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A theater intervention to promote communication and disclosure of suicidal ideation

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ABSTRACT

Young adults from Montana have a higher rate of suicide than their national counterparts. There is a clear need for targeted interventions to address this disparity. The authors evaluate a community-based, narrative theater project designed to increase awareness and use of suicide-prevention resources among eastern Montana youth. As a first step, seven group interviews with Montana young adults ($n = 27$) were conducted to identify current perceptions about suicide and suicide prevention. Interviews were conducted before and after subjects were exposed to a community-based theater production about suicide. Emergent thematic categories were organized using the four main constructs of the extended parallel process model. After the performance, participants expressed increased awareness of prevention resources; perceived susceptibility to the threat of suicide and depression; and self-efficacy for accessing help and assisting others. There were mixed results for perceived response efficacy. Implications and recommendations for intervention development are discussed.

Give sorrow words; the grief that does not speak
Whispers the o'er-fraught heart and bids it break. (Shakespeare, *Macbeth*)

Montana currently has the highest suicide rate in the nation (Centers for Disease Control and Prevention [CDC], 2015). In an effort to understand why, researchers collaborated under NIH¹ funding to pilot a community-based, peer-to-peer, theater-centered suicide-prevention program throughout the eastern region of the state for three years. The *Let's Talk* program engaged young adults to write and perform original theater productions about suicide for their peers and communities. Each performance was followed by an actor-audience discussion, facilitated by a licensed mental health counselor.

Let's Talk was designed to increase people's awareness of suicide, and promote help-seeking and referrals for at-risk individuals. *Let's Talk* was chosen as the name for the program in order to confront common misconceptions surrounding communication and disclosure of suicidal ideation. Research indicates that talking is precisely what needs to happen to prevent suicide; one team dubbed this association a 'Papageno

effect,' after a character in Mozart's opera *The Magic Flute*, who 'refrains from suicide because of three boys who draw his attention to alternative coping strategies' (Niederkröthaler, Reidenberg, Till, & Gould, 2014, p. 234).

Using theater programs as a suicide-prevention tool is not new. In 1974, Jackson and Potkay (1974) reported favorable reactions from college-aged audiences to an educational play regarding suicide. More generally, interactive theater has long been recognized as a tool for promoting prosocial behavior and addressing deeply-held stigmas (Miller-Day & Hecht, 2013; Rich & Cargile, 2004; Rodriguez, Rich, Hastings, & Page, 2006). Seeing coping skills modeled through performance or direct interpersonal contact may give students the confidence needed to help their peers in ways not sufficiently supported by traditional curricula (Seibold & Thomas, 1994).

Drawing from research on interpersonal influence processes and performance studies, the hope for this program was to increase help-seeking and intervention through peer-to-peer discursive approaches to education, intervention, and outreach (American Association of Suicidology [AAS], 2016; Rodriguez et al., 2006; The JED Foundation, 2016). As with alcohol prevention and other public health topics, research on suicide prevention shows that didactic education and awareness-raising alone will not reduce the risk (Gould, Jamieson, & Romer, 2003; Niederkröthaler et al., 2014). Instead, more direct and personal forms of influence are needed (Rich & Cargile, 2004; Wasserman et al., 2012). Young adults need to be willing and able to intervene in life-threatening situations affecting their peers. In step with narrative empowerment education, actors in this project were instructed to use personal experiences to communicatively reduce audience members' resistance to openly discussing the risk of suicide, the use of professional help, and the strategies needed to intervene in suicidal ideation and attempts (Miller-Day & Hecht, 2013; Seibold, Cantrill, & Meyers, 1985; Seibold & Thomas, 1994; The JED Foundation, 2016).

Our short-term goals were to educate small groups of students in eastern Montana about the high prevalence of suicide in our state and to increase acceptance of open communication about the topic. The long-term goal was to diffuse a similar curriculum throughout high schools and colleges statewide. Although the incorporation of the *Let's Talk* program by one high school into its standard curriculum is one indication of success, we conducted this study to evaluate the program's effectiveness more scientifically, using the framework described below.

Let's Talk has several components: providing suicide-prevention training to the writer-actors; creating and maintaining a website with videos, phone numbers, and contacts to help in a crisis; posting flyers throughout the schools; and initiating a publicity campaign through local television and newspapers to draw in widespread community support. At each production, *Let's Talk* participants provide reference cards containing crisis prevention hot-line numbers and mental health resources to every audience member. Researchers wanted to determine if *Let's Talk* performances are effective delivery methods for communicating the extent of the state's suicide crisis throughout eastern Montana high schools, colleges, and surrounding communities.

We used the Extended Parallel Process Model (EPPM) (Witte, 1992, 1994) to examine the threat and efficacy components related to the goals of the *Let's Talk* program. We specifically sought to answer the following research questions:

RQ1: Does *Let's Talk* increase participants' perceived susceptibility and severity of suicide?

RQ2: Does *Let's Talk* encourage participants to help themselves, and others? (Perceived self-efficacy)

RQ3: Does *Let's Talk* educate participants about the effectiveness of professional help and other available resources, and their potential to save lives? (Perceived response efficacy)

Our hope was that a performance uniquely informed by the actors' personal experiences presented to audiences made up of their peers, would increase their own and audience members' awareness of suicide, stigma, and where to go for help in a crisis. The idea behind the peer-to-peer delivery was that students would present a stronger message to people their own age.

This article uses data collected during in-depth small group interviews ($n = 27$) to examine perceptions of suicide among high school and college students, as well as the effects of the *Let's Talk* program. The actors and audience members at the university, where one part of the study was conducted, were traditional and non-traditional college students. The actors at the high school plays were adolescents, and their audiences were comprised of other students and community members.

Background

Montana has ranked in the top five states in the nation for the highest number of deaths due to suicide for more than 30 years (Rosston, 2016). The suicide rate statewide was 23.9 per 100,000 in 2014, nearly double the national rate (CDC, 2015). Among other factors, isolation in rural communities and easy access to firearms contribute to the high number of suicides in the state (Uken, 2012). Abundant alcohol consumption, illegal substance abuse (especially methamphetamine), vitamin D deficiency (caused by long, dark winters), and a stoic 'cowboy up' mentality also play a role (Schmidt, 2016). Montana has limited resources to provide mental health care that meets the exponential growth in need, and in-patient psychiatric care is limited. The Billings Clinic is the only mental health hospital serving a vast region that covers much of eastern Montana, Wyoming, and the western Dakotas (Billings Clinic, 2016).

Demographically, eastern Montana is predominantly blue-collar, with jobs clustered around the energy industry (oil, natural gas, and coal) and agriculture (Billings Area Chamber of Commerce, 2016; Falstad, 2009), and '46 out of Montana's 56 counties are considered "frontier counties" with an average population of six or fewer people per square mile' (50 States Facts, 2016). Our research team was uncertain how the play would be received by students and community members in this environment. The concept of using theater to promote public health communication was relatively novel to the region. Results are presented here from the pilot *Let's Talk* curriculum at a rural high school and a state university located in a mid-sized city (approximately 120,000 people) that draws a large percentage of its students from rural areas.

Suicide statistics

Nationally, suicide is the second leading cause of death among 10–34 year olds (CDC, 2015; Ploskonka & Servaty-Seib, 2015). People who are depressed and have a lack of impulse control, or intense, uncontrollable emotional states such as desperation,

hopelessness, anxiety, or rage are at an increased risk of suicide (American Foundation for Suicide Prevention [AFSP], 2015). Today, over 50% of college undergraduates report they have experienced some type of suicidal thinking in their lives, with 18% having seriously considered an attempt, and more than 90% of campus counseling centers throughout the nation reporting substantial increases in mental health problems in recent years (Czyz, Horwitz, Eisenberg, Kramer, & King, 2013). Contagion is a frightening potential consequence of high school and college suicides, as adolescents appear particularly susceptible to imitating the suicidal behavior of their peers (Gould et al., 2003) and young people are particularly resistant to seeking professional help (Brownson, Becker, Shadick, Jaggars, & Nitkin-Kaner, 2014).

Barriers to help-seeking

Research provides a variety of explanations to explain why most adolescents who experience suicidal ideation do not receive help from adult family members or professionals (Cigularov, Chen, & Thurber, 2008; Freedenthal, 2010). Peer confidentiality is one reason; adolescents more often confide in friends, who rarely disclose a peer's suicidal thoughts or behavior when shared in confidence (Carli et al., 2013; Dunham, 2004; Kalafat & Elias, 1992). Cigularov et al. (2008) found that barriers to help-seeking include a strong sense of self-reliance; fears of psychiatric hospitalization; uncertainty about how to talk with one's parents, teachers, or school counselors about problems; and a dearth of adults with whom students feel close. As a result, adolescents at risk for suicide often use harmful coping methods, such as isolation, and alcohol or drug abuse (Gould et al., 2003), instead of having a conversation with someone qualified to ensure they get the help they need.

Unfortunately, teens and young adults have trouble seeing that they, or people they are close to, are in trouble. According to Niederkrotenthaler et al. (2014), this is one of the largest obstacles to seeking effective help. If young people do acknowledge they have a problem, they often do not consider seeking help from others, and the most at-risk people are paradoxically the least likely to avail themselves of external resources because feeling hopeless is another barrier to help-seeking.

Prevention strategies

Over the past decade, numerous youth suicide-prevention strategies have emerged which employ a variety of programs for students and educational 'gatekeepers' (Wyman et al., 2008). Unfortunately, 'in the quest for effective suicide prevention initiatives, no single strategy clearly stands above the others' (Zalsman et al., 2016, p. 646). Many researchers compare their programs to Question, Persuade, Refer (QPR) Gatekeeper Training for Suicide Prevention,² meant to raise awareness of the warning signs of suicide (Rosston, 2016). However, strong evidence from Europe indicates that gatekeeper training of teachers does *not* have an effect on student suicide rates (Wasserman et al., 2012; Wyman et al., 2008). Gatekeeper training has not been shown to be effective, in part, because it relies on placing an additional burden of recognizing suicidal symptoms and making appropriate referrals onto the plates of fully employed individuals (e.g. teachers).

Suicide identification duties increase most for staff already communicating with students at risk (Wyman et al., 2008).

Most student-oriented prevention programs currently administered at the high school or middle school level tend to be fact-based, use lecture-style delivery, and contain content generated by external experts (Cusimano & Sameen, 2011). By contrast, the approach examined in this study gives students the opportunity to explore their own thoughts and feelings about suicide in an interactive communication project. Rodriguez et al. (2006) found that a traditional classroom approach may not be the most effective way to address sensitive health topics, such as date rape. In a review of 13 school-based suicide-prevention programs, Miller, Eckert, and Mazza (2009) found that only two studies demonstrated statistically significant effects.

Interactive learning

An interactive performance model, where students engage dynamically in their own learning through dialogue, experimentation, and movement, has been shown to be more effective than a traditional classroom approach for increasing student willingness to comfort distressed sexual assault victims (Rodriguez et al., 2006). Similarly, Rich and Cargile (2004) achieved success in confronting student attitudes about race through an interactive pedagogical approach, involving immediate feedback and discursive loops, rather than a traditional classroom model. Howard and Ferrier (2009) demonstrated how interactive theater can be effective at reducing prejudice and confronting stereotypes within the news industry. As suggested by the Narrative Engagement Framework, interactive theater can be used to elicit personal narratives, in order to develop messages that are meaningful to other members of a single community, and can also yield important information about perceptions, attitudes and beliefs within a community (Miller-Day & Hecht, 2013).

Community-based programs

In a review of 103 media interventions from around the world addressing a range of sensitive public health issues, Jepson, Harris, Platt, and Tannahill (2010) found that the most effective interventions included a strong community participation component. The few suicide curricula that involve interactive learning and/or links to the community have returned promising early results. Wasserman et al. (2012) found that interactive role-playing with students can affect both suicide attempts and help-seeking behavior, and evidence for community-based suicide intervention strategies outside of schools is growing (Kalafat, 2003; Schulberg, Bruce, Lee, Williams, & Dietrich, 2004; The JED Foundation, 2016; World Health Organization [WHO], 2010). The U.S. Air Force achieved a significant reduction in suicide rates among its personnel using a community-based, interpersonal approach to educate leaders to personally confront stigma, build a culture that promotes help-seeking behavior, and foster a sense of belonging within the community (Haggarty, Craven, Chaudhuri, Cernovsky, & Kermeen, 2006).

In addition to the need for interactive education and community-based approaches, there is a need for interventions that can lessen cultural stigma against mental health problems, open dialogue about suicide risks and losses, and promote professional counseling and prevention services. Interactive theater, a type of performance noted for its collaborative nature and ability to respond to emerging needs (Howard & Ferrier, 2009) was the

basis for the *Let's Talk* program, in order to foster cultural shifts within schools and rural communities.

A community-based theater approach to preventing suicide

Over the course of three years, the *Let's Talk* research team hosted and facilitated theater workshops with four different groups of students to address the risk of suicide. Each writer-actor group met bi-weekly for 12 weeks to share their personal experiences with suicide and/or major depression, and to collaboratively write a unique play based on their experiences. At the end of the writing-rehearsal period, the writer-actors staged performances for their peers, after which they held discussions with audience members. Each discussion was moderated by a psychiatrist and a volunteer trained to help answer difficult questions and elaborate on the discussions that unfolded during the Q&A. The performances and subsequent discussions were intended to teach other students and community members how to talk to their peers and mental health professionals about suicidal ideation, loss, and prevention.

Recruiting, writing, and rehearsal

High-school counselors and a university theater director recruited the writer-actors. Student status and interest in the program were the only screening criteria used to select these participants. They did not undergo mental health screening, but voluntary reports of mental illness or history with counseling were noted. Prior to the start of the program, all writer-actors signed consent forms and received QPR training. For participants under age 21, parental consent was obtained.

At the initial workshop rehearsal, a director (manager of a community theater and a university theater professor) gently probed the writer-actors' experiences with stress, anxiety, depression, alienation from school and home, and relationships. As suggested by the Narrative Engagement Framework (Miller-Day & Hecht, 2013) students were encouraged to share their personal narratives in order to develop messages that would be meaningful to other adolescents or young adults. During the writing/rehearsal period, discussions and improvisational exercises guided by the director addressed students' desire to be impervious to bullying, the myriad challenges faced by individuals coming from rural backgrounds, and the challenges of attending large schools. The feeling of having a 'misfit' identity, coupled with the desire to fit in, was a common theme. Overwhelming feelings of being alone, and a sense of engaging in perpetual competition with their peers, were salient throughout the discussions at both the college and high-school levels.

Throughout the playwriting process, workshop members shared journal entries, stories, memories, songs, and poetry with the director and the rest of the group. By contributing creative non-fiction based on their own experiences with self-harm (e.g. cutting), suicidal ideation, suicide attempts, and grief over a friend's or family member's suicide, the writer-actors collaboratively created an original narrative theatrical performance (Langellier, 2009; Miller-Day & Hecht, 2013, p. 658). One of the college-aged writer-actors said, in a debriefing interview:

When we first starting coming up with our script, we weren't sure how we wanted to portray our story. [The director] would ask us questions about our experiences and our message, we would answer and write on the chalkboard. We realized early on that we all had very different experiences and that we could use that. As soon as we heard J and S's poems, we started to form the idea about choreographing stories rather than using traditional dialogue. In addition, we thought about the way we deal with the voices of anxiety and depression, I feel like every piece of the performance was started by one of us and built on by all of us bouncing ideas and thoughts off of each other. Except for choreography, we knew what we wanted to say, but [the director] showed us how to say it. (Cathy, 21)

Performance and discussion

At the end of the rehearsal period, 10 performances by 5 writer-actors were staged at the university level; three performances by 15 writer-actors were staged by high-school students. Performance venues varied from university settings to community theaters to regional high schools, and audiences were recruited through classroom announcements and community-wide publicity. Before each performance, audience members were given reference cards containing crisis prevention hot-line numbers and local mental health resources. A member of the research team introduced each performance with a brief explanation of the *Let's Talk* program, the importance of the research, and the need to eradicate stigma surrounding mental illness and suicide. Each performance lasted 20 minutes, followed by a moderated 40-minute Q&A session.

In addition to dramatizing the distress that mentally ill and suicidal people experience, each performance was designed to model: (1) adaptive decision-making strategies in times of stress, (2) accessing emergency help, (3) providing ongoing support to peers during a crisis, and (4) identifying at least one caring adult in the school or community from whom to seek help (Mazza & Reynolds, 2008; Miller et al., 2009). Following this structure, in their opening scenes, the performances demonstrated the destructive power of negative self-talk. For example, the college play opened with a young woman's inner voice saying to: 'Look at all those people out there staring at you, judging you, waiting for you to mess up like you always do. All you do is ruin everything you touch.' In another play, a male high-school actor shared a monologue on experiences with and perceptions of stigma:

Each day I walk through those doors and try to make it to my locker as fast as possible. I would say it's the words that hurt most, but honestly it's the silent judgment that comes from the peering eyes of those around me. It's the whispered words that appear as my back turns to the cowardly. It's the complete lack of understanding that takes place in this melting pot of awful. Now we're asked to be who we are and embrace the weird, but how can we do that when society demands we reject ourselves. (Adam, 16)

In addition to negative self-talk and stigma, the scripts covered barriers to help-seeking. One high-school actor described the pressure to seek salvation through organized religion, and to keep one's troubles inside:

How do you ask for help? My parents told me to pray and I'll find answers. But I've tried. Obviously it hasn't worked. Pastor says it's all part of His path for me. But I don't like this path. I want a different path. One where perfection is easy. One, one where my parents don't tell me I'm going to hell whenever, whenever I'm not perfect. When we have real friends, ones who care, ones who don't tell me that I don't have the guts whenever I confide in them.

Then, as they went on, the performances became progressively more hopeful:

Reach out to someone, get some help it will help you, it might not get better, but you will get stronger, you're worth everything. Things might really suck right now. They may be worse than they've ever been, but think ok, how do I get through this? The counselors at the college here are super friendly. The people answering the phones on the hotline are literally some of the nicest people I've ever met and they will talk to you for hours and let you talk about anything.

At the end of the play, the director introduced the writer-actors and mental health professionals who would moderate the discussion, and initiated the Q&A session. The performers sat on the edge of the stage facing the audience. The first question, posed by the director or an actor, was always: 'How many in here have had some experience with suicide?' Most audience members and actors would raise a hand. Following this opening, each Q&A was different, based on the audience. Sometimes, audience members would spontaneously start sharing their own experiences with loss and asking questions of either to the moderator or the performers. For example, after one college performance, an audience member spoke up right away, saying:

My dad has been depressed and suicidal after he lost his job. He's been out of work for over a year. I brought him to your performance last week. Afterwards, our family sat down and talked about it together, but I'm here again because I'm wondering what more I can do to help my dad?

Other audiences were more reticent, in which case, the moderators would try to initiate a conversation by discussing barriers to help-seeking and highlighting available resources. One moderator told audiences: 'People think so many times, "If I ask for help, it's a weakness." The truth of the matter is an individual who is willing to seek help and to receive help is demonstrating strength. That's not a weakness.'

With more reserved audiences, the moderators would pose open-ended questions, encouraging audience members to share their concerns and discuss barriers to help-seeking and open dialogue about suicide and suicidal ideation. Inevitably, audience members would talk about their experiences. In all situations, the performers would participate in the Q&A, talking about their experiences with surviving suicide, counseling, trials and errors involved in finding the right mental health professional, and sharing their individual experiences of stigma within their communities, schools, and homes.

Theoretical context

The EPPM (Witte, 1992, 1994) theoretical framework used in this study has been used effectively to both generate and evaluate messages intended to motivate health-related behaviors (Cameron, Witte, Lapinski, & Nzyuko, 1999; Kline & Mattson, 2000; MaGuire et al., 2010; McKay, Berkowitz, Blumberg, & Goldberg, 2004; Witte, Berkowitz, Cameron, & McKeon, 1998; Witte, Cameron, McKeon, & Berkowitz, 1996). EPPM posits that respondents are more likely to change their behavior in response to a health message if both the perceived threat and their perceived efficacy (including *self-efficacy*, behavior-specific self-confidence, and *response efficacy*, perceptions of the effectiveness of the recommended solution) are high. However, Witte (1992, 1994) warns that messages that increase the audience's perceived threat without simultaneously increasing their perceived

efficacy to make a change can stimulate unhealthy coping mechanisms, including defense-avoidance, denial, or reactance (i.e. blaming the messenger).

The threat component of EPPM includes both the perceived severity and perceived susceptibility of a health threat (e.g. 'Is there really a suicide epidemic?' 'Am I at risk for suicide?'). The efficacy component of the model includes both perceived self-efficacy and perceived response efficacy. Perceived self-efficacy refers to beliefs as to whether or not one is capable of performing the behavior in question (e.g. 'I am able to get professional help if I feel I'm depressed or have suicidal ideation'), whereas perceived response efficacy relates to one's belief in the effectiveness of a specific recommendation/proposed behavior (e.g. 'Speaking with a professional counselor will help reduce my depression').

Research method

Group interview procedure

To determine the impact of the *Let's Talk* program, we conducted an Institutional Review Board-approved qualitative study, sited in high school and university campus facilities. Consenting individuals from both the writer-actor and audience groups were interviewed twice, once before and once after the 12-week rehearsal and production workshop. Seven small group interviews were conducted, three comprised of high-school students and four of college students. All writer-actors ($n = 20$) participated in the interviews; audience members ($n = 7$) were recruited in classroom settings and after-school programs. While age homogeneity is recommended in studies such as this one, the high number of non-traditional students at the university produced a broad range within our subjects – from 14 to 42 years old. Sixty-six percent of participants were female. Interview group sizes ranged from two to six people, and groups were divided by type of involvement, either audience members or writer-actors.

During these sessions, the research team collected personal narratives, field notes, and visual images (van Schalkwyk, 2010). All interviews were moderated by a university researcher trained in qualitative research methods, and were video-recorded. Following a semi-structured approach (Denzin & Lincoln, 1994; Kvale, 1996; McCracken, 1988; Miles & Huberman, 1994), interviews explored participants' attitudes and knowledge about suicide and help-seeking, as well as their past experiences (positive and negative) with suicide and mental health counseling. All group interviews were recorded, transcribed verbatim, and compared with the original recordings to ensure transcription accuracy. Personal identifiers were removed and transcripts were distributed for coding, described below.

Interview questions were derived from EPPM theory. In the post-test round of interviews, after writing/performing or viewing the play (depending on the group), participants answered questions regarding self-identified changes in their perceptions of the EPPM constructs discussed during the first interviews. Because EPPM emphasizes people's *perceptions* of threat and efficacy (rather than objective measures of threat and efficacy), post-interview questions focused on participants' perceptions of how the *Let's Talk* project had helped them (or not). For example, a typical post-intervention question (RQ2) was, 'I'm wondering if the experience of both focus groups and the play helped you feel more confident about your ability to access help ... counselors, professional resources, websites,

hotlines?’ Other questions were written to help explore RQ1 and RQ3, including the following, which have emphasis on perception added in italics:

RQ1, pre-intervention: “*What are the perceptions* that people have in Montana of suicide?”

RQ1, post-intervention: “Culturally, it seems like it’s pretty common that people distance themselves from difficult emotions or mental health problems. *Do you notice that? And why do you think* that exists?”

RQ3, pre-intervention: “Are there programs in place already that *you think* would be effective?”

RQ3, post-intervention: “*Do you feel like Let’s Talk* gave you any useful tools for helping yourself or other people?”

The emphasis in all questions was on the subjects’ perceptions, based on their experiences and beliefs, rather than on any behavioral changes made in the time between the first and second interviews.

Data analysis

Graduate research assistants received training in qualitative data analysis prior to the study. Two senior investigators and two graduate assistants read and coded the interview transcripts and documented their interpretations (Strauss & Corbin, 1990) using a priori conceptual constructs found within the EPPM: threat components and efficacy components. The entire team then compared and corroborated our coding and memos, returning when necessary to the original transcript data, looking for themes and their interrelationships (Strauss & Corbin, 1990; Wolcott, 1990). Discrepant interpretations led to in-depth discussions among research team members, and ultimately to a richer understanding of the data and of participants’ experiences. Through this iterative process, the team reached agreement on the themes pertaining to conceptual constructs found within the EPPM.

The fundamental structure of our analysis compared students’ answers collected before their participation in the program with their answers after the performances. The research team first evaluated interview participants’ (both writer-actors and audience members) overall perceptions of the phenomenon of suicide. We probed for their perceptions of the severity of the problem, the effectiveness of available resources for people experiencing suicidal ideation, and of their ability to help themselves, or other people, use these resources.

Next, we assessed specific components of the EPPM framework pertaining to subjects’ perceptions after the *Let’s Talk* intervention. We examined both writer-actors’ and audience members’ pre- and post-performance statements regarding their perceptions of the play, and of cognitive, emotional, and behavioral changes they felt were the result of their participation in the *Let’s Talk* program. Themes related to the threat that suicide poses in Montana (RQ1) were coded as *perceived susceptibility* and *perceived severity*. As the efficacy component of the *Let’s Talk* program is critical to its success, we looked most carefully at themes coded as *self-efficacy* (RQ2) and/or *response efficacy* (RQ3). For response efficacy, we attempted to ascertain whether the educational messages in the performances pertaining to professional mental health services had been heard and understood (RQ3).

Results

Threat components: writer-actors

Pre- and post-involvement in the *Let's Talk* program, the writer-actors in both high school and college expressed high perceived likelihood of attempting suicide, or losing a friend or family member to suicide, a collection of beliefs coded as *perceived susceptibility* (Witte, 1992, 1994). One example of perceived susceptibility comes from Jill,³ age 31, who has suffered from mental illness since she was 17: 'I get depressed. I've tried to kill myself and my friends have tried to kill themselves. So, suicide has always been a big part of life, unfortunately.' Losing a friend or family member to suicide was also coded as perceived susceptibility. 'I attempted a few times, but after my brother took his life shortly after returning from Afghanistan ... everyone just chalked it up to PTSD,' said Susie, 22. As a result of their own and others' experiences, all the writer-actors were highly attuned to the impact that suicide has on individuals and families, that is, *perceived severity*. The effects of suicide were often felt first-hand, as in Susie's case: 'I saw what my brother's suicide did to my parents.'

Writer-actors who had experienced mental illness personally (or in a family member or friend) perceived the threat among others, even when it wasn't made explicit:

We had way too many [audience members] who knew someone who had dealt with suicide or had committed suicide, but also a lot of people who probably had never met somebody or spoken to them about having depression, anxiety, or any type of mental illness. (Cathy, 21)

All of these discussion topics fell under the supra-code named *threat components* (RQ1).

The *Let's Talk* program did little to affect threat components among the actors with self-reported mental illness or personal losses to suicide among friends and family, possibly because their perception of the threat was already high, as evidenced in this quote from Hank, 17, a high-school actor who grew up in a family environment laden with anxiety and depression:

It's weird because suicide and depression are something that aren't brought to the forefront and a lot of people put on a face and definitely hide behind it. But the fact is, it's so common. I know I have different family members who have dealt with depression and severe anxiety and stuff. And, like, there is a lot of stuff going on with them. And I think going through [the workshop], there's a lot of motive for me specifically to help people with something they're going through, even when it's not apparent.

Threat components: audience members

Compared to the writer-actors, audience members typically had fewer direct experiences with suicide. However, they demonstrated emotional and cognitive growth after watching and discussing the experiences their peers depicted during the *Let's Talk* performances. Rebecca, 44, said of the student performers: 'If you got the best actors in the world, I don't think it would be as powerful as it was.' While audience members' *perceived susceptibility* toward their own vulnerability to suicide did not notably increase after seeing a *Let's Talk* performance, they almost unanimously agreed that seeing the performance had increased their *perceived severity* of the threat around them.

Abby, 34, affirmed that watching the play had increased her ability to acknowledge the scope of the threat, stating: 'There are really no true signs. Someone I said hi to yesterday, could easily go home and do something. You know, I mean that's ... it's crazy to think that is just a split second choice.' Rebecca apparently agreed with this conclusion, saying: 'I think maybe this is more prevalent than I realized. Because it is something that people don't want to talk about.' In short, while audience members' perception of their susceptibility to suicide did not noticeably increase after seeing a *Let's Talk* performance, their understanding of its prevalence and impact, and their willingness to talk openly about the topic increased (RQ1).

Efficacy components: writer-actors

Perceived self-efficacy (RQ2) refers to beliefs about whether or not one is capable of performing the behavior in question (e.g. 'I am able to talk to a counselor,' 'I am able to help other people'). Coded themes related to perceived self-efficacy largely revolved around interview subjects' increased willingness to talk about suicide, increased self-confidence to help others, and increased willingness to contact professional help. After the workshops and multiple performances, the college writer-actors indicated levels of empowerment and perceived self-efficacy that transcended our expectations (RQ2). One student said proudly:

I know we did [the play] in a good way. We made it really relevant, not only to us –what it's like to deal with [suicide], especially what it's like to deal with having mental disorders and thoughts of suicide in college. (Cathy, 21)

Echoing this feeling of confidence, another college writer-actor added:

We are going to use that growth and those skills every day of our lives, even when we are talking to little children. We are going to learn how to bring it down to their level so they understand ... I think every day we are going to use a skill we used from this play. (Melissa, 31)

High-school writer-actors also perceived an increased sense of self-efficacy after their involvement with the project. In response to a question about how the *Let's Talk* program made him feel, Jarred, 16, replied: 'Oh, powerful. No adult has ever asked for my help. Anyway, I just felt powerful. I just had the knowledge to help people. Words are powerful – they can hurt or help.' Increased self-confidence was also related to helping oneself. Hanna, age 15, said the play helped her realize that she had self-worth and wanted to live: 'I have the most important thing to live for ... myself.' Despite the positive outcome the program had overall, students' responses were not naïve, nor overly optimistic. While the play increased participants' awareness of the value of listening and talking to their peers, for at least one participant, it simultaneously increased his appreciation of the limitations on his ability to save people. Discussing a hypothetical situation that could end badly, Matthew, age 16, expressed a nuanced combination of ambivalence and fear:

Well, I would want them to come to me [but] I kinda don't want them to come to me ... I'll talk them through it but my words didn't really help them and they end up killing themselves, so it's a burden on me, like, 'Ahh I didn't end up helping them!' I'd be sad. I don't wanna have that burden but also I wanna help them. It's like Russian roulette.

Perceived response efficacy (RQ3) relates to one's belief in the effectiveness of a specific recommendation or proposed behavior (e.g. 'Speaking with a professional counselor helps people cope with depression'). As a group, even before their participation in the project, writer-actors were familiar with professional counseling and had confidence in its ability to work; that is, they perceived high response efficacy towards professional counseling that did not change as a result of their participation. Given that the writer-actors had volunteered for the workshop, performances, and research components of the *Let's Talk* project, this is not a surprising finding. Cathy, 21, summed up the overwhelming perception that the writer-actors expressed, saying: 'I've always been super pro-counseling. [Although] we're not qualified to help our friend beyond a certain point, we can get that friend to the place where they can be.'

Efficacy components: audience members

Most audience members' perceptions of the efficacy components of *Let's Talk* increased substantially due to the intervention. While some participants said that their feelings about professional counseling and suicide-prevention resources remained the same after the performances, nobody reported feeling *less* competent, or less likely to access professional help. Audience members indicated an increased willingness to talk openly about suicide, and increased perceived self-efficacy (RQ2). As one high-school audience member said:

I think before we'd all want to be a good friend to [a suicidal friend or family member], so we'd hope they'd come to us, but definitely after this project there's way more incentive and we're definitely more prepared for that. (Brian, 17)

One college audience member echoed this readiness to listen more closely to her friends and family, vowing to: 'Not 'act 'like I care, you know, but more of a "be present" with who you're face-to-face with, you know?' (Abby, 34).

At both the high- school and college levels, post-performance audience members also expressed increased confidence in the effectiveness of professional help (RQ3, perceived response efficacy), even if it was high to begin with. For example, when asked if the play had changed her attitude towards accessing help, Rebecca emphatically stated, 'it just added on to it.' Brian (17) said: 'I feel like we've all gained so much in terms of dealing with how these thoughts come about and how to take action.' During the Q&A sessions, audience members voiced substantially increased perceived response efficacy toward counselors, prevention resources, websites, and crisis hotlines.

An unexpected result was that after participating in the project, interviews with audience members of all ages revealed strong perceived response efficacy toward the *Let's Talk* program itself as a suicide-prevention tool. One college audience member, who, between her first and second interview sessions, had a co-worker attempt suicide, suggested that *Let's Talk* would benefit a variety of communities, including workplaces, where professionalism precludes true interpersonal communication:

I believe now more than ever that this kind of stuff is important. Like, we need to get the word out there and raise awareness. Because, I mean, [suicide] is so not the way to go Experiencing it – on top of the play, on top of everything – really reshaped the previous opinion I

had on it and I think I formed that opinion just from being on the outside looking in at everyone else, you know? (Abby, 34)

Another audience member discussed how the performance helped her feel less alone with her problems:

You know, it just helps put everything together for more application. And you know also to help understand just how many people deal with it. So you don't feel like such a freak or get lost It's just not something you talk about, but I think if we can permeate more avenues with performance than traditional clinical settings, or books on it, or things like that, I think that's going to help. (Rebecca, 44).

Discussion and conclusion

Public health programs that activate people's threat components or simply increase knowledge of a threat, without also effectively giving them tools or coping skills to eliminate or mitigate the threat, can have the opposite of the intended effect (Miller et al., 2009; Witte, 1992, 1994). Therefore, the *Let's Talk* program is designed to raise participants' perceptions of all four factors of EPPM, emphasizing the efficacy components and underscoring the message that, despite its prevalence, suicide is not an inevitable part of life.

Our analysis of *Let's Talk* suggests that theater-based, narrative engagement approaches can support comprehensive suicide-prevention programs by helping identify and address entrenched beliefs and stigmas, and by empowering participants in an unusual, engaging, and memorable way to learn about and access resources within their communities. As Hal, age 16, a high-school writer-actor, put it: "This topic in general is something hard, but it creates something so revolutionary, and in our community it's something so amazing, that I think all of us will take with us after this production."

By allowing them to share their personal stories, the narrative format of the *Let's Talk* approach enables both actors and audiences to acknowledge each other's vulnerabilities and fears, and collectively grow stronger (Miller-Day & Hecht, 2013). Langellier (2009) describes such performances as vehicles for empowerment and sense-making: "The sense of performance as constitutive emphasizes the making of stories, selves, and meanings." She suggests that, through performance, individuals can simultaneously tell their stories and co-construct meanings with audiences (Bochner, 2009; Langellier, 2009, p. 152).

The results of the *Let's Talk* program, so far, are promising, but mixed, based on participants' prior knowledge. Because Montana has such a high suicide rate, all participants—both writer-actors and audience members, in both high school and college—had fairly high perceptions of threat susceptibility even prior to their involvement with the program: "I haven't ever dealt with suicidal thoughts or anything but I've had a lot of friends who have and so it's really important to me that they can come to me and stuff" (Hal, writer-actor, 16).

For participants with little prior personal experience with suicide, participation in the program demonstrably increased their perception of the threat it poses (RQ1). As one audience member explained: "It did make me realize the masks that people have. You can't assume that people are feeling or acting a certain way, because you don't know what's under the surface" (Abby, 34). Participants in both age groups believe that replicating the program within different communities could help break the silence surrounding suicide, raising community awareness of the problem and the help that is available.

Overall, across all groups, participants' perceptions of efficacy – both perceived self-efficacy (RQ2) and perceived response efficacy (RQ3) – increased after the *Let's Talk* performances. The high-school writer-actors were extremely positive about the impact of the program, for themselves and their peers:

This program with the message we're trying to convey here – probably the most rewarding piece I've ever been involved with. And to know that we're putting something out there that's really breaking down walls to me – that's what I would say. And it's the best feeling in the world. I don't want to say this topic is good; but it's good the walls are coming down. (Kevin, 16)

Interestingly, the perceived efficacy components results are varied in a way that suggests that students' prior life experiences may produce quite different outcomes from their involvement with the *Let's Talk* program. We found that students with prior history of suicidal loss and/or depression seemed to demonstrate greater perceived self-efficacy after their involvement with *Let's Talk*, perhaps from being allowed to openly acknowledge their status as survivors. On the other hand, students with less direct experience with suicide demonstrated greater perceived response efficacy after the plays, perhaps as a result of simply learning about resources available within their communities. These findings indicate that even when targeting communities of participants who are demographically similar, future iterations of the program would be well-served by anticipating and incorporating a range of participants' emotional needs.

Furthermore, one exogenous, possibly influential factor that the research team did not anticipate, was the different sizes of the theaters where the plays were performed. The college performances were held in a small, intimate, black-box style venue (holding no more than 30 audience members, who are seated on three sides of the stage). The high-school performances, in contrast, were staged in larger venues (traditional proscenium-style auditoriums with seating capacity up to 500), leaving the writer-actors and audiences physically disconnected from each other and making both the performances and the Q&A sessions less intimate and potentially less effective. As the program continues to evolve and expand to at-risk populations beyond students, such as military veterans, residents of American Indian reservations, and senior citizens (AFSP, 2015), researchers, administrators, and facilitators must do what they can to mitigate situations and dynamics that might result in negative participant outcomes.

As for limitations, a small sample size limits our ability to generalize our findings beyond the scope of this study. The nature of our data (i.e., participants' narrative self-reporting) does not allow for definitive comparisons between pre- and post-intervention attitudes and beliefs. Furthermore, the lack of post-participation behavioral data does not allow our team to observe, or predict, whether self-reported attitude changes affect subsequent behavior. However, we must note that it is difficult to evaluate any mental health program's impact on behavior, regardless of the methodological approach; most quantitative suicide studies can only measure proximate variables that are considered predictive of suicide, such as suicidal ideation and past attempts (Bogenschneider, 1996; Izzo, Connel, Gambone, & Bradshaw, 2004; Miller et al., 2009; WHO, 2010). Clearly, more research must be conducted--preferably, using mixed-methods approaches (Niederkröthenthaler et al., 2014)--to systematically evaluate the impact of the *Let's Talk* program

on diverse communities of participants and on behavioral (or at least empirically testable) outcomes.

Nonetheless, the findings we present above are robustly supported by both EPPM theory and our interview data, and create an opportunity for analysis and further refinement of the *Let's Talk* program. The promising results of this pilot indicate that community-based theater programs, such as *Let's Talk*, offer a potentially effective approach to reducing suicide. Entire communities can become gatekeepers and guardians, and work to promote communication. In this way, communities can increase awareness of the threat of suicide, reduce barriers to disclosure, and encourage people to access resources they can use to help themselves and others.

Notes

1. National Institutes of Health under Award Number P20GM103474.
2. The QPR Institute has been listed as an evidence-based practice in the National Register of Evidence-based Practices and Policies (NREPP). <http://www.qprinstitute.com/pdfs/NREPPRelease.pdf>
3. All names have been changed.

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