Suicide Risks among College Students from Diverse Cultural Backgrounds

© Paul T. P. Wong

ABSTRACT:
This chapter reviews the recent statistics for youth suicide in North America. It identifies cultural factors that contribute to suicide in minority and international students. These factors include acculturation stress, untreated mental illnesses, lack of culturally-appropriate mental health services, discrimination, language and cultural barriers, a sense of social and spiritual isolation, academic pressure, high expectations from parents and a perceived lack of meaning in life. Warning signs often include a loss of interest in attending classes and taking part in social activities, increases in the use of alcohol and other drugs, and the usual signs of depression, reckless behavior, skipping classes, and frequent references to the desire to end one's life. This chapter also reviews the literature on meaninglessness and depression/suicide and then introduces Viktor Frankl's logotherapy and Paul T. P. Wong's meaning therapy as effective ways to prevent youth suicide because having reasons for living is logically incompatible with suicide. The life education program in Taiwan also emphasizes meaning in life and cherishing one's own life, is another promising way to prevent suicide. This chapter concludes that the medical profession needs to learn to be sensitive to cultural and existential issues in college suicides.

Introduction

Jenny Chen was the only daughter and her parents' pride and joy – an award winning pianist who graduated from high school with the highest mark in the whole province of Ontario. Her parents came to Canada to study and became quite successful; her father was a science professor at a major Canadian university, and her mother was an accomplished pianist. Both felt that it would be best for Jenny Chen to study at an Ivy League school in the United States because of her intellectual and musical gifts. Tragically, she jumped out the window and killed herself less than one year after moving to the States. Two days before she took her life, she visited her school's counselling services. The counselor who interviewed Jenny reported that she only

complained about missing home, losing interest in school, and worrying about not being able to get the grades she used to get. The counselor simply sent her away with a few words of encouragement, because she appeared to be a model Asian student, smart and hard working. Little did the counselor know that Jenny was at the end of her rope, feeling overwhelmed by academic pressure, loneliness, and a crushing sense of shame that she would never meet her parents' high expectations. She kept her problems to herself and at a moment of overwhelming pain and hopelessness, she saw death as her only way of escape from her predicament. Her brief suicide note said it all: "Dear Mom and Dad: I am so sorry that I have let you down."

Of course, this was not an isolated case. Over the past few years, youth suicide has been on the increase; it has become a serious concern to both college officials[1,2,3] and government at both the state and federal levels.[4,5] What makes suicide at the college age so unthinkable and tragic, is that, at this stage of life, youth are supposed to be busy developing their potential and preparing themselves for their future; their suicide constitutes a tragic loss for their families and society. Such loss is completely preventable when the mental health needs of the youth are met. Urgent action by mental health professionals is needed to prevent youth suicides.[5]

Definitions:

Cultural diversity will include racial, ethnic, and cultural minority groups, which may intersect with sexual orientation. In other words, within each racial/cultural group, there may be an additional minority status such as, lesbian, gay, bisexual, or transgendered.[6]

Suicide is more than a medical issue. It is increasingly seen as a cultural and existential issue as well. Leong and Leach[7] have found that the phenomenon of suicide often includes the intersection of biological, psychological, cognitive, and social/cultural factors. Taking one's

own life indicates that one has nothing to live for and no reason for existing; thus, suicide is also an existential issue.[8]

Logotherapy was founded by Dr. Viktor Frankl[9] and is known as the third Vienna School of Psychotherapy, after Freud and Adler. Frankl focuses on the search for meaning[10] as the primary human motivation rather than pleasure and power, and maintains that the ultimate aim of psychotherapy is to empower clients to discover what makes life worth living in spite of suffering. He emphasizes that meaning, as the essence of our innate spirituality, can be discovered under any circumstances and that one can says "Yes" to life no matter what. Logotherapy consists of awakening clients' sense of responsibility to discover meaning in life through a variety of techniques.

Meaning therapy was developed by Dr. Paul T. P. Wong.[11,12] He has extended Frankl's logotherapy by incorporating relevant aspects of other therapeutic modalities with meaning as the central organizing construct. While logotherapy is primarily philosophical and serves as an adjunct to psychotherapy and a medical ministry to address existential issues, meaning therapy is primarily a full-fledged psychotherapy. Meaning therapy aims at achieving both healing and flourishing through evidence-based interventions. To the extent that meaning is socially constructed, meaning-therapy is inherently multicultural, uniquely suited to cross-cultural counselling.

Objectives:

The first part of this chapter presents an overview of suicide risk for college students in the United States and Canada. It highlights the importance of cultural factors in suicide among minority and international students. This chapter pays special attention to suicide in Asian

Americans, not only because they have one of the highest suicide rates, but also because there is more research information about this group.[13,14,15,16]

The second section of the chapter reviews the risk factors for suicide for both students in general and minority students. I will introduce the concept of perceived meaninglessness as an important risk factor for suicide, because having reasons for living is logically inconsistent with taking one's own life. I will introduce appropriate instruments to assess suicide risk.

In the last section, I will recommend strategies for suicide prevention, especially meaning therapy[12] and logotherapy[9], in working with suicidal youth. I will also suggest that life education[17,18] at the high school and college levels may be a promising system-wide prevention program.

I conclude that research on cultural diversity in suicide assessment and prevention can contribute to multicultural competence in the practice of psychiatry and counseling with college students.[7,19] I also recommend that mental health professionals be familiar with Viktor Frankl's logotherapy and Paul T. P. Wong's meaning therapy as effective ways to prevent suicide.

Recent Statistics on Youth Suicide:

The suicide rate of youth has increased dramatically over the past few years.[20] The statistics of depression, anxiety, and suicide ideation, as reported in the Spring 2012 Executive Report of the American College Health Association National College Health Assessment, are troubling. During the 12 months prior to the survey, 31.3% of college students surveyed reported feeling so depressed it was difficult to function; 50.7% felt overwhelming anxiety; and 7.1% seriously considered suicide.[21] It is worth noting that suicide is the 10th leading cause of death for all

Americans, the 2nd leading cause of death for adults ages 25-34, and the 3rd leading cause of death for youth ages 15-24. More importantly, suicide is a preventable public health problem.[22]

The Centers for Disease Control and Prevention also reported that suicide is the third leading cause of death among 15- to 24-year-olds in the United States.[23] In Canada, the statistic is not any better. According to the Alberta Centre for Injury Control, suicide is the second most common cause of death for Canadians between 15 and 25 years of age. Canada's major news magazine MACLEAN'S featured college suicide in an article "The Broken Generation."[1] They reported that a quarter of university-age in Canada will experience a mental health problem, most often stress, anxiety, or depression.

Although suicide affects all youth, some groups are at higher risk than others. Boys are more likely than girls to die from suicide. In the 10 to 24 age group, 81% of the suicides were males and 19% were females. Girls, however, are more likely to report attempting suicide than boys. Cultural variations in suicide rates also exist. Native American/Alaskan Native youth have the highest rates of suicide. In grades 9–12, Hispanic youth were more likely to report attempting suicide than their Black and White, non-Hispanic peers.[24] The next section considers the cultural factors in detail.

Cultural Diversity in Suicide:

 Shadick and Akhter[25] reported that non-Whites endorse a higher rate of distress and suicidal ideation and were less likely to seek help than White students, with Alaska Natives/American Indians, Asian Americans, and multiracial students reporting the highest level of suicidal thoughts. They also found adolescents with same sex attraction were at twice the risk for suicide

than opposite sex attracted peers. For bisexual and transgendered youth, suicide risk may be even higher as they face more discrimination.

According to the Alberta Centre for Injury Control & Research,[26] suicide risk is higher among sexual minority youth, who are also more likely to experience homelessness, sexual abuse, isolation, substance abuse, prostitution, and school and family problems. Another study showed that homosexually-oriented young adult males are at 14 times more risk for serious suicide attempts than heterosexual counterparts.[27]

According to the American Psychological Association (APA) fact sheet on suicide in Asian Americans,[28] the suicide rate for Asian Americans aged 15 – 34 was consistent with the national data, however, among all Asian Americans, those aged 20 - 24 had the highest suicide rate (12.44 per 100,000).

Duldulao, Takeuchi, and Hong[29] examined the correlates of suicidal ideation, suicide plan, and suicide attempt among Asian Americans. They reported that Among Asian American adults, those aged 18-34 had the highest rates of suicidal thoughts (11.9%), intent (4.4%), and attempts (3.8%) compared to other age groups. They also found Asian American college students were more likely than White American students to have had suicidal thoughts and to attempt suicide. In another study, Chu, Joyce, Hsieh, and Tokars[30] reported that as compared to Latinos, Asian Americans with suicidal thoughts were less likely to seek help.

Asian-American youths may carrier the extra burden of their ancestry and parental pressure, compared to other minority students. They are taught that their primary duty is to honor their family and ancestry. The model minority stereotype may drive some Asian students to suicide.[31,32] There are many students like Jenny described in the opening paragraph: Their

primary identify is their family and their main purpose in life is to make their parents proud of them.

Contextual Data:

Most of the resources and data are from my professional network, involving leading researchers in cross-cultural and death studies. Some of the statistical information provided here is based on Google research of authoritative sources.

Risk Factors in Suicide

Risk factors are numerous and vary from individual to individual. However, regardless of these individual differences, the common factor is some kind of inner pain that is beyond personal control. That is why Shneidman, the father of suicidology, writes: "Near the end of my career in suicidology, I think I can now say what has been on my mind in a few as five words: Suicide is caused by psychache."[33(p53)] For college students, their "psychache" is often related to difficulties in making the major life transition from adolescence to young adulthood.

College students might be vulnerable to mental illness and suicide, because they are likely to move out from their parents' home and start life on their own in a new city. Growing up can be very hard for teens who now have to make their own decisions about relationships, sexual freedom, experimenting with alcohol and drugs, and academic and vocational decisions; in addition to assuming new responsibilities, they may go through the heartbreaks of break ups, feelings of isolation and loneliness, and academic and financial pressures, for the first time in their lives. It may be particularly difficult for overprotected Asian students who have to grow up fast to be totally on their own, trying to fit into a much more complex and demanding college

life. During this major life transition, without adequate preparation to cope with life's many new demands, college students may feel overwhelmed and become vulnerable.

Risk Factors for Students in General:

Risk factors come from both external and internal sources. Known factors for suicide among teens include substance abuse and social conflict.[34] Victimization and bullying by peers has also emerged as a contributing factor.[35] Hopelessness is a closely related emotional disorder that has been proven to be a strong indicator of suicide.[36,37,38,39] Meaninglessness, which includes the absence of life purpose and a sense of significance, is also an important risk factor. 8 Several studies have reported that loneliness is related to suicidal ideation.[39,40,41,42] Academic problems, relationship and family issues, and financial concerns can also be related factors.[39]

The National Institute of Mental Health has summarized the major risk factors as follows:[43]

- Depression and other mental disorders, or a substance-abuse disorder (often in combination with other mental disorders). More than 90 percent of people who die by suicide have these risk factors.
- Prior suicide attempt
- Family history of mental disorder or substance abuse
- Family history of suicide
- Family violence, including physical or sexual abuse
- Firearms in the home, the method used in more than half of suicides
- Incarceration
- Exposure to the suicidal behavior of others, such as family members, peers, or media figures

Risk Factors for Minority Students:

International students may face an additional set of risk factors, such as acculturation stress,[44,45,46] prejudice, intercultural conflict or discrimination,[47,48] language/cultural barriers, social and spiritual isolation,[45,46] homesickness,[45,48] conflict with parents,[48] traumas related to the refugee experience,[48] financial problems from not being allowed to work outside the academic environment and lack of financial assistance for foreign students,[45,46,49] and a lack of culturally appropriate mental health services.[46] The stigma of mental health may be another barrier preventing students from seeking mental health services.[46,50] Asian students, because of their model minority stereotype,[31,32] may experience unique sets of risk factors such as the pressure of meeting unrealistically high expectations from parents and the pride of keeping their emotional needs to themselves, as illustrated by the case of Jenny Chen.

Warning Signs:

There are always some warning signs for attempted suicides. Often these warning signs go unnoticed, especially when students are away from their friends and families who know them best and might notice any significant changes in mood or behavior such as social withdrawal, increased anxiety, and inability to cope with the demands of school.

The University of Emory identifies several suicide warning signs.[45] These include:

- Says things such as, "I don't deserve to be here," "I wish I were dead," "I am going to kill myself," or "I want to die."
- Is focused on death and dying
- Talks about wanting to attempt or complete suicide
- Writes poems, letters, or stories about death and/or suicide

- Starts giving away their things

- Prepares for death by making out a will

An Existential Perspective on Youth Suicide:

Suicide represents an existential crisis. I agree with Viktor Frankl's logotherapy[9] that the root cause of suicide is existential frustration because of unmet needs for personal significance and meaning. Individuals who attempt suicide must have struggled with some of these existential issues:

- Does anyone care whether I am alive or dead?

- Does my existence make any difference in this world?

- Was my birth a mistake? An unfortunate accident?

- What is the point of striving so hard, when all I get is disappointment and failure?

- With so few resources and so many obstacles ahead, what future do I have?

- Why is growing up so hard? How many heartbreaks and sufferings must I endure?

- Why am I feeling so alone and without any meaningful relationships?

- How long can I carry on this hopeless struggle against the mounting pressures?

- Where can I find happiness, love, and purpose is this harsh world?

- What do I have to live for? What reasons do I have to live?

Major life transition, various kinds of adversities, and one's own identity crisis can all lead to the quest for meaning.[12,51] Viktor Frankl[9] considers logotherapy to be a "medical ministry" that is uniquely designed to address existential crisis. Meaning in life serves the double purpose of giving people something to live for and making their suffering more bearable. Viktor Frankl[8] was the first psychiatrist to emphasize the vital role of meaninglessness or existential vacuum in

causing aggression, addiction, and suicide. Similarly, according to Yalom,[52] failure to cope with basic existential concerns, such as loneliness, helplessness, and the inherent meaninglessness of the world, may lead to depression and suicide.

There are numerous studies that link meaninglessness to suicidal ideation and actual suicide attempts. Lester and Badro[53] found a negative relationship between self-reported purpose in life and depression, previous suicide attempts and previous and present suicidal ideation in undergraduate students. Edwards and Holden[54] found that meaning measures were predictive of suicide variables. More recently, Kleiman and Beaver[55] reported that presence of meaning in life predicted decreased suicidal ideation over time and lower lifetime odds of a suicide attempt.

The dominant medical model would attribute suicide to mental illness and neurotransmitter imbalance,[56] however, many suicide cases, especially among international students such as the Jenny Chen case, can be better understood in terms of a total lack of meaning to counteract the psychic pain. In other words, from an existential perspective, suicide represents a rational choice given the individual's life circumstances. "An existence becoming devoid of meaning may increasingly experience suicide as an option, consciously or unconsciously."[57(p17)]

Existential or meaning-oriented psychologists do not pathologize suicide. For example, Binswanger[58] considers suicide to represent a basic aspect of human freedom. Farber[59] considers it a desperate attempt at self-empowerment, when life is devoid of meaning because of personal and socio-cultural factors.[57] From this perspective, something is terribly wrong in one's life, but not necessarily due to mental illness.

Suicide Risk Assessments:

Assessment of Risk Factors

There are three types of suicide risks assessments. The first type is based on objectively developed valid and reliable test instruments. This category includes the Beck Hopelessness Scale[60] and the Beck Scale for Suicide Ideation (BSS ®),[61] the Tool for Assessment of Suicide Risk for Adolescents (TASR-A),[62,63] Paladino and Minton's application of Lazarus's multimodal BASIC ID to a suicide assessment framework, and the SAD PERSONS scale.[64]

The Beck Hopelessness Scale,[60] consisting of twenty true/false questions, assesses negative feelings about one's future, loss of motivation, and pessimistic expectations. A score of 9 or above indicates higher risk of suicide. It is not intended for emergency situations, but can be used to screen for those who might need a more intensive risk assessment.[65]

The Beck Scale for Suicide Ideation (BSS ®),[61] consisting of 21 items that are rated on a 3-point scale of suicidal intensity, assesses the immediate intensity of a person's suicide-related attitudes, behaviours, and plans. This scale has been widely studied and has demonstrated predictive validity for death by suicide. The BSS® is available in multiple languages, including Chinese, French, Norwegian, and Urdu. Special training is needed to use this assessment.

The Tool for Assessment of Suicide Risk for Adolescents (TASR-A)[62,63] assesses immediate suicide risk in youth, using a yes/no checklist. It considers individual risk factors, suicide-related psychiatric symptoms, and acute suicide-related factors (e.g., suicidal intent or plan). It can be used as a summary of risk, but is not designed for prediction or diagnosis.

Paladino and Minton[39] have proposed the use of Arnold Lazarus's BASIC ID model as a framework for holistic and comprehensive suicide assessment. BASIC ID stands for Behavior, Affective Responses, Sensations, Images, Cognitions, Interpersonal Relationships, and Drugs or Biological Influences.

The SAD PERSONS scale[64] is an acronym used in assessment to cover the major suicide-related risk factors. SAD PERSONS stands for Sex, Age, Depression, Previous attempt, Ethanol Abuse, Rational thinking loss, Social supports lacking, Organized plan, No spouse, and Sickness.

Assessment of Positive Factors

The second type of assessment focuses on the positive factors, such as the Personal Meaning Profile[66,67] and the Reason for Living Inventory,[68] because the absence of these factors may lead to suicide. A comprehensive assessment should include both positive and negative types of assessments.

Wong's Personal Meaning Profile (PMP)[66] is a 54-item questionnaire consisting of seven sources of meaning: Achievement, Relationship, Religion, Self-transcendence, Self-acceptance, Intimacy, and Fair treatment. It is useful to identify areas where students are deficient in perceived meaning. It has good reliability and validity. Scores on the PMP are related to depression and depressive symptoms, such as suicidal ideation.[69,70] MacDonald, Wong and Gingras have also recently developed the 21-item Brief Personal Meaning Profile (PMP-B). [67]

The Reasons for Living Inventory (RFL)[68] is a 48-item scale, comprised of 6 subscales, that assesses potential protective factors (e.g., "my family depends on me and needs me", "I believe only God has the right to end a life") in those with suicidal ideation. These subscales include survival and coping beliefs, responsibility to family, child-related concerns, fear of suicide, fear of social disapproval, and moral objections. Patients rate each item from 1 to 6, according to its level of importance in not killing themselves.

Direct Questions

The third type of assessment is to confront potential suicidal patients with direct and simple questions, such as, "Are you thinking about suicide?

According to the Canadian Association for Suicide Prevention, we need to pose these direct questions to suicidal patients:

- Are you thinking of suicide?

- Have you thought about Suicide in the last two months?

- Have you ever attempted to kill yourself?

The Canadian Network for Mood and Anxiety Treatments[71] also lists such questions as

- Do you have any hope for the future?

- Do you ever have thoughts of death?

- If you died in your sleep, would that be all right with you?

- Have you ever thought of killing yourself?

- Have you formulated a plan for committing suicide?

- What stops you from trying to kill yourself?

Recommended Preventions

Garland and Zigler[20] review the current epidemiological research in adolescent suicide and suggest how this knowledge could be used more effectively to reduce the rate of adolescent suicide. They recommend integrated primary prevention efforts, suicide prevention education for professionals, education and policies on firearm management, more efficient identification and treatment of at-risk youth, crisis intervention, and treatment for suicide attempters. In addition to

individual counseling, The American Psychological Association (APA)[28] suggests various protective factors, including the family and community.[72,73]

Emory University also lists several preventative factors,[45] including:

- Friends, family, and supportive significant others

- Strong social-support network

- Responsibilities/duties to others

- Pets

- Opportunities to participate in and contribute to school and/or community projects/activities

- A reasonably safe and stable living environment

- Spiritual well-being

- Religious involvement

- Restricted access to firearms or other lethal methods

- Access to physical and mental health services

At present, the internet has become a preferred place where suicidal students seek help.[74] There are several online sources; most of them are related to some university. ULifeline (http://www.ulifeline.org/) is also a general online resource for college students where they can do self-assessment and find information on mental health issues and suicide prevention. On a smaller scale, many individual universities support a variety of student organizations that address mental health issues. These universities sponsor a variety of suicide prevention workshops and awareness weeks to continuously work towards improving student outreach.

Goldston and colleagues[75] emphasize the need for culturally sensitive and community-based interventions along with future opportunities for research in intervention development and evaluation. It is important that practitioners at the counseling services of all campuses are trained in assessment and intervention with minority students. In Jenny Chen's case, the counselor who saw her the day before her suicide did not detect the seriousness of her condition. She might have been partially blinded by the model minority syndrome that Jenny was a smart student capable of handling her personal problems. Mental health professionals need more education in cross-cultural competence in order to be more effective in helping suicidal students from diverse cultural backgrounds.[19,76]

 In terms of individual counselling, meaning-oriented therapy seems to be the logical choice in addressing the problem of suicide. Frankl has emphasized that logotherapy can "wrest meaning from life by turning suffering into a human triumph."[77(p64)] It makes perfect sense that if we can restore the clients' reason for living and turn their psychic pain into a passport to character strength, we can prevent their suicides. In fact, such logic has been supported clinically. Viktor Frankl set up youth counseling centers in Vienna for college students. He was able to use logotherapy to reduce the annual youth suicide rate in Vienna to zero.[78,79]

Life Education in Taiwan represents a curriculum-based approach to preventing suicide. Life Education curriculum was developed as a response to the alarming youth suicide rate after the devastating earthquake on September 21, 1999. The Department of Education has mandated that Life Education be taught at all levels of public education. The main purpose of Life Education is to teach students how understand the meaning of life and how to cherish their own lives.[80] After reviewing the literature on Life and Death Education in North America and Asia, Chang Sue May[81] makes a compelling case that Life Education as an integral part of school curriculum is a

logical answer to the problem of youth suicide. (The fact that I have been invited to keynote at the Life Education Conference three times in Taiwan provides concrete evidence that meaning therapy and Life Education are natural allies in promoting meaningful living as the antidote to taking one's own life.) However, empirical research is urgently needed to demonstrate the efficacy of education on life's meaning in preventing suicide.

In conclusion, college suicide represents a serious problem that affects not only students, but also their families, and communities. Cultural minority status is one of the risk factors. Suicide is not only a medical problem, but also a cultural and existential issue. Therefore, prevention calls for concerted efforts involving the medical profession, different levels of government, higher education counseling services, ethnic communities, Life Education, and families. The existential perspective provides a helpful framework for preventing suicide at both the individual and system-wide education levels. Empirical research is needed to determine the efficacy of various approaches to suicide prevention. On the one hand, we need to work towards reducing the stigma of mental illness in order to encourage college students with emotional problems to seek professional help. On the other hand, we need to work towards reducing cultural and language barriers and increasing the cultural competency of mental health professionals. Nothing less than open exchange of information and integrative collaboration can reverse the high rate college suicide.

References

1. Lunau K. The Broken Generation. *Macleans Magazine*. September 5, 2012. Available at: http://www2.macleans.ca/2012/09/05/the-broken-generation/. Accessed September 28, 2013.

2. Shtrakhman D. Cornell suicides raise concerns across Ivies. *The Daily Pennsylvanian*. March 24, 2010. Available at: http://www.thedp.com/article/2010/03/cornell_suicides_raise_concerns_across_ivies. Accessed September 23, 2013.

3. Holden JP. Concern over suicide rate at Edinburgh College. *The Scotsman*. March 11, 2013. Available at: http://www.scotsman.com/news/education/concern-over-suicide-rate-at-edinburgh-college-1-2829823. Accessed October 24, 2013.

4. Substance Abuse and Mental Health Services Administration (SAMHSA). National Strategy for Suicide Prevention: Compendium of Federal Activities. *Substance Abuse and Mental Health Services Administration (SAMHSA)*. March 27, 2009. http://www.samhsa.gov/mentalhealth/NSSPCompendium_v2_March09.pdf. Accessed October 24, 2013.

5. Office of the Surgeon General (US); National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington (DC): US Department of Health & Human Services (US); September 2012. A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention.

6. Leach MM. *Cultural diversity and suicide: Ethnic, religious, gender, and sexual orientation perspectives*. Binghampton, NY: Haworth Press; 2006.

7. Leong FTL, Leach MM, eds. *Suicide Among Racial and Ethnic Minority Groups: Theory, Research, and Practice*. 1st ed. New York: Routledge; 2007.

8. Frankl VE. *Man's search for meaning*. Revised and updated ed. New York, NY: Washington Square Press; 1985.

9. Frankl VE. *The doctor and the soul: From psychotherapy to logotherapy*. New York, NY: Random House Digital, Inc.; 1986.

10. Frankl VE. *The will to meaning: Foundations and applications of logotherapy*. New York, NY: New American Library; 1988.

11. Wong PTP. Meaning Therapy: An integrative and positive existential psychotherapy. *Journal of Contemporary Psychotherapy*. 2010;40(2):85-99.

12. Wong PTP. From logotherapy to meaning-centered counseling and therapy. In: Wong P, ed. *The human quest for meaning: Theories, research, and applications*. 2nd ed. New York, NY: Routledge; 2012.

13. Chang EC, ed. *Handbook of Adult Psychopathology in Asians*. New York: Oxford University Press; 2012.

14. Leong FTL, Leach MM, Yeh C, Chou E. Suicide among Asian Americans: What do we know? What do we need to know? *Death Studies*. 2007;31:417-434.

15. Edman JL, Andrade NN, Glipa J, et al. Depressive symptoms among Filipino American adolescents. *Cultural Diversity and Mental Health*. 1998;4:45-54.

16. Else IRN, Goebert DA, Bell CK, Carlton B, Fukuda M. The relationship between violence and youth suicide indicators among Asian American and Pacific Islander youth. *Aggression and Violent Behavior*. 2009;14:470-477.

17. Lee CM. Changes and challenges for moral education in Taiwan. *Journal of Moral Education*. 2004;33(4):575-595.

18. Muto T, Nakahara T, Name EW, eds. *Asian perspectives and evidence on health promotion and education*. New York, NY: Springer; 2011.

19. Sue DW, Arredondo P, McDavis RJ. Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development*. March/April 1992;70:477-486.

20. Garland AF, Zigler E. Adolescent suicide prevention: Current research and social policy implications. *American Psychologist*. 1993;48(2):169-182.

21. American College Health Association. *Reference Group Executive Summary: Spring 2012* 2012. National College Health Assessment II.

22. *National Action Alliance for Suicide Prevention*. 2012. Available at: http://actionallianceforsuicideprevention.org/. Accessed October 22, 2013.

23. Centers for Disease Control and Prevention (CDC). *10 Leading Causes of Death by Age Group, United States – 2010*. Atlanta 2010.

24. Injury center: Violence Prevention. *Centers for Disease Control and Prevention*. August 15, 2012. Available at: http://www.cdc.gov/violenceprevention/pub/youth_suicide.html. Accessed September 28, 2013.

25. Shadick R, Akhter S. Suicide Prevention in a Diverse Campus Community. *New Directions for Student Services*. 2013(141):71-81.

26. Suicide risk higher among sexual minority youth. *Alberta Centre for Injury Control & Research*. http://www.teachers.ab.ca/SiteCollectionDocuments/ATA/Issues%20In%20Education/Diversity%20Equity%20and%20Human%20Rights/Sexual%20Orientation/Suicide%20Risk%20Higher%20Among%20Sexual%20Minority%20Youth.pdf. Accessed September 26, 2013.

27. Bagley C, Trembley P. Suicidal behaviors in homosexual and bisexual males. *Crisis*. 1997;18:24-34.

28. Suicide among Asian-Americans. *American Psychological Association*. 2013. http://www.apa.org/pi/oema/resources/ethnicity-health/asian-american/suicide.aspx. Accessed September 25, 2013.

29. Duldulao AA, Takeuchi DT, Hong S. Correlates of suicidal behaviors among Asian Americans. *Archives of Suicide Research*. 2009;13:277-290.

30. Chu JP, Hsieh KY, Tokars D. Help-seeking tendencies in Asian Americans with suicidal ideation and attempts. *Asian American Journal of Psychology*. 2011;2:25-38.

31. Rigdon JE. *Model minority myth seen as driving some youths to suicide*: The Wall Street Journal; July 10, 1991.

32. Lee SJ. *Unraveling the "model minority" stereotype: Listening to Asian American youth*. New York, NY: Teachers College Press; 1996.

33. Shneidman ES. *Suicide as psychache*. Northvale, NJ: Jason Aronson Inc; 1993.

34. Shaughnessy L, Doshi SR, Jones S, Everett S. Attempted suicide and associated health risk behaviors among Native American high school students. *Journal of School Health*. 2004;74:177-182.

35. Kaminski JW, Fang X. Victimization by peers and adolescent suicide in three US samples. *Journal of Pediatrics*. 2009;155:683-688.

36. American Psychiatric Association. *American Psychiatric Association practice guidelines for the treatment of psychiatric disorders: Compendium 2006*. Arlington, VA: American Psychiatric Publishing; 2006.

37. Beck A, Steer R, Beck JS, Newman CF. Hopelessness, depression, suicidal ideation, and clinical diagnosis of depression. *Suicide and Life Threatening Behavior*. 1993;23:139-145.

38. Beck AT, Steer RA, Kovacs M, Garrison B. Hopelessness and eventual sucide: A 10-year prospective study of patients hospitalized with suicidal ideation. *American Journal of Psychiatry*. 1985;142:559-563.

39. Paladino D, Minton B. Comprehensive college student suicide assessment: Application of the BASIC ID. *Journal of American College Health*. 2008;56:643-650.

40. You S, Van Orden KA, Conner KR. Social connections and suicidal thoughts and behavior. *Psychology of Addictive Behaviors*. 2010;25:180-184.

41. Stravynski A, Boyer R. Loneliness in relation to suicide ideation and parasuicide: A population-wide study. *Suicide & Life-Threatening Behavior*. 2001;31:32-40.

42. Furr SR, Westefeld JS, McConnell GN, Marshall JJ. Suicide and depression among college students: A decade later. *Professional Psychology: Research and Practice*. 2001;32(1):97-100.

43. Suicide in the US Statistics and Prevention. *National Institute of Mental Health*. Available at: http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml. Accessed September 26, 2013.

44. Walker RL, Wingate L, Obasi EM, Joiner TE. An empirical investigation of acculturative stress and ethnic identity as moderators for depression and suicidal ideation in African American and European American college students. *Cultural Diversity and Ethnic Minority Psychology*. 2008;14:75-82.

45. Suicide Prevention for International Students. *Emory University*. Available at: http://www.emorycaresforyou.emory.edu/emory_student_communities/international_students.html. Accessed September 2013, 2013.

46. International Students and Suicide. *University of Maryland University Health Center*. Available at: www.health.umd.edu/node/794. Accessed September 26, 2013.

47. Wong YJ, Brownson C, Schwing AE. Risk and protective factors associated with Asian

American students suicidal ideation: A multicampus, national study. *Journal of College Student Development*. 2011;52:396-408.

48. Suicide Prevention for Asian American College Students. *Ohio State University Suicide Prevention*. Available at: http://static.ehe.osu.edu/sites/cspp/brochures/asian-american-students-suicideprevention.pdf. Accessed September 26, 2013.

49. Mori S. Addressing the mental health concerns of international students. *Journal of Counseling and Development*. 2000;78:137-144.

50. Yi JK, Lin JG, Kishimoto Y. Utilization of counseling services by international students. *Journal of Instructional Psychology*. 2003;30:333-342.

51. Wong PTP. Viktor Frankl's meaning seeking model and positive psychology. In: Batthyany A, Russo-Netzer P, eds. *Meaning in existential and positive psychology*; in press.

52. Yalom I. *Existential psychotherapy*. New York, NY: Basic Books; 1980.

53. Lester D, Badro S. Depression, suicidal preoccupation and purpose in life in a subclinical population. *Personality and Individual Differences*. 1992;13:75-76.

54. Edwards MJ, Holden RR. Coping, meaning in life, and suicidal manifestations: Examining gender differences. *Journal of Clinical Psychology*. 2001;57:1516-1535.

55. Kleiman EM, Beaver JK. A meaningful life is worth living: Meaning in life as a suicide resiliency factor. *Psychiatry Research*. August 2013;Epub ahead of print.

56. Chehil SK, ed. *Suicide Risk Management: A Manual for Mental Health Professionals*. Chicester, UK: John Wiley & Sons; 2012.

57. Potter B. *Elements of Self-Destruction*. London, UK: Karnac Books; 2013.

58. Binswanger L. The case of Ellen West. In: Angel E, Ellenberger H, May R, eds. *Existence*. New York, NY: Simon & Schuster; 1958.

59. Farber M. The phenomenology of suicide. In: Shneidman E, ed. *On the Nature of Suicide*. San Francisco, CA: Jossey-Bass; 1969.

60. Beck AT, Steer RA. *Manual for the Beck Hopelessness Scale*. San Antonio, TX: Psychological Corporation; 1988.

61. Beck AT, Kovacs M, Weissman A. Assessment of suicidal intention: The Scale for

Suicide Ideation. *Journal of Consulting and Clinical Psychology*. 1979;47(2):343-352.

62. Kutcher S, Chehil S. *Suicide risk management: A manual for health professionals*. Malden, MA: Blackwell Publishing Ltd; 2007.

63. Kutcher S, Chehil S. Tool for Assessment of Suicide Risk: Adolescent version (TASR-A). 2007. http://www.gpscbc.ca/system/files/64_CYMH_PSP_MH_Youth_TASR-A%20v2_1.pdf. Accessed September 28, 2013.

64. Patterson WM, Dohn HH, Bird J, Patterson GA. Evaluation of suicidal patients: The SAD PERSONS scale. *Psychomatics*. 1983;24(4):343-349.

65. McMillan D, Gilbody S, Beresford E, Neilly L. Can we predict suicide and non-fatal self-harm with the Beck Hopelessness Scale: A meta-analysis. *Psychological Medicine*. 2007;37(6):769-778.

66. Wong PTP. Implicit theories of meaningful life and the development of the Personal Meaning Profile (PMP). In: Wong PTP, Fry P, eds. *The human quest for meaning: A handbook of psychological rsearch and clinical applications.* 1st ed. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.; 1998.

67. McDonald MJ, Wong PTP, Gingras DT. Meaning-in-life measures and development of a brief version of the Personal Meaning Profile. In: Wong PTP, ed. *The human quest for meaning: Theories, research, and applications*. 2nd ed. New York, NY: Routledge; 2012.

68. Linehan MM, Goodstein JL, Nielsen SL, Chiles JA. Reasons for staying alive when you are thinking of killing yourself: The Reasons for Living Inventory. *Journal of Consulting and Clinical Psychology*. 1983;51:276-286.

69. Braden A. Searching for meaning: An investigation of life meaning in depressed adults. *Electronic Thesis of Dissertation*. 2011.

70. Mascaro N, Rosen DH. Existential meaning's role in the enhancement of hope and prevention of depressive symptoms. *Journal of Personality*. 2005;73(4):985-1014.

71. Suicide Risk Assessment. *Canadian Network for Mood and Anxiety Treatments*. Available at: http://www.canmat.org/cme-depression-suicide-risk-assessment.php. Accessed September 28, 2013.

72. Wong YJ, Uhm SY, Li P. Asian Americans' family cohesion and suicide ideation: Moderating and mediating effects. *American Journal of Orthopsychiatry*. in press.

73. Cho Y, Haslam N. Suicidal ideation and distress among immigrant adolescents: The role of acculturation, life stress, and social support. *Journal of Youth and Adolescence*. 2010;39:370-379.

74. Escoffery C, Miner KR, Adame DD, Butler S, McCormick L, Mendell E. Internet use for health information among college students. *Journal of American College Health*. 2005;53(4):183-188.

75. Goldston DB, Molock SD, Whitbeck LB, Murakami JL, Zayas LH, Hall GCN. Cultural considerations in adolescent suicide prevention and psychosocial treatment. *American Psychologist*. 2008;63(1):14-31.

76. Sue DW, Sue D. *Counseling the culturally different: Theory and practice*. New York, NY: Wiley; 1990.

77. Frankl VE. *Man's search for ultimate meaning*. New York and London: Plenum Press; 1997.

78. Introduction - Viktor E. Frankl & the development of logotherapy & existential analysis. In: Batthyany A, ed. *The feeling of meaninglessness: A challenge to psychotherapy and philosophy*. Milwaukee, WI: Marquette University Press; 2010.

79. Frankl VE. *Viktor Frankl recollections: An authobiography*. New York and London: Plenum Press; 1997.

80. Sun HC. Life education and its practice. *Philosophical Forum*. 2001;35:4-31.

81. Chang SM. On life-education and suicide prevention. *Life education: Research, discussion, and practice（in Chinese)*. Traditional Chinese Edition. Kaohsiung, Taiwan: Fuhwen Pubisher.; 2005.