Cultural Considerations in Suicide Risk Assessment with Youth

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School counselors are well positioned within the school building to connect with students, especially those who are struggling with suicidal ideation. As rates of suicide for youth increase, especially amongst youth from minoritized groups, those on the front lines are tasked with finding resources to meet their needs. School counselors have an ethical obligation and the training to help identify the students who need their assistance (ASCA, 2022), however, there has been little research published on how cultural factors might need to be considered in the risk assessment process.

National data indicates suicide is the second leading cause of death for youth ages 10-14 and the third leading cause of death for youth ages 15-24 in 2020 (CDC, WISQARS, 2022). Six-thousand six hundred youth died by suicide in 2020 (CDC WISQARS, 2022). Rates of suicide for children and adolescents have steadily risen over the past decade and continue to rise. In addition, according to the Center for Disease Control and Prevention (2019), more than 1 in 3 high school students had experienced persistent feelings of sadness or hopelessness in 2019, a 40% increase since 2009. Approximately 1 in 6 youth reported making a suicide plan, a 44% increase since 2009. Additionally, in 2019, about 9% of high school students attempted suicide and 3% being seriously injured in a suicide attempt. In addition, there was a significant difference in adolescents seriously considering suicide based on their sexual identity (heterosexual: 14.5%; LGB: 46.8%; not sure: 30.4%] Ivey-Stepheson et al., 2020). Suicide attempts are associated with serious consequences, including negative mental health consequences, increased risk of subsequent attempts, and death (Bergen et al., 2012; Borges et al., 2010).

When looking at the breakdown of suicide for youth from minoritized populations, the highest suicide rates can be found among American Indian/Alaska Native (CDC, 2019). For

American Indian/Alaska Native females ages 10 -14, it is the leading cause of death and for ages 15-24 it is the second highest cause of death. For American Indian/Alaska Native males ages 10-24, it is the second highest cause of death. As of 2017, the suicide death rate among Black youth has increased faster than any other racial/ethnic group with Black youth under 13 years old being two times more likely to die by suicide (Bridge et al., 2018). Suicide is the third leading cause of death for Black, non-Hispanic females ages 10-24 and for males ages 10-24. For Hispanic males ages 5-9, suicide is the 10th leading cause of death, the second leading cause of death in 10-14 year olds and the third for ages 15-24. It is the third leading cause of death in 10-14 year old Hispanic females and the second leading cause of death for ages 15-24. For Asian/Pacific Islander, it is the first leading cause of death in 10-14 year old males and second for females and the reverse for 15-24 year olds (CDC WISQARS, 2022).

Although suicide attempts have declined among students identifying as sexual minorities, these students remained 3.8 times more likely to attempt suicide relative to heterosexual students (Raifman et al., 2020). More so, sexual minority students are more likely to report experiences with poor mental health and suicide, including persistent feelings of sadness and hopelessness, seriously considering attempting suicide, making a suicide plan, attempting suicide, and being injured during a suicide attempt (CDC, 2019). Toomey et al. (2018) examined the prevalence rates of suicidality across six gender identity groups: female; male; transgender, male to female; transgender, female to male; transgender, not exclusively male or female; and questioning. Results show disparities by gender identity in suicide attempts, with female to male adolescents reporting the highest rates of attempted suicide (50.8%). Adolescents who identified as non-binary (41.8%), male to female adolescents (29.9%), questioning adolescents (27.9%),

female adolescents (17.6), and male adolescents (9.8%) followed in rankings of risk levels (Toomey et al., 2018).

Even with the increasing rates of suicide for youth from minoritized backgrounds, the counseling field has given little attention to this group. The goal of this paper is to inform school counselors of the status of mental health challenges with youth and how counselors can work from a cultural theory of suicide developed by Chu et al. (2010) and adapted by the authors to better serve children and adolescents within their schools. A case study is also provided to demonstrate the application of some of the principles of the model.

Addressing Mental Health Issues in Schools

As of 2019, one in six U.S. youth aged 6-17 experience a mental health disorder each year, and half of all mental health conditions begin by age 18 (Whitney & Peterson, 2019). Additionally, half of the 7.7 million children in the U.S. with a treatable mental health disorder did not access a mental health professional (Whitney & Peterson, 2019). Minoritized children and those from low-income homes are also less likely to have access to mental health services unless provided via school-based services (Panigua, 2013).

According to Kern et al. (2017), the identification of children and adolescents with a mental health diagnosis has significantly increased since 2004. The Substance Abuse and Mental Health Services Administration 2019 report highlights that of adolescents ages 12-17 that reported major depression in 2018, 60% went without treatment (NASP, 2021). Additionally, children come to school having experienced crisis and trauma and undiagnosed mental health-related issues. Examples of these experiences include stress, bullying, family problems, anxiety, learning disabilities, alcohol and substance abuse, and self-injurious behaviors (NASP, 2021). Because poor mental health, persistent feelings of sadness and hopelessness, and isolation

have been linked to suicidality (CDC, 2019), it is important to recognize the ongoing need for school counselors who work with youth to have access to interventions and resources. Mental health providers who work with children and adolescents, especially those who work in schools, have the best access to reach many youth struggling with these life stressors.

The American School Counseling Association's National Model (ASCA, 2019) advocates for comprehensive programming that reaches all students, increasing the likelihood a school counselor will come into contact with a student who may be struggling. School counselors who provide direct services, including crisis counseling, play an important role in ensuring they are following best practices through the use of evidence-based and research informed tools and strategies as suggested in the model. The ASCA National Model (2019) also incorporates Mindsets and Behaviors (i.e., "Demonstrate effective coping skills when faced with a problem") that align with curriculum that could help prevent suicide in the future when taught early. ASCA has also created a position statement supporting the school counselor's active role in connecting with students who are identified as at-risk of suicide (ASCA, 2020). This position statement also advocates for the use of valid, reliable AND culturally sensitive instruments in the suicide screening process (ASCA, 2020).

COVID-19 Related Mental Health Concerns

According to Savit-Romer et al. (2021) the arrival of COVID-19 has impacted children's mental health in ways never seen before. This includes heightened trauma, suicidality, drug and alcohol abuse, post-traumatic stress disorder, technology addiction, family dysfunction (Pincus et al., 2020). Moreover, vulnerability factors like developmental age, educational status, pre-existing mental health condition, being economically underprivileged or being quarantined due to infection or fear of infection determines the quality and magnitude of impact on children

(Singh, et al., 2020). As Shen et al. (2020) state, the pandemic may increase the long-term adverse consequences on children and adolescents; specifically due to vulnerability factors such as developmental age, current educational status, having special needs, pre-existing mental health condition, being economically underprivileged, and a child/ parent being quarantined due to infection or fear of infection. The authors also noted that post-pandemic mental health issues in children manifest in various ways. For younger children (3-6 years old), they appeared to be clingier to adults/caretakers. Older children exhibited higher levels of inattention and hypervigilance about COVID-19. Overall, it seems children and adolescents did experience increased anxiety, irritability, restlessness, internet compulsivity, hoarding, and exposure to abuse and harm (Oosterhoff et. al. 2020; Shen et al.,2020). As Panchal et al. (2020) emphasized, the increased isolation due to long-term quarantine and social isolation was also a risk factor for suicide; and the lack of access to school-based mental health services may exacerbate mental health concerns and crises.

Suicide Assessments with Children and Adolescents

School counselors searching the literature for resources on the topic of children and suicide risk assessment will find few options within counseling journals. However, we can learn from fields outside of counseling. Miller (2018) determined that warning signs and risk factors should always be assessed collaboratively in children. Risk factors for suicide are an essential part of helping identify children who may be more vulnerable to suicide. Due to a lack of predictability in research of suicide risk factors and knowing even less about young children and suicide, we should consider these as only one part of understanding the child/adolescent (Miller, 2018).

Risk factors such as previous suicide attempts, and warning signs such as suicidal ideation, suicide plans, and feelings of sadness, place children/adolescents into a higher risk category (Barrio Minton, 2007; Rudd, 2017). Internal risk factors for suicide include feelings of worthlessness, negative automatic thought processes, and hopelessness (Ridge Anderson et al., 2016). Warning signs for suicide also include any preparatory behaviors such as planning or practicing for a suicide attempt. Although a small body of research has explored suicide risk among young children and adolescents, the basics of suicide risk assessments (SRAs) have remained the same for all individuals (Erbacher et al., 2015). Models of SRAs generally recommend practitioners assess risk and protective factors; identify suicidal ideation, intent, and plan; and combine the information into a clinical, or risk formulation (King et al., 2013).

Need for Cultural Consideration

While data available provides valuable information such as statistics, prevalence, attempts, trends, and demographics, limited information exists regarding the role of cultural considerations when working with children and adolescents experiencing suicidal ideation. As school counselors will likely provide services to youth from all backgrounds, cultures, and demographic characteristics, it is essential they develop cultural sensitivity when working with different populations. While it is important to keep in mind that any child could be at risk for suicide, it is equally important to learn how the different cultures represented address behavioral health issues and suicide risk and take that into consideration when developing prevention and intervention strategies (SAMHSA, 2012). For example, in addition to recognizing transgender adolescents disproportionately report higher rates of suicide attempts compared to cisgender adolescents, Toomey et al. (2018) stated suicide prevention efforts can be enhanced by

recognizing the variability within transgender student groups, particularly the elevated risk for female to male and nonbinary transgender adolescents.

Effective suicide prevention programs and assessments require an understanding of the cultures of students, their families, and communities (SAMSHA, 2012). As Chu et al. (2010) stated, the cultural meanings of suicide – what suicide means and what is considered acceptable to motivate suicide – represent a key intermediary step that may determine if individuals with certain suicide risk profiles will consider suicidal behaviors. By identifying the "cultural mediators" and "cultural brokers," practitioners can best design and determine culturally competent suicide prevention and assessment approaches. Accordingly, cross-cutting issues such as acculturative stress and protective factors within cultures, the roles of religion and spirituality and the family in culturally sensitive interventions, different manifestations and interpretations of distress in different cultures, and the impact of stigma and cultural distrust on help-seeking behaviors are important aspects when considering interventions in adolescent suicide prevention (Chu et al., 2010; Goldston et al., 2008; Phillips & Luth, 2020). Most importantly, counselors should consider that marginalized youth and families with histories of oppression, victimization, and other forms of trauma may have reservations when working with individuals who represent authority and power (Chu et al, 2017). Culturally sensitive services should also be collaborative; thus incorporating the insights of both science and culture into the assessment and intervention process. Nevertheless, counselors need to understand that suicide is not limited to specific groups of people and be aware that any young person may consider or attempt to die by suicide.

Strategies to Incorporate Cultural Considerations in Risk Assessment with Youth

A growing body of literature has examined cultural factors that impact risk for suicide. In a 2010 article, Chu and colleagues conducted a comprehensive literature analysis focusing on

culture-specific findings related to suicidal behavior in four groups – African Americans, Asian Americans, Latinos, and individuals self-identifying as members of LGBTQ community. From their review, they found four major categories of culturally specific risk. The first category, *cultural sanctions*, focuses on messages of approval or acceptability supported by one's culture. More specifically, Chu and colleagues noted that the context of culture not only influences acceptability of suicide as an option, but also the shame and unacceptability related to life events and experiences. They also found that religion, attitudes about suicide, coping beliefs, and moral objections play a role in cultural sanctions regarding the acceptability of suicide. The second category, *idioms of distress*, was described as one's means of attempting suicide, their likelihood to express suicidality, and the way suicide symptoms are expressed. They highlighted cultural differences in signs of suicide risk, how mental illness impacts risk for suicide, the likelihood that symptoms of suicide will be expressed, suicide methods, and behaviors such as substance abuse, aggression, and impulsivity. Notably, the authors argued that cultural differences in preferred method for suicide, how risk is expressed, and differences in the likelihood to disclose are essential to consider in suicide assessments and risk management. *Minority stress*, the third category, encompasses the stress experienced by cultural minorities due to their social identity or position in society (Meyer, 2003). This stress, and both experiences with discrimination and the internalization of negative messages, can lead to risk for suicide. Social disadvantages, such as low socioeconomic status, low educational attainment, homelessness, also play a role amongst risk for suicide amongst cultural groups. An area related to minority stress is acculturative stress – stress resulting from the acculturation process in which individuals experience a range of stressors that impact their mental health (Chu et al, 2010). It is an additional factor that has been found to shape risk for suicidal behavior amongst racial and ethnic groups (Gomez et al., 2011)

and has been related to hopelessness and increased vulnerability to suicidal ideation and depression (Polanco-Roman & Miranda, 2013). This is especially true for African Americans and Latinos (Chu et al., 2010). The final category, *social discord*, focused on conflict or alienation from family, friends, and/or one's community. Across the literature, a lack of social support significantly impacts risk for suicide; however, differences across culture play a role. This includes family rejection, family conflict, and alienation from friends, family, and a social community.

Despite the body of research focusing on cultural factors that impact risk for suicide, these factors have not been integrated into standard suicide risk assessments, tools, or models (Chu et al., 2019). Considering the role of these key cultural factors, Chu and colleagues (2010) developed a cultural model of suicide, which is a developmental, theoretical framework of suicidal behavior. The goal of the model is to provide an empirically based framework to improve the assessment of suicide risk amongst cultural minority groups. Chu and colleagues presented three theoretical principles that are rooted in their model: (1) culture shapes the various types of stressors and strengths that lead to suicidal behavior, (2) cultural meanings that are associated with both stressors and suicide shape the development of suicidal tendencies, the threshold of tolerance for psychological pain, and subsequent suicidal acts, and (3) culture shapes the expression of suicidal thoughts, intent, plans, and attempts (p. 36).

Case Study

Michael is an African American, 12-year-old cisgender male in the 7th grade. Michael lives in a predominantly White community, with only a few other students of color who attend his school. Michael has always done well in school and has enjoyed video-gaming with his friends online. Recently, Michael has lost interest in activities and is not sleeping well. He often

has nightmares that wake him in the middle of the night. One of Michael's friends has reported to his school counselor that Michael has posted some alarming messages on social media about wanting to end things.

After hearing from Michael's friend, the counselor invited Michael into her office. The counselor communicated to him that she heard he'd posted some messages about ending his life on Instagram. She also told him she'd heard he'd posted some hashtags that have been known to symbolize suicide. She invited Michael to share how he is doing. The counselor wanted to ensure that substantial time was taken to develop rapport in hopes of creating a safe and welcoming environment. The counselor asked gentle probing questions about Michael's current thoughts and how those thoughts had transpired. The counselor used gentle assumptions and a normalizing frame when talking with him, saying things like, "it sounds like there have recently been some struggles in your life that have led to you feeling suicidal" and "I've talked with other teens who've had some of these same struggles and they have also had thoughts of suicide, can you tell me more?" A strengths-based approach to suicide assessment relies on empathic connection and collaboration with the student (Sommers-Flanagan & Sommers-Flanagan, 2021). It is important the school counselor spends time listening to the child's story and not push the assessment process along too quickly.

After talking with Michael, the counselor learns that he has been watching the news with his parents and has seen video footage of the George Floyd murder. He has also seen protesting in large cities that is being shown across social media platforms as well. Some of Michael's friends at school have asked him how he feels about it and he admits that he has struggled with how to answer their questions. The images from the murder online have given him nightmares

and caused him to have some fear of police officers in his community (though that has not happened in the past).

The first principle of The Cultural Model of Suicide acknowledges that culture affects how suicidal thoughts, intent, plans, and attempts are expressed and the language or method a student chooses to use (Chu et al., 2010). The counselor would strive to understand how this might be expressed within the different groups of people they work with. While building this connection with the student, the counselor would want to spend time listening for how culture might affect the types of stressors that lead to suicidal thoughts or behaviors. Counselors with knowledge of minority stress, social discord, and cultural sanctions (the 2nd principle of the Cultural Model of Suicide) are more likely to connect how these might play a role in the child or adolescent's experience (Chu et al., 2010). The counselor should also be careful not to make any assumptions based on the student's minoritized status, but instead ask gentle probing questions while also relying on the knowledge they have acquired about different identities and intersectionality of these identities. It is also important for the counselor to be aware of what is currently the particulars of a student's social context and consider how this might be causing distress for the student. Incidences of violence, such as the murders of George Floyd and other Black Americans that have been broadcast on TV and in social media are traumatic for anyone, but especially for Black youth. Other crises such as living through the Covid-19 pandemic, which has caused financial and emotional strain on many families as they endure job insecurity, isolation, or even loss of loved ones, have taken a toll. Counselors recognize that hate crimes against minority groups have risen dramatically in the past 5 years and acknowledge how this has been distressing for many children and adolescents.

In talking with Michael, the counselor learns more about how Michael feels alone in his experience as one of the few African American students in his school. He also feels he does not have adults to connect with at school or who he sees as role models or someone he can ask questions about the racial unrest occurring in the country. Michael states that his parents want to protect him from what is happening and therefore, limits their discussions, but he is feeling a lot of anger, confusion, and sadness. Using Chu's 2nd principle, the counselor is aware that Michael's minoritized status may be causing him stress and asks, "as a young African American male, what are some things that cause you stress?"

Lastly, the school counselor would evaluate the cultural meanings associated with how stressors and suicide affect the development of suicidal tendencies (cultural sanctions and messages of acceptability), the third principle of the Cultural Model of Suicide (Chu et al., 2010). Similar to the second principle, this would require the counselor to spend time learning more about possible meanings different groups associate with suicide and how this might be communicated. If the counselor is unfamiliar with these different meanings or messages, they would take a very open and curious stance in working with students to not miss or dismiss their messages.

Throughout the risk assessment process, the counselor is listening, checking in with the student on the information they are gathering, and supporting the student. The counselor is gathering details about the student's suicidal ideation, including frequency, triggers, intensity, and duration. The counselor is also inquiring about any suicidal plans, including specificity, lethality, availability, and proximity while displaying calmness and curiosity (Sommers-Flanagan & Sommers-Flanagan, 2021). The counselor also asks the student about any previous attempts, their level of self-control, and their current agitation tolerance. Because the counselor embraces a

strengths-based approach, they also ask about wellness, strengths, and positive experiences (Sommers-Flanagan & Sommers-Flanagan, 2021).

Next, the counselor asks about and explores the individual's reasons for living and their reasons for dying to fully understand their story and level of distress. Lastly, the counselor and student engage in collaborative problem-solving and safety planning for assessment, treatment, and decision-making purposes. Because the counselor is working with a minor, they will be contacting parents or guardians to assist in the safety planning and decision-making process. Throughout the assessment process, the counselor is sensitive to cultural considerations and works from a culturally competent framework while also considering the developmental level of the child or adolescent. Lastly, the school counselor will most likely work with the school district's protocols completing the necessary documentation.

Next Directions: Culturally Competent Counselor Training in Suicide Risk Assessment

Counselors who work with youth benefit from considering the influence of cultural factors when assessing for suicide. Counselor training and development focus on the knowledge, attitudes, and skills one needs to become an effective counselor (Ratts, et al., 2016) as well as leaders (Ratts & Greenleaf, 2018). Ratts and colleagues updated the Multicultural and Social Justice Counseling Competencies which provided a framework for understanding the awareness and knowledge needed to be practice in the field ethically (MSJCC, 2016). Therefore, in regards to knowledge, the counselor benefits from assessing their understanding of the student's: culture, family dynamics, micro, meso, exo, and macrosystems. Counselors need to spend time learning about the children, families, and communities they serve. A counselor can spend time building relationships with students to know more about how the student perceives the different systems

they interact with and how this might be a stressor in their life- and the potential for how this might impact their suicidality.

The counselor would also want to evaluate their understanding of systemic racism and how this affects minoritized individuals, especially within their own communities. It is also important counselors understand the vulnerability of the profession. For example, there is a lack of representation in diagnosis and treatment of people of color in scholarly work (Armstrong, 2021). Behavioral health is particularly vulnerable to implicit bias because the diagnosis and treatment of mental health conditions rely heavily on provider discretion and were not designed to account for or accommodate the nuances of race, ethnicity, or culture (Armstrong, 2021). Lastly, counselors need to have knowledge of warning signs of suicide and principles of therapeutic assessment, especially in regard to working with children and adolescents.

When considering the attitudes one has, it is important to recognize how life experiences affect one's perceptions. As Victor Armstrong (2021) stated, "based on your life experience, is your perception incomplete or flawed? Are you as a clinician finishing my story based on your perception?" A counselors' unconscious attitudes toward historically marginalized populations can have a direct impact on outcomes for individuals seeking mental health treatment. Implicit bias is woven into the fabric of behavioral health and influences a provider's ability to engage in truly person-centered care (Armstrong, 2021). School counselors do not provide mental health treatment in the school setting, but they do provide responsive services to students in distress and therefore, it is helpful to be aware of those unconscious attitudes.

Counselors also need to recognize their own attitudes about suicide and how this might affect their work with a child or adolescent. Counselors should spend time reflecting on their

values and biases related to suicide and to individuals who are suicidal. Asking questions such as, “what do I think of people who attempt suicide” or “is it okay (or typical) for an adolescent to have thoughts of suicide” are helpful questions for reflecting on your biases.

Lastly, counselors need training in developing their skills in conducting risk assessments with individuals who are traditionally underserved. Counselors need skills in the developmentally appropriate ways to work with children and adolescents who are thinking about suicide. Traditional talk-therapy may not work with young people who struggle to communicate how they are feeling verbally. Counselors also need to develop their skills in building rapport with a wide variety of students of different ages and from diverse groups. It is recommended counselors consider addressing cultural factors as discussed in Chu et al.’s Cultural Model of Suicide (2010). It is important the counselor consider how culture affects the way a child or adolescent expresses their suicidal thoughts, intent, plans, and attempts.

Cultural factors play a key role in predicting suicidal behaviors, risk for suicide, and protective factors (Chu et al., 2019). Counselors who work with children and adolescents from minoritized groups have an obligation to understand how cultural factors might affect the suicide risk assessment process. Counselors strive to learn more about working with diverse groups of children, being diligent in responding to signs of distress and using their ethical guidelines to inform their practice. Counselors embrace a developmental and strengths-based approach to tackle the difficult responsibility of helping youth through their suicidal ideation and ultimately, to save lives.

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