inclusion in a productive workforce by virtue of being within the private sphere, and instead were regarded as morally and vocationally driven to provide care and perform reproductive labor in the home. As such, labors of caring within the U.S. have frequently been viewed as being fundamentally altruistic and linked to (primarily women’s) unpaid obligations to care in private: an obligation to care for children, to care for the needy, the chronically infirm, disabled, the mentally ill, the elderly.



As I stated at the outset of this project, it is no coincidence that my informants, articulated within this framework of care as work, are all women.

Despite being perceived as weak in its gendered associations with the private sphere and emotion work, as a form of labor, care extends well into the public: care workers are one of the fastest growing workforces in the United States and have historically contributed significantly to reshaping workers' rights in the context of the welfare state (Adams 2013; Boris & Parreñas 2010; Nakano Glenn 2012). Research on care work has also challenged previous understandings of emotional labor and job alienation (Duffy 2011; Saks 2000). Arguments show that caregivers often construct a belief that they "are a natural" in administering care, a position that allows workers to naturalize caregiving in order to find it more rewarding. Embedded in these studies are notions of morality and altruism in care work and that these sentiments should be reward enough—these kinds of pervasive moral discourses within caring labors exacerbate unequal working conditions for care workers (Malkki 2015; Muelhebach 2012).

It has been argued also that care is little valued in society except when it is honored publicly (Tronto 1993). As an exclusively unpaid yet markedly care-ful labor, volunteer work in the United States has not been approached with the same intensity as studies on care and emotion work, despite being so closely related. I would contend that volunteer work differs from previous understandings of productivity in labor because it is, in fact, a highly visible form of labor. In community mental health care in the United States, for example, volunteers frequently outnumber those in paid professional roles (Allahyari 2000) and, as my ethnography illustrates, also take key leadership positions in community mental health. My informants were all highly visible members of this community. As social welfare programs lapse in the United States, these kinds of care workers come to serve a distinct purpose: volunteer laborers meet the needs of disadvantaged

communities, particularly where state and federal aid is inefficient or unavailable. Anthropologists working on issues of domestic humanitarianism have shown the various contexts within which charitable organizations and volunteer laborers have become a saving grace of underserved groups (Adams 2013; Malkki 2015; Feldman & Ticktin 2010).

Situating care as a form of socially viable, exploitable labor in the United States has been a fruitful mode of framing anthropological questions regarding *why* volunteer workers care (and work) at all. One line of inquiry that is particularly useful is to do with the relational nature inherent in care and care work. Scholarship on care as relational has sought to explain the ways in which we connect to and with others, how we become attuned to others' needs, and how this reciprocal care serves to construct our social personhood. The relationality of care falls under what Judith Butler argues is an inescapable notion of human interdependency: as vulnerable beings (“infants,” in her metaphor), we as human subjects are shaped through our relation to and connectedness with others, and this shaping informs our own subjectivity as much as it does our relationships beyond ourselves (Butler 2004). As our own needs connect to and are shaped by the needs of others, so we are constituted as caring subjects and subjects of care through this relationality. The moralities embedded in these relational exchanges have been articulated by feminist scholars as being the ethics of care.

Care ethics follow Tronto's definition of care as something that we do—a practice—to meet the needs of those who are vulnerable out of a moral sense of self. Tronto argues this is realized through the memory of having been cared for ourselves. Through the act of caring for others, then, we reflect back an idealized reciprocal care, which constitutes ourselves into a caring subject; this is articulated also by Malkki in humanitarianism, which she talks about as “self-to-self” care (Malkki 2015). To care relationally is “to engage with vulnerability by recognizing

someone as a subject in need of receiving or capable of providing care” (Hanrahan 2018) and to have our needs acknowledged in turn. But such reciprocal forms of caring are often imbalanced—especially within regimes of care that rely upon unequal exchanges of power, such as in the doctor/patient exchange. As Mol argues, doctors and health care professionals are themselves embedded in everyday “logics of care” that are aimed at the best interests of their patients, despite the structural imbalances that are entangled with most health care providers’ abilities and limitations to care (2008). Neither patients nor doctors ultimately wish for an outcome of harm within these exchanges of care, but the inequalities persist nonetheless.

But as Butler writes regarding relationality, “ethics requires us to risk ourselves precisely at moments of unknowingness” (2005). There are, in other words, risks involved in acknowledging the limitations of relating to others’ needs, to caring for others and for our selves. As scholars of care in contexts of medical or humanitarian intervention have shown, acknowledging these risks is not enough: in exchanges with subjects in need, caregivers must work amidst their limitations, even if their working reinforces inequalities. Care’s relationality “hinges on the fact that multiple components are brought into relation and into connection” (Hanrahan 2018:2); not all of these may cause harm, but not all are neutral or benevolent, either. Arguably, one of the most vulnerable spaces for relational care to exist in a grey space between help and harm is within the therapeutic encounter, where, as Matza writes, there exists a “deep fissure” between the self and other—one that is ultimately unknowable, maybe even unrelatable (2018:26). In drawing on therapeutic, humanitarian, and affectively-informed approaches to care, suicide prevention seems especially open to the potential of care’s harm, or at least to its inadequacies. The narratives that follow show how those who come to care in suicide are brought into connection with different forms of care-

as-work from multiple vantage points, each of which provide important insights into care worker subjectivities.

### **3.3 Learning to Care in Suicide's Wake**

Becoming involved in prevention work, on any level, frequently stems from what is often a personal impetus to care about the issue of suicide. In more cases than not, workers in suicide prevention have either struggled themselves (with depression, with suicidality) or have lost a close friend or family member. But, as I mentioned at the outset of this chapter, this was not always the case. Karen's story reveals a very different trajectory that lead her to becoming an active agitator for the visibility of suicide and the need for prevention efforts in Hawaii. Karen, a professor at the largest university campus in the state, often remarked on this "accidental" entry into caring about suicide. Having worked with youth for many years, she had come to find herself counseling many of her students through difficult issues. It had become a secondary job, she admitted, for many teachers these days to be "a shoulder for students to sometimes cry on." Karen was also deeply displeased with the way she perceived the university's handling of "difficult topics, including suicide" among its student body. She told me she had felt that, for a long time, people in Hawaii generally didn't like "to dirty the place up" with stories that were unsettling, especially ones involving death. Speaking of one such instance, she told me about a fatal traffic accident that had happened in the center of the university's campus:

There was a kid who got killed on a moped. It was in public, right on campus, middle of the day, there were lots of people who saw this—saw everything. And they [the administration] said nothing about it. So I and my colleague wrote to them and asked,

“What are you doing?” You have to say something compassionate, you know? This *happened*. Even if it’s not a student, it’s a human being who’s dead, and dead on their property. A week later, someone else got hit at that same intersection, at this crossing. So then the administration sends out this message, saying that this person got hit there and they say, in the email, “As you all know, someone died at this crosswalk last week.”

Karen threw her head back oddly with laughter as she told me this: “I mean, how would anyone have known that?”

Before the tragic death of the Good Samaritan in the fall from the dorm towers, Karen told me about another student, Steven. Steven was a graduate student that Karen had never met, but she later found out that he had worked closely with one of her graduate students and a close colleague, whom she said were both “shattered” by the news of his death—although neither one of them were told he was dead until long after his funeral. Steven’s body had landed next to Karen’s student, a student she said appeared agitated in her class a few days after witnessing the death. The student was shaking, she told me. “Steven,” he repeated the name several times. “His name was Steven.” Karen walked her upset student to the counseling center when he told her what he’d seen and that he had since found himself having a hard time concentrating, that he wasn’t sleeping. But, because he didn’t admit to the on-call counselor that he was feeling immediately traumatized, Karen told me that the student was unable to get an appointment to be seen for another four days. Karen felt furious about this, but her anger was most poignantly focused at the university administration for not alerting her—or anyone, it seemed—about Steven’s death on campus in the first place. Hadn’t they thought about the people who might have known him, or had him in class? Hadn’t they thought about the students who might have seen him die?

It was not long after Steven’s death that the Good Samaritan died in the tragic fall.

However, in this instance, the local media became immediately involved in reporting on the death of the student who died trying to save another student's life. The magnitude of the accident in fact caused the story to become somewhat sensationalized through media coverage. Despite the wide circulation of the story, the university itself still released no comment. Karen explained to me that her anger became directed at the inefficiencies of a bureaucratic education system that she felt was "too rooted and territorial and ignorant" to change its ways. But most of all, she was angry at the lack of care shown by the university to its students and faculty, to the people they were supposed to care about. In her mind, the university was a community made up of neighbors—students, staff, and faculty—and when something tragic occurred, the neighbors should be informed. The neighbors should know and care, "because they're neighbors. That's what neighbors do." Instead, Karen was perplexed by the ongoing administrative silence.

In part, Karen's critique relates to the idea of acknowledgement as care. Although she hadn't known any of the victims herself, Karen felt it was important not to simply forget that these people had ever existed; she wanted them written into some kind of public memory. This shows the importance of how acknowledgement is itself an act of care. In her work within the Centro mental health clinic for migrant refugees in Italy, Cristiana Giordano (2014) explains how ethno-psychiatrists practice better care when they stop searching for the "cure" and instead acknowledge the concerns that intersect their patients' lives beyond what matches neatly with their diagnosis. While this is, of course, a different contextualization than I am presenting here with Karen, the emphasis on acknowledging and, in a greater sense, legitimizing those in need of care—whether it's the memory of their life or the validity of their complaint—is much the same. Giordano writes that through acknowledgement, "one can move from the politics of treatment," which for her, enforce a categorization of care—in Karen's university's case, the care that demands only certain

deaths be mourned while others remain secret—to “a different kind of politics of life and care” (2014:287) that places the subject-in-need front and center.

In Karen’s continuing frustration over her university’s lack of acknowledgement-as-care, she became motivated to learn about the university’s protocols in instances of any type of campus death. She quickly realized that there was no protocol for handling deaths of any kind. This was absurd, she felt, but not unsurprising: the bureaucracies in Hawaii, she told me, have “excuses for why they don’t deal with anything sensitive. They never want to offend anybody.” In the case of her university, the administration “claimed the campus is too culturally diverse to propose a protocol. But, wait a minute,” she stopped: “Berkeley is more diverse than we are, and they have a death protocol—almost every university does.”

The protocol Karen was referring to, in relation to any death on university property, simply means that there are outlined steps to follow regarding the dissemination of information following an event of death on or otherwise affecting a campus community. Protocols like these are especially necessary so that the families of victims are notified before the news is made public. U.S. universities typically release a statement acknowledging the event, expressing condolences, and highlighting any relevant and available resources that the university has in place. This is the most common and most sensitive way of responding to a death on campus, and it becomes a particularly useful mechanism in addressing suicide.

As part of her efforts to bring “Hawaii into the 21<sup>st</sup> century,” Karen and several of her like-minded graduate students worked together to present a package of materials to the university administration that included models for dealing with student deaths taken from other universities nationwide. They had pooled their resources, spoken to experts on grief and loss, contacted other universities to learn of their protocols, and put their own protocol draft together. Karen emphasized

to me that a lot of legwork—not just hers, but others’ as well—went into the creation of this proposed protocol. I couldn’t help but notice that there is some irony in the fact that Karen was pushing for a protocol to begin with—something that is so integral to characterizations of what is considered “cold institutional care” (Thelen 2015)—as the primary means of bringing care into the picture on campus. In further bringing together and mobilizing the (unpaid) hard work of others, she illustrates the power in what Vincanne Adams refers to as the “affect economy” (2013). Adams writes how affective responses to injustice or suffering, particularly in the wake of public health and disaster<sup>21</sup> crises, promote “structural relations of inequality, providing armies of free labor” (2013:10) among those who are emotionally incentivized not only to care, but to produce very tangible aftereffects.

In response to Karen’s presented protocol, the university administration gave her their reasons for the silence on Steven’s and other deaths on campus. Their reasons were disappointing to Karen—but they also bring importance to the relational kind of care that Karen was positing. As Karen explained, the university said that because there is no campus police force, the Honolulu PD takes over in cases of indeterminate death. They told her that the police had not satisfactorily communicated back with the university. The administration also told her they didn’t announce the death because they thought that maybe the student hadn’t actually died, and “that would be embarrassing to the institution.” Karen also expressed that while “every stolen moped is reported to the community, deaths are not, because there’s a rule that thefts must be reported. There’s no rule about deaths,” she said. And they didn’t want to make one anytime soon for fear of stepping

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<sup>21</sup> In her case, post-Katrina disaster clean-up as the result of charitable or faith-based volunteers in New Orleans.



on cultural toes. “They said cultural issues are very complicated in Hawaii.” Karen rolled her eyes when telling me this. “I guess a moped is more important than a person.”

The lack of transparency in communicating deaths led Karen on a search to confirm rumors of other student suicides with the county coroner. She had heard rumors and stories from the campus community, but there “was no record or list, just what people tell each other.” So she called the coroner’s office, which she said seemed off-putting at first.

“I had to explain to them that I was a faculty member, trying to find out who’s died here over the past few years,” she said.

Death information being part of public record, Karen was eventually able to learn the names of several former students who had died by suicide, both on and off campus. Once she had these put together, Karen called for a meeting of deans. Only one showed up.

“What struck me was that he seemed to react by being sympathetic, but only insofar as it affected him,” she told me. “He said something like, ‘I am so lucky that nothing like this happened in my area.’ And so I asked him, ‘Well, did you know about the Iraqi war vet? Because he was in your department, and he’s dead.’”

Karen’s self-imposed mission to care about those students lost to suicide dramatically changed her life, and in some ways took on a life of its own. After she published an op-ed about the callousness of the university to its suffering students, she started receiving messages from other concerned faculty members, from students, former students, the parents of one of the victims of suicide. Karen didn’t realize it at the time, but what she had started was gathering the momentum of something resembling a cause. It was during this time that Karen decided to name her group the *Mālama Hui*—*mālama* meaning compassion in Hawaiian, *hui* a term meaning a collective or organization: collective compassion. The *hui* started simply as a space for others who felt a more

compassionate response to suffering among college students was needed, but it evolved to include more and more members.

The idea behind the *hui* was twofold. First and most important to Karen was to grow enough of a presence to pressure the campus administration into formally acknowledging the problem of suicide on campus. Specifically, Karen wanted a death protocol on campus that included an obligatory statement wherein the deceased were identified and their deaths acknowledged. Karen presented many drafts of these protocols and submitted them—seemingly “in vain,” she told me, as her emails all went unreturned—to various deans. She consulted with grief and bereavement specialists at other institutions in order to inform the creation of this protocol. It didn’t get her anywhere, but eventually those people joined the *hui* as well. Karen needed these people on her side: she was a history professor, she reminded me, and this was not something she knew much about. Perhaps that was part of why it was never taken seriously by the deans, she surmised, implying it may have had something to do with her reputation on campus as an agitator. “Let’s be honest,” she said, “they probably don’t even read my emails.” The second purpose of the group was to gather like-minded people together and by doing so, create a space for a more compassionate response to suicide and mental suffering in Hawaii. In creating this collective centered around compassion—literally, a compassionate group—Karen both attracted and sought out other caring members of the community. She interpellated others as well, turning those who were perhaps more ambivalent about these issues into actively caring subjects.

The *hui* was an informal, unadvertised group, so membership in it simply meant being put in contact with everyone else and vice versa—not unlike the Prevent Suicide Hawaii Task Force, almost anyone could get involved. Belonging to this group came down, quite straightforwardly, to care. In fact, at first, it seemed like caring was perhaps the only requirement of belonging to the

group. As I was also invited to join this group and got to know more about the others involved, I learned that there was something else behind this somewhat undefined requirement to care. I can best articulate this as caring *in the right way*: as a member of this group, were your thoughts and motivations in line with Karen's in articulating what she wanted to change regarding attitudes toward suicide and suffering in Hawaii? Moreover, did you, as a member of this group, feel there was something lacking in the responses and attitudes of Hawaii's institutions (whichever ones they may be, but with a focus on the university) to this problem? As such, care here was specifically related to institutional responses, acknowledgement and transparency. Since I was invited to join this group, I assumed that my status also meant that, to Karen, I was considered "someone who cares" in the right way.

Karen's call to suicide care was, as she stated, accidental. She had no real reason to become involved other than her own observations of a system that she felt was badly broken. But her call to action—both to care about suicide at all and then to care enough to form this collective and, later, actively push its agenda—was very purposeful. It arose out of a sense of injustice that she witnessed occurring to people whom she never met, but felt deserved better. Specifically, for all of the as-yet unnamed individuals who had at one point felt so desperate that death was their resolution, Karen's desire for a public commitment to their memory was perhaps the only way to extend care beyond their deaths. Karen's care was driven by a moral sense that death "demands a response from those left behind" (Das & Han 2016). Like the Good Samaritan, Karen and those members of the *hui* were called forth to respond, not just to suicide but to loss and to suffering and to the void of care that seemed to surround those whose identities had been marked by the method of their death rather than the memory of their life.

Didier Fassin writes that, in viewing lives statistically, they become "not only more distant;

they are also more opaque” (Fassin 2016:777). He explains, in an example taken from Thomas Schelling (1984), that when people are faced with helping a real person—a “little girl with brown hair” who needs an organ transplant to make it to Christmas—versus supporting a hospital in need of funds to provide preventative care to a statistical but inevitable number of patients, the check will almost always be signed over to the little girl: “We are more susceptible to act in favor of the little girl than of the prevention measure not only because we are moved by her concrete situation, but also because we cannot seize the abstract reality of the second example” (2016:777). For the institution that Karen was pushing against, not naming the dead was an intentional way of managing an otherwise “concrete situation,” like the hypothetical little girl’s. Not naming or acknowledging the dead rendered their lives into an abstract reality, as socially and morally invisible (2016:777).

Karen’s purposeful care, without an explicit personal connection to care at all, is central to my discussion on care precisely for how she attends to this social (and, for Karen, moral) invisibility. With Karen, it wasn’t prevention *work*—in putting all of this, as she said “legwork” into her efforts, she never ran hourly workshops or trainings or distributed information in any formalized way. You would not have known, from reading her many accounts or emphatic calls for attention to the deceased, that Karen didn’t actually *know* any of the victims of suicide in Hawaii—she only “knew people who knew people” who knew victims—but she was activated to care about these deaths in such a way that it became some of her life’s most important work. Karen’s is an example of what it means to be “watchful” in suicide. For Karen in particular, “watchfulness” does not require a deep, personal connection or affective tie; rather, as Lisa Stevenson writes in relation to suicide prevention hotline workers, it requires nothing “except that one is a caring human being” (2014:87). I recall how Karen told me of a girl, a recent alumna of

the university that she had never met herself, who had died by suicide out of state about a year or so before. “Students here on campus had this beautiful service for her, out by the water, and took tons of photos. We decided to post them on our (*hui*’s) page, just to say, ‘here’s someone that we just want you to know about. Here’s someone whose life should be remembered.’” Those students, Karen told me, hadn’t known the girl, either.



**Figure 11 Empty Flowers/Leis Stand, Honolulu Airport (April 2019)**

### **3.4 Survivors of Suicide Loss**

While Karen’s entry into suicide care revolved around a form of justice-seeking for some acknowledgement in the face of uncaring public silence, Iolani faced something entirely different. Iolani, and many others like her, is a survivor of suicide loss. Survivors are the people that are left behind: they are the families, friends, neighbors, and colleagues of those who have died by suicide.

The depth of pain and the unimaginable struggle to make sense of their own lives following their proximity to a loved one's suicide is something survivors share with one another. As I have mentioned throughout, survivors of loss represent a significant percentage of the workforce in suicide prevention. Much of the time, this work is unpaid—for example, survivors often volunteer their time to speak to and with other survivors of loss. In one sense, this was a therapeutic act for their own self-care as much as for others. But it was also not uncommon for me to encounter someone in a highly visible professional position in suicide prevention who was also a survivor themselves. This section tells Iolani's story.<sup>22</sup> It is a story about someone who was painfully thrust into a world where caring about suicide was unavoidable.

The Pālolo stream that flows through Mānoa, where I had been living during my fieldwork, continues on through Waialae Ave up through the Kaimuki area, which is where I was set to meet Iolani in her home in Wilhemina Rise. Our first ever exchange at the awareness walk in Ala Moana Beach Park was brief, but since then I was able to attend one of her suicide prevention training sessions, where we had a chance to talk more. She agreed to an interview with me, and so on this day, I was invited to meet her at her home. I had been dreading meeting with her outside of public event functions, somewhat anxious over the fact that her private life had, to this point, been shared only amongst a crowd. I was unsure how this might shift when in the intimate setting of her own home.

Iolani's son, Kaleo, had killed himself more than fifteen years before. She had since

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<sup>22</sup> As I explain in section 1.4.7, to protect the confidentiality of the survivor-workers I spoke with and to honor the memory of their lost loved ones with maximum sensitivity to the specific details of their stories, I combined multiple stories of loss into one amalgam composite character, as represented by Iolani.

become an outspoken member of suicide prevention campaigns throughout the state of Hawaii, sharing her story and the stories of Kaleo’s life with all who would listen. It was, as she put it, both a way to “lift him up” and a way to “put a face to suicide.” She said that talking about him was always bittersweet, but she knew how “important it is to share these words with others.”

Since Kaleo’s death, Iolani had taken on many informal and formal roles in community suicide prevention. By the time I met her at the awareness walk, she was already cemented as a central figure in suicide prevention work in Hawaii—not just on Oahu, but throughout the state. Within all of the many overlapping circles of community prevention outreach, she seemed to be known and known well by almost everyone. Her actual role was a little more unclear: unofficially, she was the head organizer of community outreach, the head volunteer of volunteers, even known affectionately as “Auntie Iolani” to all those involved. A former pediatric nurse’s aide in years past, she was warm and outgoing, soft but also outspoken, and fundamentally took her nearly decades-long role in volunteer work within this community very seriously. Officially, Iolani was the state liaison for the American Foundation of Suicide Prevention’s Hawaii chapter, the founder of the Prevent Suicide Hawaii Task Force (PSHTF, discussed in previous chapter), and the go-to person regarding information on any and all programs dedicated to the purpose of saving lives from being lost to suicide. While so much of the rhetoric surrounding these prevention efforts in Oahu claimed to save lives, Iolani believed, with all that she had, that the work she and others did in this community truly was life-saving. For her, preventing suicide was entirely personal—and yet she had also become a professional within this community, and saw it as her job to “care and to pass life forward.”

Almost 20 years ago, at age 16, Iolani’s youngest son purposely drove his car off a cliff near Waimea. Car accidents in Hawaii were not uncommon, but Kaleo had left a note. The details

of his note were never shared outside of the family, and I never asked, but Iolani had told me that the note was left for them to find on their kitchen table. Kaleo told his family that he couldn't take it anymore and that he was sorry. This was all I knew about the event of his death, as Iolani did not talk much about the whys or hows of her son's suicide. To her, the details were not only irrelevant, they were also dangerous. Those working in suicide prevention agree that sharing the methods, causes, or rationales of a suicide death is not useful, and can in fact be harmful to vulnerable individuals who may be considering the same. In addition, contagion was a serious concern in Hawaii: things "move faster in the Islands," I was told, and so the methods of suicide deaths were typically reported sparingly<sup>23</sup> in the media for fear of copycats—although this was not always the case.

Iolani's house was small and a little dark inside, despite the midday summer sun. She greeted me and gestured inside towards an overstuffed floral sofa. When I walked in, I felt a little like I was meeting with a different person than the one I'd met several times before. Her generally warm and welcoming demeanor seemed to harden when it was just the two of us, and in those private conversations she became a little more distant. She had deep set eyes that strayed, and I could never tell if she was bored or irritated when talking to me, and I tried to keep our talks short for that reason.

There was a row of photographs on a wooden shelf in her living room, all of them of her and Kaleo. I sat studying the pictures while she went into the kitchen to grab a glass of tap water.

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<sup>23</sup> I also try to refrain from what may otherwise be seen as sensationalizing a suicide by reporting on the method of death. Only when that particular method may be helpful to understanding a larger point do I reveal these details.



Encircling the photos was a yellow and white lei, and at the center of them rested a smooth, painted stone that spelled out his name in green. In one of the photographs, Iolani stood with her arms around Kaleo and her other three sons, one of whom was wearing graduation robes and several leis around his neck. I pointed to the photo.

“That looks like it was a good day,” I commented, as she walked back into the room.

“That was Neil’s graduation,” she said. She set the glasses down. “We were all so proud that day. Everyone kept saying to him, ‘you’re next, Kaleo.’”

Iolani had five children in total, Kaleo was the youngest. They were all boys except for her third, a daughter, all of them “good kids.” In contrast to the others, she told me that Kaleo was always pretty quiet. “He was a very good-natured child. He did well in school, listened to his teachers, never fussed. He was a sensitive soul, kept to himself.” She told me that Kaleo was a straight-A student at Kaimuki high school, the same school his mother went to in her youth, and only a short walk from their family home. He excelled in “any subject that required a lot of focus, like math. Anything that required attention to detail. He was very detail oriented.”

I had heard Iolani tell people before that her confusion about her son’s suicide was that he didn’t seem to be struggling: not at home, not in school. Nothing bad had happened to him—at least, nothing he had shared with anyone while he was alive. “He was affectionate. He was always giving me hugs when I came home from work. My other boys were sweet too, but he was special like that. He was a real mama’s boy,” she said. “But you know, sometimes, all of that is just a mask that someone is wearing.”

A few months after Kaleo died, Iolani became stuck in what she called “a cycle of grief,” where she found herself alternating between feeling absolutely miserable and full of energy. Part of it, she felt in retrospect, was that she had stopped leaving the house. Kaleo was the baby. As a

voluntarily retired mother of five, there was no one to look after once he was gone. Her husband was still kicking around his job as a city bus driver. Her other kids were either married with babies of their own or were pursuing education and careers—pursuing lives independently from their mother. This was how it was supposed to be, Iolani reminded herself. She thought briefly about returning to work in pediatric nursing, but it had been several years since she'd left and she didn't want to feel like she was moving backwards.

Looking back, Iolani said that nothing had seemed possible after Kaleo's suicide. Though she could not remember exactly how long it took her to become active again, it was likely for this reason—her not leaving the house—that her children convinced her (and their father, also) to attend group counseling with other survivors of suicide loss. At first, Iolani said she was skeptical that therapy would help. Having worked in healthcare as a pediatric nurse's aide in Honolulu, Iolani did not have much faith in positive psychiatric intervention. Part of her job had included working with young children in the foster care system, many of them with residual psychiatric problems from within the homes where they had been removed. She had seen the system's failures and tended not to think highly of psychiatry in Hawaii.

But even just in looking, Iolani soon learned that there were limited resources for this kind of therapy—in fact, there seemed to be no counseling available for survivors of suicide loss in Hawaii. Now was when, Iolani told me, her own personal need to cope transformed into activism. With the lack of resources available to people in her situation, Iolani said she realized there was a gap that she might be able to help fill. Instead of focusing on the past, she now saw a future ahead where there was something she could *do* about suicide, not just for herself or for the memory of her son, but for others in equally tragic circumstances.

The energy that this brought to Iolani's life became “a little hard to stop once it got going.”

As I met her, nearly 20 years after she began this work, she admitted to me that she never anticipated that she'd end up where she was now—where *they* were now, as a community.

“We all have stories about how Iolani sort of lit a fire underneath us,” Iolani’s colleague at the Prevent Suicide Hawaii Task Force (*see*: section 2.3) said when introducing her to a group of us gathered at a statewide suicide prevention conference. “In the wake of the tragedy of losing her son, Kaleo, she transformed her life to service and to help prevent more suicide and suicide attempts in Hawaii.”

“She’s been absolutely instrumental in the Task Force,” another member said. “It was her vision that we needed a survivor organization in Hawaii. She was the one that pushed us to apply for the charter for the American Foundation for Suicide Prevention, to get ourselves our own chapter,” he said, and turned to face Iolani. “*Mahalo* for all of the passion you’ve placed in our hearts for this work and for the continued health and wellbeing that you spread everywhere you go throughout the state.” As another told me later, “every movement has a heart, and Iolani is ours.”

Iolani, who was well-connected to the community in Oahu, told me that she had reached out to her friend on City Council after Kaleo’s suicide. She had set some lofty goals, wanting to accomplish substantial things during this period, she told me. One of those things was setting up a local chapter of the American Foundation for Suicide Prevention—an organization that would help to establish a Task Force in Hawaii—which she was able to do with funding from the State Department of Health. The other was to put forward a bill dedicating a small part of the annual state budget to suicide prevention initiatives and setting up a state-funded, statewide Task Force.

“In context of the, what, 13-billion-dollar budget? Setting aside \$50,000 or so for, you know, saving lives—you wouldn’t really think that would be a leap of faith. You’d think that would be a pretty easy in,” said Jay, a now-state House Representative in Hawaii. Iolani and Jay

had put the bill together in the mid 1990s, but explained how it died on its last day in Congress. “Think about what would happen if a catastrophic number of people were losing their lives to suicide. If you talk about 150 people dying in a hurricane, a crash, a flood. You know, that’s not the point. The number should not be the point. One life is priceless,” Jay said. Several years later, they passed the first bill dedicating state support to suicide prevention. “We got our local chapter. And now, in May of 2019, I’ve got another bill going on the floor to make this Task Force permanent, and set up a statewide suicide prevention committee.”

Iolani’s connections were helpful in her making strides in advancing suicide prevention efforts in Hawaii, but they were not essential. As her story draws from those of similarly active individuals who were also survivors working in prevention, this shows that the mobilizing effects of personal trauma promote real labor value in suicide care. In the previous section, Karen pushed the boundaries of her own free labor (and that of others) in attending to what she determined to be a care-less system. But Karen’s care was not associated with professionalization—in fact, Karen had surmised that it was in part *because* of her lack of expertise that the university hadn’t taken her seriously. Iolani, and other survivors facing similar circumstances, began from a starting point of affective care rooted in personal experience that was mobilized into producing real value.

But, as Vincanne Adams has also suggested, the value of affective labor is dependent on its associations with tangible outcomes: affect calls for “emotional responsiveness and generates an inducement to action, and as such it generates new business investments and free labor for a struggling socio-economy” (2013:174). The link to/with professionalization that Iolani had elevated her status as someone in the community and expanded the networks of suicide prevention in Hawaii. This is similarly the case with Sonya, from the previous chapter. This is an important point because it highlights the potential of affect to produce real productive labor value: in this

sense, prevention rests on people like Iolani and Sonya who will take up the responsibility of care up to and including professionalization. In other words, they are affectively engaged to work in prevention *and* they have legitimized this affect productively through further professionalization.

For Sonya, the director of Mental Health America in Hawaii, learning to care about suicide was shaped entirely through her lived experience as a survivor of a different kind. She told me she felt she could identify what she referred to, in chapter two, as “desperate feelings” in other people because she’d experienced this desperation herself firsthand. Sonya, who had studied social work in graduate school and worked in a women’s homeless shelter prior to becoming the director of MHA in Hawaii, saw her own authority as one rooted in experience and often shared this with the public. In person, Sonya explained this expertise clearly and without any shame: she told me about her suicide attempt within the first half hour of our conversation. She’d grown up in a planned community in Southern California, she told me, and was “the lesbian child of conservative Jewish parents.” Her first suicide attempt happened during a particularly bad year when she found herself living on the street in Sacramento. She had been in and out of women’s shelters, both as a volunteer and as a resident. She hadn’t known it yet at the time, but her behavior during that time of her life, which she described to me as “erratic,” was “classic bipolar disorder. I didn’t know it, but I had a dysfunctional brain. It finally blew up in my face.”

Surviving her suicide attempt made Sonya realize “that there was something really wrong.” After a voluntary stay in a mental institution, she learned that she was bipolar, a diagnosis that she said she feels very confident in and is therefore very public about. I asked her about her comfort with this public identity: did she not feel anxiety that her authority could be questioned because of the irrationality associated with the mentally ill (Martin 2007), or as Sonya framed it, her admitted “dysfunctional brain”? She told me she didn’t feel anxious at all. Though a lot of people might see

the mentally ill as unreliable, Sonya felt that her actions proved otherwise: “It’s a part of who I am. I know my limitations and I act accordingly. I embrace it.”

And Sonya did actively embrace this identity. She told me she felt that her survival from suicide made her more knowledgeable about her job, knowing what it feels like to suffer mental anguish on that scale. Anthropologist Emily Martin has argued similarly regarding how her subjectivity as someone living with a diagnosed mental illness allowed for better insight into her study of manic depression (2007). Like Martin, Sonya too seemed to impart that her authority in being able to care for others was due to her own subjective knowledge: perhaps people trusted her more because of what she’d been through. Maybe what she’d been through allowed her to see others more clearly, too. As she put it, “who better to talk to these people than one of their own?”

In questioning the social construction of mental illness, Ian Hacking proposed different terms for theorizing the classification of mental disorders in his notions of interactive and indifferent “kinds.” For him, the interactive kind applies to a type of feedback loop which includes individuals and their classifications. There is an interaction, he says, between how we understand those who have been diagnosed, how those diagnosed understand themselves, how institutions take shape around them, and the independent classification *of* a diagnosis. The awareness of one’s classification within a diagnosis further affects how they perceive and conduct themselves. The example is of depression as a type of classification through which our biology can be changed by following a lifestyle of prescribed modifications reinforced by psychiatry: the depressed person adopts behaviors that appear to change the chemical condition of the brain synonymous with the classification of depression and its remediation (1999:123). Psychiatric classification is thus a problem of “moving target” diagnosis and diagnosed (114): we are always engaged in conversation with classification and vice versa. This concept shows that there is a dynamic movement between

our classifications and ourselves—we are not one thing or another. Sonya, for example, personifies this through her acceptance of her own diagnosis. To her, having the knowledge of her own classification shaped her social and personal utility and transformed her experience into expertise.

This type of engagement with care informed by a personal diagnosis constitutes a form whereby the person or thing being cared for is also a “moving target.” As those in this chapter have shown, the positionality of those *cared for* and those *caring* in the context of suicide are also dynamic subjects whose roles and authorities shift temporally: those within encounters of care and caring, such as Sonya, change places between subjects providing and/or receiving care. And similarly, they change classification as irrational and rational subjects via their proximity to what counts as a professionalized form of care. In becoming a “rational” subject, Sonya went through some form of legitimization herself: first, through her formal education in social work and then, through her role with Mental Health America. Iolani, too, was transformed from a victim of suicide loss—someone who had become socially invisible, someone who felt unproductive—to someone in a highly visible, public-serving role with real consequence. Her choice to enter into this role of caring for others opened up transformative possibilities that not only gave her, as she put it, “something to do” with her painful past, it also provided her with new affective experiences—new forms of caring for herself through the social care of others. Additionally, Karen found herself creating a new social group of compassionate individuals—a sociality emerging as a form of communal care around her efforts to care outwardly for strangers.

As Malkki argues, care of the self is one of the central reasons why many seek out the chance to care publicly for others to begin with. This relational form of care, she says, allows people to feel a “part of something other and bigger than themselves, to *imagine* themselves [...] as members of a greater ‘community of generosity’ and help” (2015:12). In each instance, those

described in this chapter connect in some way to this type of sociality. As Iolani talked about wanting to “pass life forward” to others, it was also the case that she was, in fact, passing her own life forward—even perhaps passing her son’s life forward, as something no longer bound to its finality but rather with a social life of its own. The self-care of Sonya, vis-à-vis her work, relates directly to her own history of illness, recovery, and the knowledge she had to offer others caught in this same cycle. She found “her people” in this kind of care. For Karen, finding a cause to fight for—the acknowledgement and public care of others—gave her a profound new sense of direction. Even though her self-care was not as aligned with personal healing as it may have been for Iolani and Sonya, she drew a larger and larger social circle around herself as part of her efforts to bring people together within a compassionate cause. These stories offer insights into care worker subjectivities and sociality, revealing what seems to be a constellation of possibilities of care in care worker experiences. I now turn to the final section of this chapter, which shows, by contrast, how being trained to care presents yet another possibility of care in this context.

### **3.5 Being Trained to Care**

Becoming trained in suicide prevention is a strange thought exercise—or at least it was for me. On the one hand, it is difficult to conceive of a situation in which some of the rather obvious material presented in trainings and workshops would not be intuitive to someone in any proximity of administering care to the potentially suicidal. On the other hand, trainings provide specific sets of skills that many people need as a condition of employment. As I mentioned in chapter one, the types of trainings that exist for becoming a caregiver in suicide hinge on two temporal moments of care: *intervention* and *prevention*. Each of these sites of care in suicide treat its urgency in



different ways. Intervention occurs at the level of an encounter, a defined moment wherein the care-seeker, usually a caller (as in the hotline, text, or chat encounter), is acutely experiencing symptoms of suicidality that constitute a “crisis.” A crisis, in the context of suicide, is a perceived level of threat: is the person on the other end of the encounter in immediate danger of experiencing or inflicting harm on themselves or others? A suicide crisis is handled from multiple angles, triaged by its urgency, oftentimes engaging with emergency medicine, law enforcement, or both. A person who seeks help in suicide and admits to being at acute risk of harm is intercepted with EMTs and police officers on site, whereas those who claim to be experiencing thoughts of suicide might be referred to an E.R., to a therapist, or to another specialist.

Prevention, in contrast, operates at the level of community engagement and functions primarily as outreach intended to inform and reduce, rather than stop an individual instance of, suicide from occurring. Those I discuss in chapter four invoke the importance of *aloha* as part of being a caregiver in suicide—theirs is a broad application referring to both intervention and prevention, although from examining their explanations of *aloha* closely, it seems its utility lies in its applicability in prevention. But as Stevenson and others (Backe 2018) have written, the crisis intervention model can similarly be useful for understanding where and how different modalities of care converge when those providing care are bound by anonymity and the rigidity of scripts. As I learned throughout this project, and as I have mentioned throughout, becoming trained in suicide prevention is not difficult: the process is neither discriminatory nor rigorous. In some cases, workshops purport to be able to train suicide prevention specialists “in as little as one to two hours.” Over the course of this research, I attended several training sessions as both a participant and as an observer. On more than one occasion, I was somewhat surprised to receive a certification

at the end of the session—it seemed that, after a day of educational presentations and some roleplaying, I too had become a certified suicide prevention specialist.

For my purposes here, and to conclude this chapter on the subjectification of care, I share an institutional training program, called QPR, that was designed for those with some proximity to professional work in mental health and sponsored, on this occasion by a healthcare network in Honolulu. This was a typical community workshop in suicide prevention that uses institutional language in training “gatekeepers” to provide care in suicide. “Gatekeepers,” as I will explain below, occupy a variety of positions within a wide sphere of what is considered mental health care. These kinds of workshops are available nationwide<sup>24</sup> and provide a kind of best practices approach to prevention. Including a discussion of training in this model of care is important not merely to furthering the argument of this chapter about X and Y, it also helps in setting up the stakes for why and how *aloha* care offers something different in its approach.

### **3.5.1 *Question, Persuade, Refer***

A wide sidewalk curved up and around the front entrance of a large hotel near the city center, where I was to attend a different suicide prevention training in a conference room one morning in downtown Honolulu. The sidewalk just outside the hotel was cluttered with shopping carts spilling over with plastic bags, stuffed full into puffy circles that held clothing items, canned

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<sup>24</sup> I previously attended a QPR training session where I live, in Pittsburgh, PA. The presentation and material were all consistent with what was presented in Hawaii.

goods, and various other colors and shapes I couldn't quite make out, except to know that these belonged to the several homeless who were congregating nearby on the sidewalk. Standing just beyond a group of them was an elderly man in poor physical shape and minimal clothing, who appeared to be in the throes of an episode of schizophrenia, shouting and gesturing aggressively towards an invisible figure in front of him. I stepped out of the way of this scene as I continued to walk along the path to the hotel entrance. As I entered the hotel, I was stopped in the front lobby and asked to fill out a required registration sheet and nametag. The hotel clerk holding the registration forms checked my identification. Perhaps sensing some unease at the immediacy of this interaction, the clerk informed me that I was welcome to proceed to the hotel restaurant for free coffee—just make sure “your nametag is visible.” As he said this, I caught his eyes looking outside at the man on the nearby street, hallucinating a conversation into the open air.

Attending trainings like this one often made me feel viscerally disconnected from the realities of those upon which they intend to intervene. In this particular case, walking past a group of homeless mentally ill suffering in broad daylight and into a comfortable building boasting free amenities felt surreal and sad, knowing that the topics we would address in the training focused, in part, on how to recognize a crisis in other people and what to do about it. When I got to the conference room, I noticed how few people I recognized and felt strangely out of place. It seemed that most of those in attendance were affiliated in some way with clinical work—EMTs, clinicians, medical aides, and so on. After watching a short opening video presentation, the purpose of the training was explained in greater detail to the group of about two dozen people. The certification we were there to receive was called Question Persuade Refer (QPR).

As it was explained to us, QPR—meant to remind users of the life-saving CPR—was designed to be an accessible, brief, and memorable educational program to teach “gatekeepers,”

whom the program defines as “those who are strategically positioned to recognize and refer someone at risk of suicide (e.g. parents, friends, neighbors, teachers, coaches, caseworkers, police officers),” the warning signs of suicide and how to respond. In educating people broadly on these topics, the “practical and proven” program adopts a three step response to engage with the suicidal person: *question* their motivations, *persuade* them to get help, *refer* them to services (Aldrich, Wilde, and Miller 2018; Litteken and Sale 2018). Explaining the first step of the program, questioning someone’s intentions, the instructor stressed how it’s important to directly ask a person showing any potential warning signs: “Are you thinking of killing yourself?” Clear and direct language was important, the instructor said. The idea of this scenario produced some grumbles and low laughter from a small group of clinicians sitting in the back of the room. The second step, persuading the individual to seek out and accept help (more laughter from the back) was explained to use as a process of triage based on severity: “If it’s an immediate problem—if they are going to harm themselves, or they have a weapon—they should be taken to the E.R. If they are just having thoughts of suicide, persuading is more about accepting future help.” Following the persuasion step was referring the person to the right level of care. The instructor referred us to memorize two toll-free hotlines and suggested that those working “in the field” (such as EMTs) carry a card with a list of resources.

QPR was essentially a process of shifting responsibility from the immediate caregiver (in this case, it could be any of us in the room) to various levels of care—in other words, triaging as a way of “prioritizing those who must receive medical care immediately over those who may wait” (Nguyen 2010:10). Within the triaging process are subjective and potentially inaccurate assumptions about which kinds of behavior “count” as requiring immediate care versus those that are less time-sensitive. My concerns in this triaging model in suicide are twofold: in assessing

someone's need, the severity of symptom must be somehow explicitly stated, which is not always possible for those with suicidal ideation. For someone's intentions to be explicitly stated either requires the caregiver to successfully interpret their signs and symptoms, or it requires a suicidal individual to express their intent. Another concern is that the training itself is so brief: QPR training in fact boasts its efficacy by claiming that certifications can be achieved in workshops "as short as 1-2 hours." Anyone, almost anywhere, can become certified in prevention; QPR is endlessly convenient and trainings are accessible online or in person. The program even emphasizes that it is customizable to train within specific demographics: for example, if the focus of the training should be on youth or school students, the session can incorporate local data regarding statistics on suicide among students and can address the district's protocols for responding to suicidal behaviors. While there is nothing inherently flawed with this system, it struck me as being overambitious: the idea of becoming certified in suicide prevention in such a short time, recognizing the "immediate" signs of suicide, and making clear and direct inquiries to the suicidal was, as the attendees' laughter perhaps implied, somewhat hard to believe.

After watching another short video, we were instructed to break into groups of three for a roleplaying exercise. I moved myself closer to the laughing clinicians in the back and formed a trio with two of them, both about my age or perhaps a little younger, a young man and woman. We introduced ourselves to each other briefly—they were both working as EMTs—as we looked down at the papers that had just been handed out to us. We were to roleplay a situation: one of us would be a person considering suicide and the others would have to employ QPR. I was handed a card that explained my fictional situation: I was in debt, had just lost my job, was supporting a family of four, and was considering suicide. The other two were supposed to be my concerned family members. We each had a list of prompts on the card—they would ask me a question based

on the short situation written out on the card, and then they would listen to my responses (which were meant to show warning signs of suicide). The goal was for them to ask me the “right” questions and refer me to treatment, following the QPR strategy.

Having been given the “victim” card, I waited for their questions so I could answer as though I was exhibiting one of the warning signs we learned about during this training (withdrawal, talking about finality or death, giving away possessions). The young woman started us off, asking me, somewhat awkwardly: “How was your day at work?”

Me (reading from my card): I lost my job today.

Young woman (reading): Oh, no. How are you feeling about that?

Man (to us): I mean, I bet she’s feeling pretty bad, right?

We stopped, all of us smirking a little in agreement. Of course, anyone who’d just lost their job would be feeling badly, he said. He continued, reading: “We can help you look for another job.”

Me (reading): I don’t know how I’m going to support our family.

Young woman (improvising): Are you having thoughts of suicide?

She and the man both laughed, and I found myself joining in. We all found it funny, one of us saying something along the lines of “well, that escalated quickly.” And it had: it wasn’t a natural conversation at all. I reminded myself that it wasn’t designed to be, but we still struggled to find a good rhythm in this exercise. We started again—we were supposed to be talking about how our fictional family would get by financially.

Man (reading from his prompt card): We can sell the car and some other things.

Me (reading): We can sell my sports equipment. I won’t be needing it anymore.

Young woman (reading): We don’t have to sell that, that’s yours. That’s important.

Me (reading): Don't worry. I won't be needing it anymore.

Man (reading): What do you mean?

Me (reading): I won't need it where I'm going.

Man: No one talks like that. Why, where are you going?

Young woman (to him): She's going to kill herself, *obviously*. (to me) Are you having thoughts of suicide?

Man: But who would actually ask that? And who would just say "yes! Yes, I'm planning to kill myself."

The young woman laughed, also in disbelief. "I know," she said. "This doesn't happen."

This moment during the training event was illustrative of how forced the process of being trained to care feels, especially in its reliance on canned responses and static interpretations of black-and-white symptoms. It was evocative as well of how being trained to care in suicide is somewhat emotionally and spatially disconnected from the way that care might actually manifest in real time. Although this exercise related to a fictional situation, and one that was moreover dependent on our own group dynamics, we each expressed trouble relating real life to this model. On the one hand, the clinicians felt it unrealistic that someone might be so lucid during a crisis. Both group members, clinicians in emergency medicine, told me they had a hard time believing that anyone would be so forthcoming about expressing thoughts of suicide. In their experience, working with "addicts, overdoses, and the homeless," there was often barely a response to any medical questioning at all. On the other hand, though both expressed doubt in the applicability of the training in general, they digressed that: "We just need to have the certification." Having this institutional program's certification, achieved in just a few short hours, legitimized their ability to

care for the potentially suicide should it ever be necessary<sup>25</sup> in their jobs. But in many ways, this training seemed to underprepare workers for the possibilities—and the nuances—that may or may not be exposed in suicide care. It also begged the question (to me) of whether or not having an affective incentive to care, drawing on some kind of deeper knowledge of crisis, might in fact be invaluable in providing this kind of care.

### **3.6 Conclusion: Becoming Subjects of Aloha Care**

How do we become caring subjects? In suicide, what does it mean to learn (or to be trained) to care? This chapter has shown some of the different trajectories of those who become involved in suicide prevention, each of whom bring multiple perspectives, personal histories, knowledge, and self-motivated causes into their work. As it does in so much of the United States, suicide prevention in Hawaii relies on these complex, intimate connections because it functionally relies on the caring labors of “Good Samaritans” like Karen, Iolani, and Sonya. As Sonya mentioned to me in chapter one, volunteers and otherwise caring individuals make up double the paid workforce in prevention. The individuals in this chapter show how care extends beyond the need to help/heal the self (Malkki 2015): here, they are powerfully motivated by a sense of moral citizenship (Muehlebach 2012) to others in need of care, whatever form that may take. For Karen, care was in compassion and acknowledgement. For Iolani, it was in resources. For Sonya, care was about

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<sup>25</sup> I asked them if it was common, in their area, to face an emergency situation with a suicidal person. In a sense, they told me: “we pick up a lot of addicts and a lot of homeless.”



knowledge in shared experiences—about relatability. All of these women occupy different but equally important spaces in the network of suicide care.

I want to conclude this chapter by emphasizing what I said at the beginning: experiences of care and care work do not simply fall on one-or-the-other side of a spectrum in the dichotomous model of effective or ineffective, professional or nonprofessional—and by proxy, “good” or “bad” care in its associations with either thing. Rather, as those in this chapter have shown, care—and the many paths *to* care—can be both at the same time. As those in this chapter illustrate, being a subject and provider of care often blurs the space between these distinctions. Many of those introduced here walk a fine line between professional and personally-informed care. This leads to questions about the importance of affect to “good” care, as well as the potential lack of evidence to support institutional approaches as offering enough (or any) affective incentives to care at all. The following chapter illustrates why this both/and approach to suicide care is central to caring with *aloha*, which is, as I will reveal, the prescribed method of care in suicide prevention in Hawaii. The subjectivities of those in this chapter shape how we might look at whether or not caring with *aloha* has the potential for bridging some of the impenetrable gaps between caregivers and those in need.

## **4.0 Caring with Aloha**

### **4.1 Putting Aloha in the Work**

As the previous chapter showed, remembering the lives of those lost to suicide brings many people into suicide prevention initiatives, whether as a professional or volunteer. Indeed, it is often the friends and family of individuals who have died by suicide that take on some of the most important and active roles, particularly in community mental health care. Referring to themselves as survivors of suicide loss, many of these individuals become affiliated with national organizations, like the American Foundation for Suicide Prevention (hereafter AFSP), and become certified to offer programs and workshops on suicide prevention, run support groups for and with others, tell their stories and experiences of suicide, and promote awareness to those at risk within the community. These are almost exclusively unpaid positions, despite their organizational affiliations. In addition to Iolani, I had the opportunity to meet a number of survivors of suicide loss throughout my time in Hawaii, all of whom confirmed that it was a direct personal loss that had prompted their work in prevention. Central to their purpose, they told me, was the idea that sharing their own lived experiences might help others recognize and respond to someone considering suicide.

At one of the first meetings of survivors that I attended in Hawaii, a father and survivor of suicide loss spoke candidly about his 18-year-old son, who had died by suicide a few years before. Holding back tears, he told a small group of us that he had missed his son's cries for help, that there were some "clear warning signs" that he felt he hadn't taken seriously enough. He was only able to see this, others in the room reassured him, with the advantage of hindsight. But he explained

how his son displayed uncharacteristically reckless behaviors in the weeks before his death—like skateboarding into traffic, surfing in prohibited spots—so much so that his closest friends had called to express their concerns, saying he was acting unlike himself.

“So, I got off the phone with them and I asked him, ‘you’re not thinking about suicide, right?’ You know, and then I answered it for him. I said ‘right?’ I didn’t give him a chance to tell me for himself. So he never told me.”

In Iolani son’s case, however, there were no warning signs. Everything that Iolani ever said publicly about her son Kaleo seemed to contradict the reality of his suicide. The attractive, happy, and athletic young kid from Kaimuki high school who was popular, well liked, and thought to have “everything going for him” by his friends and family, who his mother said looked forward to his upcoming summer break and restoring his brother’s old car—how does that person wind up dead by their own hand?

Prevention lectures, trainings, and workshops repeatedly outlined the types of warning signs to look for in a suicidal person: were they withdrawn from their normal social activities? Did they talk often about death, or (as in our group training example) try to find homes for the things they planned to leave behind? Did they, as the father of the 18-year-old pointed out, display reckless behaviors or act out of character, as his son’s friends had noticed? Are these cries for help? I wondered to myself about how these signs manifested in real care for real people, in real time. How do we learn, as workshops in prevention were designed to do, to see these signs? What if, as these grieving parents had articulated about their children, we don’t notice them enough? When there are no signs, how do we know to care?

For Iolani, when speaking with me again in early 2019, the answer was simple: we use our *aloha*. Using your *aloha*, according to Iolani, meant being “fully present” with and for others. It

meant both talking with and listening to others' experiences, struggles, and needs. Care with *aloha*, as she and others in this chapter explained to me, meant sitting with a person—keeping watch with them—for “as long as it takes.”

“It’s not just talking,” said Rita, one of Iolani’s colleagues with the AFSP. The three of us were sitting together in an emptied-out hotel conference room following a presentation they’d both just finished giving. “It’s really listening. Listening is such an incredible art. Not just simply being there for someone, but fully listening to that person’s story. You know, sometimes people are saying the same things over and over and over again, and we miss it. You have to be listening with your *full* body, looking for body language—that’s using your *aloha* to care in the work that we do.” Iolani nodded, her eyes closed and whole face smiling, standing behind Rita as she said these words to me.

These words—being present (both in literally occupying a physical space and in a more cerebral sense), listening, staying with others—are what distinguish this form of care from others. In this chapter, I view care with *aloha* as an example of what Angela Garcia refers to as the healing potential of a type of “watchfulness” in preventing suicide. In Garcia’s account of addiction and dispossession in the Rio Grande, she references a Biblical passage from the book of Matthew. The passage describes the moment when Christ asks his disciple to stay with him in the hours before his death. Garcia defines this as a type of care for others in the midst of struggle: *Remain here and keep watch with me* (Matthew 26:38). Her usage of this passage relates specifically to an ethnic community where Christianity remains central to corporeal experiences of life and death, yet it speaks beyond the case in evoking a type of continuity and unconditionality of care for those in desperate moments of need. She asks, “might things have turned out differently if we were to remain watchful with one another? How many overdoses might have been prevented, suicides

interrupted?” (Garcia 2010:181). For Garcia, then, the notion of watchfulness:

suggests an ethics of community and a form of care. To remain watchful *with* one another—not over or against the other—is to offset forms of alienation [...] and to insist on the persistence of certain intimate ties. It is a practice that opens up the possibility of being-together, which is, in the end, the very heart of social commensurability. In the midst of loss, insecurity, and abandonment, the healing potential of social commensurability, of keeping watch with one another, remains vital. (2010:182)

Keeping watch *with one another* in Hawaii is, according to my informants, what defines their work in prevention. Staying with someone for “as long as it takes,” using your “full body” to listen, and “being fully present” as a caregiver is the essence of what it means to care with *aloha* in Hawaii.

In this chapter I suggest that the social commensurability offered by *aloha* puts watchfulness into practice by administering a form of responsive, relational suicide care. As affectively signaling values of compassion and patience in caregiving, *aloha* operates as a kind of shared language between practitioners and those at-risk and in need of help in suicide. What makes this commensurability doubly effective—and in this instance, with implications beyond the case of Hawaii—is that there already exists a type of relatability between patient and provider in suicide care: Because the majority of caregivers in prevention are drawing on personal experiences, the care gap that typically exists between provider/patient or caregiver/care seeker has the potential to be much smaller.

This chapter also argues that the person-centered format of care with *aloha* in Hawaii disrupts the traditional model of “anonymous care” that Stevenson argues pervades in U.S. suicide prevention services. Care with *aloha* provides an alternative to these dominant models of protocol-informed suicide prevention. The very purpose of care with *aloha* is to maintain the centrality and

identity of the individual—their name, their family’s names, their own personal experiences and *mo’olelo*, or story—rather than attempting to address the suicidality of individuals in what Stevenson reveals is an overwhelmingly depersonalizing model, one of declaring life’s unique value to no one in particular. Prevention workers in Hawaii, as I show throughout the narratives in this chapter, explicitly aim to do the opposite—yet, of course, they cannot always succeed. Here, I also contend with the reality that care, even in its most ideal forms, can still be inadequate or even harmful.

This notion of care’s potential to harm is an important contingency underlying my discussion of *aloha* as a form of suicide care. While it is true that *aloha*, as it was articulated to me, promotes an attentive, empathetic, and personalized form of care that would seem to, at the very least, be capable of meeting the unique needs of any individual, no approach of care in suicide prevention can ever be fully successful or fully attuned to every person at risk. In the midst of a crisis as singular and existential as suicide, prevention work—no matter how engaged and well-intentioned—is still unpredictable in its outcome. Individuals are dynamic, and encounters of care are not bound to their temporality, but rather have unknown effects that stretch beyond them. As Tomas Matza writes regarding this therapeutic “fissure” between provider/patient: “How certain can anyone be of the effects of any practice of care when knowing one another, and indeed ourselves, can be so elusive?” (2018:26). In suicide care, as with all forms of patient-centered therapeutic care, even the best, most responsive efforts are sometimes not enough to bridge that space between. Still, as I show below, care with *aloha* strives determinedly towards that goal.

This chapter also attends closely to Hawaiian language, meaning, and terminology. What has *aloha* historically meant to *Kānaka Maoli*—the original Aboriginal Polynesian people of Hawaii? As a word *aloha* has also been overused and misunderstood in popular discourse. I also

address this issue by considering the context of Hawaii's colonial history. How has this word been used to mark both an "authentic" Hawaiian identity and a fictional "Hawaiian" sentimentality? What machines (colonial, commercial) are implicated in the (re)production of *aloha*? And lastly, how have these histories contributed to the use (or misuse) of *aloha* in the context of suicide care? I present these perspectives in order to situate care with *aloha* as a practice and as a form of caregiving that characterizes community mental health approaches to suicide in Hawaii. I do this while also acknowledging my limitations as a scholar: I do not claim to have expert knowledge of Native Hawaiian ideology, lifestyle, or language. In using this word, I also do not mean to suggest that I understand what it has come to mean to those who choose to revere it. Rather, I report what those people I spoke with in Hawaii, many of whom are *Kānaka Maoli* themselves and many of whom are not, have shared with me about their experiences with, understandings of, and reverence for the word and concept of *aloha*. At the outset of this chapter, I want to express my uncertainty in theorizing this or any Hawaiian word, given the centrality of place to its meaning.

Because of this, I begin this chapter with a critical examination of the term *aloha*, its colonial history, its co-option in the present, and its role as a place-holder among Native Hawaiian activists, who are in this moment still fighting for their independence. Following this first section, I then examine what the term *aloha* means to those who work in suicide prevention and articulate it as part of their work. Specifically, I ask: how has the attitude and sentiment of *aloha* been central to their own definitions of care work? Here, I articulate how this shared understanding of *aloha* puts Garcia's idea of "watchful" care into practice: as she only imagines its potential, I show here what "watchfulness" might actually look like in prevention. The third section of this chapter illustrates how the concepts of watchfulness in *aloha* shift somewhat when put into practice as part of suicide prevention work with others. I describe this in terms of offering an alternative to

Stevenson’s description of the “anonymous care” of suicide prevention, as care in Hawaii is anything but depersonalizing. The purpose is to actually *know* those with whom you’re interacting, rather than minimizing familiarity in these encounters. Following this, the final section of this chapter illustrates the complexities of *aloha* as a form of care and explores some of the contradictions and instabilities inherent within it.



**Figure 12 "Kapu" Near Makapu'u Beach, July 2017**

**Figure 13 "Aloha The Bus," April 2019**

## **4.2 The Spirit of *Aloha***

Hawaii’s “cloudy political history vis-à-vis the continental United States” and its image as a “gendered, eroticized, and primitivized playground” has pervaded its image in the Western imagination (Diamond 2008:8). The word and concept of *aloha* was just one of the casualties of the tourism-fueled colonization of Hawaiian society. Found in all Polynesian languages to



represent a cross-culturally similar definition of love and compassion, *aloha* has taken on a more serious meaning in Hawaii than in other parts of the Pacific. It was notably described by Hawaiian scholar Mary Pukui as an embodiment of the feeling between a mother and her child (Pukui & Elbert 1986). But it has also moved into a more popular space. In 1986, the Hawaiian state government passed bill §5-7.5, “The Aloha Spirit Law,” as part of its efforts in revitalizing Hawaiian culture across the state. Among other things, the law—which is, in effect, a mandate to service workers—encourages each person, particularly those holding public office or working in the tourist economy, to “think and emote good feelings to others” as part of being a “good,” representative Hawaiian. This subtle passing of *aloha* into law followed a period of high tension within the local government and the short-lived but aggressive Hawaiian Renaissance of the 1970s.

By the early 1980s, unrest between indigenous groups and the state had resulted in several legal advances in *Kānaka Maoli* status in Hawaii. First, the public acknowledgement of the historical injustices committed against Hawaiians prompted the opening of the state’s Office of Hawaiian Affairs. Second was the termination of military bombing tests on the uninhabited island of Kaho’olawe, which had been taking place continuously since the attack on Pearl Harbor in 1941. Both of these were moderate victories for indigenous groups in Hawaii, who were at this time agitating for a sovereignty movement. But the idea to codify the spirit of *aloha*—referred to by the Hawaiian government as the *Kānaka Maoli*’s “gift” to the world—into state law, though intended to extend Native Hawaiian philosophy into the operative governance of the state, was met with controversy from all sides. For those in opposition, the very idea that such a term could or would be defined by the state implied a fundamental contradiction in what *aloha* represents. The Aloha Spirit Law defines *aloha* according to the Hawaiian language and declares that, as a spiritual concept, it “express[es] the charm, warmth, and sincerity of Hawaii’s people” (§5-7.5 “*Aloha*

*Spirit*” 1986). The law was thought to be the official way of merging the “working philosophy of Native Hawaiians” with the modern functions of the state—a way to fuse both of these histories into the contemporary governance of Hawaii. In other words, it was an appeal to Hawaiian sympathies and a suggestion that the state wished to reflect Hawaiians’ laws *as* law.

Hawaiian activist and scholar Stephanie Nohelani Teves writes that Hawaii has, through its pervasive *aloha* ideology via tourism and militarization, enforced what she terms the Aloha State Apparatus. As Althusser wrote, when the source of repressive power is something invisible, when we simply take for granted the fact that some things we’ve known all our lives—behaviors, cultural norms, even language—are obvious and natural rather than constructed for a purpose by the state, we become subjects of the Ideological State Apparatus (Althusser 2008). Consent among individuals and groups, Althusser argued, is manufactured through ideas and representations that train us as subjects to adopt a particular ideology as true and infallible: we are hailed by the state into a particular form of subjectivity, and hailed further by our identities within the state. Anthropologists have used Althusser’s notion of interpellation before to refer to how ISAs shape national identity and social personhood (cf. Allison 2011). In Teves’ spin on this, the sentiment to “live *aloha*” has been naturalized and commodified as representing the very fabric of Hawaii’s character, so much so that she feels there is no longer a distinction in meaning between *aloha* as it was once believed by *Kānaka Maoli*, or the *aloha* of tourist slogans or in soft laws written by state representatives. As Teves argues, the usage of the word *aloha* by these sources conjures the indigenous subject and engages them in performing their culture. As *aloha* has become the identifier of the state by name<sup>26</sup>, speaking the word *aloha*, or hailing people with it, in Hawaii not

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<sup>26</sup> Hawaii is officially known as “The Aloha State” within the U.S.

only “holds its users to an expectation of behavior that is welcoming and loving,” it also “hails subjects in a state or secular voice [...] harnessed by ideological state apparatuses that in turn interpellate subjects into believing in *aloha*” (Teves 2015:708).

Belief in *aloha* is a complicated thing in Hawaii. Beyond the region and within popular discourse, *aloha* has been happily and colloquially co-opted by tourist companies, media artists and production companies, and even by mainstream consumer brands that have nothing to do with the state. Each of these use *aloha* in ways that misrepresent indigeneity and induce audiences to believe in a Hawaiian phrase that loosely invokes a greeting, a lifestyle, and a “native” ideology. In Hawaii, native and non-native locals and settlers have come to revere *aloha* more generally as a term and as a way of life, loaded with spiritual significance—a kind of cornerstone concept in a uniquely Hawaiian religion, the origins of which are not entirely clear. “Live *aloha*” is a philosophy unto itself, and not just in Hawaii: the lifestyle associated with *aloha* extends into hashtags, bumper stickers, party décor, themed bars, t-shirts, and pseudo-religions in and beyond the Islands. Among the many words the Hawaiian dictionary uses to articulate a definition of *aloha* are love, affection, compassion, sympathy; to show kindness, mercy, pity, charity; to venerate; to remember with affection; to greet, to hail (Pukui & Elbert 1986).

The Aloha Spirit Law, which mandates that these sentiments be expressed through all public interaction, breaks down the words that make up *aloha* as each being representative of the “distinct characteristics” (§5-7.5 “*Aloha Spirit*” 1986) of the Hawaiian people:

*Akahai*, meaning kindness to be expressed with tenderness;

*Lokahi*, meaning unity, to be expressed with harmony;

*Oluolu*, meaning agreeable, to be expressed with pleasantness;

*Haahaa*, meaning humility, to be expressed with modesty;

*Ahonui*, meaning patience, to be expressed with perseverance.

These five concepts that make up *aloha*, the law states, are “the working philosophy of Native Hawaiians and [were] presented as a gift to the people of Hawaii” (§5-7.5 1986); as if to imply that the origins of contemporary governance were the generous offerings of Hawaii’s original inhabitants.

Understanding a word with these varied yet adjacent meanings would be straightforward if not for the colonial history behind the translation of the Hawaiian language into English. As many scholars have explained (Silva 2004; Kanahale 1986; Diamond 2008; Kirch & Sahlins 1992), Hawaii’s history post-Western contact is characterized by a long and complex process of ideological colonization: first through Christian missionary groups, who were among the first Westerners to settle and later cultivate businesses in the Islands beyond agricultural development, and later through the forced annexation of Hawaii by the U.S. government. The earliest efforts to translate Hawaiian into English were part of the larger, more insidious goal of translating the Bible for consumption by Native Hawaiians, whose language was being further suppressed through Western education. The influence of Christianity as replacing Polynesian religion in Hawaii was a key weakness in the eventual fall of the Hawaiian monarchy, whose leaders have been criticized by *Kānaka Maoli* for the perceived ease of their indoctrination into Western religion (Osorio 2002; 2014). *Aloha*, as it was first written into the English vocabulary, was understood as a greeting and translated as a concept entangled with ideas of Christian *agape* love, as in the unconditional love of the Christian God. Because of the relationship between religion and the dissolution of the Hawaiian monarchy, Hawaiian scholars have come to more critically view the term *aloha* in its modern configuration as an evolution of colonialist Christianity—some even reject any spiritual

associations of *aloha* entirely on these grounds. A majority of others, however, still cling to the spiritual significance of *aloha* as a marker of cultural identification and community resilience.

Despite its relevance for many *Kānaka Maoli*, it remains difficult to separate the legacy of colonial violence from the spirituality of *aloha*, even as it is practiced today by indigenous groups. The place of *aloha* within everyday rhetoric in Hawaii, and in particular through dominant media channels and “soft laws” such as the Aloha Spirit Law, has all but stripped the term of its spiritual significance. Hawaiian activists who critique the adoption of *aloha* into a perceived “authentic” indigenous discourse in fact view the contemporary commitment to the “spirit of *aloha*” as continuing the projects of tourism that have flattened Hawaii into a place of “safe and soft savagery” (Diamond 2008:26). In the global imagination, the image of Hawaii “as an American playground graced with Hawaiian *aloha*” (2008:26) pervades and the language and culture of its people—lumped together as the “spirit of *aloha*”—continue to be capitalized on as a kind of “marketable natural resource” (26) which feeds into the projects of tourism that dominate the state. The ideologies that continue to pervade the popularization of *aloha*—as a word, as an idea, and as a belief system—are representative of Hawaii’s continued colonial entanglement and of incipient forms of violence against indigenous groups in and outside of the Islands.

And yet the persistent, if misguided, cooption of the term as felt by *Kānaka Maoli* has also resulted in an insistence on defending *aloha* as something central to indigenous rights discourses in Hawaii. For those who continue to revere it, *aloha* as a concept and practice is entangled with all of these histories: belief in *aloha* is simultaneously “a blessing, a responsibility, and a double bind” (Teves 2015:705). While there is a hesitance among Hawaiians to concede that the *Kānaka Maoli* experience with *aloha* is based on “a history of colonial dispossession, military occupation, and touristic fantasy” (705), the taking back of *aloha* has also reinvigorated a sense of social

commensurability among indigenous Hawaiian communities. Defending *aloha* has become more pertinent as the threat to indigenous rights to land continue to escalate in the Islands. As I write this, in the middle of July in 2019, construction has stalled on the building of a Thirty Meter Telescope at the peak of Mauna Kea, the highest volcanic mountain on Hawaii island and the most sacred location in Hawaiian mythology.

An estimated 2,000 protestors, including *kupuna* (elders) from across the Islands, have engaged in non-violent demonstrations which have resulted in roads being shut down for more than a week to the oncoming construction crews. The telescope project, estimated to cost around \$1.4 billion, aims to become the most sophisticated imaging technology in the world and would allow astronomers to look closer into deep space than ever before (Miller 2016). However, its placement on the mountaintop of Mauna Kea—which is already lined with similar constructions that were built over the years past—is contested because of the sacredness of the land. *Aloha*, and in particular *kapu aloha*, is at the center of these non-violent protests. *Kapu* (a word which translates<sup>27</sup> to “restriction”) *aloha* enacts the same sentiment that was behind the passing of the Aloha Spirit Law: *kapu aloha*, as practiced by elders and cultural practitioners in Hawaii, is the restraint of living in union with the five concepts of *aloha*. Living in kindness, love, and affection,

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<sup>27</sup> It has also been written about as forbidden or taboo (Kirch & Sahlins 1992). Contemporary Hawaiians that I spoke with generally treat *kapu* as a restriction. For example, there are certain places throughout Hawaii, typically otherwise unmarked sites that have some historical or cultural significance, that are sprayed with the word *kapu* to keep out trespassers, even though these places are accessible to the public..

*kapu aloha* forbids<sup>28</sup> violent conflict. Those *kupuna* protesting along the roads of Mauna Kea, tying themselves to cattle grates and linking arms with others ahead of police vehicles, are sitting in watchfulness with the earth itself—the *aloha ā’ina*—for “as long as it takes.” The rallying cry of these *Kānaka Maoli* groups has been: “Do not mistake our *aloha* for weakness.”

It is so important to outline the history of *aloha* as a word and as a concept, especially as I am engaging with it explicitly as representing a form and a practice of care in Hawaii. In talking about and using the concept of *aloha* to distinguish suicide care in Hawaii, I want to stress that this was the language and the term that my informants insisted on using to articulate their type of care work. During my fieldwork, I encountered *aloha* being used by nearly everyone with whom I interacted, from taxi drivers to professors to leaders in suicide prevention. In speaking *aloha*, it did not appear to matter when an individual was white (*haole*) and a transplant to Hawaii (a “settler,” to use the colloquial term) or when the user was *Kānaka Maoli*/Native/part Hawaiian, Chinese, or Filipino, or any combination of anything. The pervasiveness of this word being spoken indiscriminately in everyday Hawaiian life shows how naturalized the Aloha State Apparatus, as Teves theorized it, has become. Even I felt over time, though I did not participate, that I was

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<sup>28</sup> The idea of *kapu aloha* refers specifically to the restriction of behavior: of acting with *aloha* in all things (Osorio 2014).. Because the concept of *aloha* is multiplicitous, *kapu aloha* is the overarching rule but it does not unilaterally prohibit any and all violence. *Kapu aloha* coexists with the concept of what is *pono*—in harmony—and so it is possible there may be situations where violence is necessary as part of acting in *aloha*. Violence is, after all, an integral part of the Hawaiian story: Kamehameha’s army sacrificed hundreds of thousands of their own people, in some instances driving women and children to *pali* cliffs and throwing them below, in their efforts to unify the Islands into the Kingdom of Hawaii.

welcome or encouraged to use the term, either as a greeting or to invoke the concepts that *aloha* embodies so well in its multi-layered definition(s). On some level, this hints to the perhaps forced social commensurability of *aloha* in Hawaii as indiscriminate regarding its users or even its usage.

Among my informants working in suicide prevention, *aloha* was frequently used in tandem with describing their work. As a concept it was also central to the function of their work. This led me to question whether *aloha* as the default-approach to suicide care in Hawaii was conflated with the broad idea of *aloha* as the dominant sentiment in Hawaii. From the conversations that I present in the following sections, *aloha* easily came to stand in for all of those words that are situated in the Hawaiian dictionary. As Iolani put it, quoting directly from the Aloha Spirit Law:

This is what we do, and we do it with *aloha*, and you know what *aloha* is, right? It's not hello and goodbye. It's being totally present. And I'm going to share that here, with you, what *aloha* means [she quoted]: "*Aloha* is more than a word of greeting or farewell or a salutation. *Aloha* means mutual regard and affection and extends warmth and caring with no obligation in return. *Aloha* is the essence of relationship, in which each person is important to every other person for collective existence. *Aloha* means to hear what is not said, to see what cannot be seen, and to know the unknowable." I'm going to leave you with that, before we can ever get into our trainings or anything like that, we need to bring our *aloha* first and be ready, nonjudgmental. Be ready to accept when we're asked to do something, [we're asked] because the belief is that you can do it and do it your best.

Even within Iolani's heartfelt explanation of *aloha*, already some contradictions emerge regarding what it is meant to embody: on the one hand the idea of requiring no reciprocity, of acting with *aloha* with "no obligation"; and on the other hand the importance of relationships, which are inherently reciprocal. I attend to these contradictions throughout my discussion of *aloha*



as a form of care. I discuss how *aloha* came to stand in for—and also sometimes contradict—all of the above descriptors. And ultimately I describe how *aloha* also resembles a complex form of Garcia’s imagined watchfulness.

### **4.3 Aloha as Watchfulness**

As mentioned in the previous section, the word *aloha* became a stand-in term referring to the characteristics and qualities associated with suicide prevention work in Hawaii. In this section, I map this type of care onto “a form of life” that Angela Garcia describes as watchfulness in relation to suicide (Garcia 2010:150). Being watchful, she imagines, might be one way to prevent others from self-destruction, either by overdose or suicide. As she describes it, a life afflicted or ended by suicide is “embedded in a set of intimacies” that constitute a way of life wherein suicide (or, for my purposes, suicide care) is “intimately connected to the idea and experience of life” rather than to death or to another fixed point external to life itself (2010:152). As many characterizations of the word imply, *aloha* is a lifestyle unto itself. The narratives that follow also show that caring with *aloha* is a way of life in Hawaii. It reflects an ongoing commitment to prevention work as something that is not fixed in protocol or allocated to shifts; rather, it extends out into everyday experiences of caring for others—being watchful for as long as it takes—and transcending conventional expectations of care-giving. In this section, I draw from conversations with my informants that describe or otherwise define *aloha* in terms of what it means to “be present” and to be watchful, a word and an action that is consistent with the sentiments attached to *aloha* in general. This analysis helps to show how suicide care in Hawaii provides a viable alternative to Stevenson’s “anonymous care” through its explicit focus on “watchfulness” as a mechanism of

caregiving. This, I show, offers a productive model for suicide prevention work that is useful beyond the case of Hawaii. As a secondary thread to this argument, I address some of the potential colonial trappings that are present in, or perhaps perpetuated by, *aloha* as a form of care, and what consequences this might have for my argument.

Like many advocates, Rita had a history of suicide in her own family. Her uncle, a close presence in her life growing up since she'd lost her father to suicide before she had a memory of him, killed himself when she was in her late twenties. It was just after she'd had her first child, she told me. She explained how her family had first tried to hide the circumstances surrounding her uncle's death from her, fearing that she was too vulnerable with new motherhood to cope. "But I knew," she told me. "I figured it out."

Rita and I were sitting together with Iolani, her colleague for almost ten years now, in a hotel conference room in downtown Waikiki, awaiting their AFSP-sponsored presentation. A middle-aged white woman originally from the mid-West and a self-described "transplant" (or as Iolani phrased it, "a snowbird") to Hawaii, Rita found herself giving talks like this one almost weekly. She lived on the island of Kauai but flew all over the state to give these kinds of presentations.

"She's dedicated to the work," Iolani remarked about Rita.

"All of us on Task Forces are," Rita replied. "We're all dedicated—we have to be."

A crowd of a little more than sixty people packed into the air-conditioned conference room to hear the AFSP's updates to suicide prevention strategies, as presented by Iolani and Rita, the chief officers of Hawaii's local chapter. The presentation they gave on this day was part of a larger statewide event focused on sharing information and knowledge with a wide network of community prevention leaders and workers in Hawaii. This presentation was somewhat different than the other

AFSP-sponsored presentations I had attended in my previous years in Hawaii. Headed by Iolani and Rita, this particular program was geared towards Hawaii-specific prevention strategies and sought to include Hawaii-specific tactics and terms for addressing suicide within Hawaii's communities. By attending, I assumed that those who had gathered identified themselves as part of a greater Hawaiian community wherein this knowledge was valuable and of use.

The topic of the presentation was the importance of *aloha* in the treatment of those in need and the use of *mo'olelo*<sup>29</sup> as a tool in suicide prevention. *Mo'olelo*, or “talking story” in English, refers to the Hawaiian oral tradition of sharing knowledge and wisdom through the stories of their *ohana*, or family. “Talking story” is similar to the concepts surrounding myth and legend; in contemporary Hawaii, though, everyone's own personal history is their *mo'olelo*—it is not necessarily rooted in a historical or legendary past, but rather one's *mo'olelo*, as it has been described to me, is everything that has ever happened to a person and is unique to that individual's life experiences. All *mo'olelo*, in any context, is considered part of someone's story and is worth intimately sharing.

Rita began by retelling the story of her uncle to the people who had gathered in the conference room. Iolani followed, lifting up the name of her son Kaleo to the group, as the “reason we are all here, because of that one person we lost who started us on this journey.” They then went around the room, asking each participant to introduce themselves and their specific line of work and to tell their *mo'olelo* or “story.” When it came time for me to introduce myself, I explained who I was (a graduate student from Pittsburgh) and what I was doing in Hawaii. I shared my interest in learning about Hawaii's effective suicide prevention strategies. I also explained that I

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<sup>29</sup> *Mo'olelo* literally translates as “story,” and refers to an oral tradition of history-sharing.

had no personal connection to suicide, other than my interest in better understanding prevention.

From the introductions or “stories” shared by each member of the group—some talked more, some talked less—it became clear that the group on this day was made up of many positions, all broadly fitting under the banner of community mental health, and all united in caring about suicide prevention in Hawaii. Among them were elementary and high school teachers and counselors, psychiatry residents at Queens hospital, EMTs, police officers, graduate students. Most people knew one another<sup>30</sup> already, some introduced themselves to others from across the room, many had mutual connections, friends, or colleagues. The variety of professions in the crowd emerged through their *mo’olelo* and echoed the level of statewide interest in keeping up to date on suicide prevention strategies. I took this as an example of just how much community mental health relies on itself to provide support.

After these introductions, Rita brought the group back to their central purpose of the day, which was to talk about the importance of *aloha*, *mo’olelo*, and, “being able to find out that little bit of information that someone imparts, that’s really important in relationship building, and that comes first in our work.” The focus of the presentation turned to the importance of “bringing your *aloha*” into your work as a tool of prevention and as a method of establishing a relationship<sup>31</sup> in encounters of suicide prevention.

I noted that there were several contradictions in this part of the presentation. First, the idea of “bringing your *aloha*” seemed individualized or internalized in a way that was inconsistent with

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<sup>30</sup> I was the standout outsider, but was welcomed warmly and encouraged to participate in sharing my own *mo’olelo*, which I did.

<sup>31</sup> Or, as I am also choosing to read it in this and the following chapter, as establishing patient trust.

cultural understandings. Second, it was also somewhat disorienting that Rita, a transplant to Hawaii, was the one charged with articulating the necessity of *aloha* to compassionate caregiving in suicide. In one sense, this setup reveals the reach of *aloha* as a term beyond being explicitly linked to Hawaiian indigeneity. At the same time, the term being “explained” to a group of Hawaiians (and by this I mean mostly by location/position, not explicitly by their ethnicity) by a white (*haole*) non-Hawaiian and non-local as the “expert” in this context illustrates the complexity of *aloha*’s entanglement with its own colonial history and appropriation. That no one expressed unease at this arrangement only enhances this complexity.

In order to explain *aloha* as a kind of prevention strategy, Rita first talked more about the timeline of risk in suicide and how prevention efforts can align with a suicidal person’s needs. Rita clarified a misperception regarding the timeline of what is considered to be the “greatest risk” point in suicide. Contrary to what many think, the AFSP identifies the time immediately *following*, rather than preceding, a failed or stopped suicide attempt—the days, weeks, even months—as the greatest point of risk in a suicidal person’s life. As one psychiatrist explained it to me later for clarification:

If a suicide is prevented from happening, that doesn’t mean that the risk of suicide has actually decreased. In fact, it’s the general opinion that the highest risk is immediately following the missed attempt. The idea being that person already took that risk to a certain level and failed. Just getting to that point, that was most of their fear gone. There’s not much more courage required from there to try again, to try and get it right.

To manage this risk, Rita explained how critical it is to be the type of caregiver who will sit with a person at risk, “wherever they are—in the hospital, in their house, for however long you need to, you need to just be present” until their risk has passed. In her explanation of this, I noticed that Rita was utilizing, somewhat interchangeably at times, two different understandings of what

it means to “be present.” First, she was referring to physically being available—being a physical presence, a body in the room—to another person in a time of need. This reflects somewhat on Scheper-Hughes and Lock’s idea relating to the healing potential and “communicative presence” of the physical bodies of others in bringing the “sick” person back to a state of wellness (Scheper-Hughes & Lock 1987).

Second, Rita was talking about accessing a state of mind: a subjective perspective, it seemed, of being aware, cognizant, and responsive within a particular moment as it is happening to and around you. How these operate as tools in prevention, according to what she was saying, was part of the greater task of calling on your *aloha* and utilizing “that *ahonui* part of it, that patience. That is what it takes and that’s what you can do that others can’t, because you have that *aloha* deep down within you,” Rita said to the group. Using your *aloha*, according to her, provided the means to “be present,” in both of the above iterations, when interacting with someone at risk of suicide—physically and emotionally occupying a state of watchfulness. Rita opened this discussion up to the group, asking them to share their own definitions of *aloha*:

Rita: What does *aloha* mean to you, and how do you take it into your community and into the work that you do? Anybody?

Audience member #1: It means having *kuleana* for your community and you know, always going above and beyond just to help people.

In mentioning *kuleana*, the audience member invoked a term that can be loosely translated as “responsibility.” The word *kuleana* also refers to a kind of reciprocal relationship between a person who is responsible and the thing/person for which they are responsible.

Rita: So, *kuleana* for your community, going over and above, for your commitment, what you’re passionate for—what else does *aloha* mean?

Audience member #2: *Aloha*, it means love.

Audience member #3: Service, listening.

Audience member #4: It's like a mode of communication with someone else, it's like you start from a point of love, so it's like, no—no judgement. You know, nothing else, just—just pure. Just a pure connection, a pure communication.

In response to these meanings of *aloha* from the group, Rita acknowledged that all are central to the efficacy of care in suicide. In particular, though, she stressed approaching care with “pure communication” and without judgment as being one of the most necessary components of interacting with someone who is considering suicide. No matter what is being revealed through that person's *mo'olelo*, she said, the caregiver listens and listens without judgement. Rita stressed that it is the willingness to be open and to be present in this way that allows for the possibility of being able to “live our *aloha* and pass that *aloha* forward” to others in their time of desperation. I understood from previous conversations that Rita meant “passing *aloha* forward” in the sense of saving that person's life.

“It's hard to do that [listen without judgement], because we are natural life savers,” Rita said to several concerned nods from the group. “We want to drag them from one end and pull them to another end, but really, it's that *aloha* that we bring without judgment, and that willingness to *listen* [that] furthers trust” between those on opposite sides of exchanges in care.

Trust, as Annemarie Mol argues, is central to success in patient-provider care (2008). In her book on *The Logic of Care*, Mol envisions “good” care not as one informed by patient choice within the consumer health model, but rather as the result of an ongoing collaboration between providers and patients in establishing trust, typically in the sharing of knowledge. However, Mol keeps the clinic in view as the central site of care, whereas in suicide care, there is no such place.

Instead, it seemed that “the site” of care in suicide, for Rita, could be anywhere—as long as you brought your *aloha*. Iolani chimed in and affirmed this. “The essence of *aloha* is just being present,” she said. “It’s showing up for others as if there is nowhere else that we need to be in that moment but right there.”

At this point, Rita prompted the audience to imagine themselves in an encounter with another health care provider: you are a patient at the doctor with a long list of things that you want to convey, she said, but you feel pressured by time and by your lack of relationship with your doctor. You are only there because of a stuffy nose, but you know that your stuffy nose is because you’ve had a migraine—you know that the migraine is because you haven’t slept in a week, that you haven’t slept for so long because someone in your family has recently died and you’re depressed. A care provider in this situation, she explained, should be able to see beyond the symptom of the stuffy nose. An effective care provider should be able to ask the right questions to get to the bottom of the discomfort, to the source: “that’s what we’re talking about, that’s what it means to be fully present, fully engaged in body, mind, and spirit.” Again, it seemed that she was referring here to patient trust. “That’s the essence of *aloha*,” she continued. “Only then can we make those kinds of heart connections with others.” Rita used this phrase “heart connections” while gesturing with her hands a kind of reciprocal exchange stretching out from her chest to another person’s, from her “heart” to another’s.

This image that Rita used to illustrate a two-way interaction between a provider and seeker of care evokes what Judith Butler explains binds us relationally as vulnerable subjects in need of social interaction with other vulnerable subjects. Butler, drawing on the Lacanian concept of the individual’s desire for social recognition within a symbolic order, writes that shared precarity and vulnerability with others connects us as humans in relational exchanges that constitute our own



social personhood: “If I seek to preserve your life, it is not only because I seek to preserve my own, but because who ‘I’ am is nothing without your life, and life itself has to be rethought as this complex, passionate, antagonistic, and necessary set of relations to others” (Butler 2009:44). As I showed in the previous chapter, the identity of a caring subject in suicide prevention depends upon these relational exchanges with other vulnerable, caring subjects. But as Rita and Iolani explained to the group here, the abilities that they, as providers of care in suicide, had to offer in prevention were unique to them with *aloha* informing their care: “that’s what you can do that others can’t,” they said to the group. “Because you have that *aloha* deep down within you.” Rita and Iolani had explained to these care providers that relational exchanges are central to the work of prevention, that through investing in these interpersonal relationships with others, we establish a deep trust and open the potential for our exchanges of care to become life-saving. Moreover, this was accomplished by bringing your own unique *aloha* into encounters of care. All of these explanations of *aloha* as a form of suicide care—being available, being present, listening without bias to others’ *mo’olelo*, and being ready to do all of this with your *aloha*—all contribute to an operative definition of what it means, in practice, to be watchful.

In Garcia’s discussion of watchfulness, she remarks on a passage from Wittgenstein that she interprets as “a call to attend to the unscripted” in our relational observations of and with others, particularly those in the midst of “deep suffering,” as in suicide by overdose (2010:155). In observing those who perceive themselves to be unimportant, or unobserved, she writes of an “ethical call to recognize the intimacy and dependency that exists between the observer and the observed, the ethnographer and her subject” (155). I would extend this analogy to also include the caregiver and care-recipient in relational exchanges of “deep suffering” like those in suicide prevention. As my informants here have shown, their care seems to rely on intimate relationship

building, of knowing the person on the opposite side of the encounter as much as possible, of listening to their story without judgement, of establishing trust within this place of social commensurability. Part of this links, I think, to the idea of “making sense of oneself through the story of someone else” (Callahan-Kapoor 2013). Being watchful, then, is less to do with the responsibility of being a good or informed care provider and more about being a receptive human presence—of being present, in both senses. In the next section, I examine more closely how these ideas of *aloha* care shift when put into practice.



**Figure 14 Healing Crafts Table, Suicide Prevention Conference, Waikiki, April 2019**

#### **4.4 Practicing *Aloha* Care**

This section examines how care with *aloha* moves beyond its idealized definition as a form of watchfulness and is put into practice. Here I illustrate how *aloha* as a practice counteracts the socially detached models of suicide prevention in the United States. In *Life Beside Itself*, Lisa

Stevenson highlights the tensions between the humanitarian sentiment of U.S.<sup>32</sup> mental health care and the reality that their primary mediation in suicide is depersonalizing, or “anonymous” (2014). Stevenson’s argument about the U.S. model is not that those working in suicide prevention are insincere or incapable of providing care, but rather that most prevention workers—specifically, those occupying unpaid or otherwise informal roles—in suicide are institutionally disallowed from acting on or bringing their own expertise into their interactions with those seeking care. For most care workers in suicide, following protocols and scripts become the only mechanism of their care, while the protocol itself depends on the ability of these caregivers to successfully interpret an array of subjective behaviors symptomatic of an “authentic” expression of suicidality. Caregivers in suicide at this level are trained to simply recognize<sup>33</sup> and respond to an idealized suicidal subject within a predictable sequence of events. This kind of protocol-informed care, Stevenson argues, happens at the expense of the wellbeing of those seeking care—and yet, as I have emphasized, the caregiver’s limitations do not lessen the need for their care in these moments of intervention.

As Stevenson points out, to practice care in the typical model of U.S. suicide prevention “requires no particular qualifications except that one is a caring human being” (2014:87). This low bar for entry into the field, though operating in close proximity to professionalized forms of care,

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<sup>32</sup> Stevenson critiques suicide prevention strategies broadly in the North American context, as her case is in Alaska/Canada. What applies in her characterization of suicide prevention in Canada is shared in her context of the United States as well.

<sup>33</sup> A similar theme of being trained to recognize mental illness is applicable in anthropologist Tanya Luhrmann’s work (*Of Two Minds*, 2000) on how psychiatry residents become able to diagnose disorders based on arrangements of symptoms that are often ambiguous and require subjective interpretation.

is rarely challenged within dominant mental health strategies, despite the perceived unpredictable potential of harm—for both those seeking and those providing care in these otherwise high-stakes interventions. In a broad sense, there is an overreliance on undertrained workers and volunteers across a wide spectrum of community engagement in the United States, not just in health care (cf. Adams 2013). The overwhelming workforce of care in suicide are not typically licensed counselors, but rather are these undertrained volunteer workers, whose ability to follow protocol constitutes their work as a stopgap along a predictable path of institutional liability. In this way, many mental health care workers themselves often feel they are interchangeable and that their care is somewhat irrelevant (Brodwin 2013; Myers 2015).

I would emphasize some inconsistencies here that, especially within the dominant U.S. health care model that valorizes professionalization and (bio)medical authority, there is an inherent irresponsibility in the shuffling of those seeking care for suicide to those who are little prepared to intervene effectively. Instead, the neoliberalization of medicine in the United States promotes this type of self-help and patient responsibility in health care. Care-seekers in suicide become tasked with their own intervention, or worse: one function of anonymous care in these instances of suicide is that it flips the traditional caregiver relationship and instead “invests the client with the capacity to enact their own recovery and self-regulation rather than relying on the individual expertise and insights of a particular volunteer” (Backe 2018:469). This is not only an unsustainable model for preventing the desperate, isolated individual from ending their life, it also does not take into account how care seekers, operating within this neoliberal self-help system, might feel as though they failed in their efforts to adequately seek help for suicide.

As I mentioned at the outset of this chapter, the format of suicide care in Hawaii disrupts the anonymous approaches of mainstream suicide prevention in the U.S. in a number of obvious

ways. Looking at Stevenson's particular ethnographic case, care's potential harm in suicide prevention reproduces ironies of postcolonial public health interventions that use empty rhetoric, which she argues encourage Inuit survival while also expecting them to die (2014). Stevenson in fact writes that, amongst the Inuit, whom she argues are biopolitically unproductive to the state, anonymous care in suicide prevention exceeds its potential to harm and becomes "murderous" (2014:7).<sup>34</sup> Part of the severity of her case lies in the history of the tuberculosis epidemic among Inuit and the role the Canadian government played in simultaneously seeking to "cure" while also shipping away hundreds of effected Inuit citizens to sanatoriums, where many later died with no family present. It would be a stretch to place her characterization of harmful care that is murderous within my context in Hawaii. However, it may be possible to link care's harm vis-à-vis its history with mental health care and Native Hawaiian health, but only insofar as how public health tends to statistically implicate indigenous groups as being disproportionately affected by adverse mental and physical health. This misrepresentation, most anthropologists would agree, is frequently the result of ignoring more structural socioeconomic disparities that impact the health (broadly speaking) conditions of minority groups, including Native Hawaiians. In an ethnographic case focused entirely on indigenous groups in Hawaii, which my ethnography is not, it may well be possible to argue that institutional health care is murderous. However, as this section illustrates,

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<sup>34</sup> In Stevenson's articulation of prevention among the Nunavut in Canada, her vision of care's harm includes colonial powers that extend their social control into therapeutic exchanges of suicide prevention, which she outlines are murderous to the indigenous community.

those working in Hawaii offer alternatives to Stevenson's case that, at the very least, go beyond what is typical of most U.S. models of suicide prevention.

First and most significantly is through the practice of *aloha* as a form of watchful caregiving in contrast to dominant, neoliberal models of depersonalizing suicide care. The format of watchful care is to strive towards, rather than away from, the personalization of relationships in exchanges of care. It also places the importance of investing in relationships as being central to prevention's purpose, emphasizing care's relationality and the necessity of intimate exchanges between caregivers and recipients. The watchful caregiver is an integral, not an interchangeable, component in prevention: rather than focus their abilities on invoking scripted measures, a watchful caregiver uses their own insights to build trusting relationships with those in need of care, even when it goes beyond their purview. In talking about care as practice, it might be useful to consider what Bourdieu writes (1972) are integral components in practice theory: time and agency. As suicide prevention inherently hinges on a timeline of action, it becomes important to acknowledge how those administering suicide care have access to time and agency. If a caregiver is speaking with suicidal person, then in fact there is time within which you can negotiate their subjectivities: as my informants might suggest, this is the time within which you build relationships, and by doing so, establish trust and potentially change the care seeker's subjectivity in suicide. Care providers also have agency in making choices in these exchanges: as Rita said earlier in this chapter, listening is an art. To this point, so is speaking: what you say, when you say it, and how you say it require not just intuition, but choice. If *aloha* is something that needs to be "brought" by a caregiver into an encounter, then it is possible for a caregiver to choose not to use *aloha*—it is merely prescriptive that they would.

To this point, in practicing *aloha* as a form of care, many of those I spoke with talked about how their encounters were informed by *aloha*, as though they were being guided by something that is “deep down within you.” In this sense, practicing *aloha* was like harnessing an intuition or an affect, drawing on some kind of internal knowledge guiding their actions. From what my informants described, it is not enough to simply understand the sentiment behind caring with *aloha*. Rather, one must accept the responsibility of practicing that *aloha*, of striving to know the unique *mo’olelo* of each affected individual in order to humanize and personalize—to customize their care—in their exchanges with that particular individual. These attributes of watchful care with *aloha* set it apart not only as a type of prevention strategy, but reveal how care with *aloha* is both a way of living and being, and a practice.

As I have mentioned previously, those working in prevention frequently described their work as a “way of life,” and that their impetus to help others affected by suicide was not simply to “help as a pastime” (Malkki 2015), but rather it was their job, even if unpaid. Moreover, many caregivers claimed that their prevention work was about life itself, not about suicide. When I spoke with several workers about this, they referred to themselves as “life promoters” and their actions as “passing life forward.” In some sense, these phrases ring similar to what Stevenson explains is “anonymous” care—a type of empty rhetoric couched in new-age psycho-babble. But it also seemed that these sometimes redundant or repetitive phrases stood in for something that was simply difficult to put into words, almost like *aloha* as a word itself.

In speaking with Iolani about what it means to practice care in suicide, she too made a distinction between the “life and death part” of prevention. In this work, she said, “we’re talking about life *thrust*. We lost someone—a loved one, a neighbor, whoever it was, we lost someone to suicide—that’s the death part of it. But we [as workers] practice the life part of it, the life *thrusting*

part of it.” The “life thrusting part” of it, Iolani explained, is “the action piece, which is practicing *mo’olelo* and practicing *aloha*.” I asked Iolani how she might explain what it means to practice *aloha* as an action; she simply explained that practicing *aloha* meant “being fully present” in your daily interactions with others, not simply in instances of need. Rather, knowing everyone around you—who you are with every day, who you know, and who you don’t know—and building on those interrelationships in order to “make yourself available so that people can share their *mo’olelo* with you.”

She pointed out that I had once done this with her: we would not have been talking together, she explained, had I not first shared with her, and she with me. *Aloha* made us available to each other. And, as I’d been able to share my *mo’olelo* with others in various groups in Hawaii, my story was now a part of their story and theirs a part of mine. This description of practicing *aloha* showed that it was not just about presence, but was about trust and openness, which Iolani simply referred to as “relationship.” Relationship, she told me, should always be at the forefront of action with *aloha*. If you have your relationship in place, she told me, “then the rest of your business gonna come natural [sic].”

As my informants have expressed throughout this chapter, the importance of investing in relationships and listening to the *mo’olelo* of others without judgement is one way that *aloha* care maintains its focus on the person at the center of risk, rather than relying on scripted encounters. What this suggests in practice is that interactions with others are never predictable, nor do they lend themselves to a predictable response. Instead, the idea of being “ready with your *aloha*” suggests being flexible as a caregiver, being open to the unpredictability of care, and being willing to make adjustments to your own preconceptions of how to respond to others’ needs. An example of this occurred during Rita and Iolani’s presentation, when a member of the group interrupted



their discussion to express her dissatisfaction with the care that she and her family had previously received through Rita herself:

Group member (in tears): I'm here because I'm just very frustrated. You know, my cousin committed suicide three years ago, and he was the happiest kid, he never fell into all that, the depression. Never used drugs, never drank—he was like the happiest go lucky kid, you know? And then I get a phone call one day at midnight and he'd shot himself. And you know to this day, our entire family... and that's why I'm here because, okay, how do we deal with it? You know, all us Hawaiians, we lift up the carpet (swish swish swish), push it aside, you know? And I'm the opposite you know, I wanna know: why? Nobody knows, to this day.

Iolani: Yeah...

Rita: So, well, first of all, I'd—we'd like to offer support—to offer your family support—because I think, you know, getting together and talking about it—

Group member (interrupting): Well, you know Rita, I did contact you. I did. And I went behind my entire *ohana's* back... oh, I got reamed for that. (Rita: I know.) And that's the hard thing, you know (Rita: I know. It is, I know.), we all come from Kauai, and everybody knows everybody and our family's huge and everyone knows everybody's business, I mean they know more about me than I know about myself—which is okay, you know? But you know what I'm saying? I *reached out* to you.

Rita: I know, and so I'd like to offer you support, after this—

Iolani (interrupting): Can I say this, though? (Iolani walked away from the stage and over to sit across from the woman, who was wiping her eyes.) Oftentimes, you're just never going to know why. (She paused, touched the woman's shoulders.) You're going to beat

the crap out of yourself, you're going to do all of the 'coulda, shoulda, woulda,' and it's going to be really, really rough and traumatic. And then there comes a time where you say, enough is enough. Because if someone didn't leave a note or anything like that, and what happens too a lot of times, even if they did, you know... it's a mask that that person was wearing. And you just don't know. There's things that's gone on, that you'd never know—you'll *never* know. And you can only imagine, but that's not good, either. Is it? It's, you're just... creating a lot of trauma for yourself—and I can say that, myself, looking back. Until you actually maybe decide that it's time, yeah? Time that you can find that peace. But that pain, that's always gonna be there. It's just managing it, yeah? So, you can feel maybe some comfort as to... so, he's no longer here, but remember that they're not their suicide, even when they die by suicide. They're not their suicide, and they have another great life that you can remember, and just speak everything to that.

The room went quiet as Iolani embraced this woman, who was nodding in agreement with what she was hearing. This conversation having occurred in front of a group of onlookers created some tension in the room, as Iolani had interjected to comfort her in spite of Rita's assertions in offering assistance. It seemed instead that Iolani was listening more deeply, and hearing a particular need being expressed from someone who had just shared her pain with a room full of strangers.

As an onlooker, I saw Iolani's interaction with this woman as coming from a place of listening with *aloha*, without judgement. She was attuned to her needs and she acknowledged them—not unlike how Cristiana Giordano (2014) refers to the ethno-psychiatrist looking beyond the diagnosis to the real needs of patients as they themselves express them (*see*: section 3.3). Iolani offered her consolation without hesitation, unraveling an intimate one-on-one encounter despite the presence of an audience. This was an example of what Rita said to me at the beginning of this

chapter: “Sometimes people are saying the same things over and over and over again, and we miss it. You have to be listening with your *full* body, looking for body language—that’s using your *aloha* to care in the work that we do.”

Rita, somewhat embarrassed, attempted to bring the dialogue back full circle:

Rita (addressing the woman): I thank you for sharing that, because, again, and I’m going to use this as an example, forgive me—but we didn’t start here today trying to figure out with her, you know, “why?” This is what we’re talking about, about being present and connecting to the heart. You know, she shared a very powerful, intimate story as she continues, right? Because the journey is a journey, a *continuing* of healing.

Moving on to the next topic, it appeared as though Rita had mostly mitigated what appeared to be a crack in the veneer of her earlier explanation of *aloha* as care. But, I wondered, why did Rita not intervene in the moment in the same way as Iolani? If *aloha* is something “deep down within you,” why was Rita unable to succeed in calling on it in that moment? Iolani and Rita’s actions appeared to be following different paths, despite them both claiming the importance of listening with *aloha* as so central to good caregiving. Within this encounter, though, only Iolani heard the implicit needs of the woman expressing them.

What is it that makes these two versions of practicing *aloha* care so different? Is there some colonial dimension that makes *aloha* accessible only by Iolani, as a Hawaiian, as opposed to Rita, a “transplant”? Or is it more the case that *aloha* as a type of care is, as all care is, dependent on the individual caregiver and therefore inconsistent? Whatever the case may be, these inconsistencies undermine the potential of *aloha* as care. Care is unreliable because people are unreliable; it is inconsistent and flawed because people are inconsistent and flawed. While this scene with Iolani shows what “watchful” care might actually look like in practice, there is a deeper “easier said than

done” aspect to the story: In one sense, Iolani demonstrates that listening with *aloha* is, as Rita mentioned, “an art” that requires deep investment and commitment on her part. In another sense, in practicing *aloha* as a prescribed form of care, it becomes a protocol of its own: based on how Rita and Iolani had explained it above, those trying to enact *aloha* as a protocol for care should expect to share in the same level of knowledge and expertise that Iolani was able to conjure in the above encounter—but, Rita’s and Iolani’s discrepancies in this moment make clear that this is not the case. The final section explores some of these apparent instabilities of *aloha* and questions its potential as a form of care.

#### **4.5 Instabilities of *Aloha* Care**

Practicing *aloha* was an important part of prevention work in Hawaii. It was, in a sense, a care protocol that can either be used or not used. As the scene above showed, there are some expectations and guidelines to follow in practicing care with *aloha*, but not all caregivers practice it the same way. Somewhat awkwardly, Iolani stepped in during Rita’s presentation to interrupt what she felt was an incomplete response to the implicit needs of the woman in the group who was searching for answers. Iolani, not Rita, seemed to be listening with her *aloha* and “making heart connections” with someone in need of her care. While it did not appear to matter to Iolani that this encounter unraveled in front of an audience, Rita hung back, somewhat defeated. This scene reveals some of the instabilities of a prescriptive type of *aloha* that intends to care for and about others in ways that cannot always be implemented or taught.

#### 4.5.1 *Failures of Hawaiian Care*

This final section examines some of the contradictions and instabilities of caring with *aloha*. This includes times when it was not part of the picture at all, and times where questionable personal agendas or beliefs appeared to play a role. I focus on two additional scenes: first, I turn to Kiana's story as an example of when *aloha* is not a part of care and the harmful effects this has for those in need of help. Second, I turn to another caregiver, Luana, who ran a similar workshop session to Iolani's and Rita's on the same day. I look at this exchange as a place where potentially harmful beliefs were connected to *aloha*, introducing the possibility that care can have negative effects beyond the encounter itself. These narratives offer some contestations not simply to the ubiquity of *aloha* in suicide care in Hawaii, they also present the idea that *no* single approach to care is ever fully adequate and that care is often characterized by its instability.

When I met Kiana for an interview on a nearby campus, I was sitting outside at a shaded table underneath some trees in an empty student food court called Paradise Palms. It had been so hot recently, and so long since the last good rain, that the normally thick green seagrass on campus around us was now a brittle yellow. Even the edges of the palm leaves above us looked browned and paper-dry. I had first connected with Kiana, a 28-year-old social worker in Honolulu, at a workshop. We had been seated at the same table, both of us seemingly a little out of place in eating our vegetarian lunches while those around us indulged in the provided ham and cheese sandwiches. We began to chat, about our work and in general. When asked, I explained why I was in Hawaii, and Kiana lit up: she said she would love to discuss her experiences in what she called a "failure" of Hawaii's mental health care system.

I learned that Kiana had, as an undergraduate, suffered her first of several serious episodes of major depression. She was living on a college campus at the time and told me she'd sought

treatment from a few different sources, but “none of them worked out.” We agreed that we would talk about it over a coffee in a couple of days. But when we met on the day of the interview, Kiana’s enthusiasm for talking seemed to have waned. She sat down across from me, folded her hands in her lap, then put them on the table, then folded them up again. She seemed nervous, so I tried to reassure her: she didn’t have to share anything she didn’t want to. In fact, she didn’t need to talk to me at all. She shook her head.

“No,” she explained. “I’m not upset or anything. I’m happy to talk. It just still makes me angry,” she clarified. Specifically, Kiana was angry that despite having done “everything right, everything you’re supposed to do,” no one seemed to listen or take her seriously.

“It was like I was speaking another language,” she told me. “No one cared.”

Kiana, who told me she was part Hawaiian and Samoan, grew up in Makawao, a small rural community in central Maui. Her graduating class in the public high school only had about 30 people in it—it was a small town. As a teenager, she was social, had lots of friends and boyfriends, was active in sports and popular at school. She got along well with her family and her teachers. Despite it being a close-knit community, she told me there was never a sense that her life wasn’t full of things to do or people to hang out with. And yet Kiana seemed to struggle, inwardly, with what she later realized was major depression.

Growing up in Maui in what she referred to as a “traditional Hawaiian home,” Kiana never heard much about mental health—certainly never about depression or suicide. At the time, there was no suicide prevention or awareness in her public high school.

“It just wasn’t something we learned about in school or really talked about,” she explained.

I asked if that was also the case at home.

She nodded. “Maybe even more at home. Even when I was so obviously depressed, you

know, no. No one ever asked me or talked about it.”

In talking about this, Kiana placed blame on her teachers—she said they should have been trained to recognize these things “like how they are now.” We referred back to the conference that we’d both attended—many of those who were sitting at our table with us were public school teachers. Perhaps, she said, public education is becoming better equipped in addressing sensitive topics that impact young people.

But when it came to her family and friends, she had a different perspective to share. She explained that she learned about mental health from “the internet, not from real life. In real life, people here guard their feelings. Especially people who are close to you. I guess then I felt like I had to guard my feelings, too. Plus, no one here wants to be a burden,” she said, gesturing around her as if to say that suffering cannot coexist with what was around us.

I asked if she could clarify what she meant.

She told me that mental health or illness “is not part of the picture” for Hawaiians. “As a kid, I had problems. But nobody in my family or at school talked about emotions, you know? It just wasn’t something you did. We didn’t share feelings.” Kiana told me she didn’t tell anyone close to her what she was experiencing, least of all her parents. She explained that it was a very un-Hawaiian thing to do, to share feelings.

I asked if she meant that in regards to her family or more broadly.

She explained there was an overall hesitance of Hawaiians to “share feelings,” which she surmised was a combination of an embedded sense of inferiority, a feeling that “our problems aren’t important,” as well as a larger culture of not drawing attention to oneself. Within Hawaiian families, including her own, Kiana felt that emotional problems weren’t dealt with in a healthy way: “Everyone in my family was coping in all the wrong ways [with lots of things]. I didn’t have

enough information then to recognize that my experiences at home were unhealthy. A lot of kids wouldn't know that things [at home] aren't just the way they're supposed to be." Within her small town, lots of kids at school had similar family problems that were "obvious." With kids, she said, "you can always tell when things aren't right at home."

In a move that felt very different from what Iolani and Rita had talked about in their workshop, Kiana actually blamed Hawaiian culture for what she perceived to be a social stigma surrounding mental suffering. For her, "Hawaiian cultural attitudes" weren't *aloha*, they were "staying quiet, not asking questions, and being humble." This exacerbated problems in homes and caused young people to hide their emotions.

I asked her how she felt this related to the "spirit of *aloha*" in Hawaii.

Somewhat tongue-in-cheek, she replied rhetorically: "That bullshit?"

When I asked if she ever told anyone about her suicidality, she told me that she did when things got really bad—this was during college in Oahu, she explained. She described herself as having unwelcome thoughts: it wasn't that she wanted to die, she told me. It was that she didn't want to keep *thinking* about wanting to die. These thoughts of death would interrupt her brain on an otherwise normal day and she knew that something was wrong. Like any young person in the 21<sup>st</sup> century, she turned to the internet to find suicide prevention resources but told me she was "overwhelmed" by taking the next steps.

She decided to call her university's student counseling center to figure out what services they provided. She was assigned to a counselor, she told me, but was informed that she couldn't be seen right away unless she was suicidal. "That's what I was told by the person who answered the phone. So I told them the truth." Kiana said this information got her a next day appointment, but that the encounter left her feeling worse: "I wasn't suicidal enough. She [the counselor] asked



me if I had a plan to kill myself, and I vaguely did, but she didn't think it was specific enough to count. So, we moved on and didn't talk about it anymore." Her next appointment with the counselor would be in five weeks—that was the next available session because of a long waitlist.

Kiana told me she had no backup plan after this counselor's failure. Defeated, she went home and Googled a private psychologist in Honolulu. She found one and left a voicemail: "I left a voicemail message saying I was suicidal. The secretary called back to schedule for later that week. When we met it was like, 'Well, you seemed to have gotten over the worst of it.' I didn't feel I could say much of anything after that."

Kiana explained that her experiences made her feel that she didn't "suffer enough, [she] wasn't suicidal enough." No one listened to her, she said, even after her having reached out on her own—she had taken the initiative in seeking out her own treatment because no one close to her had expressed concern or worry. On the one hand, she said she felt that the lack of care she was shown was because she didn't meet the right criteria for receiving care to begin with. But on the other hand, she also felt that some of the concepts that were thrown around in Hawaii—words like *aloha* and *ohana*—were something of a smokescreen. Kiana felt that *aloha* was something "people hide behind." Like the Aloha Spirit Law, she felt that *aloha* was a suggestion for how to behave—it didn't mean that everyone took it to heart. You couldn't go to jail for not acting with *aloha*. It was difficult for me to discern which "people" Kiana meant, but when I asked her directly, she told me that *aloha* did not define her experience receiving care in Hawaii.

On the day I first met Kiana at the workshop, we were sitting with someone else at our shared table who remarked, on my being from out of state, how unique Hawaii was in being able to care for people: "We're not a giant state—we actually have the capacity to take care of each other. We have the capacity to reach out to a couple thousand people, and to come together quickly,

in a day or two and see each other. It's pretty extraordinary, what we have here in Hawaii." But this idea of Hawaiian exceptionalism was not reflected in Kiana's experiences as a Hawaiian seeking care. In her experience, she was passed over. In her experience, she was anonymous.

#### **4.5.2 *The Psychic's Gift***

It was late in the afternoon on the same day that I'd attended Iolani and Rita's session on Hawaiian-specific suicide prevention. After lunch, I gathered my things and made my way into a different conference room where Luana stood at the front. She welcomed everyone into the room, including Rita and Iolani, as people trickled through the door and began to sit down. This session was similarly focused on the importance of *mo'olelo*, but this time in relation to survivors of suicide loss in finding "hope and healing."

Luana introduced herself, a tall woman with broad shoulders framed by long, thick hair. She explained that she was here today to talk about coping with suicide loss, especially for those of us who are or who know others "near to suicide." In particular, we were going to discuss the power of *mo'olelo* in reshaping the "stories" of those lost to suicide, specifically in relation to creating healing narratives out of the trauma of loss. In talking about loss, Luana stressed the importance of using "clear and direct language" as opposed to "blaming words, like 'commit suicide.'" "We say 'died by suicide,' she added. "That's clear and direct. Clear and direct language is important especially for survivors, because it's actually adding more trauma to their already trauma [sic], because now you're saying committed, and you know—that blame, that just adds more trauma."

As we had done in the previous workshop with Iolani and Rita, everyone attending briefly

introduced themselves as we went around the room. Some immediately identified themselves as survivors of loss (like Iolani and Rita, both of whom were in attendance in this workshop). We began to delve into a “listening” session of *mo’olelo*, as individuals shared their experiences and journeys of healing. Some people chose to share stories of suicide, too, mentioning their loved ones—saying how many years or months it has been since they passed, sharing a bit about why they were here on this day. Because I never lost anyone close to me, I mostly hung back in this discussion and observed. In going around the room, another young woman made a comment about the suicide of her close friend as having been a choice:

Young woman: I know we don’t like to say it was a choice, but in the end, it was a choice. I never like to buy into that, but being this far on that path, realize that it is a choice. And it wasn’t a good choice.

Luana (nodding): Right. We’re gonna, just gonna put that out there—no matter how great someone’s life may have been, that [suicide] wasn’t the right choice. And that’s what we teach, and we gotta stand on that.

Luana stressed that, in talking about those we love who had made this choice, we as survivors must realize that “they are not their suicide,” but rather, suicide was simply one bad choice they’d made.

Several people nodded in agreement with the idea of choice, but one older man in the room had a hard time with this, asking, how do you make sense of their choice? Specifically, how do you make sense when it comes “out of nowhere”? He explained that his niece had been beautiful, popular, happy—no drug use, nothing. Her suicide came out of the blue, leading him to wonder if there was something more sinister behind her death. Luana responded by reminding us that everyone, even those who appear to be the happiest people, is wearing “a mask. It’s a mask that they’re wearing. They literally mask their pain.” The man was still visibly trying to grasp this

explanation, when another audience member offered her experience of how her family came to terms with her nephew's suicide:

Group member (to the room): Well you know my auntie had gone to Vegas, and she was sitting next to this lady who was a psychic. And she says look to the right. My auntie looks to the right, there's nobody there, right? And she says "Travis is standing right there, and he's hugging you." And my auntie just broke down.

Luana: Wow. Wasn't that wonderful? To know that he was present?

Group Member: And then the psychic told her to tell us, especially to tell me, tell her "I'm *pono*—I'm good. I'm not in pain." And there was nothing in his toxology, you know, nothing. So that's how I dealt with it, my auntie called me, we're all crying, you know.

Luana: You see? We shift from how they died to how they lived. You see, he was telling you right there, Travis was saying: "I am not my suicide, I am that bright smile, that happy go lucky human being." Wow, that is a wonderful gift that the psychic gave you.

The room was full of teary-eyed participants, except for the man who had just moments earlier expressed difficulty understanding his niece's suicide. While he seemed to be struggling with this characterization of the psychic speaking to the deceased nephew, Luana only compounded it further: "what a beautiful gift from the psychic."

The fact that Luana was in a position of some credibility in leading this discussion and chose to support the psychic as having given a "beautiful gift" allows for potentially damaging possibilities beyond this moment. In addressing this "beyond," I want to turn to something that Iolani said to us at the very beginning of this workshop:

Before this is said and done, think about what you're going to cause when you walk away.

This is not a one shot deal here. You're taking what you're learning. You're going to take

it back to your communities. You're not gonna put it down on your desk, or put it aside— with your *aloha*, you're going to help to pass life forward.

There is something unsettling in this final example with Luana. Bringing in this subjective, almost supernatural experience and confirming it as a viable possibility for healing seemed to place a false sense of hope in those who did not have (or would not have) this same experience. The very idea of the psychic interacting with the dead nephew seemed, to the main the audience (and also to me) like it surpassed the threshold of what might be considered helpful, especially in a conversation about the aftereffects of trauma. In fact, it seems almost as though this example's fantasy of hope could present a potential obstacle for someone needing to come to terms with the reality of a death by suicide.

In this case, the psychic cannot answer questions any more than Iolani can answer them about her own son, or the man about his own niece. The psychic can only present a kind of emotional red herring—a distraction that obscures, rather than provides real healing. Then again, what is considered “real healing” or productively therapeutic, as appeared to be the case with the family of the deceased nephew, is not consistently the same from one person to another. As Iolani asked us to “think about what you're going to cause” after these encounters, it is important to wonder what the scene with the psychic might have *caused* for that man in the room, or for others with similar concerns that weren't expressed. It is this impossibility of knowing “what you're going to cause” that makes this kind of unscripted care appear, at times, to be so precarious.

## 4.6 Conclusion: The Flawed Caregiver

As a concept, *aloha* is everywhere: ubiquitous to Hawaiian society and to expressions of Native Hawaiian activism, yet also written onto coffee cups, the sides of buses, the printed shirts of businessmen in downtown Honolulu. How can *aloha* sustain both of these discourses? Are both of these discourses—one as a signifier for righteous action and “watchful” care and another as a symbol of cheap consumerism—present in *aloha* as a form of suicide care? What are some of the boundaries drawn around *aloha* in suicide care, specifically in the practice of caregiving? From the examples within this chapter, it seems to be the case that there are almost no boundaries at all.

In *Scripting Addiction*, E. Summerson Carr (2010) writes about the lack of boundaries of one of the practitioners working in a community rehabilitative center. Laura, the therapist, crosses the lines sometimes: sharing a cigarette with her clients, having private conversations after working hours, playing the role of “friend” a little too much. Laura’s actions are regarded as “dangerous” within a system of inpatient rehabilitative treatment that relies on the strength of its policies and protocols. Carr does not suggest that Laura is a “bad” caregiver; however, it is implied that by failing to meet certain expectations—expectations of caregiving that were set as best practices for a reason—her care is called into question. Luana, Iolani, and Rita all cross boundaries in this chapter: sometimes, this results in what might seem to be a “positive” outcome, as in the case of Iolani’s interruption. But Rita and Luana both seemed to be precariously balancing “good” and “bad” outcomes in their interactions as caregivers.

So what makes a “good” caregiver in suicide? Is it “listening, with your full body” as Rita suggested? Is it being able to adapt to providing care based on an affective ability to interpret others’ implicit needs, as Iolani showed in her example during the group workshop? Or is it enough to simply be physically present, to be “watchful,” for others in need of care? In situations of

therapeutic caregiving in particular, there is almost no measure by which care can be determined as being good or bad, effective or ineffective. Similarly, there is no way to know whether or not the aftereffects of care may produce harm, as with the psychic's story, that may well "extend beyond" the temporal space of care (Matza 2018:26). The lack of boundaries in caring with *aloha* make it even more difficult to assess in these terms of help/harm: care requires a both/and framework for this reason. This chapter has illustrated some of the complexities in suicide care, particularly as the assumption of care with *aloha* is that it has the capacity to be more deeply relational and therefore more effective in contrast to the "anonymous" approaches of mainstream prevention. But as this chapter has also shown, *aloha*, like anonymous care, has the potential to speak to everyone and no one at the same time.

## 5.0 Conclusions

*Can one effectively empathize and assist another person's grief, if one has not personally experienced bereavement? Perhaps nothing short of the personal reality of illness or of doctoring can fashion this wisdom.*

—Arthur Kleinman, *The Illness Narratives*, 1988

The task of “administering life” is central to Foucault’s theory of biopower (HS 1978) and by extension, to suicide prevention as a strategy of the state: prevention work in suicide, despite being only loosely medicalized, is ultimately a biopolitical endeavor concerned with preserving life through its concentration on the prevention of death (Stevenson 2012). In Foucault’s terms, as discipline works towards rendering subjects obedient, biopolitics manages populations from every stage of life from birth to death (Rose 1996; 1999). But how can biopolitics manage suicide, when the control over death is ultimately one’s own? As I have viewed suicide as both a case study and broadly in the United States, who has “the right to die” and who (or what) beyond agency over one’s own life governs that right?

As caregivers in suicide have shown throughout this ethnography, the biopolitical reach of prevention is impressive: in the United States, suicide prevention is one of the top most concerns of community mental health today. In Hawaii, networks of suicide care emerged all across the state, fueled by unpaid efforts and motivated by personal incentives to care about those at risk. While prevention efforts in Hawaii have been successful in averting a crisis, even the best efforts to care are not always adequate to stop suicides. Even the best care, given in the best possible way at the best time, is not always enough to dissuade someone from taking their own life. This fact



can make prevention work feel, at times, like a futile venture—especially given the resilience of individual agency.

As this dissertation has helped to illustrate, destabilizing a history of positivist claims and assumptions about the suicidal is one of the greatest challenges for an anthropological approach to suicide. Suicide is persistently represented as being individual, pathological, and willful. Such representations conflict with fundamental questions of (bio)power and agency, and clash with even greater issues of ethics and existence. For anthropology especially, one of the most difficult challenges in making sense of human agency in suicide is finding a way to interrogate the pervasive assumptions—medical, moral, motivational—that are made about it. But there is also a fundamental paradox at play in constructing the suicidal subject in terms of agency. On the one hand, suicide is intentional and an act of personal choice; on the other, victims of suicide are often seen as having been limited in this choice-making, succumbing to external and internal forces beyond their control: mental illness, social pressures, economic collapse and failed aspiration (Chua 2014), to name a few. But even in suicide, individual choice and will is limited by the biopolitical administration of life itself.

The ongoing “reliance on and denial of agency” that scholars tend to ascribe to the suicidal is a “tension” at the center of an anthropology of suicide (Broz & Münster 2015:5). During my fieldwork, I frequently found myself grappling with some of these ethical questions: with so much of the focus on *preventing* suicide, what is it that limits our perspectives of those who have chosen to die by suicide? Specifically, is our inability to engage with these individuals representative of a greater inability to view or lend some validity to their choice? Of course, these questions get at something far more controversial than I hope to suggest, but for the sake of argument: isn't the choice to die in fact one's own to make?

Schopenhauer thought of suicide as a human right, often citing it as a case study in writings on freedom and self-will. Schopenhauer argued that suicide is the ultimate expression of individual power, that “there is nothing in the world to which every man has a more unassailable title than to his own life and person” (2004:25). For Schopenhauer, suicide was an act of freedom in which the person rejects a life lived under certain and (subjectively) unbearable terms, rather than a rejection of the will to live at all—a kind of all-or-nothing approach to quality of life. Jean Améry similarly wrote in favor of suicide as an expression of individual freedom from humanity (1976). In contrast, Albert Camus argued that escaping reality through death is contradictory to the idea of self-freedom if the self ceases to exist as a result (Camus 1955).

Some of the more contemporary ethical debates on suicide fall within a larger moral discourse linking suicide to doctor or state-assisted euthanasia and the nature of medicalization via the “right to die” movements (Tierney 2010). Thomas Szasz claims that suicide should be viewed as a “personal *solution*” to which medical authority should have no bearing on death as a right: “we are just as responsible for how we die as we are for how we live” (Szasz 1999). As individuals practice birth control (more or less) freely in society, Szasz argues that individuals should also be capable of practicing “death control.” In his short editorial, “Suicide as a Moral Issue,” he writes:

[D]ying voluntarily is a choice intrinsic to human existence. It is our ultimate, fatal freedom. That is not how the right-thinking person today sees voluntary death: he believes that no one in his right mind kills himself, that suicide is a mental health problem. Behind that belief lies a transparent evasion: relying on physicians to prevent suicide as well as to provide suicide—and thus avoid the subject of suicide—is an evasion of personal responsibility fatal to freedom. (Szasz 1999:41)

Like Schopenhauer’s, Szasz’s argument provokes questions of individual agency in suicide

that are made more complex by the nature of it as a life-ending act. At the same time, to call self-death an “expression of freedom,” as Schopenhauer once did, is not an entirely unfair claim: if it can be called anything, suicide is at the very least agential. In fact it is because of its agency—the implied conscious choice behind taking one’s life—that suicide is so demarcated from any other cause of death in society (Hacking 1995). And yet the absurdist retort of Camus rings ethically true: how can death possibly be self-liberating? Particularly among a demographic faced with increasingly greater constraints to a perceived quality of life, it is not exactly salient to suggest that the suicide of a 16-year-old is a well-informed decision. All of these points seem, despite their controversy, worthy of discussion—yet they still dance more closely around the idea that, as Luana said, suicide is “the wrong choice.” Is it really up to us, the people left behind, to determine whether the choice was right or wrong?

The question of agency in death that Foucault posits in asking who has the “right of death” is central to his theories of biopower, yet he oddly gives very little consideration to the possibility of death as personal choice. Foucault refers instead to the historical moment where the shift from the “old power of death” is replaced and “carefully supplanted by the administration of bodies and the calculated management of life” (1978:138): the “ancient right to take life or let live was replaced by a power to foster life or disallow it to the point of death. [...] Now it is over life, throughout its unfolding, that power establishes its dominion; death is power’s limit, the moment that escapes it” (HS 1978:138). As Lisa Stevenson has also noted, Foucault explicitly states here that the body’s physical death escapes power: “within a biopolitical regime, death itself ‘is outside the power relationship. Death is beyond the realm of power’” (Foucault 2003:248 *in* Stevenson 2015:96). Rather, power over death—and specifically, within populations—can only be controlled statistically: the governing power, then, is a power over death *rates*, as Foucault and Hacking have

both suggested.

Suicide prevention relies on statistics, on the numbers from youth self-reports, on suicide death rates: nearly all models of public health concern depend upon such criteria not only for funding, but for prioritizing action and response. As these rates appeared to rise in Hawaii, community involvement rose almost in tandem. As I have shown throughout this dissertation, many of those who became involved in prevention work did so because of their own experiences and losses. The concern they have shown—for the struggling others within their community and for those who have died without much notice—reveals the importance of placing care as the object of focus in suicide prevention. As chapter one laid out, care is the operative in all prevention work: it is the object on each side of the exchange. From the perspective of those in need of help, care is what is sought after in a crisis. For those on the other side, care is the means through which they can attempt to show the value in someone else's life, to make others see that value for themselves. In the two-way exchange of therapeutic caregiving, care is fundamentally relational. To limit care as being bound to an either/or definition misses the point of its purpose. As I suggested in chapter one, we—as scholars and as citizens of a society that desperately needs to rethink the meaning of “care” in mental health care systems—should open our view of care as something that instead exists on a flexible spectrum. Care must be multi-dimensional because its subjects (and objects) are so dynamic.

Chapter two took this approach in showing how care and concern take shape in a place like Hawaii, where suicidality among a young demographic was distressingly on the rise, in stark contrast to its reputation as a tropical paradise. In mapping out this concern, I showed how systems of care in Hawaii are not bound to one single organization, but rather are fragmented throughout the state with deep roots stretching from local church organizations to the State Department of

Health—here, care is about community. In this sense, I showed how community members often perceived of suicidality in Hawaii from multiple angles of concern and worry. I framed these as “costs of living,” which revealed a range of potential issues: from intimately personal ones like Gloria’s to broad social issues, such as homelessness and those most impacted by late capitalism’s reach in Hawaii. Threaded through all of these discussions was the insistence that caring about preventing suicide comes down to addressing a broad constellation of things, not simply pathology or even societal distress.

Chapter three focused on how workers become engaged in caring for others in suicide. Some are brought into visible and therefore arguably more socially productive roles, and others like Karen move somewhat behind the scenes of care systems, but still produce tangible effects of caring socially and compassionately for others—even just as an acknowledgment *of* others. This discussion highlighted the importance, and also the irony, of subjective connections to the cause of suicide prevention producing a real workforce of caring individuals. At the same time, it highlights the complexity of care being relational in prevention work: many of the individuals in this chapter occupied differing levels of expertise, affect, and professionalization, revealing the need to view care as something falling along a spectrum.

The fourth and final chapter of this dissertation presented *aloha* as something many suicide prevention workers felt was central to their caregiving. Here, care with *aloha* became a viable option in caregiving, a way of “keeping watch” over others more compassionately than protocol-informed institutional models typically allow. This characterization of *aloha* pushes against what Stevenson has posed to be the problem with “anonymous” approaches in suicide prevention that all but ignore the actual person in need of help. Still, *aloha* has its own set of conflicts and limits, including its entanglement with colonialism in Hawaii and the inconsistencies in its

implementation. This chapter showed how caregivers, although attempting “watchful” care, are sometimes unable to perform the same quality of care from one person to the next, suggesting the possibility that this type of care has the potential to cause harm to some and help for others.

What does it mean to be a good—or, if not “good,” perhaps a successful—caregiver in suicide? Putting aside the idea that care is neither always one or always the other, I turn to Arthur Kleinman’s epigraph that begins this conclusion: “Can one effectively empathize and assist another person’s grief, if one has not personally experienced bereavement?” How can caregivers in suicide get at whatever intangible thing it is that makes another person want or try to end their life? How can they change that person’s mind except for providing “successful” care in the right moment? Knowing what someone considering suicide needs to hear or see or know is an impossible task to which there is no perfect solution. As Kleinman suggests, perhaps the “wisdom” of experience is the best predictor of knowing, intuitively, what might succeed for someone else in that moment. But this personal knowledge or experience cannot itself be a predicator of caregiving in suicide—or truly in most situations of health care. It shouldn’t take a physician getting cancer themselves to know that others wish and want to be cured of it themselves. I suppose the true ethical dilemma in suicide is that the “cure” seems to be, at least from the perspective of the suicidal subject, in their own hands.

The inconsistencies in *aloha* as a form of care speak to larger dilemmas of caregiving that extend far beyond suicide prevention: on the one hand, *aloha* destabilizes the anonymity that Stevenson shows dominates most models of suicide prevention and mental health care by proxy. The importance of relationships, intimacy, and human connection highlighted in models of caregiving would seem to be a good thing—as a practice, this embodies, rather than simply rhetorically hints at, “watchfulness.” As Angela Garcia imagined it, “watchful” care has the

potential to heal in situations where healing may otherwise be out of reach. On the other hand, though, caregivers who provide “watchful” care with *aloha* are trying to operationalize a concept that is deeply intuitive, differing from one person to the next, and altogether unreliable as something that can be taught and implemented. These inconsistencies and dilemmas come down to concerns about professionalization in health care: the role of best practices, standardization, and protocol are necessary and important, if sometimes seemingly un-caring, elements in a structure of care that, I would argue, has room to accommodate both personal and professional.

There are a number of “loose ends” at the end of this project, and several threads that I hope to follow in future. First, I believe this research would benefit from an engagement with a closer proximity to suicide prevention and intervention services. The type of care that exists in these exchanges is elusive to most social science researchers, but I feel it would add an invaluable component to a larger discussion on care’s limitations in suicide. Second, I have only begun to scratch the surface of the many colonial dimensions of *aloha* care in Hawaii; I can imagine this to be a key concern of this project moving forward, and moving outside of Honolulu and through the other spaces of the state, where rural and more isolated communities face greater risk for suicide. Ultimately, this project has aimed to provide a more complex and holistic perspective of suicide as both an individual phenomenon and as a social concern that requires a greater level of compassion and flexibility in understanding, in practice and in policies of prevention. By studying suicide care in community settings, I have tried to call attention to how these communities highlight their own strengths and resiliencies and how they put together their own practices of care to address problems like suicide on their own terms. In the context of Hawaii, this took the shape of many things, but care with *aloha* was front and center. Though imperfect, I hope that the discussion it ignites will allow for a more humanistic approach to prevention and a more

compassionate perspective on suicide as something that is part of the human experience.



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