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COMMENTARY

Empathy, Compassion, and Connection Should Be Central in Suicide Assessment With Youth of Color: Commentary on Molock et al. (2023)

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Molock et al. (2023) offered an excellent scholarly review and critique of suicide assessment tools with youth of color. Although providing useful information, their article neglected essential relational components of suicide assessment, implied that contemporary suicide assessment practices are effective with White youth, and did not acknowledge the racist origins of acculturation. To improve the suicide assessment process, psychologists and other mental health providers should emphasize respect and empathy, show cultural humility, and seek to establish trust before expecting openness and honesty from youth of color. Additionally, the fact that suicide assessment with youth who identify as White is also generally unhelpful, makes emphasizing relationship and development of a working alliance with all youth even more important. Finally, acculturation has racist origins and is a one-directional concept based on prevailing cultural standards; relying on acculturation during assessments with youth of color should be avoided.

Keywords: suicide assessment, culture, youth of color, suicide prevention, acculturation

In the article, "Culturally Responsive Assessment of Suicidal Thoughts and Behaviors in Youth of Color," Molock et al. (2023) wrote persuasively about how psychologists need to improve their approach to assessing suicidality in youth of color. We fully support this ambition. Increasing sensitivity to cultural factors in psychological assessment is essential, and we appreciate the authors' scholarly review. At the same time, we believe the authors neglected several important issues related to suicide assessment in general and suicide assessment with minoritized youth in particular.

Despite excellent content, the authors did not address relational dynamics inherent in all psychological assessments (Jobes, 2023; Sommers-Flanagan & Shaw, 2017). As examples, they never used the words trust, empathy, respect, compassion, or relationship in the article. This is a missing piece because no matter how knowledgeable psychologists are regarding assessment tools for youth of color, if they do not show respect, cultural sensitivity, cultural humility, initiate a working alliance, and be aware of their social location, psychologists are unlikely to gather reliable, valid, and useful information to provide a culturally oriented case conceptualization (Beitel et al., 2021).

Youth of color often have lived experiences of personal and intergenerational oppression. Within Indigenous youth populations, suicidality may be conceptualized as an expression of "historical, cultural, community, and family disruption" rather than as an individual mental health problem (Wexler & Gone, 2012). As a consequence, health care providers should be transparent, relational, collaborative, and aware of the possibility that many youth of color and Indigenous youth may fear displacement and coercion (Jobes, 2023; Sommers-Flanagan & Sommers-Flanagan, 2021). Transparency is crucial to address patients' fears of being removed from their homes and communities. In many settings, when working with youth who may fear coercion from prevailing cultural authorities or Western institutions, hospitalization should be carefully considered and approached

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gently. For example, before asking about suicide, providers can say something like:

> I'll be asking you about suicide. I know that can bring up fears of hospitalization. I want you to know my policy. My goal is to listen and work with you to understand and resolve the pain and distress in your life. Together, we might decide hospitalization is a good choice. More often, even if someone is having many thoughts of suicide, we can find better options than hospitalization.

After reassuring clients that uttering the word suicide will not result in immediate hospitalization, administration of a questionnaire may ensue. Standardized questionnaires, although well-intended and sometimes helpful, can be emotionally activating, and their use is not without risk (Bryan, 2022; de Beurs et al., 2016). Questionnaires (administered either digitally or in person) can be introduced with a collaborative statement:

> The Patient Health Questionnaire (PHQ-9) includes nine important questions. I hope you'll answer them honestly. But I want to learn much more about you and your life than is covered by these nine questions. When we've finished the questionnaire, we'll talk together about your answers, and I'll also be interested in hearing stories about you, your life, and how you're feeling.

Health care providers need to recognize that historical trauma in youth of color can contribute to suicide risk (Wexler & Gone, 2012). Affirming that historical trauma increases distress, while listening respectfully and with interest, is vital to effective assessment and treatment (Sommers-Flanagan et al., 2024, 2024). Suicide risk assessment tools are never applied in a relational vacuum. The provider's stance as an accepting and affirming person who listens is foundational.

The authors accurately noted that contemporary suicide assessment tools have not been adapted for use with diverse youth, and they took valuable steps toward enlightening readers about how assessment tools might be adapted. However, their critique implied that contemporary suicide assessment tools work well with youth who identify as White. This assumption is not true. In their most recent recommendations, the United States Preventive Services Task Force (Mangione et al., 2022) concluded that the evidence supporting screening for suicide risk among children and adolescents was "insufficient" (p. 1534). Even screening proponents acknowledge, "there is currently little to no data to show that screening decreases suicide attempt or death rates" (Cwik et al., 2020, p. 255). As Franklin et al. (2017) reported in their 50-year meta-analysis, prediction of suicidality among predominately White populations is only slightly better than chance. Across settings, little to no empirical evidence indicates that screening assessments provide accurate, predictive, or useful information for categorizing risk (Bryan, 2022). Again, because the underlying assumption that suicide assessment predicts death by suicide (or is helpful) for youth who identify as White is incorrect, the primary goal of suicide assessment with youth of color and youth in general should be relational connection (Beitel et al., 2021; Jobes, 2023).

When local cultural values clash with dominant suicide assessment protocols, local culture prevails. To maximize the cultural validity of assessment, providers should honor collectivist worldviews. Emphasizing relationship, respect, trust, empathy, and putting culture in the center of clinical work—not only with individual clients but also in interactions with and increasing knowledge of diverse communities—is essential (Gone, 2022). Cultural humility is a central guiding concept for this. Could we approach communities with cultural humility and ask:

> Have you been concerned about the potential suicidality of a community or family member? What do you notice about community and family members who become suicidal (e.g., the ways they talk, behaviors, and social interactions?). How do people in your community think about others who have had suicide-related behaviors? What is commonly believed about what happens, and what should happen, when someone thinks about or acts on suicidal impulses?

These questions, and more, could help us humbly learn about suicide risk from local cultures.

For their final recommendation, the authors write, "take steps to mitigate the historical harms caused by psychological assessments developed in the context of structural racism" (p. 853). We agree and believe that mitigating historical harms requires a challenging level of scrutiny. For example, ironically, the authors discuss acculturation without considering that acculturation has racist roots related to forced assimilation and systemic racism (Cromer et al., 2018). In an early work, Thurnwald (1932) made the racial superiority assumptions underlying acculturation clear; he emphasized that there is a "giving" people and an "accepting" (acculturated) people, writing, "a recourse to violence is often unavoidable unless one party is, in some way, accepted as a 'superior'" (p. 562). When White psychologists conduct assessments with youth of color, the youths' ability and interest in exhibiting acculturated behaviors may be influenced by their awareness of historical oppression and/or worries about present coercion from someone holding power. One, among many, problems linked to assumptions that one race or group is superior to another is that not all values, traditions, tools, and ideas given by the so-called superior group are, in fact, worth accepting.

We are aware that acculturation has been repeatedly identified as contributing to suicidality in various minoritized populations (Polanco-Roman et al., 2023). However, assessing acculturation is multidimensional and complex. Patients, who desire to become more or less acculturated, may not have had acculturation opportunities because of historical effects of ethnocide, genocide, and discrimination. Other contextual variables, such as first language, experiences of oppression, bullying, bias, and intergenerational or historical trauma directly affect how much youth of color will be able or willing to accept the prevailing culture. Unfortunately,

acculturation is a one-directional concept that relies on dominant, context-based cultural standards. White people are not judged by similar standards. If acculturation into the prevailing White culture was inherently protective against suicide, White clients would be likely to have low suicide rates. In fact, excessive masculine-oriented acculturation may partially explain why White males are far more likely than other demographic groups to use firearms and to die by suicide (Kaplan et al., 2012; Walther et al., 2023). We do not have special wisdom to offer regarding acculturation in assessment, other than to emphasize that it is complex, has racist origins, and can be oversaturated with judgment.

In conclusion, to improve suicide assessment protocols for youth of color, providers should embrace antiracist practices, behave with cultural humility, value transparency, and integrate relational skills into the assessment process. This includes awareness, knowledge, and skills related to cultural attitudes consistent with local, communal, tribal, and familial values. Molock et al. (2023) addressed most of these issues very well. Our main point is that when psychologists conduct suicide assessments, relational factors and empathic attunement should be central. Overreliance on standardized assessments—even instruments that have been culturally adapted—will not suffice.

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