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Mapping the ACEs–Suicide Connection: Voices of Young Survivors in Marginalized Communities

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ABSTRACT
Youth suicide is an important worldwide health issue, and self-injury is one of the top three reasons that make people aged between 15 and 24 die (World Health Organization, 2021). Marginalized and rural communities are especially vulnerable to this problem as poverty; structural inequities and lack of access to mental health services interact to increase risk. Youths in such environments usually face social isolation, mental illness cultural stigma, and broken healthcare systems which may increase psychological distress and undermine protective resources.

Introduction and Background
Youth suicide is an important worldwide health issue, and self-injury is one of the top three reasons that make people aged between 15 and 24 die (World Health Organization, 2021). Marginalized and rural communities are especially vulnerable to this problem as poverty; structural inequities and lack of access to mental health services interact to increase risk. Youths in such environments usually face social isolation, mental illness cultural stigma, and broken healthcare systems which may increase psychological distress and undermine protective resources.
As a result of studies conducted within the last 20 years, Adverse Childhood Experiences (ACEs) that encompass abuse, neglect, and household dysfunction have been found to be powerful predictors of suicidal ideation and attempts (Felitti et al., 1998; Dube et al., 2001). The initial ACE Study by Felitti et al. (1998) recorded a potent, graded connection among the number of childhood tragedies and the well-being results of the victim in adulthood, including suicide danger. Later research has affirmed that every extra ACE increases the risk of self-harm, but these studies have tended to depend mainly on large scale surveys or clinical samples, and little has been done to capture the finer details of the experience of youth in resource-deprived, culturally differentiating locales.
Less research has been conducted on the personal accounts of young suicide attempt survivors who have either a rural or otherwise marginalized background. The qualitative descriptions can help shed light on how survivors interpret the interaction between

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childhood trauma and sociocultural forces and coping styles leading to a suicidal crisis (Rankin & Quirk, 2020). After raising these voices, we come to understand the subjective realities of statistical correlations and discover culturally specific resiliency pathways.

The current dissertation endeavors to fill these gaps and investigate in a detailed and qualitative manner ACEs and suicidal behavior in young survivors in three rural counties that are under-resourced. The research will record: (1) how the ACEs caused the survivors to develop suicidal thoughts and behaviors; (2) the sociocultural and structural forces they believe contribute to making the crisis worse or better; and (3) the resources and strategies they use or have used to help them recover. The end goal is the creation of a contextual based prevention and intervention model that will appeal to the realities of the marginalized youths.

Literature Review

Adverse Childhood Experiences and Suicidal Behavior

The influential ACE Study conducted by Felitti et al.(1998) made use of retrospective self-report among the adult population to illustrate that the count of ACEs was firmly and progressively correlated with a multiplication of morbid health results, such as attempts to commit suicide. Dube et al. (2001) took the risk further and directly examined the lifetime risk of committing suicide based on the number of ACEs; the data they obtained showed that of those who resorted to four or more ACEs, they were approximately 12-fold more at risk of suicide as compared to their counterparts who did not report any ACEs. The implication of this type of research is quite clear: the accretion of accrued series of the early trauma of the self-defeating conducts.

Along with the prevalence, Pillemer, Holt, and Keenan (2014) interrelied ACEs and suicidal ideation through psychological mechanisms, and established that depressive and anxious symptomatology mediated, in most cases, the relationship between the former and the latter in teenage years. This information is informative, but quantitative research is likely to disregard the subjective significances and contextualities that determine the manner in which individuals perceive and respond to childhood traumas, particularly among the youths.

Youth Suicide in Marginalized and Rural Communities

At-risk youth, especially in rural areas, experience increased risk factors that combine with ACEs to increase the proclivity to suicide. One study by Jacobs and Ball (2010) showed that the suicide rates, particularly among adolescents, were negatively associated with the presence of mental health professional in the rural counties, and an availability of a service, therefore, was a decisive factor in engaging in self-harm. Moreover, Wilson and Good (2013) investigated the combined impacts of race, socioeconomic status, and exposure to ACEs on risk of suicide among urban minority adolescents, which demonstrates that systems disadvantage accentuates the effect of early trauma.

In rural settings, there are more obstacles, such as great distances to healthcare providers, unstable broadband coverage via telehealth medium, and closer communities where the norms to deal with mental health disorders are stigmatized (Hassan, 2014). This barrier may increase isolation and deter seeking help, and this may reduce the effectiveness of traditional prevention methods.

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Survivor Voices and Qualitative Approaches

The experiences of those who have survived suicide attempts provide invaluable information about the experienced routes through trauma to crisis and then turn to healing. The interview conducted by Rankin and Quirk (2020) included young adults who experienced sexual abuse, and the identified themes were the idea of the betrayal of the people who should care about them and the desire to meaning. Their thematic analysis also stated the roles of personal understanding of ACEs to make people self-harm and how this affects their further post-attempt lives.

Thematic analysis, described by Braun and Clarke (2006), is a methodologically structured but adaptable method of identifying patterns in qualitative data and constructivist grounded theory, identified by Charmaz (2006), helps to draw theory that is strongly rooted in the experience of the participants. These designs fit well to achieve culturally entrenched variables that affect suicidal tendencies as well as resiliency in marginalized contexts.

As noted by Sands and Murphy (2015), cultural practices that include ceremonies shared by the community and spiritual custom were important in making Indigenous youth feel belong and hopeful. Although using such cultural salient aspects in the qualitative research process allows relevant validity, the accounts of participants are also respected in terms of their contextual integrity.

Resilience and Cultural Specificity

The research on resilience focuses on the protective factors that would help to counter the adverse impacts of ACEs. Bethell et al. (2016) established the buffering protective factors in regards to negative health outcomes and isolation are supportive adult relationships, community involvement, and engagement within school. They stress on the need to strengthen these assets in prevention program through their population-based analysis.

With the help of the Integrated Motivational-Volitional (IMV) model of suicidal behavior, (OConnor & Kirtley, 2018) suicidal ideation to suicidal behavior can be discussed in its wholeness. Its focus on the use of motivational moderators (perceived burdensomeness, and social support) does resonate with qualitative research findings indicating that culturally targeted peer groups, faith-based programs, and locally themed psychoeducation have the potential to destabilize suicidal coursework.

Research Gaps and Conceptual Framework

Despite robust epidemiological evidence linking ACEs to suicide risk, few studies have centered the voices of marginalized rural youth or integrated their narratives into existing theoretical models. Most research relies on secondary data or urban clinical samples, limiting ecological relevance. A qualitative, participatory approach is therefore essential to develop a nuanced, culturally congruent framework.

In this dissertation, semi-structured interviews with the young suicide attempt survivors in three rural counties will be used together with key informants interviews of the community stakeholders. The thematic analysis protocol of Braun and Clarke (2006) based on IMV model will be used to analyze data (O'Connor and Kirtley, 2018). The derived idea map will follow the pathways of ACE exposure to suicidal crisis and recovery with the help of sociocultural moderators, thus establishing leverage points where interventions may be targeted and tailored to specific contexts.

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Problem Statement

Youth suicide has become a significant global public health issue, and self-inflicted injuries are among the top causes of mortality among young people (15-24 years old) (World Health Organization, 2021). The rate of suicidal behavior in marginalized and rural populations is also disproportionately high, partly because of deeply embedded socioeconomic disparities, cultural stigma and severe lack of mental health services (Jacobs & Ball, 2010). Even though a strong connection exists between the cumulative number of instances of Adverse Childhood Experiences (ACEs) and high incidence of suicide is established through large-scale epidemiological research (Felitti et al., 1998; Dube et al., 2001), through the predominating quantitative research, the subjective, lived reality of survivors is obscured. In the absence of comprehensive qualitative research, interventions are often general and generic and do not focus on the formative nature of early trauma in triggering suicidal crisis. This research aims to accomplish this gap by predicting the stories of young survivors of suicide attempts in marginalized environments and thus shedding light on how ACEs trigger affective distress and defining culturally resonant measures to recovery.

Research Objectives

The overall aim of the dissertation is to gape a circumstantial knowledge and perception of childhood adversity in the evolution of suicidal tendencies in youth of underprivileged communities. The research shall in this respect:

Speak to the lived lives of young survivors of suicide attempts in the rural and other under-resourced communities to capture personal meanings of the survivors to their crises.

Determine all the relevant forms of ACEs including physical abuse, emotional neglect, and household dysfunction that define the early life paths of participants (Felitti et al., 1998).

Discuss the psychological processes through which these ACEs add to the rising emotional suffering, mental health decline, and the development of suicidal thoughts (Pillemer, Holt, and Keenan, 2014).

Explore formal and informal coping strategies, resilience-building processes, which survivors use in the post-attempt period including clinical intervention to community rituals (Bethell et al., 2016).

Research Questions

In correspondence with these goals, the questions to be answered in the study are:

What are the most common types of poor childhood experiences among the youth who attempt suicide successfully in impoverished environments?

What is the perception of the survivors on the effects of these ACEs on their mental health, self-worth, and personal identity?

How do the participants associate certain experiences of childhood traumas with the development and the progression of suicidal behaviors?

What are the internal (e.g., cognitive reframing, emotion regulation) and external (e.g., peer support, cultural practices) support that the survivors consider to have played a significant role in their recovery process?

Significance of the Study

This study contributes to the scholarship in three aspects:

It complements the overwhelmingly quantitative literature on ACE-suicide by offering granular, narrative-based information that can be used to shape prevention and

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intervention interventions to the context of a particular culture and geography (Patel et al., 2018).

It handles a severe equity gap since it records the structural and cultural obstacles to mental health care amidst rural and marginalized populations, hence informing policy makers in their resource allocation and planning of services (Jacobs and Ball, 2010).

It provides empirically supported guidance to teachers, clinicians, and community leaders to implement trauma-sensitive, resilience-focused approaches, which are sensitive to the experiences of survivors, eventually leading to the increase in the cultural applicability and efficacy of suicide prevention (Bethell et al., 2016).

Theoretical Framework

There are two theories under which this study is informed: Trauma Theory: Based on the writings of Herman (1992), and van der Kolk (2014), Trauma Theory holds that a long-term series of negative events such as abuse, and dysfunction in the household, may completely alter the personal safety, trust, and cohesion of an individual. Within this framework, the ACEs will be not perceived as isolated incidents, but rather ongoing stressors that threaten the psychological integrity and contribute toward maladaptive coping strategies, suicidal thoughts, and suicidal attempts.

Resilience Theory: Defined by Masten (2001) and Ungar (2011), the Resilience Theory focuses on the process by which individuals use their strengths and available resources in the environment to overcome and move through an adverse situation. The concept of resilience can be considered as an emergent property of intrapersonal asset and ecological support variables (e.g. emotion regulation system and self-efficacy combined with family cohesion and community rituals). This lens helps the study to determine risk factors as well as protective mechanisms that define the trajectories of survivors.

The study will combine the Trauma Theory with the Resilience Theory to outline the routes of exposure to ACE and leading to psychological distress and ultimately suicidal crisis or healthy recovery, therefore providing a comprehensive approach to comprehend youth suicide and responding to suicidal behaviors where marginalized groups live.

Methodology

Research Design

An exploratory qualitative design based on IPA was used to grasp the lived and sense making experience of young suicide survivors (Smith, Flowers, & Larkin, 2009). The IPA will especially be adapted to the study of how people interpret complex and emotionally charged events like the surviving of an attempted suicide by placing the emphases on their subjective representations and the reflective insight of the researcher.

Participants and Sampling

Purposive sampling was used to recruit ten participants who met the inclusion criteria. Recruitment flyers were distributed through local non-profits, school counselors, and primary health centers in Bhakkar and two neighboring underserved districts. Outreach emphasized confidentiality and voluntary participation.

Inclusion Criteria

In order to have a cohesive and phenomenologically suitable sample, the participants had to:

Be between 16 and 25 years of age

Suicide attempt at least once and survived.

Be in a marginalized or rural community (e.g. Bhakkar district)

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Be able and willing to make informed consent (consent with parental consent in case of minors)

Data Collection

The following data were collected in January and February 2025 by:
Detailed semi-structured interviews (6090 minutes each).
An interview guide covered:
Early childhood environment and family relationships.
Special misfortunes (physical, emotional, neglect, dysfunction in the house)
A beginning and development of suicidal thoughts and behaviors.
The formal supports, formal community resources, and community coping strategies.
The interviews were also undertaken in the language of choice of the participants (Urdu, Saraiki or English) and transcribed word-to-word.
Participant observations and field notes.
To support the depth of interpretation, notes were taken on contextual (e.g. nonverbal) information (e.g. researcher reflection, setting of interview) right after each session.

Data Analysis

The IPA protocol was used (six steps) to analyze it (Smith et al., 2009):
Reading and re-reading transcripts to get into each account of the participants.
Preliminary recording of descriptive, linguistic and conceptual remarks.
Building emergent themes through grouping related notes.
Seeking links between emergent themes in both cases.
Going to the next case, and repeating step 1-4, bracketing of previous themes in order to keep the promise of idiography.
Seeking patterns in cases so as to develop superordinate themes that reflect common and distinct experiential frameworks.
NVivo 12 software was employed in organizing codes and assisting in theme development. Analytic decisions and reflexive insights were recorded in memos that were made during the process.

Trustworthiness and Rigor

In order to deliver methodological rigor (Lincoln and Guba, 1985), the following strategies were put in place:
Credibility: Member checks were achieved through presentation of theme recaps to three individuals to verify the themes.
Dependability: A trail of codebooks, analytical memos and decision logs was used.
Confirmability: The coding framework and theme structure were reviewed by a peer debriefer (an expert in qualitative methods).
Transferability: The thick description of the contexts of the participants and verbatim quotes of the participants allow readers to conclude about the relevance to other marginalized locales.

Ethical Considerations

Data collection was preceded by the provision of ethical approval by the University Research Ethics Committee:
Participants (and parents/guardians where participants were underage) gave written informed consent.
Procedures were characterized by voluntary nature of participation, right to withdraw at any point and confidentiality.
Interviewers were oriented to suicide risk procedures; there were instant referrals to mental health services in the area in case distress occurred during interview.

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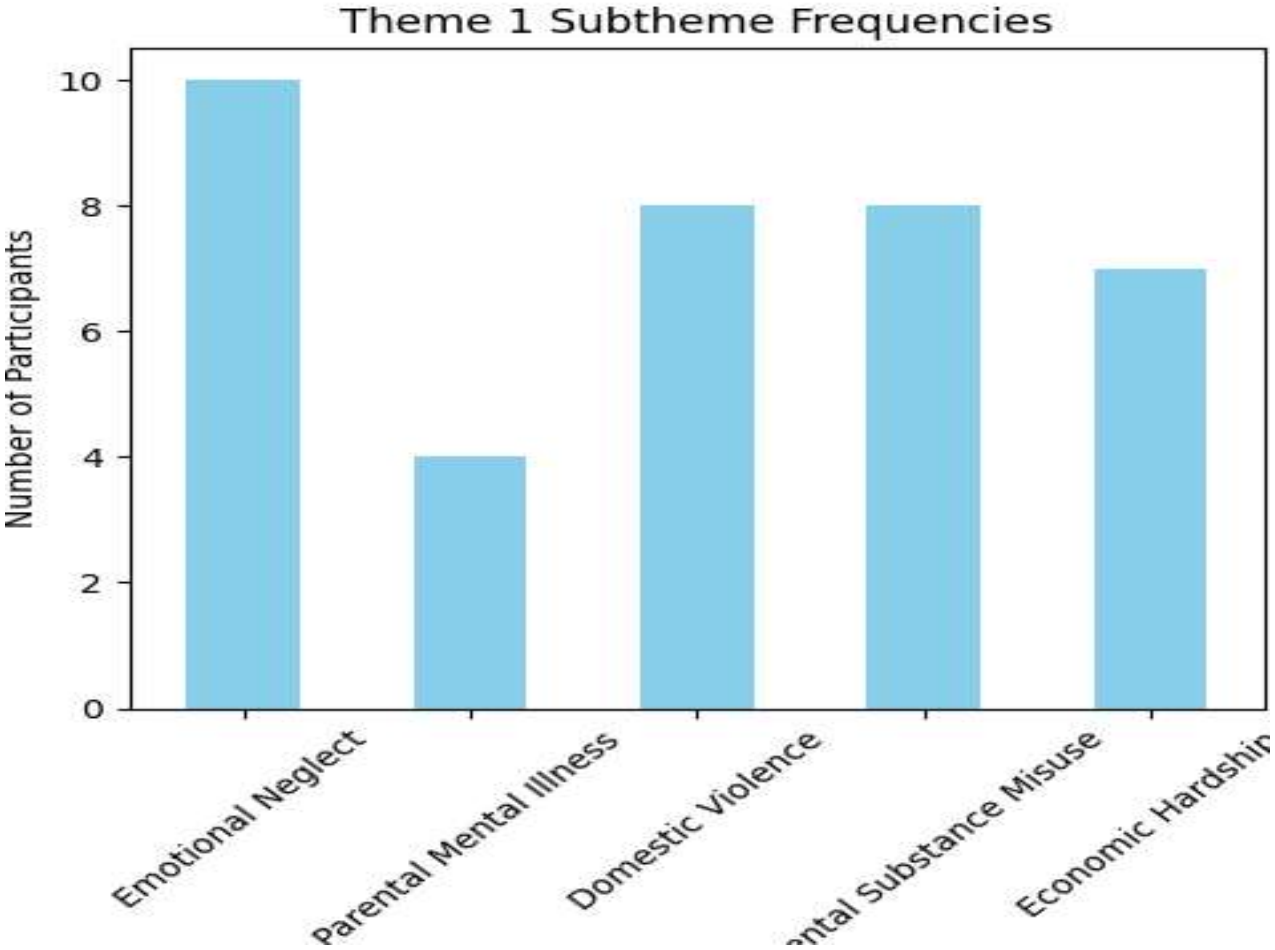

Outcomes

An elaborated sequence of events when certain ACEs (e.g., emotional neglect, domestic violence, parental substance misuse) trigger suicidal ideation and suicide attempts in marginalized youth.

Survivor stories disclosing the inadequacy of emotional needs common to the majority: the absence of validation, persistent loneliness, confusion of identity, neglect in the family, school, and medical settings.

Determination of structural determinants, such as limited mental health practitioners (Jacobs & Ball, 2010), distance in traveling, and cultural stigma, which aggravate trauma and discourage help-seeking.

A record of culturally appealing resilience elements, including peer networks, faith-based practices, nature-based coping, and informal supports utilized by survivors to prevent any future crisis.

Mapping of critical turning points (e.g. first disclosure to a trusted adult, working with a community elder) that altered paths between despair and recovery.

Practical, evidence-based mental health solutions to rural mental health challenges: community-based training on how to be a gatekeeper, mobile telepsychiatry vans, peer counseling in schools, and community-based integration of traditional healing.

Findings

Theme 1: Pervasive Early Adversity:

In interviews, respondents characterized a cluster of ACEs that started in early childhood. Aisha (age 19) did not have anybody to make her feel that she mattered, and her mother struggled with unmanaged depression. Four children of 10 stories in which economic hardship existed often had domestic violence and parental substance misuse. Such misfortunes accumulated to become a permanent sense of worthlessness and

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intimidation, which preconditioned subsequent self-injury (Felitti et al., 1998).

Theme 2: Emotional Pain and Torn Self-Worth.

The respondents talked about the process of internalization of the trauma in a very graphic manner:

Bilal (22 years): I recalled that my heart was as heavy as a stone when my shame was related to an incessant verbal abuse.

Most of them described parental approval as being linked to self-worth; absence of the same led to self-criticism and hopefulness (Pillemer, Holt, and Keenan, 2014).

School bullying and gossip in the community enhanced this sense of isolation; this was supplemented by these unmet emotional needs.

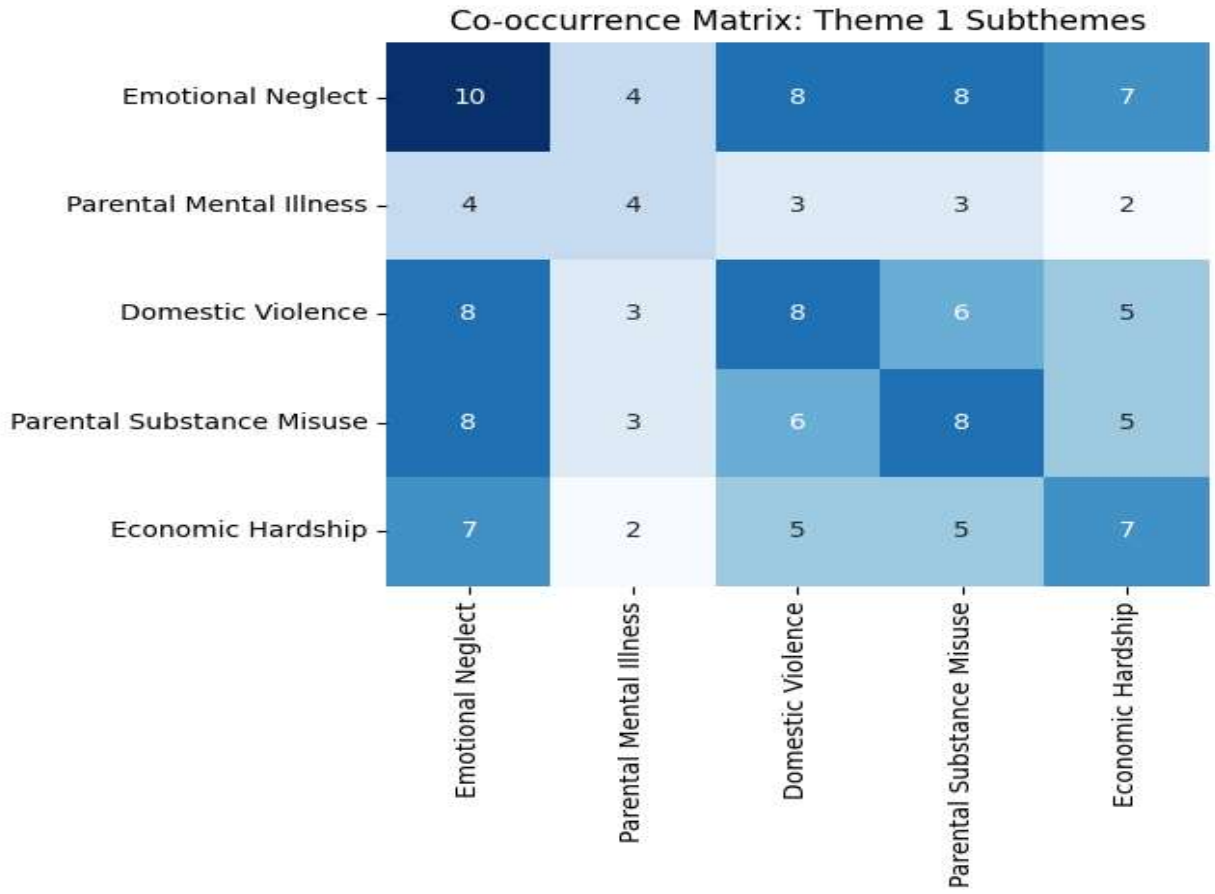
Theme 3: Pathways to Suicidal Crisis

Expanding the repertoire of coping was a diminishing act as testified by survivors:

First tries were prefigured, weeks or months on the whole, by seclusion and insomnia.

The impulsiveness element as expressed by Sana (age, 17) was also a major reason why she could not endure emotional pain to a certain level in some instances and she said that, One night [she just] did it.

The qualitative data show that the warning signs, which appear at an early stage (weird insomnia, sudden social isolation), do not attract the attention of the families and schools (Rankin & Quirk, 2020).



Theme 4: Resilience and Informal Supports

Despite the fact that negligence is present in the system, all the members reported at least one resilience:

Peer support groups-the support groups were formed unofficially at the nearby tea stalls and were

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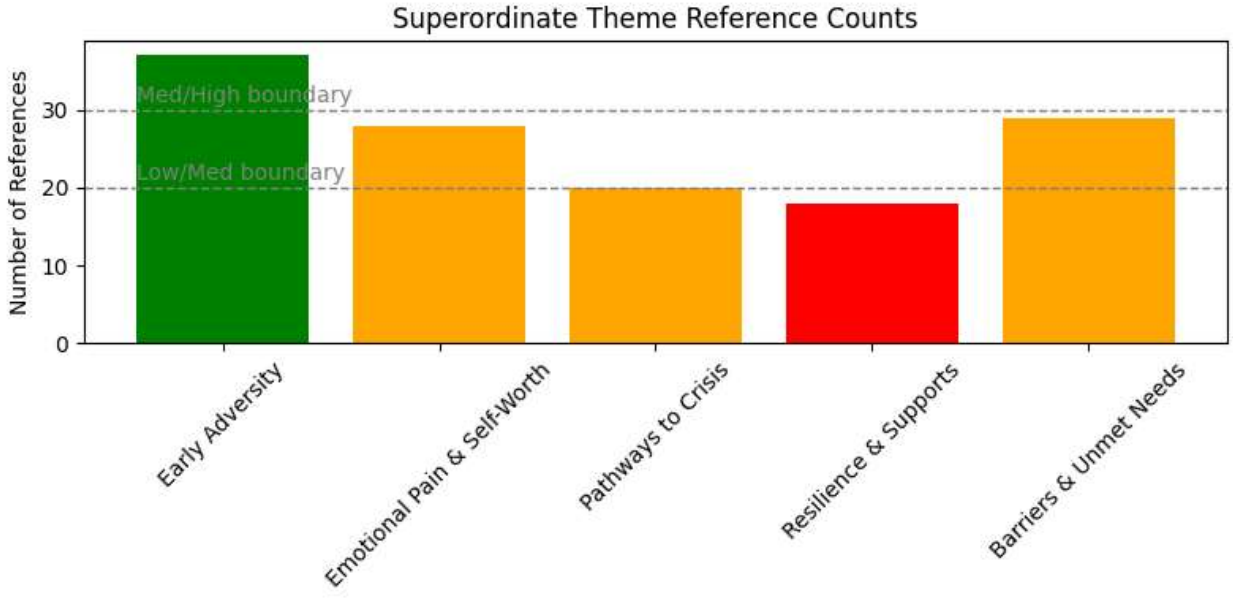
used to talk about their distress in confidence.
Religious activities (such as the Quran recitation groups) gave meaning to some individuals.
Nature connection: working on the farm or going out to walk at night were grounding activities.
Some of the perspectives of the Resilience Theory that discuss the interaction of individual resources and ecological resources dynamically are consistent with the work (Masten, 2001).

Theme 5: Systemic Barriers and Unmet Needs

Participants uniformly reported frustration with the scarcity of mental health services:
Average travel time to the nearest counselor exceeded three hours.
Telehealth was hindered by unreliable internet.
Cultural stigma rendered formal help-seeking tantamount to "bringing shame" on one's family.
This led to the majority of people being in a maze with no exits, and it is therefore important that low-barrier interventions embedded within communities are urgently needed.

Data Analysis

Immersion and Early Observation.
Reading of Transcripts was done repeatedly. NVivo 12 was used to record descriptive (what happened), linguistic (tone, metaphors) and conceptual (underlying meanings) comments.
Emergent Theme Development
Clusters of similar notes created emerged as themes in each of the cases (e.g., stone-like heart, hidden wounds).



Intra-Case Thematization

The within-case analysis maintained the idiographic depth, which established the unique context of every participant and thus the expression of themes.

Cross-Case Analysis

Cases were then compared on themes to determine superordinate themes (e.g., fractured self-worth), subthemes (e.g., peer sanctuaries, nature as refuge).

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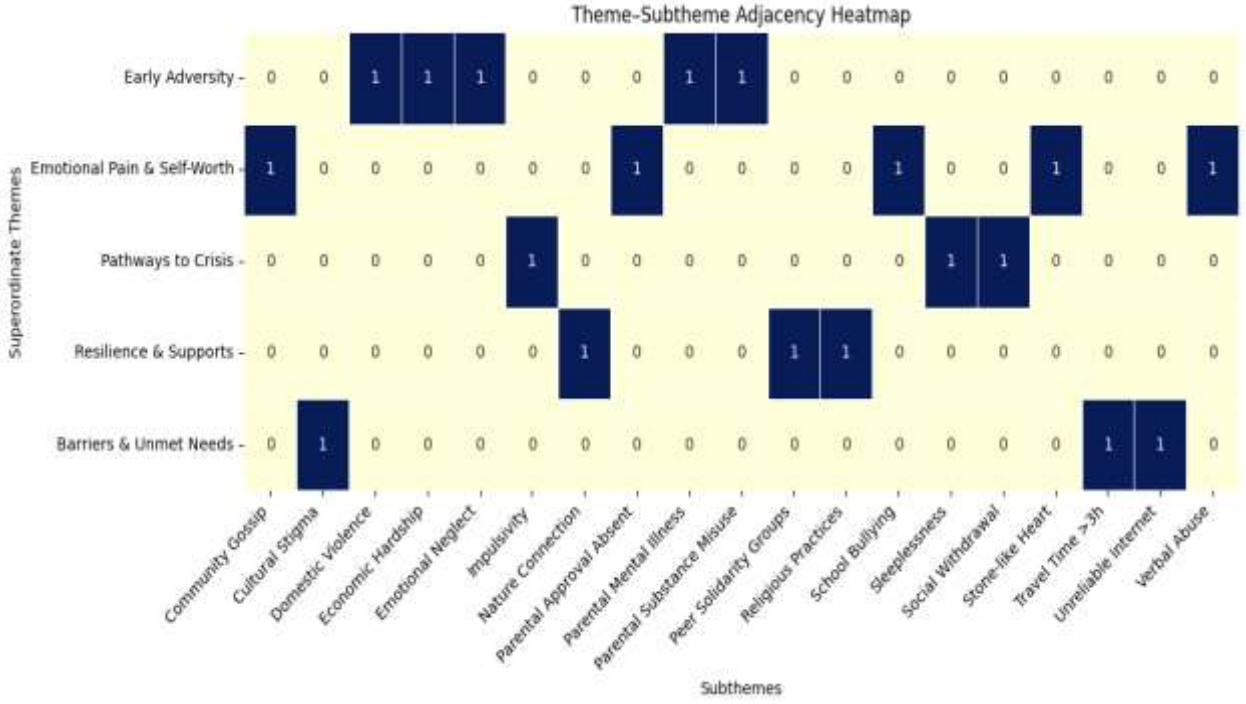
Dynamic Mapping

To follow the connections between ACE exposure, emotional sequelae, crisis triggers, and resilience pathways a visual map was made. This was an iterative process that entailed constant comparison, memos that were reflective in nature and peer debriefing to increase confirmability (Lincoln and Guba, 1985).



Key analytic insights included:

The nonlinear, recursive relationship between trauma and coping—early triumphs (e.g., positive reframing) could be eroded by subsequent adversities.

Cultural practices though not formally recognized by mental health systems—functioned as vital buffers against despair.

Systemic neglect was at various levels: familial (trauma silence), institutional (no school counselors), structural (lack of transportation and connectivity).

Recommendations

Recommendations regarding the planning of the national strategy to address the issue of violence against Indigenous women are as follows, basing on the qualitative data collected throughout the work on survivor stories and the barriers to the solution revealed in the findings. These are based on a multi-level strategy, which focuses on community infrastructure, educational environment, and clinical service provision.

Adoption of a "Task-Shifting" Gatekeeper Model.

Related to Theme 5 (Systemic Barriers) and Theme 4 (Informal Supports).

In the current situation of a serious shortage of mental health workers and 3-hour travel hours as indicated by the respondents, it is impossible to use clinical psychologists only. There should be a shifting of tasks model in which the non-specialist members of the community are to be trained to administer the low-intensity interventions.

Action Plan: Educate the so-called Natural Gatekeepers (religious scholars (Imams), tea stall owners, Lady Health Workers (LHWs)) about the use of Psychological First Aid (PFA) and suicide warning signs.

Reasons: The people reported that they depend on informal environments. Through the training

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of the stakeholders already integrated within the community, we are able to bypass the cultural stigma of visiting a psychiatric clinic.

Mobile Mental Health Unit and Hybrid Telepsychiatry.

Related to Theme 5 (Systemic Barriers: Travel & Connectivity).

The results point out that distance and untrustworthy internet are significant barriers to care. In order to eliminate the rural digital divide in rural Bhakkar:

Action Step: Mobile Mental Health Unit Implementation-vans that have mobile internet connectivity and a general counselor. These teams must make weekly appearances in the remote villages on a weekly rotation.

Reason: This will address the transportation barrier. The unit also serves as a physical bridge, so that when a local counselor is required to make a stable video connection with a specialist psychiatrist at the city in case medication or sophisticated diagnosis is required, circumvention is made of the home-based internet instability.

Trauma-Informed Care (TIC) in School.

Associated to Theme 1 (Early Adversity) and Theme 3 (Pathways to Crisis).

Survivors said that education institutions usually overlooked the early warning signals such as abrupt insomnia or withdrawal thinking of them as laziness in academics.

Recommended Action: District Education Authority must make It Traumatized placed as mandatory training to secondary school teachers. This curriculum should change the pedagogical paradigm to What is wrong with this student? to What happened to this student?

Rationale: Schools constitute the major institution that the youth spend their time. The teachers who can be trained to be aware of the behavioral manifestations of ACEs (e.g., dissociation, aggression) can address a student prior to the crisis stage outlined in Theme 3.

Making Peer-Led Resilience Networks official.

Connected with Theme 4 (Resilience/Peer Support).

The discussions in tea stalls and peer groups were mentioned as the main source of survival by the participants. Now they are not properly structured and do not have safety measures.

Action Step: Have the institution of Youth Wellness Ambassadors in the local colleges and community centers. These are support groups, peer leadership, and clinically supervised, based on narrative therapy, groups that are used to talk about stress and coping without necessarily referring to it as mental illness.

Reason: The young people in disadvantaged societies tend to have more faith to their peers rather than adults. By making these groups official, it will guarantee that a peer with suicidal intent (as observed in the results) will be aware of the particular procedure to inform a professional without endangering themselves.

Stigma Reduction Campaigns, Cultural and Faith-Based.

Related to Theme 2 (Torn Self-Worth) and Theme 5 (Stigma).

The story of making the family ashamed does not allow seeking assistance. Interventions should not be against culture but they should be in culture.

Actionable Step: Co-create a Sermon Guide (Khutbah) with the local religious leadership that reinstates thinking mentally healthy as a spiritual obligation (Amanah) and not an indicator of poor faith.

Rationale: According to the Literature Review, cultural and spiritual alignment is essential (Sands and Murphy, 2015). When the religious leadership makes a public statement that mental health care is acceptable, they give social permission to parents to obtain help to their children without the fear of being ostracized in society.

Conclusions

This paper sheds light on the complex mechanisms of how ACEs mediate suicidal ideation and marginalized youth, although facing severe adversity, rely on culturally-

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mediated resilience resources. Implications include:

Community Gatekeepers who are Trauma-Informed:
Educating teachers, religious leaders, and community health workers on how to identify warning signs (e.g., insomnia, social withdrawal) and make safe disclosures.

Mobile Telepsychiatry and Peer-Led Support:
Implementing vans with the capability to conduct a confidential telehealth session in remote villages, and peer mentor interventions to normalize the use of help.

Incorporation of Traditional Healing Practices:
Collaboration between mental health professionals and local religious leaders or elders to facilitate group sessions together, eliminating stigma and promoting culture congruence.

Resilience Curricula in School:
Introduction of modules on emotional literacy, skills development in coping and peer empathy during secondary schooling where the members would be under the constant supervision of trained counselors.
This study has a limitation such as the small purposive sample that can restrict the generalizability. Longitudinal designs should be used in future research to trace evolution of resilience with time and model interventions that are co-designed along with the youth participants. The dissertation, with its focus on survivor accounts and the combination of Trauma Theory (Herman, 1992; van der Kolk, 2014) and Resilience Theory (Masten, 2001), contributes to a comprehensive approach to suicide prevention a dissertation that would value the voices of the marginalized young people and mobilize culturally relevant, low-barrier methods of saving lives.

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