Self-Harm and Suicide Prevention
Resistance Medicine
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The Suicide Crisis

There are steadily increasing rates of suicide in the United States. Elevated risks for suicide are associated with social, economic, and political standing.

Even when the state intervenes to address suicide as a public health crisis, it refuses to address the underlying causes of many suicides. The state blames the person who dies by suicide, while eschewing responsibility for the influencing factors it can control.

Rather than blaming suicide entirely on the mental and emotional life of an individual, we must look at the patterns that cause vulnerability to suicide much earlier than someone's individual crisis. The conditions that lead to increased risk of suicide include political and social marginalization and oppression (poverty, living in a rural area, being unhoused, being a person of color, being elderly, being on the LGBTQIA+ spectrum, being chronically and acutely ill, being a veteran, and being a migrant or asylum seeker). Suicide risk is often decontextualized from the structural marginalization and oppression that increase it.

The overarching government of the US and individual state governments defund mental health services, put healthcare out of reach for millions of Americans, and are additionally so-structured that suicide risk has increased across a huge swath of the population.

For example, rates of suicide among Black youth have risen faster than in any other racial/ethnic group in the past two decades, with suicide rates in Black AMAB people aged 10 to 19 years old increasing by 60 percent. Early adolescent Black youth are twice as likely to die by suicide as compared to their white counterparts. A study found that Black youth growing up in disadvantaged communities, with high rates of joblessness, low family income, limited educational opportunities, and disrupted family structures, experienced greater numbers of young AMAB Black suicides as compared to the suicide rate amongst Black AMAB children and teens in less marginalized areas. (Kurbin et al., 2006)

Another example is that counties with higher poverty rates have higher suicide rates, with a sizable portion of the high suicide rate in those states concentrated in counties in which Native American people constitute the majority of suicides.

A lack of social integration in a community increases the risk for suicide. Social integration is the degree to which a person is linked to or involved with their social environment at different levels, including community, family, and intimate relationships, as well as whether they have a sense of belonging across social, economic, and political spheres.

The lack of social integration is often blamed on the individual for failing to integrate into their community, rather than on the aspects of our social structure that might isolate someone. Studies have found that generations of people suffering from a lack of economic and educational opportunities lead to reduced social integration for that family's members. But instead of looking towards the root causes of those lacking opportunities, the individual is blamed for their low socio-economic status and inability to integrate into society.

Public policies shape economic development, job opportunities, vocational training, income support, affordable housing, affordable food, affordable healthcare, adequate education, etc. These social forces undermine individual mental health, but they aren't individually focused. Instead, they are based on a policy regime, an alignment of systems, institutions, instruments, and coalitions that create and maintain the policies and rules that govern a specific issue. It is more than just a list of laws, but rather the practical and dynamic relationships between the laws and policies, and the goals of those who create them.

The policy regime of the United States claims that the mental health crisis and suicide as a public health crisis are individual problems, while creating and maintaining the policies and rules that increase the risk for suicide.

Unfortunately, even mental health providers can have willful blindness to this issue. Many providers approach suicide as an act of an unwell individual without considering the reality of the individual struggling against structural injustice. Rather than "just" an extreme action taken by a mentally unwell person, suicide is often a response to a complex combination of personal and structural conditions.

When the state spends money on supporting the common people, rather than on supporting billionaires and corporations, suicide rates drop. Overall, per capita spending on people has a significant effect. In 2009, the "cost" of reducing suicide risk nationwide was $45 per capita in public assistance funding (Flavin and Radcliff, 2009).

States that have higher access to mental health care have lower incidences of mental illness and lower rates of suicide.

Numerous studies have found that residents of GOP-controlled areas have higher rates of suicide. This is linked to multiple factors. Conservative state policies result in worse socioeconomic status for the vast majority of people, concentrating wealth in the hands of a very few. Conservative policies also tend to gut education, mental health services, and social safety net services. Vulnerable populations already suffering from country-wide marginalization and oppression are even further marginalized, including LGBTQIA+, Native American, Latine, and Black populations.

Rural areas, which tend to be overwhelmingly GOP-controlled, tend to have much higher rates of suicide, partially due to the lack of socioeconomic opportunity, but also due to the lack of physical and mental health services. As rural hospitals close, suicide rates go up.

Restriction of reproductive rights for AFAB people also causes a higher risk of suicide for AFAB people of reproductive age (Zandberg, et al. 2023).

Additionally, GOP-controlled areas have higher rates of gun ownership. Weak gun laws correspond to higher levels of suicide. Firearms are used in approximately 50 percent of all completed suicides in the US. If a gun is in a home, the potential for suicide in that home increases, especially amongst people aged 15 to 24 (Brent and Gridge, 2003).

Culturally, GOP-controlled areas tend to have a societal emphasis on individual autonomy and responsibility for one's own mental health, rather than a societal responsibility. People are expected to "get over" mental health difficulties or not make it anyone else's problem. Stigma may be higher. Additionally, people may be expected to turn to churches for help and support, rather than to mental health providers. How much help someone can get from a church is highly variable.

One way to potentially shift the cultural consciousness around suicide is to use the "fluid vulnerability theory" (Rudd, 2006), but add to it.

The fluid vulnerability theory claims that people have a baseline risk for suicide that is comprised of various interconnected factors, including the person's family history, physical health, nutritional status (malnutrition being a contributing factor to suicide), mental health, personality, problem-solving skills, and personal resiliency. People with a higher baseline risk for suicide tend to respond to acute stress and crisis

with an increase in suicidal ideation. That risk fluctuates as they go through their life, due to the interconnecting vulnerabilities (Wolfe-clark and Bryan, 2017).

This theory isn't wrong, but it is incomplete.

The fluid vulnerability of any given person is also heavily influenced by the pressure exerted on their life by the systems they operate within and rely on, including the policy regime that is the background of their day-to-day life. Some people are subject to relentless oppression and marginalization. Those people are then often, in studies, found to have a higher fluid vulnerability than people who don't face constant action and inaction by the policy regime that oppresses them. That pressure causes them to be more vulnerable to crisis.

There is a structural variability that isn't being taken into account, and until it is addressed, any model of mental health vulnerability is incomplete.

Suicide framed as a public health issue has to emphasize the overall health of the public, not individual pathology. Any attempt to address suicide as a public health crisis MUST take into account the policy regime driving people to suicide.

How Communities Address the Crisis

As the United States' mental health-related policy regime increasingly fails to address the structural basis for increasing suicide rates, some movements have turned to communities to support those who are struggling with their mental health.

Programs are starting to train lay people (non-professionals) to help individuals dealing with mental health issues. A new social justice movement has sprung up to address the suicide crisis, consisting of paraprofessionals and lay people who are trained to respond to mental health crises.

A professional, in this context, would be someone with credentials, certification, and licensure to address issues of mental health crises. This would include people in the fields of psychology, psychiatry, therapy, nursing, social work, and mental health education.

A paraprofessional does not necessitate corresponding credentials, licensure, and/or degree(s), but does consist of someone with some training, such as emergency medical technicians trained to be part of a crisis response team. Some people will also count clergy counselors, people with Mental Health First Aid training, and people with

Psychological First Aid training as paraprofessionals, while others would say they are volunteer lay people.

For our purposes, we will focus less on whether someone would be considered paraprofessional or a volunteer lay person, and more on whether the training is formalized training (certificates in Mental Health First Aid) or informalized training (apprenticeship or mentorship under a resistance medic, member of the clergy, etc).

Not only are there not enough mental health professionals to meet the needs of the population of the United States, but many cannot afford their services or access community mental health centers that may or may not exist in their region. Additionally, people who belong to oppressed and marginalized communities are often locked out of opportunities to obtain the education and credentials to support their own communities.

It is a collaborative connection, with both parties - the volunteer and the person they are assisting- benefiting. The volunteers are sometimes the only support people in those communities can access. Volunteering may be the only way for someone from those communities to become a person who supports the mental health of their community.

Many volunteers share a social status and identity with the population they serve, which helps to reduce or even eliminate distrust in their assistance and to reduce stigma and stereotypes further harming the at-risk person (Kalafat & Boroto, 1977; Giblin, 1989; Andrews et al, 2004).

One reason people don't seek out mental health support during a crisis is "difference anxiety," where a person within a group fears relying upon someone who won't understand them and their specific struggles. Difference anxiety reduces a person's cognitive resources to deal with the stress they are under. It also increases their guardedness (Stephan & Stephan, 1985; Vorauer, 2006; Amodio, 2009; Bergsieker, Shelton, & Richeson, 2010; West, Pearson, & Stern, 2014: Xenias & Maio, 2012; Stephan, 2014; Godsil & Richardson, 2017).

Difference anxiety has been found to damage people's conscious and unconscious stress and coping strategies (Trawalter Richeson, & Shelton, 2009; Okun, Chang, Kanhai, Dunn, & Easle, 2017), which reduces their overall resiliency to whatever they are struggling with, including against suicidal ideation. Overall, there are worse health and mental health outcomes if a person cannot connect with the person assisting them (Zimmerman & Bambling, 2012; Godsil & Richardson, 2017; Constantino, Morrison, Coyne & Howard, 2017; Wampold, Baldwin, Holtforth & Imel, 2017).

Different Forms of Volunteer Community Support

Crisis Centers:

In 1953, an Anglican clergyman named Chad Varah founded a crisis telephone service called the Samaritans. It was and is staffed by volunteers trained in suicide prevention. Their services are provided to anyone, regardless of their socio-economic status, religion, faith, or spirituality, sexual and gender identity, culture, age, etc.

They operate both phone hotlines, suicide prevention workshops, and support groups.

Since the founding of the first Samaritan crisis center, more community organizations have opened crisis centers, some focused on specific communities and others offering their services to anyone.

Suicide Prevention Centers:

The Los Angeles Suicide Prevention Center (LASPC) was founded in 1958 by Edwin S. Shneidman and Norman Farberow, along with Robert E. Litman and Sam (Mickey) Heilig. They started the center with a grant from the National Institute of Mental Health as a place to study and prevent suicide. The program at the center is now called the Didi Hirsch Mental Health Services. The center trains mental health professionals, operates a 24-hour hotline, and offers suicide prevention trainings for students, teachers, school counselors, clinicians, first responders, and more.

The model quickly spread across the United States. Most volunteers were housewives. To this date, many of those who receive training as volunteers are housewives, retired nurses, and street medics.

Mental Health Crisis Hotlines:

Crisis hotlines provide support and assistance for mental health crises, including suicide. Some operate 24 hours a day, seven days a week.

An example is the national crisis hotline run by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Disaster Distress Helpline.

The national suicide hotline was not fully defunded in 2025; however, a specific, specialized service for LGBTQ+ youth was terminated in July of 2025. The "Press 3" option, which connected callers to counselors trained to support LGBTQ+ youth, was shut down. SAMHSA has stated that its normal hotline would focus on serving all those who are seeking help.

There are both carceral and non-carceral crisis lines. A carceral crisis line is one which will contact the police and involve law enforcement in a mental health crisis. A non-carceral line will not contact the police or work with law enforcement.

Texting Hotlines:

In 2013, a texting hotline was created for those who cannot seek help using a voice call. Texting 741741 anywhere in the United States will connect a person in crisis with the local text line of a trained volunteer, but the speed and availability of response are limited by the number of volunteers in an area. (https://www.crisistextline.org/)

Crisis text lines average 2.41 active rescues every day. The line supports over one million people per year.

Internet-Based:

Although quite a bit of research has found that the internet has caused an increase in suicides, other research has also found that there has been a growth of online suicide prevention chats and support groups. (Robert et al., 2015; Krysinska et al., 2017)

Online interventions using trained volunteers may be more effective than phone hotlines, as teenagers sometimes hesitate to call them (with the exception of white AFAB teenagers).

Support Circles:

Some suicide crisis centers offer support circles, some of which are hosted and led by professionals, some of which are hosted and led by volunteers with variable levels and kinds of training. Some support circles are offered outside of suicide crisis centers, at community centers, churches, mutual aid centers, etc.

All of these services can assist their communities due to the efforts of volunteers. What kind of training, whether it is formal or informal, and how much training someone gets before volunteering, is variable, depending on the service and program.

School Mental Health Programs:

Many schools (elementary, high school, and college) programs that focus on the reduction of suicide are volunteer-staffed. They are sometimes volunteer-led, with peer-to-peer education and training for volunteers.

Other:

There are volunteer mental health programs that focus on specific populations, including Native American, veterans, the elderly, LGBTQIA+ people, the neurodivergent, people accused of juvenile crimes, the previously incarcerated, the unhoused, people struggling with substance use, and more.

What is a Gatekeeper?

It is better for volunteers to be members of the communities they serve, those who have face-to-face contact with the members of those communities on a day-to-day basis.

The term for this used to be “gatekeeper”, which first appeared in 1971. Dr John Snyder defined a gatekeeper as “any person to whom troubled people are turning to for help.” It would have referred to the people who were deeply involved in their communities, trusted by the members thereof, and able to connect a person with others in the community who could assist them.

Recent mental health programs have tried to recruit and train “gatekeepers” to identify those at risk for suicide and connect them with assistance.

Gatekeeping training is available in the military, schools, universities, and medical facilities. They teach people about suicide risk, reduce stigma, increase the willingness of others ot intervene in mental health crises, and help people be aware of what resources exist to connect people to.

However, it should be noted that the term “gatekeeper” has a pejorative context amongst young people and other communities including many in the transgender community, which may impact the use of this term going forward.

Trainings

Question, Persuade, Refer:

A popular program is the Question, Persuade, Refer program, which was developed by Spokane Mental Health and Paul Quinnett. The QPR Institute (established in 1999) conducts training of Master Trainers, who then go out into communities to train others on the technique. The trainings are short, no more than 90 minutes, and focus on teaching people to recognize the signs of someone at risk for suicide. They are then trained to offer hope and, if necessary, to get help from emergency services to save a person's life.

Applied Suicide Intervention Skills Training (ASIST):

The precursor to ASIST was created in 1983 by Richard Ramsay, Bryan Tanney, Roger Tierney, and Bill Lang. ASIST is a program that trains all skill levels to prevent suicide in their communities, with a focus on building safety networks in their communities. Rather than just training, they provide communities and organizations with a roadmap to address suicide on a broader level.

Ask, Care, Escort (ACE):

ACE is the model used by the United States Army, which has been employed by some medic collectives for specific communities.

Mental Health First Aid (MHFA):

Mental Health First Aid (MHFA) is a program that teaches people to recognize and address mental health problems, syndromes, and disorders, and substance use disorders, so that they can intervene until professional help can step in. It is used to recognize the problem, provide the person suffering with a peer who cares, and then connect them with professional assistance. It teaches people to identify risk factors, signs, and symptoms in members of their family, friends, community, work colleagues, etc.

Youth Mental Health First Aid is a modified program that focuses on teaching people to recognize risk factors, signs, and symptoms in youth and intervene in ways that are more effective with younger people.

Mental Health First Aid also helps to educate the trainees in ways that helps them recognize and combat their own internalized stigma around mental health problems and reduce that stigma in their communities.

The core steps include Assessing, Listening non-judgmentally, Giving reassurance and information, Encouraging someone to get professional help, and Encouraging someone to self-help (ALGEE).

Psychological First Aid:

Psychological First Aid is used as part of a disaster response and is designed to help people traumatically affected by a disaster to be more stable and access resources so they can recover. It was originally designed only for those with mental health backgrounds (therapists, psychologists, psychiatrists, etc.), but has now been structured so that it can be offered by other responders, including self-deployed responders, such as street medics.

Contrary to some opinions, it isn't actually designed to offer therapy (which is intended to treat a mental health condition), but instead to reduce initial stress and encourage adaptation and resiliency. It doesn't assume that people have or will develop a mental health problem or disorder or address or focus on mental illness. It can be used in the field during disasters, but also later at temporary shelters, in hospitals where people are treated for their injuries, etc.

Some, though not all, Psychological First Aid trainings will include helping someone who is responding to acute stress, trauma, a crisis, or a disaster with suicidal ideation or a suicide attempt.

The core actions of PFA include engagement, safety, stabilization as needed, gathering information, providing practical assistance, connection, psychoeducation on healthy coping tactics, and linkage with services as needed.

Efficacy

In general, longer, more detailed trainings are more effective than briefer, less thorough trainings (Condron et al. 2018). Additionally, if the gatekeepers do not keep educating themselves and pursuing training, the positive changes diminish (Lipson, 2013; Mo, Kin, & Kin, 2018).

Better-trained volunteers are more likely to use effective, cognitive-focused strategies than those who were not trained thoroughly (Gilat, Tobin, & Sharhar, 2012).

A review of 42 studies (which is quite old at this point, Durlak, 1979b) found that trained volunteers were equal to or even significantly better than professionals at preventing suicide. Newer studies have also found that professional training is not required for someone to effectively help someone who is struggling with suicidal ideation (Steisel 1972; Summers, Faucher, & Chapman 1973; Siegel 1973; Simonson & Bahr 1974; Getz, Fujita, & Allen 1975; Morgan & King 1975; Morgan & King 1975; Pope et al. 1976; Pope et al. 1976; Hoffman & Warner 1976; Creaser & Carsello 1979; Rickel, 1982; Stein & Lambert 1984; Berman & Norton 1985; Bright, Baker, & Neimeyer, 1999; King et al. 2003; Garber-Epstein et al. 2013).

Why Aren't These Methods More Effective?

Restrictions:

- Not enough funding
- Incorrectly allocated resources
- Lack of trainers
- Not enough volunteers
- Limits on volunteer time
- Burnout amongst volunteers
- Distance barriers (especially in rural areas)
- Language barriers
- Informing people that the resource exists
- Getting people to utilize the resource

But Also

Some people want to be able to shunt all blame onto an individual's mental status, without acknowledging the context. Many people who exist in a privileged state (affluent, descended from colonizers, perceived as white, able-bodied, neurotypical, etc.) do not like to consider themselves responsible for or implicated in other people's suffering.

The truth is that there is a complex web of suffering we are all stuck in, although it affects each of us differently based on the intersections of our marginalization and oppression.

"Purity politics" (Against Purity: Living Ethically in Compromised Times, Alexis Shotwell, 2016) attempt to take the world to an imaginary "pure" state, where everyone

can ignore slavery, genocide, sexual assault, colonial violence, etc., because those are things that only happen to people who aren't "pure."

People try to control the complexities of suicidal ideation by assuming impurity on the part of the person suffering, rather than acknowledging the reality of the world that drives someone to such despair.

Mainstream efforts dedicated to suicide prevention are often based on the idea that a person is autonomous and individual, fully responsible for their own choices, and that everyone starts from the same pure place and ascends or descends from there. Suicide is framed as an exclusively individual problem. The onus is on the individual to "fix" themself, rather than on society to be fixed.

The psychological understanding of what counts as "good mental health" in the United States is also often rooted in individualistic Western ideology, dismissing other cultural perspectives as invalid.

The approach to "fixing" the suicide crisis often includes the idea that all suicides are preventable, even if the methods for accomplishing that are deeply coercive and involve involuntary detainment.

Some people in the field of studying suicide treat suicidal ideation as a derangement that has no foundation in the mind's adaptation to struggle and that all people who struggle with suicidal ideation at any point in their lives have a mental disorder (Joiner et al., 2016). People struggling with suicidal ideation are pathologized when, in actuality, anyone can respond to trauma, crisis, disaster, and despair with a desire to escape it, even if by severe methods. Fearing and condemning suicide pathologizes it and also contributes to the stigma around it. Contextualizing suicidal ideation as a fundamentally normal response to abnormal circumstances can help someone be willing to reach out for help.

Some approaches to suicidal ideation dehumanize the person they attempt to assist, treating them as a syndrome, rather than as a person. They strip the person out of the context of their life, which makes the suicidal ideation a disease, a contagion, instead of a response to an unjust world. Suicide is often a relational response, as in a response to distress, suffering, and despair.

Preventing suicide is vital. But how we talk about the value of human life has implications beyond addressing suicide. "Solving" the problem of suicide needs to not act as though saving any person's life justifies the state fully controlling that life, which

contributes to the state attempting to control the lives of those who struggle with mental health, fetuses in the uterus, etc.

The three basic issues that are being ignored by the mainstream approach to suicide are:

- Suicidal ideation is a normal response to trauma, crisis, disaster, and despair.

- Suicidal ideation isn't devoid of context. People are influenced by the ways they are oppressed and marginalized, by whether they have support, by whether they can access resources, and by whether they can see any hope for change in their circumstances.

- Suicidal ideation does not and cannot strip someone of their right to control what happens to their body, including their right to die.

A Slow Death

Some people turn to suicide when they feel they are dying slowly anyway. It is often easy for people to recognize that when it comes to the elderly, the chronically ill, and the acutely ill. But, even then, the Right to Die movement faces a great deal of opposition, especially in the Calvinist-based Protestant influenced United States.

But there are other slow deaths that a person may wish to escape from, other circumstances where a person may feel as though they are slowly dying. These include people who are unhoused or extremely socio-economically disadvantaged, people who are actively being hunted by the government and (if found) will be returned to potential torture and genocide, people suffering under an ongoing genocide, people who cannot live their lives as their true selves without facing violent reprisal, etc.

It is hard to even talk about why someone might feel they are dying a slow death without contributing to the ableist ideas about what a "good life" is and who has one.

Recognizing that someone feels as though they are already dying does not mean validating that they should kill themself. It means empathizing with them and attempting to alleviate their suffering without their death.

Non-Suicidal Self-Injury

Non-suicidal self-injury is intentional harm of the self that is not intended as a suicide attempt.

A person may engage in self-injury without experiencing suicidal ideation, or they may engage in self-injury while experiencing suicidal ideation but without having an active plan to take their own life. Sometimes, non-suicidal self-injury is part of the buildup towards a person taking their own life.

Non-suicidal Self-Injury Can Consist of:

- Depriving oneself of food
- Depriving oneself of sleep
- Overexercising to the point of exhaustion and injury
- Scratching
- Hitting
- Cutting
- Carving
- Burning
- Piercing
- Pinching
- Pulling hair
- Scratching
- Punching until fists are bruised
- Banging oneself against objects
- Viewing harmful websites, photos, and videos
- Deliberately overdosing on substances to cause harm, but not death
- Wearing clothing that is is insufficient to protect the body from harm from weather conditions

Although some people feel temporary relief following the act of self-injury, that relief is temporary. As a person continues to self-injure, their fear of pain and injury may become reduced. That can increase the risk of suicidal thoughts, plans, and attempts.

Anyone may engage in non-suicidal self-injury, regardless of their background.

Signs and Symptoms of Non-Suicidal Self-Injury:

- Negative thoughts
- Hopeless thoughts
- Feelings of isolation
- Feeling that no one cares
- Feelings that they deserve to be punished
- Feelings that they are bad or evil
- Desire to communicate their mental and emotional state to others
- Anguish
- Depression
- Desperation
- Despair
- Stress
- Feelings building up
- Feeling there is no other way to release or relieve emotional pain or numbness
- Self-injurious behaviors listed above or signs of cuts/bruising/burning, etc.
    - Cuts are often to forearms/inner arms and upper legs and may look like small parallel cuts/scratches, but may be single cuts, larger cuts, or to other areas of the body
- Hiding behavior from others
- Inappropriate clothing for an activity or weather in order to conceal the body

Risk Factors and Comorbidities:

- Childhood trauma
- A history of emotional, physical, or mental abuse
- Unstable family
- Bullying
- Depression
- Major Depressive Disorder
- Borderline Personality Disorder
- PTSD
- C-PTSD
- Eating Disorders
- Substance Use Disorder
- Previous suicide attempts or self harm, even years ago

Anyone may engage in non-suicidal self-injury, regardless of their background.

Complications from non-suicidal self-injury can include infections and accidental serious self-injury that requires medical intervention.

There is a stigma associated with non-suicidal self-injury. People may fear someone noticing because of how they might respond. They may hide their signs and symptoms and reject offers of help.

The sooner a person can get help, the better.

Suicide

Signs and Symptoms of Suicidal Ideation:

- Negative thoughts
- Hopeless thoughts
- Feelings of isolation
- Feeling that no one cares
- Feeling that they are a burden on others
- Feelings that they deserve to be punished
- Feelings that they are bad or evil
- Desire to communicate their mental and emotional state to others
- Thoughts of revenge
- Anxiety
- Anger
- Rage
- Anguish
- Depression
- Desperation
- Despair
- Stress
- Hopelessness
- Feelings building up
- Feeling there is no way to release or relieve stress
- Feeling there is no reason to live
- Feeling there is no purpose in life
- Mood swings
- Talking or writing about death, dying, and suicide
- Isolation
- Withdrawal
- Changes in behavior and functioning at school or work
- Giving away possessions
- Acting reckless
- Increasing or chaotic substance use
- Threatening to hurt or kill themself

- Looking for ways to kill themself
- Seeking access to tools to use to kill themself

Risk Factors:

- Childhood trauma
- A history of emotional, physical, or mental abuse
- Unstable family
- Bullying
- Depression
- Major Depressive Disorder
- Anxiety Disorder
- Borderline Personality Disorder
- PTSD
- C-PTSD
- Eating Disorders
- Substance Use Disorder
- Poor physical health
- Disability
- Chronic and/or Acute Illness
- Not being accepted as LGBTQIA+
- Being part of an oppressed minority group (Native American, Black, Latine)
- Being AMAB
- Being socioeconomically isolated or disadvantaged
- Being a veteran
- Previous suicide attempts

The stigma around suicidal ideation is extremely common, well-known, and difficult to overcome. People tend to hide that they are suffering from suicidal ideation to avoid that stigma. They fear being thought of as weak, irresponsible, cowardly, or attention-seeking. This may make them resistant to receiving help.

Strategies to prevent suicide have to focus on creating and building trust and connectedness. If a person feels that they will receive a negative response from someone, they are very unlikely to be open about their struggles.

Early prevention is vital.

De-escalation of Suicide

OSCAR MODEL:

- Observe
- State Observations
- Clarify Role
- Ask Why
- Respond

If a person has observed that someone else is exhibiting signs of non-suicidal self-injury or of suicidial ideation, they can approach them and ask how they are doing.

If they are brushed off with a quick response, such as “I’m fine,” then they can state their observations. Observations can include a statement that someone has been going through a hard time and the concerning signs and symptoms the responder has noticed.

They can then clarify their role, which can often prevent defensiveness. A role someone can list would be friend, family member, member of a shared community, medic, or even “I’m a concerned person and I want to help.”

If the person acknowledges they’re struggling, the next step is to ask why. It is important to listen non-judgmentally.

When listening, it is important to set aside judgments about the other person, their situation, their choices, and how they are expressing themself. Most people experiencing stress, desperation, and despair want to feel heard before being offered advice or resources.

The most important attitudes to have with non-judgmental listening are acceptance, genuineness, and empathy.

Acceptance means respecting the person’s background, culture, personal values, experiences, and feelings. The responder should not criticize, trivialize, dismiss, or deny what someone is expressing to them. They should not conclude that someone is weak, lazy, or crazy for struggling.

Genuineness means not holding one set of attitudes while expressing another. People can often tell when they are receiving false sympathy or when someone is outwardly expressing nonjudgment while judging them internally. A responder should not exaggerate their empathy in their expression, but instead display their genuine compassion.

Empathy means attempting to truly connect with the person and understand what they are expressing. However, the responder should avoid over-empathizing to the point where they experience vicarious trauma. The responder should also not say, “I understand what you are going through.” Each person’s experience, even of the same situation, will be unique.

It is important to do this while not interrupting. It is also sometimes necessary to ask gentle clarifying questions or use verbal expressions to indicate continued interest. Some gaps and silences are normal, as it can take a while for someone to find the right words to express themselves. The person should avoid arguing with the person they are trying to help. They should avoid expressions of shock, anger, disgust, etc.

If a person expresses that they are struggling with wanting to stay alive or continue existing, it is best to ask them directly if they are thinking of killing themself.

It is important for the person not to use prevaricating words. They need to not attempt to be subtle. They shouldn’t use the phrase, “thinking of harming yourself,” as this is imprecise and can refer to non-suicidal self-injury. They also need to not ask in judgmental ways, such as “You’re not thinking of doing something stupid, are you?”

It is a myth that talking directly about suicide puts the idea into someone’s head or makes them more likely to take their own life. It is the opposite - talking directly about suicide and contextualizing it as the taking of a human life actually reduces the chances of a person taking their own life.

If a person expresses that they are thinking of killing themself, they need to be asked directly if they have a plan for how to kill themself. They need to be asked if they have already taken steps to end their life. If they have an active plan in place, they cannot be left alone. It may be necessary to escort them to a mental health provider or contact a Crisis Response Team. Remember that in North Carolina, all adults are mandatory reporters.

If a person is engaging in non-suicidal self-injury or suicidal self-injury and has injured themself severely, with gaping or heavily bleeding wounds, infections, burns larger than 3/4s of an inch, or overdose on substances, then emergency medical intervention will be necessary. One can perform first aid while they wait for EMS.

If there is no active plan, the conversation can continue on how a person may best be supported. The de-escalating person can inquire about whether there are people the

person trusts they can turn to for help, about changes in their life that are causing them to despair, and about whether they are receiving treatment for their mental health.

If the person, during this intervention, expresses that they are hallucinating (hearing voices, seeing things, etc.), then de-escalation will also need to address disorganized thinking and active psychosis. The person may also appear to be responding to what are called “internal stimuli,” i.e. answering back to voices that others cannot hear.

The final step is to respond to what someone has expressed. This can be with statements that make it clear that what they shared was heard and understood. It can also include a follow-up plan, such as “May I check in with you in a couple of days?” or “Would you like to make plans to meet up again in a week?” etc.

If the person chooses not to share with the responder and refuses to acknowledge the problem or share the source, the responder should ask if they can check on the person later.

The END Method

The END Method refers to empathy, normalization, and de-escalation, which is used to help people who are in active mental and emotional distress, including the states that lead to non-suicidal self-injury, suicidal ideation, and suicide attemps.

Empathy

Empathic communication has been found in studies to increase compliance and collaboration and reduce acts of self-harm. Please understand that we are not referring to the spiritual and/or magical concept of “being an empath” but instead, an innate skill that humans have that can be honed into a method of communication that can be perfected with practice.

Before attempting to use empathic communication, it is helpful to have a mental map of the conversation.

What?

What is it that the de-escalating person wishes to communicate? Do they wish to communicate that they recognize and understand the emotional state and difficulty of the struggling individual?

Who?

Who is the person they are talking to? Are they talking directly to the escalated person? Is this a person who is suffering from stress, trauma, desperation, and/or despair? Or are they seeking help for the escalated person from their support system, the community they belong to, etc.? If talking directly to the struggling person, they need to be genuinely concerned with who that person is and take that into account during de-escalation. If they are talking to other people in that person's life, they also need to take into account who that person is - a parent/guardian/caregiver, a teacher, a partner, a friend, a support circle, a mutual aid group, etc. They need to be careful not to violate a person's privacy without strong reason to do so. It may be necessary to violate a person's privacy to inform a member of person's support network that they are in active suicidal crisis, but that should be done only when a person is in crisis and not casually as gossip. They also need to be careful that they do not engineer a negative response from friends, family, community, etc. that could worsen the state the person is already in.

When?

When is it best for the communication to occur? Is it better to wait for a private moment or to intercede immediately?

How?

How one uses empathic language is extremely important to whether or not it is effective. There is body language that helps and body language that makes it less effective. There are sentences that one shouldn't use during empathic communication and ones that are recommended by mental health professionals. The tone of voice, facial expressions, body movements, distance, and positioning between bodies, etc., all matter.

Where?

Where is the communication happening (or will happen)? Is the empathic communication happening in front of everyone involved, or are the escalated person and the de-escalating person stepping away? Is it happening in a neutral place or a place that is emotionally fraught?

Verify

What effect is the empathic communication having on the escalated individual? Is it helping them to feel understood, connected with, and as if someone is going to help them resolve their issue, or is it making them feel more isolated and despairing?

Empathic communication requires that the de-escalating person be able to clear their mind and focus on the goal, employ the techniques even during difficult

communication, and act with actual care and respect. They cannot feign or fake their empathy. Importantly, empathy is not mirroring, which will just escalate the situation.

As we explored in the first portion of the guide on Boundary Setting and De-escalation, people's Psychological Boundaries help them differentiate what they are feeling from what someone else is feeling. De-escalation relies on recognizing the mental and emotional state of someone else and attributing to that person beliefs, feelings, and intentions. Humans have an entire specific network in their brains dedicated to doing this.

Empathic Communication Has Two Basic Steps:

1. Recognize the mental and emotional state of another person
2. Communicate with that person in a way that establishes a bridge with that other person. That bridge aims to convey that the de-escalating person recognizes and understands the mental and emotional state of the escalated person without judgment.

What NOT to Say:

These are examples of things people tend to say to those who are in crisis, which are NOT examples of empathic communication, but which might seem to be, because they are based on caring about what someone is experiencing.

"Don't worry."
"Everything is under control."
"Everything is going to be fine."
"It's not that bad."
"I know exactly how you feel."
"Calm down."
"Don't think about that."
"You shouldn't feel that way."

Empathic communication isn't exactly a normal way of talking.

The de-escalating person has to clear their mind of their own emotional and mental struggles, anything they are preoccupied with and distracted by, or that is distressing them. They need to set it aside for later.

The de-escalating person should keep their voice level and calm, their body language open and relaxed, their sentences short and easy to understand, with gaps for the other person to speak, etc.

The de-escalating person should focus on communicating with the person, not at the person. They should connect with them emotionally if they can, not by focusing on how they would feel in the same situation, but on how they think the other person is likely feeling in the moment.

It is preferable, however, to use a hypothetical form of description of an emotional state. Doubtful expressions invite communication from the person.

Examples:

“Maybe you feel like nothing will ever be better.”
“It seems as though you feel really alone.”
“Can you tell me why you feel so hopeless?”

Empathic communication works well for people with severe anxiety, panic attacks, psychomotor agitation, depression, demoralization, and for people in active psychosis. It works well for people in delusional states and people who are experiencing a manic episode. It can work well for people who are in oppositional anger, outright opposed to the ideas or ideals represented by someone else. It also works well for de-escalating non-suicidal self-injury and suicidal ideation.

However, it does not work to de-escalate situations of acute intoxication by substances (not withdrawal, active intoxication) and people with organic brain disorders, such as dementia.

Normalization

Normalization is the process by which the emotions, thoughts, experiences, and actions of a person are not pathologized, but instead, understood to be a normal part of the expression of the healthy range of human emotion.

Normalization is primarily used within the context of Cognitive Behavioural Therapy, but can be applied as part of psychological first aid by people who are not trained and licensed mental health providers.

It is based on the idea that a person is more likely to recover from a period of crisis if they are not treated as though their response to the crisis is abnormal. They are also more likely to recover if they, internally, think and believe that recovery is possible and that their responses to trauma and crisis are within the normal range.

Normalization focuses on decatastrophizing the mental and emotional crisis, contextualizing traumatic events, improving a feeling of control and self-mastery, and reducing feelings of stigmatization and shame.

People experiencing suicidal ideation have been found to positively respond to normalization, especially as opposed to stigmatizing catastrophization. Normalization, rather than catastrophization, which claims that everyone is negatively impacted by stress and trauma, can help them recover more quickly and more thoroughly.

Stress and desperation can cause anyone to experience some level of psychopathological symptoms, which do not necessarily become a chronic condition. Instead, they are often transient consequences of acute circumstances. However, someone who has an ongoing mental health disorder may find that their symptoms are exacerbated and triggered by stress.

Catastrophization is a cognitive distortion that can be addressed as a step in the de-escalation process. However, care needs to be taken that the normalization does not appear to be minimizing someone's experiences or problems.

Examples of Normalization Language:

"I recognize this is hard for you. I think it would be hard for me, too. I think it is normal to struggle with something like this."
"Many people would likely feel this way if they were going through something like this."
"A lot of people struggle with similar thoughts/feelings during times of extreme stress."
"Given what you're going through, it is very understandable why you would feel like that."
"Your feelings are a normal reaction to a difficult situation."
"Under pressure, the brain can easily develop harmful thoughts. That's part of the normal human condition."
"We all have a specific stress threshold, and when we cross over it is normal to experience extreme things."

Normalization is especially effective for panic attacks, depression, substance use during times of stress or trauma, crisis, after an acute trauma, during periods of

non-suicidal self-injury, and when someone is experiencing suicidal ideation. It is still effective for active psychosis, but has to be done carefully so as not to validate any delusions they might be holding, but rather validate the emotions around their delusions.

Normalization can be used even if a person is experiencing thought disturbances, delusions, and hallucinations, but the normalization has to be focused on reducing loneliness and shame, rather than on making a person believe that the de-escalating person believes in their delusions.

De-escalation

De-escalation is the third step of the END method. To de-escalate is to reduce the level of intensity.

In the case of this guide, we are referring to the de-escalation of non-suicidal self-injury and suicidal ideation. De-escalation is used to interrupt the impulse to harm or kill oneself and direct a person towards accepting support so they can recover. That is done using a combination of both verbal and nonverbal communication.

It first needs to establish a bridge of communication, a relationship of sorts, between the de-escalating person and the escalating person. The most effective techniques focus on eliminating differences and disparities between people so that there can be a feeling of mutual trust.

In order to build an effective and successful dialogue, it is necessary for the de-escalating person to understand the person they are de-escalating. This extends to attempting to understand their psychological floor (as much as possible, from what can be understood of a person based on limited interactions). This includes the person's apperceptional, epistemological, and transcendental roots, whatever is causing their desperation and despair.

Enhancing Personal Resiliency BEFORE and DURING De-escalation:

The de-escalating person should be confident in their sense of purpose.
They should be aware of and ready to enforce their boundaries.
They should feel in control of themself.
They should remind themself of their own power to act.

De-escalation Power Map:

Before engaging in de-escalation, the person should review the power map of what they can do, what the escalating person can do, and what others can do in the situation.

Safety:

De-escalation ALWAYS begins with a safety assessment. Is it safe for the person to engage? Are they aware of potentially harmful objects, escape routes, who may be at risk, and where aid may come from if needed?

If the person has a weapon, have they already used it on themself, or are they acting as though they intend to?

A de-escalating person should not enter into de-escalation with a person who has already become violent (made threats, attacked themself or others) or who has a weapon unless they have no other choice. The choice to enter that situation should be made in a risk-aware fashion, with acknowledgement that someone might get hurt.

The de-escalating person should be twice their arm's distance from an escalated person, with an escape route open to them. In an enclosed space they should not position the other person between them and the door.

Effective Communication for De-escalation:

Avoid open antagonism
Avoid being rigid
Minimize points of conflict
Search for anything that could be a starting point for understanding
Search for a point of agreement
Search for a point of collaboration
Remain open to communication

The De-escalating Person Should:

Avoid making verbal assumptions about a person's perspective or experiences (even while internally attempting to make a map of a person's perspective)
Avoid openly contradicting the escalating person
Avoid overpraising and overcomplimenting the escalating person
Avoid talking over the escalated person
Avoid making accusations
Avoid judgment
Avoid statements that assign blame
Avoid smiling

Avoid aggressive gesturing, like pointing fingers
Avoid making the person feel infringed upon or trapped

Use "I" Statements, Rather Than "You" Statements:

"I want to help you."
"I think I would also be upset if this were happening to me."
"I believe you that what you're going through is really hard."
"I think that you might be really scared."
"I don't want you to die."
"I want to support you so that you can feel there is some hope for the future."
"I sympathize that this is a difficult time. I really do want to help you."
"I want to understand how we got to this situation. Can you help me?"
"Is there someone I could call that you trust?"

Suggest Alternatives:

"Rather than hurting yourself, which might feel good for a minute but may not feel good after, maybe we could sit down together and talk?"

"Instead of trying to get through this on your own, maybe we can try to get through it together?"

The PFA Method

- Look: The de-escalating person should observe the situation to identify potential safety risks and determine who may need help. They need to approach people in a calm, non-intrusive way.
- Listen: They should pay attention to the person's concerns and feelings without judgment. They should ask simple, respectful questions and allow them to speak freely. They should offer calm and comfort.
- Link: They should connect the person with immediate practical needs (like food or water), their loved ones, and other social support systems. This may include offering mental health resources to address suicidal ideation or getting them immediate help to interfere with an active plan or attempt to take their own life.

Other Key Steps and Principles:

- Prioritize safety: the person offering PFA has to ensure the physical and emotional safety of themself and the individual first.
- Offer support, not advice: They should avoid telling people what to do and instead, offer practical help and empower them to use their own strengths.
- Provide comfort and calm: They should try to help the person feel safe and reduce their immediate distress. This is not a substitute for professional counseling.

- Empower with information: They can provide information on common stress reactions and healthy coping mechanisms to build resilience.
- Know their limitations: They need to set boundaries and recognize when a situation requires professional help, and know how to refer them to the appropriate services.

Individual Resilience

Personal resilience in adults can be understood in four dimensions, according to Robert J. Taormina's theory. They are Determination, Endurance, Adaptability, and Recuperability.

Determination is defined as the sense of purpose, the mastery of oneself, and the willpower to persevere. It is a conscious choice.

Endurance is the strength and fortitude a person can possess to face difficult situations without giving up. This can be physical, mental, and/or emotional.

Adaptability is the ability to be flexible and resourceful, adjusting to changing circumstances during adversity, crisis, and disaster. It may involve conscious efforts to change one's thinking and be flexible in response to tribulations.

Recuperability is the ability to rebuild, physically, mentally, and emotionally, from adversity, and regain a sense of safety, stability, and personal value. The ability to physically recuperate is often what people think of when they think of personal resilience, but it is far more than just physical recovery that matters. However, that doesn't mean it doesn't matter - taking care of the body with adequate fuel and hydration is vital for mental and emotional recuperation, as well. Recuperability is the characteristic of resilience that allows people to recover, with recovery as the goal or recouping.

People who are resilient, continuing to adapt and function in the aftermath of a trauma, should not be assumed to be "out of risk" for developing PTSD or other mental health conditions. Resilient people may actually not recognize that they need help, may not know how to ask for it, or may be assumed by those around them to be so competent as to not need it, even when they do ask.

Some things have been found to weaken individual resilience.

Unfortunately, the very thing that helps people identify that they may be struggling with their mental health and need help, making more information available to people about mental health disorders, can actually weaken resilience. All "negative" mental and emotional symptoms are now being pathologized by both the professional mental health community, as well as often by people who have no mental health training, degrees, certifications, and/or licenses.

This can cause a person to weaken their own resilience by assuming that any presentation of a negative mental or emotional state is abnormal or dangerous. This can worsen the symptoms of their stress by denying them some of the skills they can use to handle that stress.

People are also sometimes encouraged in training on crisis and mental health to dismiss or denigrate the wisdom and capability of the communities they serve and the people in them. Communities and individuals have sometimes developed their own resiliency, and having someone come in and dismiss that can make them not rely on their own methods, taking away the tools they use to get through periods of difficulty, desperation, and despair.

Catastrophizing also reduces resiliency. When a de-escalating person dramatically catastrophizes, they make it harder for people to feel resilient. They also weaken their own resilience.

Building individual resilience first involves recognizing how frequently people are resilient in the face of adversity. Resiliency ends, not when symptoms of a crisis start, but when people give up against them. It is important to note, however, that seeking mental health support is not the same thing as giving up and can be a healthy part of coping if it is not pathologized.

Things People Can Do to Build Their Personal Resilience:

- Recognize their own autonomy
- Acknowledge that adversity can be overcome
- Realize that they may have to make difficult choices to be active participants in their recovery, but that they are capable of doing so
- Be flexible in their coping methods. Everyone copes differently, and there isn't a "correct" model of self-care during periods of stress, crisis, desperation, and despair, only certain things to avoid, like using substances to distract from the situation.
- Shift priorities

- Recalibrate expectations
- Re-create safety
- Distract themself (research has shown that in emotionally intense contexts, distraction can be more effective at reducing distress; however, only cognitive reappraisal allows for proper emotional processing, which is important for long-term resiliency. Distraction can become a harmful coping mechanism).
- Use Cognitive Reappraisal
- Fully experience a trauma's cognitive and emotional impact and significance
- Accept the significance of the trauma, crisis, or disaster, but don't exaggerate it
- Maintain goals
- Focus on hope
- Master oneself
- Continue with life

A breakthrough in developing a model of adult personal resilience scale was made in a study (Wei & Taormina, 2014), with 10 items for each of the four dimensions of personal resiliency. All the items were based on a comprehensive review and analysis of the studies on building resilience that occurred before 2014. Wei and Taormina found 40 items that fit on the four dimensions, but this was reduced for creating the model to 20 items to avoid confusion and difficulty.

The 20 Items for the Four 5-Item Subscales of Adult Personal Resilience

Determination

1. Once I set a goal, I am determined to achieve it
2. I persevere at the things I decide, despite difficulties
3. Being determined is an important part of my character
4. I keep trying for the things I want until I reach them
5. It is in my nature to be persevering

Endurance

1. I am able to live through difficult times
2. I can withstand difficult situations
3. I can endure the problems that life brings
4. I can survive even the hardest of times
5. I can endure even when I am attacked

Adaptability

1. I have the ability to adapt to difficult situations
2. I can change to fit into many kinds of circumstances
3. I can find ways to adapt to unexpected conditions
4. I am well able to adjust to problems that confront me
5. I am very flexible when my environment changes

Recuperability

1. I recuperate even from things that hit me hard
2. I recover from any misfortune that happens to me
3. I am able to bounce back from any kind of adversity
4. I always resume my life regardless of the type of setback
5. I can recover from any type of problem

Building Community Resilience

Collective Action

Addressing the suicide crisis has to include collective action to address systemic injustice. We have to dismantle the policy regime that increases people's despair to the point where they see no other escape but death.

We have to respond to the suicide crisis by deconstructing the white and affluent supremacy in the US. We need to respond by supporting the acutely and chronically ill with access to good healthcare. We need to tear down patriarchal structures that promote toxic masculinity and that dehumanize and objectify AFAB people, trans women, and femmes of all genders. We need to fight for LGBTQIA+ rights.

Specific things a community can do to help support a person who is actively suicidal include:

Address the core problem. If a person is jobless, help them find a job. If they are homeless, help them find shelter. If they are starving, help them eat. If it is specifically holiday stress, try to help them resolve it.

Continue to try to engage with the individual who is depressed or suicidal. Social isolation can increase depression and suicidal ideation, which can result in self-isolation. Attempts to include individuals who are depressed or suicidal in social activities, while allowing them to participate without requiring them to mask, can be highly beneficial.

A Note on Holiday Stress

Although there is a persistent myth that suicide rates are higher during the holiday season, research conducted by the Annenberg School for Communication at the University of Pennsylvania using data aggregated by the CDC shows that this is not the case. It is a counterfactual myth, largely promoted by media coverage of the suicides that do occur during that time period.

However, according to research done by the Trevor Project, LGBTQIA+ youth in crisis reach out to the Trevor Project 20 to 40 percent less on the days of Thanksgiving, Christmas, and New Year's Day, but consistently at least 20 percent more on the two days following such holidays. Therefore, there does seem to be a higher crisis rate among LGBTQIA+ youth during the holidays, and suicide data collected in a systematic way does not include information on gender identity beyond what is assigned at birth or sexual orientation. Therefore, it is impossible to truly determine whether suicide rates are higher among LGBTQIA+ individuals during the holiday season.

What If Someone Can't Seek EMS?

In some areas there are Mobile Crisis Teams who will come to a person's home or location and assess them, which can be safer than calling 911. A Mobile Crisis Team is a group of behavioral health professionals who respond to individuals experiencing a mental health crisis in their community to provide immediate support, de-escalation, and stabilization services. They are an alternative to law enforcement or emergency room visits for many situations, offering services like counseling, risk assessment, and referrals to treatment.

Please note that the following is, under the vast majority of circumstances, not recommended. In almost all cases, someone who is actively suicidal should receive professional assistance. Professionals simply have more training and resources to help someone who needs it. However, there are circumstances under which seeking professional help will result in enormous harm. These include (for example) a fascist government that is putting people who experience mental health crises into forced labor camps, or where nominal law enforcement officials are targeting hospitals and disappearing individuals who are receiving treatment.

In such cases, volunteers can hold vigil with/over someone who is actively suicidal. Have individuals with de-escalation training stay with the impacted individual in shifts, so that there is always someone with them who can talk them down if

necessary. This needs to be continued until the impacted individual is making actual progress, rather than just wanting the volunteers to leave them alone.

During this, the de-escalating persons must remove items that could be easily used to commit suicide from the area. This includes guns, cords, belts, and ropes, pills, other weapons, etc.

Being involuntarily committed comes with being medicated. In cases where a non-institutional intervention is needed, if there is a friendly allopathic physician who can prescribe relevant medication, that is wonderful. If there is not, then it falls to the herbalists and healers within the community to provide the highest level of care that they can with the resources that they have available, according to the best available scientific research. This can, and should, be considered a call to action for herbalists and healers to educate and involve themselves.

Primary Sources

The full bibliography has been omitted from the print version of this guide for length, but can be requested by emailing staff@sanctumofthecraft.org. The following is a short bibliography of the primary sources:

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