

Diversity & Suicidal Behavior

Current suicide risk assessment tools do not contain guidelines for mental health clinicians on how to tailor risk assessment and crisis management procedures for diverse patient populations, including sexual orientation, race/ethnicity, and religious diversity. The current fact sheet was designed to assist mental health clinicians when assessing and managing suicide risk among diverse patient populations.

The CLEAR (Center for LGBT Evidence-based Applied Research) is in the process of evaluating a brief evidence-based tool for culturally-competent suicide risk detection that complements and improves existing assessment procedures for use with African American, Asian American, Latino, and LGBTQ populations—the Cultural Assessment of Risk for Suicide Instrument (CARS).

<http://clear-research.org/projects/suicideinstrument.html>

Sexual Orientation Diversity

Attending to issues of sexual diversity in suicide prevention refers to the consideration of common and unique risk factors and treatment concerns for lesbian, gay, bisexual, and transgender (LGBT) individuals. Current empirical research has yielded the following findings regarding suicidal behavior in LGBT individuals:

LGBT individuals are at increased risk for suicide, non-lethal suicide attempts, and suicidal ideation. A population based study in Denmark conducted over the 12 months following the legalization of same-sex registered domestic partnerships (RDP's) found that risk for suicide *among men* was 8 times greater for men in RDP's than for men in heterosexual marriages and twice as high compared to unmarried men (Mathy, Cochran, Olsen, & Mays, 2011). A meta-analytic review found (King et al., 2008) that LGBT individuals were two times as likely to have a lifetime history of a suicide attempt compared to heterosexual individuals, with risk especially elevated for gay & bisexual men who were four times as likely to have a lifetime history of a suicide attempt. Increased risk for suicide attempts has been documented in population-based studies (Meyer, Dietrich, & Schwartz, 2008; Paul et al., 2002; Silenzio, Pena, Duberstein, Cerel, & Knox, 2007), as well as family/twin studies (Balsam, Beauchaine, Mickey, & Rothblum, 2005; Fergusson et al., 1999; Herrell et al., 1999). Risk for suicide attempts among LGBT males is highest before age 25 (Russell & Toomey, 2012).

Increased risk for suicide attempts in LGBT individuals is likely due to factors shared with non-LGBT high risk groups (e.g., LGBT individuals are at elevated risk for mental disorders; King et al., 2008) and factors related to the social experience of the LGBT population, including **the experience of stigma, prejudice, and discrimination** related to sexual preferences (Hatzenbuehler, 2011; Meyer, 2003).

LGBT youth are at increased risk for suicide attempts and suicidal ideation (Spirito & Esposito-Smythers, 2006). A window of particularly elevated risk is at the time of disclosing one's sexual orientation to others: loss of friends after sharing one's sexual

orientation is a strong predictor of suicide attempts among gay, lesbian and bisexual youth (Hershberger, Pilkington, & D'Augelli, 1997).

Clinicians working with LGBT clients may wish to consult the following resources in order to increase their **cultural competency** when working with suicidal LGBT clients:

- The American Association of Suicidology, Information on Special Populations, Lesbian, Gay, Bisexual and Transgender:
<http://www.suicidology.org/web/guest/stats-and-tools/special-populations>
- [Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients](#). Adopted by the American Psychological Association Council of Representatives on February 26, 2000. Available online:
http://www.apadivision44.org/resources/apa_guidelines.php
- The American Psychological Association, Division 44, Society for the Psychological Study of Lesbian, Gay, Bisexual, and Transgender Issues:
<http://www.apadivision44.org/>
- The National Coalition for Lesbian, Gay, Bisexual, and Transgender Health:
<http://www.lgbthealth.net/index.shtml>

Further reading:

- A short book chapter that provides an overview of mental health issues with LGBT clients, as well as recommendations on conducting EST's with cultural sensitivity when treating LGBT clients: Gordon, K. H., & Castro, Y. (2007). The assessment, diagnosis, and treatment of psychiatric disorders in lesbian, gay, and bisexual clients. In J. D. Buckner, Y. Castro, J. M. Holm-Denoma, and T. E. Joiner (Eds.), *Mental Health Care for People of Diverse Backgrounds*. Seattle, WA: Radcliffe Publishing.
- The American Psychological Association's *Handbook of Counseling and Psychotherapy with lesbian, gay, bisexual, and transgender clients (2nd Edition)*; Bieschke, Perez, Ruperto, DeBord, 2006) contains chapters on providing psychotherapy, as well as an overview of research on psychotherapy with LGBT clients.
- An article that reviews the findings and recommendations of a taskforce convened by the American Foundation for Suicide Prevention: Haas et al. (2011). Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations. *Journal of Homosexuality*, 58, 10-51. DOI: 10.1080/00918369.2011.534038

Ethnic & Racial Diversity

Attending to issues of ethnic and racial diversity in suicide prevention refers to the consideration of common and unique risk factors and treatment concerns for individuals of diverse ethnic and racial backgrounds. Current empirical research has yielded the following findings regarding suicidal behavior and ethnic/racial diversity:

In the United States, suicide rates differ by race and ethnicity: In 2009, age-adjusted suicide rates by race were as follows: White = 13.07, Black = 5.17, Native American = 11.91, Asian American = 6.28. Regarding ethnicity, the rate for those who identify as Hispanic was 5.3 (CDC, 2012).

Suicide rates in young African American males exhibited a sharp increase between 1981 and 1994 (AAS African American Fact Sheet). Walker (2007) has proposed that acculturative stress, which is the stress that someone experiences as he or she moves from one cultural framework to another, provides a potential explanation for this rise in suicide rates in African American men.

Native Americans die by suicide at markedly elevated rates (AAS USA Fact Sheet). Suicide rates are higher in tribes that reside in the Northern Plains, and this group also tends to have a lower sense of social cohesion than tribes of the Southwest (Van Winkle & May, 1993).

Among youth in the U.S., **Hispanic youth attempt suicide more frequently than other groups**. Data from the CDC's Youth Risk Behavior Surveillance System (YRBSS) indicate that in 2003, the prevalence of suicide attempts was higher among Hispanic youth (10.6%) than white (6.9%) and black youth (8.4%). For attempts requiring medical attention, prevalence was higher in Hispanic females (5.7%) than white females (2.4%) and black females (2.2%). Prevalence was also higher in black males (5.2%) and Hispanic males (4.2%) than white males (1.1%). Zayas, Lester, Cabassa, and Fortuna (2005) suggest that suicidal behavior in these youth may be explained by examining interpersonal variables: a conflict may exist between a cultural emphasis on family unity and an individual desire for autonomy.

Clinicians may wish to consult the following resources in order to increase cultural competency when working with suicidal clients of diverse ethnic and racial backgrounds:

The American Association of Suicidology's website (<http://www.suicidology.org>) contains a Fact Sheet on "African Americans and Suicide," as well as numerous fact sheets *in Spanish* on suicide prevention, including warning signs.

The website of National Organization for People of Color Against Suicide (NOPAS; www.nopcas.com) contains links to articles cultural competence in suicide prevention.

The American Foundation for Suicide Prevention (AFSP; afsp.org) is sponsoring an "International Project on Suicide Prevention Strategies." Their website includes proceedings from a workshop that were published in the *Journal of the American Medical Association*.

The Suicide Prevention Resource Center (SPRC; www.sprc.org/) and AFSP have collaborated on a Best Practices registry for suicide prevention interventions. The website contains a list of interventions and descriptions, including an intervention targeting Native American individuals (American Indian Life Skills Development/Zuni Life Skills Development).
http://www.sprc.org/featured_resources/bpr/ebpp.asp

The Office of Minority Health has a website with suicide prevention resources, as well as resources on cultural competency: www.omhrc.gov

Further reading:

Leong, F. T. L., & Leach, M. M. (2008). *Suicide Among Racial and Ethnic Minority Groups: Theory Research & Practice*. New York: Routledge.

Horton, L. (2006). Social, cultural, and demographic factors in suicide. In R. I. Simon & R. E. Hales (Eds.), *The American Psychiatric Publishing Textbook of Suicide Assessment and Management*. Arlington, VA: American Psychiatric Press.

Wendler, S. (2006). Cultural Competence in Suicide Risk Assessment. In R. I. Simon & R. E. Hales (Eds.), *The American Psychiatric Publishing Textbook of Suicide Assessment and Management*. Arlington, VA: American Psychiatric Press.

Religious Diversity

Attending to issues of religious diversity in suicide prevention refers to the consideration of religious and spiritual factors when assessing and managing suicide risk, as well as providing psychotherapy to suicidal clients with diverse religious/spiritual backgrounds.

Current empirical research has yielded the following findings regarding suicidal behavior in religiously diverse individuals:

Religiosity—self-perceived importance of religion—functions as a protective factor against suicidal behaviors in many studies and across many cultures, but not all:

- Higher self-reported religiosity has been shown to be associated with *lower* rates of past suicide attempts among adult samples from Canada (Blackmore et al., 2008), Native Americans (Garrouette et al., 2003), Afghan refugees (Jahangir et al., 1998), as well as adolescents in the U.S. (Nonnemaker et al., 2003).
 - In China, females die by suicide more often than males (at a rate of 1.1 to 1; World Health Organization, 2003). Religiosity may function differently among Chinese women, thus providing one potential mechanism to explain the difference in the gender ratio (i.e., in most other countries, more men die by suicide; Zhang & Xu, 2007). Among a sample of Chinese women who recently attempted suicide, *higher religiosity* was associated with *higher* levels of intent to die (Zhang & Xu, 2007).
 - Higher religiosity is associated with lower levels of suicidal ideation among American and Kuwaiti college students (AbdelKhalek & Lester, 2007), as well as African American and white adults in the U.S. (Walker & Bishop, 2005). Higher self-reported religious well-being is associated with stronger reasons for living (and not attempting suicide; Ellis & Smith, 1991).
- 2. Regular participation in religious activities** is a protective factor for lethal and non-lethal suicide attempts.
- Participation in religious activities has been shown to be less frequent among older adults in the US who died by suicide compared to older adults who died by natural causes (Nisbet et al., 2000).
 - Reductions in church attendance in the U.S. have also been shown to correlate with increased suicide rates (Martin, 1984).
 - However, research suggests that regular church attendance is protective against suicide attempts, while infrequent church attendance elevates risk for attempts (compared to non-attendance; Blackmore et al. 2008)
 - Church attendance is also associated with lowered beliefs in the acceptability of suicide in both African American men and women (Stack, 1998). Lower moral and religious objections to suicide are associated with a greater number of lifetime suicide attempts (Lizardi et al., 2008).
- 3. Not all aspects of religion/spirituality** are protective against suicide.

- As mentioned above, infrequent church attendance has been shown to be associated with greater likelihood of a suicide attempt compared to individuals with no attendance (Blackmore et al., 2008).
- Among women in China, greater religiosity has been shown to be associated with greater intent to die when making suicide attempts (that were non-lethal).
- Religious strain, including religious fears and guilt and beliefs in having committed an unforgivable sin, are associated with *greater* levels of suicidal ideation, as well as *stronger* desire to discuss these issues in psychotherapy (Exline et al., 2000).

Clinicians interested in treatment considerations and recommendations for specific religious affiliations may wish to consult Brown & Van Orden (2007), Koenig (1998), and Richards and Bergin (2000). The latter text dedicates individual chapters to the major religions represented in America, including breakdowns by denominations, (e.g., there are separate chapters for Roman Catholicism and Eastern Orthodox Christianity). Each chapter begins with an overview of the beliefs and practices of the religion for readers who desire general information about religious groups in addition to specific treatment guidelines, as a way to help build up culture-specific expertise.

Brown, J. S., & Van Orden, K. A. (2007). The assessment, diagnosis, and treatment of religiously diverse clients. In J. D. Buckner, Y. Castro, J. Holm-Denoma, & T. E. Joiner, (Eds.), *Mental Health Care for People of Diverse Backgrounds within an Empirically Informed Framework*. Oxford: Radcliffe Publishing. Koenig, H.G. (1998). *Handbook of religion and mental health*. San Diego (CA): Academic Press.

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