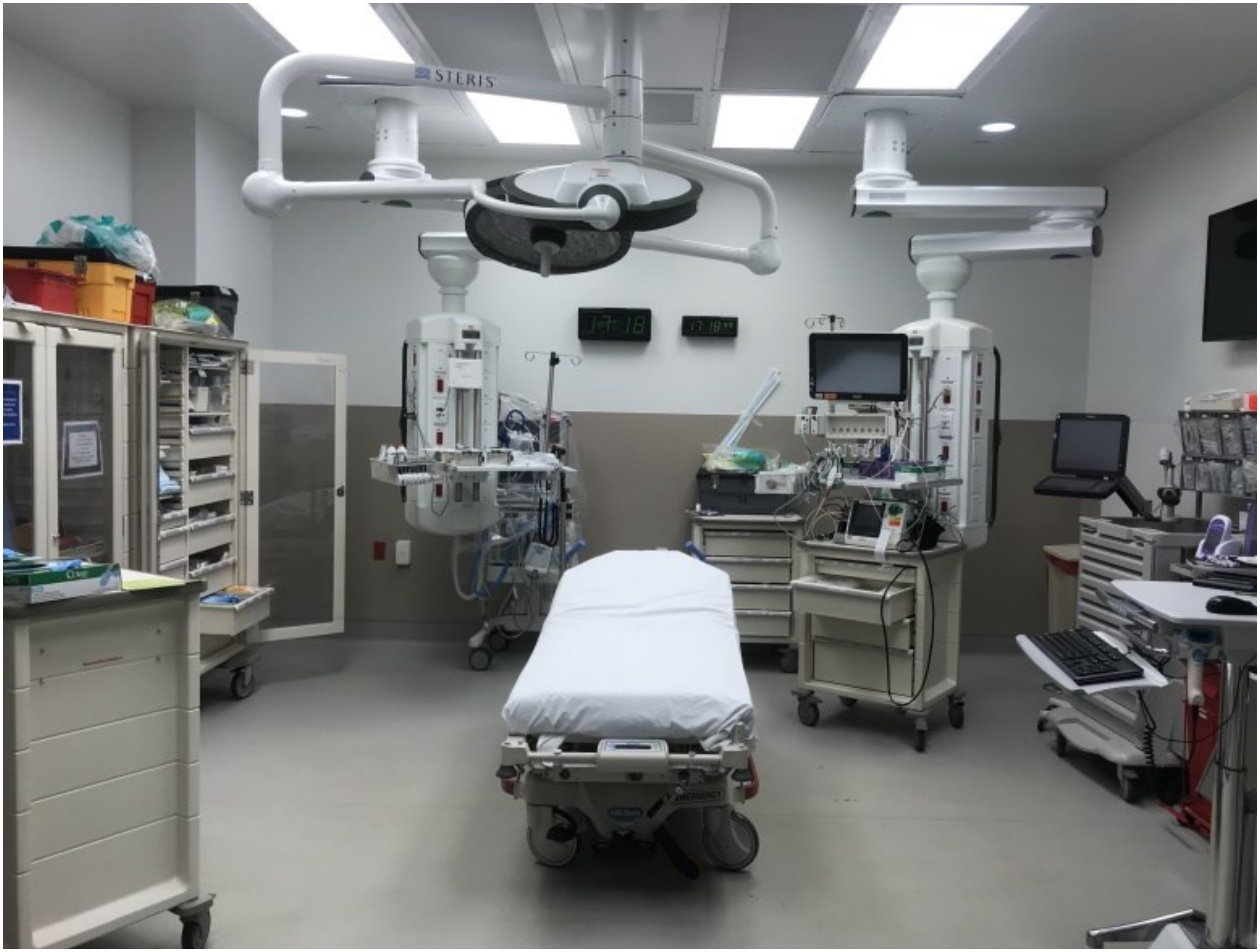

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The Journal for Undergraduate Ethnography

Young Adults and their Parents: The (Mis)understandings that Construct Mental Illness

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ABSTRACT

While public awareness about young people's mental health has been on the rise, the context in which it is studied has many gaps. Adolescent mental health is often studied within the context of family relationships but the same is not true for young adults over 18 years old. Drawing on interviews with young adults who have mental illness and their parents, I found that the parent-child relationship is a relevant context in which ideas about what mental illness is are constructed. Through the conscious presentation of self within the unique expectations of this relationship and the feedback from parents or children, young adults construct definitions of mental illness which guide their ideas of self and actions in the relationship. By considering this specific relationship and life stage, I hope to contribute to a more specific understanding of the social construction of mental illness and to highlight its practical implications in the lives and relationships of young adults.

Keywords: mental illness; family; young adulthood

When I was fifteen, I was diagnosed as bipolar. To me, this meant that there were days when I felt on top of the world, incapable of focusing on any one task, and days when simple things like being awake felt impossible. To psychiatrists, this meant I experienced mania and depression, requiring medication and therapy. To my parents, it meant they had a teenager who was always doing either something irresponsible and impulsive or locked in their bedroom, requiring disciplinary responses to ensure they grew up to be responsible. My relationship with my parents and the result of seeing my experience through two different lenses—as a profound emotional struggle and as problematic behaviours—impacted how each of us understood what mental illness was.

As I have transitioned into adulthood, my relationship with my parents has shifted and so has my experience of mental illness. Without parents functioning as gatekeepers for things like appointments and medications and having never had the kind of relationship where I shared much about my feelings, my mental health is not something we talked about. Because I perceived relationships with friends, roommates, and partners as more relevant to my mental health, I found that my experience of mental illness changed. Without any authority figure trying to raise me, the interactions around my symptoms and emotions were different. Additionally, as my parents were, in a way, released from being responsible for my actions, our interactions (or lack thereof) around my symptomatic behaviour also changed both of our understandings of mental illness.

Noticing how my parents and I each understood mental illness, and how those understandings changed with age, made me want to further investigate the links between young adulthood as a life stage, parent-child relationships, and mental illness. Approaches to the study of mental illness have focused on coping and support strategies between young people and their parents with most of the focus directed towards adolescence (Armitage et al, 2020; Draucker, 2005; Griffiths et al., 2011; Heerde et al., 2014; Honey et al., 2013; Moses, 2010). Family studies have considered the interactions of parents and children, but generally overlook the role of mental illness within that relationship. For mentally ill teens, parents are often both an immediate source of support in crisis and the gatekeepers to professional help. Though they are not usually the first line of support as their children become adults, parents do still provide material and emotional support. The relationship can become ambivalent in this transitional period as both parties negotiate new levels of independence and closeness. As young people enter adulthood, neither their mental illness nor the influence of parental relationships dissipate. Understanding how this relationship informs each party's understanding of the young adult's mental illness has implications for personal coping, parenting strategies, and their relationship moving forward. Taking a symbolic interactionist approach, I sought to explore the construction of mental illness in young people's relationships with their parents by interviewing both young adults with a mental illness and their parents.

Diagnosing the Situation: Symbolic Interactionism, Ambivalence, and Mental Illness

Relationships as symbols

I used symbolic interactionism to frame my thinking about the project and analysis of my interviews. This framework fits best with my goal of deriving how interactions between parents and adult children influenced each other's perspectives on what mental illness is. Mental illness is not only a biomedical or psychiatric construction, but a social one, defined by experiences and behaviours that deviate from social norms. The category of mental illness, and subcategories of specific diagnoses are reified through consensus and convention (Walker, 2006). Symbolic interactionism proposes that our understandings of concepts are constantly evolving as we interact with others and incorporate information from this interaction. LaRossa and Reitzes (2009, 135) posit that social interactionism "focuses on the connection between symbols (i.e., shared meanings) and interactions (i.e., verbal and nonverbal actions and communications)." This framework considers social interactions to be both expressing and continually shaping meanings.

One example of how social interactions shape our understanding of mental illness is stigma. Stigma is a set of negative views toward a particular group that functions to keep people "in," "down," or "away," that is, behaving properly, unempowered, and non-tainting (Link and Phelan, 2014). Link and Phelan (2014, 25) contextualize this concept in the case of mental illness, saying:

> A person interacting with someone who carries a stigmatized status may behave differently, with hesitance, uncertainty, superiority, or even excessive kindness. The person with the stigmatized status reacts, responding perhaps with less self-assurance or warmth, causing the interaction partner to dislike him/her.

As such, stigmatizing beliefs are confirmed and internalized, and the stigmatizing definition of mental illness is reified. Though I applied a symbolic interactionist perspective to all interactions, Link et al. (2015) define a specific type of stigma as "symbolic interactionist stigma": the perceptions by others that a mentally ill person anticipates. Symbolic interactionist stigma again describes a process of mutuality wherein the stigmatized person and their interaction partner both actively engage in constructing mental illness' role in their interaction. Moses (2010) pays specific attention to the relationship between parental stigmatization of youth self-stigmatization, finding both higher stigmatization by parents and higher self-stigmatization by youth when parents attempt to conceal youth mental health symptoms. In this example, parental hiding of the youth's mental illness conveys shame, which the youth internalizes.

Stigma is one clear and relevant example of a way that mental illness is constructed in social interactions, but it is not the only one. It is entirely reasonable to believe that positive social interactions can influence a more positive view of mental illness, for example, conveying acceptance and normalcy through support and nonchalant discussion of the subject.

Ambivalent Apples from Ambivalent Trees

The central task of parenting is to prepare children for independence, though in the 2000's, the age of independence is later than in previous decades (Gitelson et al. 2006). In "emerging adulthood," roughly ages 18-25, parents continue to provide emotional and financial support and pass on family values (Gitelson et al. 2006; Vassallo et al. 2009). Emerging adulthood is thus a transitional period of being "less dependent rather than independent" (Gower and Dowling, 2008). This period has been qualitatively studied, but usually in a one-sided manner, investigating how parents view their role as their child ages or how young adults relate to their parents; studies rarely address both perspectives (Gitelson et al., 2006; Gower et al., 2008; Pejlert, 2001; Pillemer et al., 2012). By interviewing both young adults and parents, I attempted to address this gap in the specific context of young adult mental illness and young adult perspectives.

One common theme of parent-young adult relationships is ambivalence. Ambivalence "emphasizes the tensions between social structure and individual lives," related to symbolic interactionism and role theory as it deals with the meaning of a relationship as produced through role uncertainty (Bengtson et al. 2004; van Gaalen et al. 2006). It represents the tensions between parenting and growing up, dependence and independence, closeness and distance (Pillemer et al. 2012). Yet another way to think about it is solidarity versus conflict, which describes the tensions between familial love or alignment and interpersonal struggle (van Gaalen et al. 2006). Solidarity has many specific dimensions such as intimacy, agreement, dependence, integration, opportunities, and familism (Bengtson et al. 2004). Few relationships are entirely harmonious or conflictual, so a degree of ambivalence is almost universal, but the parent-child relationship in young adulthood is particularly ambivalent as both sides must re-evaluate their role in the relationship (Pillemer et al. 2012; Bengtson et al. 2004).

While it is a common trope that adolescents engage in lots of parental conflict, meta-analysis also show that conflict generally peaks early in adolescence and decreases thereafter (Arnett, 1999; Laursen et al. 1998). The initial rise in conflict may not be entirely the adolescent's fault. Adolescents and their parents both express more contempt toward the other through avoidance behaviours in the teen years. Listening to recordings of their conversations, both teen girls and their mothers rated each other as less friendly in adolescence than they did in childhood (Kahlbaugh et al. 1994; Beaumont, 1996). Interestingly, Kahlbaugh and Haviland (1994) found from their in-home observations that while avoidance increases, teens do not hesitate to approach their parents to engage with them socially, indicating that the development of ambivalence in parent-child relationships is a complex process and not one solely defined by teen-initiated avoidance.

Familial Façades and Mental Illness

The family can be a place of both support and stress for people with mental illness (Griffiths et al. 2011). Heerde et al. (2015) discuss how seeking help from family members can be advantageous but can also draw tensions between the dependence involved in this support and forming independent identities and coping strategies. Their survey results demonstrate that seeking help from family and receiving support from family are two distinct factors; families can be unequipped to provide adequate help or can sometimes cause increased harm and stress. High parental criticism is strongly correlated to adolescent self-injury, and parents of children with mental illness feel high levels of worry, instability, and self-blame (Pejilert 2001; Muhlbauer 2002; Wedig et al. 2007; Song et al. 2014; Armitage et al. 2020). These studies generate deep qualitative data. However, most are only interested in the impacts of mental illness on teens or parents: what parental behaviours impact the teen, and what are the parental narratives of the teen's struggle? My approach of interviewing both young adults and parents aimed to begin bridging this gap in perspectives, putting the two narratives in conversation with one another.

There are common processes in the parent-child relationship regarding mental illness. Just as parents and their children engage in mutual avoidance in the teenage years, the process of opening up about mental illness is also mutual. Draucker (2005) used interviews with 18–21-year-old youths who experienced depression as teens, and interviews with their parents to investigate parent-child interaction patterns in adolescence. She found that both parents and adolescents engaged in active behaviours whereby the adolescent hides and the parent chooses not to see evidence of the adolescent's depression. As the adolescent begins to hint at their experience, the parent too is in an active state of 'kind of' knowing, figuring out what to do with the knowledge while maintaining some ignorance. Finally, when the adolescent opens up, the parent is again in an active role of asking questions and making use of their new knowledge. Draucker (2005) termed these behaviours "maintaining the façade," "poking holes in the façade," and "breaking down the façade." Each of these stages requires active participation from both sides, and I am curious about how interactions at each stage construct "the problem."

Honey et al. (2013) address interaction again, this time interviewing mentally ill youth on their perceptions of how parents influence their behaviour. The youths in this study identified their parents as either facilitating behaviours (making desired behaviours easier), persuading to behave certain ways (encouragement), or controlling (forcing), and that they responded differently depending on how they viewed their parent's motives, their own autonomy, and their acceptance of parental authority (Honey et al. 2013). This is of relevance to my study because how the teens respond depends on their perception of adult motives, demonstrating that youths might construct their mental illness differently whether they feel that they are being excessively controlled or being cared for. The relationship between young people and their parents regarding mental illness is under-studied, but deeply valuable in assessing congruences and incongruencies in experience and perception, and contextualizing understandings of mental illness within familial relationships.

Most literature on parent-young adult relationships is one-sided, researching either parents' or young adult's impression of the relationship. Similarly, research on youth mental illness in the context of family either focuses on youth experience or parental experience. I argue that this is inadequate and represents a major gap in the literature. Parent-young adult relationships involve participation from both parties; by considering this from a symbolic interactionist perspective, we can better understand how each side arrives at the meanings they draw from interaction with the other. Furthermore, studies of mental health in the context of parent-child relationships have often focused on teens, excluding young adults (Draucker 2005; Honey et al. 2013). As neither mental illness nor the parental relationship immediately dissolves when a person turns 18, and parents see their role as continuous, it is important to critically consider how both parties impact each other's experience and understanding of mental health.

Methodology

I conducted semi-structured interviews with two groups of people: young adults who have a mental illness, and the parents of young adults who have a mental illness. For the purposes of this study, young adulthood was defined as ages 18-30. Due to COVID-19 it was not always possible to meet participants face-to-face, so six of nine interviews were completed via Zoom, two in person, and one by phone. As for mental illness, I did not require any proof or confirmation of diagnosis, only self-disclosure from the young adult. I did not want to exclude those who were not professionally diagnosed. Similarly, I asked parents to disclose what mental illness their child has and how they knew to confirm that there was more than mere suspicion.

Hour long interviews allowed me to build rapport and trust, and to deviate from my interview guide to follow up on interesting statements from my participants. Interviews also allowed me to ask participants to reflect on multiple memories. I was able to discover overarching narratives of mental illness and relationships that people constructed over time through these interviews. The purpose of using these qualitative methods was to identify recurring narratives and ideas across participants as a start towards filling the gap of research on parent-young adult relationships and mental health.

I recruited via snowball sampling, beginning with posting my recruitment ad on my personal Facebook profile and in Dalhousie University-related groups, primarily because this was the main group of people available to me, but also because most university students fall into my desired age range of 18-30 and could recruit their parents. Though the only demographic I intentionally sought was people who are 18-30 and have a mental illness or parents of this group, I recognize that beginning my study in university-related groups and snowball sampling, my demographics were limited. A future study controlling for other demographic markers like class, race, and gender may yield more illuminating data, but this is beyond the scope of this study.

I used two interview guides, one for young adults and one for parents, which mirrored each other as closely as possible. They centered around the subject of mental illness, asking young adults about their history with mental illness, its effects on their life and their relationship to their parents, and asking parents what they know about their child's mental illness history, how it impacts them, and how it impacts their relationship. I also asked about the general status of their relationship, such as how frequently they interact, what their relationship is 'like' generally, and what they want it to be like. While the goal was to center the interview around mental illness, questions about more general aspects of the parent-child relationship rounded out my data, often leading back to the subject of mental illness and uncovering relevant information.

I audio-recorded the interviews and transcribed them afterward. I analyzed each transcript by coding for themes, first for top-down themes from my literature, then bottom-up looking for recurring ideas and interesting cases. For the first top-down analysis, I kept in mind the concepts of ambivalence and stigma, and Draucker's (2005) interactive stages of breaking down the façade. Using a symbolic interactionist lens, I looked for how participants described their relationships and interactions with either their parents or their child, and how these descriptions conveyed information about mental illness. I was interested in how the participants chose to narrate their interactions, revealing meanings created in the interpretive process through narrative, tone, and language (Handberg et al. 2014).

The nature of my research was to investigate mental health and family relationships in depth, which may be sensitive for some individuals. I found it reasonable to assume, however, that individuals who knew they would be uncomfortable delving into these subjects would either not respond to my ad or opt-out after I described my research to them. All respondents were briefed on what they would be asked to do and the topics of the interview. They were also given a consent form to sign and informed that they could opt-out at any point up until my thesis is submitted. When participants became upset during the interview, I offered to stop recording, give them a break, stop completely, and withdraw any responses they have already given if they wish. I aimed to listen empathetically and actively not only for data collection purposes, but out of respect for my participants who shared personal information with me and to provide participants support in this task. I kept my participant's identities anonymous, and in case any parent-child dyads participated I did not identify any relationships between participants in this document nor confirm participation or discuss others' responses during interviews.

This study is limited by a small sample size, specifically by the small number of parents I was able to interview. I interviewed seven youth and two parents. I had hoped to interview an equal proportion of youth to parents to address both parties' involvements in constructing mental illness, however due to the timeline and interest, I was unable to recruit additional parents. The perspectives of the two parents interviewed gives a small glimpse into what could be learned from the parent's side but does not represent parents of mentally ill youth more generally. I argue that this research is still valuable as it addresses the gap by which young adult mental health has rarely been considered in a familial context at all, and the two parent interviews revealed similar themes both to each other and the youth interviews, encouraging the usefulness of including parents in this research topic. Through these interviews, I attempted to answer how the parent-child relationship shapes both parties' understanding of what mental illness is. I found that mental illness is a site where the parent-child relationship is re-negotiated in young adulthood.

Making Messes, Cleaning Up: Stigma, Worry, and Façade

The people I spoke to have a range of relationship types with their parents or young adult children. Of the young adults that I interviewed, none identified as men, some identified as cisgender women and others as non-binary. Both parents were mothers. Some parent-child relationships were extremely uninvolved, with one young adult even describing their parents as more "like acquaintances" than parents, while others considered their parents their best friends. There were a host of factors that contributed to the closeness of the relationship. Most young adults indicated that their relationship stayed more or less the same since they were in their early teens while many young adults described coming to better understandings of their parents with age and maturity. None described their relationship as going from very distant to very close or vice versa.

One commonality across interviews is that all participants had working theories to describe why they thought their parent or child behaved in certain ways, and they attributed value and meanings to those actions. For example, beyond asserting that a parent did not want their child to use their diagnosis as an excuse, participants often expanded to more general statements about their parent's experience of mental illness and resulting belief that it should not prevent them from normal functioning. One young adult, Charlie, said that their father did not take their depression seriously and maintained expectations of them that felt incompatible with their mental illness. Charlie attributed this to the fact that their father was depressed and managed it without therapy or medication by "just pushing through it." Though their father revealed that he had been depressed to Charlie, Charlie independently made the connection between his experience of depression and his expectations of them. Every interviewee made attributions about why their parent or child felt and behaved in certain ways and used that knowledge to inform their choices about how to manage that relationship.

Young Adulthood Exposes Stigma

Almost every young adult participant felt that living separately from their parents had improved their relationship, but, overall, no dramatic shifts in the relationship came up. One young adult, Eliott, who sees their parents as "acquaintances," says that they might be more open about their mental health "if it was something that [they] did all the time or something that became more normal," elucidating a common sentiment that most participants were as open about mental health as was already normal for their families. A common theme was that it is easier to talk about mental health intentionally through deliberate conversation while living apart, as it was no longer brought up in arguments when behavioural symptoms caused issues. Another young adult, Emily, used the phrase "not making messes in their face" to describe how her relationship to her parents improved with distance. Though she still discussed her mental health with them, she no longer had to worry about her obsessive-compulsive behaviours irritating her mother. Distance gave more control to both parents and young adults to decide when and how to broach the subject of mental illness, rather than having it arise from the display of symptoms.

In young adulthood, symptoms of mental illness became primarily the young adult's responsibility, and the parent's levels of knowledge and involvement decreased, in a way affirming mental illness as a normal part of life that the youth gains independence and autonomy over with age. From a parent's perspective, Jennifer struggled with accepting that her two adult daughters did not want to talk about some topics with her, but did not push the subject, saying "they just shut us up, not in a rude way but it's their life, that's their decision." She reveals that even if it is difficult for her, mental health is a topic that she believes her daughters have authority over how and when they chose to discuss it. Lisa, the other mother with whom I spoke, similarly said that:

> My daughter may hide some things from me to protect me. I think if she had a cigarette, she wouldn't share that with me because she knows it might upset me, but I feel like she has a cigarette on occasion. It's not because we're not close enough to share that, it's just a boundary thing, an unnecessary fact.

Lisa's perspective is one that permits and encourages independence. Rather than creating ambivalence via a conflict between closeness and distance, Lisa appears to have accepted that she and her daughter are close and keep some things private from the other. It may be more helpful to think of experiences of mental illness as a boundary between parents and their young adult children, rather than a stigmatized secret. It appeared that my young adult participants mostly felt that mental illness was like other aspects of their lives, and as adults they each deserved autonomy in what they shared.

Conversely, the relief young adults and parents felt in having distance from each other also conveys that mental illness is better heard about than seen. Behavioural expressions of mental health issues were considered the cause of relationship difficulties for some participants. As adolescents, multiple young adults reported that their mental illness disrupted their sleep patterns, which often resulted in fights or unhappiness when parents tried to wake them up for school. Other symptoms, like repetitive behaviours, mood swings, or impulsive money spending that the young adults struggled with in adolescence would upset parents and result in arguments. Improvements to the relationship with physical distance may illustrate stigma as more complex than fear, hatred, or disdain. Instead, mental illness may be stigmatized by only wanting to deal with it at a distance, through edited verbal reports rather than by witnessing and living with the behaviours.

This discussion within the context of young adults choosing not to disclose mental health concerns also recalls Link and Phelan's (2014) symbolic interactionist stigma. The young adult's feelings that mental illness is something that would be out of the ordinary, anxiety-inducing, or otherwise negative to discuss with parents set the tone of the conversation. Rather than parents solely enacting stigma, both sides approach the interaction with stigma on their minds. No parent or young adult I spoke to intended any harm to their child or parent, nor believed that their parent or child intended harm to them. Beyond surface level ideas of stigma — the undesirability or abnormality of certain traits — it is present when we engage in behaviours intended to keep mentally ill people behaving properly, from corrupting others, and unempowered to change their circumstances (Link and Phelan, 2014). Eliott was unsure whether their parents have disclosed their diagnosis to their sister or not; they did not know if their parents wanted to give them autonomy over disclosure, or if they did not want to talk about it. They could have been trying to conceal the diagnosis, or they could be granting Eliott the freedom to craft their identity through conscious disclosure. Regardless of intention, the uncertainty has planted the idea for Eliott that it is possible their parents want this diagnosis concealed. Eliott now approaches the idea of disclosure with this uncertainty in mind, influencing Eliott's actions, and in turn, other's reactions.

Boundaries and stigma intertwine in young adulthood in ways that may be impossible to completely disentangle. Stigma may be part of the reason for setting a boundary around to what extent or in what ways parents and young adults discuss mental illness. In this study, those young adults with closer relationships to their parents told me that they were intentional about how they communicated. Rebecca, a young adult with bipolar disorder, described her mother as her best friend and main support for her mental health. She said that while her mother understood depression from experience, she did not understand manic symptoms as well. The pair overcame this gap in understanding through what Rebecca called "logical conversation." Over time, Rebecca taught her mother how to be helpful during manic episodes. Rebecca said that her mother became more helpful after she was able to communicate about her experience and give feedback on what was and was not helpful, and her mother adapted to that feedback. According to Rebecca and other participant's stories, these kinds of explicit discussions around what the experience of mental illness felt like, the young adult's needs, and their expectations of parents reduced stigmatizing interactions. The boundary of not talking about mental illness with parents may contribute to the stigma, just as stigma may contribute to the need for that boundary.

Love is Worry

The responsibilities and expectations associated with the parent-child relationship specifically facilitate definitions of mental illness that are unique to this relationship. Many young adult respondents identified that they would turn to either friends or parents depending on what kind of issue they were facing; only two felt that they would turn to their parents no matter what kind of mental health issue. In considering what determines the difference between an issue they would bring to friends or parents, participants indicated a working schema of what kinds of reactions they could predict from each audience based on past experience and knowledge of the other's personality. Young adult participants made calculations about their desired outcomes — both for their mental health and the relationship itself — and whether it would be worthwhile to seek those outcomes from parents. The young adults shared similar ideas around ideal outcomes of talking about mental illness with a parent. Ideally, they would listen closely and validate the legitimacy of your feelings and be able to calm you down. As one participant put it, to "say the right things and say them in a soothing voice." Parents should not show feelings of fear outwardly to their children and not tell their children what they ought to do. In reality, however, different participants felt their parents met these ideals to different extents. Hunter described some of the reasons they would or would not talk to parents, saying “my dad is really good at talking me down from anxiety,” but also noting that when they were having anxiety about money troubles, phone calls home would create more stress. They resolved that “if it's something that’s not involving them [Hunter’s parents], [my dad] is really good at keeping me level-headed.” Robin also stated that they would share almost anything with their mother, except “anything related to [their] struggles with eating disorders […] that is something where I just think she couldn’t hear without totally breaking down over it.” Young adults described their parents as worrying about them, leading them to “nag,” become anxious, minimizing, or taking control. Though they each expressed sympathy for their parents' situations, expecting these outcomes led young adults to consciously manage how, when, and if they would to discuss mental illness with their parents.

The unique aspects of the parent-child relationship may make meeting these ideal outcomes more difficult for parents than other types of relationships. Parents are assumed responsible for their children in ways that lovers or friends are not commonly thought to be. A parent’s first responsibilities are to meet the child’s basic needs, keep them in good health, and keep them alive. The two mothers I interviewed described their role as parents to involve facilitating their children becoming themselves, imparting important values, being a safety net that is always there, and to help them be happy--- all of which continue throughout the parent’s life. The parent-child relationship is also unique in that (until the parents are elderly) there is minimal reciprocity expected, and the relationship is presumed to exist from the child’s birth to the parent’s death. These responsibilities are so fundamental, the relationship considered so primary, it makes sense that to fail would be a great source of anxiety.

In this context, we can understand why parents may be quicker to “nag” and take control of a situation in which their child is expressing unhappiness or acting unlike themself as the parent knows them, or in which their life may even be in danger. One young adult, Hunter, likes that their friends can be “a little more chill or more casual” about hearing that they are struggling, and they might offer to do small things without “dropping everything;” though they do care, their friends do not have an explicit responsibility for Hunter’s wellbeing. Their parents, on the other hand, tend to launch into a flurry of questions like “do you need to go see a doctor,” or “do you need serious help?” when Hunter expresses to them that they are struggling. They describe their relationship to their parents surrounding mental health as, “you feel like you really have someone that cares so much about you and is so anxious about you that it gives you anxiety.” Hunter’s acknowledgement of parental love and preference for the less intrusive support from friends is indicative of ambivalence, as they are caught between familial bonds and independence (van Gaalen et al. 2006). While they recognize their parents to be expressing love and concern for their wellbeing, their parents’ level of concern is not calming, and perhaps puts responsibility on them not to struggle to avoid causing anxiety.

The relationship between having responsibility for another person, the amount one worries about them, and being compelled to act is worth further investigation. In this limited example, it seems reasonable to say that as parents are primarily responsible for their children (at least in their youth), this results in worry, and they may thus be more compelled to act in order to “fix” the situation and decrease worry rather than listen. Parents might feel responsible for taking action to help their children — by making appointments or imposing ultimatums — especially in young adulthood, while their children are only slowly transitioning toward independence. This complicates the findings of Vassallo et al. (2009) who suggest that parents of young adults primarily see their role as listening and giving advice, rather than providing material and financial goods. In the case of young adult mental illness, their independence may be reduced, either genuinely by the mental illness or only in the parental imagination. We can understand it as a normal piece of the transition to adulthood in the same way as managing money, schoolwork, and career that is over time transferred from parental responsibility to the child. Alternately, we can see it as a unique responsibility in the case where the parent believes, whether correctly or not, that mental illness impedes the child's capacity for independence, having such a fundamental impact on quality of life (or even survival) that it is exempt from the usual transference out of parental responsibility. What participants described appears to show a mixture of both, wherein adult autonomy over conversations about mental health increased, yet these two parents still felt an urge to take control of the situation when something worrying was disclosed. From the parental perspective, ambivalence manifested in uncertainty about where on the spectrum between dependence and independence their child stood, potentially defaulting towards dependence when they felt worried.

Jessica, mother to two adult daughters with mental illnesses, described the difficulties of allowing them to be independent within the context of their previous struggles. As teenagers, one daughter had anorexia nervosa, the other what Jennifer called "the effects of trauma." At one point or another, she had feared for each of their lives due to their illnesses, whether from malnutrition or suicidality. Jessica and her husband took on the challenge of learning as much as they could about trauma and mental health, finding counsellors for their daughters and themselves to help the family cope. The daughter with anorexia did not want to undergo formal treatment, and Jessica and her husband "treated" her at home by preparing meal plans, supervising her eating, and imposing a weight goal for her. Jessica told me that her daughter had gained and maintained the weight goal and was physically well but, according to her, would struggle mentally for the rest of her life. As young adults, her daughters do not turn to Jessica for support anymore; they frequently deem topics of conversation "too triggering." Jessica told me she respected their decisions not to open up to her but did not like it. For one, she said it was challenging to have normal family interactions while always avoiding serious topics of conversation. She also did not approve of what she considered avoidance as a coping strategy, saying "if you never want to reflect on what the problem is, and your feelings, it's never going to be solved." Jennifer was responsible for solving problems for her daughters at one point in time, with very high stakes; it makes sense that now, accepting their independence in terms of disclosure might feel uncomfortable.

Some of the ideal reactions were easier for parents to achieve than others or were only achievable by parents. One idea that came up in terms of how young adults wanted to be supported by parents was the idea of parents as a safety net. While we can understand it negatively in terms of parents as a last resort, some young adults expressed this idea positively in terms of knowing that when their mental health is at its poorest or there is a situation they cannot handle, they feel secure knowing their parents can help. Several young adult participants described situations of "panicking" or "having a breakdown" and turning to their parents, and the idea that "they're always there for me" as something they appreciate — even if they have criticisms of how their parents have responded in the past. The positive elements of parental involvement in their young adult's mental health also have to do with responsibility in terms of their guaranteed long-term presence and ability to act.

The two mothers I interviewed certainly represented the concept of a guaranteed long-term support in their interviews. Before even beginning to ask questions, Lisa let me know she was going to get herself a box of tissues because she knew she was likely to cry when speaking about her daughters. She described a very close relationship with each of her daughters from a young age, and still wanted to support them as much as possible as adults. She noted that the greatest change to her relationship with her children was that, now that they are adults, she does not "have to be superwoman all the time" and can be more reciprocally vulnerable. She described a vulnerable situation with one daughter in which she acted "regrettably" by dismissing her mental health concerns, but after reflecting on what her daughter said and her own perspective on parenting, she concluded that her role was to "constantly [be] the student where [her] daughters are concerned," to always learn from them about their needs and experiences. She was able to move forward better supporting her daughter after re-affirming her commitment to always listening and learning — something that seems unique to the parental commitment and biographical knowledge of a child. True to her statement at the beginning of the interview, Lisa began to cry early on as she described each of her daughter's accomplishments and her love for them.

These young adults consciously decided what to tell their parents about their mental illness based on how helpful they thought disclosure would be, as well as a consideration of how to protect their parents' feelings and values. Even though some of the young adults I spoke to mentioned actions their parents had taken that they felt specifically traumatized by, they also said they would not tell their parents they felt that way. There were also many scenarios in which young adults described consciously figuring out how to say things the right way, at least partially to protect their parents' feelings.

Robin, a young adult who recently started taking medication for their mental health, had to talk about it with their mother so she could help with the assessment process, but knew they would have to approach her in a specific way. They described their mother as preferring natural alternatives to pharmaceuticals and trying to avoid them wherever possible. From Robin's perspective, "it just took it being explained to her from someone that she knew she could trust, which was me, and someone that she respected and someone who wouldn't condescend her or like act as if it was because she had failed somehow as a parent" to understand and support the assessment and medication. Robin used examples of friends' experiences with medication to help assuage her concerns and updated her on how it improved their life. Their mother's support was important to Robin, and it was also important to them that their mother's feelings were considered throughout this assessment that conflicted with their idea of their mother's values.

While Robin's experience demonstrated an instance where sharing information in a particular way protected a parent's feelings, others mostly discussed instances where they chose not to share information to protect their parent's feelings. Nicole, on giving up on asking her mother for support with stressful events in her life, said, "I just don't really share things with her 'cause I don't feel like she can take it." On top of being unhelpful to Nicole, she emphasized that her mother was unable to handle her own emotions. Charlie, who did talk to their mother about some more general symptoms of their depression, did not talk to her about the traumas they feel to be underlying causes of the depression. They said, "I can't be open with my mom about, like, you and [the rest of] my family unit was like a huge traumatic experience for me." Nicole and Charlie both described positive memories of their mothers, and a desire to maintain the relationship. They both indicated that there were certain things they could not or would not share because it would harm the relationship by bringing up negative emotions. While it may be technically possible for Nicole to discuss her mother's unhelpful reactions or for Charlie to discuss their mother's harmful behaviours in a way that does not judge or critique their parenting, it does seem incredibly challenging. Many young adults I spoke to explained why their parents behaved the way they did, often alluding to generational lack of awareness or their own mental health struggles, potentially helping them make peace with the things they could not discuss.

Façades: From "False Front" to Tidying Up

For Draucker (2005), the façade refers to an active and mutual process that parents and adolescents engage in to conceal evidence of the adolescent's depression, and the slow tearing down of this false front to reveal the truth. While the concept of façade was a helpful starting point, it did not perfectly fit with my findings. In Draucker's (2005) model, the façade is maintained, then holes are poked, then it is broken down; breaking down the façade and knowing are the end point. All of my participants' parents were aware of their young adult's mental illness, in most cases for many years. When reflecting on the teenage years, the narratives my young adult participants shared generally fit with this concept of façade, but after they broke down the façade and their parents knew, life continued. Framing the narrative this way works well when the story ends before adulthood. Adolescents generally live with their parents, making the management of their mental illness more central to their relationship as evidence can be seen at any time. They also generally require parental assistance to access professional mental health care, emphasizing the importance of knowing. However, this model conceptualizes knowing as an event, and the procession from façade to knowing as linear. My participants described these initial events of breaking down the façade and knowing, but as the relationship continued post-knowing, the knowledge shared did not always remain current. New developments or the ongoing, everyday experiences of life with a mental illness were not always shared.

In the ambivalent age of young adulthood, the young adults and parents I spoke to were in an ongoing state of "kind of knowing" and "kind of sharing." The young adults maintained semi-façades; not fully concealing, but not being fully open. They spoke of glossing over and beautifying certain parts of their experiences that would be too scary or hurtful for parents to see. Rather than maintaining a façade as in a false front on a building, the process that the young adults engaged in was more akin to tidying up an apartment that is usually ridden with beer cans and takeout containers when they know parents are coming over. Their parents knew about their diagnoses, past histories, and some details of how they were doing; they had seen the true front at some point in time. These young adults were only making it sound more palatable by saying and not saying certain things or figuring out how to say them right.

Conclusion: Mental Illness and the Ambivalent Age

Mental illness in the relationship between young adults and their parents represents an additional challenge to independence on top of the usual ambivalence of the young adult age group. While there are typically conflicting drives for parents to preserve closeness and young adults to assert independence, this was very present in the specific scenario of managing and communicating about mental illness. Beyond preserving the relationship as it had previously been, in the case of mental illness management, parents may be driven by concern for their children's safety and wellbeing beyond the typical concern for a non-mentally ill child. For young adults, the intensity of their need to assert independence may be heightened by several factors directly related to mental illness within this relationship: protecting a parent's emotions, avoiding overreaches of parental control, and forging new supportive relationships. The experience of ambivalence is deeply present in this situation for both parents and young adults, the sense of uncertainty and the stakes seem higher around issues of mental illness than other aspects of the young adult's life.

Mental illness is constructed in the parent-young adult relationship through communication about the mental illness, non-communication about the mental illness, and background knowledge of each other. One of the most common themes in each interview was the continuity of the relationship's dynamics, meaning that the extent of communication about mental illness was likely to continue as it had been in previous years. The precedent of communicating or not informed how both parties continued the relationship in most cases. My interviewees also used information about what parents or children had responded positively or negatively to in the past to aid decisions about what and how to share in the future. On top of this, they factored in calculations about helpfulness, and how sharing or not sharing would impact the relationship.

In sum, the relationship between young adults and their parents constructs both parties understanding of mental illness through ambivalence. In my research, I found complex tensions between closeness and distance specifically related to dimensions of support and independence surrounding mental illness. The transitional processes of young adults self-directing their own mental health care exposes many tensions as young people attempt to manage the positives and negatives of increased independence and re-negotiate the parental relationship. Not enough parents were interviewed to say how parents feel categorically, however in future research I would love to investigate this further, exploring the emerging themes of this study as the mothers I interviewed described the unique challenges of parsing their place in caring for a young adult with mental illness.

Of course, a sample of nine cannot speak for mentally ill young adults and their parents as a whole. Within that sample, all of my participants were white, none were men, and all of the young adults were college or university students. A more diverse and larger sample would be more conducive to a generalizable study. However, I am satisfied with the results of this study as they identify new themes in this area of research.

Several young adult participants identified as non-binary and their gender transition was a relevant aspect of their mental health and relationships with parents. This would be an interesting area to research specifically in the future using literature on transgender and non-binary mental health and family narratives. Furthermore, no young adult participants said they felt closer to their father than their mother. The gendered dynamics of mental health support and family dynamics should be further investigated, drawing on feminist literature and observing whether this phenomenon carries over in a larger sample. Given the differences in mental health presentation between men and women, I would also be interested to see if participants who identified as men fit within the themes I identified in this study. Ultimately, a robust longitudinal study using a larger sample size would help to study the themes I have identified as they arise and potentially reduce with age, as the literature would suggest that ambivalence reduces in adulthood (Pillemer et al. 2012).

Being critically aware of the dynamics of care, worry, and ambivalence as they influence this central relationship between parents and young adults allows us to add depth to the discussion of mental illness management. This has both clinical and sociological implications. Clinically, informing understandings of relationship functions to best support young adults and parents, who may feel distressed by their uncertainty of how to navigate this relationship and benefit from learning that it is common to feel ambivalence. Sociologically, nuancing our discussion of stigma and ambivalence gives us new avenues through which to discuss mental illness. Studying the family as an institution where meaning is produced allows us to speak to the more common and everyday experiences of mentally ill people, rather than focusing too narrowly on formal institutions or too broadly on the concept of stigma in general.

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It is Not OK to Die (With Dignity) in America: An Analysis of the United States' Denaturalization of Death and its Intimate Relationship with the SARS-CoV-2 Pandemic

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ABSTRACT

The SARS-CoV-2 pandemic (COVID) transformed the everyday life of millions around the globe; however, many Americans never believed the virus—or the threat of death—was real to begin with. This research analyzes a systemic denaturalization of death and its processes within the United States, and subsequently identifies a public health crisis stemming from the biomedicalization of aging, illusory expectations of end-of-life care, and a generational pursuit to achieve a 'good death' within a capitalist economy. Informed by over 1,300 hours of first-hand participant observation in two public health institutions in Indiana and interviews with medical providers discussing the impact their own (de)naturalization of death on patient care, this paper dissects American's social and cultural behavior regarding death, its processes, and its intimate connection to the SARS-CoV-2 pandemic. While most Americans describe their worst nightmare for end of life, they are most often suffering and dying exactly as they fear: institutionalized and isolated. This explores why this is so.

Keywords: death; denaturalization; SARS-CoV-2; biomedicalization of aging; structural violence

Two Health Institutions, One Systemic Parallel

In June of 2019, while entering "Room 12" of the rural ED in my hometown with my colleague and close-friend, Kris, a Registered Nurse, we introduced ourselves to Unidentified Nevada (UN, a pseudonym), who had just arrived from a local nursing home by ambulance. According to nursing home staff, UN was an 87-year-old white male who had lived at their facility for the last year-and-a-half, and he had far from a good bill of health. UN was bed-ridden, mute, had zero limb mobility, his eyes glazed over when they were not sealed shut, and his skin was clammy, jaundiced, and riddled with bruises from failed IVs. The chief complaint was hypotension. UN's family seldomly visited him in the nursing home, stated the nursing home staff, and UN lacked a living legal document that granted him a pass to die with the little dignity he had remaining. After recognizing the nursing home's effort to restore UN's blood pressure had previously failed, my main concern was that UN would go into cardiac arrest, and I would have to be the one on top of UN, an 87-year-old male, gravely ill and frail, performing chest compressions to "save" UN from the ostensible medical failure of death. After making UN comfortable and attempting to restore some of his dignity before the attending physician came in to give his assessment, Kris closed the curtain upon exiting, looked me in the eyes, and said "Creighton, it is not OK to die in America."

Fast forward to September 2019, just a few months prior to the arrival of SARS-CoV-2 to the United States, I anxiously arrived at the level-one trauma center in Indianapolis for my first shift as a student intern. I quickly began to be acquainted with the rooms, the environment, and the staff I would be working with for the remainder of my shift. Hours went by, and it was quiet—a word never to be spoken aloud due to healthcare superstition—with zero patient intakes in the trauma bay following my arrival. Finally, five hours into the shift, a trauma alert came in: an incoming 58-year-old female found unresponsive along the roadside, cardiopulmonary resuscitation (CPR) ongoing with no success. "Nothing further, see you in twenty minutes" ended the call. Holly (pseudonym), Registered Nurse, was assigned to this patient. Holly sprang into action preparing "Shock Room 1" for the incoming cardiac arrest ensuring the room had plentiful supplies, and the necessary medications were out and ready for immediate use — all ensuring that the incoming patient would receive the highest standard of care. "So, are you ready?" I asked Holly. After a sigh, "yes I am" she responded. "It's still so different from [nursing] school, but we have a great team tonight" Holly added. Moments later, the patient, "Unidentified Wyoming (UW)," arrived in the trauma bay with paramedics actively performing CPR. "Shock Room 1" (Figure 1) soon occupied nearly fifteen medical personnel, all working together to "save" UW. Amidst the chaos, I observed the life-altering scene with the new lens of "it's not OK to die in America" weighing on my mind. UW looked rough; matted hair infested with lice, unbathed and pale white skin, feet plagued with thick, dead, black skin, bed bugs crawling all over her lifeless body, two IVs in each arm and one in the neck tasked with quickly administering medications, bodily fluids soaking her clothes and bed sheets, thick tubes down her throat delivering oxygen to her lungs, and numerous personnel and their entire body weight taking turns delivering two inch chest compressions at a staggering two compressions per second. This horrific scene, with UW's condition deteriorating every second despite depleting two trauma bays of their epinephrine supply, went on for two and a half hours. Resuscitation efforts continued in the intensive care unit upstairs, as attending physicians urged their colleagues to "continue doing everything you can," to "not give up." UW was transported to the intensive care unit mid-code, where her heart stopped again enroute to the elevator. UW was officially pronounced deceased an hour later. The aftermath (Figure 2) left medical personnel physically and emotionally exhausted and UW died alone, intubated, and robbed of any dignity she had remaining.

This contemporary reality shared by Unidentified Nevada and Unidentified Wyoming—dying alone, intubated, and no longer in control—foreshadowed the reality thousands of Americans would face during the deadly SARS-CoV-2 pandemic in the following years, and served as examples demonstrating the way in which elderly populations were dying already within US healthcare regimes.

The experiences detailed above of UN and UW were by no means exceptions to the observed paradigm shift of death being the new, and ultimate, medical failure — they were the epitome of this new era identified by this research, an era where lack of proximity to death causes death to be prolonged and violent, and death has evolved into the new "quantifiable" medical failure.

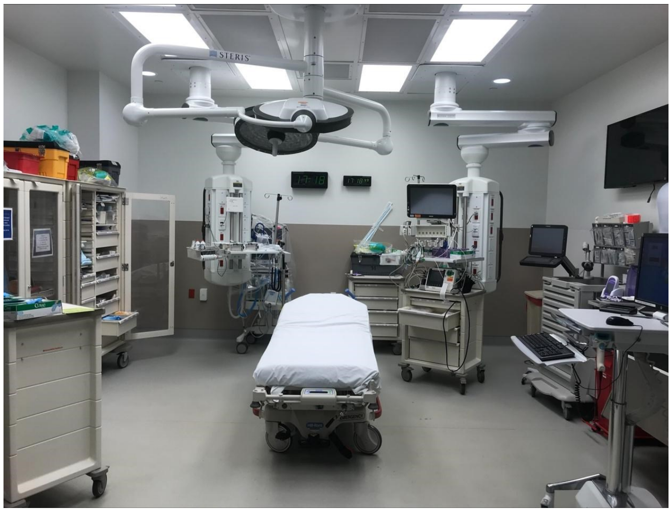

Figure 1: "Shock Room 1" Before UW's Arrival (17:18). Photograph by author.

This research explores a public health crisis instigated by systemic death-denying culture within the United States as the mentality promotes unnecessary suffering among those who are deathly ill, and among healthcare professionals tasked with aggressively prolonging treatment to overcome the contemporary medical failure of death. Specifically, this research sought to answer the following questions: When did death culturally evolve from a natural phenomenon to a medical failure in United States? When is it acceptable to view death no longer as a medical failure but rather as a natural process? When is enough treatment *enough*?

I used three forms of data collection: semi-structured interviews with medical staff, participant and institutional observation, and in-depth engagement with literature. Real patient and provider encounters are detailed throughout this essay and the names of all patients and some medical staff have been replaced with pseudonyms to be compliant with The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and/or to protect the privacy of interviewees, as requested. Patient names with the format of "Unidentified State" were naming methodology used within the emergency department as it allowed patients to receive immediate care under a name already in the system, rather than waiting for patients' identities to be verified for record-keeping and billing purposes. I have kept that trend alive within this essay and named all patients as such for uniformity purposes. Additionally, I use the word "American" throughout this essay to describe the local and greater population in which these death and dying phenomena were observed to exist within geopolitical boundaries. I understand "American" incorporates a wide array of experiences, cultural norms, and a diverse set of factors I cannot address in the limited scope of this paper, including racism, ageism, sexism, and other institutional forms of inequality that

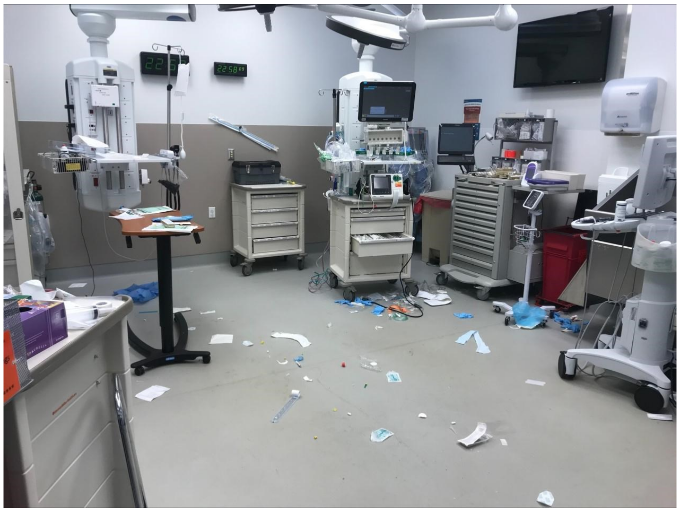

Figure 2: "Shock Room 1" After UW's Transport to the ICU (22:58). Photograph by author.

affect how lives—and deaths—are valued different within this broad category. Future research exploring these forms of institutional inequality, however, is strongly encouraged. All other details included within this essay, unless noted otherwise, were first-hand patient encounters I experienced between two distinct settings in Indiana: a stand-alone emergency department (ED) in my rural, 12,000 person hometown of Connersville, and the “Shock Rooms” of the emergency department at one of two level-one trauma centers in Indianapolis. I gained access to these health institutions through an internship program designed to make connections with medical staff and aid in patient care. Details from patient encounters were recalled from memory and written reflections after each shift, and I was careful in respecting patients’ death experiences, obtaining permission from medical staff to take notes and observe each case, and addressing any practical dilemmas with medical staff following applicable patient encounters. Formal interviews, some audio recorded with permission, were conducted with two critical care physicians and four ED and ICU nurses, and informal interviews were collected from additional nurses, respiratory assistants, medical technicians, and healthcare volunteers throughout debriefs of patient encounters or by casual conversation. Despite the stark differences in levels of care and accessible resources between the two institutions, one systemic parallel remained: death and its processes—its untimeliness and its denaturalization by patients and providers—all were recognized prior to, but magnified by, the onset of the SARS-CoV-2 pandemic. By “denaturalization,” I mean making or viewing something (in this case, death) as an unnatural phenomenon (Merriam-Webster 2022).

The Politics of Death and the ‘American Way’ of Dying

In the United States, the politics of death—when, how, where, and the social circumstances by which one dies—raises crucial questions about the cultural and political values placed upon people’s lives. As is evident by certain political attempts to dismiss Covid-related deaths, or by cultural norms that minimize the visibility of death and dying, the American way of contending with death seems to center around delay and evasion. As stated in Warehouses for the Dying, Dr. Paul Merik, a critical care physician at Sentara Norfolk General hospital, stated “Americans not only don’t want to die, but they are also unwilling to accept the reality of death” (Whoriskey 2019). This phenomenon, American’s unwillingness to accept death and its realities, gained significant momentum during the SARS-CoV-2 pandemic as Americans’ intent to evade death while being in a state of ‘ignorance is bliss’ became ever so apparent. When SARS-COV-2 first came to the United States, the Centers for Disease Control (CDC) advised Americans that the virus may be one’s death sentence, particularly if the patient was elderly or suffering from a pre-existing condition that had compromised one’s immune response. In order the slow the spread of the virus and to protect oneself and their neighbor from being infected, the CDC recommended the combination of mask wearing and social distancing. Both recommendations were highly refuted and politicized by nearly half of the United States’ population. Despite the CDC’s warning of the high transmissibility of the virus and the higher death rate when compared to the common strains of influenza, a large portion of the American population and elected government representatives continued to downplay the severity of the threat, and, as a result, Americans were (are) dying institutionalized, intubated, isolated, and no longer in control. The cultural response to SARS -CoV-2 should not register as such a surprise; this is the way many elderly Americans are dying already. Whether denying the severe threat of death by SARS-CoV-2, or not allowing death to happen “naturally” when it is time, evading the realities of death leads to untimely death—whether over-extending and prolonging life, or in the case of SARS-CoV-2, shortening lifespans.

Due to ground-breaking research and discovery, medical advancements have prolonged the lives of those living with chronic illnesses (Kaufman 2006, 22). In return, these advancements created an increased burden on healthcare resources backed by an increase in challenging discussions and attentive treatment near the end of one's life, resulting in patients and their surrogates arriving to health institutions with illusory expectations of the kind of care administered (The Lancet Respiratory Medicine 2016). Death is not portrayed as an enemy in need of defeat within solely the ICU ward, however. As Hannig (2017) articulates:

> [L]ook at the plethora of contemporary fantasies of immortality, which range from anti-aging creams to efforts to download a person's brain so he or she can continue to live virtually, to cryonics, the practice of freezing and storing bodies or body parts in the hope that future scientists will thaw them and bring them back to life.

The dedication to evading death is more prominent within the United States than it is to confront, prepare for, and accept the inevitable despite death being the one universal phenomenon known to exist among all living organisms. Why is this the case, particularly within the United States?

According to Anita Hannig (2017), anthropologist and associate professor at Brandeis University, Americans did not begin avoiding death until the end of the 19th century. Up until that point, Americans were comfortable with the aspects of death as most individuals lived their final days within their home, and families took care of their own dead. Jones et al. (2014), authors of Extending Life or Prolonging Death, claim the biomedicalization of aging initiated a new form of medical care where complex and expensive care became routine without contemplation of what was being accomplished with the goal of viewing the aging process as an entity capable of being controlled with modern medicine. This new form of medical care, where aging is viewed as a medical issue, has been studied extensively by Dr. Sharon Kaufman, medical anthropologist and Emeritus professor at UC San Francisco, as biomedicalization of aging has laid the foundation for widespread utilization of aggressive prolongation of life treatments in the present day (Jones et al. 2014; Kaufman, 2013). In other words, the biomedicalization of aging has resulted in life being so highly medicalized that aging is viewed as a procedural failure rather than as an expected stage of life. Cardiopulmonary resuscitation (CPR), for example, is performed today on every applicable patient unless otherwise noted via the form of an advanced directive or 'do not resuscitate' (DNR) status; however, when CPR became widespread in the 1960s, it was not considered ethical to be performed on those unlikely to recover, typically those with previous chronic illnesses and older in age (Hillman 2012; Kaufman 2006, 118).

These themes of rationing care and allocating medical resources among those most likely to survive (and contribute to the economy) draw parallels prevalent in organ transplantation, where the paradigms of organ transplantation and the biomedicalization of aging overlap, and tensions between "fairness and the tyranny of potential" in an aging society clash, as described in Kaufman's (2013) scholarship. Throughout hundreds of hours being around healthcare workers, of whom share years of experience on the front lines, many conversations were made about death, dying, and the gruesome process death becomes once institutionalized. Medical professionals spoken with throughout my fieldwork shared a common understanding regarding naturalization and acceptance of death, and expressed strong conviction of not wanting to be institutionalized during their final days. Throughout these conversations, Kris often told me "Creighton, if my children have me in the hospital on life support, do me a favor and stick a piece of gum down [the ventilator tube]." This perspective shared among medical staff is similar to the perspective of the US population in the 19th century, as Hannig (2017) describes, where individuals were routinely exposed to the stages of death and dying among their loved ones within their own homes, and therefore were comfortable with the natural stages of dying.. However, these profound preferences shared by medical staff are far from the views and mentality of the average American and the system by which they live. It was not until healthcare became mass-institutionalized that the remainder of Americans underwent a systemic change regarding viewing and coping with death. In similar ways the biomedicalization of aging and discussions of resource allocation brought systemic changes to US healthcare regimes, I observed throughout my fieldwork the similar extent and consequence this new era of medical care, where aging as a medical failure, evolves to death being the new medical failure.

The critical and emergency care specialties have developed the ability to prolong the lives of thousands, if not millions, of Americans each year (Kaufman 2006, 22). In return, the aging population will develop chronic illnesses associated with 'normal aging' (Alzheimer's, cardiovascular disease, cancers, diabetes, etc.) many of which are not amendable to the interventions offered within the intensive care unit (Kaufman 2006, 22). Nevertheless, individuals with these chronic illnesses can be kept alive with the aid of modern-day machinery and pharmaceuticals (Hillman 2012). These patients and the like, including UN and UW, were referred by medical staff as "circling the drain." This phrase was often said in passing between healthcare providers, and the meaning it held was the end-all-be-all: someone was on the verge of death and being kept alive strictly with medical intervention. "Circling the drain" was rooted in the open secret of the (inevitable) dying process: infection, septic shock, and hypotension, followed by pneumonia, organ failure, and the infamous death rattle. However, the contemporary dying process is not adequately represented by the phrase as it fails to fully contextualize how Americans are dying in present time: institutionalized, intubated, and stripped of one's dignity and autonomy. By "dignity," I mean the maintenance of one's own physical and spiritual value that supports the individual's idea of self-respect, and recognizes one's ambitions and capacities with how to be treated, particularly when it comes to end-of-life. This definition was inspired by Social Care Institute for Excellence, but with some slight modifications to address the practical dilemmas during whose death experiences informed this essay (SCIE 2022). Neither the desire to have one's life prolonged nor the ability to prolong the lives of others are necessarily what consumers and medical teams are asking for; however, health institutions and their aggressive life-prolonging medical practices are a major contributor to the unsustainable cost of healthcare, and further fuel the contemporary medical failure of death (Hillman 2012).

Breaking Down the Numbers – *Before* the SARS-CoV-2 Pandemic

Analysis of the 2016 fiscal healthcare data revealed the nation's medical bill added up to $3.7 trillion — about 18 percent of the nation's total GDP (Reid 2017). As "one in every six dollars spent went to healthcare," financial experts concluded that approximately "five percent of the United States' population accounted for 50 percent of all medical costs" for the 2016 fiscal year (Reid 2017). More specifically, in the same $3.7 trillion-year of 2016, one quarter of the Medicare budget was allocated toward strictly end-of-life care and ICU admissions. This may be attributed to the financial incentives built into the Medicare and Medicaid programs which encourage providers to render more services, particularly those more intensive in nature, than are necessary or beneficial (The Lancet Respiratory Medicine 2016). To visualize the magnitude of spending in terms of ICU beds, the United States has an average of 25 ICU beds per 100,000 people, whereas the UK allocates an average of 5 ICU beds per 100,000 (Hillman 2012). Despite the availability of more ICU beds and a much higher spending budget and rate, the United States and UK share similar patient outcomes upon comparison of the care received and the ailments treated and could indicate inappropriate ICU utilization within the United States (Hillman 2012). More specifically within the United States, a study compared patient data and longevity of those who opted for high-intensity treatment to those who did not undergo high-intensity treatment and found no significant contrast in patient outcomes (The Lancet Respiratory Medicine 2016). While one may view the additional spending and emphasis on end-of-life care as a sign of valuing the lives of elderly people, one may also view the excessive spending and emphasis on high intensity end-of-life care as enablers of a systemic capitalization on dying Americans and the quantifiable medical failures such as death.

Every health institution has one or more departments designated as the institution's top source of income, and, according to Dr. Joseph

Smith, a Pulmonary Critical Care physician at Eskenazi Health and a sub-internship associate for the Indiana University School of Medicine in Indianapolis, the Intensive Care Unit (ICU) is one of the top departments providing income to hospitals throughout the nation. Exploring fiscal data from 2011 among 1,882 hospitals in 29 states from Barrett et al. (2011), Healthcare Cost and Data Project, the highest proportion of ICU utilization came out to be $5,914,560.23 per hospital, and the lowest proportion of ICU utilization came out to each hospital reaping $725,082.74 for a grand total of each hospital of the 1,882 hospitals studied to have billed approximately $6,639,642.97 for solely ICU utilization in 2011. The grand total assumes every hospital possesses and offers equal capabilities, which is untrue; however, if each hospital billed equally and had a proportionate number of patients in respect to each other, then each hospital of the 1,882 counted would reap the greater than $6 million ICU utilization bill in 2011. The data provided demonstrates the magnitude of the billing if each institution was proportional to each other, and more importantly, demonstrates how the system profits off Americans during their inevitably most vulnerable times.

The data from 2011 and 2016 concludes a continual emphasis on providing high-intensity care within the United States, with little to no indication of slowing down. Most of the care resulted in the loss of life succeeding the initiation of care as "hundreds of billions of dollars are spent treating Americans who are within hours, days, or weeks from their death" (Reid 2017). While not all the patients referenced in the Healthcare Cost and Data Project died and treatment was not necessarily given to prolong their lives and evade death, many Americans will receive the most care ever received within the last hours of their life, with over one-third of Americans undergoing operations within the last month of their life (Reid 2017; Kaufman 2006, 1). This statistic supports the "pay-for-service" healthcare system within the United States which rewards institutions for additional treatment and investigation. In return, however, the "pay-for-service" system has increased the challenge of coding or quantifying a "good death" within the United States (The Lancet Respiratory Medicine 2016; Jennings 2007).

While it may be intuitive to assume that the sicker one is the more care they will receive, the United States healthcare system has not undergone major structural change to exhibit the qualifications for a "good death," especially among those subjected to dignity-compromising treatments to combat complications related to chronic illness(es). Instead, the US healthcare system evolved to be more efficient in combining morality and capital, all within the name of health, to gain the long-awaited profit from common and expensive end-of-life procedures that are nearly universally administered, regardless of if the patient is unlikely to recover from the administered treatments. Is a "good death" within the United States only achievable if the death is "good" for the economy?

The Search for a "Good Death" and Interviews with Dr. Smith and Dr. Carlos III

During an interview with Dr. Joseph Smith, Smith described what he qualifies as a 'good death' as being "surrounded with family, being at peace with the circumstances leading up to his death with acceptance of an end and being free of pain and suffering." Similarly, Dr. Carlos III, a Pulmonary Critical Care physician at Eskenazi Health, described a "good death" for himself as being surrounded by his children, pain-free, and described the circumstances that constitute death as "points of no return" regarding the futility of the brain and circulatory flow. Upon comparison of Smith's and Carlos' viewpoints to a survey given to Americans about preparing and providing care for individuals nearing the end of life, 7 in 10 Americans (71 percent) share a common goal with Smith and Carlos as "helping people die without pain, discomfort, and stress" should be more important when it comes to healthcare at the end of individuals' lives (Hamel et al. 2017). However, 4 in 10 (37 percent) Americans of the same group claim the system places "too little emphasis on helping people die without pain, discomfort, and stress" and 33 percent believe the United States places "too little emphasis on extending life" (Hamel et al. 2017).

Although most of the United States population, including the physicians interviewed for this research project, have profound preferences for how they would like to spend their final moments of life, 49 percent of Americans believe they have too little control over their medical decisions with that percentage rising to 63 percent among those who are in fair/poor health (Hamel et al. 2017). These statistics strongly correlate to the data point that 7 in 10 Americans would like to die within the comforts of their own home; however, only 4 in 10 believe they are likely to spend their final moments at home (Hamel et al. 2017). Despite this data coming from the consumers of the United States' healthcare system, a system where autonomy is allegedly valued, it is as though the fates of where and how Americans will spend their final days of life are predetermined given Americans' acceptance that their wishes will likely be neglected.

The ones providing the care, however, possess a different and stronger conviction for how and where they intend to spend their final days of life. According to a 2014 study conducted at Stanford University, 88 percent of physicians from a variety of specialties and backgrounds would not want invasive or intensive medical intervention at the end of their life and would opt for a do not resuscitate order for themselves if applicable (White et al. 2017). Similarly, the physicians interviewed for this project, Dr. Carlos and Dr. Smith, both stood with the 88 percent surveyed for the Stanford study, but Dr. Carlos made clear the contingency of his decision being persuaded by the circumstances leading up to his decision to withhold or continue treatment. The question was then raised as to why these physicians administer high-intensity care when they have decided to forego the same treatments for themselves; do the physicians not have faith in the medical interventions that they are providing to increase longevity and aid in one's quality of life? Have the physicians 'beat the system' and naturalized death whereas Americans tend to avoid the subject all together? When posed the question to Smith, his initial response was 'wow' and was followed by moments of silence as he formulated an answer. Smith then proceeded to explain how he finds comfort in providing the care he would forego for himself by "consolidating with the council of the situation, such as the patient, their family, or surrogate if the patient is incapacitated." From there, he would "express the severity of the situation and what options, if any, there are for the next course of action within the treatment plan." He goes on to say, "If I do everything I am trained to do and I do so in a manner without compromising my own integrity, then that is sufficient for me to provide the care—the same care which I would forgo for myself."

Smith continued his response describing the "very high bar set for physicians," preventing them from denying treatment without a solid legal basis and a holistic understanding of the situation. Smith began to elaborate on a case he had experienced recently where he felt the surrogate's wishes were not in the best interests of the patient; however, legal questions were raised by himself and his team on how they would prove the intent of the surrogate's wishes and disprove that the requests of the surrogate were in line with the patient's requests. Ultimately, physicians in the United States cannot implement the concept of futility very easily as that would eliminate the patient's autonomical rights—the autonomical rights that Dr. Carlos believes is a "driving home point" for the United States healthcare system. Dr. Sharon Kaufman, in *And a Time to Die* (2006, 117), wrote about the discourse autonomical rights have within the US healthcare setting, where some providers, like Dr. Carlos, believe autonomical rights is essential for reducing or eliminating pain, loneliness, and humiliation that commonly accompany patients during life-prolonging (or death-prolonging) treatments. Other providers, such as Dr. Smith, have a greater time choosing between treatments labeled "heroic" or "humane" (Kaufman 2006, 118). These tensions are prevalent in other healthcare systems around the globe, however, in some countries the handling of patients' autonomical rights is navigated by medical training rather than institutional policies.

Comparative Case Study of Doctors and Death: USA vs Netherlands

The United States' approach to providing healthcare possesses a significant difference regarding physicians making decisions to withhold treatment from critically ill patients in European countries such as the Netherlands. Citing A Nationwide Study of Decisions to Forego Life-Prolonging Treatment in Dutch Medical Practice, 17 percent (874 patients of 5,146) of decisions to withhold treatment were made by physicians without discussion with the patient and/or family, and with zero knowledge of the patients' wishes (Groenewoud et al. 2000). 42 percent of patients whose treatment were halted by the wishes and orders of the physician died within 24 hours or less, and 25 percent of those patients and families were not involved in the physician's decision to withhold treatment (Groenewoud et al. 2000). With lack of discussion being no exceptional finding given the structural and cultural difference in interpreting death within the Netherlands, "of the decisions to withhold cardiopulmonary resuscitation in incompetent patients admitted to a public teaching hospital, 21 percent had not been discussed with family members" (Groenewoud et al. 2000). More specifically, within the intensive care unit, 25 percent of physicians reported foregoing life-sustaining treatment without the consent of the patient and/or the relatives (Groenewoud et al. 2000). Breaking down the condition of the patients whose treatment decisions were made by the physician with and without discussion of others involved, 67 percent of patients were not fully competent and only 13 percent of those not fully competent had their wishes known and on file within their medical records (Groenewoud et al. 2000). The study indicated that the motives of the physicians were "practical" and resorted to removing autonomy in excruciating circumstances where "[the physicians] thought the decision (the halt of treatment) was clearly the best for the patient" (Groenewoud et al. 2000).

Despite the increase in compromised autonomy as observed in the Netherlands, the rate of death of those deemed critically and/or terminally ill did not increase over time and did not appear to be significantly disproportionate to the population who were not battling critical and terminal illnesses. Upon comparison of the Netherlands to the United States, the only increased statistic noted was the Dutch ICU utilization and the number of individuals who succeeded death with their dignity intact. As stated previously, however, physicians in the United States do not have the power to withhold or discontinue treatment without some kind of legally backed consent and knowledge beforehand. Although US physicians possess the power to override a patient's decision due to the physician's medical knowledge of the circumstances at hand, the decisions made among the shareholders of the power dynamic must be evaluated and approval from a legal authority must be warranted. Due to the complexity of the United States' healthcare system and the fluidity of rights and legal actions between patients and providers, medical providers are often cornered in strengthening the longevity of this public health crisis within the United States while in constant search for a moral remedy.

Centering the Margins

Perhaps the most overlooked and most affected population by this public health injustice are the medical providers (the "medical heroes" coined during the beginning of the pandemic) who devote their lives to the United States healthcare system and its consumers, but also face a moral conviction when the consumers can no longer be satisfied by the guidance and recommendations granted by the interpretation of medical data. After analyzing Smith's recent patient experience detailed during the interview, physicians and other medical personnel are obligated to be complicit in the systemic notion of prolonging life upon the requests of the patients or their appointed surrogates. In a study that was conducted in 2003 among critical care physicians, most of the respondents indicated "they were comfortable with making recommendations and viewed it as appropriate and part of a critical care physician's duty" (Yaguchi et al. 2005, 165). However, within the same study, "50 percent of the US critical care physicians surveyed stated "it was inappropriate to make a recommendation if the surrogate did not request one," with only one-fifth of respondents reporting they always give surrogates recommendations (Yaguchi et. al 2005, 165). Although the results of this study display the limitations self-reporting studies possess; the data from the study provides insight to the way end-of-life care is administered within the United States from the views of those providing the care.

An explanation for why these physicians were hesitant to make recommendations regarding a patient's care may be due to their role as "patient ambassadors." While advocating for what is best for the patient, the duty of a physician in a highly demanding field, such as critical care and emergency medicine, often thrives on embracing uncertainty. One patient plan does not resemble another given different medical/family histories, ages, lifestyles, environments, etc., and as a result, it is nearly impossible for physicians to practice with full confidence within time-sensitive circumstances. Dr. Smith and Dr. Carlos also mentioned the limitations and legal pressures preventing them from "backing away" and solely allowing the decisions to be made about the patient by the patient-appointed surrogates. To do this, the physician assumes the surrogate understands all the complexities involved, such as the underlying medical condition, treatment options, and prognosis — which is less than ideal in an emotionally draining moment for a family member or representative who shares a personal relationship with the patient (Hillman 2012). This move is solemnly done within United States medicine, however, and as mentioned previously, there are many stakeholders in medical institutions whose consent is required for these seldom-made decisions. Nevertheless, the institutionalized end-of-life medicine practice remains to be nothing more than supermarket medicine for its consumers.

Medical providers possess a significant and direct role in the care Americans receive, meaning the medical staff and their complicities to the healthcare system's inability to accept death as a stage of life, but rather a medical failure, are committing acts of structural violence themselves. While it is inappropriate to villainize medical providers, it is important to understand and assume that "good people do things for bad reasons," and to explore how medical providers are doing so on a national level (Rubaii 2020). As a result, patients often suffer a cruel and prolonged death because of the United States' lack of expertise in handling end-of-life care, and due to the perpetuated illusion that prolongation-of-life care correlates to a restored quality of life among the ill and dying (Hillman 2012). The culture of the Intensive Care Unit was founded upon restoring homeostasis in a rapid and effective manner; however, with the technological abilities to rectify the system's wishes to keep individuals alive for as long as possible, "medical providers feel like they are inflicting more harm on patients whose lives are compromised, but their last (awoken) wish, along with the wishes of the family, enforce you to continue efforts" (Koesel and Link 2014, 331). Consequently, end-of-life care and the utilization of aggressive measures have been cited as two of the most prevalent conflicts within the ICU, resulting in staff burnout and poor quality of care, and further inflicts additional suffering among the most vulnerable patients (Koesel and Link 2014, 331).

Unidentified Illinois (UI) was one patient who struck me the most regarding the conflict between the oath of "do no harm" and the legal barriers of "doing everything you can." UI, a 90-year-old white male from a nursing home in Indianapolis, was brought into the ED due to a rapidly deteriorating case of sepsis following a bacterial infection. Rather than being treated in the "Shock Rooms," providers sent him upstairs to the ICU, and I anxiously trailed behind. We arrived to "Room 52," greeted by a dozen medical personnel ready to assess UI and develop a patient care plan. Discussions were made about intubating Unidentified Illinois. UI was in-and-out of consciousness, with the periods of consciousness being ghostly in presence. Despite being irresponsive to commands, UI would respond with groans and slight physical resistance to those who touched him. Despite his conscious absence in the room, the fear between the attending physician and Unidentified Illinois was prevalent. The medical resident assigned to this patient, Dr. X (pseudonym), weighed the options with the attending physician on staff: to intubate, or not to intubate? UI's vital signs were rapidly dropping, with oxygen levels hovering in the high 60s low 70s (out of 100), despite being on continuous oxygen. From a 'medical textbook stand-point,' intubation would be necessary, however, on a moral basis, the trauma induced to the patient would overshadow any benefits from the intubation. Ultimately, the decision was made by the resident and attending physician to intubate the patient as the patient was not on file for being a DNR, nor was there a legally appointed surrogate present. In other words, the medical staff were in a legal bearing to "maximize efforts to return the patients to their baseline levels" all while balancing the oath of "to do no harm"—common themes touched on during interviews with medical staff following the case.

Supplies were gathered for the resident to perform the intubation, however, the resident refused to do so until the patient was fully sedated—something the attending physician argued would take too much time. "I am not intubating this patient until [UI] is fully sedated!" The resident yelled out under the pressure. "Doc, the patient really should have more sedation medication before we do [the procedure]," Miranda, a Respiratory Therapist, added. "We do not want this patient to aspirate in the process." Miranda's comments struck me, not because of her objections, but rather because they exposed the shift in the treatment process: the intubation is necessary to "do no harm" by coinciding with the patient's requests (or lack thereof) to minimize the deteriorating conditions, while simultaneously running the risk of doing harm by prematurely intubating the patient before full sedation. It is this moral and legal conflict which fosters the idea of death being a medical failure. The worst possible outcome. The attending physician refuted the recommendations made by his colleagues, quoting the lack of time the patient has until UI's heart would stop completely. The scene was horrid. UI, not fully sedated but also not fully conscious, struggled and fought the intubation with the little energy he had remaining. Medical staff and I were then tasked with holding UI's arms and legs down so that the intubation process can occur more smoothly, while simultaneously, administering sedation medication into UI. "Everything will be OK [UI]! We are helping you breathe!" One nurse reassured UI. Eventually, UI was sedated, but died several hours later in full code.

The treatment described above with UI was adopted by US healthcare regimes in the 1980s –1990s to treat aging as a medical issue, with the implication if someone inevitably reaches old age, the patients and their deaths would be deemed as a medical failure. This may seem counter-intuitive—why would the patient's death be deemed a medical failure if the treatment provided to them failed? Simply put, because the patient reached the inevitable old age and are dealing with the complications of the aging process, all of which are immediately followed by death, the patients are now out of scope with the capabilities modern medicine possesses, and the patient is left with nothing more for modern medicine to provide them. As stated by Kris during an interview: "because medications and treatments have altered the aging process, there is some hope that, despite [the patient's] comorbidities, we can optimize them enough to bring them back to the baseline they came in at." This point is important—and commonly highlighted within the ICU and ED—as it demonstrates the limitations modern medicine has when dealing with end-of-life care. Throughout observations made during my clinical experience and patient encounters detailed in interviews with medical staff, there is no "reversal" of ailments happening at the bedside when the patient reaches the inevitable state of "circling the drain." It is at this point that the treatment focus shifts from combating the aging process (the "circling") to combatting death itself (the "drain") and the paradigm shifts from aging as an amendable entity to death as a looming medical threat—the new "thing" to overcome. Patients and their families often arrive to the ICU with the illusory expectations that suddenly all comorbidities would be resolved given the magnitude of resources and machinery at the patient's disposal (let alone the financial burden these resources and machines cost to acquire and use by the patient). The reality is, however, most end-of-life treatments result in death becoming prolonged and violent, rather than providing patients the means to overcome their current circumstances. Death, therefore, represents quantifiably and figuratively, the ultimate failure within US healthcare regimes, and this failure is at the expense of patients' dignities and livelihoods, and the medical providers' moralities.

American Self Reflection

The United States' healthcare system carries mixed reviews among the US population regarding end-of-life care. Citing a 2017 study titled "Views and Experiences with End-of-Life Medical Care in the US," 25 percent of respondents rated the care as "good," 27 percent rated "fair," and 22 percent rated "poor" (Hamel et al. 2017). In terms of autonomy, the majority (87 percent) believe that patients and their families should have the greater say regarding which treatment options to pursue for patients who are seriously ill and nearing the end of life, while just 8 percent believe doctors should have the greater say (Hamel et al. 2017). The data presented on autonomy currently reflects the system Dr. Carlos refers to. Dr. Carlos also falls within the majority who appreciates the autonomy of US medicine rather than the "paternal-led" medicine observed in other countries. Aside from autonomy, Americans state to also prefer honesty from their healthcare providers, no matter the prognosis (Hamel et al. 2017). Just 7 percent say that when a patient is seriously ill, it is more important for their doctors to emphasize hope, while the vast majority (88 percent) say it is more important for doctors express full honesty, even if there is little chance of recovery (Hamel et al. 2017). However, it has been observed in the past and present that when medical professionals present the objective information of a loved one's condition, trust is extracted from the science and medicine and is applied to one's faith or opinion (Field 1997; Schenker et al. 2012). In other words, while a significant portion of Americans desire honesty and bluntness, that desire does not correlate with acceptance of the circumstance, nor does it indicate that death is accepted and embraced. This phenomenon strongly correlates with the American response to mask-wearing, social distancing, and receiving the COVID vaccine during the SARS-CoV-2 pandemic.

Despite the autonomous nature of US healthcare, the public sees room for improvement when it comes to giving patients control over end-of-life medical decisions. About half (49 percent) believe most people in the U.S. have too little control over decisions about their own medical care at the end of life, while four in ten (38 percent) feel patients have about the right amount of control (Hamel et al. 2017). Among those who identify with their own health as being fair or poor, an even higher share (63 percent) indicate feeling they have too little control over their medical decisions (Hamel et al. 2017). When discussing this data with Dr. Smith, Smith indicated that options are available; however, not many seek the alternative options until it is too late to have full control over the circumstance (McHugh et al. 2015). Given how options are currently on the market to remedy this public health crisis, resources remain under-utilized by many Americans (including by those who feel they have too little control over their fate). This reveals Americans not only deter death itself, but also the decisions about it.

Impact of SARS-CoV-2

The United States' healthcare system and the cultural views of death consist of direct and indirect acts of structural violence, the morality and economy of death, and the politics of death and dying. Death as an entity evolved from an accepted inevitable series of events to a feared, evaded, and violent demise capitalized upon via the trafficking of morality between the vulnerable and systemically complicit. With medical breakthroughs prolonging the lives of millions, Americans are living longer, thus leading to further complications and expenses throughout one's lifetime to which the thought of an "end" is repulsed by the living and the economy. Regardless of the kind of exchange done, through financial means or by morality, Americans are unnecessarily suffering; patients are suffering from a prolonged death given the system's lack of expertise and emphasis in end-of-life care, and medical staff are drowning in their own acts of structural violence. Amidst the onset of the SARS-CoV-2 pandemic, the CDC emphasized the danger SARS-CoV-2 may pose to those with pre-existing conditions—nearly three-fourths of the adult population within the United States—with ~30% of those with a “deniable” pre-existing condition per the standards of the health insurance market (Reid 2017). This data demonstrates that medical breakthroughs stemming from biomedicalization of aging have curated the perfect storm for a pandemic, such as SARS-CoV-2, affecting the ever-vulnerable populations. After decades of treating aging as a medical issue and the curation of breakthrough treatment options for life-altering diseases, along with the systemic denaturalization of death and the American superiority and immortality complex, the United States suffered the worst possible outcome from the SARS-CoV-2 pandemic for a developed nation.

Years without a national public health crisis, such as SARS-CoV-2, passed which allowed the systemic denaturalization of death and the façade that Americans were indestructable to brew and spread into succeeding generations. In reality, however, Americans were dying within healthcare institutions in the same violent ways they are dying from Covid. Alas, a violent death wave hit by “unprecedented” means: over one million American lives taken from SARS-CoV-2 (CDC 2022). Perhaps, however, the SARS-CoV-2 pandemic is not directly responsible for the deaths of one million Americans, but rather is an opportunistic infection taking advantage of the United States’ weakened healthcare infrastructure and its illusive death-preventing capabilities and demonstrating the violent extent death is capable of the longer is it prolonged, avoided, and viewed as a medical failure, rather than a universal demise with violent capabilities.

Conclusion and Future Directions

As demonstrated throughout this research, death in the United States is taboo and viewed as a medical failure within US healthcare regimes. Thus, discussions regarding end-of-life preferences are dismissed with loved ones and medical personnel, and the fear of the “unknown” is comforted by the bliss of ignorance. Americans strengthen the magnitude of this two-fold public health crisis as their acceptance for a predetermined institutionalized fate is greater than their acceptance for the once universal truth of death. To restore the dignity of dying Americans, death needs to be naturalized — something that has not been done on a structural level in the United States for hundreds of years. While many discussions have already taken place between patients and surrogates detailing preferences leading up to and following one’s death, the societal and cultural barriers of death being taboo need to be demolished for true resolution to take place —where prolonged suffering is no longer the accepted outcome for dying Americans (Kaufman 2006, 117). It is therefore the duty of the medical profession to foster these conversations about death and dying to Americans, and aid Americans in viewing death as a successive stage of life.

Given the profoundness of death, there is no simple or binary solution in naturalizing its existence, but rather systemic change needs to be undergone to restore Americans’ dignity during the dying process, and to minimize unnecessary suffering among the dying and the medical providers. There is no better time than now, amidst a global pandemic, to confront the relationship between SARS-CoV-2 denial and the politics of death-denial systemically. Rather than perpetuating the deceptive narrative that the United States possesses vast life-saving capabilities within the critical care specialty, and thereby forcing medical staff to compromise dignity of their own, healthcare institutions and stakeholders possess a moral obligation to reveal the open secret of the limitations within the critical care specialty regarding the lack of treatment for the inevitable. Healthcare providers across specialties must educate patients on the offerings of hospice and palliative care, and advocate for policy change to increase the accessibility of advanced-directives and DNRs for all individuals, regardless of health status and age. Palliative care is currently offered on the market; however, its services remain under-utilized and inaccessible by much of the public due to lack of education and lack of proximity to alternative end-of-life treatments (Kaufman 2006, 278). To increase accessibility, funding and expertise need to be allocated into the palliative care sector to allow for an increase in education to build a larger demand for the specialty, especially within rural and medically under-funded communities, and to foster a swift transition of care from critical care specialties to at-home care. While this research explored the tension in which death is viewed as a medical failure within US healthcare regimes, future research is encouraged to explore other ways Americans are suffering and dying without dignity outside medical institutions, such as from the politics of environmental contamination, racism, police brutality, and gun violence.

One’s quality of life and the restoration of dignity on one’s deathbed have been missing focal points within the United States healthcare system for decades, and Americans have been ‘circling the drain’ while paying the consequences of the nation’s inability to accept death, and view it as a legitimate entity, until it comes knocking on their door. Despite the overarching cultural belief within the United States, death is not a medical failure; however, the United States’ inability to accept, prepare for, and naturalize death and its processes is the most detrimental failure of them all.

I have learned from my life in medicine that death is not always an enemy. Often it is good medical treatment. Often it achieves what medicine cannot achieve—it stops suffering.

—Christiaan Barnard (Good Life, Good Death 1980, 144)

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The Journal for Undergraduate Ethnography

Narratives of Tradition and Transcendence: A Nuanced Examination of the Magnolia Phenomenon

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ABSTRACT

Two instantly recognizable structures grace the skyline of Waco, Texas. Rounded, looming, and rusted, the Silos form a geographical indicator of the presence of Chip and Joanna Gaines' home-centric empire — Magnolia. A brief drive through Waco soon reveals that Magnolia and its distinctive subculture are unlike any other entity within the city. Magnolia is not Waco, yet it defines Waco. Within this project, I seek to better understand the unique subculture of Magnolia juxtaposed against the drastically different environment of Waco. To fully understand the inner workings of this subculture, I compile details from frequent visits to Magnolia occurring over a period of three months, noting everything from the layout of the grounds to the products sold to the people who enter Magnolia's gates and their tendencies in a field notebook. My studies help me to assemble a comprehensive picture of Magnolia's unique subculture and its effects, both positive and negative, upon the city it inhabits. In doing so, I hope to contribute to scholarly understandings of the inequitable outcomes resulting from gentrification within Waco, addressing the lack of knowledge within existing literature about Magnolia's role in this process.

Keywords: gentrification; urban development; Magnolia; Waco

Purple flowers dance up and down on their trailing vines, whipped back and forth by tempestuous winds. An overcast sky, heavy air, and the indecisive wind accompany me on a moody first day of study at Magnolia. As I stroll past the stately wrought iron fence that separates Magnolia property from the rest of the city block, ducking to avoid the dancing vines, the familiar melody of Ella Fitzgerald's "Cheek to Cheek" greets me. Growing louder as I turn the corner, past window boxes of tidy flowers, the song follows me as I enter through the gates, prepared to begin my ethnographic study on the people and customs that await inside.

The physical layout of Magnolia may be visualized best when divided into two halves sprawling across a rectangular property spanning two city blocks. The first half of Magnolia begins with the petite white bakery tucked away in a corner of the property, just outside of the fence. Passing by the bakery and into the gate, one encounters the massive white structure of Magnolia Market, styled after the rustic grain barn from which it was partially constructed. Across from the market looms the (now iconic) Silos, two rotund, rusty white buildings that fade into Waco's picturesque skyline. At their feet are plots of ornamental gardens. The manicured landscape of Magnolia stands in sharp relief to the neighboring city blocks which boast an old Baptist church, a school football field, and a Salvation Army shelter. On the day of my first visit, a homeless woman rests on a curb just outside Magnolia's wrought iron fence. Terribly thin, she sits on a street corner opposite Magnolia with her head in her hands. A police car drives past her cautiously. The sobering scene forms a strange contrast to my experience inside.

Between the market and the Silos lies a massive square of green AstroTurf, dotted with plush beanbags and reverent guests. These guests mostly consist of white women ranging from their late twenties into their sixties. Many of these women are accompanied by their families, leading their husbands who dutifully trail behind holding shopping bags and young children alike. Some women, instead, come in pairs or bring only their significant other. Many others travel in multi-generational family units, and still more explore the property in all-female groups. Seldom few come alone.

There seems to be an informal dress code among the women; an array of loose dresses, bright colors, soft pastels, and delicate florals catch my eye. Men are dressed more casually, but children wear their Sunday best. Each woman has carefully curled or straightened hair that they fuss or primp before taking photos. Selfies and group shots, individual portraits, in front of the Silos or on the green, with their iced tea jars and their brown Magnolia bags, or some combination thereof. Four middle-aged white women break this unspoken dress code donning matching, custom-made, bright purple, heathered t-shirts which read, "GIRLS TRIP: Cheaper Than Therapy." Becoming aware of my gaze, the women glance uncomfortably at me before retreating to a nearby food truck.

Just around the corner lies the second half of Magnolia, marked by the shopping village comprised of small, uniform, white shops constructed around a slightly smaller manicured green, between the Old Church and the storefronts of Magnolia Home and Magnolia Press. Security guards dressed in black roam the perimeter of the green and the fence. Though, against whom or what they guard, I cannot tell. This area, too, is bustling with activity and tourists, however, their demographic is markedly different from those I observed at Magnolia Market. These guests are almost all senior citizens, white adults aged 65 and older, who stroll from shop to shop, peeking in windows and milling around stores, and rest on benches dotted around the central green as they recount their purchases, engage in lighthearted discussions, and take group photos. The senior citizens all wear brightly colored lanyards holding large, laminated nametags, suggestive of some sort of group association. Curious, I approach a group of three older women who have situated themselves on a bench for a break. The women are eager to answer my questions, informing me that they hail from Illinois and Missouri and have been traveling on an eventful bus tour for the past few days. Realizing the extent of their dedication, I ask one woman whether Magnolia lived up to her expectations. "Oh, it's everything I could have hoped for," she gushes in reply. Later in our conversation, the same woman wonders aloud how Waco residents feel about the relatively new presence of Magnolia and the subsequent flow of tourists into their city. Her tone reflects a self-awareness, an understanding that Waco residents may not hold Magnolia quite so dearly as she does. I reply with similar curiosity, assuring my new friend that the search for an answer to this same question is the reason I am here. Magnolia—the celebrated home décor empire that rebranded Waco, Texas into a tourist destination—is drastically unlike the rest of Waco, both visually and otherwise. Even so, it has transformed the city and brought a unique, insulated subculture to downtown Waco.

To ground my research, I will briefly describe the manner in which Magnolia and the 'Gaines phenomenon' (Trapasso 2020) more broadly came into being. The story begins when Joanna Stevens and Chip Gaines met in 2001, soon after they had both graduated from Baylor University in Waco, Texas. The couple married in 2003, and Joanna stepped into the role of the designer within Chip's business of renovating (or 'flipping') houses in the Waco area. Around the same time, the couple took out a loan to open a store they named Magnolia Market, fulfilling Joanna's dream of running a home goods business. After the couple had successfully been renovating Central Texas houses for a decade, they were noticed by the HGTV Network which produced a show starring the couple. The pilot for their show, dubbed 'Fixer Upper,' eventually garnered over one million views. The concept struck a chord with viewers who tuned in with increasing numbers to view feel-good stories of families finding and creating their forever homes in a newly revitalized city with small-town charm. Growing to become wildly popular, 'Fixer Upper' put the Gaines, Magnolia Market, and Waco on the map. The influx of money from the show allowed the Gaines to pursue other passion projects, such as purchasing two city blocks in the heart of downtown Waco, the home of two large, abandoned silos. This would become the site of many new ventures, including Magnolia Market at the Silos, Magnolia Press, Magnolia Home, Silos Baking Co., The Shops at the Silos, and more. During this period, the Gaines expanded Magnolia Reality (founded in 2007) and opened a restaurant, Magnolia Table, across the highway.

After the opening of Magnolia Market at the Silos in 2015, tourists began to flood into Waco, visiting the Silos at a rate of 35,000 a week (Brodesser-Akner 2016). Though 'Fixer Upper' stopped airing on HGTV after five seasons, as the Gaines elected to start their own television network, Waco's newfound popularity remains undiminished. The influx of tourism has transformed the downtown area of Waco, as new businesses have sprung up seemingly overnight, and formerly worn-down streets have become picturesque and appealing. Waco—once infamous for the federal government's raid of the Branch Davidian compound, the lynching of Jesse Washington, a devastating tornado, and the Twin Peaks biker-gang shootout—has gained the reputation as an ideal place to raise a family. Beyond its houses, Waco's name has been restored. The story of 'Fixer Upper,' for many, is a story of redemption. But for longtime residents of Waco, upon whom the Gaines phenomenon' has had varying, often harmful effects, the story of Magnolia is not representative of their experience. In Waco, there exists a growing divide between those who benefit from Magnolia and those who have experienced great loss as a result of Magnolia's success. These contrasting stories provide two distinct pictures of Magnolia's relationship with Waco, separated, as it were, by a wrought iron fence.

Methodology

I conducted my ethnographic study over three months from September–November 2021 for my Professional Writing and Rhetoric 4309 Undergraduate Research and Publication class at Baylor University. For this class, I was instructed to choose a unique subculture as the subject of a multi-month research and writing project. I chose Magnolia as my subject as I live as a student in Waco and am intrigued by the dissonant messages I encounter about Magnolia's effect on the city at large. To begin my study, I visited Magnolia Market at the Silos three different times, each for a period of a few hours, to sit and record my observations in a field notebook. During this period, lasting a few weeks, I also searched for relevant scholarship to inform my understanding of Magnolia's varying effects on Waco. My scholarly research, paired with my observations, led me to seek interviews with three people: a former Magnolia employee, who I will refer to by the pseudonym 'Megan,' a local couple with expertise in Waco's real estate market, Brian and Ashley Bundy (who I contacted through a distant family connection), and Anthony Betters Sr., a local Wacoan, 2022 Board President of the Dr. Pepper Museum, and City of Waco representative. These interviews were conducted in person and recorded after each participant signed a consent form detailing their knowledge of my project, their consent to use their words in my final report, and their right to request to read my report before it was submitted. I conducted my interview with the former Magnolia employee in September 2021, my interview with the Bundys in October 2021, and my interview with Anthony Betters in May 2022. After I finalized the bulk of my research and my interviews, I returned to Magnolia once more in October 2021 to gather notes on Magnolia's annual 'Silobration' event before writing my final report.

Gentrification, Space, and Place: A Review of the Literature

To reach a better understanding of the phenomenon at work in my college town, I sought to undergird my firsthand research at Magnolia with scholarly literature about urban growth in Waco and beyond. One source, a Waco realtor, sheds light on how Waco has changed since the Gaines were first televised. Examining local trends in home pricing, migration, and property taxes, Clare Trapasso analyzes what has happened in Waco real estate as a result of what she terms the 'Gaines phenomenon,' 'Chip and Joanna effect,' and 'Fixer Upper effect' (Trapasso 2020). As she observes,

> The city has changed in good ways — and in bad for locals…Certainly, not everyone in Waco is a fan of their hometown's newfound fame. The Gaines phenomenon has led to swarms of tourists descending on the city. And out-of-towners with seemingly unlimited budgets are driving up real estate prices to new heights, leading to higher property taxes for longtime Waco dwellers (Trapasso 2020).

Higher property taxes are only one manifestation of the change resulting from the descent of tourists and out-of-town residents into a newly crowded Waco. Another tangible change is evident in the cost of local homes, whose average prices "shot up nearly 52.1% from 2015 through 2019 in McLennan County, which includes Waco… That's a tough pill for many longtime residents to swallow, particularly if they're making area wages" (Trapasso 2020). This shocking change in home prices is two-fold: on one hand, the drastic increase in home prices has made it much more difficult for local Wacoans to purchase a home that fits their needs. On the other hand, homeowners in Waco now live in and sell homes that have grown in value. It is a change reflective of new wealth flowing within the city that helps some and hurts others, furthering an already existing inequity.

Vast inequalities have been present in Waco for decades, a result of practices traceable to the Jim Crow era. For instance, as early as the 1930s, the Federal Housing Administration utilized practices of scoring neighborhoods on a color scale to help government agencies and banks decide whether they would issue housing loans or mortgages to applicants from various neighborhoods. The criterion for a good or bad score was almost entirely based on race. Consistently, neighborhoods with African-American residents were assigned low scores and marked in red. As a result, applicants from these communities were denied housing loans from government agencies and private banks alike. The practice of redlining was prevalent in Waco and continues to be relevant today. The income disparity between neighborhoods with majority white residents and neighborhoods with majority non-white residents in Waco speaks to the modern inheritance of historical inequality. According to a 2021 report from Prosper Waco, many Wacoans are seeing an increase in their incomes. However, Wacoans who live in neighborhoods mostly comprised of minorities are seeing the opposite to be true: their incomes are stagnating, or even decreasing (Rhodes 2021). At the same time, economic activity prompted by tourism grows in Waco exponentially, almost overnight. This disparity points toward the reality of gentrification at work in Waco.

Understanding the complexities of this situation requires a nuanced perspective, one that Joel Kotkin and Wendell Cox offer in their writing for the Center for Opportunity Urbanism. Arguing that it is "time to move beyond the focus on gentrification led by the 'creative class'" (Kotkin and Cox 2019, 72), the authors note that,

> Life may have improved for many in our urban centers, but, as we have seen, many others are being left behind. Gentrification strategies, often focused on the downtown core, have done little for either the remaining middle or the largely impoverished working class, who together comprise the majority of urbanites (Kotkin and Cox 2019).

Their findings suggest that this is due to the "massive funds that are spent to attract more of the creative class and appeal to the hyper-affluent" which "have not, and will not, improve life for most urbanites" (Kotkin and Cox 2019, 72). In fact, "for many, this approach can only mean further impoverishment, largely due to higher rents, or lead to mass migration out of the cities that, for some, have been home for generations" (Kotkin and Cox 2019, 72). This principle is at play within Waco, where higher rent, property taxes, and home prices have forced longtime Waco residents out of their family homes in deference to the flood of affluent newcomers. Undeniably, Magnolia has helped Waco in remarkable ways and has even served to bring renewed life and activity to surrounding towns. Even so, Magnolia has not equitably grown Waco and has prompted gentrified circumstances that are nothing short of devastating for many longtime Waco residents.

Waco's real estate and citywide development practices are built upon attracting middle-class peoples to frequent and settle into increasingly gentrified areas of town, rather than investing in low-income families to create generational wealth and stability within communities of Waco's longtime residents. In Waco, affordable housing is becoming increasingly difficult to find and secure as it often becomes unaffordable due to rising property taxes or is demolished to make way for new development. The latter circumstance befell the Oak Lodge Motor Inn, a massive property which formerly occupied downtown Waco. This 72-room motel provided affordable housing for many years for those in the Waco community who would otherwise be houseless. Conditions at the property were said to be terrible. As one Waco Tribune-Herald reporter observed, "during the last city inspection of The Oak Lodge Motor Inn at 1024 Austin Ave. after the 2019 fire, the property racked up 32 code violations, with officials noting failing walls, foundation and ceilings, broken windows and doors, and a lack of carbon monoxide and smoke detectors" (Saegert 2021). Yet, for many Wacoans living on fixed incomes or government assistance, Oak Lodge was the only housing option they could afford.

The developers responsible for the demolition of the Oak Lodge Motor Inn saw the situation differently. Describing Oak Lodge as "one of the last problematic properties in the downtown area" (Saegert 2021), developers planned to replace the inn with appealing condominiums and retail areas. "They plan to tear down the 72-room motel and replace it with a complex of 15 residential spaces totaling 23,757 square feet and three retail spaces totaling 8,710 square feet," the reporter continues. "The expected sales price for the larger condo units would be $452,000 each, and the expected sales price for the lofts would range from $204,000 to $312,750 each" (Saegert 2021). A few blocks away, in the heart of downtown, the same developers have built a restaurant and hotel, also meant to attract affluent tourists. These changes would act as a "'welcome' sign into downtown for visitors, indicating they have reached the city core" (Saegert 2021). When the developers first announced their plans to demolish the Oak Lodge Motor Inn, they assured Wacoans that work on the project would begin only after current residents had secured new places to live (Saegert 2021). However, as another reporter tracking the story writes, "most leaving Oak Lodge 'will have no place to go, will end up sleeping on someone's couch or in a car'" (Copeland 2021). The former residents of Oak Lodge are what one local homelessness advocate describes as the "invisible homeless" —people who face housing insecurity, but often are not perceived or supported as such (Copeland 2021). The widespread, chronic housing insecurity in Waco is evidence of a "systemic issue that Waco doesn't have the resources for" (Copeland 2021). The development of affordable housing is crucial in addressing this issue yet continues to be pushed aside in favor of development policies centered around alluring the middle class to Waco.

Kotkin and Cox (2019) advocate for urban solutions that serve whole populations, rather than targeting tourist groups, arguing that "to successfully promote interaction and engagement that lessens bifurcation, cities have to start making improvements beyond their 'hot spots.'" For Waco, this could take the form of construction that expands beyond the flashy I-35 corridor and into the pothole-ridden neighborhood streets, housing solutions for the growing homeless population, and increasingly accessible job opportunities in the areas of manufacturing and production. In this way, Waco might "rather than depend on 'luring' a middle class… endeavor instead to build one" (Kotkin and Cox 2019, 73).

The gentrification of Waco has exacerbated previously existing social divides within the city. Authors Andres Duany and Elizabeth Plater-Zyberk (1992) explain this happening through the concept of economic segregation. In their view, this segregation has dangerous and far-reaching consequences for individual and community life. As they explain,

> A whole generation of Americans has now reached adulthood cut off from direct contact with people from other social classes. It is now entirely possible for a child of affluence to grow up in such a class ghetto, attend an Ivy League university and perhaps a top law school, and enter the working world without acquiring any firsthand knowledge of people unlike himself or herself. As a result, more and more Americans regard one another with mutual incomprehension and fear, and that accounts for no small share of the tension in our national political life (Duany and Plater-Zyberk 1992, 11).

To combat this segregation, many designers and architects plan public utilities designed to encourage a "sense of place" that "draws people out from their private realms to stroll and loiter with their neighbors," mixing economic classes and exposing people to the public (Duany and Plater-Zyberk 1992, 21). Magnolia represents such an attempt at creating a public gathering place. Yet my observations reveal that it is people from similar economic, racial, and political backgrounds that frequent Magnolia — people who generally are not even from Waco. In this way, Magnolia creates an artificial sense of place, unrepresentative of the city and its population.

Anthropological theories of space and place are also helpful in contextualizing these differing ideas about the spaces that Magnolia has both claimed and created. For tourists, these spaces feel deeply symbolic or sacred, calling to mind ideals of religious faith and family connection. At the same time, these spaces feel inauthentic to Wacoans who perceive Magnolia's messaging as contradictory to their lived experiences. Anthropological theories of space may help us to understand the origin, as well as the nuance, of these differing conceptions. Pauline McKenzie Aucoin (2017, 3) notes,

> Space is considered by anthropologists to be a central element of social life… Engaged with and experienced both as a physical and ambient dimension, as distance, location, or topography, space is recognized as an important cultural medium, an idiom through which individuals can think and that can be culturally organized to produce spatial practices that are social, aesthetic,

> political, religious or economic. Once embedded with significance, spatial constituents can be made to carry meaning as part of a geo-symbolic order.

Space, like time, is an invaluable medium through which cultural exchange takes place. By setting apart a space for cultural exchange and imbuing that space with meaning, the Gaines have created a gathering place, or a "framed space that is meaningful to a person or group over time" (Aucoin 2017, 3). As Aucoin (2017, 4) explains, when "sites take on cultural meaning, they come to be distinguished from generalized space as places." The Gaines, by transforming two formerly rundown city blocks home to abandoned grain silos, have distinguished this forgotten space as a cultural hub, a place definitive of Waco. This illustrates another important aspect of the concept of space: far from having a fixed meaning, space may be imbued with different meanings as the surrounding culture changes. In other words, "analysis requires recognition that while space is situated in cultures, its meaning is not fixed and may be contested and changed over time through a dialectical, sometimes political process that reveals the praxis of space" (Aucoin 2017, 4). The Silos, once symbols of Waco's bygone prosperity, have become symbolic of a new vitality present throughout the city. As our collective perceptions of Magnolia clash and change, so too will the symbolic nature of the Silos morph in our cultural understanding.

The Central Green

Magnolia is never empty. Even during the odd hours of a Monday afternoon, Magnolia boasts a steady flow of patrons, a full parking lot, and grounds bustling with activity. This bustle is concentrated in Magnolia's vibrant central green, a large rectangular turf squarely positioned between the Market and the Silos and lined by shaded picnic tables and an array of food trucks. I position myself at the only available seat to jot down notes. Every other table is filled with families sipping iced sweet tea in mason jars with striped straws, enjoying a quick bite to eat, or reviewing their treasured purchases toted about in brown paper bags. As I look around, I count eleven food trucks lining the perimeter. Though each food truck contains different wares, each markets its products using similar buzzwords such as 'custom,' 'artisan,' and 'gourmet,' conveying the impression of an exclusive experience uniquely tailored for each guest. Naturally, the guests who partake in this experience are those who can fit within the class structure and afford the cost of Magnolia's wares. This creates a rather uniform demographic of patrons who primarily consist of white, middle-class families. On the green, most families follow the same rhythm: parents wait in line to purchase food while their children play behind them on the green — the perfect place for a game of tag. While they run around or play with toys provided in a bin, adults who need a rest lounge on black and white striped beanbags in the shade.

From my vantage point of a picnic table, I identify another unique demographic occupying the green: adults taking photos. While the content of these photos remains largely consistent—photos in front of the Silos or the market with shopping bags and iced tea in hand —the people taking these pictures differ considerably. One style of picture-taking, which I have deemed the "vacation style," appears to be more casual. Family groups, typically large and multi-generational, attempt to line up in front of the Silos, wrangle their children into standing still for a split second and take a photo where almost everyone's eyes are open. While staged, the resulting photo tends to be at least somewhat true to life. This group's clothing tends to consist of comfortable everyday wear. One person engaged in this style of photo-taking activity was a white, fifty-something-year-old man wearing a 'Blue Lives Matter' shirt.

In contrast, another group of picture-takers fill the green, a type I designated the "influencers." Traveling with a single companion or small family unit, influencers carefully curate a highly stylized appearance, usually expressed through expensive, boho-style clothing. For them, Magnolia is as much about being seen as it is about seeing. Those who accompany the influencer type are similarly well-dressed, lending a photo-readiness to their group as a whole—except for one (typically male or older female) individual, who is denoted as the photographer, as was the case in a pregnancy announcement I witnessed being shot on the green. The influencers pursue a meticulous photo-taking process: lighting, angle, framing, and pose are all considered in crafting the perfect shot. The result is one far more distanced from reality than the semi-functional family vacation photos.

The Old Church

Another smaller green lies on the other side of Magnolia property surrounded by the tidy white shopping village of identical white cottages under the shade of the Old Church. Also comprised of turf instead of grass, the green is framed by meticulously groomed foliage and carefully placed stone paths. Not a single detail is amiss. These details work together to craft an environment that is not so much a photo destination as it is a place to pause and reflect, either within the walls of the church or under its shadow. As I note these findings, I witness a tender scene unfold on the opposite side of the green: a young mother sits on the turf under the shade of a tree holding a sleeping infant to her chest. It is a touching picture, one that calls to mind historical imagery of the Madonna and Child, one of serenity, transcendence, and holiness.

Undergirding this scene is the presence of the Old Church, a situation which lends an air of sacredness to the Magnolia grounds. The instantly familiar structure of the church creates a feeling of a divine ordinance, the sense that God's presence and favor are here. Tall, square, wooden, and white, with triangular vaulted ceilings and a picturesque bell tower, the church draws one's eye in and up toward the heavens. Stepping past the entrance into the church, one encounters clean walls of white shiplap (an instantly recognizable feature of Magnolia's brand) broken up by dark trims, vaulted beams, and huge windows. As a result, the church is filled with natural light that dances over the backs of the dark wooden pews. Two slender trees adorn the front of the room, potted in soft green moss. The white walls and sunlight flooding the room as well as the inclusion of natural elements work in tandem, giving an impression of purity, wholesomeness, and an alignment with that which ought to be. The evocative nature of The Old Church and its strategic presence lend to the carefully curated space of Magnolia's grounds. Operating as a symbol of the divine, the church imbues the space with meaning and communicates "special realities" that relay "the basic dynamics of culture" (Low 2013, 6). The Old Church, a definitive part of Magnolia's subculture, conveys the sense of Magnolia as a sacred space operating in accordance with a higher order.

Not many guests visit the church, and those who do take a minute to gush over how pretty the inside is before moving along. Very few devote time to reading the plaque outside, which details the process of Chip and Joanna's discovery and renovation of the old church. Notable on the plaque is the statement that the Gaines "restored" the church to be used for a "new purpose" ('The Old Church' n.d.). Be that as it may, the renovation process required most of the church to be completely replaced, including its foundation and frame. This revelation prompts a stunning conclusion. The Old Church is not an entity that is truly restored or one which births genuine restoration of those who wander within its wooden doors. Instead, like Magnolia, the church was artificially imposed on the city landscape. Stripped of its religious purpose, the empty church commodifies religious symbolism for Magnolia's gain, commercializing the sacred to convey authenticity.

Interview with the Bundys

At this point in my research, I decided to seek out a firsthand account of how Magnolia has changed Waco culturally and economically. To gather answers to my growing bank of questions, I contacted Ashley and Brian Bundy, a local couple who have worked as realtors in Waco for the last decade. Ashley and Brian met each other at Baylor University, married, and went overseas to do missionary work for a few years after college. They moved back to Waco in 2008—as Ashley described, their church home is in Waco, and the transition back felt natural. Brian got his real estate license two years later and Ashley quickly followed suit. I began by asking the couple about how Magnolia has changed Waco's real estate industry. Brian replied by describing how at the start of his career, he had no trouble easily finding investment houses to flip, but once Fixer Upper aired,

> Everybody and their dog wanted to be Chip and Jo. It brought all these investors and was the advent of what was already going on with HGTV. Chip was not the first house flipper on TV… there was something about Chip and Joanna that was different from HGTV. I think it was something about small-town America. People could wrap their minds around a $300,000–$400,000 house and identify with that, instead of those $1,000,000 listing TV shows in Los Angeles or New York.

Expanding on this thought, Brian touched on the literal and figurative following Magnolia gained in the years after the pilot of Fixer Upper aired. “There’s something weird, like, there’s a cult following, I mean another buddy of mine used to joke about how like Joanna could spit in a bowl and sell it for $400 because it had her DNA in it. It was just really weird in that regard.”

I inquired about the masses of people flooding into Waco. Ashley confirmed my suspicions, asserting, “There’s not enough to supply for the demand. And so, the prices have just shot up.” Expounding on why this might be the case, Brian added his thoughts about how Obama’s presidency may have contributed to the demographic shift, prompting conservatives, who “want their second amendment rights,” “want to raise their kids in a school district that isn’t going to be super liberal," and "want a faith base” to move to Texas. I followed up with the following comment:

> That’s interesting, especially when you’re talking about why people feel the need to come to Texas, either religious reasons or rights, freedoms, tradition, raising a family. Those are all things that you see on the show, too.

Ashley agreed:

> And that’s why people were drawn to them, this feel-good, traditional good value, you know — family, home, hard work. And I think they just are drawn to them… for better or worse, some people. I mean, we’ve had several clients, like one, literally, I drove around for them for a day, and like they went to lunch, and coming back they said, ‘it didn’t exactly look like the show.’ There are some ugly sides to Waco that they didn’t realize were there. And then I had another couple that moved here, because of the show, for like 18 months. And they’re like, it’s too hot. They don’t like it. It (the show) is not always the best reason to make a move.

Processing this, I took a moment to change gears, and asked:

> From another vantage point, y’all have lived here for quite some time now. How would you see — people are calling it the ‘Gaines Phenomenon’ or the ‘Fixer Upper Effect’ and just so many things — how do you see that changing Waco?

Brian simply noted that “it’s made it a destination.”

Ashley shared her thoughts on the Gaines and the change they’ve brought to Waco:

> They’re sincere people (and) have done a lot of good for Waco. And I do feel like they tried, too. Honestly, when they first started, I thought they would take off and go to a bigger city. But they stayed here and encouraged and tried to feature local businesses. The community is changing, and at the same time, a few of the people that they have gotten behind have really done well. It’s changed their lives. I do think they are for local businesses to flourish.

Brian nodded along, adding:

> I mean, people complain and moan about their property taxes and want to blame it on Chip and Joanna. It’s true. But as with anything, it’s like, ‘well, that house that you had that was worth $150,000 is now worth $250,000. So, you want to complain about that, too?’ I mean, it’s like how you can’t have your cake and eat it too. That’s not their fault… And I know I don’t know all the stories. And I know that they don’t publicize it too. But I know they’ve been

> generous to people like if they know someone's story, and they hear, like, a single mom has struggled with this or that, they've done a lot of good in that regard. Just to let people know.

I thanked my interviewees for their time and perspective, which reemphasized and added nuance to my understanding of Waco's economic trends in housing, undoubtedly influenced by Magnolia. Though these trends are beneficial for some, such as homeowners who can afford to pay rising property taxes and profit by selling their homes at higher values, for others reliant upon fixed or low incomes, rising property foreshadow the loss of generational homes. This circumstance is a compelling instance of Magnolia's disparate influence on Waco's diverse community. With new knowledge in mind, I returned to Magnolia with a more nuanced perspective, my eyes attuned its both its positive and troubling aspects.

Interview with Anthony Betters

For further perspective on the complex relationship between Magnolia and the city of Waco, I conducted an interview with Anthony Betters Sr., a local Wacoan and active community member who has spent over fifteen years in public service. Mr. Betters has lived in Waco his entire life. During our interview, he relayed the story of his mother's migration to Waco at age thirteen and her subsequent struggle to raise her children alone. After renting several properties downtown, his mother eventually entered into a lease-to-own agreement with David Hoppenstein, a real estate mogul who owned a significant number of properties in Waco and Central Texas in his lifetime. She was not the first person in his family to do so—Mr. Betters could recall four or five generations of family members renting from David Hoppenstein, as they lacked the financial backing to place a deposit on a permanent home. "The disparities," Betters observed, "are very very tough." Anthony Betters' mother threw herself into meeting lease payments. If she had missed a payment, she could have been turned out of her home, her money permanently lost. For thirty-five years, Betters estimated, his mother worked to pay off her home. Now, after generations of renting, she owns her property.

Mr. Betters analogized this situation to that of the sharecroppers in the post-slavery period of Reconstruction in the southern United States. Sharecroppers were tenant farmers responsible for cultivating the land of plantation owners in the South. According to this arrangement, if it was a bad year and the crop disappointed, the owners would be financially unaffected, but the sharecroppers would be put in debt to the owners. Often this created inescapable situations of inequality, comparable to slavery. For the Betters family, Anthony Betters' mother has finally broken that cycle. A man of faith, Betters shared this story as a testament to God's provision, evidence of an answered prayer. Hoping to continue his mother's trajectory, Betters has worked to create generational wealth in his family by opening a family business, BETTERS4U Services. Through this business, Betters hopes to "help develop family members pursue talents and aspirations in a business approach" in order to "alleviate generational poverty," as is detailed on his LinkedIn profile. This, for Betters, is a continuation of the answer to his mother's prayer: he noted, "now, in her later years, she's starting to see a glimpse of what she prayed about in what her kids are experiencing."

Mr. Betters also serves in municipal government for the city of Waco, working in the division of watershed protection. His office is located in the Mae Jackson building downtown, named after the first African-American woman elected mayor of Waco. Now, Mr. Betters informed me, he is the only African-American man in the building. He saw the irony of this circumstance. In another capacity, Mr. Betters works as the 2022 Board President of the Dr. Pepper Museum in Waco. He is the first African-American man to lead in this role. Since his presidency (and other changes within the Board of Directors), the museum has undergone changes aimed at transforming the museum into an experience reflective of the many cultures within Waco. The museum now features an exhibit that can be experienced in Spanish, as well as English, and the new 'Sit Down to Take a Stand' exhibit at the soda counter details the history of sit-in protests during the Civil Rights Movement and highlights the courage and dignity of black Americans who peacefully protested for their rights under affliction from whites. Given Mr. Betters' commitment to exploring multicultural perspectives, I was eager to ask about his perspectives on Magnolia and Waco's changing culture. For his part, Anthony Betters was eager to offer up his perspective as representative of some of the concerns and issues that the larger community of African-Americans see in Waco's changing culture, as well as within Magnolia's unique subculture.

After learning of Mr. Betters' background, I asked him how he thought Magnolia had affected Waco as a whole, and whether it had affected Waco equally. He answered immediately that Magnolia "impacts the whole city," and that Waco's recent revitalization proved that "Waco can be one of the vibrant cities in the United States." Betters credited the mayor and city managers for this development, noting that this reflects their progressive attitude towards the rise of new economic opportunities across the city. Drawing from his own perspective as a city employee, he observed, "the city is trying to change that whole outlook to where everybody can prosper from what's happening in the city. However, we all know that we will not all will benefit from it."

Mr. Betters also mentioned how the word "gentrification" is often brought up in conjunction with this conversation. For him, gentrification is a crucial aspect of how this "time of change" has impacted everyone throughout the city. He noted that in East Waco, wealthy people have begun to renovate homes, which increases their value tremendously. This causes property taxes to rise for the entire neighborhood, which is problematic for people who cannot afford to pay rising property taxes for their homes, even if they have owned those homes for generations. Oftentimes, these people are forced to move out. As a result, the demographics of the neighborhood change, as more upper and middle-class folks move in, and longtime residents migrate out. He stressed, "we haven't fully seen all of that, we just see a glimpse of that right now," warning that changes in Waco, at least partially resulting from Magnolia, have only just begun.

While Betters described Waco as a "vibrant city that's growing," he qualified that a characteristic of growth is "wanting to see everybody reach their full potential." This full potential, the "heartbeat" of the city managers, is "for [the] prosperity of all cultures." Betters expressed that he would like to see Magnolia change in this respect, as he remarked that he cannot "see" the celebration of all cultures visually when he visits Magnolia and notes the overwhelmingly white demographic that frequents its grounds. "That's what I would like to see a little bit more of at the Magnolia side of it," he explained, "is to embrace the cultures of people of color."

At Magnolia now, "you can smell the money," Betters laughed. In a more serious tone, he noted, "you can see the richness of our country, and how a certain group is left out." He connected this economic disparity to the systemic racism that has suppressed African-Americans nationwide, evident, he said, "especially what I can see in Waco." He acknowledged that this point is contentious, noting,

> Some may debate that and say, 'you know what, you need to pull up by your own bootstraps.' I hear that...but different communities or families are completely different. I didn't come here with no family, no land, no nothin'. My momma didn't have anything to give us except for a prayer.

A Window into Home

As I enter Magnolia Market, I am greeted by the sight of an elderly woman clutching brown Magnolia bags, pushed in a wheelchair by her middle-aged daughter, and accompanied by her thirty-something-year-old granddaughter. This familial scene is repeated in many manifestations throughout Magnolia Market and Magnolia Home, where multi-generational groups of women mill about and shop together. Observing these women, I begin to understand Magnolia as a destination that not only attracts families from all over the country but also brings together multiple generations under the ideals of home and family. Primarily consisting of white mother-daughter groups, the women meander about Magnolia, delicately turning over products in their hands, admiring their quality and aesthetic. Next door in Magnolia Home, one white, middle-aged mother and her two, twenty-something-year-old daughters interact with a friendly salesman engaged in showing them a dining room rug. As the salesman lays the rug out on the floor, explaining its design, the women stare distantly at the rug. “It’s so pretty,” they gush repeatedly, unable to say or do much else.

The rug, like other objects at Magnolia, is elegant, muted, and comfortable. Its cozy feel echoes the overall tone of the store, which puts forth a carefully curated yet comfortable experience. Each intentionally arranged item, whether a chair, light fixture, placemat, or rolling pen, gives an illusion of realness, quality, and authenticity. Interpreted through anthropological spatial theory, these objects “evoke experience, thus molding experience into symbols and then melting symbols back into experience” (Low 2013, 5). The “existential and phenomenological reality of place… its smell, feel, color, and other sensory dimensions,” is a crucial aspect of embodied experience, and often determines how people relate to different places (Low 2013, 5). The material realities of both stores—Magnolia Market and Magnolia Home—evoke feelings of being at home and at peace, which in turn creates an inviting sense of place. This welcoming sensation is diminished, however, when one takes note of the price of the products in each store. Like the three women admiring the rug, I too felt a sense of overwhelming distance because of the cost of Magnolia products. Though I am the daughter of middle-class parents and have always lived comfortably, Magnolia products are completely unattainable for my family’s price range, let alone my collegiate budget. While I knew Magnolia was by no means synonymous with the people of Waco, I began to see that the tall iron fence and security guards form only superficial layers of division. Any true question of who is welcome at Magnolia is answered by the price tags. Who fits into Magnolia’s vision of home? Those who are undeterred by the price of its products. In this way, the prices of Magnolia wares gatekeep far more effectively than the security-patrolled fence patrolled ever could.

The Historic Grain Barn

In the back of the Market lie two unassuming double doors. Past these and down polished concrete steps, one enters the Historic Grain Barn. At the foot of the stairs lies a large vinyl sticker that reads, “100 Years of History,” lending an air of long-standing tradition to the space. Of course, the unspoken conclusion of the sticker’s argument is that Magnolia serves as a continuation of this long-standing tradition—that tradition itself is at the very heart of Magnolia. As I wander about the barn, noting the tall, vaulted ceilings, metal walls, and exposed rusting rafters, I consider the history of the space, curious about the purpose for which the grain barn was built. What did it formerly hold? Now, it is merely the home of a transient stream of tourists.

Interspersed throughout the Grain Barn, tables hold a wealth of Magnolia wares, including Magnolia pins and stickers, the Gaines’ books, and racks of Magnolia caps and mugs. One wall is entirely filled with cupboards of Magnolia t-shirts. Many registers and a winding checkout line occupy another. The remaining free walls are burdened with many of the same signs I noticed inside the Market, both in greater variety and quantity. Home, family, faith, and friendship are all common themes on these signs of soft leather or rustic iron.

One sign, significantly larger than all the rest, hangs on a roll of paper almost as large as a person suspended on a prominent wall in the back. The sign displays a lengthy belief statement of sorts. Curious, I step closer and note the first line, which reads, “We believe in home, that it should restore us from today and ready us for tomorrow” (“Magnolia Manifesto” 2021). Transfixed by the sign, I leave the barn considering its place within Magnolia as a whole. It is only later in an interview with a former Magnolia employee that I found out the significance of the sign as the center of Magnolia’s belief and being. It is called the Magnolia Manifesto. In my conversation with a former Magnolia employee, whom I will refer to as Megan, as she prefers to stay anonymous to remain in good standing with the company, I began to see how this Manifesto permeates everything Magnolia says and does.

Flipping through the packets given to her at Magnolia's orientation, Megan found two copies of the Manifesto and explained to me how this was incorporated into her training:

> So okay, it's in this one, too, I think. Yeah. So it's in both of the orientation packets they give us... They say, why do we exist? Inspiring the pursuit of a life well loved. What do we do? Good work that matters. How do we work? Learning, ownership, and being a team player. So, we always, they have, a lot of these kind of life principles and things that they would talk to us about, just to kind of try to get us inspired.

When asked how that fits into Magnolia's culture, Megan pointed to the signs that pepper Magnolia's walls:

> Magnolia overall, is just supposed to be like, all about togetherness and stuff like that. Like literally all of their signs, either say something about life well-loved, do good work, something with together, something with miracles, just they're all like these inspirational quotes and stuff like that.

I responded that I had made note of the prevalence of these signs on my last visit to the market and wondered about their significance.

Megan confirmed the importance of the messages conveyed on the signs, explaining that:

> Whenever we had our orientation, they would sit us all down in a room, and then they would go over these PowerPoint-type things. And so they would break up the Manifesto into like different sections, and then talk about how we could embody each of these sections... So we believe in human kindness, I think that might even be in here. It has to be in here. It probably is 100%. But it says every Magnolia employee is personally responsible for ensuring guest experience is being met to the highest standard. So it really is all about making sure that that guest experience is just going really well. So that's kind of how the Magnolia that's what they want everybody to perceive about Magnolia their brand when you're entering into it.

Processing this information, I replied, "It's interesting, it seems like the Manifesto is just so much more defining than I initially thought." "It's a big part of Magnolia," Megan reaffirmed, "They really base a lot off of it, even though, you know, a lot of people don't realize that."

Though unassuming compared to the looming Silos, the Historic Grain Barn forms the heart of Magnolia, a physical and symbolic center of history and tradition. The beliefs conveyed in the Magnolia Manifesto, hung on the Historic Grain Barn, are the basis from which all actions of the company flow. After talking with Megan, I conducted a bit of digging regarding the Grain Barn's history. I learned that the barn was originally home to a cotton mill whose products were stored in the Silos. At the turn of the century, this mill brought renewed industry to Waco, only to collapse due to bankruptcy a few decades later. The buildings sat empty for nearly half a century. Years later the Gaines encountered the buildings and sought to restore them under the same vision of bringing industry and new life to Waco. Whether history will redeem or repeat itself, no one knows.

Conclusions

Two lines of the Magnolia Manifesto have not ceased to haunt me from the moment I first encountered them. They read, "We believe everyone deserves a seat at the table and everyone has a story worth telling. We believe in human kindness, knowing that we are made better when we all work together" ("Magnolia Manifesto" 2021). I see this ideal expressed so strongly at Magnolia, yet my studies reveal that it is an ideal only partially realized. The homeless woman who sat outside the fence on my first day at Magnolia did not have a seat at the table. Whomever the security guards are on alert against do not have a seat at the table. Native Wacoans, distressed and displaced by rising property taxes, do not have a seat at a table.

Magnolia believes fervently in the value of stories and storytelling, yet the only stories told at Magnolia are those that travel to Waco. Much like the old church “renovated” by the Gaines, the stories that Magnolia values are artificially implanted, and do not accurately convey a wholistic narrative of Waco. The story of Waco is not told for what it is, nor are the stories of Wacoans elevated by Magnolia in accurate ways. The stories of this insulated subculture are incongruous with the stories of the broader Waco culture and serve to perpetuate an inauthentic narrative masquerading as truth. The truth is more complicated than the simplistic story Magnolia would prefer to tell, a false narrative of tradition and transcendence, undermined by a city both more broken and more whole than Magnolia would presume, lying just outside the wrought iron fence.

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The Influence of Internalized Homophobia on Vietnamese Gays' Partnering Processes

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ABSTRACT

This research examines the connection between internalized homophobia and the partnering process among gay people in Vietnam. It explores their criteria for finding a committed partner, which is based on perceptions of gender roles, gender expression, and sex roles. It shows that their concepts of an ideal type of partner and relationship are rooted in what they have learned and internalized in a heteronormative environment, which devalues androgynous gender expression and gender nonconformity. It also explores the use of dating applications among Vietnamese gays and how this partnering method can lead to internalized homophobia and discrimination within the LGBTQ+ community. This study expands upon current understandings of LGBTQ+ people in Vietnam and their relationships with each other and contributes to the library of queer studies in Asian, Confucian regions.

Keywords: internalized homophobia; Vietnam; LGBTQ+ community; heteronormativity

Kien contacted me through his Instagram when I posted there to recruit participants for this research. He is a 26-year-old gay man living in Hanoi. Kien comes from a small village, a three-hour drive away from the city, where his childhood was full of prejudice from people who said he was too girly and had arguments with his father about how he acted. He was bullied at school for being “different” from other boys. Every time he was told he was not masculine enough, Kien recounted that he tried his best to cover his real personality:

> In my high school years, there were a lot of tears every night. I felt uncapacious, I hated myself for not being the same as everybody. I didn’t know who I am. Society put a label on me and the village where I came from; everybody seemed to be affected by the traditions from the past and patrilineal culture. I had a crush on a guy in high school, but I couldn’t let him know because I was afraid that he would hit me.

His experiences in the past have led him to believe that being gay is not right, and he used to try to shape his appearance and gender expression to conform to society’s expectations of manhood. In a heterosexist environment like Vietnam, “compulsory heterosexuality”—the ideology that heterosexuality is assumed and enforced—affects LGBTQ+ people heavily, making it harder for them to come out and live authentically as themselves. It also creates unnecessary hierarchies based on masculinity and femininity (Rich 1980, 631-60). As a consequence of being socially stigmatized, a gay man can have internalized homophobia.

"Internalized homophobia" refers to the inner conflict between what people perceive they should be (i.e. heterosexual) and how they experience their sexuality (i.e. homosexual or bisexual) (Herek 2004, 6-24). Internalized homophobia attributes LGBTQ+ people with negative stereotypes, stigma, and prejudice about themselves and their queerness based on the social and cultural norms of heterosexuality and heteronormativity. LGBTQ+ people subconsciously turn those ideas inward, believing that they are true. It is commonly experienced through the process of identity exploration and self-acceptance (Cass 1979, 219 -35). In addition to experiencing negative mental health consequences, victims of internalized homophobia might even experience the extreme form of internalized negative social conceptions, or "sexual orientation rejection" (Meyer and Dean 1998, 160-86). Most importantly, internalized homophobia forces LGBTQ+ people to conform to a socially stigmatized identity that, at the same time, results in self-hatred and discrimination towards other LGBTQ+ people.

This research sheds light on the influence of internalized homophobia on the partnering process of Vietnamese gay people by taking into account their ideal types of partners. It also demonstrates the nuances of how Vietnamese gay men embrace their sexual orientation and gender identity within a heteronormative environment, as well as their journey to feeling validated within the LGBTQ+ community.

Being Gay in Vietnam: A Heteronormative World

In a survey conducted in 2010 by the Vietnam Institute for Studies of Society, Economy and Environment (iSEE), 87% of the participants did not understand the concepts of LGBTQ+ and the equal human rights that they should garner within society (Nguyen 2020). However, compared to neighboring countries in the Southeast Asian region, such as Singapore, Malaysia, or Indonesia, Vietnam is often perceived as a better environment for LGBTQ+ people to live as there are no legal mandates that are actively discriminatory against homosexual people and homosexuality (Bloomberg News 2015).

Before discussing being LGBTQ+ in the Vietnamese heteronormative world, it is important to define “heteronormativity.” The term, made famous by Michael Warner (1991, 3 -17), argues that it refers to a normative belief that sexuality and marriage should happen between two people of the opposite sex. Gender identity, on the other hand, refers to how we define ourselves in the continuum of genders. It can be the same as one’s assigned sex at birth or different from it (Stoller 1964, 453-57). Sexual orientation is about who we are attracted to. It can be “straight”—which means you are attracted to heterosexual people, “gay”—attracted to men, “lesbian”—attracted to women, or anything in between. Sexual orientation is a spectrum, and living in a heteronormative world makes it harder for that spectrum to be fluid. This is especially the case among gay/homosexual men, as they have to conform to the norms of masculine heterosexual expression, behavior, appearance, and morals. This can make them feel like being homosexual goes against social norms and they become unable to acknowledge their sexual orientation. These psychological challenges can lead to internalized homophobia.

In *The Velvet Rage*, psychologist Alan Downs (2005) describes how his patients overcome the pain of being raised in a heterosexual world. He divides the route to living authentically as a gay man into three stages. In stage one, when a gay boy grows into manhood, his actions can be praiseworthy and his achievements validated by others, but they can be inauthentic to him. Downs compared the route to their sexuality with "a quest." For many gay people, the quest can lead them to a traditional heteronormative role, which entails being the man of the family, while others can be led toward sexual conquest. Whichever way they proceed, the result is usually the same (Downs 2005). According to Downs, gay men do not believe in themselves, as the more they seek validation from others, the more unsatisfied they become. The consequence of failing to achieve authentic validation is rage and anger at not being able to live as who they are. Downs further stated that even when gay men are more comfortable with their expression of sexuality, they may have yet to deal with the internally "toxic shame" that continues to hound them; they feel inferior about their sexuality because the world defines being homosexual as something abnormal. This is when stage two begins. The search for validation happens again at this phase, but instead of being validated by concealing their sexuality, they try to find support to affirm that being homosexual is worthwhile and deserves recognition (Downs 2005). Finally, to discover an authentic life is the last stage. Gay men decide to construct their lives as they want, with their passion and devotion, instead of being dependent on others' validation of them. However, Downs’ work focused mostly on White middle-to-upper-class gay men who came to him for psychological therapy. Therefore, the concepts of “being gay” and “being homosexual in the heteronormative world” are specific to a Western context. Moreover, the definition of “living authentically” and the three stages of manhood are not universal. In Vietnam, gay men’s queerness and self-authenticity can be experienced and embraced differently, as defined by one of my participants:

> I was born and raised in a rural area. Therefore, I did not have any knowledge about what being gay would feel like. Everything I learned when I was younger about being gay is from the discrimination and stigma of my parents. Ever since I moved to Ho Chi Minh City for university, I found myself at peace as I got to know more people who share the same sexual identity as me. I felt freedom in the city as there was no judgment. However, whenever I came back to my family home, I had to “put on a role” of a straight man, talking about getting married to a woman or some sexist jokes. I can only feel like myself when I am surrounded by my LGBTQ+ friends and when I am away from my family.—Nguyen, 22, gay man

Nam, 25, a gay man living in Ho Chi Minh City who had come out to his family, defined “living authentically” in this way:

> After coming out, I felt free to express myself to my parents, dress up in any clothing style I like, and behave without having to worry about others’ opinions. It is my definition of “living authentically.” Basically, you can be whoever you want to be and feel the most “you” all the

> time. Getting to know my boyfriend, who has also opened up with himself and his sexual identity, is such a blessing for me. I do not hide myself whenever I am with him, and we do not have to conceal our relationship in public.

Rather than feeling validated by others' opinions, my Vietnamese informants defined “living authentically” as feeling comfortable being themselves and having autonomy over their self-expression or sexual identities. To fulfill their authentic selves, they must learn how to disregard heteronormative and homophobic ideologies despite the persistence of heteronormative stigma.

Being homosexual in Vietnam was not taboo until the arrival of Buddhism and Confucianism (Heiman and Cao 1975, 89-95). Homosexuals and transgendered people were seen as "diseased" and living outside social norms. However, they were not criminalized. In the 20th century, under the influence of America, especially the impact of Americans' lifestyle and culture during the Vietnam War, South Vietnam was an open and friendly society with more places for homosexuals to integrate and gather. Although the authority of the Republic of Vietnam at the time disapproved of homosexual activities, Vietnamese homosexuals could meet openly and regularly in luxury restaurants in downtown Saigon (Heiman and Cao 1975, 89-95). However, compared to gay relationships, lesbians earned more empathy and acceptance within society because they could easily be perceived as a couple of friends (Pastostter, n.d.). Heteronormality in Vietnam has therefore had a particularly strong influence on homosexual men, forcing them to conform to the gender role of traditionally-designed masculinity.

Even though the LGBTQ+ movement has been populated in Vietnam with various pride events and mass media coverage, slow changes to the government policy do not align with the efforts made for equality and rights. The lack of sexuality-related curriculum in the educational system demonstrates that it takes a long time for the LGBTQ+ community to earn their freedom in expressing their sexual identities under the law. According to Kate Hodal (2020) of The Guardian, verbal and physical bullying toward LGBTQ+ people are common within society, as people were taught at school that "homosexuality is a disease" or "mental illness," which puts pressure on students to be heterosexual.

Patrilineal Kinship: The Man's Responsibility

As a country influenced by Confucianism throughout history, Vietnam has a strongly patrilineal cultural heritage. A preference for families to have sons persists throughout the country, especially in the North. Eldest sons often inherit the family property, as well as the responsibility of performing rites on behalf of their deceased relatives, something that women are not allowed to do. Due to the patrilocal norm, the eldest son continues to live in the natal house and care for parents in their old age, and continues the family line by having male offspring (Brown 2012). Patrilineal kinship also places pressure on women who marry the first son to produce male heirs. Having a son is thought to protect a marriage from polygyny, divorce, and even domestic violence (Bélanger 2002, 321-34).

Such Vietnamese traditions, mostly influenced by Confucian teachings, have standardized the ideal image of a man and masculinity. Men are not supposed to have a feminine appearance and must conform to the heteronormative and patrilineal family regime (Horton and Rydstrom 2019, 290-305). Judith Butler, in “Gender Trouble,” stated that the configuration of power constructs the binary relation between "men" and "women." They also introduced the concept of gender as performative, which implies that humans are taking on an acting role to be seen as a "man" or a "woman." Butler strongly emphasized that within patriarchal societies, the performance of binary genders shapes the naturalized illusion of binary gender identity. These performative acts have caused "gender trouble" (Butler 1990, 33).

Discrimination toward LGBTQ+ people can make them feel ashamed about their sexual orientation and gender identity. However, each person's experience with internalized homophobia is personal. Many gay people rarely relate to the stories and journeys of fellow gays. They are on their own, and they have no idea if their sexual orientation or traits are shared by others. Their perceptions of homosexuality are built based on their own understanding of it, which is curated by others – mostly by the heterosexual community (Moss 2001, 1315-34). The knowledge is internalized through time by gay people, constructing their mindset and systematizing their ideology about what is acceptable of a gay man in terms of appearance, behavior, morals, or other phenomena.

This heteronormative environment has a huge impact on society, especially on people's mindsets. Therefore, perceptions of homosexual people are not always positive. "The heteronormative world" that is painted by existing literature is largely informed by the views of the Western world, currently posits a certain tolerance toward gay people. However, there is a lack of research on LGBTQ+ people in Asia and from Confucius post-socialist backgrounds. This research aims to provide a more nuanced look into the Vietnamese gay community and their struggle in embracing their gender expression, queerness, and relationship with broader society. It sheds light on internalized homophobia among Vietnamese gay people through testimonials of how they see themselves in a heteronormative environment, and provides examples that show how internalized homophobia can influence their partnering processes.

Method

This research was conducted in Hanoi and Ho Chi Minh City in Vietnam. These two cities represent the North and South regions of Vietnam, which are distinct in terms of viewpoints, culture, and tolerance towards the LGBTQ+ community. The qualitative data collection and analysis included one-on-one interviews with participants who are gay, living in Hanoi and Ho Chi Minh City, and through chats with users of the gay dating application Grindr, with the location set in the central area of both cities.

Pseudonyms were used for all participants, 15 of whom identify as gay; 7 currently live in Hanoi and the rest in Ho Chi Minh City. All are in the age range of 20 to 30 years old. Recruitment occurred on social media, from my personal Instagram account, asking for informants. However, most of the interviewees were recruited from the Facebook groups created for the Vietnamese homosexual community by non-governmental organizations for LGBTQ+ rights.

One-on-one interviews were conducted on the video conference application, Zoom due to travel restrictions and safety concerns during the COVID-19 pandemic. Each semi-structured interview lasted from 45 minutes to 1 hour. The questionnaire was based on their knowledge of internalized homophobia, their status of coming out as well as their viewpoints towards the correlation between internalized homophobia and partnering processes. It also included their criteria in choosing partners as well as questions related to their insights into their gayhood. When the travel bans were lifted, I traveled to both cities for further research in LGBTQ+ bars, using the method of participant observation. I performed observation and short interviews through chats on the popular dating application for gay people in Vietnam called Grindr. While using dating applications as a research tool, there were certain benefits and challenges that I faced. Dating applications, to me, are the easiest and fastest way to encounter the LGBTQ+ people in Vietnam, as there are still not many communities or queer-friendly places where they meet and communicate.

The Construction of Ideal Types: Perceptions of Masculinity Among Vietnamese Gay Men

When asked about their ideal types of men in terms of appearance, personalities, and compatibility, most participants shared the same tendency of idealizing people whose gender expressions and behaviors are as close to heterosexual men as possible. They reported feeling more comfortable around people who are more conventionally masculine and "straight-acting" as they want somebody to protect them. Kien, a gay man whose gender expression is perceived to be gender non-conforming, stated that his first boyfriend, who was "exactly his type," "looks nothing like a gay man at the first impression:"

> I still look for those who are more masculine than me because I feel that I need somebody to take care of me, making me feel loved; somebody who is determined in the way they act and speak; somebody who knows what they aim for; somebody who treasures me.

Heterosexual masculinity is a key component in the development of antigay bias within any society or community. These biases are absorbed by gay people and become internalized forms of homophobia. It is a popular belief in Vietnam that to be masculine, one must be heterosexual. Any male who is not heterosexual is consequently feminine or has a desire to become a woman. Heterosexual masculinity enforces the traditional gender norms, making gay men believe that being homosexual is immoral and that they need to behave in ways that are consistent with the socially constructed ideas of a heterosexual man. Being with a person whose looks and behavior can be perceived as heterosexual is also a method for gay men to avoid the stigma and homophobia of their surroundings. For example, gay men whose gender expressions are close to heterosexual people are perceived as "friends" in the heteronormative environment rather than a couple within a romantic relationship.

Several gay participants maintained that they tend to keep a certain distance from androgynous people and do not feel comfortable being in a serious relationship with them. They often labelled their negative impressions of such individuals as being "too feminine:"

> I feel comfortable with those who act like straight people, with manliness and enough aggression. Their clothing style or behavior should not be androgynous or too feminine. I want my partner to be someone who can protect me, not too girly to be "sisters."—Lam, 20, gay man from Hanoi

> I tend to keep a distance, sometimes I do judge people who act femininely or too much of themselves. My preference for a partner and also for a friend is someone who looks like a "normal man" with masculine behavior and appearance. I feel unbearable to be in the same room with gay people who are too ostentatious in their appearance, wearing heavy makeup, or have over-the-top expressions when talking or walking. Sometimes I find them grotesque and trying to get people's attention.—Minh, 23, gay man from Ho Chi Minh City

Internalized homophobia can result in deriding other people whose gender expressions are more fluid or open, especially those who have come out and are proud of their gender identity or sexual orientation. Gay men with internalized homophobia tend to conform to heteronormative society's stereotypes. In Confucian environments like Vietnam, heteronormativity is inevitable. Therefore, gay men can be exposed to negative ideas about homosexuality and being homosexual, which deeply affects how they see fellow gays as their partners. Internalized homophobia affects Vietnamese gay men in their choices of partner and ideal types, as being with somebody whose appearance and personality are perceived as heterosexual can make them feel validated and accepted both in the LGBTQ+ community as well as the broader society.

Sex Roles and Gender Roles

Another aspect of understanding perceptions of ideal types among gay men relates to sex roles. In same-sex intercourse, "top," "bottom," and "versatile" are the terms to describe them. The "top" is the person who penetrates, while the "bottom" is the person who receives the penetrated engagement. A "versatile" means that a person can do both (Underwood 2003,105). These self-labels not only reflect preferences during sex but also are conflated with gender and social roles, affecting the behavior and expression of gay people. These gender roles in same-sex relationships are rooted in their perceptions of heterosexual couples. The "top" is expected to be the one who upholds traditional norms of masculinity in their behavior and action, to lead the relationship with patriarchal power. The "bottom" is analogous to a woman, and is representative of submission in a gay relationship. Conformity in gendered roles puts pressure on gay people in shaping themselves. However, it is crucial to note that heterosexual gender roles are also derived from socially constructed stereotypes and patriarchal norms. This is reflected in Vietnamese society through families that have been heavily influenced by Confucianism's expectations regarding gender norms (Vu and Yamada 2020). There are certain limits for both partners in a heterosexual relationship. Confucianism created a vision of women being powerless against their husbands, and they are submissive to the male's orders and have no decision-making roles in the family (O'Harrow 2021). These concepts and beliefs have been embedded in the mindset of Vietnamese people through generations, creating stratification within heterosexual couples and families. Internalizing these ideas through their upbringing and educational environment, Vietnamese homosexual people embody these socially constructed gender roles and apply them to their partnering processes. Gay people tend to alter their appearance and behavior to correspond with their preferred sex roles so that they can attract other people. Kien, for instance, identified himself as a "bottom," and therefore he feels it is hard to get along or be in a serious relationship with other bottoms:

> I met my first boyfriend on the dating app. He texted me first but did not publicize his pictures because he had not fully come out at that time. He looks nothing like a gay man at the first impression, exactly my ideal type. Exactly as I have guessed, he is a top. I have always been looking for a top who has to be more masculine than me because I feel that I need somebody to take care of me, making me feel loved; somebody who is determined in the way they act and speak; somebody who knows what they aim for; somebody who treasures me.

All informants have a clear preference for sex roles in their partnering choices. First, they want to be comfortable in terms of sexual intercourse. Second, they have stereotypical expectations about the correlation between sex positions and gender roles in a relationship. Especially on dating applications, they often cite their preference frankly on their bio. Ultimately, there is no "natural" connection between gender roles and sex roles, as the participants often assume (Tortora et al., 2020). Such presumed associations are the direct consequence of social stigma in a heteronormative environment and the lack of exposure to homosexuality from a young age. These factors make gay people believe that they should follow the structure and traits of heterosexual romantic relationships. Therefore, the common gender roles of men and women dominate the inward beliefs of gay people, leading to the perception that sex roles can be perceived as social roles in romantic relationships.

Internalized homophobia is thus the result of embodying a stereotypical "correct way of being," made and passed on in the heteronormative world. It has led to discrimination against certain types of gay people. Internalized homophobia makes it harder for gay people to live authentically as themselves, and the partnering process becomes more challenging as they have to find someone who has their preferred sex roles and gender roles.

Coming Out

Coming out is often considered a defining moment in a LGBTQ+ individual's life. Coming out can also be understood as the state of having embraced one's sexual orientation, gender identity, and being open about them with others. The experience of coming out is distinct for every individual. It can be affected by various factors such as upbringing, environment, and perceptions towards one's sexual orientation. The presence of internalized homophobia also plays an important role in the decision to come out (Kahn 1991).

I use the phrase "fully come out" for those who have revealed their sex and gender identity to everybody, including their families, and the term "partially come out" for people who have not told their families but have been open in their other relationships: friends, partners, co-workers, etc. When asked if coming out is an important factor required in the partnering criteria, there were two groups of ideas among my participants: Those who have fully and partially come out (group 1) would ask their partners to also come out or at least have the intention of coming out in the near future, while those who have not come out and a small group of "partially come out" individuals (group 2) mentioned that they do not require their partners to be open with their sexual and gender identity.

Group 1 indicated that as they are open with their sexuality, and it is comfortable for them to be in relationships with someone who does the same. They do not want to be in a discrete relationship. If their partner has not come out, they prefer somebody who intends to come out because they feel that the relationship has a greater potential for longevity. They also expressed that being in a relationship with someone who has not come out means that they also must "go back to being secretly gay," which makes it harder for them to fulfill their sense of authentic self. Long, for example, explained the difficulties he faced while being in a secret relationship with someone who had not come out yet:

> I do not feel comfortable dating someone who is still "in the closet" as I have publicized my sexual identity; I have the right to express my feelings and behave like myself – a gay man in public. Being in a discrete relationship makes it harder for me as I have to ensure that my behavior and expression, or my actions will not go beyond the boundaries when we are in public. At the same time, we have to act like a couple of male friends when we are outside. All romantic actions or our true feelings can only be disclosed when we are in a private space.—Long, a 22-year-old gay man in Ho Chi Minh City

Group 2 showed less intensity and pressure towards coming out while looking for their partner as they have not fully accomplished this themselves. They respected the long and tragic process of acceptance and revelation; therefore, they understood their partners' choice of not coming out. They also stated that they feel comfortable and emotionally stable in a discrete relationship. However, a small proportion of individuals in group 2 said that while there is no pressure to tell each other's families about their relationships, they should be open among their close friends so they can feel more "comfortable."

These two contradictory standpoints demonstrate the level of ease members of each group feel about their gender identity and queerness within their specific environment; in this case, Hanoi and Ho Chi Minh City. The differences in how society perceives the LGBTQ+ community puts pressure on young gay men, forcing them to make the choice of whether to come out or not. Some feel that being with someone who has come out is wrong or will not be validated within the context of mainstream society. Therefore, they prefer clandestine relationships or relationships with those known only in a small circle of friends and relatives.

Hanoi has undergone many changes in its regime and political system, as well as in culture and traditions. As residents of the historic capital of Vietnam, however, Hanoians are still very much influenced by traditional ideas, especially Confucianism and hereditary customs. Therefore, gay men in Hanoi face many prejudices, and pressure to adhere to mainstream gender norms. Many interviewees, for instance,stated that they attempted to alter their appearance and attire to conform to the conservative settings in Hanoi's public spaces, where verbal and physical aggression towards LGBTQ+ people is common. Coming out in a feudal and Confucius-influenced society is considered a difficult process. A group of Hanoian participants mentioned that they have not fully disclosed their sexual orientation to their families because most of them are not financially self-sufficient. This means that if their families reject them or expel them, they will have nowhere to go. As Kien said:

> I am still a student. I have not had a stable job. If I came out to my father as a gay man, he would beat me to pieces and expel me out of the house. A family from the North like us is still affected a lot by tradition and even religion. I cannot see the future of me after coming out, but the suffering is unbearable.

In comparison to traditional Hanoi, Ho Chi Minh City is more "open," with a wider range of gay nightlife and LGBTQ+ scenes. With the arrival and integration of foreign tourists and expats, Ho Chi Minh City adopted greater tolerance and acceptance towards the LGBTQ+ community. Many participants describe it as a "no judgment" city, where they may feel comfortable expressing their queerness and gender expression in public, or even going on a date as a homosexual couple, without fear of being judged by others. Pop culture is one of the key indicators of friendliness toward the LGBTQ+ community in Hanoi. LGBTQ+ people have opportunities, even though there are not many, to express themselves on the mass media in Ho Chi Minh City, gaining understanding and sympathy from a part of the public.

However, during my interviews, gay participants in Ho Chi Minh City still face disfavor from their families. Hoang, a 30-year-old male, said that his mother does not accept his long-term boyfriend as she expects him to conform to heteronormative norms, which means he should get married and have kids with a woman. However, when it comes to seeing other LGBTQ+ people in the media, Hoang's mother does not seem to have such harsh reactions.

Differences in culture and social viewpoints thus affect how gay men in Hanoi and Ho Chi Minh City view the coming out process. In many instances, internalized homophobia informs the development of a sense of negativity toward oneself. As many have been exposed to antigay bias throughout their lives , some wish to conceal their sexual orientation (Hafeez et al. 2017). This can result in unnecessary stereotypes about outness, which can lead to internalized homophobia, as it makes gays deride people who are proud of their same-sex orientation. One of the most popular stereotypes about gay people who have come out is that they are usually androgynous, or "queer," as they tend to be more open with their gender expression to the public. Oftentimes, Vietnamese gays who have come out are mistakenly perceived to be feminine, which can lead to discrimination against them by those who have not come out. This correlates with the pressures associated with the proliferation of the ideal types of masculinity among Vietnamese gay men, as mentioned above.

Dat, a 22-year-old gay man from Ho Chi Minh City, faced criticism, stereotypes, and erroneous assumptions from fellow gay people after mentioning that he came out to his family. While using dating applications, he received comments such as "coming out means you can be feminine-acting." Some people he met on these applications feel "pressured" to be with someone who is publicly gay as they have not yet disclosed their sexual identity; they do not want others to find out about them being gay if they go out with him. Dat expressed his concerns about finding a partner in the future as he feels there are more discrete gays who care about other people's opinions than those who love him for who he is and they do not care if he has come out or not. Similarly, Tuan, a 25-year-old gay man in Hanoi, expressed his concerns after having come out and becoming publicly gay:

> I have never thought that being an openly gay man, it would be a burden for me to find a partner in Hanoi. Most of the people I have met after I mentioned that I had come out to my family, their first reaction was admiration and asked me if I could keep the relationship in secret, as they have not come out yet. Moreover, they stereotyped me for being "free" to express my queerness all the time, which they cannot do. Some men even told me not to be "too much gay" when I went out with them.

Therefore, having fully come out does not necessarily mean that gay men can live authentically due to certain internalized homophobic perspectives from fellow gays in their community.

In contrast, the state of having "fully come out" can also affect how LGBTQ+ people see themselves and others. They take on the pride of being openly gay and view others who have not come out with the initiative of asking them to be more open with their queerness. All five openly gay men (group 1) prefer to be with someone who is comfortable with embracing their sexual identity and behavior. As mentioned above, they prioritize those who have already come out while finding partners or encourage their partners to accelerate their final decision to be openly gay. However, for most informants, coming out is a difficult task and requires time and consideration. They need to truly accept and tolerate their gender identity, and deal with their families and consequences, as well as the community among them.

Ultimately, as the heteronormative Vietnamese society "allows" gay men to conceal their sexual orientation as a way to protect themselves from stigma and discrimination, it is mutually understood among gay men that coming out is not an essential component of their gayhood. It is thus alright (among gay men) to have discreet relationships. However, as discussed above, this can have deleterious consequences for individuals. While for many of my participants, coming out is still not an important factor in finding a partner, being in a secret relationship might affect the quality or duration of a relationship, especially if a couple has to be careful about gender identity in public and cannot fully be themselves.

Internal Discrimination within the Gay Community, Dating, and Dating Applications: Safe spaces but not for all

"Are you top or bottom?", "Masc4masc," "Looking4now," and many more. These are the common phrases that are seen on dating applications such as Grindr (exclusively for gay, bi, trans, and queer people) and Tinder (for both heterosexual and the LGBTQ+ community). These phrases, which the users put on their profiles, reflect the preferences and expectations of the person who is using the applications to look for their partners. They position others into boxes (top, bottom, masculine, etc.) and gendered roles, which can become a hurdle for many if they do not fit others' criteria or preconceptions.

Grindr, established in 2009, is the most popular gay mobile application in the world (Horvat 2016). Its location-based feature attracted users because they can talk with different people within their geographical area, which is a convenient way to find a disposable meetup or hookup. Grindr is perceived to be akin to a gay bar but potentially scarier and more complicated (Kapp 2011). While people go to a gay bar to meet others who share the same sexual orientation as them, with Grindr, they can stay at home and see if their neighbor is gay or not, or even ask for sexual intercourse with them. Because of its popularity and its special location-based feature, Grindr is the most popular app for gays in Vietnam. It is also a place where ex-pats meet locals. In many ways, the foreign culture of hookups or one-night-stands is learned and practiced by Vietnamese people via Grindr or other international dating apps. The application itself has gradually become a significant aspect of Vietnamese gay culture.

Most informants chose to use dating applications to find their partners, as they mentioned that there are not many LGBTQ+-exclusive activities or places for them to network. Moreover, dating applications make it easier for them to initiate conversations, as they feel comfortable talking about themselves, their sexual orientation, types, and interests. By chatting and getting to know each other before meeting in real life, gay men feel safer and can build a certain amount of trust in others. Moreover, compared to social activities and hangouts organized for LGBTQ+ people, dating applications can keep them from disclosing their actual identity (as they do not have to use real pictures). It is understood among users that people on the apps belong to the LGBTQ+ community. Therefore, for those who have not come out, they have a safe place, and many informants said that dating applications increase their reach and grant them opportunities to find LGBTQ+ partners.

Another reason that participants gave for being on the application is sex, which Grindr makes more accessible and easier than ever. They can choose a person who is also interested in having sexual intercourse with them without having to go to gay bars.

Informants who completely detest the application said that they try their best to avoid using dating applications to find partners. The most common reason is the judgmental and negative attitudes that these dating applications bring about. As they are picture-driven, people's bodies and images are the focal points. According to my informants, for Vietnamese gays, the archetypes of shirtless and muscular torsos are the most common representations on various apps. They are glorified by others for being masculine, regardless of their chosen sex roles (top, bottom, versatile). Feminine appearance is discriminated against, as they are deemed to be too effeminate and passive. These preferences correlated with the ideal types that gay people mentioned above.

Khanh, a-20-year-old gay man in Hanoi, told me about his experience while using Grindr: "I try to avoid those bodybuilders and masculine-looking men because I think they have heteronormative viewpoints, and they tend to be judgmental." He also became a victim of body-shaming on Grindr, with criticism from fellow users as effeminate, "girly and skinny:"

> I recognized Grindr is not a place for me as there was too much negativity and discrimination. However, it is difficult to stop using it as I want to socialize with other gay people and find a partner eventually. I also have tried to change my behavior, worked out, and changed my clothing style so that I can be more like a man. I used to think that this would help me get better exposure to other people on the app. However, I felt afraid that if one day I found a partner, he would not love me for who I really am but for the person I pretended to be.

Through Khanh's experiences of forcing himself to change to fit constructed stereotypes within the gay community on Grindr, we can see how internalized homophobia can lead to discrimination towards other gay people. This often makes dating applications an unsafe place for Vietnamese gays to fully express themselves. Through their choices of images, the users visually showcase themselves and judge each other. Users tend to be obsessed with looks and judge others by their pictures on the apps, often labelling others as too "masculine" or "feminine." Through a few lines on the chat function, a person can make simple assumptions and stereotypes about another, according to their expectations of how a "top" and a "bottom" should behave. The labels of "masc" (masculine), "femme," or "straight-acting," among others, cause anxiety among gay people about their appearance and behavior. This can lead them to conceal their queerness to fit in the expectations of fellow gays. It can make the partnering process easier, but in the long term, they will not have ownership of their sexual identity and they often absorb the negative stereotypes of internalized homophobia.

Commitment in Gay Relationships

Internalized homophobia is thus a barrier to a genuine and non-judgmental homosexual partnership. The higher the level of internalized homophobia that a gay person has experienced, the more negative their relationship's outcome can be. Herek, Meyer and Dean (1998) state that the unfounded beliefs that LGBTQ+ people are incapable of intimacy or sustaining long-term, stable relationships contributes to prevailing stigmas around being homosexual. Moreover, same-sex relationships' longevity is strongly affected by heterosexism and sexual prejudice.

However, the data collected from my interviews departed from Herek, Meyer and Dean's explanation. More specifically, participants in group 2 (those who have partially come out or have not come out) stated that being in a long-time and serious romantic relationship with a man puts pressure on them to open up about their relationship and sexual identity at some point in the future. This means they have to disclose themselves as gay and acquire acceptance from others (family and other circles). Therefore, they often choose to engage in disposable hook-ups or they have discrete "friends with benefits" arrangements to avoid facing this revelation. The self-devaluation that gay men absorb (under internalized homophobia) impacts how they view and act in a relationship with another person. They often feel "wrong" to be in a relationship with a same-sex person. Their partner is akin to a mirror who always reminds them about their sexual orientation, which does not fit with the socially constructed beliefs and ideology in Vietnam.

By participating in various types of relationships, including friends with benefits and hookups, among others, those that do not require long-lasting affection can palliate their feelings caused by stigma and internalized homophobia. As Anh attests:

> When I was in a relationship with my ex-boyfriend, I forced him not to reveal our relationship as I was scared of judgments and discrimination, even from my close friends. We used to choose dark or empty places in the city to meet as I did not want to be seen. I broke up with him eventually because we had a fight on whether to tell his friends about our relationship or not. Now, I am still single, and I do not want to be in any other relationships as I feel the pressure that one day, I have to reveal my sexual identity. I tend to meet people on dating applications and usually end up having sexual intercourse with them. No strings attached, no promises. These activities eased my mind because I am still in the closet.—Anh, 25 years old, gay man in Hanoi

Another factor that can lead to internalized homophobia among gay people and their ideas of relationships is the lack of exposure to non-heterosexual identities. Vietnam is not an environment that is free and tolerant for gay people to fully represent themselves, due to traditional beliefs, censorship, and the slow progress toward having LGBTQ+ people represented in public media. Some gay people thus harbor heterosexist prejudice about same-sex relationships or about being homosexual in general. These stereotypes can result in infidelity among gay partnerships and affect the length of their commitment. Among 15 informants, 6 were in a romantic relationship, with an average length of 1 year in duration. For those who are single, 5 experienced same-sex relationships. The reasons for their breakups include “not willing to come out,” infidelity, and conflicts about their sexual expression or queerness. Some were told by their former partners to be more manly or to dress and act straight. Moreover, bottoms were demanded by tops to be submissive and obedient. This explains how internalized homophobia and heteronormative ideology can lead to discrimination and negative stereotypes even when they are in a same-sex relationship. Gay men with internalized homophobia are thus associated with a lack of satisfaction in relationships. This can be rooted in image concerns, their expectations of partners with assigned gendered roles, sexual problems, or fears of coming out.. As long as they have a stigma about themselves and others regarding their sexual orientation and queerness, they are still under the effect of internalized homophobia – which eventually leads to the failure of relationship commitment.

Conclusion

Internalized homophobia influences the partnering process of Vietnamese gay people. The set of negative attitudes and antigay bias rooted in a dominant heteronormative environment has reinforced negative perceptions of gay men that they then internalize and direct toward themselves and others, making the partnering processes more difficult. As a Confucian and Asian country, Vietnamese society holds antipathy towards the LGBTQ+ community. Compulsory heterosexuality is expected of young men, with negative stereotypes and beliefs about homosexuality, which are later on internalized by homosexual people. This leads to Vietnamese gays’ tendency to build their ideal types and partnership preferences based on the traditional viewpoints of how a heterosexual man should look or behave. They apply gender roles - which originated from patriarchal stereotypes of the heterosexual relationship - in finding their partner. This, in turn, affects their coming out process as gay men, and they cannot live authentically due to the conformity to heteronormative norms. Internalized homophobia makes it harder for Vietnamese gay people to find long-lasting relationships and commitments as they are still intimidated by their own sexual identity and are not willing to embrace it.

With the development of dating applications, the partnering processes can become more disposable and sex-focused. This leads to further discrimination within the gay community. They judge others' physical appearance, label sex roles, and force individual requirements about gender expression on others. It makes finding a life partner difficult because gay men experience internalized homophobia and cannot accept the gender identity and queerness of others. They discriminate and react negatively to individuals who are living as they are.

Positive representations of the LGBTQ+ community in public culture play the most important role in fostering acceptance and tolerance towards homosexual people in Vietnam. Media creators should take responsibility for representing all identities accurately and respectfully. Some members of the LGBTQ+ community have been described using words like "delicate" or "sensitive." Presently, the government stays neutral when it comes to LGBTQ+ issues. But the stigma, prejudice, and discrimination faced by LGBTQ+ people in the country persist, and to tackle these kinds of attacks, the government needs to shift from being "neutral" to being more decisive. The lip service for equality and human rights in Vietnam should not stop at pledges and promises; these need to be put into action. This starts with raising awareness, with education (sex education, LGBTQ+ education), with same-sex couple representation, with breaking fundamental misunderstandings and stereotypes towards LGBTQ+ people, and with overcoming problems like internalized homophobia. Once Vietnamese gay men can feel safe and free to embrace their identity, their partnering processes will no longer be affected by antigay biases or prejudice.

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