Black Mental Health and the New Millennium: Historical and Current Perspective on Cultural Trauma and ‘Everyday’ Racism in White Mental Health Spaces — The Impact on the Psychological Well-being of Black Mental Health Professionals

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Roger Kline in his report *Snowy White Peaks* (2014) reported that in the National Health Service (NHS) the proportion of senior managers who are Black and Minority Ethnic (BME) had not increased since 2008 – but had fallen over the previous three years. Such data suggest that discrimination is still a problem within the NHS. Kline also found the NHS treats BME staff less favourably than white staff in their recruitment, promotion and career progression. Kline’s findings suggest that NHS discriminatory practices favour white applicants and are a predictor of patient care. Kline also reported that these same BME staff were significantly more likely to be bullied at work. Much like those BME Kline reported in his study who were bullied, I was a victim of bullying in the NHS as well, so much so I decided to no longer work for the NHS and work privately. This is not an uncommon occurrence for people of colour – my colleagues who work for the NHS often complain how difficult it is to work in the NHS due to the constant bullying, harassment, abuse, and negative racialised interactions/communications between Blacks and whites (e.g. daily and constant insulting micro-aggressions in the workplace/train- ing institutions, see further description of micro-aggression below) (Guttridge, 2020). The bullying is not always blatant but more often it is ‘coded’/nonverbal – a look, stare, stance or being the last one in the queue constantly for admin support/assistance, e.g. typing up assessments, letters, etc. Or it’s the support staff’s unwillingness ever it seems to help you in the same way they do with white staff who they often cannot do enough for. If you are a person of colour working in the NHS your work/contributions are valued less and you are usually criticised more. Many Black colleagues for these reasons despise working for the NHS. Beside Kline’s research, where is the evidence for such claims? You see it with your own eyes every
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day how your white colleagues are treated and how you and your Black colleagues are treated! Every person of colour (and white ones too if they being honest) who are reading this will understand exactly what I am saying, if they have ever worked in the NHS.\(^1\) I would be remiss here if I did not as well mention the inequalities around *racialised work references*, supervisors do for whites versus references that they do for Black workers. People of colour constantly complain of unfair differential/racialised references they receive when compared with white colleagues for comparable work. White supervisors know they are often only providing people of colour low/biased racialised references, so do their managers, and no one say anything or does anything about it! These differential/racialised references stay with the Black candidate for the rest of their working career and lives and these differential/racialised references can ruin careers or, at the very least, be a barrier to future employment options and climbing up the ladder. Differential/racialised references are both unethical and immoral. And much more research needs to be carried out on these racialised injustices in the workplace that people of colour have complained about for years, while NHS supervisors and management turn their backs and constantly deny it happens or is happening.

Hence, although I commend Kline’s report and effort to address the inequality and widespread discrimination in its various forms against BME staff in the NHS, I believe he did not go far enough. There are not just discrimination and inequalities in e.g. bullying and *differential work referencing* concerning people of colour who work in the NHS, but across the board in services, provisions, resources and in the treatment of people of colour in mental health, particularly when relating to Black males who unfairly oftentimes end up in the criminal justice system, because they more often than not do not have access to traditional mental health mainstream services, or they fear altogether using traditional mental health services because they believe the services to be racial/gender biased. Is it possible this bias and police overzealous behaviour towards Black males, when held in police custody with mental health issues, die disproportionately after use of force or restraint than receive the medical help they deserve and need? No wonder Black males are more likely to be over-represented in mental health facilities and hospitals. (see Sharon Walker’s chapter for in this book further discussion).

There are also high levels of inequalities and discrimination towards people of colour in most of the academic/graduate training institutions in the UK for those people of colour who want to work in mental health. Such students are less likely to have support of any kind, be encouraged, they receive less financial support, by the way of teaching or research assistantships when compared to whites, white

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\(^1\) First and foremost, the authors of this book and I want to show our gratitude towards the NHS as our book nears completion. We applaud the efforts and courage of the NHS and the NHS Volunteer Responders that are involved in the COVID-19 pandemic and the dangerous and unpredictable climates you work in every day. We all stand shoulder to shoulder with you. Nevertheless, the sad truth is that the problems addressed in this chapter do in fact exist and need to be eradicated. We hope that, in the future, these issues will be addressed with the same fervour, energy and passion with which the current crisis is being tackled as we strive towards a better world and society for all races.
supervisors/academics tend to disapprove of them doing ‘Black research’, which they feel oftentimes is not legitimate, is unimportant or they are ignorant of cultural research, or ‘fear’ this kind of research being done altogether. Because of the lack of support/encouragement, lack of a diverse teaching/supervisory staff and cultural competence model at the teaching institution or university in question, many people of colour in our Black community never graduate to work in their chosen profession – mental health – because they are either ‘pushed out’ or dropped by the department.

As such, in this book we felt it was important for us to put a ‘face’ on many of these people of colour who were merely a statistic in Kline’s book. These people of colour who are constantly victims of discrimination and racism in Kline’s book are real people and human beings whose voices must be heard. It was important for us to tell some of the stories of these people of colour and to put a ‘face’ on their lives. Therefore, this book chronicles the rich stories, ethnographies and anecdotes of people of colour and their racialised/discriminatory interactions and communications with white authority figures in mental health that have had a devastating impact on their lives.

Everyday Racism

Discrimination and inequalities regarding people of colour are often perpetuated by white management, academic staff, colleagues and support staff, in both overt and covert racist ways e.g. implicit bias, in ‘everyday’ interactions/communications such as bullying and racial ‘micro-aggression’. These forms of discrimination and racism work both on an institutional level and on a personal level, but we believe it is the day-to-day, personal level or ‘everyday’ form of racism rather than institutional racism that is more degrading, demoralising and devastating and deteriorates one’s mental health more over time.

Therefore, institutional racism does not go far enough in explaining the often hostile ‘everyday’ racialised interactions/communications between whites and Blacks that affect the relationships between people of colour and white authority figures.

We believe racial micro-aggressions can be more profound and vicious than ‘institutional racism’ (the ‘comfortable/safe’ form of racism that has become so over-used) in which no one ever seems accountable because ‘the institution did it!’. It seems that this form of ‘virtual racism’ – that is, racism that is out there somewhere in a cloud – cannot be traced back to individuals, despite the fact that systems, structures, policies and governance (e.g. institutional racism) are created, run, operated and maintained by individuals – with names, I might add! That is, they place racism in institutions as inanimate lifeless structures. Yet when an individual or group is guilty of a racist act in the workplace, they hide behind the ‘institution’. Very rarely is the person(s) made accountable or responsible because they hide behind the cloak of the ‘institution’, so nothing is ever resolved because the faceless/nameless entity is somehow not really a person but the ‘institution’. So oftentimes no one is ever held responsible for the act. Nevertheless, while racial micro-aggressions are offensive and often hostile or vicious (whether intentionally or not), at least the victim can ‘place/identify’ the wrongdoer, which is the first important/critical step to rectifying/healing.

Hence, our book, The International Handbook of Black Community Mental Health, is the first book to go beyond institutional racism in health care and address
the destructive racialised communications/micro-aggressions (‘personal level’ racism) in both mental health/academic settings between Black mental health providers/Black graduate students training to be mental health providers and white authority figures. These white hegemonic/white privilege driven destructive racialised communications impact services relationships, treatment outcomes and graduation rates. Thus, one of the primary goals of our book was to move beyond institutional racism as an inappropriate model/political non-accountable driven model of racism and begin to examine racism in mental health on a more personal level: ‘everyday racism’, implicit bias and micro-aggression, and the devastating impact it has on people’s lives. We believe personal level racism is a more adequate model for understanding how racism impact and affect treatment, stereotypes, inequalities, resources, access to mental health services, misdiagnoses, among other areas.

Because of the various forms of discrimination, racism and inequalities found within an organisation, together with a lack of cultural competence among white managers and staff in mental health services, mental health provisions and services for people of colour have been in crisis for a long time. The Care Quality Commission (2011) has highlighted the need to address inequalities in mental health service provision for people of colour. No wonder, then, that people of colour in the UK are four times more likely to be sectioned and detained under the Mental Health Act, die in police custody, are more likely to be diagnosed with mental health problems and be admitted to hospital for mental illness. According to the mental health charity Mind, young African-Caribbean men are more likely to face negative experiences when they use mental health services, resulting in poor mental health outcomes (Tugwell, 2017). People of colour living in the UK have lower rates of common mental disorders than other ethnic groups but are more likely to be misdiagnosed and diagnosed with severe mental illness (Tugwell, 2017). They are more likely to enter mental health services via the courts or the police rather than from primary care, which is the main route to treatment for other groups. They are similarly over-represented in high- and medium-secure units and prisons and criminalised rather than being medicalised for mental health issues. Research reveals that 56% of patients in mental health units who have been sectioned are Black, which is more than any other ethnic group (reinforcing the myth of Black men as ‘big, bad and dangerous’ – see Majors, 2001 for further discussion). People of colour tend to receive higher levels of psychotropic medication rather than being offered talking therapies such as psychotherapy (Tugwell, 2017). In comparison, white patients are often presented with a variety of cognitive and behavioural therapies aimed at not developing a dependency on medication, because there is more focus on promoting continuity and stability in managing their mental illness. Therefore, white patients often report positive clinical experiences that are situated around self-help, empowerment and wellness (Arday, 2018).

The lack of access to talking therapy may affect suicide rates among people of colour. In the UK, whites have higher rates of suicide than African-Caribbeans. However, recent research reports that suicide rates, particularly among young African-Caribbean men, are increasing (Bhui & McKenzie, 2008; Samaritans, 2018; see Columbia Suicide Prevention questionnaire/protocol in the addendum to this chapter). In the UK and internationally, programmes focussing on suicidal prevention in the Black community are expanding. One of the successful international
suicide prevention organisations, Choose Life International, is developing a range of national and international seminars and conferences, as well as telephone and face-to-face counselling, to reduce the number of suicides in the Black community.

Racialising and Biased Roots of Schizophrenia

One of the most disturbing issues in the Black community is the over-/misdiagnosis of schizophrenia, particularly in Black males, by white mental health providers, who lack the cultural competence, knowledge and training to diagnose people of African descent correctly or adequately. African-Caribbean people are 3–5 times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia in the UK and they are 17 times more likely than white males to be diagnosed for schizophrenia or bipolar disorder even when they do not suffer with such mental health disorders (Davie, 2014).

Black men are more likely to be over-diagnosed with schizophrenia not only because of ignorance, a lack of knowledge, training and cultural competence but also for political reasons and for social control. The Diagnostic and Statistical Manual (DSM) was created by the American Psychiatric Association (APA) to classify/diagnose mental health disorders. In the mid-to-late 1960s, schizophrenia as a diagnosis began to become more gender-specific, politicised and disproportionately applied to African-American men. While the Black man’s symptoms might have played a part in the diagnoses, it is very clear that such diagnoses in the 1960s had more to do with their connection to the civil rights protest/city riots in that decade and Black men’s involvement in parties and organisations like the Black Panther Party and Nation of Islam. Black men were unfairly viewed in society as violent and dangerous. Thus, this biased diagnosis of ‘racialised aggression’ reflected the political zeitgeist. During this period of race-based diagnoses, the APA changed the paranoid subtype of schizophrenia to a disorder of masculinised belligerence.

Professor Jonathan Metzl in his book *The Protest Psychosis: How Schizophrenia Became a Black Disease* (2010) said Black men during this time were viewed by the APA, as reflected in the DSM, as hostile and aggressive, and ‘delusional’, for their participation in protest activities and for belonging to political organisations. Metzl said that such diagnoses of schizophrenia were therefore politically driven. (These interpretations have historical roots in the Eugenics movement, see *Even the Rats Were White* by Robert Guthrie).

Hence, in the 1960s, many Black men were diagnosed with schizophrenia because of racism and the political period they lived in and not because of their clinical symptoms (Guthrie, 1968; Metzl, 2010; Thomas & Sillen, 1972).

There is an underlying assumption that Black men are ‘big, bad and dangerous’. This stereotype still prevails within society and is reflected in mental health services, provisions, diagnoses and treatment. Therefore, institutions and therapists are less likely to empathise with Black men or feel comfortable offering them ‘talking therapy’, because they are often ‘feared’ by organisations and therapists who provide therapeutic services. As such, treatment for Black males tends to be ad hoc and crisis oriented.

Race-based or politically driven over-diagnosis of schizophrenia continued throughout the 1980s and the 1990s. A number of articles from leading psychiatric and medical journals showed that doctors diagnosed the paranoid subtype of schizophrenia in
African-American men 5–7 times more often than in white men groups. Sadly, during this time pharmaceutical companies jumped on the ‘racial stereotype’ bandwagon, showing the ‘so called angry Black men’ protesting in the streets to promote antipsychotic drug sales (Metzl, 2010). White and Parham (1990) propose a Black psychology/Afro-centric psychology to prevent over-diagnoses and racial stereotyping of people of African descent in mental health. (See Professor Joseph White’s ‘the Father of Black Psychology’ Foreword in this book for further discussion on this subject.)

Roots of Mistrust

Biased, political and race-based diagnoses of Black men have historical roots. During slavery, slaves who escaped bondage were called crazy or mad by plantation owners. In the 1850s, psychologists felt that slaves who ran away from their white masters did so because of a mental illness called ‘drapetomania’. Drapetomania is considered the beginning point for scientific racism. Medical journals of the time also described a condition called ‘dysaesthesia aethiopis’, which was a form of madness characterised by ‘rascality’ and disrespect for the master’s property. Brutal beatings were considered to be the ‘cure’ (Metzl, 2010).

Because of this traumatic history and ill treatment, Black males often do not feel comfortable accessing formal/traditional mental health services for help and support and therefore tend to reject any idea that they have ‘mental illness’. They see mental health as more politically driven even today. Thus, they view such mental health labels/services as nothing more than ‘stitch-up jobs’ to hurt and pathologise them. Because of feelings of being ‘stitched up’, Black males have developed a ‘cultural paranoia’ (Grier & Cobb, 1968) and a ‘cultural mistrust’ (Terrell & Terrell, 1981) when around whites. Given this backdrop it is understandable that people of colour do not trust white hegemonic, Eurocentric mental health services – they are not comfortable with them and therefore often will refuse; if they do hesitantly access services, they usually soon disengage, resulting in a further deterioration of mental health.

Both ‘cultural paranoia’ and ‘cultural mistrust’ are considered acts of justified suspicion (being on constant guard) that Blacks often use when engaging with whites, particularly white authority figures (see the ‘Cool Pose’ theory, Majors & Bilson (1992) for examples of how both ‘cultural paranoia’ and ‘cultural mistrust’ are manifested in everyday life). Both behaviours are employed by Black individuals to protect themselves and make them less vulnerable when around whites, given white people’s hegemonic power to hurt Black people. Both ‘cultural paranoia’ and ‘cultural mistrust’ are considered by Black psychiatrists and psychologists to be examples of positive cultural adaptive strategies rather than pathology. Nevertheless, while ‘Cool Pose’ can be viewed as a positive cultural adaptive strategy, it can also be problematic. Because of constant trauma, racial micro-aggression and impact of everyday racism, Black males adopt a ‘Cool Pose’ (Majors & Bilson, 1992) as mentioned above. The ‘Cool Pose’ is a defence par excellence and is an expression of cultural masculine identity, which works very well in most situations to help Black males counter racism. But there is a flip side, it can work so well, it can be hard to shut down. That is, many Black males become so conditioned to keeping up their guard due to racism, that even without a particular threat they
still may keep their ‘Cool Pose’ guard switched on regardless, which can cause its own stress – secondary extreme stress. I have termed this conditioned strength, “the problem of selective indiscrimination” (Majors, 1987; Majors & Billson 1992).

That is, because of the constant perception of a perceived threat of white racism and mistrust of whites, many Black males’ Cool Poses stay switched on as a way to protect themselves, which can be harmful to their psychological well-being.

Much like cultural paranoia and cultural mistrust, Richard Majors and Janet Mancini Bilson in Cool Pose: The Dilemmas of Black Manhood in America (1992) describe how Blacks adopt a ‘Cool Pose’ as a defense when they feel threatened or sense mistrust by white hegemonic forces, as a way to protect, empower, preserve self-esteem and ‘keep whites off guard’.

People of colour attempt to mediate the psychological impact of everyday racism and racial micro-aggressions by developing such coping/adaptive strategies as cultural paranoia, cultural mistrust and Cool Pose (Majors, 1992). Nevertheless, ‘everyday racism’ and racial micro-aggression can cause trauma and be very damaging to the mental health and well-being of people of colour as mentioned above.

The mistrust, constant threat or the anticipation of threat of interracial interactions (with whites) can create a healthy mistrust/paranoia in many and in others it may create a state of ‘Black anxiety/Black extreme anxiety’ due to constant/perceived threat of white interracial interaction(s) and resultant stress. This Black anxiety/Black extreme anxiety has a historical context. That is, the historical baggage of slavery and its intergenerational ‘memory’ along with the de facto discrimination over many years has created Black anxiety/Black extreme anxiety (‘Black racialised anxiety’) in many people of colour. People of colour learn early in their lives that whites wield/yield a lot of power to maintain, control, hurt and punish ‘for those people of colour who do not stay in line, be defined by them or do not obey’ (see Bobby Wright’s Mentacidal argument). These historical ‘control’ institutions towards people of colour are maintained and reinforced today by white privilege/white hegemony, everyday racism (personal-level racism), institutional racism and racial micro-aggressions (e.g. racialised interaction/communications both in the workplace and in society). Given the impact of different forms of racism on people of colour, the well-known psychiatrist Professor Alvin Poussaint in the Preface to this book, argues for the importance of the American Psychiatry Association (APA) adding ‘extreme racism’ (white directed racism) as an official category in the DSM (The Diagnostic and Statistical Manual of Mental Disorders). I would argue in addition to extreme racism, different forms/levels of ‘Black anxiety’/‘Black extreme anxiety’ be considered for inclusion to the DSM as well due to the psychological impact of white-related stress. Both forms of these kinds of racism are due to actions of white aggression, whether direct or indirect, and therefore these behaviours are on a continuum of white psychopathologic behaviours.

Joseph White and Thomas Parham in The Psychology of Blacks: An African American Perspective (1990) argue for the need for a Black/African-American psychology (e.g. Afro-centric) to prevent ‘deficient-specific interpretations’, inferior diagnoses, stereotyping and pathologising people of African descent. They also argue for the importance of a Black/African-American psychology to promote the uniqueness, cultural values and world views of people of African descent (see also Jones, Black Psychology, 2004).
Wade Boykins, a well-known American psychologist, has developed a socio-cultural/psychosocial model in education that is applicable to positive Black mental health. We believe his cultural model, which focuses on ‘verve’, prevents mental illness, promotes resiliency and leads to positive healthy outcomes and ‘wellness’ for people of colour (Boykins & Bailey, 2000). Ransaw (2019) also argues for the importance of developing an emancipatory education framework to counter oppressive ideologies towards people of colour and promote the uniqueness of Black culture.

While both cultural paranoia and cultural mistrust act as positive adaptive strategies over a long period, constant exposure to toxic environments and climates and ‘everyday’ racialised interactions and communications can lead to trauma and pathology.

Everyday racism usually takes the form of racial micro-aggression because of the constant insults and acts of humiliation that wear victims down. Racial micro-aggressions and negative racialised interactions between whites and Blacks can come from anyone, but they more often than not come from white authority figures and whites in power. The centrality of whiteness/white hegemonic privilege drives racial micro-aggressions towards Black staff/therapists and Black service users in mental health settings every day. Racial micro-aggressions and negative racialised interactions and communications also affect students of colour in universities as well. As stated earlier, many graduate students of colour who attend universities to train as providers, therapists and academics disproportionately either drop out or are pushed out of graduate school because of the lack of personal support or support to allow Black graduates to conduct research on and write their theses and dissertations on Black topics. Constant micro-aggressions, and offensive remarks by academic staff or white academic staff, wear people down and over time contribute towards a variety of mental health problems among people of African descent (see Sharon Walker’s chapter in this book). Micro-aggression in mental health is reflective of everyday life for people of colour. Examples of micro-aggressions in the workplace/academia are not only prevalent there, but in everyday public life as well, including when a woman clutches her purse in fear when a Black man walks past her on a street, or when she sees a Black man coming along the street and she quickly crosses over so that she does not have to walk past him. Or when security guards follow Black men in stores but not white people, thinking the Black men are not there to buy anything but rather to steal (Lowe, 2015).

Racial and Cultural Trauma

Micro-aggressions over an extended period of time can lead to traumatisation and symptoms resembling post-traumatic stress disorder (PTSD) in reaction to the constant and daily degrading insults that can cause a sense of hopelessness. As Smith (2010) states,

“The accumulation of emotional and physiological symptoms resulting from subtle and overt forms of racial verbal and non-verbal micro-aggressions at the societal, interpersonal, and
institutional level can lead to traumatic psychological and physiological stress symptoms."

No wonder, given the impact of racial micro-aggressions, that people of colour often suffer from race-/culture-specific PTSD. While people of colour like anyone else can suffer from PTSD, the trauma tends to be in the past and finite. We therefore believe PTSD is limited when seeking to understand victims’ feelings of ongoing, day-to-day threat and danger. Therefore, PTSD does not capture the racialised aspects of continuous trauma that people of colour often face. We believe a more racial-/cultural-specific trauma model would be more appropriate and nuanced for understanding and interpreting PTSD-specific features/stress among people of African descent. Therefore, we prefer a framework that considers models such as continuous traumatic stress (CTS), post-traumatic slave syndrome (PTSS) (DeGruy, 2005), battered race syndrome (Ratliff, 2014) and racial battle fatigue (see Smith’s chapter in this book). All of these racialised trauma-related frameworks consider that daily encounters with white hegemonic racism and the day-to-day impact of ‘everyday racism’ first posited by Essed (1991) and other conditions created by white hegemonic forces, such as persistent poverty and unemployment, hyper-vigilance, hopelessness, environmental racism, living in squalid, gang-infested and crime-ridden neighbourhoods, can cause stress, anger, anxiety, hopelessness, depression and suicides in addition to other mental health challenges (see Majors & Gordon, 1994, for further discussion).

Let’s look briefly at each of these models that help to explain racial and cultural trauma. The first framework I would like to address is continuous traumatic stress (CTS). CTS is a model developed in the 1980s by a group of mental health professionals working in apartheid-era South Africa, who were attempting to provide psychological support to victims of political violence within a context of ongoing state racial repression. CTS as a framework helps us to understand the psychological impact of people of colour living in high-stress environments where there is a realistic threat of present and future danger. Threats of harm for many people of colour never go away, and this creates an internal ‘state of emergency’ (Vitelli, 2013). People experiencing CTS are usually more preoccupied with what could happen to them in the present or the future (‘anticipatory anxiety’) than with the past.

The second framework is Post Traumatic Slave Syndrome (PTSS), (DeGruy, 2005), which focuses on historical and intergenerational trauma. PTSS argues that centuries of slavery, systemic racism and oppression have resulted in the development of multi-generational adaptive behaviours. PTSS can also cause trauma in the next generation, for example, ‘transgenerational trauma’ (Sullivan, 2013). The child may internalise their family’s experience of trauma or the PTSS may be a result of parental rearing styles (e.g. strict authoritarian rearing). Another major way that stress can be transmitted across generations is biologically, through the uterine environment. Exposure to harmful stimuli at this stage can have detrimental effects. Empirical evidence has shown that trauma experienced by a mother during pregnancy can affect her offspring’s physiology and psychology (Yehuda & Lehrner, 2018). We are also aware of the
very real dangers and concerns regarding how Black women are treated in pregnancy, together with overall care for Black, Asian, minority ethnic (BAME) women. Recent statistics illustrated within the fifth MBRRACE-UK (2018) annual report of the Confidential Enquiries into Maternal Deaths and Morbidity highlight the high mortality rate of Black women in pregnancy in the UK. Results from 2014 to 2016 show that Black women in the UK are five times more likely to die in childbirth compared with white women (MBRACE, 2018). Therefore, the exposure to generational trauma for the Black child is ongoing, both before and after birth, affecting their attachment and emotional and social development.

Battered race syndrome (Ratliff, 2014) compares the abusive relationship between a man and a woman in battered woman syndrome and the 400-year abusive relationship between America and African-Americans and stress/traumatisation.

Finally, racial battle fatigue (Smith, 2010, see his chapter in this book) is a term coined in 2003 by Smith to explain the social and psychological stress African-American males have endured historically at the hands of whites. Smith believes stress develops from having to constantly deal with blatant racism and micro-aggressions. His work helps us to better understand combat stress and the racial undertones, nuances and extreme stress African-Americans historically endure from whites.

Racial micro-aggressions (e.g. ‘personal-level racism’) that can lead to trauma/pathology then help us to understand the various kinds of racialised interactions and communications that white staff often have with both service users and people of African descent who work in white mental health establishments (e.g. managers, mental health providers, team leaders, staff, therapists and support staff) as well as the Black graduate students’ negative racialised experiences/supervisory relationships at universities.

Many of the clinical authors of this book who have worked in local mental health establishments have been targets of vicious racial micro-aggression attacks. These attacks have been both overt and covert and also non-verbal, taking the form of degrading insults, isolation, humiliation, name-calling, rolling of the eyes, staring. Additionally, support staff are often reluctant to provide the same kind of support that’s provided for white colleagues/staff in the office and if they are provided support, they are the last ones in the queue to receive help or support from support staff e.g. support staff are often unwilling to type up their documents, assessments or letters. These are just a few examples of other forms of ‘subtle’ racialised micro-aggressions that people of colour have to deal with on a daily basis when working with white colleagues either in mental health or academic spaces. When people of colour complain about this treatment, they feel the white establishment does nothing at all. Thus, people of colour tend to be reluctant to complain because of office ‘stigma/politics’, indirect retaliation, being ostracised, fear of losing their job or being ‘blacklisted’, or fear of losing opportunities in the future for promotion or being phased out because they made a complaint. These racial micro-aggressions by white mental health providers create a toxic and hostile working climate that communicates very clearly to people of colour who work in mental health: ‘you are not welcome or wanted here’.
These behaviours seem to have increased significantly in the UK following the vote on Brexit (Booth, 2019).

No wonder, with such alarming levels of care and inferior level of treatment, many people of colour in the UK distrust white personnel, staff and mainstream mental health services, and therefore are reluctant to engage with them (Sinusi, 2018). Many people of colour feel that mental health services in this country are not there to provide help or support but rather are a mechanism to stigmatise them and delay their recovery. People of colour often feel white mental health providers yield significant power over them and make culturally insensitive decisions that hurt or harm. We place health care providers/managers at the centrality of hegemonic ‘whiteness’ (Grey, Sewell, Shapiro, & Ashraf, 2013). The Black community often feels white mental health providers and managers are biased, stereotype them, fear them, regarding them as more aggressive or dangerous than others (particularly young Black males). They do not believe white providers and managers are properly trained (or feel the need to be), or are capable or culturally competent to deliver adequate mental health services to the Black community (Abbott, 2014). In our experience, white therapists are often not comfortable serving people of colour and refrain from doing so when there they have a choice to serve audiences they are more comfortable with, especially in relation to Black males. Many Black service users view providers and managers and therapeutic agencies/organisations as inflexible white space that reinforces white Eurocentric models of health care which are dismissive of Black culture and values (Mind, 2013) – see Professor Joseph White’s Foreword on the history of ‘deficit psychology’ and the importance of Black/Afro-centric psychology to understanding people of colour.

Cultural Competence

One specific strategy to improve services and access is cultural competence. As discussed, many of the problems in mental health are due to a lack of appreciation and understanding of cultural competence. Cultural competence is the ability to relate effectively with individuals from various groups and backgrounds. Culture can be defined as the behaviours and non-verbal behaviours (see Andrews & Majors, 2004; Majors, 1991), customs, identities, attitudes, racial identities, lifestyle, values, experiences and beliefs shared by a group of people. For example, the author of this work, during many visits to East Africa, while working in indigenous villages, learnt that when certain tribal members described or explained particular mental health problems they would do it somatically rather than mentally. For example, rather than describe depression as a mental condition they might say ‘I have a headache’. Some cultures did not recognise or know how to describe symptoms associated with stress, depression or certain mental health problems in traditional western ways (Arday, 2018).

Because of cultural mistrust of white health providers, people of colour often engage with their social networks and friends in spiritual ways, such as praying or seeking community support, rather than accessing local mental health services. Therefore, culture can influence such things as social networks, customs, beliefs, dress, language, religious orientation, customs and foods people eat, among many
other things (Pedersen, 2002). Cultural competence is also a tool that helps us interpret culture-specific nonverbal behaviours, nuances and subtleties (Majors & Gordan, 1994).

From a mental health point of view, culture influences how people from different backgrounds (e.g. racial) address emotional and mental distress, seek help, use support and cope with various problems. Individuals, institutions and mental health organisations and providers would benefit greatly from applying cultural competence models if they are to offer culturally appropriate services, prevention, outreach, assessments and interventions. Cultural competence also promotes self-awareness of the health care provider. Self-awareness is the first step for mental health providers towards understanding personal and cultural values, biases, stereotypes and beliefs. This self-awareness should help individuals appreciate, connect and empathise with patients who may not be from their own culture. Through a cultural competence framework, staff and service providers are challenged to continually examine their own beliefs, and to work with mutual transformation as they develop their skills, and appropriately apply interventions that are culture and context centred, and authentic to what is sometimes called the BAME clients’ and families’ value system (Pedersen, 2002). The government and the NHS must improve access to better health care and dismantle the legacy of inequalities and endorse policy driven actions that make use of a culture-specific applicable framework that is so critical for improving mental health equity in people of colour.

People of colour express a desire for greater diversification regarding service providers. People of colour therapists and service providers tend to be more empathetic towards understanding the plights and experiences of other ethnic people of colour (Arday, 2018). As Grey et al. (2013) and MIND (2013) found, people with an ethnic background who have experienced racial discrimination in health care have a preference for ethnic similarity regarding health care providers. They feel people of colour who are service providers are more empathetic, do not fear them, overreact or misdiagnose them when compared with white service providers (White & Parham, 1990). As such, health care must become more diversified and culturally competent to meet a vastly growing world population of people of colour. Therefore, policies, modalities, methodologies, strategies, programmes and training material targeted towards people of colour must become more culturally relevant, cognizant and sensitive if they are to meet the needs of this population and prevent an even greater or deeper crisis in mental health than there is now. In addition, financial resources must be provided for white health care providers to undertake compulsory continuing professional development training. Cultural competence training should move beyond its current status among many white service providers as an unimportant ‘tick box exercise’.

**Conclusion**

Given this sad portrayal and status of mental health in the Black communities, *The International Handbook of Black Community Mental Health* can be depicted as a response to the plethora of challenges experienced by people of colour. We therefore have developed this book to inform, challenge, change attitudes, educate,
raise awareness and influence and shape policy that will hopefully improve mental health services, eradicate inequality, discrimination, negative racialised communications/micro-aggressions and improve the treatment of people of colour who access mental health services.

Tangible actions must be reflected through diversifying health care staff within mental health services, and developing culturally sensitive systems and culturally appropriate interventions for both Black providers and service users, if things are genuinely to change.

People of colour experience mental health differently. These experiences are often situated within and tinged by racist connotations. Given these negative racial ascriptions, people of colour are often misdiagnosed, treated differently within mental health services and consistently experience poorer satisfaction and less productive outcomes (Vernon, 2011).

This Handbook includes not only statistics and discussions in traditional areas of mental health but also but puts a ‘face’ on Kline’s (2014) victims in the NHS by presenting and highlighting rich stories, ethnographies and anecdotes of personalised trauma experienced and endured by people of colour, not only within mental health settings but among students involved in academia/graduate training in our universities. We shift the paradigm of academic mental health books to moving beyond statistics and theory-laden text as mentioned above to hearing about people’s lives and their described experiences of everyday racism and micro-aggressions. In doing so, we challenge sensitive and taboo/controversial subjects many individuals are not comfortable dealing with or talking about.

The covert subtleties of everyday racism, micro-aggression and implicit bias, particularly in academia, and their detrimental impacts are steeped in oppressive practice, with the blame often put on the person of colour (Sue et al., 2007). Racial micro-aggression is a more adequate model than institutional racism for understanding race dynamics and racialised interactions/communications such as those between white authority figures/management and black providers/service users and supervisory/supervisee negative cross-cultural communications.

In this book, not only do we look at the entire family life cycle of people of colour and mental health, we also address the over-representation of Black men in the mental health system and other inequalities in mental health services. We recommend applying emotional literacy and emotional wellness and cultural competence strategies and models for both people of colour and Black males to address racism, discrimination and inequalities, and to improve their lives. By not just focussing on ‘problems’ inherent in mental health, the editors and contributors in this book looked at on solutions: offering new frameworks, methodologies and therapeutic models that seek to redress many of the problems found in the mental health service and universities. Thus, The International Handbook of Black Community Mental Health is a timely and essential tool, which we hope will play its part in helping to both enhance white providers’ knowledge and insight into Black mental health, develop knowledge towards providing a better experience and service for Black providers and service users, and improve the experiences and lives of people of colour who access mental health services. The time for change is now.
References


Guthrie, R. (1968). *Even the rats were white*. Boston, MA: Addison-Wesley.

Guttridge, R. (2020, March 13). A third of black or minority ethnic Walsall Manor Hospital staff say they were bullied or harassed by colleagues. *Express & Star* [UK]. Retrieved from https://www.expressandstar.com/news/health/2020/03/13/a-third-of-black-or-minority-ethnic-walsall-manor-hospital-staff-say-they-were-bullied-or-harassed-by-colleagues/


Addenum

Empowering Communities and Schools to Prevent Suicide and Violence with
The Columbia Suicide Severity Rating Scale (C-SSRS)
The C-SSRS: A Few Simple Questions to Find People at Risk and Prevent Suicide

\[ \sim 80\% \] of school shooters had a history of suicidal thoughts or behavior


Just ask a few questions to find people who need help before it’s too late,
Prevent violence before it starts.

What is The Columbia Suicide Severity Rating Scale (C-SSRS) Screener?

The C-SSRS is a few simple questions about suicidal thoughts and behavior that empower communities, families and individuals to find people who are at risk and prevent tragedies before they happen. The C-SSRS tells the teacher, parent or peer who needs a next step, and provides setting-specific recommendations.

- **Simple**: You can ask as few as two to six questions, with no mental health training required to ask them.
- **Effective**: Experience shows that the scale uniquely identifies those who would otherwise be missed.
- **Efficient**: Use of the scale redirects resources to where they are needed most, preventing unnecessary interventions that are often costly, traumatic, and lead to disengagement from the needed care. The C-SSRS provides evidence-based thresholds to connect those at risk to the right level of care.
- **Free**: It’s available at no cost.
- **The Most Evidence-Supported**: The scale originated in a NIMH adolescent suicide attempter treatment study, and generated an unprecedented amount of research that validates the questions’ value.

Regarding the C-SSRS, “We found another big piece of the school shooting puzzle – an antibiotic for suicide. This ... could fundamentally change the game for early identification and intervention.”

*Ryan Petty, parent of a Marjory Stoneman Douglas High School shooting victim from Parkland, FL*
“If implemented to the extent of its capacity across the country, the Columbia has the potential to keep the 64 million children in our schools safe physically and mentally by helping prevent school violence.”

James Shelton, Former Deputy Secretary, U.S. Department of Education

Youth and Suicide

- Approximately 16% of US high school students report seriously considering suicide
- Each year, 8% make one or more suicide attempts (CDC, 2015)
- 25% of teachers report being approached by an at-risk student
- An estimated 51,518 U.S. adolescents are hospitalized each year for self-inflicted injuries, resulting in total annual costs of approximately $477,580,000 (CDC, 2010)
- Suicide is the second leading cause of death among U.S. college students, and less than 20% of students who die by suicide received any campus-based mental health services
A Critical Protection Strategy for Whole Communities

- In schools and on college campuses, the C-SSRS creates a tight/comprehensive network of support, when it is used by teachers, coaches, public safety officers, student life staff, resident advisors, and most critically, peers.
- The C-SSRS has been successfully implemented in many schools and systems across the US (e.g., every teacher in Tennessee) and abroad (every school teacher in Israel).

Putting these simple questions in everybody's hands creates a common language and a linking of systems. This facilitates care delivery and enages the whole community in helping to prevent tragedy.
Having a common language to talk about difficult topics such as suicide fosters an essential protective and promotive factor for all youth - social and psychological connectedness to school or “the belief held by students that adults and peers in the school care about their learning as well as about them as individuals…” (CDC, 2009)

Build Connections by Simply Asking

Just asking the questions can be a positive action. When we ask a student, an elder, a partner how they’re doing, it signals that someone cares about them. This simple action promotes connectedness – a critical protective factor against suicide and violence.

The C-SSRS creates a common language. Having a common language with clear definitions of suicidal thoughts and behaviors is critical for developing school safety and response protocols. Schools distribute the Columbia Community Cards to teachers, coaches, parents and students, so that everyone is empowered to ask about suicide:

THE POWER OF ASKING

High-risk students who get screened are less distressed and suicidal than high-risk students who do not receive screening. (Gould et al, 2005)
Steps You Can Take

Firearms
- Keep firearms locked in a safe and ammunition stored in a separate location.
- Biometric locks are best because youth often know safe combinations or can find keys.
- Ask a friend or family member to store a firearm for you while you work on becoming healthy again.
- Check out a local shooting club or local police precinct to see if they have temporary storage options.

Medications
- Never keep lethal doses of any medication on hand. Work with your doctor and pharmacist to make sure you have a safe dosage in your home.
- Consider keeping medications locked in a safe place or have a responsible adult monitor use.
- Properly dispose of medications you no longer need.

THE C-SSRS IN ACTION
Saving Lives: Preventing Suicide & Violence

Follow this link or scan this code to watch a short demonstration of how to ask questions with the C-SSRS screener

https://tinyurl.com/CSSRSDemoVideo

After putting the C-SSRS in everybody’s hands, the U.S. Marine Corps had a 22% reduction in the number of service member suicides.

At Centerstone, one of the largest behavioral healthcare providers in the United States, the suicide rate among its Tennessee patients was lowered by 65% within the first 20 months of implementation.

Utah reversed an almost decade-long increase in suicide deaths.
The Columbia Lighthouse Project
is dedicated to improving suicide risk assessment prevention across all sectors of society. The suicide assessment method developed in collaboration with other academic medical centers, the Columbia Suicide Severity Rating Scale, is used extensively in healthcare and education systems, state-wide suicide prevention programs, military, as well as academic and industry research in the US and abroad.

In order to help integrate the C-SSRS into your prevention protocols, we will:
• Help select the right screening tool and modify it for your setting
• Answer questions about how to use the tool and provide hands-on support
• Direct you to resources that can bolster your suicide prevention efforts

For support, copies of the tool, or additional information, please visit cssrs.columbia.edu

Identify risk. Prevent suicide. Together, we can make a difference.
“We all have the potential to use the C-SSRS to save a life.”

– Keita Franklin, Director
U.S. Department of Defense Suicide Prevention Office

The C-SSRS has been endorsed, recommended, or adopted by:

- World Health Organization
- FDA
- SAMSHA
- CDC
- NIH
- Action Alliance

Identify risk. Prevent suicide.
Together, we can make a difference.

www.cssrs.columbia.edu
COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Lifetime Recent

Version 1/14/09 m9/12/17


Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in The Columbia Suicide History Form, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B., & Mann J. J., Risk factors for suicidal behavior: Utility and limitations of research instruments. In M. B. First [Ed.] Standardized Evaluation in Clinical Practice, pp. 103–130, 2003.)

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact posnerk@nyspi.columbia.edu

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## SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4, and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

<table>
<thead>
<tr>
<th>1. Wish to be Dead</th>
<th>Lifetime: He/She Felt Most Suicidal</th>
<th>Past 1 month:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, describe:</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Non-Specific Active Suicidal Thoughts</th>
<th>Lifetime: He/She Felt Most Suicidal</th>
<th>Past 1 month:</th>
</tr>
</thead>
<tbody>
<tr>
<td>General non-specific thoughts of wanting to end one's life by suicide (e.g., &quot;I've thought about killing myself&quot;) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you actually had any thoughts of killing yourself?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>If yes, describe:</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act</th>
<th>Lifetime: He/She Felt Most Suicidal</th>
<th>Past 1 month:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, &quot;I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it, and I would never go through with it.&quot;</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you been thinking about how you might do this?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>If yes, describe:</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan</th>
<th>Lifetime: He/She Felt Most Suicidal</th>
<th>Past 1 month:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to &quot;I have the thoughts but I definitely will not do anything about them.&quot;</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you had these thoughts and had some intention of acting on them?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>If yes, describe:</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Active Suicidal Ideation with Specific Plan and Intent</th>
<th>Lifetime: He/She Felt Most Suicidal</th>
<th>Past 1 month:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>If yes, describe:</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

## INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

<table>
<thead>
<tr>
<th>Lifetime - Most Severe Ideation:</th>
<th>Most Severe</th>
<th>Most Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent - Most Severe Ideation:</td>
<td>Type # (1-5)</td>
<td>Description of Ideation</td>
</tr>
</tbody>
</table>

## Frequency

How many times have you had these thoughts?

<table>
<thead>
<tr>
<th>(1) Less than once a week</th>
<th>(2) Once a week</th>
<th>(3) 2-5 times a week</th>
<th>(4) Daily or almost daily</th>
<th>(5) Many times each day</th>
</tr>
</thead>
</table>

## Duration

When you have the thoughts how long do they last?

<table>
<thead>
<tr>
<th>(1) Fleeting - few seconds or minutes</th>
<th>(2) Less than 1 hour/some of the time</th>
<th>(3) More than 8 hours/persistent or continuous</th>
</tr>
</thead>
<tbody>
<tr>
<td>(4) 4-8 hours/most of the day</td>
<td>(5) 1-4 hours/a lot of time</td>
<td></td>
</tr>
</tbody>
</table>

## Controllability

Could/can you stop thinking about killing yourself or wanting to die if you want to?

<table>
<thead>
<tr>
<th>(1) Easily able to control thoughts</th>
<th>(2) Can control thoughts with little difficulty</th>
<th>(3) Can control thoughts with some difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>(4) Can control thoughts with a lot of difficulty</td>
<td>(5) Unable to control thoughts</td>
<td>(6) Does not attempt to control thoughts</td>
</tr>
</tbody>
</table>

## Deterrents

Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?

<table>
<thead>
<tr>
<th>(1) Deterrents definitely stopped you from attempting suicide</th>
<th>(2) Deterrents probably stopped you</th>
<th>(3) Uncertain that deterrents stopped you</th>
</tr>
</thead>
<tbody>
<tr>
<td>(4) Deterrents most likely did not stop you</td>
<td>(5) Deterrents definitely did not stop you</td>
<td>(6) Does not apply</td>
</tr>
</tbody>
</table>

## Reasons for Ideation

What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn’t go on living with this pain or how you were feeling) or was it to get attention, revenge, or a reaction from others? Or both?

<table>
<thead>
<tr>
<th>(1) Completely to get attention, revenge or a reaction from others</th>
<th>(2) Mostly to get attention, revenge or a reaction from others</th>
<th>(3) Equally to get attention, revenge or a reaction from others</th>
</tr>
</thead>
<tbody>
<tr>
<td>(4) Mostly to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)</td>
<td>(5) Completely to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)</td>
<td>(6) Does not apply</td>
</tr>
</tbody>
</table>

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0-50804-1: Lifetime Scale (Version 1/31/09)
<table>
<thead>
<tr>
<th>SUICIDAL BEHAVIOR</th>
<th>Lifetime</th>
<th>Past 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual Attempt:</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is any intent to die associated with the act, then it can be considered an actual suicide attempt. There does not have to be any injury or harm, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intending intent: Even if an individual denies intent to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident but no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Have you made a suicide attempt?</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Has subject engaged in Non-Suicidal Self-Injurious Behavior?</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interrupted Attempt:</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumps: Person is poised to jump, is grabbed and taken down from ledge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Aborted or Self-Interrupted Attempt:</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>When the person takes a step toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preparatory Acts or Behavior:</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Acts or preparation towards immediately making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Actual Lethality-Medical Damage:**

| No physical damage or very minor physical damage (e.g., surface scratches). | Enter Code | Enter Code | Enter Code |
| Wilting physical damage (e.g., laceration speech, first-degree burns, mild bleeding, sprains). | | | |
| Moderate physical damage: medical attention needed (e.g., consciousness loss, somnolence, rash; second-degree burns, bleeding of major vessel). | | | |
| Moderately severe physical damage: medical hospitalization and likely intensive care required (e.g., coma, tetanus without reflexes, brain damage). | | | |
| Severe physical damage: medical hospitalization with intensive care required (e.g., coma, without reflexes, third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). | | | |

**Potential Lethality:** Only ask if Actual Lethality=0

| Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage, laying on train tracks with oncoming train but pulled away before run over). | Enter Code | Enter Code | Enter Code |
| Behavior not likely to result in injury | | | |
| Behavior likely to result in injury but not likely to cause death | | | |
| Behavior likely to result in death despite available medical care | | | |

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