

Warning Factors, Coping Mechanisms and Culturally Sensitive Intervention: An Evaluation of Efficacy and Accuracy in Addressing African-American Suicide

Che Wilson

Introduction

Suicide remains a complex issue to understand and diffuse. It is as such because its existence relies upon the skewed interpretations one has regarding society and him/herself. These two entities have become inadequate and, consequently, ineffective for the client. For the African American contemplating suicide, society does not, in general, provide an option for unlimited growth, help and opportunity. What little is available comes with strings attached, which a mind weakened by suicidal ideation cannot understand. That is why the social support systems of the family, the Church and religion are so important in the African American community. African Americans must create what society has often times denied-encouragement, commitment and resources given without bias. This bias, manifested in the forms of subliminal, institutional, and blatant racism along with individual and social prejudices, creates stress that, in turn, produces emotions that may influence suicidal ideation. These emotions include depression, anger, agitation and feelings of hopelessness. This paints a dismal picture, but it can be dramatically improved by the implementation of cultural awareness. If mental health professionals would begin to acknowledge, appreciate and, accordingly, integrate ethnicity into their method of treatment, not only would the client benefit from the responsive treatment, but the professional and the client would gain critical analysis skills. This new found knowledge would not be contained to the professional's office; rather, it would expand to be included in all interactions made, deliberately initially and later by nature. This is the way in which society begins to change and shed its restrictions on providing effective

mental health services. When the client is fully actualized the goal of successful treatment can be actualized as well.

Risk Factors and Warning Signs

Depression, drug and/or alcohol abuse, feelings of worthlessness, neglecting friends and family.... The aforementioned are all common risk factors or warning signs of suicide.

It is believed that risk factors can highlight one's propensity towards committing suicide. Risk factors are those behaviors or conditions that the individual possesses or engages in prior to suicidal ideation. Identifying these risk factors requires asking questions of a client that he/she may not be willing to admit to. The mental health professional must ask these questions in such a way that the client answers truthfully and completely. The manner in which the professional questions the client must be deliberate, yet, not insulting. Getz, Allen, Myers and Liadner (1983) write in *Brief Counseling with Suicidal Persons*,

Your client's perception of you is in part based in reality. It is determined by your actual behavior in the session but to some degree is influenced by distortions from the past. Reactions of your client that are not based on the reality of the counseling situation are termed *transference*. This is the phenomenon of displacement onto the counselor of feelings the client has about other significant persons in his life (p. 14).

The professional must also make the client aware of the risk factors he or she exhibits.

Rudd et al. (2006) define risk factors as any factor empirically shown to correlate with suicidality, including age, sex, psychiatric diagnosis and past suicide attempts (p.256).

Concerning African Americans, the two race specific risk factors for suicide are: 1)

being male and 2) being in the age bracket of 15 to 24. African American males in this

age bracket committed 352 suicides in 2007, compared to 54 for African American women in this same age bracket (Center for Disease Control and Prevention, 2009).

While a risk factor assessment is necessary to accurately evaluate the client's level of suicidal ideation, it may neglect the issues that are currently affecting the client. The professional must be able to look beyond the profile that has been created for the client and begin to evaluate the individual. There are characteristics that may make themselves known during a session that are more pertinent to the client's current state than the past mental health history that was divulged or how he or she scored on a battery of tests. Further, inquiring about the client's current mental state and overall emotional well-being implies that the professional is actively concerned about the client. Rudd et al. (2006) refers to these current behavioral factors as warning signs. Warning signs are defined as:

The earliest detectable sign that indicates heightened risk for suicide in the near-term (within minutes, hours or days). A warning sign refers to some feature of the developing outcome of interest (suicide) rather than to a distinct construct (e.g. risk factor) that predicts or may be casually related to suicide (p. 258).

The following table outlines the differences in risk factors and warning signs in relation to nine characteristics:

Differentiating Warning Signs and Risk Factors for Suicide

Characteristic Feature	Risk Factor	Warning Sign
Nature of relationship to suicide	Distal	proximal
Definitional specificity	defined constructs (e.g., DSM- IV diagnosis	Poorly defined constructs (e.g., behaviors such as buying a

		weapon
Empirical Foundation	Empirically derived	Clinically identified/derived
Population	Population dependent (i.e. Individually applied clinical samples)	Individually applied
Timeframe	Implies enduring or longer-term risk	Implies imminent risk

Characteristic Feature	Risk Factor	Warning Sign
Nature of occurrence	Static nature (e.g., age, sex, abuse history)	Likely useful only within constellation
	defined constructs (e.g., DSM-IV diagnosis)	Poorly defined constructs (e.g., behaviors such as buying a weapon)
Empirical Foundation	Empirically derived	Clinically identified/derived
Episodic or transient nature (i.e., warning sign resolves)	Limited implications for intervention	Specific intervention demanded
Implications for Clinical Practice	Limited implications intervention	Specific intervention demanded
Experiential Character	Objective	Subjective
Intended Target Group	Experts and Clinicians	Lay public and clinicians

This table has been extracted from "Warning Signs for Suicide: Theory, Research and Clinical

Applications” by M.D. Rudd, AL. Berman, TE. Joiner, M.K. Nock, MM. Silverman, M. Mandrusiak, K.

Van Orden & T. Witte. (2006). *Suicide and Life-Threatening Behavior*, 36, p. 287.

Closed-ended questions should be asked to determine if there are any immediate warning signs that need to be addressed. The close-ended approach is direct and very pointed. It is often used to gain specific information or when the client is unable to comprehend the vagueness of the open-ended approach. The close-ended approach can be extremely helpful. When the professional feels that the client may be withholding crucial information about a suicide plan, a close-ended question such as “You said you have pills at home?” should be asked (Getz et al, 1983). Close-ended questions force the client to admit to or deny crafting a strategy for committing suicide. In this assessment, the professional can better understand how serious the client’s intentions are.

In regards to risk factors and warning signs, race plays a role in the assessment of possible risk factors and a connecting role in assessing warning factors. Since the risk factor serves as a profile for the client, it can only be trusted to a certain degree. While African American women between the ages of 15 and 24 committed 54 suicides, 3.4% of the total deaths for that age bracket, in 2007, it should not be assumed that a client of this background would only be depressed and not suicidal (Center for Disease Control and Prevention, 2009). It is imperative that mental health professionals assess the individual and not a stereotype of behavior. Each client has his or her own individual mental health needs, which cannot fit into a pre-measured profile. Race connects the risk factor and warning factor in instances that involve race as a contributor to the overall problem. For example, the client is an African American male who has unsuccessfully tried to find work for three months. He has sought professional help on his own to treat his self-diagnosed depression. The professional must take into consideration the stress

that the man carries due to his minority status and how that affects his interactions with potential employers. He has also the stress of being unemployed, a defined risk factor of suicidal ideation. There is a possibility that he attributes his lack of employment to racial bias, and will soon no longer attempt to look for employment. Inherent stress has then been multiplied by two (no prospect of a job or money) and intensified by a feeling of anomie. The professional must assess the immediate warning signs and determine if the client has the appropriate coping mechanisms to ward off any possible self harm.

In comparing African Americans and White suicide attempters for risk factors, Roy (2003) hypothesized that there are no significant differences in risk factors for either ethnic group. Roy (2003) used a sample of 253 substance abuse patients who had attempted suicide, 158 of which were African American and the remaining 95 White. All participants were given the following questionnaires: the Eysenck Personality Questionnaire (EPQ), the Foulds Hostility and Direction of Hostility Questionnaire (HDHQ) and the Childhood Trauma Questionnaire (CTQ) (Roy, 2003). On the CTQ, Roy (2003) found that African American participants scored significantly lower on the emotional abuse subscale (28.0) than White participants (31.8). This is indicative of the role social support plays in the African American community. African Americans tend to live in larger households and an increase in the number of supportive familial ties in the support system has been posited as a protective factor against suicide (Roy, 2003. p. 446). Otherwise, there were no statistically significant differences in the overall scores for each questionnaire. While there may not be a difference in risk factors pertaining to suicide for different ethnicities, it is important to consider differences in coping mechanisms various ethnicities use to combat suicidal ideation.

Coping Mechanisms

Getz et al. (1983) suggests that professionals pose 16 questions to the client to determine the severity of the suicide risk. These 16 questions are as follows:

1. What prompted the identified client to seek help now?
 - a. Family, community pressures?
 - b. Self-referral
2. In the client's words, what happened that caused this crisis?
 - a. What are the unconscious determinants as you understand them?
 - b. What are the dynamics involved?
3. How is the client trying to solve this crisis? Is it working?
4. How was the client functioning before the crisis?
5. Is there any noticeable difference between then and now?
6. Has anything like this happened before?
 - a. How effectively or ineffectively was it handled?
 - b. What was the outcome?
7. How has this client handled other similar situations?
 - a. What worked?
 - b. What did not work?
8. What are the client's environmental supports? (Family, friends, Church, work, recreation)
9. Is this a chronic or an acute situation?
10. What does the client say is the most important problem to be worked on right now?
Do you agree?
11. What do you the counselor see as the most important issue(s)?

12. If there is a difference between what the client sees as important and what you see as important, what if anything can be done to resolve the difference?
13. Are you and the client working together?
 - a. Do you have the potential to form a working alliance?
 - b. Do you have the support of the client's family and friends?
14. What is the client's suicidal status?
15. What is the client's mental status?
16. Are there community resources available to help? (pp. 81-82)

In regards to coping mechanisms, the professional would focus on questions one (1) through eight (8). If the client came on his own volition, rather than by prodding or force, that shows that he/she is fully aware that his/her coping level is not optimally functioning. That is not to say that the client that was forced to come is not aware of his situation. Embarrassment, fear or feelings of shame could prevent an individual from receiving help even when he/she knows that help is desperately needed. When the second question is posed, the professional can begin to connect the emotional response to the physical problem. The answers to questions three (3) through eight (8) will tell the professional how the client copes with stressful situations and who, if anyone, serves as a coping mechanism for him/her.

Within African American¹⁶ society, the Church has served as the core of the community by providing spiritual nourishment, serving the community at large as an agency of social services, providing a platform for politics and creating a safe haven from the majority society in which African American mores flourish and strengthen the bond among all who attended. In a study by Taylor, Lincoln and Chatters (2005), the relationships among African American church members were analyzed. It was noted by Chatters, Taylor, Lincoln and Schroeffer (2002) in a

¹⁶ The terms African American and Black are used interchangeably.

previous study that slightly more than half of the respondents surveyed received help from both their family and church networks (Taylor, Lincoln and Chatters p. 502). For the 2005 study, 680 respondents to the National Survey of Black Americans (NSBA) conducted between 1979 -1980 and 1987-1988 were asked to be interviewed via telephone for a third time regarding their church relationships. The respondents in this sample ranged from 24 to 92 years of age ($M=49.66$, $SD=15.93$); approximately 67% of the respondents were women and 46.7% were married; and, more than half (56%) of the sample resided in the South (Taylor, Lincoln and Chatters, 2005, p. 505). With regard to socioeconomic status, the average income was \$21,848 ($SD= \$16,973$) and the average number of years of education was 11.80 ($SD=3.337$) (Taylor, Lincoln and Chatters, 2005, p. 505). The three variables measured were closeness, interaction and support. Approximately 278 respondents (40.9%) said that they were very close to their church members, while 326 respondents (47.9%) reported being fairly close (Taylor, Lincoln and Chatters, 2005, p. 505). Of the remaining 76 respondents, 68(10%) responded that were not too close to church members and 8(1.2%) reported not being close at all (Taylor, Lincoln and Chatters, 2005, p. 505).

For the variable of interaction, 174 (25.6%) of the respondents said they interacted with fellow church members everyday (Taylor, Lincoln and Chatters, 2005, p. 505). 226 (33.2%) interacted with each other at least once a week. Seventy nine (11.6%) reported interaction a few times a month, while 53 (7.8%) reported interaction of at least once a month (Taylor, Lincoln and Chatters, 2005, p. 505). 44 (6.5%) respondents interacted with church members a few times a year, 72 (10.6%) hardly ever and 32 (4.7%) never (Taylor, Lincoln and Chatters, 2005, p.505). Those reporting receiving support from the church often numbered 203 (29.9%) (Taylor, Lincoln And Chatters, 2005, p. 505). 210 (30.9%) reported receiving support sometimes, while 117

(17.2%) said hardly ever and another 150 (22.1%) said never (Taylor, Lincoln and Chatters, 2005, p. 505). It would be beneficial to know if those receiving support “hardly ever or never” were those that supply the support to those responding “often or sometimes.”

When responses were broken down by the subscales of age and gender, older congregants and women interacted more with fellow congregants, and, as a result, received more support (Taylor, Lincoln and Chatters, 2005). The majority of the respondents, 88.8%, expressed being very or fairly close to fellow church members and 58.8% reported interacting with each other daily or at least once a week. The church family, then, plays a pivotal role in the lives of many African Americans. It is a social network in which the participants are well acquainted with one another and share the common bond of religion. Religion and strong social support are two strong combatants of suicidal ideation, as they both foster hope and inner strength.

It has been proposed by many that religiosity serves a coping mechanism or protective factor against suicide. Gibbs (1997) hypothesized that high social support, religiosity and southern residence all serve as protective factors against suicide for African Americans (Wingate, Bobadilla, Burns, et al, 2005, p. 615). Wingate, Bobadilla, Burns et al. (2005) considered the roles of religiosity in combination with southern residency and social support in suicide among African American men. The study employed the use of The National Comorbidity Survey (NCS) administered between September 14, 1990 and February 6, 1992. There were 5,877 participants that completed the entire survey, but, for this study, only African American and white participants were selected, reducing the number to 5,125 (Wingate et al. 2005). Of those 5,125 participants, 299 were African American men and 384

were African American women; 182 of the 299 African American men resided in the South (Wingate et al., 2005, p. 619). To measure religiosity, the following four questions and scripted answers were asked:

- 1) In general, how important are religious or spiritual beliefs in your everyday life? (very, somewhat, not very, not at all important)
- 2) How often do you attend religious services? (more than once a week, 1 to 3 times a month, less than once a month, never)
- 3) When you have problems or difficulties in your family, work, or personal life, how often do you seek spiritual comfort? (almost always, often, sometimes, rarely, never)
- 4) When you have decisions to make in your daily life, how often do you ask yourself what God would want you to do? (almost always, often, sometimes, rarely, never)

(Wingate et al., 2005, pp. 619-620)

To measure social support, the following (6) questions and scripted answers of a lot, some, a little, and not at all were posed:

- 1) How much do your relatives really care about you?
- 2) How much do they understand the way you feel about things?
- 3) How much do they appreciate you?
- 4) How much can you rely on them for help if you have a serious problem
- 5) How much can you open up to them if you need to talk about your worries?
- 6) How much can you relax and be yourself around them? (Wingate et al., 2005, p. 620)

The same six questions were asked again, this time replacing relatives with friends. To measure suicidality, participants were asked to answer yes or no to the following four questions:

- 1) Has there ever been a period of 2 weeks or more when you thought a lot about death either your own, someone else's, or death in general?
- 2) Has there ever been a period of 2 weeks or more when you felt like you wanted to die?
- 3) Have you ever felt so low you thought about committing suicide?
- 4) Have you ever attempted suicide? (Wingate et al, 2005, p. 620)

There were 2,896 Whites and 130 African American men that answered the questions regarding suicide. Data collected revealed that all 5,125 respondents scored 0.62 (SD= 1.02) on the suicide scale. Possible scores ranged from zero (0) to four (4), with four being the highest score possible (Wingate et al, 2005, P. 620). Order correlations were performed between suicidality and religiosity for the African American male participants. A regression analysis was then performed using social support, religiosity and region as independent values and suicidality as the dependent value. It was found that there was a positive correlation between region and religiosity, resulting in those from the South (compared to those in all other regions of the country) with a higher sense of religiosity (Wingate et al, 2005). There was a negative correlation between region and suicidality, resulting in those from the South having lower levels of suicidality (Wingate et al, 2005). Region did not have a strong correlation, positive or negative, with social support, though there was a positive correlation between religiosity and social support. Social support had a negative correlation with suicidality, which lacked a significant correlation with religiosity (Wingate et al, 2005, p. 621). The regression analysis showed that region was more of a controlling factor against suicide than religiosity, although those from the South reported higher levels of religiosity.

Tested on its own, religiosity failed to have a strong negative effect on suicidality. It could be proposed that religiosity is viewed by many as a component of social support

and regional mores. Assuming that this is a valid position, social support increases one's participation in religion. The effect of group size and solidarity upon an individual's sense of completeness should be considered when speaking of religiosity. In a study entitled *Suicide Acceptability and Religious Well-Being: A Comparative Analysis in African American Suicide Attempters and Non-Attempters* by Anglin, Gabriel and Kaslow (2005), 200 low income African Americans, 100 male and 100 female, who had either attempted suicide and were in psychiatric treatment or had no history of suicidal ideation or completed attempts, were chosen for the purpose of proving the hypothesis that religion has a negative correlation with the acceptance of suicide. The Demographic Data Questionnaire, an original measurement created by the authors, was used to assess gender, age, educational level, marital status, monthly income, religious affiliation, physical and mental health history and access to guns (Anglin, Gabriel and Kaslow, 2005, p. 143). The Suicide Acceptability Scale was modified to include three, rather than one, questions regarding the acceptability of suicide for men, women and oneself. The Spiritual Well Being Scale was also used with the Religious Well-Being (RWB) sub scale.

The 200 participants ranged in age from 18-64 ($M=32.8$). Fifty two percent were at least high school graduates, 43% were employed, 82% were not homeless, 56.5% had a monthly income between \$500.00 and \$1,999.00, 50.5% identified themselves as Baptists and the average number of children per participant was 2.4 (Anglin, Gabriel and Kaslow, 2005, P. 144). Using univariate analyses of variance (NOVA), the only significant differences in demographics was that the age of suicide attempters was younger (6.7 years) than non-attempters and non-attempters also did not identify themselves as religious (Anglin, Gabriel and Kaslow, 2005). There was a significant negative correlation between religion and acceptance of suicide.

Univariate analyses of covariate (ANCOVAs) was used to compare suicide attempters and non-attempters on the Suicide Acceptability Scale and the RWB subscale. Attempters scored higher in acceptance of suicide and lower than non-attempters in religious well-being (Anglin, Gabriel and Kaslow, 2005, p. 145). Again, religion is seen as a protective factor against suicidal ideation and attempts. This study does use a socio-economically biased sample, all participants of low income and basic educational background and employment level, but does employ a scale that measures individual spirituality. Although religion is tested in a subscale, spiritual well being implies one's own connection to God, not a form of worship dictated to those that follow it. This allows for a more accurate assessment of a person's spiritual beliefs and their application of those beliefs in everyday life.

Revisiting question eight (8) from the list of 16 used to measure severity of suicide risk, "What are the client's environmental supports?" (Family, friends, Church, work recreation), a professional would want to ask an African American client about his/her support systems, specifically inquiring about family and friends, church attendance, a church family and his/her personal relationship with God. As the study by Anglin, Gabriel and Kaslow (2005) confirmed, religiosity has a negative correlation with suicidal ideation and the act of suicide itself. Even if the client denies close relationships with family and friends, it is highly unlikely that he/she will deny a relationship with God. Religion has strong, deep roots in the African American society. Behavioral health issues can distance this relationship, but it cannot erase it. Harold Koenig, M.D., a presenter at the Mental Health Needs for Returning Soldiers and Their Families conference held in Columbia, MO March 8-10, 2007, said that religion serves as a buffer to hopelessness, which is a huge contributor to suicidal ideation. Dr. Koenig stressed that religion should not be forced upon or introduced to clients, but, rather it should be recognized as a valid

and efficient coping mechanism. In *Treating Suicidal Behavior* by Rudd, Joiner and Rajab (2001), six (6) questions are suggested for determining a patient's level of hopelessness:

1. What is the structural content of the patient's suicidal belief system?
2. Why does the patient want to die by suicide at this moment?
3. What is the meaning attached to the precipitant by the patient?
4. What conditional rules/assumptions are operative (i.e. what conditions has the patient established to support his/her suicide?
5. What are the most prominent symptoms that essentially fuel the patient's upset and dysphoria?
6. What strategic and concrete steps could be taken to 1) disprove the conditional assumptions, 2) restructure the meaning associated with the precipitant, and 3) diffuse the most prominent symptoms? (p. 165).

If the precipitant is race related or a by-product of institutional racism, then it may be more difficult for the professional to diffuse the suicidal ideation without engaging in a conversation on race that produces coping mechanisms that the client is comfortable with and willing to use.

Jang and Lyons (2006) applied Agnew's general strain theory (GST) to African Americans and utilized coping mechanisms. Agnew's strain theory proposes that strain, a negative relationship with others in which the individual is not treated as he or she wants to be treated, produces a negative effect that leads to deviant coping behaviors to alleviate strain and subsequent emotions (Jang and Lyons, 2006). Agnew posited that anger is the driving force behind deviant behavior. This anger can be directed toward others or inwardly confined. Since

African Americans experience higher levels of strain due to accepted societal racism, GST can be applied to social problems confined to the African American community. The three (3) types of strain identified by Agnew are the failure to achieve positively valued goals; the removal of positively valued stimuli; and, the presentation of negative stimuli (Jang and Lyons, 2006, p. 252). Jang and Lyons (2006) noted that at the time of publication, only one study of GST and its relationship to African Americans had been published since the theory was introduced in 1992. Agnew (Jang and Lyons, 2006) went onto theorize that social support has a negative correlation with deviant coping behavior. Two (2) of the previous three (3) articles mentioned in this paper have concurred, showing that social support is a consistent buffer to suicidal ideation among African Americans.

For this study, Jang and Lyons (2006) used data collected from the 1980 National Survey of Black Americans (NSBA) to test these hypotheses:

- 1) strain is positively related to negative emotions
- 2) social support is negatively related to negative emotions
- 3) negative emotions are positively related to withdrawing behavior with inner-directed emotions being more strongly related to the behavior than outer-directed emotions
- 4) any direct effects of strain and social support on withdrawing behavior decrease when negative emotions are controlled for.
- 5) social support weakens the positive relationships (a) between strain and negative emotions (b) between strain and withdrawing behavior and (c) between negative emotions and withdrawing behavior (p. 258).

Of the 2,107 respondents, 1,281 were female. The survey asks the respondents if they or

their significant other have a personal problem that cannot effectively be dealt with.

Of the respondents said 1,281 “yes,” 763 said “no” and 63 responded “don’t know”, which was treated as missing data (Jang and Lyons, 2006, p. 259). Those that claimed to have a personal problem were then asked about their social networks, specifically family and friends. This same group was also asked about potential support from religious networks.

The ordinary least squares (OLS) regression was used to test the hypotheses, using the method of listwise deletion of missing cases, resulting in a final sample of 1,211 respondents (Jang and Lyons, 2006, p. 261). It was found that strain and potential support had a measurable effect on emotions in the way originally hypothesized. The hypothesis of negative emotions and withdrawal behavior being more strongly related to inner-directed emotions than outer-emotions was not proven to be statistically significant.

Potential support was proven to weaken the relationship between negative emotions and withdrawing behavior, but, overall, potential nor perceived support significantly decreased strain itself. Broken down demographically, women were more likely than men to respond to strain with inner-directed emotions, such as depression and anxiety, and thus more likely to engage in inner-directed, self- destructive forms of deviance, such as drug use and eating disorders rather than outer- directed crime, such as violence (Jang and Lyons, 2006, p. 268). Men were found to report lower levels of negative emotions in reaction to personal problems than women, as Mirowsky and Ross (1995) found in a sample of mostly White Americans (Jang and Lyons, 2006, p. 267). African Americans of various socio-economic levels answered this survey, and it was found that the majority experience anger as well as depression in dealing with problems in their lives. Overall, it was found that strain is directly linked to negative emotions, which can be minimized by social support.

Another study involving coping mechanisms unique to African Americans was done by Utsey, Ponterotto, Reynolds and Cancelli (2000). Entitled *Racial Discrimination, Coping, Life Satisfaction, and Self-Esteem Among African Americans*, 213 African American college students, 137 of which were female and the remaining 76 male, completed four surveys to measure how they dealt with instances of racism. The Coping Strategy Indicator (CSI), the Satisfaction With Life Scale (SWLS), the Index of Race Related Stress (IRRS) and the Rosenberg Self-Esteem Scale (RSE) were completed by all respondents. The CST was modified from asking respondents to think about a worrisome situation to asking respondents to think of a situation when they experienced racism. To ensure that equal distribution of the types of racism would be reported, each group of college students was primed for a specific racism type (i.e. individual, institutional, cultural) (Utsey et al, 2000, p. 76). The three subscales of the CST, problem solving, seeking social support and avoidance, would be used later in a regression analysis. The RSE was also modified so that a higher score, not a lower score, on the survey were indicative of higher self-esteem.

After collecting data from the four surveys, it was found by Utsey et al. (2000) that women ($M=2.24$, $SD=5.46$) scored significantly higher on the CSI subscale of seeking social support than men ($M=10.06$, $SD=.546$) did. Utsey et al. (2000) also noted that it was statistically significant that the seeking social support CSI subscale and the cultural racism condition were the best predictors of racism-related stress (p. 77).

From this determination, it was hypothesized that the scores on the CSI subscales along with the subscales of gender and racism conditions could predict one's score on the IRRS, SWLS and RSE. This hypothesis did not prove to be true. The avoidance subscale score provided a negative

Score provided a negative beta score when applied to the SWLS and RSE. This suggests that the CSI avoidance subscale is the best predictor of life satisfaction and self-esteem for African Americans (Utsey et al., 2000, p. 78). One prominent reason for the hypothesis not testing true was the fact that the respondents were all students attending a Historically Black College or University. They may be biased in their low incidences of perceived racism because they were learning and maturing in a race-friendly environment. The age, as well, (M2 1.35) may have biased the results of the scores on the CSI subscales. Generally youth, especially those in a positive, upwardly mobile environment, will have a more optimistic view of life and themselves. The CSI subscale scores, therefore, may not correlate with an overly upbeat assessment of the respondent's self.

All of the four articles analyzed for coping mechanisms unique to African Americans have listed social support, especially amongst women, as a dominant coping skill relied upon by African Americans experiencing problems in their lives. Separate or intertwined with social support is religiosity. Revisiting the 16 questions asked by Getz et al. (1983), when interviewing African American clients the professional must receive firm answers from the client regarding questions eight (8) (What are the client's environmental supports?) and nine (9) (Are there community resources to help?). It is important for the professional to differentiate between existing support systems, potential support systems and support systems that are available, yet unfamiliar, to the client. The client may realize, while making this distinction, that his/her existing support systems may be enhanced by potential and unfamiliar support systems. Likewise, a client that claims to have no support system, existing or potential, may be enticed to familiarize him or herself to available support systems that will become his/her main support system in the future. Again, religion should not be forced upon a client, but it should be offered

as a coping mechanism that can provide hope and social support through a church family. The professional should also introduce the concept of spirituality, meaning emphasize the client's individual relationship with God. The client may be resentful of church and even fellow church members who, in the eyes of the client, have done nothing to help him/her. This negative opinion of the church should not taint the omnipotent presence of God in the client's life.

Cultural Competency in Treatment

Now that coping mechanisms specific to African Americans have been identified as statistically significant and relevant to their treatment, the implementation of these skills in treatment will be examined. Few (2005) compared accessibility to and satisfaction of staff and assistance between African American and white residents in domestic violence shelters in rural Virginia. Rural residency in itself is a cultural factor to be considered, in addition to race. A Survey of African American women in Virginia found that 70% were unaware of domestic violence shelters in their local and neighboring communities (Wilson, Cobb and Dolan, 1987). This survey was not administered to white women, so it is unknown what their knowledge of domestic violence services was. The issue of advertising services to everyone in the community is addressed later by participants in the study. Three research questions guided Few (2005) in her study:

- 1) Are there differences in how Black and White battered rural women seek and receive help from their social networks and community?
- 2) How do battered rural women describe their experiences in domestic violence shelters?
- 3) What are battered rural women's perceptions of the efficacy of shelter staff and services (p. 490)?

Fourteen (14) domestic violence shelters in southwest Virginia agreed to take part in Few's (2005) study. Thirty (30) women, ten (10) African American and 20 White, agreed to be participants in

the 16 month study. These women completed a survey created by Few (2005) that asked about the forms of violence they had been subjected to by their partners, social support received, coping mechanisms and their overall experience in the shelter. The women then were interviewed, both individually and in “focus groups” of three (3) to four (4) women. All of the women were comfortable with the group interview. As Few (2005) noted, this allowed women to speak more openly about their experiences because they were shared experiences.

The interview protocol consisted of questions that asked the participants to recall, amongst other things, help seeking strategies, community response and shelter experiences. The answers to these questions were qualitatively analyzed to answer the three research questions previously mentioned. Five (n=3, Black, n=2 White) of the 30 women reported that they were aware of shelter services in their area. 12 of the white participants said that the police encouraged them to go to a shelter compared to only two (2) African American women (Few, 2005). 15 White women claimed using the police as a threat against their abusive partner, whereas no African American respondents reported doing so. For them, they felt that the police would not provide adequate protection.

Few (2005) went on to note that African American women had higher social support than their White counterparts. Nine of the ten (10) African American said that friends and family would provide temporary shelter for them whereas only five (5) out of 20 White respondents could agree with that statement (Few, 2005, p. 493). Four (4) of the ten (10) African American respondents came from communities where the African American population was less than five (5) percent (Few, 2005). These women reported experiencing racism outside of the shelter to Few (2005) and, in the beginning, were concerned about the racial attitudes of the staff. The remaining six (6) African American respondents resided in the only shelter in southwest Virginia with an all African American staff (Few, 2005). All of the respondents felt comfortable with the

level of care they received from the staff as well as the access to help they were given. One African American respondent summed up the experience with this quote,” ‘We’re all just the same here. We see past the skin color and the bruises’ “(Few, 2005. p. 495). This should be the mission statement of every mental health professional; in viewing the client as an individual first, the professional gains the advantage of gaining the client’s trust which then leads to a smooth road to recovery.

In accounting for ethnicity in counseling, the professional must take into consideration his/her own ethnicity. Utilizing the process aspect, Collins and Pieterse (2007) look at the strengths gained in multicultural counseling competencies. The Multicultural Counseling Competencies (Sue, Arredondo & McDavis, 1992) are divided into three areas: knowledge, skills and awareness (Collins and Pieterse, 2007, p.14). Specifically, Collins and Pieterse (2007) define cultural competency in counseling as a process that involves engaging in an honest exploration of one’s experience of racial and cultural reality (p.15). This is an ongoing effort that requires the professional to be aware of the ebb and flow of the racial dynamics in society. It also allows the professional to confront any personally held prejudices he/she may have as well as become aware of the stereotypes associated with his/her own race. Collins and Pieterse (2007) believe that “applying the process perspective to the multicultural awareness component of the tripartite model, we derive a unique view of awareness (active racial/cultural awareness) that emphasizes engagement in and commitment to a daily process of increased and increasing levels of awareness” (p. 14). The training and implementation of cultural awareness in counseling has not become standardized. Some forms of training include reaction papers, journal writing, role playing, cross- cultural immersion experiences and cross-cultural simulation experiences (Collins and Pieterse, 2007). Feedback from participants suggests that these exercises do help the

professional, but with attitudinal changes being difficult to measure, it is often encouraged that training include different forms of training rather than focusing on just one form so that the professional can learn to apply cultural awareness in a variety of situations.

In addition to emphasizing the process aspect of multicultural awareness, Collins and Pieterse (2007) suggest employing the critical incident to further one's understanding of awareness in the moment. Critical incident analysis is described as "an observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act" (Collins and Pieterse, 2007, p. 17). It involves two phases: the critical incident itself and the reflective examination of the incident (Collins and Pieterse, 2007). An example of a critical incident that a professional may encounter is as follows:

An African American man comes to his weekly session, this time accompanied by his wife and teenage son. The counselor, a White woman, is pleased to see that her client has involved his family. She expresses her joy to the family, and in introductions, she says to the son, "Whoa, you're tall. I bet you play basketball. You even look like a basketball player, with your braids and, what do you young folks say-bling?" The son gives an awkward laugh, the client slightly rolls his eyes and the mother jumps in to say that he is on the basketball team, which is headed to the state championship for the second straight year. The professional is glad to hear the wife speak and moves onto begin the session, hoping that she won't say anything else offensive.

As the professional gathers her notes, she must begin the analysis of the incident. The first step is acknowledgement (Collins and Pieterse, 2007). The professional has acknowledged that she has said something offensive based upon the reaction from her client and his family. The second phase is confrontation (Collins and Pieterse, 2007). At this stage, the professional should

confront her audience with her acknowledgement and encourage their acknowledgement of the situation as well. The third step is reflection (Collins and Pieterse, 2007). All four individuals need to reflect on the conversation, stating which words seemed offensive and why. The conversation may become muddled with comments about situations that happened outside of the office, which is great. All parties are opening up and reflecting on situations in which culture or race produced a negative response from someone. The professional should listen intently and add comments. She should listen to examples of behavior the client and his family find offensive and watch for them in her everyday life. This is intertwining the process aspect of multicultural awareness with the objectives of critical incident analysis. The fourth step is commitment (Collins and Pieterse, 2007), in which all individuals again acknowledge what happened; have openly discussed the situation coming to a mutual understanding and appreciation of each person's faults and strengths in regards to cultural awareness; and, finally, each individual commits to continuing to engage in open discussions regarding culture and race.

Conclusion

The strengths of the African American community lie in the social support systems of the family, Church and religion. These three strengths often overlap, which, in turn, creates a tight-knit community in which assistance is available on several levels. The dominant society, though, does not reflect this constant presence of aid. This can be remedied through the implementation of cultural awareness in the mental health field. Should an African American seek professional help for a mental crisis, he/she should be assured that the professional is culturally competent to see beyond stereotypes; to understand that certain treatment methods may be more beneficial than others; and, be willing to incorporate the client's strengths in the plan for recovery. Cultural competency is more than an understanding of a particular people, it is

an acceptance of the mores that group values and the commitment to include those mores in all exchanges.

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