

Suicide Response in American Muslim Communities: A Community Case Study


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This community case study describes the experiences of two neighboring Muslim communities in the United States, following respective incidents of suicide. Case summaries are first presented to contextualize the community response to the suicides. Subsequently, the discussion highlights relevant cultural and religious factors that impacted the responses of mosque leadership, mental health professionals, and the communities at large. Concerns related to the deceased's afterlife, community connectedness, privacy, shame, and communication barriers were prominent in each case and shaped the courses of response. The COVID-19 pandemic and divergent responses to external support played significant roles in creating disparate outcomes in these communities. The discussion emphasizes the need for dissemination of evidence-based, religiously grounded, and culturally competent curricula for implementing mental health awareness programming and long-term suicide prevention efforts. Insights about cultural and religious factors influencing community responses were derived from the described cases in this paper and informed the development of a comprehensive suicide prevention, intervention, and postvention manual and training program tailored for Muslim communities.


Keywords

suicide • suicide response • Muslim • Islam • community case study


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Introduction

Suicide is a leading cause of death in the United States, accounting for over 47,500 deaths in 2019 (NIMH, 2019). National suicide rates have increased over the past two decades, necessitating new strategies to prevent premature death and support the bereaved (Hedegaard et al., 2018). Despite the proliferation of suicide research in the general population, suicide research with American Muslim samples is limited. However, some findings have begun alluding to unique risk factors for this population (for example, Islamophobic discrimination and marginalization) that may put American Muslims at greater risk for suicide (Samari et al., 2018; Awaad et al., 2021). Research investigating the mental health needs of this population in relation to suicide therefore warrants investigation.

American Muslims are an ethnically, racially, and socioeconomically diverse minority group accounting for 1.1% of the US population (3.45 million) (Mohamed, 2018). Muslims living in America face many sociocultural challenges, including marginalization due to religious and racial discrimination (Pew, 2017; Cover, 2016; Rousseau et al., 2011). A 2018 survey found that approximately 1 in 2 American Muslims (48%) have experienced at least one instance of racial or religious discrimination (Abu-Ras et al., 2018). Among Muslims who are identifiable through their religious garments or appearance (such as wearing the hijab), instances of discrimination are even more frequent (Pew, 2017). Religious discrimination against Muslims living in America has increased over the past two decades, as has self-reported stress and anxiety in this population (Kishi, 2017). The trend of increasing discrimination against American Muslims is particularly salient, given findings that marginalization and related sociocultural stressors are associated with higher rates of suicide (Cover, 2016). Most recently, a large-scale survey investigating suicide across religious groups found evidence that American Muslims may be twice as likely to report a past suicide attempt compared to other religious and non-religious groups (Awaad et al., 2021).

Alongside further epidemiological investigations of suicide within Muslim populations, qualitative research is needed to gain insight into Muslim communities' interactions with suicide. The current body of suicide research has not adequately captured the nuances of effective prevention or response among American Muslims, leaving inadequate guidance for mental health professionals, community leaders, families, and researchers in times of crisis. Using two neighboring American Muslim communities as case studies, the present article explores salient cultural and religious factors that informed decision-making in the wake of separate incidents of suicide. To our knowledge, this descriptive approach to understanding American Muslim community responses to suicide is the first of its kind and aims to provide a foundation for further qualitative and quantitative research, as well as community prevention and response efforts.

Methods

The present paper details the experiences of two neighboring Muslim American communities and their responses to incidents of suicide. The two suicides occurred several months apart and appear unrelated. Immediately following the suicides, leadership from the respective communities approached the Stanford Muslim Mental Health and Islamic Psychology Lab (SMMHIP) to obtain guidance for developing a community response, supporting the families of the deceased, and facilitating healing in their communities. The first community received information in the form of a virtual conference call with two Muslim mental health experts affiliated with the SMMHIP Lab, whereas the second community had no conference call, but received an early draft of a suicide response manual tailored for a Muslim audience produced by the SMMHIP Lab. Implications of these delivery methods are explored in this paper.

Information regarding each community's experiences was collected several months after the incidents through a series of semi-structured interviews, initially intended to facilitate program development and implementation. Three interviews were conducted with each community (six total interviews): one with local mosque leadership, one with family members bereaved by the suicides, and one with members of the community who played significant roles in supporting the grieving families and organizing mental health education programming. Each interview was conducted over Zoom by researchers from the SMMHIP Lab. The researchers shared a Muslim identity with the participants but had no additional connections to the participants or the community under consideration (such as location, relation, etc.). All researchers received brief sensitivity training regarding suicide and empathic listening prior to conducting interviews. Participants were informed of their right to not answer any questions as they saw fit and to end the interview at any time. All participants verbally consented to sharing their de-identified stories and experiences for analysis, writing, and publishing for the benefit of healthcare professionals, researchers, and the wider community.

Interview questions explored the timeline of events following the suicides, each party's role in these events, and personal reflections regarding the long-term aftermath of the incidents (see Table 1). Additional questions focused on the involved parties' perceptions regarding the stigma of mental illness and suicide in their community and how these stigmas impacted their decisions. The families of the victims were specifically asked to share their reactions to various acts of support they received from leadership and the wider community. Families were not asked directly about the details of their loss (such as method of suicide, potential reasons for the incident, or the psychological state of the victim beforehand).

Due to the emergent nature of these two cases, a formal submission was not made to an ethics review board. Consequently, no direct quotes or identifying information are presented in the current paper. However, given 1) the importance of the topic, 2) lack of existing research on responses to suicide among Muslim populations (and no research to our knowledge focused on responses in American Muslim populations), and 3) contact from multiple Muslim communities

Table 1. Interview questions asked during semi-structured interviews with Mosque leadership and local volunteers, and the family members of the deceased.

Mosque Leadership And Local Volunteers	Grieving Families
After news came about the incident, what were reactions you heard from the community and leadership?	In the time following the loss of your son, what were responses from your community and leadership that you appreciated?
What steps did the community take right after the incident to care for the family and to care for the community?	Can you describe a timeline for us of these events? Who was involved along the way?
What long-term steps were taken for prevention in the future?	In the long term, have you kept using any supports from your community or leadership?
What were the main difficulties and worries you and other community leadership faced?	Was there anything you wish had been different about the response from your community and leadership?
What advice do you have for other communities hoping to prevent similar incidents?	What advice would you have for other communities hoping to prevent suicide and support families who have lost people from suicide?

in the US and other Western nations seeking support following suicide-related crises, we believe a description of these cases is necessary to provide foundations for further research and program development and implementation. Moreover, the primary motivation of this paper is to provide a resource for Muslim communities and clinicians facing suicide crises. To this end, we describe salient themes that emerged from the interviews without using a formal analysis to respect the confidentiality of the communities and individuals interviewed, while also providing valuable insight into the concerns and effective response strategies that can be implemented in Muslim communities.

Case summaries are first presented to describe relevant contextual information regarding each suicide to help illustrate decisions that informed each community's response efforts. Second, thematic inferences from the interviews are presented which explore five primary themes that guided the community response efforts and underpinned the reactions of the involved parties. Third, a discussion contextualizes these themes within the broader literature on suicide response in other populations, and offers important considerations for researchers, clinicians, leadership, and volunteers involved in Muslim communities impacted by suicide. Finally, the paper proposes the necessity for comprehensive, evidence-based suicide prevention, intervention, and postvention programming tailored to Muslim communities.

Case 1

The victim of the first suicide was a man in his 20s who lived in a suburban, middle to upper-middle class, ethnically diverse Muslim community. The victim is survived by his mother, father, and siblings, all of whom were regular attendees of mosque programming and considered by mosque leadership to be active community members. In the wake of his passing, the mosque's imam and several volunteers from the area led the community's response effort.

To obtain religious and scientifically informed guidance, community leaders arranged a conference call in which two affiliates of the SMMHIP Lab consulted with more than 70 participants from community leadership and local volunteers. The primary concerns addressed during the consultation were: 1) ensuring that grieving family members were treated respectfully, 2) clarifying the spiritual and metaphysical connotations of suicide for the family and wider community, and 3) organizing a public mental health awareness event to discuss suicide and mental illness. The imam's role in the response consisted of visiting the family to offer condolences, addressing their spiritual concerns, and delivering scripturally and psychologically informed *khutbahs* (Friday sermons) about suicide and depression to the wider community. Additionally, a two-month long meal train was organized wherein friends and community members ensured that meals were brought to the bereaved family's home to support them while they grieved.

During public engagements, the imam and other leadership did not specify the nature of the deceased's death, including during the *janazah* (funeral) prayer, nor did they explicitly mention the family when publicly discussing suicide and mental illness. Any disclosure of such details was left to the family's discretion. Community members who approached with questions regarding the nature of the death were told that there had been an accident.

Two weeks after the initial incident, a community-wide mental health awareness event was held to promote awareness for mental health concerns. The structure of this program was planned during consultation with the SMMHIP Lab and was based on recommendations that had been utilized in other American Muslim communities. Mental health professionals, both Muslim and non-Muslim, were invited to the mosque to host an open panel titled, "Breaking the Stigma," where the community's concerns could be voiced, and their questions could

be answered. During the event, appointed professionals facilitated breakout discussion circles grouped by age and gender about suicide, mental illness, and seeking help. The grieving family was given the option to attend, but ultimately decided against it due to the concern that discussions could be re-traumatizing.

Case 2

The victim of the second suicide was a man in his 20s who lived in a nearby middle to lower-middle class, ethnically homogenous Muslim community. The victim is survived by his mother, father, and siblings, all of whom were well known by mosque leadership and participated often in religious community programming. His passing took place on a day of religious significance, and during the COVID-19 pandemic. The strict social distancing protocols during this time were cited as a significant barrier for this community leadership's response.

Following the incident, leadership from the local mosque contacted the previous, neighboring community for guidance on how to support the family and broach the topics of mental illness and suicide in their community. Instead of a direct consultation with affiliates of the SMMHIP Lab, this community was delivered an early draft of a suicide response manual that was crafted by the lab's suicide research team. It contained recommendations for sensitive language, evidence-based explanations of mental illness and suicide, Islamic scriptural commentary on those issues, and a template for a *khutbah*. While the draft was received by mosque leadership, they found few opportunities to operationalize the recommendations and did not report using it as a primary reference for addressing the community or the grieving family.

Mosque leadership offered financial support for funeral proceedings, as well as a list of local mental health resources to the victim's family. Like for the previous family, the mosque organized a two-week meal train for the family as well. Lastly, private sessions with a local Muslim chaplain were attended by the family to address spiritual concerns regarding their son's death and provide emotional processing to maintain and strengthen their relationships while they grieved.

Mental health awareness programming was not implemented for the wider community at this time. The victim's family members, as well as board members of their mosque, expressed the belief that their ethnic community held a particular stigma toward mental health issues and would likely be averse to open discussion. Additionally, social distancing restrictions resulting from COVID-19 would have necessitated a virtual format, and the mosque board members believed their community was not prepared to navigate the necessary technology.

Thematic Inferences from Interviews

Numerous considerations and barriers to planning and implementing effective suicide postvention response with American Muslims were highlighted during interviews with the two communities. Responses were different in each incident, suggesting the importance of considering community-specific cultural and religious variables impacting both the decisions and needs of Muslims living in America during such a crisis. However, although Muslim communities across the United States, and in these two specific case studies, are ethnically, culturally, and socioeconomically diverse, concerns regarding spirituality, shame, privacy, and communication may be shared when responding to a suicide. Therefore, the following section outlines several religious and culturally relevant factors warranting consideration when working with suicide in the context of Muslim American populations.

Spiritual Implications for the Deceased

Muslim communities share a common belief regarding the existence of an afterlife in which individuals are rewarded or punished based on their actions while alive. Pending judgment from God, individuals who act in a manner consistent with acceptable ethical principles outlined within the corpus of Islamic law will find reward by way of heaven, whereas those who transgress ethical bounds and do not attain God's mercy will be destined to hell (Hillenbrand, 2015). Given Islam's strong ethical stance against suicide, self-inflicted death understandably generates questions, concerns, and discussions about the afterlife (Anees, 2006). In both cases, the families of the deceased reported that the spiritual standing of their sons were a source of significant worry. Without the relevant scriptural knowledge, there was significant distress arising from fears that the act of suicide is an unforgivable sin, that funeral processions could not proceed, and that prayers could not be made for the deceased. For a family that holds religiosity and spirituality in high esteem, the implication that a child would face spiritual consequences appeared to compound the distress and trauma of experiencing a sudden loss.

Regarding the specific cases outlined in the present paper, community leaders who had religious training responded to the family's concerns by giving clear explanations regarding the Islamic stance on suicide. This explanation validated the concern that suicide is generally considered a sin within Islam but clarified that condemnation in the afterlife can be tempered by God's mercy and the potential for forgiveness. Through this nuanced discussion of ethics, community leaders alleviated concerns regarding funeral rites, and compelled both the family and the wider community to continue praying for the deceased. These actionable comments from community leadership apparently helped family members begin to alleviate their pain regarding the circumstances of the deceased's death. In both instances of suicide, the role of religious and spiritual coping was instrumental to family members in the grieving process. Messages of hope for the deceased in the afterlife made it possible for family members to rely on the religion-inspired cultural healing strategies (such as mindful patience, acceptance of God's will, communal prayers, meal trains, etc.) to which they were accustomed.

Shame

Neither family reported facing explicitly negative or judgmental interactions with members of the community or leadership. Nevertheless, a common theme across family members was a sense of concern that their sons' death would be a topic of conversation among others in the community. In service of this concern, mosque leaders and volunteers in both communities decided not to publicly acknowledge that the deaths were suicides. Interviewees reported that these decisions were not intended to hide the incidents out of shame, but to respect the privacy of the bereaved through acknowledging that the reactions of community members could not be controlled. The preeminent concerns of community leaders appeared to be responses from individuals who were not acquainted with the families of the deceased. In such instances, community leaders were concerned that the news, without the necessary knowledge about either mental illness or the Islamic stance on suicide, may lead to harmful assumptions, comments, or rumors regarding the parents, families, and the deceased.

To manage community perceptions of the deceased and their families, religious leadership in the first mosque attempted to proactively establish an empathic community response by modeling support for the family, such as organizing funeral proceedings and leading prayers for the deceased. Moreover, the religious leadership's response for the community included two khutbahs about mental illness and suicide in the weeks following the incident.

The victims' families had differing approaches regarding the extent to which they disclosed the nature of their sons' deaths. In the first case, the family of the victim reported that broaching the topics of mental health and suicide was necessary and important. Consequently, they were open about the nature of their son's death in their personal interactions. This family reported a sense of duty following their son's death and believed that his case had the potential to initiate change in the community. This expression of vulnerability appeared to facilitate the family's interactions with the community, and they reported that their candor allowed them to have authentic conversations about their difficulties. Moreover, they reported that openness helped them feel more connected with others during their grieving process and facilitated their long-term healing.

In the second case, the family reported beliefs that they would be shamed by members of their community for the nature of their son's death. Consequently, this family reportedly wished to be less open about the nature of their loss. For instance, the family expressed that the lack of socialization due to the COVID-19 pandemic facilitated their desire for containing the details of their son's death as much as possible. The family reported beliefs that within their ethnic enclave, including members of their extended family, mental illness, and especially suicide, carries significant stigma. Consequently, the family reported a sense of discomfort publicizing the circumstance of their son's death until more education and prevention programming was in place in the community.

These families' differing degrees of openness highlight the need for leaders and support figures to develop an understanding of each family's unique perceptions of shame in their community, and their degrees of comfort with emotional expressiveness. These factors can play a key role in processing the grief following suicide. Namely, the second family reported much less comfort with expressing their emotions than the first family. In such cases, connecting the family with private professional help was helpful in facilitating the development of healthy coping skills. The private counseling sessions offered to the second family by the local Muslim chaplain promoted coping strategies by guiding the family in open discussions of their emotions with one another.

It is important for leadership to know that not all families are emotionally prepared to share their loss with the wider community. However, the necessity of respecting a grieving family's autonomy and privacy should be balanced with the need to implement timely mental health awareness and suicide prevention programming in the wake of a suicide. The case of the first community was exemplary in that effective community programming was implemented without referencing the victim or identifying the family. However, in the second case, concerns about gossip and judgement were prevalent, and were deemed to outweigh the needs for community programming. However, even in this case, the strong prevalence of shame suggests that programming intended to educate the community and challenge mental health stigma may be even more necessary and impactful. If successfully implemented, confidentiality can and should be maintained while challenging existing stigmas, ultimately allowing bereaved families to grieve in a more supportive environment in their community.

Community Connectedness

These two cases highlight the value of social capital in Muslim communities, as demonstrated through the timely and consistent socioemotional support following the incidents. The interconnected nature of these two communities facilitated community-wide organization and mobilization. For instance, both communities were efficient in establishing meal trains and maintained these meal trains for an extended time. These extensions of support were cited by

family members of both victims as invaluable in supporting their grieving processes. Moreover, local volunteers offered time and dedication as applicable to the family's circumstances, including offering support and counseling services to the grieving families and advocating for and implementing mental health awareness and suicide prevention programming.

Privacy

While the strength of community bonds was highlighted in both cases, the issue of privacy was also an evident concern of both the religious leadership and the families of the deceased. The primary concern appeared to be that a small proportion of the community would be insensitive to the families' pain and ask potentially jarring questions to satisfy personal curiosity. For instance, some family members noted that they had become avoidant of conversations with members of their community because of the belief that they would face interrogatory questions for details regarding the method of death. Some family members were notably concerned that such interactions would be too challenging to endure.

To ameliorate this concern, religious leadership made directed efforts to manage privacy on a public level through teachings directed toward the community (such as mental health awareness programming), in which they emphasized that the goal of visiting a victim's family should not be to satisfy one's curiosity. Rather, visiting the bereaved is an Islamic duty founded on principles of offering condolences, prayers, and other forms of emotional and pragmatic support for families.

Knowledge and Communication Barriers

In both community cases, interviewees emphasized the clear demand for structured programming to prevent suicides before they happen and to respond to suicides after they happen. Interviewees highlighted a belief that the general community was not adequately educated about the spiritual or psychological implications of mental illness and suicide. The cases of suicide in these communities, and several others, are punctuated by each community's immediate need to seek support from an external source (for example, the SMMHIP Lab) to help plan and implement a community response. Had leadership in these cases been unaware of the SMMHIP Lab's existence and were unable to access adequate guidance from another source, the challenges and barriers they faced may have been exacerbated. These communities' need for guidance emphasizes both the present shortage of adequately trained mental health professionals within the Muslim community and a consequent gap in knowledge and preparedness in many communities. These reports highlight the need for further research that investigates suicide systematically within Muslim communities. Moreover, there is a clear and pressing need for the development and widespread dissemination of suicide prevention, intervention, and postvention strategies that are culturally and religiously sensitive toward the needs of this population and grounded in evidence-based practice.

Discussion

The case studies within this paper emphasize the complex, strenuous nature of the suicide bereavement process. Several important themes, including the spiritual implications for the deceased, shame, community connectedness, privacy, and knowledge and communication barriers were salient in the suicide response efforts of the two American Muslim communities highlighted

in this article. Given that literature about suicide among American Muslims remains sparse, our case inferences provide valuable insight into how existing knowledge about suicide bereavement, community response, and program implementation applies to this growing minority population. To illustrate important considerations for clinicians, researchers, community leaders, and volunteers working in American Muslim communities impacted by suicide, we contextualize themes generated from our case studies with findings from the broader literature.

Our case studies capture the importance of sense-making or meaning-making in suicide bereavement, defined as the desire to construct a subjective understanding of the loss experience. In the general population, the inability to make sense of one's loss is associated with complications in the grieving process (Currier et al., 2006). However, previous findings suggest that spiritual and religious factors can be important in the meaning-making process following sudden deaths. Religion and spirituality can inspire hope, acceptance, and continued connection to the loved one following a suicide, resulting in increased psychological well-being and quicker resolution of grief (Lynn Gall et al., 2016). Notably, themes constructed from our interviews alluded to the potential for meaning-making to be interrupted among Muslims whose loved one's died by suicide, which is considered a moral sin in Islam by the majority of classical Muslim authorities (Anees, 2006). In the case studies, family members noted significant concerns regarding the spiritual state of the deceased and the permissibility for the bereaved to use traditional religious coping (such as funeral rites, prayers, etc.) for an individual who has killed themselves. Our findings are consistent with previous research in non-Muslim populations suggesting that spiritual concerns in the aftermath of a suicide are a source of significant distress for survivors and can trigger crises in faith, leading to further complications in the grief process (Lynn Gall et al., 2016; Castelli Dransart, 2018; Jahn & Spencer-Thomas, 2018). These findings suggest that specific attention should be given to facilitate bereaved Muslims' meaning-making processes following a suicide loss, especially when they are struggling to reconcile their loved one's death with their religious beliefs. Moreover, these findings warrant further systematic investigation of the suicide bereavement process among American Muslims.

The findings of this study also add to the body of literature exploring how social processes around suicide loss survivors can hinder their bereavement. Suicide loss survivors report significantly more feelings of guilt, shame, and responsibility compared to those who lost loved ones by other means (Pitman et al., 2016). Moreover, concerns related to gossip, judgement, and negative media portrayals of the deceased are implicated in the development of negative emotional responses to suicide and in the desire to conceal the true nature of one's loss (Jordan, 2001; Hanschmidt et al., 2016). The detrimental impact of social stigma and shame was clearly demonstrated in the case of the second community where the family aimed to conceal the nature of the death. They reported that concerns related to external judgement, misrepresentation of the deceased's circumstances, and culturally-driven stigma led them to remain reticent in the months following their loss. Consequently, the stigmatizing social circumstances appeared to have been a direct hindrance to healthy grieving, which often requires open discussion of the nature of a traumatic loss, suicide or otherwise, to facilitate one's emotional processing (Feigelman et al., 2017). Previous findings suggest that individuals who fear judgement from others in their social context can find themselves more isolated and lonelier following their loss, leading to exacerbated feelings of grief (Peters et al., 2017). This underscores the need to combat stigmatizing attitudes in some Muslim communities to facilitate improved social support for those who are bereaved.

In contrast, our case studies also highlighted the value of community in encouraging healthy coping following suicide. Individuals who engage in vulnerable reflection and conversation about their loss have been found to experience greater ease following bereavement than those

who conceal their feelings regarding their loss (Maple et al., 2009). In the case of the first community, the family reported a sense of duty to initiate change in the community as well as a desire to seek social and emotional consolation through openness. They reported that the choice to share their story led them to feel less alone in their struggle and more connected with one another while they grieved. Moreover, previous findings from non-Muslim communities suggest that individuals from religious communities tend to have a desire to rely on individuals in their community (Čepulienė et al., 2021). However, it is important to note that support should be non-judgemental and practical. For instance, Vandecreek and Mortran (2009) highlighted examples of pragmatic community support that facilitated a bereaved family's coping, including helping clean the home, preparing meals, and discussing religious questions non-judgmentally. In this regard, our observations about the community response, which included a community-organized meal train, frequent visitation, and assistance with household chores, echo previous research. Moreover, these findings suggest that non-judgemental, practical social support may be a universal element of healthy grieving across religious groups. However, a dearth of research exists exploring Muslim communities' responses to sudden deaths. Moreover, given the diversity of cultures across Muslim groups, including differences highlighted in the two community responses in this article, additional research is warranted to explore the role of community support across different Muslim communities in the United States and other Western nations.

Religious and community leadership had an important role in facilitating individual and community-level grief in our case studies. Leaders appeared to be vital in alleviating concerns regarding suicide as a mortal sin and appeared to provide permission for the wider community to grieve using Islamic coping mechanisms. Previous research from non-Muslim religious populations suggest that members of the clergy can be helpful in navigating spiritual issues following suicide, allowing the bereaved to have an outlet for expressing their feelings, and help to assuage stigmatizing beliefs amidst their congregation (Vandecreek & Morttram, 2009; Jahn & Spencer-Thomas, 2018; Castelli Dransart, 2018). Similarly, our findings suggest that imams and religious leaders helped both the families and community members navigate the aftermath of the suicides. For instance, the family in the second community expressed appreciation for private counseling offered by a Muslim chaplain, which helped attenuate both their spiritual and emotional concerns. Similarly, religious leadership's educational programming and public addresses to the community (such as mental health awareness events and khutbahs) helped mitigate the propagation of gossip and judgement in the case of the first community. Those who work with American Muslim communities can reference these considerations during a suicide crisis. Imams, chaplains, and other leaders in supportive roles can encourage healthy vulnerability among suicide loss survivors to aid their bereavement process. Religious and community leadership can also consider using public forums following suicides to minimize negative outcomes by encouraging community members to offer other forms of respectful and culturally familiar forms of social support, such as visitation, food trains, prayer gatherings, and so on.

Insights gained from the two cases described in this paper, and the cultural and religious factors that influenced their responses, make the case for continued development of comprehensive suicide training materials tailored for Muslim communities. A robust framework built on evidence-based research and Islamic scriptural guidance is needed to disseminate effective tools and curricula to both leadership and the wider community to optimize understanding and resource utilization. Furthermore, training programs need to be developed and conducted by Muslim mental health professionals through live instructional sessions focused on operationalizing the recommendations.

The benefit of conducting live training modules as opposed to offering resources without consultation was evidenced by the disparate experiences of the two community cases following their communication with the SMMHIP Lab. The first community received a conference call with two Muslim mental health experts affiliated with the lab. The second community only received a suicide response manual draft from the lab. Leadership from the first community reported that the conference call with the SMMHIP Lab affiliates provided them the framework, reassurance, and sense of urgency for their mental health awareness event. The opportunity to ask follow-up questions, create a plan of action, and address concerns in real time all made this virtual consultation a valuable learning experience for both leadership and local community volunteers. The act of gathering dozens of people from various spheres of influence in the community also promoted community-wide buy-in. These reflections from the community leaders underscored the effectiveness and acceptability of teaching suicide prevention and response guidelines through live, interactive training sessions.

The COVID-19 pandemic and related restrictions limited the second victim's community from responding as robustly as the first community. Mosque board members reported that the pandemic-related restrictions limited their interactions with the grieving family and impeded their ability to address the wider community in mental health programming. The physical closure of the mosque also removed the gathering spaces where discussions typically took place, leaving leadership unaware of what conversations and rhetoric were circulating among members. As a result, they felt it was not feasible to play a guiding role in the community. These may have been circumstantial barriers, but the fact that this community received a response manual with no direct consultation was also salient. Explicit training and guidance may have facilitated the use of virtual or socially distanced mental health awareness programming. Additionally, implementation of long-term prevention efforts may have been feasible if more investment had been generated among leadership. Unfortunately, neither alternative programming nor prevention efforts were fully established in conjunction with trained mental health professionals, and the delivery of tools and curricula without consultation or follow up with leadership and local volunteers may have resulted in a less than optimal response in this community.

Conclusion

The community cases described in this paper had divergent experiences following respective incidents of suicide. The COVID-19 pandemic and means of receiving external response guidance played significant roles in creating the disparate outcomes in these communities, but the primary concerns related to the afterlife, community connectedness, privacy, shame, and communication barriers were prominent in each case. These factors appear salient in terms of both the cultural and religious framework of Muslim communities. Moreover, these two suicides, and numerous others for which the SMMHIP Lab has been contacted to consult on, highlight the dearth of research and guidance on suicide prevention. Future research is needed to explore the unique suicide risk and resilience factors among American Muslims to inform further prevention, intervention, and postvention efforts. Rising suicide rates in the United States, accompanied by the increasing marginalization of American Muslims, are causes for concern regarding suicide in this population (Hedegaard, 2018; Samari, 2018). New research, tools, and community-wide strategies are needed to mitigate this significant concern.

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