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The Racial-Cultural Framework: A Framework for Addressing Suicide-Related Outcomes in Communities of Color

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Abstract

Suicide-related outcomes are a major public health challenge in communities of color in the United States. To address these challenges, this Major Contribution makes theoretical, empirical, and practice-related contributions to scholarship on suicide-related outcomes among people of color. In this article, the authors present a new framework to conceptualize previous suicidology scholarship, address existing literature gaps, and inform counseling psychologists' future work on suicide-related outcomes in U.S. communities of color. The framework consists of three components and nine principles that highlight the types of constructs, populations, and preventive interventions that should be emphasized in theory, research, and practice addressing suicide-related outcomes in communities of color. The authors explain why suicide-related outcomes in communities of color deserve attention, describe the framework, and discuss implications of the framework for future practice and training. It is hoped that this framework can serve as a resource and impetus for new paradigms of suicidology work in communities of color.

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Over the past decade, suicide-related outcomes have emerged as a topic of interest among counseling psychologists (Westefeld, 2011; Westefeld, Range, Rogers, & Hill, 2008). In a Major Contribution on suicide in *The Counseling Psychologist* (TCP), Westefeld et al. (2000) argued that because suicide risk is a common problem that many counseling psychology practitioners encounter when working with clients, it is important for counseling psychologists to be informed of the latest suicidology theories, research, and preventive interventions. Despite this developing interest, suicide-related outcomes remain a relatively peripheral topic in counseling psychology scholarship. To identify counseling psychology articles that focused primarily on suicide-related outcomes, we used the database *PsycINFO* to review scholarship from 2000 to 2011 in counseling psychology's two flagship journals, the *Journal of Counseling Psychology* (JCP) and TCP. We examined articles with the words, *suicide, suicidal*, or *suicidality*, in their titles and found only three articles in JCP (Flamenbaum & Holden, 2007; Gutierrez, Osman, Kopper, Barrios, & Bagge, 2000; Wong, Koo, Tran, Chiu, & Mok, 2011) and six articles in TCP (Choi, Rogers, & Werth, 2009; and five which were published in the 2000 Major Contribution) that met this criterion.

In contrast to suicide-related outcomes, multicultural issues related to people of color have been strongly represented in scholarship published in TCP and JCP (Buboltz, Deemer, & Hoffmann, 2010; Fouad, 2008). More broadly, counseling psychologists have been at the forefront of cutting-edge multicultural scholarship, including social justice (Vera & Speight, 2003), racism (e.g., Sue, 2003), acculturation and enculturation (e.g., Kim & Abreu, 2001), and culturally relevant prevention (Reese & Vera, 2007). Importantly, many of these topics have also been cited by scholars as areas deserving further attention in suicidology research and practice (Goldston et al., 2008; Joe, Canetto, & Romer, 2008; Leong & Leach, 2008). Furthermore, counseling psychology's emphasis on human strengths (Walsh, 2003) can provide a less pathological view of suicide-related outcomes by addressing protective factors that buffer against suicide risk. Therefore, counseling psychologists may be uniquely suited to contribute to theories, research, and practice on suicide-related outcomes among people of color.

Overview of This Major Contribution

Suicide-related outcomes are a major public health challenge for people of color; in 2010, 3,674 non-Whites in the United States died by suicide (American Association of Suicidology [AAS], 2012). The study of suicide-related outcomes among people of color deserves attention for several reasons. For one, although White Americans generally die by suicide at higher rates than people of color, the disaggregation of suicide data reveals elevated suicide rates in specific racial minority subgroups (Xu, Kochanek, & Tejada-Vera, 2009). For instance, in 2007, Native Americans aged 20 to 24 had the highest suicide rates (30.48 per 100,000) among all U.S. racial and age groups (Center for Disease Control and Prevention [CDC], 2011). In addition, because of differences in cultural and racial socialization, research findings on suicide-related risk and protective factors as well as preventive interventions based on White-majority samples are not necessarily generalizable to people of color (Choi et al., 2009).

Building on Westefeld et al.'s (2000) synthesis of suicidology theories and research, our Major Contribution is the first in TCP to focus primarily on suicide-related outcomes among people of color.

Comprising two articles, this Major Contribution extends the literature on suicide-related outcomes in several ways. First, this Major Contribution responds to calls for culturally relevant practice addressing suicide-related outcomes in people of color (e.g., Goldston et al., 2008). Rogers and Russell (2014, this issue) argue that cultural barriers to suicide risk assessment are much broader than difference in values and beliefs between the clinician and client. They present a set of five *compatibility heuristics* as a framework to help clinicians overcome cultural barriers to effective suicide risk assessment.

Second, in this article, we present guidelines for theory development, research, and practice relevant to suicide-related outcomes in communities of color. Although several scholars have conducted literature reviews on suicide-related outcomes among people of color (e.g., Goldston et al., 2008; Langhinrichsen-Rohling, Friend, & Powell, 2009; Leong & Leach, 2008; Range et al., 1999), these reviews tend to focus on summarizing the rates of suicide-related outcomes as well as risk and protective factors across communities of color. In contrast, we advance the literature by presenting a new conceptual framework—the Racial-Cultural Framework (RCF)—to conceptualize previous suicidology scholarship, address existing literature gaps, and inform counseling psychologists' future work on suicide-related outcomes

among U.S. communities of color. The central thesis of the RCF is that people of color's race and culture-related experiences should guide theory, research, and practice associated with suicide-related outcomes in communities of color. Furthermore, our framework emphasizes an ecological perspective that locates the causes of suicide-related outcomes not just in terms of individual pathology but also in inequitable and oppressive systems (Alcántara & Gone, 2007; Kenny & Hage, 2009). Consequently, our framework also emphasizes the importance of community- and environment-centered interventions in the prevention of suicide-related outcomes (Romano, Koch, & Wong, 2012). It should be noted that although our framework was developed to address suicide-related outcomes, it can be also adapted to address other illnesses and problems relevant to communities of color.

Before continuing, we clarify our use of terms in this article. *Suicide-related outcomes* include a broad range of suicidal activities, including suicide ideation, plans, attempts, and deaths. *Suicide ideation* refers to thoughts about killing oneself. Relatedly, *suicidology* refers to theories, research, and practice relevant to suicide-related outcomes. We use the term *people of color* or *communities of color* to refer to people of racial and ethnic minority backgrounds residing in the United States, including Asian, Black, Latino, Native, and Pacific Islander Americans. In addition, *culture* includes a set of values and beliefs that influences norms, practices, and institutions, whereas *race* is the social category to which people ascribe psychological meanings and stereotypes based on perceptions of physical characteristics (American Psychological Association [APA], 2003).

Overview of the Framework

The RCF consists of three interrelated components that are further categorized into nine principles (see Table 1). We propose a key question that each of the three components addresses: *What?* (Component 1, a focus on constructs), *Who?* (Component 2, a focus on populations), and *How?* (Component 3, a focus on interventions). What follows is a discussion of the three components and nine principles.

Component 1: Constructs in Theories and Research on Suicide-Related Outcomes

The first component of the RCF focuses on constructs that should be addressed in theory and research on suicide-related outcomes in communities of color.

Table 1. The Racial-Cultural Framework for Addressing Suicide-Related Outcomes in Communities of Color.

Component	Questions	Principles
Constructs	What constructs should be emphasized in theories and research addressing suicide-related outcomes in communities of color?	1. Examine the contributions of systemic inequities and oppression (e.g., racism) to suicide-related outcomes
		2. Address the complex ways in which cultural constructs serve as risk and protective factors in suicide-related outcomes
		3. Assess culturally relevant lay beliefs and attitudes about life, death, and suicide-related outcomes
Populations	Who (which communities of color) should be given more attention in suicide theory, research, and practice?	4. Disaggregate data on suicide-related outcomes to identify ethnic subgroups that have been neglected in previous suicidology work
		5. Adopt an intersectionality perspective (e.g., intersections of race and gender) to address suicide-related outcomes in communities of color
Interventions	How should suicide preventive interventions in communities of color be conducted and what should be the focus of these interventions?	6. Adapt culturally relevant suicide preventive interventions
		7. Collaborate with communities of color to devise, implement, and evaluate suicide preventive interventions
		8. Increase access to treatment resources
		9. Incorporate environment-centered suicide preventive interventions

Principle 1: Examine the Contributions of Systemic Inequities and Oppression

Consistent with recent counseling psychology scholarship that emphasizes ecological perspectives on psychological distress, we propose that oppressive environments and systemic inequities are salient risk factors for suicide-related outcomes among people of color (Buhin & Vera, 2009). Although multiple forms of oppression may predict suicide-related outcomes, we focus on racism and racial inequities because of their central relevance to the lives of people of color (Sue, 2003). A growing number of scholars have theorized that racism is an important risk factor for suicide related among people of color (Joe et al., 2008; Utsey, Hook, & Stanard, 2007; Wong & Poon, 2010). Using Durkheim's (1897/1951) theory of suicide, racism can be conceptualized as an antecedent to suicide-related outcomes because it represents societal rejection or failure to integrate successfully into society (Mullen & Smyth, 2004). Similarly, racism can be viewed as generating a sense of failed belongingness, which is, in turn, a risk factor for suicide-related outcomes (Wong & Poon, 2010). Perceived racism has been found to be associated with suicide ideation among Asian American adults (Cheng et al., 2010), gay and bisexual Latino American men (Diaz, Ayala, Bein, Henne, & Marin, 2001), and Native American adolescents (Walls, Chapple, & Johnson, 2007). Collectively, these studies addressed individual forms of racism (Thompson & Neville, 1999).

Racism and racial inequities can also occur at the macro level in the form of racial income inequalities, racial segregation, and other types of systemic inequities (Buhin & Vera, 2009; Sue, 2003). For instance, Alcántara and Gone (2007) proposed that the legacy of colonization may help explain the relatively high rates of suicide in Native American communities. Drawing from criminology research and theoretical models, two studies found support for a racial inequality suicide thesis—Black American male and Latino American suicides were elevated in geographical areas with greater Black–White and Latino–White economic inequalities, respectively (Burr, Hartman, & Matteson, 1999; Wadsworth & Kubrin, 2007). Racial economic inequality may engender resentment, hopelessness, and eventually, self-destruction because it violates the principles of equal opportunity and fair play (Burr et al., 1999).

In another study, Kubrin, Wadsworth, and DiPietro (2006) applied Wilson's (1996) deindustrialization thesis to the study of suicides among Black American men. Wilson proposed that the decline in U.S. manufacturing industries since the 1960s was particularly detrimental to less educated

Black American male city dwellers who traditionally worked in manufacturing industries. Consistent with this thesis, Kubrin et al. found that in cities with a lower proportion of individuals employed in manufacturing jobs, Black American men experienced greater economic disadvantages (e.g., higher joblessness and poverty rates), which predicted higher Black American male suicide rates. In contrast, urban industrial composition did not affect White American economic disadvantages and White American male suicide rates. Together, these studies underscore the importance of examining macro-level, ecological manifestations of racial inequities as antecedents of suicide-related outcomes.

In terms of future directions, we encourage counseling psychology researchers to pay greater attention to developing and testing theories that address the link between racism and suicide-related outcomes in communities of color. In addition to individual forms of racism, counseling psychologists are urged to address macro-level manifestations of racism and racial inequities as suicide risk factors. However, research on macro-level risk factors has typically been conducted by sociologists, epidemiologists, and public health researchers (e.g., Burr et al., 1999; Neeleman, 2002) rather than by psychologists. Because the study of macro-level suicide risk factors often requires the investigation of geographical regions, such research may require psychologists to use multilevel research designs that include the effects of geographical contexts (such as neighborhoods and metropolitan areas) on suicide risks. In this regard, one promising line of inquiry may be to test both individual and macro experiences of racism; for instance, researchers can test whether individual experiences of racism mediate the link between people of color's residence in highly segregated neighborhoods and suicide risk (cf. Acevedo-Garcia, Lochner, Osypuk, & Subramanian, 2003).

Principle 2: Address the Complex Ways in Which Cultural Constructs Serve As Risk and Protective Factors

We encourage researchers to address the complex ways in which culture can serve as both risk and protective factors for suicide-related outcomes in communities of color. Culture has had an increasingly prominent role in suicidology scholarship (Goldston et al., 2008; Lester, 2008; Shropshire, Pearson, Joe, Romer, & Canetto, 2008). Most studies on culture and suicide-related outcomes can be classified into two areas—(a) demographic differences and (b) acculturation and enculturation.

Demographic Differences. These studies typically involve drawing inferences about the link between culture and suicide-related outcomes based on

demographic differences (e.g., race). Several studies have investigated racial differences in risk and protective factors. Studies that have examined differences between Black and White Americans have consistently shown that mental illness indicators were poorer predictors of suicide ideation, attempts, and death among Black American adolescents, adults, and older adults than their White American counterparts (Abe, Mertz, Powell, & Hanzlick, 2006; Merchant, Kramer, Joe, Venkataraman, & King, 2009; Rockett, Lian, Stack, Ducatman, & Wang, 2009; Vanderwerker et al., 2007). For instance, Abe et al. (2006) found that among individuals who had died by suicide in Fulton County, Georgia, Black Americans were less likely to have experienced depression than White Americans. Similarly, two studies showed that Latino American suicide decedents were less likely to have had depressed mood or a mental illness diagnosis than their White American counterparts (Betz, Kryzaniak, Hedegaard, & Lowenstein, 2011; Rockett et al., 2009).

In contrast, interpersonal factors (e.g., relationships with family and social comparisons) have been shown to be better predictors of suicide-related outcomes for Black American adolescents and older adults as well as Asian American girls than for their White American counterparts (Liu, 2005; Merchant et al., 2009; Vanderwerker et al., 2007; Watt & Sharp, 2002). For example, Black American adolescents, but not White American adolescents, were more likely to attempt suicide when they felt their fathers and adults did not care for them (Watt & Sharp, 2002). In another study, a close relationship with one's mother exerted a protective effect on Asian American (but not White American) girls' suicide ideation (Liu, 2005). Collectively, these studies dovetail with the findings of other studies that highlight the potential contribution of interpersonal (especially family-related) risk factors to suicide-related outcomes in communities of color (e.g., Kuhlberg, Peña, & Zayas, 2010; Magat & Guerrero, 2008; Novins, Beals, Roberts, & Manson, 1999; Wong, Brownson, & Schwing, 2011).

Researchers have also assessed differences in suicide-related outcomes as a function of immigration status. Studies have consistently shown that U.S.-born Latino American adults and adolescents have higher suicide ideation, attempt, and death rates than their immigrant counterparts (Fortuna, Perez, Canino, Sribney, & Alegria, 2007; Singh & Hiatt, 2006; Sorenson & Shen, 1999). Research on Asian Americans that utilized national samples have also provided some support for the notion that immigrants have lower rates of suicide-related outcomes. Two national studies found that, in general, U.S.-born Asian Americans exhibited higher suicide ideation and death rates than immigrant Asian Americans (Duldulao, Takeuchi, & Hong, 2009; Singh & Hiatt, 2006).

Nonetheless, there are limitations in the use of demographic indicators as proxies for cultural constructs. In addition to conceptual challenges with racial comparisons (e.g., Helms, Jernigan, & Mascher, 2005), such comparisons do not allow for empirical inferences on the causes of racial differences unless researchers also assess mediation effects of these differences. Similarly, immigration status is often used as a proxy for adherence to dominant European American cultural norms and the norms of indigenous cultures for people of color (Schwartz, Unger, Zamboanga, & Szapocznik, 2010). However, in interpreting the above-mentioned findings on immigration status and suicide-related outcomes, it is difficult to assess whether immigrants tend to have lower suicide-related outcomes because of the protective nature of their adherence to indigenous cultural norms, their relative lack of adherence to dominant European American cultural norms, or both. Insofar as race and immigration status are distal constructs associated with culture, acculturation and enculturation may provide a more proximal approach to understanding the relationship between culture and suicide-related outcomes.

Acculturation and Enculturation. *Acculturation* refers to the process of being socialized to the norms of a dominant culture, whereas *enculturation* refers to the process of maintaining or being socialized to the norms of one's indigenous culture (Kim & Abreu, 2001). Acculturation and enculturation can be conceptualized as multidimensional cultural constructs that include behaviors (e.g., language, food, and music), values (e.g., independent and interdependent self-construals), and identities (e.g., attachment to one's ethnic group; Schwartz et al., 2010). There is mounting research interest in the intersection of acculturation, enculturation, and suicide-related outcomes among people of color (e.g., Goldston et al., 2008; Smokowski, David-Ferdon, & Stroupe, 2009).

Studies that examined the relationships between acculturation, enculturation, and suicide-related outcomes among Asian Americans have mixed findings. Acculturation (measured by a combination of language proficiencies and proportion of life in the United States) was positively associated with suicidal behavior among Asian American adolescents (Lau, Jernewall, Zane, & Myers, 2002). In contrast, acculturation (measured by a combination of behavioral and identity acculturation) was not significantly related to suicide ideation in a study on Korean American adolescents (Cho & Haslam, 2010). In another study, behavioral enculturation, but not behavioral acculturation, was modestly but positively and significantly associated with suicide ideation among Asian Canadian college students (Kennedy, Parhar, Samra, & Gorzalka, 2005). In a fourth study, enculturation to Asian values was not

significantly related to Asian American college students' suicidal behavior (Choi & Rogers, 2010).

Studies on acculturation, enculturation, and suicide-related outcomes among Black Americans and Pacific Islander Americans are relatively sparse. Yuen, Nahulu, Hishinuma, and Miyamoto (2000) found, contrary to hypothesis, that behavioral enculturation was linked to greater likelihood of suicide attempts. Walker, Utsey, Bolden, and Williams (2005) found no significant relationship between behavioral acculturation and suicide ideation and attempt in a community sample of Black American adults. In contrast, there has been more research on the link between acculturation/enculturation and suicide-related outcomes among Latino Americans. Fortuna and colleagues (2007) demonstrated that language acculturation was positively associated with suicide ideation and attempts among Latino American adults. However, studies on Latino American adolescents have reported mixed findings. Olvera (2001) found that language enculturation was not a significant predictor of suicide ideation. In another study, acculturation (combining behavioral and identity acculturation) was not a significant predictor at the bivariate level, but was a significant negative predictor of Mexican American adolescents' suicide ideation in the presence of other variables in a multiple regression analysis (Rasmussen, Negy, Carlson, & Burns, 1997). In a third study, neither behavioral enculturation nor behavioral acculturation significantly differentiated Latina American adolescent suicide attempters from nonattempters (Zayas, Bright, Alvarez-Sanchez, & Cabassa, 2009).

Studies on acculturation, enculturation, and suicide-related outcomes among Native Americans have focused primarily on adolescents. Behavior enculturation was positively related to suicide ideation among Native American adolescents on a Northern Plains reservation, but this association ceased to be significant when other variables were added in a multivariate model (LaFromboise, Medoff, Lee, & Harris, 2007). In contrast, Yoder, Whitbeck, Hoyt, and LaFromboise (2006) found that among Native American youth living near or on reservations in the Upper Midwest, enculturation (combining behavioral and identity enculturation) was not significantly related to suicide ideation at the bivariate level, but was a significant and negative predictor when other variables were added in a logistic regression model. Three other studies found no significant relationship between acculturation, enculturation, and suicide-related outcomes among Native American adolescents (Freedenthal & Stiffman, 2004; Howard-Pitney, LaFromboise, Basil, September, & Johnson, 1992; Novins et al., 1999).

Future Directions. What can we conclude from this morass of conflicting evidence, results contrary to hypotheses, and null findings? Perhaps it is time for researchers to move beyond a focus on direct effects of acculturation/enculturation on suicide-related outcomes to other research methodologies and cultural constructs that might better account for suicide-related outcomes in communities of color. In the remainder of this section, we present several emerging research directions to address the complex ways in which cultural constructs serve as risk and protective factors in suicide-related outcomes.

One potential explanation of the aforementioned findings is that acculturation and enculturation generally do not exert meaningful direct effects on suicide-related outcomes; rather the link between acculturation/enculturation and suicide-related outcomes may be better represented by differential effects. A few studies have shown that acculturation or enculturation exerted differential effects on the link between other variables and suicide-related outcomes (e.g., Lau et al., 2002; Wong, Koo, et al., 2011; Wong, Uhm, & Li, 2012). For instance, Walker, Wingate, Obasi, and Joiner (2008) demonstrated that ethnic identity buffered the association between depressive symptoms and suicide ideation among Black American college students. In another study, Wong and Maffini (2011) used latent class regression to identify three latent classes that demonstrated differential relationships between indicators of belongingness (e.g., family relationships) and subsequent suicide attempts among Asian American adolescents. The authors found that highly acculturated Asian Americans had a greater likelihood of being in the only latent class in which family relationships was not a significant protective factor against suicide attempts. In light of these findings, we encourage researchers to use more sophisticated methodology (e.g., moderation and latent class analyses) that can address differential effects of acculturation and enculturation on suicide-related outcomes.

It might also be appropriate for counseling psychologists to move beyond acculturation and enculturation to test other cultural constructs that are implicated in suicide-related outcomes. Acculturative stress (i.e., the stress associated with navigating two different cultures) may be a more proximal risk factor for psychological distress than acculturation and enculturation per se (Hwang & Ting, 2008). Such a perspective acknowledges that regardless of their levels of acculturation and enculturation, some people of color struggle with navigating between their indigenous culture and European American culture. One example of acculturative stress that may be a risk factor for suicide attempts is family conflicts triggered by discrepant levels of acculturation

between Latina American adolescents and their parents (Zayas, Lester, Cabassa, & Fortuna, 2005). A few studies have identified acculturative stress as a risk factor for suicide-related outcomes among Latino American adolescents (Hovey, 1996, 2000) and Black American college students (Walker et al., 2008). Conversely, research has found that biculturalism (being highly acculturated *and* highly enculturated) may be a protective factor against deleterious mental health outcomes (Schwartz et al., 2010). By applying suicidology theories that highlight social risk factors for suicide (Durkhiem, 1897/1951; Joiner, Van Orden, Witte, & Rudd, 2009), acculturative stress can be reconceptualized as alienation from one or more cultures, whereas biculturalism may represent successful social integration into one's indigenous culture and the dominant societal culture. Therefore, we encourage counseling psychologists to pay more attention to how acculturative stress and biculturalism might influence suicide-related outcomes in communities of color.

In addition, we urge counseling psychologists to move beyond a focus on individual-level cultural constructs to consider macro-level cultural constructs (Schwartz et al., 2010). One promising cultural construct that sociologists and epidemiologists have studied in relation to suicide is the ethnic density of geographical locations. Researchers have found that living in an area with a lower concentration of people with a similar ethnic or racial background was associated with higher suicide-related outcomes for Asians and African Caribbeans in South London (Neeleman & Wessely, 1999) and immigrant Latino Americans in the United States (Wadsworth & Kubrin, 2007). Living in an area with a higher ethnic minority concentration may be a suicide protective factor by enabling people of color to connect with a larger social network of people from similar backgrounds (Wadsworth & Kubrin, 2007).

Third, and arguably most importantly, suicidology scholarship, including multicultural suicidology research, has generally been characterized by a lack of strong theoretical grounding (Joe et al., 2008; for an exception, see Zayas et al., 2005). Indeed, the pathways through which cultural constructs influence suicide-related outcomes are not well understood (Utsey et al., 2007). Therefore, counseling psychologists could return to the proverbial drawing board to develop or adapt innovative suicidology theories that explain how culture is implicated in suicide-related outcomes.

Although it is not the goal of this article to propose a new suicidology theory, we urge counseling psychologists to develop suicidology theories that address what we term *the minority paradox*. The gender paradox refers to a well-documented suicide-related phenomenon that has been observed in

many (but not all) cultures and countries—women have higher rates of suicide ideation and attempts than men, but men die by suicide at higher rates (Canetto, 2008). To a lesser extent, there is some evidence that an analogous paradox exists when comparing the suicide-related outcomes of adolescents of color and White American adolescents. Asian American and African American adolescents have been found to report higher suicide ideation rates (Vander Stoep, McCauley, Flynn, & Stone, 2009) but have lower suicide rates than White American adolescents (CDC, 2011). Similarly, Latino American adolescents (especially girls) have higher suicide ideation and attempt rates (see Blumentritt, 2007, for a review) but lower suicide rates than White Americans (CDC, 2011). The reasons for the discrepancy between nonfatal and fatal suicide-related outcome rates are not well understood. We encourage researchers to explore the possibility that some cultural constructs might serve not only as risk factors for nonfatal suicide outcomes but also as protective factors against suicide deaths. For instance, Langhinrichsen-Rohling et al. (2009) posited that the Latino cultural value of marianismo might be not only a risk factor for suicide ideation and attempts among Latina American adolescents but may also buffer against suicide deaths because it emphasizes the value of living for the sake of loved ones.

Principle 3: Assess Culturally Relevant Lay Beliefs and Attitudes About Life, Death, and Suicide

Counseling psychologists are encouraged to incorporate culturally relevant lay beliefs and attitudes about life, death, and suicide in their development of theories and research relevant to suicide-related outcomes among people of color. Such beliefs and attitudes include those about the meanings, causes, and consequences of suicide-related outcomes, death, and reasons for living, as well as beliefs about how to cope with suicide (Braun & Nichols, 1997; Canetto, 2008; Rogers & Whitehead, 2008).

An examination of culturally relevant lay beliefs and attitudes is useful for several reasons. Suicide preventive interventions that incorporate the lay beliefs held by key stakeholders in a community of color will likely be perceived as more credible within the community (e.g., May, Serna, Hurt, & DeBruyn, 2005). In addition, an investigation of such beliefs and attitudes may help identify culturally relevant strengths that buffer against suicide risk, a focus that is consistent with counseling psychology's emphasis on human strengths (Walsh, 2003). In this regard, it may be useful to assess people of color's reasons for living that protect them from suicide. For instance, studies have shown that Black and Latino Americans more strongly

endorsed survival and coping beliefs and moral objections to suicide as reasons for living than White Americans (Ellis & Range, 1991; Oquendo et al., 2005). These findings may help identify culturally relevant protective factors that are salient in specific communities of color, although as discussed below, studies on reasons for living are not without limitations.

An investigation of culturally relevant lay beliefs about life, death, and suicide may also form the basis for the development of new culturally sensitive suicidology theories (Lester, 2006). Although lay beliefs about suicide are not identical to scientific theories, they may contain an element of truth that may explain suicide-related outcomes (Walker, Lester, & Joe, 2006). For instance, some scholars have observed that in many Asian cultures, suicide is viewed as a solution to intractable interpersonal problems rather than as a consequence of mental illness (Range et al., 1999; Shiang, 2000). Consistent with these notions, a study of Asian American college students lay beliefs about why Asian American college students might develop suicide ideation found that the overwhelming majority of responses described interpersonal causes, especially family problems (Wong, Koo, et al., 2011). In addition, LaFromboise and Bigfoot (1988) theorized that Native American cultural beliefs about the interconnections between the human and spirit worlds may reduce fears about death and suicide. Such beliefs can be incorporated in the development of suicidology theories relevant to communities of color.

Furthermore, culturally relevant lay beliefs and attitudes may provide insight into how communities of color cope with suicide-related outcomes as well as how their loved ones might respond to them. In a qualitative study of Black American pastors' views on suicide, Early and Akers (1993) found that suicide was viewed as an unthinkable sin, a rejection of one's Black identity, and as a "White thing" that is foreign to Black culture. Although these attitudes may serve as a buffer against suicide for Black Americans, they may also attach a high level of stigma to suicide-related outcomes. Consequently, Black Americans who hold these attitudes toward suicide, yet struggle with suicidal tendencies, may be reluctant to seek help or disclose their suicide ideation to others.

With regard to future research directions, we encourage more qualitative studies on people of color's lay beliefs and attitudes toward life, death, and suicide (Leach & Leong, 2008). Qualitative research may provide a more nuanced understanding of the subjective meanings that people attribute to suicide-related outcomes (Chung, 2010). In addition, we encourage counseling psychologists to develop culturally relevant measures of reasons for living for specific communities of color. There are other culturally salient dimensions of reasons for living not examined in existing measures. For

instance, current measures of reasons for living do not assess commitment to one's tribe and commitment to one's racial identity, dimensions that may be culturally relevant protective factors for some Native American tribes (e.g., Lester, 1997) and for Black Americans (Early & Akers, 1993), respectively.

Component 2: Populations

The second component of the RCF focuses on the populations that should be given more attention in suicidology theory, research, and practice. One factor that might explain the conflicting findings on the link between culture and suicide-related outcomes (see Principle 2) is that many studies do not assess within-group variability (e.g., gender and ethnic differences) in communities of color. Therefore, we propose two principles—disaggregation and intersectionality—to identify communities of color that deserve greater attention. Guided by the goal of providing marginalized communities of color with equitable access to resources (Vera & Speight, 2003), our discussion of these principles is informed by the following question: "Who has been neglected in suicidology theory, research, and practice?"

Principle 4: Disaggregate Data to Identify Ethnic Subgroups' Suicide-Related Outcomes

Much of previous multicultural research on suicide-related outcomes has focused on specific racial groups (e.g., Latino Americans; Zayas et al., 2009) or comparisons between racial groups (e.g., Black vs. White Americans; Abe et al., 2006). Similarly, the CDC (2011) compiled national suicide data based on five "racial" categories: *White, Black, American Indian/Alaskan Native, Asian Pacific Islander*, and *Other* (combined) as well as the "ethnic" category of *Hispanics*. Unfortunately, these categories do not allow for the examination of variations among ethnic subgroups (e.g., Chinese, Haitian, and Mexican American) within these categories. Accordingly, disaggregation of data on suicide-related outcomes is needed to identify specific ethnic subgroups that are at higher risk for suicide-related outcomes. What follows is a brief review of research that has adopted a disaggregation strategy to address ethnic subgroup differences in suicide-related outcomes.

Among the three largest Latino American ethnic subgroups—Mexican, Puerto Rican, and Cuban Americans—research has consistently shown Puerto Rican Americans to be at higher risk for suicide attempts and ideation than Mexican Americans or Cuban Americans (Baca-Garcia et al., 2011; Fortuna et al., 2007; Ungemack & Guarnaccia, 1998). Among Asian

Americans, suicidal deaths, ideation, and attempts of Chinese and Japanese Americans tend to be higher than other subgroups such as Vietnamese and Filipino Americans (Cheng et al., 2010; Lester, 1994). Research on Black Americans have found that Caribbean Black American adults had higher rates of suicide attempts and ideation than African American adults (Joe, Baser, Breeden, Neighbors, & Jackson, 2006; R. J. Taylor, Chatters, & Joe, 2011). In contrast, among Black American adolescents, African Americans had higher rates of suicide ideation and attempts than Caribbean Black Americans (Joe, Baser, Neighbors, Caldwell, & Jackson, 2009). Research on Native Americans has also demonstrated dramatically different rates of suicide-related outcomes among Native American tribes and tribal subgroups (Garroutte et al., 2003; Middlebrook, LeMaster, Beals, Novins, & Manson, 2001). For example, May and Van Winkle (1994) found that the number of suicide per 100,000 from 1957 to 1979 was 33.06 for Apache, 20.30 for Pueblo, and 7.45 for Navajo. Moreover, Novins et al. (1999) found that among three Native American tribes, the correlates of adolescents' suicide ideation were different; indeed, there was no single correlate of suicide ideation common to the three tribes.

Overall, these findings underscore the importance of disaggregating suicide-related outcome data to identify specific ethnic subgroups that may have elevated rates of suicide-related outcomes (e.g., Puerto Rican Americans) or diverse risk and protective factors. Nevertheless, the disaggregation of suicide data presents a challenge because the CDC (2011) currently does not publish national suicide data based on ethnic subgroups. To advance suicidology theory, research, and practice related to communities of color, counseling psychologists may need to advocate for public policy changes to enable suicide data on specific ethnic subgroups to be more readily available.

Although the foregoing literature review suggests the existence of ethnic subgroup differences in suicide-related outcomes within communities of color, the reasons for these differences need to be further explored. Some scholars speculate that differences in cultural and spiritual beliefs may account for these ethnic subgroup differences (Leong, Leach, Yeh, & Chou, 2007; May & Van Winkle, 1994; Novins et al., 1999). For instance, Novins et al. (1999) attributed differences in suicide-related outcomes among Native American tribes to differences in beliefs about death and suicide, interpersonal relationships, self-concept, and social support. Future research should explore suicide-related outcomes of ethnic subgroups and identify relevant mediators of these subgroup differences. Such research can, in turn, form the basis for culturally relevant suicide preventive interventions for specific ethnic subgroups.

Principle 5: Adopt an Intersectionality Perspective

In addition to the disaggregation of data on ethnic subgroups, we encourage counseling psychologists to adopt an intersectionality perspective when addressing suicide-related outcomes. The intersectionality perspective originated from the works of feminists of color and critical race theorists who found that people's experience of discrimination and privilege could be amplified or diminished depending on the intersections of their diverse identities (e.g., gender, race, and sexual orientation; Cole, 2009). For example, Crenshaw (1994) argued that Black American women experience disadvantages in ways that are qualitatively different from both White American women and Black American men. An intersectionality perspective in suicidology can help identify subgroups within communities of color that deserve further attention as well as acknowledge the unique, intersecting contributions of multiple forms of oppression to suicide-related outcomes (Diaz et al., 2001). We focus in particular on the intersections of race/ethnicity with age, gender, sexual orientation, and socioeconomic status.

Age. Suicide rates in communities of color vary quite drastically as a function of age (CDC, 2011). Although Native American adolescents and young adults have the highest suicide rates among the major racial groups of a similar age range, among older adults aged 65 to 85, the number of suicides per 100,000 for Native Americans (7.58) is lower than that of White Americans (16.08) and Asian Pacific Islander Americans (APIAs; 8.91; CDC, 2011). An analysis of the 2007 CDC suicide data for each major racial group reveals differences in the age group that is most at risk. The age group with the highest number of suicides per 100,000 was 30 to 34 years for Black Americans, 20 to 24 years for APIAs, 50 to 54 years for Latino Americans, 20 to 24 years for Native Americans, and 45 to 49 years for White Americans (CDC, 2011). Consistent with an intersectionality perspective, it appears that the intersection of race, ethnicity, and age engender unique suicide risk and protective factors across diverse communities of color. For instance, the suicide rate for older African Americans aged 65 to 85 (3.87 per 100,000) is less than half the rate for African Americans in the 30 to 35 age category (9.03 per 100,000), although it is not known what risk and protective factors might be responsible for this difference. Collectively, these findings underscore the importance of adopting a developmental and lifespan approach to understand suicide-related outcomes in communities of color (cf. King, 1998).

Gender. Across all major racial and age groups in the United States, men die by suicide at higher rates than women (CDC, 2011). Consistent with the gender paradox found among White Americans and in many other countries (Canetto, 2008), there is some evidence that women of color have higher

rates of nonfatal suicide-related outcomes than men of color. APIA men have been shown to report lower suicide ideation and attempt rates than their female counterparts (Else, Goebert, Bell, Carlton, & Fukuda, 2009; Grunbaum, Lowry, Kann, & Pateman, 2000). Duldulao et al. (2009) also found that U.S.-born Asian American women reported higher rates of lifetime suicide ideation than U.S.-born Asian American men. Similarly, Latina American adults and adolescents have been found to have higher risk of suicide attempts than their male counterparts (e.g., Fortuna et al., 2007; Zayas et al., 2005). Joe et al. (2006) showed that African American women had higher rates of suicide attempt than African American men; however, this trend was reversed for Caribbean Black Americans—Caribbean Black American men had a higher attempted suicide rate than Caribbean Black American women as well as African American women and men.

In addition to these findings, the 2007 CDC suicide data categorized by race, gender, and age reveal several noteworthy trends. Although APIAs generally have lower suicide rates than the overall U.S. suicide rates, there were two exceptions—among APIA women from all age groups, those aged 20 to 24 and those aged 65 to 85 have the highest suicide rates, and these rates also exceed the overall U.S. suicide rates for women in similar age groups (CDC, 2011). Among Latino American men, the suicide rate was highest among older adults aged 65 to 85 (16.22 per 100,000), whereas among Latina Americans, the highest suicide rate was found among those in the 25 to 29 age group (3.40 per 100,000; CDC, 2011). These results highlight the value of examining the intersections of race, gender, and age when examining suicide-related outcomes in communities of color. They also suggest that certain groups with elevated rates of suicide may have been neglected in previous suicidology research and practice. Although we are not aware of any published research that has examined risk and protective factors associated with suicide-related outcomes among older Asian American women and older Latino American men, one promising theoretical explanation that deserves further research attention is the cultural scripts model (Canetto, 1997; Stice & Canetto, 2008). According to this model, the extent to which suicidal behaviors (e.g., suicide deaths and attempts) are perceived as feminine or masculine varies across culture and affects the rate of suicide-related outcomes among women and men in a given culture. Applying this model, suicide rates within a specific cultural group of women (e.g., older Chinese American adults) would be high if these women perceive killing oneself as a feminine act.

Sexual Orientation. A few studies have shown that lesbian, gay, and bisexual people of color have higher rates of suicide-related outcomes than heterosexual people of color (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007;

Pinhey & Millman, 2004). In particular, discrimination due to a dual minority status (i.e., racism and homophobia because of one's racial and sexual minority statuses) has been theorized to increase the risk of psychological distress (Diaz et al., 2001). However, evidence for the dual minority status hypothesis remains inconclusive. Cochran et al. (2007) found that gay and bisexual Latino and Asian American men were more likely than their heterosexual counterparts to have reported a recent suicide attempt, although these findings were not compared with the suicide attempt rate of gay and bisexual men from other racial backgrounds. Therefore, more research is necessary to test the impact of dual minority status on suicide-related outcomes in communities of color. An alternative intersectionality approach is to focus on unique discriminatory experiences that arise from the interface of race and sexual orientation instead of viewing racism and homophobia as distinct experiences. For example, a study of gay and bisexual Latino American men found that many participants reported experiencing racism by members of the gay community; 62% reported they had been sexually objectified because of their race or ethnicity and that experience was associated with increased likelihood of suicide ideation in the past 6 months (Diaz et al., 2001).

Socioeconomic Status. Consistent with research on White Americans' suicide-related outcomes, lower socioeconomic status has been found to be positively associated with greater risk for suicide-related outcomes across several communities of color (Clarke, Colantonio, Rhodes, & Escobar, 2008; Diaz et al., 2001; Duldulao et al., 2009; Wadsworth & Kubrin, 2007). One study showed that Latino American communities demonstrated higher suicide rates when they were economically less affluent (Wadsworth & Kubrin, 2007). However, researchers have found a reverse trend for Black American men. Among Black American men, a higher socioeconomic status has been shown to be associated with an increased suicide rate (Jackson & Williams, 2006). In line with an intersectionality perspective, this finding suggests that the meaning and consequences of social class may vary across communities of color (Cole, 2009). For many Black American men, a higher social class may reflect increased exposure to discrimination as well as the disappointing experience of being in an occupation that is not commensurate with their educational qualifications (Jackson & Williams, 2006).

Component 3: Interventions

The third component of the RCF provides four recommendations on suicide preventive interventions for communities of color. Although crisis interventions and psychotherapy are important means of suicide prevention (Joiner et al.,

2009), more than two thirds of people who die by suicide do not seek professional psychological help in the year prior to dying by suicide (Luoma, Martin, & Pearson, 2002). This rate of professional help seeking may be lower in communities of color due to stigmatization about mental health, impediments to resources and help services, as well as systemic barriers, such as historical experiences of oppression (McCabe et al., 1999). Therefore, the prevention of suicide-related outcomes in communities of color needs to include other interventions in addition to crisis and psychotherapeutic interventions (Romano et al., 2012). Guided by ecological perspectives on prevention (e.g., Alcántara & Gone, 2007), Principles 6 to 9 address universal and selective preventive interventions. Universal preventive interventions target an entire population regardless of suicide risk (e.g., the use of public service announcements [PSAs]), whereas selective preventive interventions target the needs of individuals who are at risk for developing suicide-related outcomes (Joiner et al., 2009).

Principle 6: Adopt Culturally Relevant Suicide Preventive Interventions

We encourage counseling psychologists to use culturally relevant suicide preventive interventions with communities of color (Joe et al., 2008). *Cultural relevance* refers to interventions that incorporate the cultural practices, beliefs, values, norms, and customs that form the core of a community (Barrera & Castro, 2006; Castro, Barrera, & Martinez, 2004). Culturally relevant interventions are essential because risk and protective factors for suicide-related outcomes differ across culture (see our discussion of Principle 2), which limits the generalizability of suicide preventive interventions used in White-majority populations. Moreover, the use of preventive interventions that are congruent with the cultural norms of a community increases the credibility of the interventions within the community (Reese & Vera, 2007).

There is a growing body of literature about culturally relevant suicide preventive interventions for Native American communities (Hamilton & Rolf, 2010; Middlebrook et al., 2001). LaFromboise and colleagues (LaFromboise & Howard-Pitney, 1995; LaFromboise & Lewis, 2008) developed the Zuni Life Skills Development Program, a suicide preventive intervention that focused on life skills training for high school students in a New Mexico Zuni reservation. The intervention was tailored specifically to address Zuni cultural manifestations of symptoms associated with suicide. Furthermore, the curriculum commenced with an invocation from a Zuni leader who reminded students that their lives were their most important possession. LaFromboise

and Howard-Pitney (1995) found that high school students who attended the program had lower levels of suicide probability than a no-intervention group. In another study, May and colleagues (2005) monitored a population-based suicide preventive program for adolescents and young adults above 15 years in a New Mexican Athabaskan tribal reservation. The program included a multifaceted range of culturally relevant interventions (e.g., community education for adults, school-based curriculum, and clinical services) that targeted suicide risk factors specific to the tribe. The authors found a significant decrease in suicide attempts and gestures from 1988 to 2002.

In a third study, Muehlenkamp, Marrone, Gray, and Brown (2009) created a culturally relevant multidimensional campus-based prevention program for Northern Plains Native American college students that included educational (e.g., gatekeeper training) and cultural/spiritual components. Grounded in the notion that connecting students with traditional Native American cultural practices strengthened their resilience against suicide, a spiritual advisory committee was formed to coordinate and provide cultural and spiritual ceremonies (e.g., talking circles, sweat lodge ceremonies, and cleaning ceremonies) to these Native American college students. Hence, the program provided students direct access to cultural and spiritual activities that were integrated into their university life. The authors found that Native American students who participated in the program reported greater suicide knowledge.

There are a few culturally relevant interventions for Black American communities that have focused on women and youth. In a church-based suicide prevention program directed at Black American youth (Molock, Matlin, Barksdale, Puri, & Lyles, 2008), the authors proposed that a suicide educational curriculum be integrated with communication mediums that have cultural relevance to the Black American church. For instance, sermons and Sunday school lessons would emphasize the importance of seeking professional mental health for suicide-related outcomes. Another intervention involved an outpatient 10-session, group-based intervention for suicidal, low-income Black American women who were survivors of intimate partner abuse (Davis et al., 2009). The intervention was developed with appropriate consideration of contextual factors for this population. Black American women are often not inclined to seek help from institutions responsible for their oppression, and many feel that counselors do not understand the context in which they live. To address these concerns, the preventive intervention integrated the transtheoretical stages of change model by Prochaska, DiClemente, and Norcross (1992) with sensitivity to gender, culture, and systemic barriers (Heron, Jacobs, Twomey, & Kaslow, 1997). The intervention included collaborations with community agencies that supported women and

incorporated the use of Afrocentric theory and Black feminism/womanism to empower participants (Davis et al., 2009). Although all intervention participants had attempted suicide within the year prior to their participation, only 13% attempted suicide within a year of their participation. In addition, almost 90% of participants reported extremely high or high levels of satisfaction with the intervention.

Unfortunately, there is limited peer-reviewed documentation of suicide preventive interventions for Asian, Pacific Islander, and Latino American communities. Therefore, we encourage counseling psychologists to develop culturally relevant suicide preventive interventions for these communities as well as for Black American men, a group that has demonstrated increasing rates of suicide attempts over the past few decades (Joe, 2010). Furthermore, an important limitation of most suicide preventive interventions (including culturally relevant suicide preventive interventions for communities of color) is the general lack of empirical evidence that these interventions reduce rates of suicide deaths (Joiner et al., 2009). For instance, after the introduction of a population-based suicide preventive program for Native American youth, May and colleagues (2005) found a reduction in suicide gestures and attempts but not suicide deaths. Accordingly, more research is needed to demonstrate the effectiveness of culturally relevant interventions in reducing suicide death rates. Another limitation of culturally relevant suicide preventive interventions is the need for greater theoretical grounding. Joe et al. (2008) observed that without a good theory, it is difficult to determine which aspect of a suicide preventive intervention is responsible for the desired outcomes. Therefore, we encourage counseling psychologists to take the lead in developing theory-based suicide preventive interventions for communities of color.

Principle 7: Collaborate With Communities of Color

Integral to the formulation and implementation of culturally relevant suicide preventive interventions in communities of color is collaboration with leaders and members of the community (Sullivan et al., 2001). Whereas cultural relevance addresses the content of a suicide preventive intervention, we propose that collaboration is a critical means through which an intervention becomes culturally relevant. Communities that lack social and economic power are often the focus of well-intentioned interventions developed by people outside the community with little input from community stakeholders (Fondacaro & Weinberg, 2002). Such interventions are less likely to be culturally relevant and to be supported by community members. In contrast,

culturally relevant suicide prevention programs involve collaboration between researchers and community stakeholders to create and implement interventions that integrate the needs of the community, culture, and evidence-based programs (Skaff, Chesla, Mycue, & Fisher, 2002).

Collaboration with community stakeholders helps establish egalitarian partnerships with local communities (Reese & Vera, 2007). Collaboration facilitates the implementation of culturally relevant interventions because people within a community can provide insight into the cultural values of their community (Reese & Vera, 2007). In other words, members of a community are viewed as experts on their own culture and understand their community's values, history, and coping strategies. In addition, involving community members in all phases of the preventive intervention builds new strengths by empowering community stakeholders to be agents of change within their own communities (Romano & Hage, 2000; Skaff et al., 2002). The active involvement of community members in preventive interventions also increases the likelihood that the intervention would be supported by the community over time, which, in turn, increases participation in the intervention (Hage et al., 2007).

Collaboration can take place at several phases of a preventive intervention, including (a) identifying important leaders, members, and stakeholders; (b) designing a preventive intervention; (c) implementing the preventive intervention; and finally (d) evaluating the intervention (Lerner, 1995). Several suicide preventive interventions for Native American communities illustrate the value of researcher–community collaborations. Two preventive interventions documented in our foregoing discussion (Principle 6) involved widespread collaborations between researchers and tribal members. Extensive input was sought from Zuni tribal members in the development of the Zuni Life Skills Development Program through the use of focus groups (LaFromboise & Lewis, 2008). For example, input from tribal members led to a title change of the program from Zuni "suicide prevention" to Zuni "life skills development." Similarly, collaboration between researchers and tribal members in the development of the suicide preventive programs for an Athabaskan tribe involved more than 50 interactive group discussions on the problems to address in the community (May et al., 2005). Moreover, the implementation of the intervention involved people from different facets of the community, including schools, neighborhoods, and local mental health professionals to provide services in nonstigmatizing environments. For example, neighborhood volunteers were selected as "natural helpers" to provide counseling to clients who preferred to receive help from trusted laypeople. In a third study, researchers conducted a community-based participatory

project to examine suicide-related outcomes in White Mountain Apache adolescents and young adults (Mullany et al., 2009). In collaboration with tribal leaders, researchers explored suicide rates and methods among community members between 2001 and 2006. Tribal leaders made the executive decisions about the data to collect and the data they wanted released. Researchers supported these requests by developing and standardizing measures, collecting data, and conducting data analysis (Mullany et al., 2009).

To summarize, we encourage counseling psychologists to establish collaborative partnerships with community stakeholders in their design, implementation, and evaluation of culturally relevant suicide preventive interventions for communities of color. Given the benefits of collaboration, researchers can also assess whether the quality of researcher–community collaboration mediates the effectiveness of suicide preventive interventions. In addition, researchers can also test whether collaboration increases the social validity of suicide preventive interventions (i.e., the extent to which community members and participants approve of the intervention).

Principle 8: Increase Access to Treatment Resources

Research has consistently revealed racial disparities in the use of crisis and psychotherapeutic services, with White Americans using these services at higher rates than people of color. In an assessment of a school-based suicide prevention program, Kataoka, Stein, Lieberman, and Wong (2003) found that Latino American high school students who were at high risk for suicide were underidentified for follow-up crisis interventions relative to White American students, despite previous documentation of higher suicide attempt rates among Latino American youth. In addition, after contact with the suicide prevention program, Latino American students were less likely than non-Latino American students to seek follow up for mental health services outside of school (Kataoka, Stein, Nadeem, & Wong, 2007). Similarly, Freedenthal (2007) found that among suicidal adolescents, Latino and Black Americans had a reduced likelihood of using mental health services relative to White Americans. Overall, people of color have reduced access to mental health services, are less likely to receive services even if access is available, and receive poorer quality of care in comparison with White Americans (U.S. Department of Health and Human Services [DHHS], 2001). Possible reasons for racial disparities in the use of professional mental health services include the stigma of suicide and mental illness, the lack of culturally and linguistically competent services, and a lack of financial resources (U.S. DHHS, 2001). For instance, among people of color living at or below the

poverty line, the main avenue for care is through emergency services during times of crisis rather than through mental health services (Heron et al., 1997).

Reducing barriers and racial disparities in access to treatment resources for suicide-related outcomes is consistent with counseling psychologists' growing interest in social justice research and practice (Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006). In particular, we highlight two preventive interventions that have commonly been used to increase the use of mental health services by suicidal individuals—suicide screening and gatekeeping.

Suicide screening is a common suicide preventive strategy to identify those at risk for suicide. Respondents who score above a particular threshold on these screening tools are deemed to be at risk for suicide and are identified for follow-up interventions. Several studies have explored the utility of suicide screenings in schools, which often involves the administration of a screening tool to as many students as possible (e.g., Brown & Grumet, 2009; Peñta & Caine, 2006; Scott et al., 2009). Screening tools typically involves questions on participants' mental health symptoms (e.g., depression and anxiety). However, among people of color (relative to White Americans), mental illnesses are poorer predictors of suicide-related outcomes, whereas interpersonal factors (e.g., family relationships) are better predictors of suicide-related outcomes (see Principle 2; for example, Abe et al., 2006). Hence, in addition to assessing mental illness symptoms, suicide screening tools that are used in communities of color may need to be adapted to include culturally salient risk factors, such as interpersonal isolation and family conflicts.

In addition to suicide screening, gatekeeping is another commonly used suicide preventive intervention. Gatekeeping involves training and encouraging people in contact with potentially suicidal individuals to identify suicide warning signs and to refer them to professional help (Paris, 2006). Gatekeeping may help increase the use of mental health services because research has shown that the majority of people who seek counseling services were prompted by someone to seek counseling (Vogel, Wade, Wester, Larson, & Hackler, 2007). Gatekeeping interventions used in communities of color are most effective when directed at social network members whom individuals are most comfortable seeking help from. For instance, previous research indicated that Black American youth who attended church regularly preferred young adult gatekeepers (Molock et al., 2007); therefore, Molock et al. (2008) proposed that a concerted effort should be made to recruit young adults for a church-based gatekeeping program for Black American youth. In another study, Chu, Hsieh, and Tokars (2011) found that relative to Latino Americans, Asian Americans were less likely to seek help for suicide ideation from all types of professional sources except medical professionals;

therefore, the authors proposed training medical professionals to recognize suicide warning signs among Asian American patients and to make appropriate referrals to counseling when necessary.

Overall, we urge counseling psychologists to explore ways to increase access to treatment resources in communities of color. There is more evidence on the existence of racial disparities in the use of treatment resources than on *why* these disparities exist. Therefore, we encourage research to identify mediators of racial disparities in the use of mental health services among suicidal individuals.

Principle 9: Incorporate Environment-Centered Interventions

In line with our emphasis on macro-level sources of suicide-related outcomes (see Principle 2), we encourage counseling psychologists to use environment-centered suicide preventive interventions with communities of color. Such interventions shift the focus of attention from psychological problems to macro-level causes of suicide-related outcomes. Examples include interventions directed at the media and advocacy to introduce public policies that address macro-level risk factors.

The media can play a powerful but dangerous role in promoting suicide contagion by glorifying suicide or providing excessive information about the methods used by people to die by suicide (Jobes, Berman, O'Carroll, Eastgard, & Knickmeyer, 1996). That is, media portrayals of fictional as well as actual suicides can provide a social model for subsequent suicide and suicide attempts (Gould, 2001; Pirkis & Blood, 2001). Studies have found that television portrayals of suicides have led to increased rates of suicide deaths and attempts using the same methods portrayed (Gould, Jamieson, & Romer, 2003). Moreover, suicide contagion tends to be most prevalent among people who share similar life experiences and demographic characteristics as suicide decedents portrayed in the media (Gould, 2001).

Given the danger of media-influenced suicide contagion, educating media professionals about responsible portrayals and reporting of suicides is an important means of suicide prevention. Gould (2001) recommended that media reports of suicide should avoid portraying suicide as heroic or romantic, exercise care with publishing pictures of suicide decedents, avoid providing detailed descriptions of suicide method and site, and provide information about local treatment resources. Gould also reviewed evidence showing that suicide rates in Austria and Switzerland declined after media guidelines on the reporting of suicides were introduced. Although such guidelines have been widely disseminated to media professionals (Gould et al., 2003), it is

unclear whether professionals who work for ethnic minority media organizations (e.g., journalists who write for a Mexican American newspaper) are familiar with these guidelines. The challenge of media contagion is compounded by the rise of the Internet as an important source of news. One recent study found that a significant proportion of websites on Asian American suicide-related outcomes provided either inaccurate or inappropriate (e.g., descriptions of suicide methods) information about suicide deaths (Park, Kwok, Yan, & Wong, 2010). Accordingly, counseling psychologists can help prevent suicide contagion by educating professionals involved in ethnic minority media on guidelines for responsible media reporting of suicides.

Although the media can be a source of suicide contagion, it can also be a means of suicide prevention through PSAs. A PSA could target a community of color to raise awareness about suicide and reduce stigma about seeking mental health services (Leong, Leach, & Wong, 2011). For example, a PSA on a radio station for Vietnamese Americans could provide information about suicide warning signs, access to help services, and other information about suicide prevention using language that accurately represents cultural conceptualizations of suicide (Leong et al., 2011; Olson & Wahab, 2006). Such information can also serve a gatekeeping function by encouraging members of the community to refer people to appropriate help resources (Joiner et al., 2009).

In addition to engaging the media, counseling psychologists can also advocate for public policies that reduce macro-level suicide risk factors in communities of color. Given our foregoing discussion of the link between racial economic inequality and suicides (see Principle 1), it is possible that environment-centered public policies that reduce racism and racial inequities (Buhin & Vera, 2009) may also prevent suicides in communities of color. For instance, counseling psychologists can advocate for socially just macroeconomic policies that reduce racial economic inequality. Another example of a macro-level factor that has implications for public policy is the ethnic and immigrant density of geographical locations. As our foregoing discussion of Principle 2 demonstrates, low immigrant and ethnic minority concentration in a geographical area may be a risk factor for higher suicide rates in communities of color (Neeleman & Wessely, 1999; Wadsworth & Kubrin, 2007). Such findings raise questions about the wisdom of refugee resettlement policies that encourage the dispersing of refugees across geographical areas to reduce the density of refugee concentration in a particular area (Desbarats, 1985). Accordingly, counseling psychologists can educate government leaders and public policy makers about suicidology research that can inform immigration and refugee resettlement policies.

Another public policy that can reduce macro-level suicide risk factors in communities of color is suicide means restriction. Research has shown that reducing access to certain suicide means (e.g., firearms and bridges) has been followed by a reduction in suicide rates (Daigle, 2005). For instance, a Canadian study that used interrupted time-series analyses concluded that a new law on firearms restriction may have been responsible for a reduction in suicide rates (Carrington & Moyer, 1994). Means restriction is effective because many people have a preference for a suicide method; hence, people with restricted access to a suicide means may not necessarily turn to alternative means of suicide (Daigle, 2005). There is evidence that the means by which people choose to die differ across race and that certain communities of color may have preferred methods of suicide (Lainer, 2010; Lester, 1994). Stack and Wasserman (2005) found that Black Americans were more than 2 times as likely as White Americans to use violent means of suicide (e.g., hanging and firearms). Another study showed that from 1979 to 1997, the rates of firearm suicides among Black American males aged 15 to 24 years increased more than their White American male counterparts (Joe & Kaplan, 2002). In a third study, Asian American suicide decedents were found to use hanging at higher rates than White American decedents (Shiang et al., 1997). Accordingly, counseling psychologist can identify suicide means that are salient in specific communities of color and, where appropriate, advocate for restriction of access to these means.

Perhaps the most glaring limitation in the literature on environment-centered suicide preventive interventions is the lack of research on the effectiveness of such interventions in communities of color.

For instance, we are not aware of any published research that has evaluated preventive interventions related to media-influenced suicide contagion, the use of PSAs, and suicide means restrictions in communities of color. We encourage counseling psychologists to address these areas in future research.

Overall Practical Implications and Conclusions

Our overarching practice recommendation is for counseling psychologists to be more engaged in preventive interventions to reduce suicide-related outcomes in communities of color. As illustrated in Principles 6 to 9, suicide prevention work that is grounded in ecological perspectives requires counseling psychologists to move beyond their traditional role in providing psychotherapy to other professional roles, such as consultancy, training, outreach, and advocacy (Hage et al., 2007; Vera & Speight, 2003). Nonetheless, this call to action creates a conundrum because it is unclear whether the

above-mentioned suicide preventive interventions are regularly incorporated in the curricula, practica, and internships provided in counseling psychology training programs. Indeed, prevention training appears to be lacking in most graduate psychology training programs (Hage et al., 2007). Accordingly, the full implementation of our practice recommendations requires the infusion of multicultural suicide preventive interventions in the training of counseling psychologists. Examples include practicum training in which students collaborate with ethnic minority community agencies to develop and deliver gatekeeping training, the infusion of ecological perspectives in the curriculum of doctoral training, and coursework that emphasize the knowledge and skills needed to develop a prevention program (Matthews & Skowron, 2004).

To conclude, in this article, we present a new framework, the RCF, to conceptualize previous suicidology scholarship, address existing literature gaps, and inform counseling psychologists' future work on suicide-related outcomes among communities of color in the United States. Grounded in racial, cultural, and ecological perspectives, the RCF addresses the types of constructs, populations, and preventive interventions that should be emphasized in theories, research, and practice relevant to suicide-related outcomes in communities of color. Our hope is that this framework can serve as a resource and impetus for new paradigms of suicidology work in communities of color.

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