OVERVIEW

Suicide is the second leading cause of death for people ages 15-24 (AFSP). Suicide rates have risen across all ages since 2000 (AFSP). Suicide intervention trainings have also become more central to health-related curricula. As these trainings increase, their potential for impact also grows. Where is this impact seen the most? Analyzing this question through the ways identity, suicidality, and preventative trainings interact with each other reveals the need to acknowledge intersectional identities.

Kimberle Crenshaw coined the term "intersectionality" while examining the damaging and inaccurate representation of identities as singular that erases Black women and others of multiply marginalized identities (1989). Crenshaw demands anti-racist and feminist work to be completely recast in light of intersectional discourse. In translating suicide prevention trainings to account for intersectionality, it is imperative to recognize that merely replacing identities interchangeably is not enough. An entirely new framework must be created to make room for people's whole selves and the communities they live in, without forcing them to choose and silo themselves into an existing model. **Currently, most training and prevention efforts implicitly uphold the social order built on institutions of white supremacy and heteronormativity that rely on the silencing and destruction of non-normative bodies to maintain dominance.** Placing more value on normative lives leads to more efforts to save people whose bodies and minds are deemed more valuable and productive. This is reflected in the continued inequity of resource distribution and pervasive discrimination people with multiply marginalized identities face.

Suicide trainings disregarding identity completely, at best, remain complicit in, and at worst, perpetuate violence against people with multiply-marginalized identities. If a queer Black person is caught between suggestions of Black community ties to increase their sense of social cohesion and fears of family abandonment as a result of conceptions of traditional Black masculinity and cis-heteronormativity, where can they turn? Without intersectionality, bodies in these liminal spaces remain unseen.

As it exists currently, mental health practitioners and other social service agents agree on the importance of cultural sensitivity, but they use different approaches and strategies with varying levels of efficacy (Bhui et al., 2007). **At present, the vast majority of identity-based cultural competency trainings focus on one axis of identity, ignoring the reality of the intersectional identities people hold** (Pritchard, 2013). However, even addressing true cultural competency among mental health practitioners ignores the reality of cultural mistrust and stigma around formal help-seeking because of limited culturally sensitive prevention efforts for suicidal youth.

For those less-likely to seek formal resources for treatment, culturally informed and empowerment-based support are key (Kaslow et al., 2010). These should include identity-based role models, culturally-relevant coping methods, tools to build on the strengths of the community, and highlight existing networks of support (Kaslow et al., 2010). Interventions need to be community-wide, fostering a sense of cohesion within the specific community itself (Clifford et al., 2013). Interventions also need to be community-led, centering their own characteristics and values, leading to integration of interventions into the community's mission (Astor et al., 2005). **By getting to know the specific community more intimately, a training can be designed to highlight and maximize community strengths and target specific systems, dynamics, and resources to focus on in the future.**

INTERSECTIONAL
suicide prevention

MODULE OUTLINE
facilitators

Day 1

- Pretest
- Training environment
- Get to know this community and its values
- How risk factors and trauma appear in this community
- Help-seeking and support in this community
- Mental health crises and conversation strategies

Between Days 1 & 2

- Consolidate notes from each topic of discussion
- Create role play scenarios based day 1 discussion
- Research community resources based on help-seeking discussion

Day 2

- Brief review of day 1
- Review case study responses
- Role play scenarios
- Community cohesion and resources
- Posttest

After Day 2

- Consolidate and distribute resources into a document, sorting them, if applicable, by categories of identities addressed and types of healing/help-seeking
- Follow up for further community-building

DAY 1
facilitators

Pretest

Training Environment

Who is in the room?

- Brief introduction with names, pronouns (optional), position within or ties to the training group.

Why is this training important to this group?

- What are your goals for the session?

What expectations do you have for the environment of the training session? Create a living list.

- "I" statements
- Kindness to self and others when discussing these topics and responding to case studies/role plays
- Make space, take space
- Trust intent, name impact, own impact

What power dynamics exist in this space? How can we keep the integrity of the training given the existing power dynamics?

- Acknowledge the goals of the group (i.e. mission statement) while looking at the reality of what community looks like (i.e. data).
- Allow space for discussion of current organizational activities. This is a space for growth, which can sometimes lead to reevaluating current practices or mindsets.
- Understand the purpose of the training and the collective goals the group agrees upon.

Establishing and Analyzing Community

Who is in your community? What makes them part of your community?

- Draw distinctions between what makes someone "in" or "out"--it's blurry, right?
- What diversity lies in your community? How might people of different identities both positively and negatively experience your community differently?

Modal subject:

- Are there characteristics you associate with someone who epitomizes your community?
- Who may be marginalized in your community? How are they marginalized? Why are they marginalized?

What does distress look like in your community?

- Have you observed distress in other people, or have people confided in you about emotional distress?
    - How does this manifest in people you know in your community? How might this manifest in different parts of the community or different communities entirely? This could be direct conversation about emotional or mental health issues, talking about physical discomfort,

withdrawing from social interactions, or something else.
    - How can we be sensitive to these differences?
- Who is commonly approached in distress? Who is acceptable to divulge these issues to?
    - Family members, religious leaders, mental health professionals, medical doctors, other community leaders, peers
- Are there certain phrases that you associate with distress or wanting help? These may not be direct.
- Are there certain behaviors you associate with emotional distress? Are these signs close to indicators of other types of distress? Signs of suicidal ideation or other mental health concerns are not isolated. These experiences are intertwined with physical health, social relationships, feelings of community and belongingness, spiritual connectedness, and more.

Assessing Risk

Thwarted belongingness and perceived burdensomeness are two primary, root risk factors for suicide. Sleep problems, either sleeping too much or too little, correlates with suicide because they lead to greater feelings of isolation from spending time awake when others are sleeping, sleeping when others are awake, and feeling too tired to engage fully with people during waking hours.

- What does it look like for a person to belong and matter in your community?
- Why would someone not belong?
- How can you increase your own feelings of belongingness? How can you help another individual feel more like they belong?
- How can your community communicate more clearly and effectively values that make people feel more like they belong?

Different communities may be more or less likely to be exposed to particular types of trauma. The roots of these types of events may be in histories of systemic violence, discrimination, and oppression. While these large systems may seem distant to some, their effects frequently trickle down in both obvious and innocuous ways.

- What events of interpersonal or intergeneral harm occur in your community?
- What are the effects of this trauma? What are some ways you've seen or experienced them manifest?

Help-seeking and Healing

Help-seeking may vary in different communities based on networks of care and who are trusted community members. Healing is both internal/individual and relational/community-based, and help-seeking may able differ within your community depending on identity and the different facets of your community people have access to.

- What are ways people in your community heal or try to seek help for themselves? What does this look like?
- What does cultural sensitivity look like? For people who have accessed any resource, service, or space they felt understood and empowered them on a cultural level, how did you feel cared for? What did

they do? How can you tell when you can trust a organization?

- Oftentimes, this is listening and meeting people where they're at. If an organization has a history of employing people from a specific culture, that may be a sign of their cultural sensitivity and knowledge. If people from this organization are connected with other cultural organizations, this is also a good indication of their community ties and the relationships they have built.
- What are services in your community that are sensitive to culture? They don't need to be intentionally geared toward mental health.

- How do people in your community build trust?
- Who are trusted people in the community?
- What are potential barriers for people to seek help?
- What skills do people in your community already possess to help them heal? What are ways gatekeepers can build on those skills?

Mental Health Crises and Suicide

Distress may lead to suicidal ideation. What happens when we identify distress and want to have a conversation about it?

- What are our immediate reactions to mental health crises?
- Are these reactions empathetic? Do they center community values, keeping in mind the way your community expresses and handles distress? Do they harness inherent community strengths and relationships?

Practical Strategies for the Conversation

If you feel someone may be facing a mental health crisis or feeling emotionally unwell, think about how you want to facilitate and promote healing.

Check in with yourself. Do you have the mental and emotional capacity to have a potentially intense conversation?

- If not, this does not make you selfish or negligent. It is possible to start the conversation by checking in with them and offering to follow up at a later time. Knowing your own boundaries is healthy and makes you better able to care for yourself and others in the future.

Think about the motives of the conversation.

- What makes you want to have a conversation with someone?
  - Have you been observing signs of distress? Why do you feel they may be at risk?
- If your motives are centered on your observations and come from a place of care and empathy, it may be good to check in. Be genuine about wanting to meet them where they're at, and try to enter the conversation without expectations.

Where is the conversation taking place?

DAY 1
facilitators

- Try to find a space that allows for comfort and privacy, perhaps somewhere that is familiar to them.

How do you start the conversation? Have a regular conversation with them--whatever is regular for the rapport you've built with them in this relationship.

- **Open-ended questions** are key. Invite them to elaborate on how they're feeling and what's going on. Keep in mind how people in your community tend to communicate thoughts and personal experiences. Use open-ended questions throughout the conversation to **avoid making assumptions** about how they're feeling.

When you come to a point you want to broach the subject of suicide or a different mental health crisis, be honest and direct. In the context of your care of their experiences, and ask the question directly. For example:

- "I've been noticing recently and throughout our conversation I'm hearing [sign/risk/behavior you have observed or they shared], [another sign], and [another sign]. Are you feeling suicidal?"
- Especially when asking about suicide, do not use indirect phrases like "you're not thinking of doing anything stupid/irrational/crazy/you'll regret, right?" This indicates you are uncomfortable broaching the subject and, before they answer your question, already stigmatizes a potential response. This may make you an unviable person to share with. Using direct language does not put the idea of suicide in their mind.
    - Practice asking the question out loud in pairs. There is no need to respond to the question. Reflect on how it feels to ask.

If they say no, do continue to have a conversation with them about the signs you observed.

- While they may not be experiencing a crisis, they may still appreciate support.

If they say yes, take a breath.

- **Thank them** for telling you. They have shared something oftentimes very personal and difficult with you. Hold their experience with kindness.
- Ask them a few clarifying questions about any **plan** they may have, **method**, **means**, and **time frame**.
- If they are acutely suicidal, meaning they have a plan, including a method, access to means, and a determined time frame, be sure to follow up and check in with them about this later in the conversation.
- Thank them for telling you.

Throughout the conversation...

- **Paraphrase**. Repeat back the content of the experiences they share with you, using some of their key words. This indicates you are listening and it allows them the opportunity to correct you if you misunderstood something. Try phrases like, "I'm hearing that..."
- **Validate**. Paraphrase their emotions and let them know their feelings and reactions are understandable and warranted. This can make them feel heard and understood--you are meeting them where they are at without assumptions. Try phrases like, "that sounds really difficult," or "I'm sorry that

happened--I can only imagine how scary that was."

- Use **verbal non-verbals** and **attentive body language**. Do not interrupt them when they are speaking, but indicate you are listening to them with affirming body language and speech fillers, like "mhm," nodding, and mirroring their body positioning.
- Use **"I" statements**. When you are paraphrasing, validating, or making other comments throughout the conversation, try to use "I" statements to express how you are perceiving the situation and avoid sounding assumptive or accusatory. For example, instead of saying "you should have told me," try saying "I want to know more."

If you feel the conversation coming to a close, think about connecting them to someone or something.

- This could be another conversation with you, a meeting with a trusted community member, an organization, a community event, or an individual activity.
- Ask permission before giving resources or referring them to someone else. This part of the conversation may take a different tone that focuses less on their current experience and more on their immediate future plans. Asking for permission to shift the focus on the conversation allows them to choose whether or not they want to move to a potential solution.

DAY 2
facilitators

Review Day 1

Pass out consolidated notes.

Case Studies

Debrief.

- Share responses in small groups.
- Any particularly challenging points?
- Different reactions? Similar reactions?
- Cases from your lived experience to share or seek advice on?
- What other information or training would help you address these cases and others?
    - Incorporate these responses in new role play scenarios.

Role Play

Activity Format

There are two characters involved in each role play, the person noticing distress and the person experiencing distress. Both people and all observers of the role play will receive some information about the context of the conversation. The person experiencing distress will receive the scenario's description of their individual situation. They should reveal details piece by piece, as they would in an organic conversation. The person noticing distress will not receive a description of the individual situation they are about to respond to.

Role plays should be conducted in front of the large group, in individual pairs, and collaboratively as a large group. Each role play, timed to last around 3 minutes, should be debriefed immediately after it finishes. Each individual should only hear or participate in each role play scenario once.

- To model the role play exercise, the facilitator and one group member should conduct a role play in front of the large group, with the facilitator as the person observing distress and the volunteer as the person experiencing distress.
- Individual members of the group will forms groups of three. Two of the people will pair up for one-on-one role plays while the other keeps time and observes, switching off between who is experiencing distress.
- To conclude this portion of the session, conduct a large-group role play. Here, the facilitator will be the person experiencing distress, and the rest of the group will collectively play the person noticing distress, taking individual turns to speak. This works best if group members are sitting in a circle and follow a predetermined order to speak. This can be a longer role play, and each person should respond multiple times.

Debrief Format

At the end of each role play, take a few minutes to debrief.

- State observations of what happened during the exercise. For example, comment on when the person experiencing distress chose to elaborate more, repeated themselves, or had a change in tone.

- "When you said ____, I noticed ____."

- People in each of the roles--noticing distress, experiencing distress, and observing the role play--have different and valuable perspectives to add.
    - The person experiencing distress might debrief by saying, "When you said ____, I felt like you were trying to understand where I was coming from, so I opened up more about what was going on."

Activity Debrief

After the entire role play portion of the training is finished, debrief the experience.

- What surprised you about this activity? What came naturally? What was challenging?
- What were especially effective questions, phrases, or body language cues used by people noticing distress?
- Any other situations or techniques you feel are important to address?

Community Cohesion

Interventions are most successful when they foster a sense of community cohesion and work at creating and fostering a culture that makes people feel they belong and matter.

- Besides in crisis situations, how can you use this training to create a healthier community? Think about communication, services, programs, and culture.
    - There are aspects of many different types of interactions, from individual to collective, that contribute to community cohesion.
- What already holds your community together? How can we build on these aspects to strengthen it in ways that build compassion and resilience?
- What are resources in your community you would connect people with if they were experiencing emotional distress?
    - Come up with a list, keeping in mind the diversity of community members, different help-seeking tendencies, and community values.

Let's not let the conversation end here. **Are there any potential collaborations between community members, organizations, or leaders you think would be important in building a more empathetic and compassionate community?**

- What would you like to see in your community?
- What changes might it take to get there?
- Who in this room might have power or stakes in those changes? Outside this room?

There's an opportunity for further community building and organizing here. Is this something your community would benefit from? If yes, let's set up the next meeting now, along with a few point people.

ROLE PLAY GUIDELINES
facilitators

Role plays allow participants to practice the techniques they have learned and observe how they play out in the flow of conversation. They are most effective when role play scenarios are relevant to the community. Be sure to incorporate input from day 1 and the case study debrief when creating community-specific role play scenarios.

Example Scenario

These are guidelines--the role players can add details as necessary and as feels natural in the flow of conversation.

Context:

You are both students in the same class, and you are fairly good friends. You are chatting as you leave class.

Individual Situation:

You have been having a difficult time recently, feeling down and out of place. Your grades are fine, and you tend to bury yourself in schoolwork to avoid interacting with friends or calling your loved ones. You are a senior and don't really see the point of putting too much effort into friendships because you're all graduating soon. You are not very close with your parents, who live far away. You are not feeling suicidal, but you are feeling down, numb, and disconnected.

WORKS CONSULTED

Alcántara, C. & Gone, J. P. (2007). Reviewing Suicide in Native American Communities: Situating Risk and Protective Factors within a Transactional–Ecological Framework, Death Studies, 31(5), 457-477, DOI: 10.1080/07481180701244587

Astor, R,. Meyer, H.A., Benbenishty, R., Marachi, R., & Rosemond, M. (2005). School Safety Interventions: Best Practices and Programs. Children & Schools, 27, 17-32. doi:10.1093/cs/27.1.17.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: a review of model evaluations. BMC Health Services Research, 7(15). https://doi.org/10.1186/1472-6963-7-15

Blosnich, J. R., Brown, G. R., Shipherd, J. C., Kauth, M., Piegari, R. I., & Bossarte, R. M. (2013). Prevalence of Gender Identity Disorder and Suicide Risk Among Transgender Veterans Utilizing Veterans Health Administration Care. American Journal of Public Health, 103(10), E27-e32. DOI: 10.2105/AJPH.2013.301507

Chu, C., Buchman-Schmitt, J. M, Stanley, I., Hom, M., Tucker, R., Hagan, C., Rogers, M., Podlogar, M., Chiurliza, B., Ringer, F., Michaels, M., Patros, C. H. G., & Joiner, T. E. (2017). The Interpersonal Theory of Suicide: A Systematic Review and Meta-Analysis of a Decade of Cross-National Research. Psychological Bulletin, 143. 10.1037/bul0000123.

Chu, C., Hom, M., Hirsch, J., & Joiner, T. E. (2018). Thwarted Belongingness and Perceived Burdensomeness Explain the Relationship Between Sleep Problems and Suicide Risk Among Adults Identifying as Sexual and/or Gender Minorities. Psychology of Sexual Orientation and Gender Diversity. 10.1037/sgd0000301.

Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted Suicide Among Transgender Persons. Journal of Homosexuality, 51(3), 53-69, DOI: 10.1300/J082v51n03_04

Clifford, A. C., Doran, C. M., & Tsey, K. (2013). A systematic review of suicide prevention interventions targeting indigenous peoples in Australia, United States, Canada and New Zealand. BMC Public Health, 13(463), https://doi.org/10.1186/1471-2458-13-463

Durant, T., Mercy, J., Kresnow, M., Simon, T., Potter, L., & Hammond, W. R. (2006). Racial differences in hopelessness as a risk factor for a nearly lethal suicide attempt. Journal of Black Psychology, 32(3), 285-302, DOI: 10.1177/0095798406290468

Goldston, D. B., Molock, S. D., Whitbeck, L. B., Murakami, J. L., Zayas, L. H., Hall, G., & Nagayama, C. (2008). Cultural considerations in adolescent suicide prevention and psychosocial treatment. American Psychologist, 63(1), 14-31.

Gould, M. S., Cross, W. , Pisani, A. R., Munfakh, J. L. and Kleinman, M. (2013), Impact of Applied Suicide Intervention Skills Training on the National Suicide Prevention Lifeline. Suicide Life Threat Behav, 43: 676-691. doi:10.1111/sltb.12049

Kaslow, N. J., Leiner, A. S., Reviere, S., Jackson, E., Bethea, K., Bhaju, J., Thompson, M. P. (2010). Suicidal, abused African American women's response to a culturally informed intervention. Journal of Consulting and Clinical Psychology, 78(4), 449-458. http://dx.doi.org/10.1037/a0019692

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. University of Chicago Legal Forum, 1(8).

Mann, J. J., Apter, A., & Bertolote, J. (2005). Suicide Prevention Strategies: A Systematic Review. JAMA, 294(16), 2064–2074. doi:10.1001/jama.294.16.2064

Miranda, J., Bernal, G., Lau, A., Kohn, L., Hwang, W., & LaFromboise, T. State of the Science on Psychosocial Interventions for Ethnic Minorities. Annual Review of Clinical Psychology, 1(1), 113-142.

Molina, N. (2006). Medicalizing the Mexican: Immigration, Race, and Disability in the Early-Twentieth-Century United States. Radical History Review (94), 22–37. doi: https://doi.org/10.1215/01636545-2006-94-22

Nock, M. K., Park, J. M., Finn, C. T., Deliberto, T. L., Dour, H., J., & Banaji, M. R. (2010). Measuring the "suicidal mind:" Implicit cognition predicts suicidal behavior. Psychological Science, 21, 511-517.

Nock, M.K., Stein, M.B., Heeringa, S.G., Ursano, R.J., Colpe, L.J., Fullerton, C.S., Hwang, I., Naifeh, J.A., Sampson, N.A., Schoenbaum, M., Zaslavsky, A.M., & Kessler, R.C. (2014). Prevalence and correlates of suicidal behavior among soldiers: Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). JAMA Psychiatry, 71, 514- 522.

Pritchard, E. D. (2013). For Colored Kids Who Committed Suicide, Our Outrage Isn't Enough: Queer Youth of Color, Bullying, and the Discursive Limits of Identity and Safety. Harvard Educational Review, 83(2), 320-345. https://doi.org/10.17763/haer.83.2.7n07k41t2kn26708

Puar, J. (2017). Introduction: The cost of getting better. In The Right to Maim (1-31). Durham and London: Duke University Press.

Quinnett, Paul. (2007). QPR Gatekeeper Training for Suicide Prevention The Model, Rationale and Theory.