KATHY FITZJEFFRIES:
Welcome back today too. We hope you enjoyed the first as much as I did. As the facilitator for today's session I would like to welcome you to deconstructing the myths and addressing the reality of suicide behavior in the African-American community.

My name is Kathy FitzJeffries. Let me tell you a little bit about myself and that I will introduce our presenters and get on with the show. I have 40 years experience as a licensed clinical social worker and a licensed clinical addiction specialist. Practical applications is my private practice where I provide clinical supervision, and I am also an educator.

As a person of non-color, over the past 25 years I have found myself within the context of the cultural humility. I began recognizing how my implicit bias is, my white privilege and white fragility unfairly within the organization for which I was employed. And I recognized how critical it is for myself and others who are white to speak out and take action to dismantle racism.

I am also grateful to be a member of NAADAC. It does distress me more of us who are white have not join this committee. It is my hope, and every time I facilitate one of the summits, I beg for others to hear the call. For those of us and my white colleagues, please step up and become an active member of our committee.

Immediately following the event you will find the quiz on the exact same part of the website you use to access this event. If this is your first time attending NAADAC event, make sure you save the checkbox next to the guard during the session which is also saved on a dedicated webpage for this event. Please remember we will have a live question and answer time with our presenter. Make sure to send any questions you have in the question and answer box. We do not want questions in the chat because it goes by so quickly.

Here is a short video from our sponsors. I am going to need to ask a question from Jesse because I am not seeing the video. Has it been completed yet?

SPEAKER:
It played, yes... Video did not play. Let me try again. That's weird. Share sound. Let me try back again.

(Video plays)

SPEAKER:
Don't be like Debbie, use ICANotes. Better notes, less typing. Try us for free...

KATHY FITZJEFFRIES:
Thank you. Now I am pleased to introduce to you our presenter. Renata L. Nero, PhD, is a retired professor of psychology and Sharon Kate Burroughs professor from Houston Baptist University.
During her 25 year tenure at HP, she served as chair of the psychology department, director of graduate programs in psychology, and program coordinator for preprofessional art therapy and school psychology programs.

Currently, Renata is a licensed clinical psychologist in private practice and chair for the executive board for the Ashley Jaden foundation – a suicide awareness and prevention organization. She is a former president of the Southwest region Board of Directors for the Christian Association for psychological studies. And holds platinum advocate membership in the Texas psychological Association. Renata earned a doctoral degree in clinical psychology from the University of Massachusetts at Amherst and completed pre- and post-doctoral internship training at Baylor College of medicine. The microphone is yours.

RENTA L NERO:
Thank you so much Kathy for your introduction. I would like to thank NAADAC for providing this platform that allows for the exploration of topics that will help to better engage the black community. Given the recent high-profile suicides that have occurred, today’s topic is not only important, it is also timely.

I am going to share my screen at this time. And I am going to put this in presentation mode. So that all of you can follow along with me. OK, I am having a little bit of a problem with getting this in presentation mode. OK. I don't know if Jesse can help me with this.

SPEAKER:
Maybe try stop sharing again and before you share put it into…

RENTA L NERO:
OK. Let me try this. OK, I will go with that. Alright, I think we are in a mode now where we can start to view the slides.

One of the reasons why I thought it was important to address…

SPEAKER:
Sorry Doctor Nero, your slides are not shared. You have to share the screen again. We will get it guys. We are so close.

RENTA L NERO:
Alright. Almost there. Great, wonderful. One of the reasons I wanted to talk about the topic of suicide within the African-American community, is because of the myth that African-Americans do not take their lives.

One of the things that has been considered kind of normative within the African-American community is hiding pain. Even back in 1895, Paul Lawrence Dunbar wrote the poem we wear the mask. This poem talked about the act of concealing one's emotions from the rest of the world. But it also addresses the cost of that concealment. And even over 100 years later, we are still dealing with the
pain. And we are dealing with the hiding of our pain. Not just from the rest of the world. But even from each other, and from ourselves. I think it is important to hear what is this pain about. Author Terry Williams specifically addresses black pain in this clip.

(Video plays)

SPEAKER:
I think three of the hardest words to respond to honestly in the English language are "how are you?" We lie. I wrote this book because I wanted to sound an alarm. So many people are in deep emotional pain, for many of us the pain has become normalized. We don't know what our pain looks like, sounds like, feels like. I think many of us think we are the only ones and cannot dare show a kink in the armor. Meanwhile, everybody that we know, everybody on the planet has holes in them. And you never know how many holes there are in the person next to you.

I know that depression is universal. Lack people in this country have a whole other set of circumstances that impact on our pain. We either internalize it and we have major illnesses, hypertension, heart disease, cancer. Or it comes out. We will self medicate with drugs, alcohol, food, sex, gambling, working 24/7, and the hurting and killing each other.

Three years ago I experienced what was probably the darkest bouts of depression I ever experienced. Literally broke down for almost 9 months. Sometimes I would end up at a business meeting and would literally marvel at how I was able to wear that mask, that just two hours ago I was on the floor in tears. It was not just the pain that I was feeling. It was the stress of pretending that I was fine. I think for so many we just do not know how to start the conversation. Black P looks like we are hurting is my expression of faith in the buck community. Let's start the conversation.

Then you find out you are not standing on the ledge by yourself. It is concrete but it is cracking every day because there are so many of us standing on it.

RENTA L NERO:
In this particular clip, the author or the speaker talks about starting the conversation. So some important takeaways from this video is just the simple question, "how are you?" Answering that question requires us to take off the mask. It also risks being viewed as weak, soft, not meeting up to societal expectations. Instead of getting empathy there is a possibility to be met with judgment. Or to have our problems trivialized or to be told that person has it much harder than they do, and say "I'm fine" when asked "how are you?".

The other thing in this video is how black pain is normalized. It is normalized in the sense that throughout the history of African-Americans in this country, especially when you consider the lynchings that took place, especially late 1800s through the early 1950s, that body hanging from the tree was considered other. That you would see lynch mobs there actually celebrating and having a picnic. Or taking pictures with the young, black men or women who were hung.

So what that suggests is that our pain is not others pain. There has even been scientific questions that
have even asked, can black bodies actually feel pain the way others feel pain? So there is a tendency to kind of normalize back pain.

In 2020, we really had a major jolt, black pain, with the videotaping of the death of George Floyd. In that particular moment we saw someone in pain, we saw people standing around doing nothing. And it was at the point when he cried out for his mother that people got a glimpse of what black pain looks like, sounds like, and feels like. And the image I have here on the screen is taken from the lynching Memorial Museum in Huntsville Alabama. So each one of these blocks represents one of 4000, 400 black men, women and even children who were lynched in the United States.

So black paint tends to be normalized and not always taken seriously. The other aspect of black pain that was brought out in the video is not being able to show a kink in the armor. A little bit later we are going to talk about the myth of the superwoman when it comes to black women. And as well as playing it cool when it comes to black men. In other words, we are told do not show pain. Some of you may have even been told growing up, stop crying before I give you something to cry about.

So showing vulnerability, showing pain has not always been embraced or accepted. The other thing that Terry Daniels brings out is that pain or depression can be internalized, externalized. So she gave the examples of developing major diseases, having health issues in terms of pain being internalized. Or the externalization of pain, overworking, and it can even come out as violence, it can come out as acting out, substance use. So oftentimes the pain may not be talked about. But it is certainly felt and it comes out in ways that are not healthy.

She mentioned wearing the mask. And then she ended with – it just looks like we are not in pain. And as clinicians it is important to note when someone sitting in front of us is in pain, whether they are showing it or not.

Three basic learning objectives for today's presentation, that by the end of the presentation you are expected to be able to list at least three risk and protective factors for suicidal behavior among African-Americans. To identify at least three resources within the community that helped to encourage help seeking behavior. And the third learning objective is to be able to articulate the importance of accessing culturally responsive care. I will say it one more time. Culturally responsive care when it comes to historically marginalized persons, and for persons who attach a stigma to receiving mental health therapy.

Let's go ahead and start the conversation by talking about the myth that black people do not die by suicide. And one of the ways to attack the myth is by providing the numbers. And so in 2019, the second leading cause of death for Blacks or African Americans age 15 to 24 was suicide. And that is pretty much what it was for the rest of the population. That for African Americans ages 15 to 24, suicide was the leading cause of death.

During the pandemic it was expected that the suicide rate would actually increase for everyone. However, when the numbers came out in November 2021, what it showed was the suicide rate actually decreased overall. It actually went down for the overall population. But it actually went up for
young adults and for Hispanics and African-Americans. So the COVID-19 pandemic for some, was like collective suffering in that people did not feel as if they were singled out for suffering for the most part. But for African-Americans and for certain parts of the Hispanic community, there was an increase in actual suicide.

Between 1991 and 2017, we started to see this rate of increase. However, it does not seem as if people were alarmed by it. But the suicide attempts for black adolescents actually increased by 73%. And the actual suicide death rates for African-American girls increased by 182% between 2001 and 2017. And so most notably, young people of color are now experiencing an increase in suicidal behavior. And this suicide increase is actually in the double digits as of 2020.

Let's start by busting the myth. Like people died by suicide. It is not at the same number or at the same rate as the overall population or as the white population. It is not at that same rate, but please know that the numbers are going up.

It is important for us to define exactly what is suicide? The most direct answer is that it is death caused by self-directed injurious behavior with any intent to die as a result of the behavior. And so whether a person uses a firearm. Whether they use a method of a fixation. Whether they choose to use an alcohol appeal for a cocktail. Any cause of death that is self-directed is considered to be suicide.

However, I think there is a better definition out there. As a clinicia this is one I use. That I see is a purpose driven behavior designed to eliminate or manage unbearable levels of pain in one's current life situation. Looking at the scale to the left of the screen, when we consider that when people get to the point they feel their pain exceeds their resources, this is someone who is vulnerable to end their life via suicide.

The other thing when it comes to suicide is that it is not based upon one thing that happens to a person. It is not one event. It is a culmination or convergence of multiple factors that lead to suicide. So again, it is important for clinicians, family members, people in the community to be aware of how all of these different factors kind of come together. Because it does take a village to begin trying to mitigate some of these numbers. So it is a convergence of a lot of different factors.

And as clinicians, when we start to see things, the adage I like to use is to encourage people to get help sooner rather than later.

This took us to a very high profile suicide that took a lot of people by surprise. I believe this was much earlier this month. And that was the suicide of Cheslie Kryst. Often when there is a suicide there is going to be a psychological autopsy performed. The psychological autopsy is a forensic technique that is aimed at identifying the specific causes of a suicide.

When people see someone like Cheslie Kryst, they cannot imagine someone like this would ever be a subject of a psychological suicide. She did not fit the typical profile, the stereo typical picture of what depression looks like. She was beautiful, talented, she was a licensed attorney, television correspondent, had a loving family, high achieving. When people looked at her, people who knew her
quite well, unless she confided in them, they did not know that she was suicidal or considering suicide.

Just some comments I have pulled that I saw people say about her. One was "she seemed so happy. She didn't fit the mold of someone who does by suicide." And Gayle King who was her mentor, actually said "what did I miss? How could I miss the signs? There were no signs." So people who actually know her are rocking their brains.

So according to Cheslie Kryst's mother, she said that her daughter has something called high functioning depression. Which she hid from everyone, again, the wearing of a mask. Including her mother was her closest confidant. And that her mother did not know until close to the very end when she actually died by suicide.

Let's look at high functioning depression, and let me start by saying this is not an official diagnosis. It is not an official diagnosis, but what it does is helps to contrast some stereotypes that we have about depression. So when we say high functioning depression, again, it is not an official diagnosis. But it does highlight the stereotype that we have about depression, and who fits the picture of who is depressed.

Often times we think of someone who is lethargic, and who looks sad. Or who is having difficulty sleeping, who is having difficulty getting out of bed and going to a job. We often don't consider people who are successful and high achieving. And even when a person has high functioning depression, they need help as well. They need help dealing with whatever pain they have, even though it may not look as if they are in pain, they need help as well. Although they may look very well pulled together, and they may not fit again the picture of what we expect, these are individuals who need pain – I mean need help with her pain. And can be assisted by either listening, and encouraging them to get help.

And the other thing is that depression, unlike some other illnesses, there are not any predictable stages. So if we are looking at it well, at least they are not at this stage yet or the stage. It is not a progressive illness. It does not have a predictable outcome. There are no set stages. So what that suggests is that it is important for people to get help once there is a recognition that there is some pain there struggling with. And that the efforts they have made for themselves are not working. And that now is the time to consider bringing in a professional.

The other thing to know about depression, and especially high functioning depression, is it is a risk factor for suicide. Even though the person might not look like the stereotypical depressed person, they are still at risk for suicide. And the one that makes it especially challenging for clinicians is the realization that not all people who die by suicide show warning signs.

So one of the other objectives that I just touched upon, high functioning depression is a risk factor for suicide and a risk factor for African-Americans who may not seek out help when they start to experience this pain. One of the things that has been said about high functioning depression is that the person may feel that, my depression is not serious enough to warrant help. Or even professional help.
Another consideration is that because they don’t look like the typical depressed person, that they may not be directed to get help as well. So in red, these are some of the things in particular that I wanted to pull out about high functioning depression. There can be a desire to withdraw from social situations even if the person forces themselves to attend. They may feel lazy, or incapable of doing more than what they are already doing. They may have imposter syndrome, that means that they feel like they are really faking it, even when they are quite accomplished. And that they are tired all of the time. That means they have a difficulty with restful sleep, even if they do fall asleep quite easily. It is not restful sleep.

Suggest some ways of sort of dealing with high functioning depression. Antidepressants or other medications. So just like with the more stereotypical depression, it has been found even with high functioning depression, medication can be effective. Exercise, low impact cardio, being careful about one’s diet, limiting sugar, caffeine and alcohol. Staying off of social media is very interesting. One of the things they called teenagers, they call them screenagers, because it is like their phone is an appendage. And they have it right next to them or are holding onto it quite a bit. It has been found that the more time we spend using social media or staying on our phones or looking at different websites, going on YouTube, whatever we may go, that that actually is going to increase some of the symptoms associated with this high functioning depression. And even people have been told, let’s stay away from the news, let’s take a news break for a while. We don't need to know what is going on 24/7 in the new cycle. And of course cognitive therapy. Cognitive therapy as well as other talk therapies can be quite effective.

Moving to the other, another one of the objectives for today's presentation, and this has to do with resources. So I was looking at the chart and I saw where we have somebody from Houston, wonderful. That is where I am. I am in Houston Texas. Did you know that one of the leading specialists in the area of suicidal behavior in the African-American community is Doctor Rhea Walker who is – sorry, I am just dropping stuff over here, please forgive me – one of the experts of suicidal behavior in the African-American community.

She has a wonderful resource called the unapologetic guide to black mental-health. The thing that I like about the title in particular is the statement “navigate an unequal system” that means it automatically takes into consideration that there are some inequities in terms of how people get help or even the quality of help that they may have. So it takes into consideration disparities. And then it says "learn tools for emotional wellness" so for the people who need resources, so that their pain no longer exceeds the tools they can use it addresses that. And I also like the part that says "get the help you deserve."

One of the things that has been found when it comes to high functioning depression is that oftentimes there is a sense of unworthiness. So telling people to get the help that they deserve, I think that is a very important message to send. So this is a resource that I would recommend. And I would especially recommend this resource for people who may feel that "I can't let people see weakness" or "I can't let people see that I am vulnerable" or "I can't share my pain, there is too much at risk."

So when Carrie Daniels talked about can show a kink in the armor, in her statement about black pain,
one of the terms that has been associated with African-Americans not showing pain, for black men is called "playing it cool." More recently it has been called the "aloof swagger." Not really showing emotion, not really showing how one feels. Because that might make one vulnerable to some sort of emotional or psychological assault or attack.

And the other thing is sometimes really internalizing views of masculinity. So that even if African-American males show up in therapy, there may be a resistance to really talking about what one is going through. And so, for this reason, culturally responsive therapy is important. And even that word resistant is considered to be a negatively tinged word, that word resistant. So looking at it as making sure that the therapist is aware that I am going to have to show myself as being credible. I will need to show myself as being authentic in order for this person to feel that they can trust me. So authenticity, showing up as someone who is credible, trustworthy, those are the kinds of qualities that are culturally responsive. Especially to African-American males who were in therapy. And the number one sought out sort of vowel that a therapist can make, especially with let's say African-American men, is when... People wanting to form that therapeutic alliance that is part of culturally responsive care, and it is especially important when dealing with certain demographics, certain demographics within the population.

For black women there is the superwoman syndrome. This is where black women are expected to put their emotions to the side because there is an expectation that they have to be strong for everyone else. They are not allowed to kind of fall apart. Let's look at the toll this kind of concealment has on black women.

Suicides along black women rose 40% from 2015 to 2020. For black teen girls, the increase was 81% in those five years. And then black people overall, including black women, are less likely to get treatment, even when they are depressed. And for those populations who do have access to treatment, there still may be a tendency to be afraid of the stigma. Again, the stigma says "you are being weak" or the stigma may say "black people don't do therapy" or "black people have other ways in which they can seek help or get help or therapy or get help for their problems, they don't need to go to some therapist." So there is a risk when it comes to not seeking help sooner rather than later.

Let's look at some of the protective risk factors for suicide in African-Americans. Historically, protective factors have been religion, spirituality. The church has often been seen as a refuge. African-American pastors in particular, have been extremely influential when it comes to either they cosign on people going into therapy or they say "no, you need to pray more, or you need to develop some certain disciplines so that you don't have this issue." Religion/spirituality has been a major force.

Self-acceptance, this one is key. Once ethnic identity and how strong one's ethnic identity is, or self-acceptance is a protective factor. If a person accepts who they are and don't allow anyone else to define them, that protects them against oppression, it protects them against wanting to do self harm.

Extended family and social support is another protective factor. So having the play aunts and the play cousins and all of those other kinds of family members who may not be blood, that protect. Having an intact marriage is a protective factor. Having access to culturally responsive care. And then old age. As
if the older a person gets, the less vulnerable they are to those things that would lead to a person feeling depressed or feeling as if they cannot manage, or feeling as if there is no hope. So the older people get, the better protected they are.

So risk factors, substance abuse. Another risk factor – just one moment, my battery is running low. Just a second... Being divorced or separated, lack of access to care, and racism and discrimination. All of those are risk factors for African-Americans. So when it comes to culturally responsive care, the major term I want to mention here, trauma informed principal. When a person has a therapist who is aware of trauma informed principles, that particular therapist understands that some of the clients may have had some adverse childhood experiences. Some of their clients may have had some discrimination, racial discrimination, that they may be an uncomfortable workplaces. That where they live may not be safe. And so having those trauma informed principles are very important.

The other thing is that these interventions expand the lens to include places outside of traditional therapy settings. So for some people, maybe the best place to get help might be the church. There is even talk about people going to beauty salons or barbershops to help promote people getting into therapy, or even having barbershops to talk to people... And then be stigmatizing mental health care. One way of doing this is to let people know that it is OK to not be OK. But it is important to get help.

So I am going to see if I can show a couple of minutes of this video.

SPEAKER:
I just want to let you know you are at the 15 minute mark.

RENATA L NERO:
OK, I am at the 15 minute mark so let me see if I can do this or not. I am going to do it. But I think I can still have 10 minutes left for questions and answers. But I want to show just the beginning of this video, because it shows a black woman whose daughter died by suicide, and her actually having that difficult talk.

(Video plays)

SPEAKER:
We were taking our first family picture. One of them in there, she is OK. We went to take the second family picture, she cried the whole time. There is a picture in there with her brother, and she is staring at it fearful, I don't know what it was about it, he was holding her hand. Even though she was as cute as she was and taking pictures, we are going to take picture she would hide her face. My name is Shirley Duncan, moved to Houston August 30, 1986, that is when we got married. She procrastinated a bit, doing her homework and things like that but she was real smart. She liked art, she did not really like math but she loved English and history.

SPEAKER:
I was always kind of envious of that because I always had to work hard in school and study, but it came naturally to her. She would look over some stuff, get the test and take A.
SPEAKER:
She was always the tallest one and would want to sit up front and they would want her to sit in back, she did not like that much.

SPEAKER:
Back and forth, younger bickering, stuff like that. But when she got older we started to get close and develop – we just decided we were best friends.

SPEAKER:
Over that way is I believe where it occurred. Where Ashley committed suicide. She shot herself in the mouth.

SPEAKER:
I was not aware of the suicidal thoughts. But as far as depression, I was aware of that, while I was in college that was when she was in high school. It seemed like when ever I left is when she went into depression.

SPEAKER:
One of the therapist said, there is something there. She's just not sharing everything.

RENATA L NERO:
I am going to go ahead and ended there. But it is a great video if you get a chance to look at this. But I wanted you to see an example of what it means to have a conversation. What does it mean to get people talking about something that can be highly stigmatized? And so what resulted from in this case, Cheryl Duncan, being able to talk about what her daughter, about her daughter's suicide, is that she started a foundation. The Ashley Jadine foundation, and with it she now works with other parents, and she works in the community to try to prevent and make aware that suicide can be prevented. That people can talk about depression. That it can be destigmatize. And that the importance of promoting help.

So as a result of her engaging in the conversation, that started the road toward healing. So it increased suicide awareness activities. It encouraged families to talk more, text blessed. The process of destigmatize mental illness. The organization partners with universities, churches, community and professional organizations.

And so the first step oftentimes is to just begin the conversation. To begin the talk. So in conclusion, it is important to accept, acknowledge, be aware, that African-Americans died by suicide. And the rates of suicide decreased overall, but increased for African-Americans in 2020. That stigma still permeates, issues around mental illness in the black community.

It is important to have these conversations to decrease the stigma so people get help sooner, rather than later. And it is also important to improve the kind of care and help that is available for people who have issues with mental illness. So creating safe environments where people can have these
conversations, training and preparing all clinicians to be culturally responsive, and to provide culturally responsive care continues to be an issue.

Providing community programs and nontraditional places, for example like a barbershop, and marginalized communities. Places where people feel safe, is a consideration. And educating ourselves about suicidal ideation, and signs to look for, and how to respond to pain.

I have provided some culturally responsive resources. These are online resources. So therapy for black girls, the Loveland foundation, black emotional mental health, also called BEAM. Ethels Club, black men heal, because they have found that is a resource black men in particularly are likely to pursue when it comes to finding a resource for mental illness.

Here are my references. That is it. So if you have questions.

KATHY FITZJEFFRIES:
And we want to just thank you for this exceptional presentation. I could listen to you for another hour or two. I think there is so much information. We do have some questions from our participants.

One question from Jenny's is, how do we manage emotions associated with being in denial versus acceptance of suicide, as many will say it was foul play, someone else did this to them. The complex grief process.

RENATA L NERO:
Thank you so much for that question. At some point, it is important to understand that we can't always reason people out of denial. We can't always do that. What we can do is listen. We can listen. So when people feel safe, they are more likely to be open to other ways of considering a situation. And going back to what (unknown name) talked about in terms of the grief process, one of the things that we do to help ourselves absorb a mental shock is OK, denial. Because to take on that kind of reality, at full force, may be too much. So yes, denial may be part of it. So being able to have a trusting relationship with someone is one of the first steps.

My emphasis would not be on breaking through denial right away. But gaining trust.

KATHY FITZJEFFRIES:
Thank you very much. We have another question. In regard – what is the reason for decrease in so many – decrease in suicide during the pandemic that you mentioned?

RENATA L NERO:
Thank you very much for that question. So when people were considering, what is going to happen with this pandemic, all of the things are really impacting society. One of the things people have come up with is, maybe it is because it was a collective pain. It was a collective struggle. We saw it happening to many people. So for some people it was a collective sort of struggle, the pandemic. However, when they started looking at suicidal ideation. So in 2020 when the American psychological Association that was staying on top of this, they were doing routine surveys, finding out where people
were psychologically, one of the things they started to find out was that suicidal ideation was higher among college students. I think it was one in five or one and four. There suicidal ideation went up. Suicidal ideation was higher in caregivers, caretakers. So people who were caring for infirmed individuals. And suicidal ideation was higher among people who were considered frontline. So those persons who had to work in the grocery store. People who did not have certain kinds of protections when it came to working, and they had to put themselves in a situation where they would be vulnerable to getting the disease, bringing it back home, people who had fewer options.

So at that time they saw increase in suicidal ideation among certain front-line essential workers. In terms of ethnicity, they saw the suicidal ideation increase in African-Americans as well as in Hispanics. And then suicidal ideation, there was also a spike in suicidal ideation after the death of George Floyd. So there were just certain events that led to some groups being especially impacted. By not just COVID, but other things that were happening during 2020, that may have resulted in this bike for some, and for others a decline.

KATHY FITZJEFFRIES:
Thank you for that response. An anonymous attendee asked, Doctor Nero, thank you so much for helping us be braver in addressing such an important and taboo topic in the black community. Do you recommend a specific model, assessment tool or treatment approach that is tailored to the needs of assessing and responding to the risk of suicide in the community? And I'm going to add one other, Elizabeth also added, do you have a favorite training for trauma informed principles?

RENATA L NERO:
And so actually, one of the things I have found to be most effective is relationship. Nothing gets done unless there is a relationship, and that therapeutic alliance. And so developing those qualities that lead to people to increase their level of commitment, to coming back to the therapy session. And so trustworthiness, genuineness, empathy, and when it comes to empathy, cognitive as well as emotional. We cannot always have emotional empathy with people, and we cannot fake it, we cannot pretend. But we certainly can have the cognitive empathy. So knowing the difference.

So I really highlight having a relationship that is based on trust, on genuineness, on empathy, that that is what keeps people coming back. That that is what keeps people coming back. And I do tend more towards CBT, I do tend more toward CBT. And then for some clients, I am going to include what is called SOCBT, and that is a spiritually oriented CBT, for those persons whose faith is integral and central to them being willing to receive help. So that is what I have found to work for me.

KATHY FITZJEFFRIES:
Thank you so much. We are out of time for the questions. We will try to see if we can get these posted, if you can respond. Because there are still so many exceptional questions here. And also, there was a request for the link to the video you showed. So we will check to see if we can get that added to our page so you can connect.

RENATA L NERO:
Oh, the videos. Yes.
KATHY FITZJEFFRIES:
Want to thank you for all you have done, and the information you have shared with us today. Thank you so much.

RENATA L NERO:
You are welcome. It is my pleasure. Thank you for having me.

KATHY FITZJEFFRIES:
I know many of you in attendance our fellow NAADAC members. You may have never attended an NAADAC event before today. We are thrilled to have all of you with us. Before we end this initial session I would like to tell you a little bit about why I love being an NAADAC member. Over the course of the past 30 years I have been a member of various organizations, and by far I found I get the most value from my membership with NAADAC. In addition to a phenomenal array of attending workshops. I would go online, check the websites, you would be amazed at the vast expertise that is there. I also have my liability insurance at a discount rate through the NAADAC. What I have also found is that I feel I have more access to get involved. Including the opportunity to kick something off my bucket list, was I always wanted to present at a national conference and I was able to do that at a national NAACP conference.

But most importantly, getting to be a part of the critical issues in the black community committee, and networking with such phenomenal colleagues. If you are not a member, I would encourage you to join. And not only do you join at the NAADAC, but at the state affiliate you also become a member as well. So definitely I would highly recommend you coming on board with NAADAC.

There is still more to come today. Please join us for our next session, a panel discussion on black professionals in excellence: overcoming barriers by stepping into our professional growth. It is featuring panelist Peter (unknown name), Helena Washington, Chanel Lawson, Curtis Dorsey, Joe Powell. With facilitator Sampson (unknown name). It will begin at 1:30 PM. During this break I encourage you to meet our sponsors. Many have zoom rooms and are waiting for you to stop by to help with ways they can support you in your practice.

You can access them by visiting the summit sponsored webpage. We hope to see you there. Thank you so much. Goodbye.