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Cultural Competency

Developing Strategies to Engage Minority Populations in Suicide Prevention

Report from the NOPCAS Task Force
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INTRODUCTION

The National Organization for People of Color Against Suicide (NOPCAS) was contracted by the Suicide Prevention Resource Center (SPRC) to develop ways to engage minorities in suicide prevention, intervention, and postvention initiatives. Under the contract, NOPCAS developed a task force of Latinos, African Americans, Asians, and American Indians to help develop a plan for SPRC. For the first phase of the project, the task force met for two days in August 2003 to identify specific characteristics that distinguish each of the sub-communities that comprise the minority community, and to discuss strategies to communicate effectively with each sub-community.

Due to the difficulty of this undertaking, the task force decided to develop a document that would outline the issues involved in engaging communities of color. The task force determined that phase II of the project would address effective engagement methods in more detail.

Suicide prevention and intervention initiatives for minority groups must be tailored to ensure social justice, ethnical acceptability, and effectiveness (IOM, 2003; Dumas, 1999). This document will address the complexities associated with defining each ethnic group represented in the task force. The document will hopefully provide readers with a better understanding of the challenges we face in communicating more effectively with specific communities, and what we might do to address the challenges.

Cultural competence results from a developmental process that depends on the continued acquisition of knowledge, the development of skills and ongoing evaluations of progress (Diller, 1999). Hence, there is a necessity for ongoing training.

Mission and Vision

The Suicide Prevention Resource Center is designed to help intervention agents, researchers, and educators obtain and use unique skills and practices that are necessary to become sensitive to cultural differences.

As a result, the NOPCAS task force is dedicated to developing an understanding among intervention specialists and agencies of culturally sensitive prevention and intervention strategies. This approach will better serve specific minority communities, and can improve the effectiveness of efforts to include other ethnic groups in program initiatives.

Target Populations: Demographic Complexities When Identifying Communities

Racial and ethnic minority populations are increasing throughout the United States. The U. S. Census (2000) indicates that the nonwhite population is expected to exceed 50 percent by 2050. There is a widespread consensus that health interventions should be tailored for specific populations (IOM, 2003).

The ordinary use of the term community refers to more than a set of people who occupy analogous locations in social or institutional structures. The term also refers to a group of people who share common interests and understand those interests in the same way. For example, communities of color or the Hispanic community can be used to indicate members of a common geographic location, or members of communities that share characteristics other than location. In fact, members of ethnic groups can have highly developed forms of association apart from geographic affiliation, such as language, lifestyles, religious belief systems, and attitudes and behaviors. These forms of association can vary in terms of dialect, tribe, religious beliefs, and class levels, resulting in a distributed cognition, or a thinking that is distributed across an entire group of people beyond one area, block or city. The following will suggest who comprises the communities in each ethnic minority group.

Latinos

Latinos, also known as Hispanics, have a population that now reaches more than 37.4 million in the United States. According to the U.S. Census (2000) 66.9 percent of Latinos are of Mexican ancestry, a population that includes U.S.-born Mexican Americans (also known as Chicanos) whose families may have been in the Southwest for many generations, as well as many recent Mexican immigrants (Tatum, 1997). Central and South Americans make up 14.3 percent and Puerto Ricans make up 8.6 percent of the Latino population while 3.7 percent are of Cuban ancestry. The remaining 6.5 percent are of other Hispanic origins.

The Latino community is unique in its diversity, and in the relatively young age of its members. These factors are critical to understanding the community, over and above reasons that members of the community may have immigrated into the United States. While the majority of U.S. society is growing older, the Latino community is growing younger. Its rapid growth and younger age can be attributed in great part to immigration. According to the latest census, Latinos are now the largest minority population, comprising 13 percent of the population (37.4 million), and accounted for half of the nation's population growth between 2000 and 2002. It is a young population, forming households in numbers similar to rates associated with the baby boomers.

African-Descent and/or Black Americans

African-Descent and/or Black Americans constitute approximately 36 million people in the United States or 13 percent of the civilian noninstitutionalized population. This population also consists of African Caribbeans, African Hispanics and Africans-second generations. This does not include the additional 2 million people who identified themselves as multiracial in the 2000 census, or who identified themselves as being black and at least one other race.

The majority of blacks - close to 19 million - live in the

South, which saw its black population increase by 3 million people since 1990. Ten southern states now have black populations exceeding one million members. Texas, California, and New York each have black populations exceeding two million members.

The overwhelming majority of Americans of African ancestry are descendants of slaves, who were forcibly brought from western Africa to the Americas during the 18th and 19th centuries. In addition, since the end of World War II, a significant number of people of African ancestry have immigrated to the U.S. from the Caribbean and Africa. Due to the unique conditions posed by slavery, many African Americans cannot trace direct cultural ties to African ethnic groups (Franklin and Moss, 1988)

The Black population grew at a faster pace between 1990 and 2000 than the total U.S. population, and tends to be younger, more concentrated in the South and in central cities than the majority population (McKinnon, 2003). However, the population is made up of numerous cultural variations.

Asian Americans and/or Pacific Islanders

Though Asian Americans and/or Pacific Islanders do not constitute a large proportion of the U.S. population, according to the US Census report (2003), there are 12.5 million Asians (4.4 percent of the U.S. population) and nearly 900,000 Pacific Islanders (0.3 percent). Asian refers to those having origins in the Far East, Southeast Asia or the Indian subcontinent, including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippines Islands, Thailand, and Vietnam. Pacific Islander refers to those having origins in Hawaii, Guam, Samoa, or other Pacific Islands.

Asians and Pacific Islanders tend to be concentrated in the West, but they are much more urban than other non-Hispanic White communities. Ninety-five percent of all Asians and Pacific Islanders live in metropolitan areas.

Although cultural ties exist among the different AA/PI communities, it is important to recognize the differences among the groups. Asian Americans and Pacific Islanders represent very diverse populations in terms of ethnicity, language, culture, education, income level, English proficiency, and sociopolitical experience. As many as 43 different ethnic groups make up the Asian-American group, and the majority were born overseas (Lee, 1998). Their population is projected to grow to 20 million by the year 2020. Asian Americans and Pacific Islanders, as groups, speak over 100 languages and dialects with an estimated 35 percent living in linguistically isolated households. It is reported that no one age 14 or older speaks English very well (President's Advisory Commission on Asian Americans and Pacific Islanders, 2001).

American Indians and Alaska Natives

The population of American Indians and Alaska Natives totaled 4.1 million in the 2000 Census. This represents more than 560 different cultural communities federally defined as sovereign entities, in which the United States has a government-to-government relationship (Tatum, 1997). American Indian or Alaska Native describe individuals whose origins are in North and South America (including Central America) and who maintain tribal affiliation or community attachment. There are an estimated 200 Native groups that are not recognized by the U.S. government. Each of these cultural communities has its own language, customs, religion, economy, historical circumstances, and environment (p. 144).

The majority of the federally recognized American Indians live in the southwest. Over half of the population lives in urban areas to be near jobs and schools. Too narrow a focus on cultural differences that exist between the Indian and nonIndian cultures may tend to obscure other important differences that exist between American-Indian Tribes. Because there are over 250 different languages spoken within the community - customs, including patterns of child rearing; attitudes towards health and illness; family structure and roles vary widely from tribal group to tribal group. This is true even for tribes within the same geographic region, such as in Oklahoma, which hosts 38 different tribes and the largest Indian population in the United States. Varying levels of acculturation, urban versus rural lifestyles, and interracial marriages are some factors that contribute to diversity in this population.

The history of American Indians includes a variety of Anglo intrusions into American-Indian society, including through systems that have influenced traditional tribal systems of education, law, and religion.

UNDERSTANDING COMMUNITIES OF COLOR

Internal Complexities

How do you sort people? Attempts to communicate suicide prevention and intervention messages to diverse populations can be complicated. What are the primary constructs? Do we consider color of skin, shared heritage, cultural beliefs, and religious beliefs?

In fact, there are various belief systems, religions practices, and behavioral patterns that must be considered for each ethnic population. Because suicide prevention and intervention initiatives focus on behavioral change - i.e., developing practices to minimize suicidality - the primary construct should be behavioral. It is important to be clear of the targeted behavior to be changed, and to understand what controls such behavior, such as attitude, perceived norms, or personal agency (IOM, 2003).

Where community or cultural history and experiences drive behavior, it is necessary to be aware of the fact that one ethnic community may have many distinct populations with various historical relationships to the United States. For example, Mexican Americans have a different history than Puerto Ricans or Dominicans. The same is true of multiple-generation African-Americans descended from U.S. residents, and those descended from recent African immigrants. Some diverse populations were incorporated into U.S. society against their will, such as Mexican Americans, African Americans, and American Indians, while other groups were not, such as African Caribbeans, Dominicans and Nicaraguans. While reducing populations to race or ethnic background can be insensitive, it can also limit the ability to recognize unique histories within a population, which in turn can undermine the effectiveness of strategies to reach diverse communities.

One of the major defining issues within groups is acculturation an appreciation for (and contact with) the dominant culture and a form of assimilation. While most ethnic groups work at assimilating with the dominant culture, and are encouraged to do so because it helps maintain positive relationships more attention needs to be focused on conflictive issues that develop once acculturated. For example, many individuals in certain groups who are proficient in English tend to disassociate, or leave behind, family members who are not. This can lead to loss of family bonds and support. Similarly, studies have shown a correlation between acculturation and elevated suicide rates among young black males (Willis, et al, 2003). The lack of a strong sense of identity in relation to the dominant group can become a key risk factor for suicidal behavior. However, this is not found to be true for U.S. born Mexican Americans compared to those who are Mexican-born (Sorenson and Golding 1988).

Because an individual is from a diverse population does not mean that he or she is not socially competent in more than one culture. Nor does it mean he or she is not comfortable with the majority culture. Bicultural and acculturated individuals might be served in the same manner as majority participants, but preventive interventions for suicidality could be tailored to meet the needs of those who are less fluent with the majority culture, as suggested by some researchers. For example, it could be argued that poverty and language prevent communities from being familiar with and proficient within the dominant culture.

Health Statistics and Suicide Rates

Table 1 Percentages of 10 leading causes of death by race, both sexes, all ages (2000)

	Black (%)	Latinos (%)	Asian (%)	
	American Indian (%)			
Diseases of heart	27	24	26	22

Malignant Neoplasm	22	20	27	17	
Cerebrovascular Disease		07	06	10	05
Chronic lower respiratory		03	03	04	04
Accidents/unintentional injuries			05	09	05
12					
Diabetes melitius	05	05	04	06	
Influenza and pneumonia	02	03	04	03	
Homicide	03	03	--	--	
Nephritis	03	--	02	02	
Suicide --	--	02	03		
Human Immunodef Virus(HIV)		03	--	--	--
Chronic liver disease	--	03	--	05	
Certain conditions perinatal period			--	02	02
--					

The aforementioned statistics are based on general race categories with the understanding that Hispanics can be of any race, but are included in the charts as a separate category. Thus, from a statistical point of view, we are lumping groups of people together blindly without respecting the complexity within the broad categories of Asians and Asian Americans, Africans and African Americans, Latino and Hispanics, and American Indians and Alaskan Natives. The statistics do not capture the complexity that arises when comparing sub-communities. Developing exact information that describes the various sociocultural processes of each ethnic category is a challenge at best. In fact, some research indicates such information cannot be fully developed at the present time because the circumstances under which diversity matters within diverse populations cannot be determined (IOM, 2002).

Latinos

There has been little research on suicide in the Latino community. As a result, statistical data necessary to understand suicide among Latinos is limited. In 2001, Latinos had a suicide rate of 5 per 100,000 compared to over 19 per 100,000 for Whites. However, in the 2003 Youth Risk Behavioral Surveillance System, Latino students (10.6 percent) were more likely than White students (6.9 percent) to have reported a suicide attempt. Also, Latino students were more likely to have made a suicide plan (17.6 percent) than White males (16.2 percent). Latino female students (5.7 percent) were significantly more likely than white female students (2.4 percent) to attempt suicide and require medical attention.

Researchers have found that among Latinos with mental disorders, fewer than 1 in 11 contact mental health specialists, while fewer than 1 in 5 contact general health care providers. Among Latino immigrants with mental disorders, fewer than 1 in 20 use services from mental health specialists, while fewer than 1 in 10 use services from general health care providers (Mental Health, 2001).

One study found that 24 percent of Hispanics with depression and anxiety received appropriate care, compared to 34 percent of Whites. Another study found that Latinos who visited a general medical doctor were less than half as

likely as Whites to receive either a diagnosis of depression or antidepressant medicine.

African-Descent and/or Black Americans

The rate of suicide among African Americans has historically been lower than that of Whites, however, the rate of suicide among young Black males increased substantially from 2.1 to 4.5 per 100,000 in the 1980s. The suicide rates increased the most for Blacks 10 - 14 years of age (MMWR, 1998). The trend reversed in the mid-1990s, and the suicide rate among young African-American males aged 15 - 24 years has steadily declined since 1994. The suicide rate for African-American women has been 2 per 100,000 for the past two decades. African American women have the lowest rate of suicide among all ethnic groups in the United States.

Asian Americans and/or Pacific Islanders

Current data on suicide in Asian American communities indicates rates of 5.5 percent for all age and ethnic subgroups (McIntosh, 2002). However, the data may be underreported, as it is calculated on the total Asian-American population, whereas suicide may be prevalent to a greater degree in particular ethnicities within the Asian-American category. For instance, suicide rates in a 20 year span (1970 - 1990) rose 54 percent for Japanese American teenagers and 36 percent for Chinese-American teenagers (Ridgon, 1991).

In 2000, suicide ranked as the second leading cause of death among Asian and Pacific Islander males ages 15 - 24 in the United States, according to the 2002 National Vital Statistics Report. Asian-American women ages 15 - 24 have a slightly higher rate of suicide than Whites, Blacks, and Hispanics in the same age group. Asian-American children and adolescents are considered by mental health providers to be highly prone to depression.

In a national survey, 30 percent of Asian-American girls in grades 5 - 12 reported suffering from depressive symptoms. Also, Asian-American girls reported the highest rates of depressive symptoms compared to White, Black and Hispanic girls (Chung, 1998). Asian-American teenage boys were more likely than their White, Black, and Hispanic peers to report physical or sexual abuse. Asian-American children received less mental health care than Whites, Blacks, and Hispanics (Ku & Mantani, 2000).

American Indians and Alaska Natives

As in the general population, injuries account for 75 percent of all deaths among American Indians and Alaska native children and youth. During 1989 1998, injuries and violence were associated with 3,314 deaths among AI/AN youth under 19 years of age. Motor vehicles were the leading cause of death, followed by suicide, homicide, drowning, and fires.

Death rates of all causes were higher among males than females. Prevention strategies should focus on the leading cause of injury-related deaths in each AI/AN community, such as motor-vehicle crashes, suicides, and violence (MMWR, 2003). American Indians have the highest rate of suicide among all ethnic groups in the United States with a rate of 14.8 per 100,000 reported in 1998. Rates were highest in Tucson, Arizona and Alaska five to seven times higher than the overall U.S. rates. The Aberdeen region, which covers North and South Dakota, Nebraska, and Iowa, also registered similarly high suicide rates.

Models of Health and Illness

Communities of color and their sub-communities view distress differently, and in ways that are nonwestern in perspective. What are some of the factors that lead to mental wellness and illness?

Latinos

There is a stigma attached to mental illness in the Latino community. In fact, while physical illness in the Latino community is culturally acceptable, mental illness is not. Latinos often describe physical symptoms to express mental distress. Consequently, many mental health problems are treated in mainstream health clinics and hospitals. They are often labeled with somatic complaints. Cultural modalities, such as *Penas*, *sustos*, or *malo* are accepted within the culture to express extreme pain and distress. These conditions are often combined with physical pain as well.

Given that individuals from different cultures may have different views of mental illness, their views of treating mental illness may also vary from mainstream culture. Often, non-Western cultures rely on more informal means of treatment, including reliance on healers instead of physicians. In the Latino culture *Curanderos* or Spiritualist Folk Healers are often preferred to medical doctors. Congress and Lyons write that the use of *Curanderos* is more consistent with the Latino's holistic view of the mind and body as one. The use of herbal treatments instead of, or in addition to health care treatment is another phenomenon in Latino culture. Culture highly influences perceptions about mental illness.

African-Descent and/or Black Americans

The psychology of African-Americans, as represented in models of mental health, has undergone various stages of development over the past 100 years. There are two main models that have been used to explain the psyche of blacks: inferiority models and deprivation/deficit models. The common thread of these models is one of European superiority (White and Parham, 1990). Africans and African Americans have historically been viewed in all aspects of human life as less than their European counterparts.

Psychological stress and difficulties were viewed by the dominant culture mainly as arising out of the impact of the culture and deficits of the individual. For Europeans the impact of the individual's personal and/or family medical history was taken into consideration when assessing psychological stress and difficulty (p.10).

In more recent times, mental health professionals have provided alternative ways of viewing the mental health of African Americans. Specifically, they have examined the impact and imposition of European culture on what is traditionally considered African-American culture and African heritage. In this light, the damage that was done by destructive social forces of the slavery experience was deemed to be harmful and pervasive to the mental well-being of people of African descent. In addition, ongoing racism that arises from constant discrimination can bring forth less than optimal well-being or mental illness. This process leads to dehumanization, deculturalization and despiritualization. Therefore, understanding suicide from this context places internalized oppression and discrimination as the central culprits that can lead to depression and suicide. Interventions to address these problems should focus on addressing the impact of internalized oppression and discrimination on the affected individuals and the African-American community at large, and should be ethnocentric in nature.

Asian Americans and/or Pacific Islanders

Traditional forms of medicine in most Asian countries e.g., Ayurveda in India and Chinese Medicine in China - increases the likelihood that Asian-American immigrants will continue to use a mixture of traditional and modern medical practices for the treatment of various illnesses. In traditional medicine, there is no separation of mind and body. Therefore, mental illness often manifests itself with physical symptoms. This presents significant challenges to the health care provider who must understand the psychosomatic origins of various symptoms and provide adequate care. Further, mental illness is often perceived as manifestations of evil, consequently a mentally ill individual runs the risk of being labeled a bad person. This lack of understanding motivates many individuals and families to hide the symptoms of mental illness and delay seeking appropriate help until they are in a state of acute emergency.

American Indians and Alaska Natives

American-Indian Tribes and Alaska Natives now have the opportunity to run programs for their communities that have typically been managed by the Indian Health Service and the Bureau of Indian Affairs. Many tribes have already exercised this option, which they consider necessary to address specific cultural needs. However, some tribes still prefer to let the federal agencies manage services related to health and educational needs. The self-determination efforts have yet to be evaluated, but the cultural aspect of services can be implemented based on each tribe's preferences.

It is argued that subsequent generations of American Indians suffer from a response entitled historical unresolved grief (Brave Heart & DeBruyn, 1998). Generations of American Indians have a pervasive sense of pain from what happened to their ancestors, and have undergone incomplete mourning of those losses. Closer examination of suicide studies reveals implicit unresolved, fixated, or anticipatory grief about perceived abandonment, as well as affiliated cultural disruption (Berlin, 1987; Claymore, 1988).

The assimilation of American-Indian children into a society that is not their own has had a tremendous impact on tribal structure. Every American-Indian child who became educated had to repudiate much of his or her own cultural background - even though it was clear to the government that the benefits of White civilization were not, even when accessible, consistently preferred by American Indians. For example, parenting skills that would have been learned within the family structure were lost. In addition, native languages were soon forgotten, making communication with elders difficult or impossible. Although it is not possible to quantify all of the changes that have occurred among the tribes, one thing is certain - major changes have taken place among the tribes that have survived.

American Indian communities face many social and economic problems, including suicide. The profound grief related to the loss of a loved one is made somewhat easier in the American Indian community because the entire community unites to mourn the loss, and to support the survivors. Native Americans are now more open to research carried out in their communities, provided they participate in the interpretation of research findings.

Causal and Contributing Factors of Suicide in Minority Populations

Role of Immigration and Acculturation

- Acculturative stress results from the adjustments and conflicts that are inevitable when migrating to a new country.
- This stress has been correlated with psychological disorders, lowered self-esteem, isolation, and changes in appetite and behavior (Roysircar-Sodowsky & Maestas, 2000).
- Acculturative stress has been significantly associated with depression and suicidal ideation in minority college students (Jha, 2001).

Sense of Alienation and Marginalization:

- Barriers to treatment among Hispanics are often created because of their inability to speak English.
- Attitudes that reflect alienation from the majority and a sense of marginalization are associated with increased depression and, thereby, suicidal ideation in immigrant and American-born minorities.
- Takahashi and Berger, (1996) indicated that an

intense desire among Japanese to belong to a group, or to become a part of the establishment may be associated in a high number of Japanese suicides. While this tendency may protect individuals from isolation on one hand, individuals who do not fit in the groups tend to feel ostracized and suicidal on the other.

- Perhaps what is unique about Asian-American suicide is how the perception of isolation from a group affects an individual's emotions and behaviors.

Role of Racism and Prejudice

- Individuals who experience racism can suffer from feelings of self-consciousness, difficulties in relationships, and isolation (Poussaint and Alexander, 2000; Root, 1992; Bush, 1978).

Approaches to Intervention

There are a number of approaches we can examine to gain a better understanding of the different suicide intervention strategies required for different ethnic groups. In fact, some groups have more developed strategies than others.

Latinos

One of the main barriers within this culture is language. Intervention cannot occur without communication. We also cannot address unique cultural challenges associated with suicide if they are not understood. Because translation is critical, a standard interpretation of technical language relating to suicide is necessary. Furthermore, because language relates to much more than words, the interpretations must translate the cultural concepts and ideas associated with suicide to in a way that captures the community's core principles.

For example, a video was used in one hospital emergency room to help explain treatment available for Latino females who attempted suicide. The video served as an effective intervention tool, and was designed to improve adherence to outpatient therapy, including utilization of staff and family therapy. The video resulted in lower rates of suicide reattempts and suicidal reideation among adolescent Latino females (Rotheram-Borus, 2000).

African-Descent and/or Black Americans

The cultural dynamics in this population show an increasing set of problems, including unemployment, delinquency, substance abuse, and teenage pregnancy, in addition to suicide, and especially among young Black males (Gibbs, 1984). For this reason, a variety of primary or universal prevention programs are needed that focus on: (1) better secondary education, (2) employment, (3) sex education and family planning, (4) delinquency prevention, and (5) drug prevention and counseling (Lester, 1998). Gibbs (1997) also notes that it is critical to increase life options for black youth especially males by raising high school

graduation rates and implementing job training programs.

Other successful strategies for early intervention include increased use of mental health clinics in inner cities and school programs to help establish strong coping skills. In addition, mental health workers and school personnel need to recognize the effects of racism on blacks, and be aware of perceiving paranoia or over diagnosing schizophrenia in African Americans. Counselors need to become familiar with social agencies and resources in inner cities and become acquainted with black culture beyond such things as music and food to incorporate behavior and attitude. It is also critical to involve Black role models in these preventive intervention programs, and in the treatment of Black suicidal patients (Lester, 1998).

Strategies should also involve treatment availability and determining which medications and counseling techniques are most effective for managing seriously suicidal individuals (Lester, 1998). The key here is to develop a close relationship with the mental health professionals and facilities within the communities.

Asian Americans and/or Pacific Islanders

There is not enough empirical research to determine guidelines for managing suicidality among Asian Americans. Studies that critically examine the efficacy of traditional approaches to suicidality among Asian Americans have focused on commonly noted trends, such as age and gender differences, but have not examined differences in suicide trends between foreign-born and U.S.-born Asian-American population. They also have not focused on such things as the effect of the length of stay in the United States. These are crucial elements that should be addressed in order to formulate action plans and provide future directions for research.

There is an urgent need to review and revise how suicide cases are reported, and how ethnicities are classified and documented. For example, a number of suicide victims registered under the Other Asian category in Cook and Du Page counties in Illinois between 1991 - 2001 were found to be of Asian-Indian descent. Statistical reports can help identify high-risk or high-need populations and provide clearer directions of evolving trends, thereby allowing intervention and preventive strategies to target specific groups and group needs. Furthermore, Asian Americans have often been grouped together with Pacific Islanders, (e.g., Hawaiians, Guamanians, Samoans, etc.) by the federal government for convenience in statistical accounting. There are major differences between Asian Americans and the Pacific Islanders and between various populations among Asian Americans. The need to report data on specific Asian ethnic groups has been highlighted by many researchers as critical to present a more accurate and complete statistical picture, and to understand trends (Baker, F. M. 1994; Leong & Lau 2001).

American Indians and Alaska Natives

It is not fully known what types of strategies are needed to address suicide in American Indian communities. However, a number of complicating factors in enhancing mental wellness must be addressed, such as a high treatment dropout rate among American Indians and a hesitancy to enter treatment. These problems are rooted in a historical distrust of the majority population to a large degree, and to the shortage of American Indian health providers (Kindya, 2003). Because of the sovereignty of Native American Tribes, it is essential to work with the leadership of the community to conduct suicide prevention research. But the benefits to the community must be made clear before American-Indian communities will agree to such research, and community members must be engaged as active members of the research team (Fisher, et al., 1998).

One successful program included collaboration between the Indian Health Service, the Centers for Disease Control and Prevention, and the University of New Mexico to support an adolescent suicide prevention program implemented by a small Western Athabaskan American Indian tribe in rural New Mexico. This was a multicomponent program based on the idea of youth natural helpers who were trained to respond to other young people in crisis, to notify mental health professionals, and to help provide health education in schools and the community. Other program components included outreach to families following a suicide or traumatic death, immediate response and follow-up for reported at-risk youth, community education about suicide prevention, and suicide-risk screening in mental health and social service programs. Evaluation data showed a reduction of suicidal acts (suicide and suicide attempts) in the target population after the program was implemented.

The American Indian/Alaska Native Community Suicide Prevention Center and Network expanded the program to target all Native-American/ Alaska-Native communities throughout the country. Adults and youth from various geographic areas of the country were identified and trained to respond to requests from communities on topics such as crisis response, development of suicide intervention and prevention programs, data collection, establishing surveillance systems, developing crisis response teams, program evaluation, and conducting postvention services (MMWR, 1998).

Another culturally relevant intervention program was administered to a Zuni Pueblo population in New Mexico using a social cognitive development model. At the Zuni Public High school, a life skills development curriculum was structured around seven major units: (1) building self-esteem, (2) identifying emotions and stress, (3) increasing communications and problem-solving skills, (4) recognizing and eliminating self-destructive behavior, (5) receiving suicide information, (6) receiving suicide intervention training, and (7) setting personal and community goals. A unique feature and strength of the curriculum was that it was specifically tailored to be compatible with Zuni norms, values, beliefs, and attitudes (LaFromboise and Howard-

Pitney, 1995).

Cultural Competencies Required to Intervene

The basis of this section is to answer the question, who can intervene within a specific community? The notion of whether one is viewed as an insider or outsider is important, as is the need to codify the role of those who are best suited to intervene in a community.

Insiders may include primary health care providers (who share the patient's cultural and linguistic background), community advocates, local alternative healers such as herbalists, acupuncturists, and clergy. Insiders can be those who are viewed as experts or those who have the trust and confidence of the patient and or community.

Outsiders are generally health care providers who do not share the patient's culture and language. Outsiders are also those who have difficulty gaining the trust and confidence of the specific community.

Latinos

The ultimate in cultural sensitivity is to strive to accept, understand, respect, and affirm the unique culture and values of each family. The best way to engage any family is to respect and work within their beliefs and values.

- Speak the language and dialect of the community.
- Be of the same ethnic and cultural subgroup as the community to ensure common meanings and experiences are shared.
- Be aware that different generations of the same community may have different primary languages. Address this issue before deciding which language to use for a specific intervention.
- Emphasize that genetic causes of schizophrenia intensifies feelings of discrimination. Some communities may feel stigmatized or shamed by seeking support. Individuals within the community may be uncomfortable with or mistrust mainstream facilities or programs. They may see these programs as unresponsive to their needs, or as threatening to their immigration status or government benefits.

African-Descent and/or Black Americans

Some individuals in certain Black sub-communities are considered, in general, to be classic outsiders when it comes to the implementation of preventive interventions in the African-American community. Professional helpers or change agents who are members of the dominant (White) culture are often labeled as outsiders, and encounter barriers to entry into the African-American community as a result (Kaufman, 1994).

Successful suicide prevention strategies in the Black community can include (1) political, institutional and

personal neutrality, thus avoiding obligations to a sponsor or a patron who might promote bias in observations and alter ways of behaving; (2) follow the rules or customs of the Insiders; and (3) identify several key informants who are generally accepted and liked by other Insiders, and who can advise, teach and direct the Outsider in ways of behaving and interpreting events.

According to Kaufman (1994), community evaluation of actions and interaction by outsiders begins to erode social myths and stereotypes compelling each side to see the other as fellow human beings, while also guarding against possible rejection. Strategies in interactions are based on the premise that it is important to be genuine and to avoid trying too hard to be accepted.

Sharing personal stories and belongings, making commitments and creating mutual obligations create a deeper awareness of one another. Using insider idiomatic expressions develops a form of settling in and signifies the capacity of the outsider and insiders to relax, enjoy, care for, explore and be with each other. For example, while the boundaries of friendship can become clearer when outsiders and those in the community exchange jargon during light banter, this and similar techniques presupposes understanding and acceptance, according to Kaufman.

Another barrier identified by Jordan, et al (2001) refers to the organizational context. They indicate that collaboration with community agencies involves special challenges. These challenges center around the fact that most Black community-based social service agencies are underfunded, understaffed and overtaxed by the multiplicity and the severity of community needs (Mincy, 1994; Wiener, 1994). Therefore, the limited resources available for implementing interventions impose actual or perceived constraints on the efforts and assistance that community-based agencies can offer.

Jordan, et al., (2001) offer a comprehensive process to address these barriers. The process has five components which include the following:

- Create a foundation for trust.
- Focus on community needs.
- Establish forum for community feedback and involvement.
- Create autonomy.
- Help train future professionals.

Asian Americans and/or Pacific Islanders

Integration of primary health and mental health services can be beneficial for Asian-American patients who experience tremendous barriers to accessing mental health specialists. (Best Practice Model: Primary Care and Mental Health Bridge Program at the Charles B. Wong Community Health Center). Research has shown that integrating mental health services into the primary health care setting can increase access to services, leading to

increased diagnosis and treatment. Unfortunately, many primary health care providers are ill-equipped to deal with mental health issues such as suicide and depression.

It is important to recognize that most cultures do not clearly differentiate physical, emotional, and spiritual problems, perhaps because this is a Western concept. Describing symptoms through somatic and spiritual complaints may lead to less social rejection and less loss of self-esteem. Utilization of community leaders, such as ministers, priest, root healers, herbalists, diviners, and natural caregivers is key in this situation.

American Indians and Alaska Natives

While an insider among American Indians and Alaska natives would typically be a tribal member, anyone who is respectful of those in the community and shows sensitivity to cultural issues will find acceptance. Outsiders will be viewed as any other group would view that person. Be sincere, honest, and ethical. Most service providers will be put to the test before trust is earned. Most tribes and/or communities will be provided an orientation as to what is acceptable for the tribe, but much will be learned by being sensitive. This is probably true for all minority communities.

It will typically be assumed in the community that permission has been obtained from the community or tribe to provide services or intervention activities. As a result, providers should always go to the leadership of the particular tribe to get permission to provide intervention services.

SUMMARY

How do you engage communities of color and communities that are culturally different? It is important to develop knowledge of who is in the community and is most influential to the particular group you are trying to reach. Each community is complex. If you are trying to reach Asian Americans, what exactly does that mean? There are various Asian-American communities. Know which groups are in your community. Does your community consist of Japanese, Chinese, Cambodians, East Indians, or others?

This phase I project was both difficult and simple. On the one hand, it is difficult to sort people and differentiate sub-communities. On the other hand, many of the barriers to reaching minorities were similar such as the role of immigration and acculturation for some Asians, Latinos, and African Caribbeans. Racism and Prejudice were also shown to be universal contributing factors among all four groups.

There are also critical questions associated with race, ethnicity and culture. Should populations be sorted by the skin color, by religious practices, or by lifestyles?

Getting various ethnic groups involved in traditional preventive intervention programs takes planning. Programmers must (1) know who is in the community, (2) identify the influential leaders, (3) create the right environment by inviting members of the community to the planning table and listening to what they have to offer, and (4) recognize the value of their alternative ways of preventive intervention procedures.

Furthermore, individuals who are biracial and/or assimilated must decide for themselves which culture they will follow when seeking treatment for mental disorders. Do they seek treatment through the system of the dominant culture or do they use the approaches of their ethnic traditions. And, which ethnic practice should be used for a multi-racial individual, for example, one who is part Japanese, part Hawaiian and part American Indian? Internal complexities are widespread among minority groups and should be recognized and discussed when approaching a community of color.

Finally, successful suicide prevention interventions in diverse communities require a sophisticated understanding of the complex dynamics of otherness, or feelings of outsidersness and insidersness. Unless this understanding is combined with a deep appreciation of the political, social and psychological phenomena, even very sincere and well-intentioned efforts to promote social change or healing are easily thwarted.

APPENDIX

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