National Hispanic and Latino

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Latinos and Suicidal Behaviors:

A Clinician´s Guide to Prevention and Treatment

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Suggested citation: National Hispanic and Latino Mental Health Technology Transfer Center. (2022, May). Latinos and Suicidal Behaviors: A clinician´s guide to prevention and treatment. Institute of Research, Education and Services in Addiction, Universidad Central del Caribe, Bayamón, PR.

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This work is possible thanks to grant No. 6H79SM081788 del DHHS, SAMHSA.

The National Hispanic and Latino MHTTC recognize the complexities associated with gender and ethnic identification. With the intention of both facilitating a fluent reading of the text and supporting an inclusive and respectful language, this document uses terms that are linguistically neutral and inclusive of diverse gender groups and identities. In this document, we also use the term Latinx to encompass ethnic identity as well as non-binary gender identification.

ACKNOWLEDGEMENTS

We acknowledge for their contributions to this product:

Luis H. Zayas, PhD
Dean, Professor, and the Robert Lee Sutherland Chair in Mental Health Social Policy in the Steve Hicks School of Social Work; and Professor of Psychiatry at the Dell Medical School of The University of Texas at Austin

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Institute of Research, Education, and Services in Addiction (IRESA)

The Institute of Research, Education, and Services in Addiction (IRESA) of the Universidad Central del Caribe leads the National Hispanic and Latino MHTTC. The Center serves as a national subject matter expert and a key resource for the workforce and communities seeking to address mental illness prevention, treatment, and recovery support to reduce health care disparities among Hispanic and Latino populations across the United States and its territories. In partnership with state and local governments, mental health providers, consumers and family organizations, Hispanic stakeholders, Substance Abuse Mental Health Services Administration (SAMHSA) regional administrators, and the MHTTC Network, the Center seeks to accelerate the adoption and implementation of mental health-related evidence-based practices.

National Hispanic and Latino Mental Health Technology Transfer Center

The mission of the National Hispanic and Latino Mental Health Technology Transfer Center is to provide high-quality training and technical assistance to improve the capacity of the workforce serving Hispanic and Latino communities in behavioral health prevention, treatment, and recovery. We disseminate and support the implementation of evidence-based and promising practices to enhance service delivery, promote the growth of a diverse, culturally competent workforce, and bridge access to quality behavioral health services. We are committed to increasing health equity and access to adequate culturally and linguistically grounded approaches.

The School-Based Mental Health Project (SMH)

The School-Based Mental Health Project (SMH) of the National Hispanic and Latino MHTTC works specifically with schools, organizations, and professionals to strengthen their capacity to provide culturally and linguistically responsive school mental health services. This initiative facilitates training, technical assistance, and capacity-building efforts led by experts in the field. Our goal is to increase awareness to attend to Latino students' mental health needs, promote the implementation of school mental health services that are culturally appropriate, encourage the use of promising and evidence-based practices, and disseminate information on practical strategies and implementation efforts of mental health services within a cultural context.

National Hispanic & Latino MHTTC
Mental Health Technology Transfer Center Network
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Chapter 1

Latinos and Suicidal Behaviors: A Clinician's Guide to Prevention and Treatment

Introduction

Most people but especially mental health clinicians know that suicide is known to every culture, race, ethnicity, socioeconomic class, country and continent, and religion. Suicide can occur at any point in the lifespan from the years of adolescence to the years of senescence. Lamentably, suicide in the modern era is being seen among youth young than adolescents. In countries with diverse population groups, deaths by suicide and suicide attempts need to be understood with the context of the person's culture and subculture, social position, and the cultural characteristics, values, and beliefs that can create risks for suicide or provide protective factors.

This clinicians' guide addresses one of the largest cultural groups in the United States today, persons of Latin American ancestry commonly referred to as Latinos or Hispanics.[1] The guide considers suicide as part of social phenomena but our attention will be to suicides and suicide attempts as deeply psychological, emotional events. The emphasis is on what drives some people to think about suicide, to plan a suicide, and to attempt a suicide. This guide is intended for mental health professionals and other health providers who are dedicated to delivering services to the diverse Hispanic or Latino population. It discusses suicidal behavior, demographics of the Hispanic population, risks for suicide, and prevention, intervention, recovery, and postvention. The guide includes two case studies of suicide attempts by teenage girls and questions for clinicians to consider in the assessment and intervention.

[1] The terms Hispanic and Latinos are used interchangeably in this report, except when there is mention of a specific group such as Mexican, Guatemalan, Colombian, and so on.

A Look at Latinos in the U.S.

The Hispanic population in the United States reached 62.1 million in 2020 from50.5 in 2010, according to the Census Bureau, making it the country's largest ethnic or racial minority and about 18.1 per cent of the total U.S. population. The 23% increase in the Hispanic population was faster than the nation's growth rate (+7%), but a slower increase than in the Asian population (+36%). In 2020, Hispanics made up nearly one-in-five people in the U.S. (19%), up from 16% in 2010 and just 5% in 1970.2 Demographic projects indicate that the Hispanics will grow to 111 million by the year 2060.

Hispanic origin groups in the U.S., 2021

Origin group	Population	% among all U.S. Hispanics	% change 2010-2021
U.S. total	62,530,000	100%	23%
Mexican	37,235,000	59.5	13
Puerto Rican	5,800,000	9.3	24
Salvadoran	2,475,000	4.0	35
Cuban	2,400,000	3.8	28
Dominican	2,395,000	3.8	59
Guatemalan	1,770,000	2.8	53
Colombian	1,400,000	2.2	46
Honduran	1,150,000	1.8	57
Spaniard	995,000	1.6	43
Ecuadorian	815,000	1.3	25
Peruvian	720,000	1.2	20
Venezuelan	660,000	1.1	172
Nicaraguan	455,000	0.7	19
Argentinean	295,000	0.5	26
Panamanian	240,000	0.4	37
Costa Rican	190,000	0.3	44
Chilean	190,000	0.3	35
Bolivian	130,000	0.2	15
Uruguayan	65,000	0.1	9
Paraguayan	30,000	0.0	42
Other South American	40,000	0.1	62
Other Central American	30,000	0.0	1
All other Latinos	3,050,000	4.9	96

Notes: Hispanic origin is based on self-described ancestry, lineage, heritage, nationality group or country of birth. Population rounded to nearest 5,000. Listed in descending order of population size; differences between ranks may not be statistically significant. Rankings and percentages based on unrounded populations.
Source: Pew Research Center calculations based on the 2010 and 2021 American Community Surveys (U.S. Census Bureau).

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Depending on where in the U.S. you practice, you will probably see groups that have had long established communities in your region or are newcomers, creating new communities. Latinos are spread out across the country, arriving and settling mostly in historically receptive metropolitan areas.

According to reports from the Pew Hispanic Center in Washington, DC, Mexicans comprise more than two-in-three Hispanics in the Los Angeles and Houston metro areas, reflecting their majority share among the national Hispanic population. But in metropolitan areas around the country, Latinos of other national origin make up the largest share among Hispanics. Puerto Ricans are the largest group in the Orlando, Florida, metro area but have decades-old presence in cities like Boston, Chicago, New York City, and Philadelphia. Salvadorans are the largest Latino group in the Washington, D.C. area. Cubans have long been and still remain the largest origin group in the Miami metro area. Dominicans immigrants and succeeding generations are seen in largest numbers in New York City, Boston, and some cities in New Jersey. In some places, such as Providence, Rhode Island metropolitan area, Dominicans represent the largest group along with Guatemalans.

The growth of Hispanic populations is also being seen in other areas of the country where farming, manufacturing, ranching, and other markets are drawing persons in search of employment. New communities are sprouting in places that have historically not had a large Latino presence. Places like Iowa and some Mid-Atlantic States, for example, have seen large growth of Hispanic communities formed as workers enter the employment markets that include farming and poultry. New Orleans saw a surge in Hondurans arriving after Hurricane Katrina in 2005, lured there by employment opportunities to rebuild the city.

[2] Krogstad, J.M., Noe-Bustamante, L. (September 9, 2021). Key facts about U.S. Hispanics for National Hispanic Heritage Month. Washington, DC: Pew Hispanic Center

For decades, persons of Mexican origin made up the majority of Latinos at 61.5% but this share has decreased from a peak of 66% in 2008. Two other groups—Peruvian and Ecuadorian—also saw a slowdown in growth. In contrast, Venezuelans, Dominicans and Guatemalans saw the fastest population growth since 2010. The Venezuelan population in the U.S. increased 76% to 421,000 in 2017, by far the fastest growth rate among Hispanic origin groups. This may be accountable to the political and economic instability in Venezuela. Among groups with populations above 1 million, Dominicans and Guatemalans had the fastest growth. Their populations grew by 37% and 30%, respectively, during this time. Puerto Ricans, the second-largest origin group, saw their population in the 50 states and the District of Columbia jump by 20%, to 5.6 million in 2017, while another 3.2 million live in Puerto Rico.[3]

What's more is that about 79% of Hispanics are U.S. citizens, a number that includes people born in the U.S. to immigrant parents, born in Puerto Rico, or who have become naturalized citizens (Puerto Ricans are at birth U.S. citizens). Spaniards (91%), Panamanians (89%) and Mexicans (79%), have some of the highest citizenship rates, while Hondurans (53%) and Venezuelans (51%) have the lowest rates.

Another important fact is that a growing proportion of Hispanic immigrants are longtime U.S. residents. In 2017, about 78% of Latino immigrants have lived in the U.S. for over ten years, an increase of about 14% from 2010. Panamanian (88%) and Mexican (84%) immigrants have the highest shares on this measure. Many Latino immigrants have been in the U.S. for decades – 46% of Latino immigrants have lived in the U.S. for 21 or more years. More recently arrived immigrants tend to be Venezuelan (58%) and Spain (38%) who typically have been in the U.S. for less than 10 years. English proficiency has increased generally among U.S. Hispanics with about 70% of Latinos ages 5 and older speaking English proficiently. This is, of course, highly correlated with years of residence in the U.S.

Suicide Data

The demographics of the U.S. and data on the different ethnic and racial groups provides a picture of how likely we are to encounter deaths by suicide in clinical practice. According to the Suicide Prevention Resource Center (2016), suicide is among the top four leading causes of death between the ages of 10 and 44. When we focus on younger age groups (i.e., ages 10-14, 15-24, and 25-34), suicide rises to become the second leading cause of death in all races and sexes. Suicide deaths are higher in age groups in the 45 to 65+ range. In 2017, the age-adjusted suicide rate (which controls for the effects of differences in population age distributions) among American Indian and Alaskan Native was 22.15 per 100,000. Among non-Hispanic whites, the rate was 17.83 (SPRC, 2017).[4] The next highest suicide rates were among Hispanics with 6.89 suicides per 100,000, African Americans at 6.8 per 100,000, and Asian and Pacific Islanders was 6.75 per 100,000. Thus, Latinos in general die by suicide at rates similar to other minority populations.

Yet for women in the high school years—from 14 to about 18 years of age—the rates of suicide attempts have been higher than non-Hispanic White teen females and African American or Black teen females. For over 30 years, biennial surveys by the Centers for Disease Control and Prevention of youth risk behaviors show that young Hispanic females are more likely to think about, plan, and attempt a suicide (See Figure 1). From 1991 up to 2015, Latinas outpaced other adolescent girls in their rates of suicide attempts. As this graph shows, adolescent Latinas are more likely to attempt suicide than were African American and non-Hispanic White girls.

The Hispanic rate in 1995 spiked to about 21 percent. This was the only year in which the rate was nearly double that of other girls. In all other years, young Latinas have registered attempts one to one and a half times higher than other same-aged girls.[5]

[3] Flores, A., & Krogstad, J.M. (2019, July 26). Puerto Rico's population declined sharply after hurricanes Maria and Irma. Washington, DC: Pew Hispanic Center. https://www.pewresearch.org/fact-tank/2019/07/26/puerto-ricopopulation-2018/
[4] Source: Suicide by Age. (2017). Retrieved May 25, 2019, from https://www.sprc.org/scope/age
[5] Zayas, L. H. (2011). Latinas Attempting Suicide: When Cultures, Families, and Daughters Collide. NY: Oxford.

And there is cause for worry: A suicide attempt is often followed by another suicide attempt. The risk of suicide in the 12 months after an index attempt is about 1.6% and about 3.9% after 5 years (Carroll et al., 2016). The estimated 1-year-rate of non-fatal suicide attempt is 16.3%. For these reasons and many others, clinicians must be very concerns about patients who threaten to or have attempted suicide.[6]

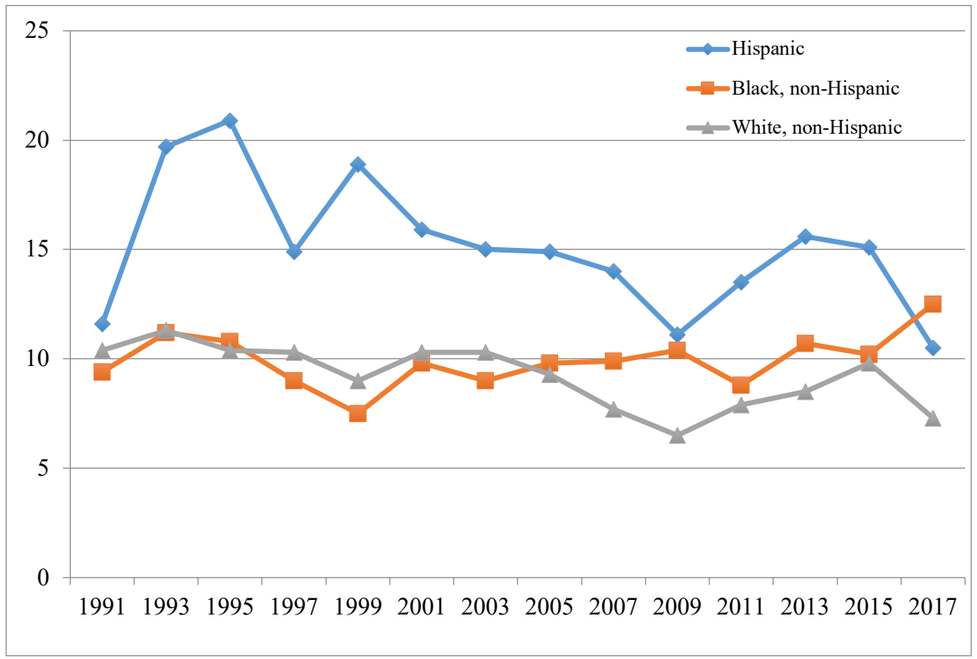

Figure 1. Three decades of adolescent female suicide attempts.

Surviving a Suicide

When a suicide takes place, it leaves devastation in its wake. Spouses, partners, siblings, parents, relatives, friends, neighbors, co-workers, and all manner of acquaintances are left bereft. Many feel guilt. Most wonder why they didn't notice the signs. In some cases, the dead person's history is fraught with past attempts and many difficulties in living, such as substance abuse, mental illness, traumatic experiences, and the loss of people they loved or loss of aspirations and goals they once had but feel that they can no longer attain. In too many cases, the suicide comes out of nowhere, at least as perceived by the survivors. On any day, we might read in the newspaper about someone's suicide and survivors are quoted. "She seemed so happy." "He had everything he ever needed: A great job and career. Success. A loving wife and beautiful children." "She was just with us last week and there was no indication of her unhappiness or despair. She had everything to live for." What seems easy to others or a sign of success to outsiders may seem to the person a burden or the affirmation that they are a fraud of a person. It may feel to the person like he or she has masqueraded through life as happy and successful when all along there existed an internal experience or even a state of sadness, a sense of not living up their full potential. This all points to the fact that we really do not know what is going on in a person's mind, if they keep their suicidal ideation and planning to themselves.

[6] Carroll R, Metcalfe C, Gunnell D (2014) Hospital Presenting Self-Harm and Risk of Fatal and Non-Fatal Repetition: Systematic Review and Meta-Analysis. PLoS ONE 9(2): e89944. https://doi.org/10.1371/journal.pone.0089944

In research, the clinical tracing of why a person died by suicide is sometimes called a “psychological autopsy.” The principle behind the psychological autopsy is to collect information about the person who died by suicide. By reconstructing the psychological and social environment of the person who committed suicide, better explanations can be derived about the circumstance surrounding the person’s death and its causes. Using this method involves interviewing people who knew the person, who were connected by blood, romance, friendship, work, collaboration, or just acquaintanceship. But it is a tender and sensitive undertaking since these are survivors who are grieving. Interviews and conversations can awaken painful emotions, memories, and experiences. The method is most helpful to scientists.

Family members and others do their own search for answers. Why? How did we miss it? What did I do to contribute to his or her anguish? What could I have done differently? In therapy—whether for the person who attempted suicide or the survivors who lost a person to suicide—part of the process is to understand what led up to suicide or the attempt. Exploring a suicide or a suicide attempt requires patience, clinical acumen, and keen judgement about how much and when the patient or family should disclose painful issues.

Who is a loss survivor? Anyone who is bereaved by a suicide in their family or social network can be a survivor. Classmates, co-workers, and even service providers who knew the person well (e.g., hairstylists, housekeepers) can be considered survivors. Approximately 7% of the U.S population report having known someone who died by suicide within the last year (Crosby & Sacks 2002). According to Berman (2011), approximately 4.5 – 7.5 immediate family members and an estimated 15 to 20 extended family members and other social members will generally meet the criteria for being considered intimately and directly affected by a suicide loss. Cerel et al., (2019) organize people exposed to a suicide loss into 4 types.

1. Suicide Exposed – those who have any connected to the deceased or to the death by suicide including witnesses of the death.
2. Suicide Affected – those who are affected by the suicide and whose reactions might range from mild to severe.
3. Suicide Bereaved Short-Term – individual who have an attachment bond with the deceased and gradually accept the loss over time.
4. Suicide Bereaved Long-Term – individual who have an attachment and grieving becomes a protracted struggle.

Communities sometimes struggle with reporting on the suicide of a young person, especially a teenager, for fear of a “contagion effect.” The contagion effect, or perhaps the copycat effect, suggests that when a person dies by suicide others will do the same, leading to the possibility of a cluster of suicides among youth who knew the person or who felt their own pain and were inspired to take their lives. While it is not common, there have been cases of clusters of suicides in some communities. When encountering a suicide, clinicians and mental health programs as well as schools and public health officials need to consider the possibility that one or more suicides can influence others to do the same. It requires quick mobilization.

Chapter 2
The Many Roots of Suicides and Suicide Attempts

Psychological and social forces play a part in suicide. Economic crises have led to CEOs and stockholders to take their lives during periods of extraordinary economic crises as they watch their entire portfolios or companies fall apart. Wars, famine, natural disasters like hurricanes, and other large-scale experiences can add to the tendency toward suicide. If we think of culture as part of a major social force, we can extend our understanding of suicide. In Asian cultures, suicide has been viewed for centuries as an honorable response to committing a shameful act. In Japan, we know of the suicide of corporate executives and politicians who died by their own hands following a shameful disclosure, such as embezzlement or a horrible oversight that brought their companies or organizations to its knees. Even in war, Japanese soldiers felt it more honorable to die, even at one’s hands, than to return home as failed soldiers. But culture, as a macro-level social phenomenon, also provides prohibitions to suicide. Most religions contain tenets against suicide.

In Latinos, acculturation has been associated to suicidal ideation and attempts. Acculturation, the process by which a person adopts values, customs, behaviors and other cultural aspects from the mainstream culture while maintaining aspects from their culture of origin, is a multidimensional construct comprised of several facets, including nativity, language orientation, social network preference, and ethnic identity. These studies show that higher levels of acculturation are associated with increased risk for suicidal ideation and attempts. Several mechanisms are identified as influential to the relationship between level of acculturation and suicide, including traditional Hispanic culture increased exposure to illicit drug use and acculturative stress associated with acculturation (Odafe et al., 2016).

Understanding Suicidal Behavior

Any attention to suicide in a particular ethnic, racial, or social group must start with an understanding of the terminology and the facts surrounding a suicide. Without an appreciation of what we mean, there is the danger of communicating without understanding one another. Following a common understanding makes it easier for clinicians to communicate with one another and for scientists to do the same. For this purpose, let’s review the terminology.

Most of us know what suicide is and we can pretty easily come to an agreement about what we each deem to be a suicide (as distinct from, say, an accident). For our purposes and those of clinicians and practitioners, the term suicide refers to death inflicted by the person on herself or himself. That is, death as caused by self-directed injuries or other deadly harms (e.g., poisoning, overdosing, jumping from great heights or into the path of a locomotive) that carry with them an intent to die (Crosby, Ortega, & Melanson, 2011).

The broadest term that encompasses a range of behaviors and actions is suicidal behavior. This term refers to any action that could cause a person to die. This may be loosely used in common language when we say someone, for example, was “suicidal” by riding a motorcycle at high speeds in heavy traffic or taking a selfie on the edge of a precipice. Other forms of behaviors may not show precise suicidal intent but rather engaging in conduct that reasonable people might consider suicidal. the term “suicide by cop” is present in our lexicon because some individuals have used provocation of a police officer with a gun, knife or other implement.

Suicide-related Terms

The term *suicide gesture* is part of the nomenclature but is seldom used. In the case of the gesture, we are typically referring to an episode of non-fatal self-directed violence, but we also assume that it is of relatively low lethality and the intent might be infused with ambivalence (Crosby, Ortega, & Melanson, 2011). Along the

lines of a suicide gesture is the term *self-harm* or *self-injury*. In this case, we are referring to an incident that was harmful, even injurious to the self but not intended to cause death. Another commonly used term in clinical practice and psychological research is *non-suicidal self-injury* (NSSI). These terms refer to the act of injuring oneself intentionally by any manner of methods, such as cutting or self-laceration even if superficial; self-battering; or taking an overdose. The difference is that there was clearly no intent to die (U.S. Public Health Service, 2001). For example, cutting is the most commonly known of self-harms, especially among adolescent girls. The cutting can symbolize many things and the act of cutting is perceived as a release of emotional distress or even a reaction to a feeling of numbness. By cutting herself, the person can feel pain and even feel themselves as a whole being. These are examples of self-directed injuries and harms but they are not intended to bring about death.

The most important term for the purpose of this guide is that of *suicide attempt*. In an attempt, the person causes self-harm with the intent to end life. The person does not die (although they could suffer serious damage to their bodies). A suicide attempt is, essentially, any intentional non-fatal self-injury, no matter how medically lethal it is, if the person admits that her actions had suicidal intent or if there is evidence, whether implicit or explicit, of suicidal intent (Crosby et al., 2011; O'Carroll et al., 1996). Within the terminology, suicide attempts can be classified into two types. A *Type I* suicide attempt is one in which there was no injury or physical harm done. A *Type II* suicide attempt contains injuries or other self-harm, so long as intent was determined to exist (Silverman et al., 2007).

Establishing Intent

Recall that earlier, the term *suicide* was defined as death brought about by a person to himself or herself. Suicide, regardless of how it was completed (e.g., hanging; shooting; asphyxiation) carried with the act an intent to die (Crosby, Ortega, & Melanson, 2011). We're probably on easy agreement in this definition. But there is in that definition a word that will always cause clinicians and researchers to be concerned. That word is *intent*. It is an important consideration since sometimes deaths occur, but the intent was not there or was questionable.

Accidents are an example of events that caused death but there was no intent to die; it was simply a fatal accident. However, there are accidents and other actions that are not as easily discerned as being inadvertent or by chance. The now well-known event "suicide by cop" has entered our lexicon and refers to a person's threatening or menacing actions against a law enforcement agent who used deadly force as deterrence or protection. Sometimes, the conditions of a fatal accident leave lingering doubt as to whether it was an accident or intent, such as in the absence of skid marks of a car or no traces of drugs or alcohol in the person's system to suggest impairment. Considering that accidents are the leading cause of death among U.S. youth and young adults between the ages of 10 and 34 (NIMH, 2018 https://www.nimh.nih.gov), we might be left to wonder what proportion of deaths by accidents carried with them suicidal intent. Homicide is the third leading cause of death among the 15- to 34-year-old population (NIMH, 2018, https://www.nimh.nih.gov). This cause of death can also raise questions of what part might suicidal behavior have contributed to the homicide.

A suicide note left behind after a suicide or discovered before the suicide may be one of the best indicators of intent. In the note, the victim may clearly state that by their self-directed injurious act they wanted to die. Even without a note, the person's act is so clear, possibly premeditated as to represent a clear intent to die. There have been incidents of adults in mid-life and in late-life with terminal illnesses who have chosen to take their own lives before the illness did; or the persons did not want to see their families suffer under the strain of caregiving or financial ruin. The indications are clear of the intent of the person wish to die. They are among the clearest means of accepting that it was a suicide intended to finish in death.

But as any clinician who works with adolescents knows, intent is an elusive factor. Even the most seasoned clinicians will have some difficulty establishing the intent behind the suicidal behaviors of adolescents. There have been the adolescent girls who share with a best friend at school that they were so angry with her parents the night before that they took an overdose of acetaminophen or ibuprofen. The friend, in shock and concern, confides to a school social worker, counselor, or teacher about her friend's suicide attempt. In the typical case, the school authorities go into action: calling the parents and perhaps having the girl who made the attempt taken to an emergency department for psychiatric evaluation. But at the hospital or clinic, the girl says she was exaggerating with her friend. Yes, she may say, that she was indeed angry but that it was only a few pills she took to relax or get rid of a headache. Clinicians are then left to determine where the truth lies and to what degree was the girl's actions a suicide attempt.

In more extreme cases, the adolescent may be found asleep or unconscious with a vial of pills next to the bed. In some instances, a passerby sees the teenager standing on the edge or a subway or train platform, looking despondent, or on the parapet of a roof, bridge, or balcony. When found and rushed to the emergency room, the clinician may deem it, correctly, as a suicide attempt. But when the teenager learns that she or he will have to be placed in a locked psychiatric service for observation and treatment, the teen may then recant. "No, I didn't mean to kill myself. It was an accident. I had such a bad headache that I just wanted some relief." Or "I wasn't planning on jumping. I was just looking down over the side." Depending on the adolescent, a persuasive argument might be what the clinician hears. In an abundance of caution, most clinicians will not be deterred in their assessment that there was the chance of serious injury or death under the circumstances.

Chapter 3
Risk and Protective Factors

In understanding any group of people, regardless of race or ethnicity or social profile, the clinician needs to have a good understanding of what the risk and protective factors exist for that group.[7] Furthermore, how these protective and risk factors interact with core cultural elements of the group with which the person identifies is important to know in suicide assessments and interventions.

Risk Factors

Over decades of research and clinical experience, professionals have learned that there are many factors that place people at risk for suicide. Whether we are discussing adolescents or adults, there are some general risk factors that cut across age, gender, and other demographics.

Family History of Suicide
One well-known risk is having a *family history of suicide*. There are many ways in which family suicide history impels a suicide. It is possible that family stories and secrets may add to the mystery or mystique of the person who suicided perhaps decades before. It leaves a family legacy that may have begun before the person was born and may still be hushed or even glorified in family lore. Experiencing the death by suicide of a family member during one's own lifetime, in which one knew of or witnessed the person who took their life, can leave survivors considering the finality of the suicide. The loss of the person by suicide may make them even more influential in family dynamics.

Previous Suicide Attempt
Related to a family history of suicide is the risk that comes from having made a *previous suicide attempt*. One attempt may beget another attempt and may also increase not just frequency but lethality. The means of the attempts may expand in scope and become more serious. Related to this risk is access to lethal means for making an attempt. Having a firearm or drugs for an overdose adds to establishing the capability to take one's life.

Loss
A major *loss*, one that feels complete and irretrievable, presents a risk factor for suicide. Among these losses the loss of someone very important in the person's life—a romantic partner, a parent or child—is a significant one. These kind of relational losses can have devastating effects on the person's sense of self-worth and of hope in forging their future without the beloved person. Financial losses can lead to suicidal ideation and perhaps even an attempt.

Two psychological experiences add to risk. One is a history of a *mental disorder*, particularly depression. A major depressive disorder can precede the suicide or suicide attempt. Even a reactive depression due, say, to the loss of loved one or the end of a romantic attachment, can bring the person to consider and make a suicidal act. The other is a feeling of *hopelessness*, when life simply shows nothing to look forward to, that nothing will get better. Social isolation, a feeling of being cut off from other people added to the mental disorder as a risk factor is chronic or terminal physical illness. Unwillingness to seek help because of the stigma and barriers to accessing mental health treatment can add to the propensity to attempt or complete a suicide.

Child Maltreatment and Neglect
A family history of *child maltreatment and neglect* can place an individual at risk for taking their lives as can a history of alcohol and substance abuse. Many individuals who have struggled with addiction and cannot break its chokehold may die through an overdose of drugs. It may appear as an accidental overdose but signs can usually be discerned too late. Likewise, a history of trauma can place the person at risk for suicide.

[7] The Centers for Disease Control and Prevention provide valuable information on their webpage and the reader is encourage to read it. https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

It is well known that the accumulation of adversity across the lifespan raises the risk of chronic illness and mental illness. Suicide can also result from the effects of a long history of trauma.

Emotional and Behavioral Self-regulation
Impulsive or aggressive tendencies that reflect problems in *emotional and behavioral self-regulation* are often associated with suicides and attempts. There may be indication that the individual has carried a diagnosis of a personality disorder (such as borderline or antisocial). In some instances, the risk factor such as poor judgement and impulsive behaviors can be influenced also by another risk factor, local or know suicide epidemic. The person may find more justification to take their life when they know of others who have done the same. In an unfortunate way, it may embolden them to proceed with the suicide when they know someone else has done it. This relates back to having a family history of suicide. This is not an exhaustive list of the risks that people face but it describes some of the most common ones.

Acculturation and Acculturative Stress
As was mentioned previously, *acculturation* and *acculturative stress* may be a risk factor for suicidal behaviors among Latinos. Latino youths tend to acculturate at a faster rate than their parents which may result in acculturation gaps. These differences in behaviors, practices and values may increase the level of conflicts between parents and adolescents, resulting in such difficulties as suicide attempts and psychological maladjustment (Zayas et al., 2005). These dynamics may seem more evident for U.S.-born Latino youths living with immigrant parents. There also may be differences between according to country of origin.

Protective Factors

There are individual and social factors that protect people from risk. Protective factors are characteristics held by the person or found in the person's environment that buffer the chance of a suicide. The Suicide Prevention Resource Center (SPRC) list the major protective factors as effective mental health care, connectedness to others, problem-solving life skills, self-esteem, and cultural factors that exist or can be harnessed to help the person.[8]

Availability of Effective Behavioral and Mental Health Care
The *availability of effective behavioral and mental health care* is vital to protecting against a suicide or a suicide attempt. This begins with a clear assessment of underlying mental health and substance use disorders. Being connected to others—family, friends, communities of others who share common interests and purpose—is an important protective factor (https://www.sprc.org/comprehensive-approach/social-connectedness). Having people to talk to and to feel a sense of belonging can make an important difference in preventing a suicide.

Life Skills
Possessing useful *life skills* including problem solving skills, coping skills, and the ability to adapt to change is a protective factor. Coping abilities and problem-solving skills are highly protective (Life skills). Developing resiliency to adversity and stress are protective as well as the ability to adapt to new challenges, places, and people. Thoughtful and restrained action is far better than reactive, impulsive decisions and actions. When change comes to a person's life too suddenly or with a speed that they cannot process cognitively or emotionally, the risks rise. But as a life skill, taking a measured approach to how and how rapidly to adapt will protect the individual from a suicide.

Self-esteem
Among the internal characteristics is *self-esteem* and a sense of purpose or meaning to life. It is a critical protective factor is a person's self-esteem. Nearly all research on the characteristics of persons who died by suicide or attempted suicide shows that a person's selfesteem is highly correlated. Self-esteem is defined as the level of confidence that person has for her or his abilities and value. Often, self-esteem can be thought of as the difference between what the person aspires to and what they actually achieve. Typically, the aspiration is an ideal which, by definition, is unattainable. But the closer one feels oneself is approaching that ideal, the

[8] For specific approaches to behavioral care services, see https://www.sprc.org/about-suicide/risk-protective-factors

higher the self-esteem. Many therapists have to work with their client's self-esteem by helping the client apply more realistic expectations on themselves. This is also related to one *sense of purpose and meaning in life*. When we think of hopelessness or helplessness, we imagine a sense of not feeling like you can handle life's challenges and that no amount of effort will change the outcomes. But indeed, when we experience a purpose in life or a mission, our outlook is far different.

Cultural Factors

Culture can provide beliefs, values, behaviors, and teachings that can be protective. Among Hispanics in the U.S. and in their countries of origin, the family is at the center of aperson's identity and a sense of protection. A well-known concept, *familism*, represents the value of close family interaction and emotions. Affection, loyalty, unity, and clear lines of emotional attachments are part of what add to the protective factors for Hispanic suicide. Maintaining good relationships and actively monitoring the well-being of other family members is part of the cultural concept of *familismo* (Marsiglia et al., 2009). This part of traditional Latino culture can act as a protective factor against negative factors.

How is familism protective? Well, research shows that family cohesion acts as a protective factor against behavioral problems among adolescents (Marsiglia et al., 2009). Cohesion enhances the level of connection between family members and the entire family. It provides a place of safety and perceived understanding of a person's distress. When familism is considered alongside acculturation (that is, a person's greater level of adoption of mainstream values, beliefs, and behavior), those families with lower levels of acculturation have greater cohesiveness than more acculturated Hispanic families. Interestingly, too, is that, although a family may be more acculturated than other Latino families, the more acculturated families may show more cohesion and familism in comparison to mainstream U.S culture or bicultural families. Results indicated that a stronger emotional bond among family members was seen in families with stronger adherence to traditional roles of parent and child in culture.

There are some aspects of family relations that help reduce the chance of suicide attempts among young Latinas. One protective factor that has been reported in the literature is that of mother-daughter reciprocity (or mutuality).[9] Reciprocity which is part of the family dynamics refers to a sharing of common trust and affection between individuals. Our research has shown that as a mother and daughter's relationship shows greater mutuality (as measured by an objective scale completed by both mothers and daughters) the probability of a suicide attempt drops by about 57 percent. Fathers, too, play important roles in their daughters lives and need to be brought closer into interaction with their daughters in which reciprocity and mutuality can be built. Thus, school social workers and other mental health providers in community settings should emphasize on enhancing the parent-daughter relationship. Maternal and paternal mentoring is vital to reducing the chances of a suicide attempt. Studies have found that perceived caring from teachers was associated with a decreased risk of suicide attempts among Latina adolescents.

A Texas-based organization "Con Mi MADRE"[10] (mothers and daughters raising expectations) has developed a successful program that builds mother-daughter relationships. Con Mi MADRE is a two-generation organization that empowers young Latinas and their mothers through education and support services that increase preparedness, participation, and success in post-secondary education. The program intentionally engages mothers in their daughter's educational journey from 6th grade through college graduation. This program, while not specifically targeting the reduction of suicide attempts, fosters precisely the relationship that reduces harmful behaviors among young Latinas.

Religious beliefs that discourage suicide or one's personal beliefs about the value of living are protective factors. Whether the protective factor comes from religious scriptures and other teachings, or from a personal belief in the importance of living, they are essential parts of buffering against suicide.

In Latino cultures, religious participation plays a significant role in Hispanic culture and is hypothesized to decrease rates of suicide among Hispanics, serving as a protective factor. In a study published in 2016, it was estimated that 70% of Hispanic individuals are likely to be born and raised as Catholic, which may account for diminished rates of suicide among Hispanics who actively practice the Catholic faith. Even though this number is decreasing as more Latinos are self-identifying as Christians, Christianity may serve as a protective factor. Specifically, it is proposed that religious practices discourage suicide, which traditionally has been associated with shame and stigma within the religious context. Given that Catholic identity serves as a protective factor against suicide, investigating religiosity and its interplay with suicide may be an important area to explore while working with Latinos at risk for suicidal behaviors (Odafe et al., 2016).

Another key process—acculturation—should also be considered in assessing and treating Latinos of all genders and backgrounds. Acculturation refers to the adoption of and adaptation to the mainstream culture.[11] Typically, Hispanic children and adolescents acculturate to the culture they are growing up in while their parents may retain elements from their cultures of origin and may be reluctant to adopt aspects of the new culture. Acculturation stress is not just the individual's struggle with adapting to the new culture but also to the strains and differences that occur between parents and offspring and between siblings of different age groups.

[9] Zayas, 2011. Latinas Attempting Suicide.
[10] www.conmimadre.org

[11] National Hispanic and Latino ATTC, 2013

Chapter 4
Assessment, Prevention and Intervention

The Suicide Prevention Resource Center (SPRC) (https://www.sprc.org) provides useful information on how to provide the best care for individuals who are suicidal. Effective care and treatment, according to SPRC, begins, first, with accessible services. Behavioral health organizations need to create "pathways for patients with suicide risk to ensure they receive follow-up and referral services in a timely manner—particularly during high-risk periods." Establishing this kind of accessibility request multiple levels of services so that those at risk for suicide can readily get the best available care "in the least restrictive setting." Treating the person who is suicidal should include the use of evidence-based approaches for assessing and treating them for other mental health and substance use disorder.

In providing assistance, clinician's should incorporate an understanding that suicide varies by culture and that Latinos may have different responses to suicide than other groups and the even among Hispanic subgroups suicide reactions may differ. Clinicians must also possess an understanding and be sensitive to the beliefs and customs regarding the family and community. Indeed, this requires recognition and sensitivity to how a family or community response to a death before intervening to provide support. Of course, bringing in necessary support and resource materials to bridge language barriers will ensure that non-English speakers are included.

Engagement and Assessment

Engagement into treatment is influenced by many factors. Among these factors is the person's previous experience with service providers. Past experiences in which the person had or perceived a negative interaction may reduce subsequent help seeking. This is often the case with Latinos who seek mental health services, not just for a suicide attempt but for other conditions. An experience in counseling can color the person's future engagement or may enter a new therapeutic relation with greater caution. For example, a 36-year-old Salvadoran woman came to see a Hispanic male therapist after having previously seen another non-Hispanic therapist. The presenting problem was longstanding depression which, while not debilitating to the woman's general functioning, appeared to stem from the loss of her mother years ago. It was a loss she had not sufficient mourned. When asked by the new therapist why she was seeking services again after the visit to the previous therapist, the woman said that it was the therapist's tone of alarm and dire expressions that frightened her away. She went on to quote the therapist as saying, "You have a very serious problem." The patient told the new therapist that she felt that the previous therapist had made the statement before the patient felt the therapist knew her well enough to "diagnose" the problem. This caused the patient to feel that there was little hope for her and no amount of restatements by the therapist, the patient could not shake the sense that her problems were irresolvable. It was an indication of how a patient can react to the words and actions a therapist may use, even in the most well-intentioned situations. Understanding the woman's reaction to the words of the previous therapist, the new therapist conveyed hopefulness to the woman, particularly since in the assessment there were no indications of suicidal or homicidal thinking or vegetative signs of a major depression.

Assessing intent, as noted earlier, is based on what the person describes or reports as past or present evidence (implicit or explicit) that he/she wishes to die, means to kill him/herself, and knows the potential consequences of the action. The examiner can determine suicidal intent by spending time asking retrospectively about past attempts, ideation, and plans, as well as inferring it in the absence of suicidal behavior.

Establishing Intent

Experienced clinicians know that asking about suicidal ideation and intent does not raise the likelihood that it will start a person on thinking about suicide for the first time or engaging in such behaviors. Many if not most individuals feel a sense of relief that the topic was raised as it conveys a non-judgmental interest in the person and recognition that the person is in emotional pain. What may have been kept inside and not told to anyone is now being named and given freedom to be expressed and discussed.

Suicidal ideation needs to be elicited from the patient and the context of the thoughts explored. The clinician can learn more about how the suicidal ideation influences the person's daily life, such as how much of a burden it is in going through their everyday routine. The clinician should not dismiss any indication of a suicidal planning process no matter whether the plan is possibly lethal or not. From gathering information on what makes the person feel better and what makes things worse improves not only the assessment of intent but also informs the treatment plan.

When the patient discloses or the clinician uncovers a suicide plan, then it indicates that the person has a plan to die and has begun preparing to die. Hence, identification of intent is made. The clinician must ask, "What is the potential and possibility that the individual will act on the plan?" What is the likelihood that the person will be found and rescued if the plan is implemented?" A final question is, "What is the relative lethality of the plan? Can it surely lead to death?"

Suicidal ideation and planning can supersede the person's rational thinking. When ideation and planning are evinced, it is prudent for the clinician to pursue a line of question about the thoughts and feelings, even if the clinician doesn't think that the person will act on it.

The Substance Abuse and Mental Health Services Administration (SAMHSA) endorses an application for computers and mobile phones titled, Suicide Safe, which provides up-to-date guidance for suicide assessments. The publication and the app is based on its Suicide Assessment Five-Step Evaluation and Triage model (a PDF copy is available at https://store.samhsa.gov/system/files/sma09-4432.pdf). The five safety steps are:

1. Identify risk factors
2. Identify protective factors
3. Conduct a suicide inquiry (asking about thoughts, plans, behavior, and intent)
4. Determine risk level and intervention
5. Document the assessment of risk, rationale, intervention, and follow-up

In addition to the typical suicide risk questions that clinicians pose to clients, there are several other considerations when working with Latinos. It has long been known that informal sources such as family and friends are used among Latina adolescents before they turn to formal health care providers. Family engagement is important especially in Latinos in preventing and treating suicide. Since immigration plays a major factor in the mental health of the individual, it is important to understand what the immigration experiences was like and the trauma that the person encounter. Immigration status will affect whether the person has access to appropriate treatment, especially for those without legal status who may fear of being reported to authorities for being undocumented. Language barriers also play a role in restricting many Latino families from seeking treatment. Due to the limitation of suicide and prevention models developed specifically for Latinos, adaptation from other therapies for disorders can be used as a reference/guide. For example, cognitive-behavioral and interpersonal therapies for depressed Puerto Rican adolescents that focused on familism by including parents to better understand the child's needs.

Intervention with Latinos

Family-Centered Models for Intervention

In Latinas Attempting Suicide (Zayas, 2011), which presents an accumulation of basic and intervention research findings on suicide attempts of teenage Latinas and others, I land explicitly on a preference for

family-centered therapies than on individual therapies for the adolescent. To be sure, there is a role for individual therapies, but these must include the family. In the book, I note that:

> *For a problem like the suicidal behaviors of Latinas that we can now confidently say is most often rooted in longstanding family problems, the therapeutic approaches that make most sense are family-centered ones. Since the suicide attempt is located in the family system, it is the members of the family system that create and perpetuate the conditions in which suicidality unfolds. The family system may willingly or unwittingly aid and abet the suicide attempt. The family must then be part of the therapy if the girl is to be saved.*

Family-oriented therapy maximizes the effects of intervention for adult and adolescent Latinos, since family therapy builds bridges between family members who were estranged or parents and adolescents who were in conflict. The family therapist's role is to help clarify expectations, justify conflicts, translate family members' cultural behavior, and encourage compromise and negotiation, particularly when generational and acculturational differences exist.

Brief Strategic Family Therapy

Brief strategic family therapy (Santisteban et al., 2003, 2006; Szapocznik et al., 2001) considers that maladaptive family interactions, alliances, and boundaries create the family's problems. The idea then is to change family functioning by, first, finding a way to "join" the family and supporting its structure, thus permitting the therapist into the malfunctioning system. Once "inside" the family, the therapist can diagnose or assess the patterns in the family that get repeated. This is done through a series of efforts to track interactional patterns and reflect back to the family its style of interacting, its affective climate, and its mood. Most often the problems are those of how power is distributed, the developmental appropriateness of boundaries, and conflict resolution. The technique of "restructuring" involves strategies that change the family, and that promote more adaptive interactions. Many of these techniques are known to clinicians but careful attention to their use in families with suicidal Latinas can have powerful therapeutic impact on the families.

MultiDimensional Family Therapy

Another well-tested intervention is MultiDimensional Family Therapy (MDFT; Liddle, Rowe, Dakof, Ungaro, & Henderson, 2004, a developmental-ecological treatment developed and used primarily for adolescent drug abuse. MDFT tries to reduce symptoms and enhance developmental functioning by facilitating change. There are several modules that the therapist follows. The adolescent module helps build a therapeutic alliance and improve her problemsolving skills and social competence. In this module, alternative behaviors that the adolescent can use are covered. The parent module also builds the alliance with parents and increases their involvement with their adolescent child while also improving parenting skills. The interactional module brings parents and adolescents together to enhance their emotional bonding and attachment and change their patterns of communication. The extrafamilial module includes collaborative relationships with other social systems that the adolescent encounters (e.g., friends, school, peer, recreational groups). Using family techniques based on MDFT decrease internalizing problems of adolescents and increases families' cohesion. These techniques also reduce externalizing and family conflict and improve family outcomes when the adolescent techniques were maximally used.

Culturally Informed and Flexible Family Based Treatment for Adolescents

A more recently developed treatment, Culturally Informed and Flexible Family Based Treatment for Adolescents (CIFFTA) (Santisteban & Mena, 2009) builds such information into its treatment manual and is designed to provide the therapist such guidance and training. CIFFTA is in its early phases of testing for efficacy and the initial study shows it to be highly promising as an intervention for substance use in Hispanic and Latino adolescents and their families (Santisteban, Mena, & McCabe, 2011). CIFFTA includes psycho-educational modules such as parenting, immigration related stressors, and acculturation, and focuses on how these factors impact each other. For example, earlier the developers noted how common psychiatric symptoms are in the context of adolescent substance use. Co-occurring depression, anxiety, and disruptive behaviors are more the rule than the exception. Some might think that these are fairly clear cut diagnostic issues that are not highly impacted by cultural issues. However, the recognition that such a problem requires treatment and the service seeking behavior that follows are not identical across families and they often vary by ethnic and racial lines. Studies have shown how problem identification and help-seeking may vary between ethnic and racial groups and how these behaviors must be understood in their cultural context (Cauce et. al, 2002). Factors such as lack of trust in larger institutions and perceived discrimination can play an important role in the problem labeling and help-seeking processes. Part of what makes CIFFTA culturally informed is it provides a framework that attempts to account for how families process information about child behaviors, how they explain the origins of such behavior, and how they decide the role that behavioral or pharmacological treatments may play in ameliorating the behavior. The inclusion of psycho-educational modules on psychiatric symptoms and their manifestations during the adolescent-stage is a first step in opening a dialogue with the family regarding their perceptions of these symptoms, how they should be labeled, and how they should be treated within the values framework of the family. When treatment manuals do not include guidance on how culture-related issues interact with core family processes, psychiatric symptoms, and the role of treatment, the therapist is left on her own to decide what cultural competence might look like in these situations.

Familias Unidas

Familias Unidas (Pantin et. al, 2003) is a group level, culturally specific family based preventative intervention that includes eight group sessions of 10 to 12 parents and four family visits. Originally intended to reduce HIV risk behaviors, Familias Unidas can be useful in suicide prevention as it focuses on positive parenting, family communication, parental monitoring, and adolescent behaviors. Sessions are parent centered with adolescent's participation limited to activities during the family visits. The intervention engages Hispanic immigrant parents in empowerment process to build a strong support network and then use the network to increase knowledge of culturally relevant parenting, strengthen parenting skills, and apply these new skills in a series of activities designed to reduce risks frequently found in poor, urban environment. Suicide risk interventions with parent involvement like Familias Unidas may be more effective for Latino youth and adolescents.

Using Stories and Rituals in Family Therapy

Storytelling and rituals in family therapy are extremely useful with Latino families that have seen large generational and acculturational issued among them. There is reason to think of families of Latinas who have attempted suicide as having lost their way and having lost their protective structural properties. Families sometimes lose their centres of gravity in making the transition from one culture to the next. Structural aspects of the family such as boundaries might be too loose or too taut. Voices may be silenced by the roles people are fitted into, in ways that the family members cannot enjoy each other, in which some members can speak and be heard, and others cannot. **Cultural tensions must be addressed directly** with family members. The tensions help increase the family's emotional awareness of their immigrant or minority experience. This approach helps both adolescent and parents appreciate the others' perspective, raising the level of empathy and understanding. **Immigrant parents often wish to learn the ways that they can be more effective parents** in a world in which their children are learning new ways and that require parents' help. Communication has been lost, and there is no glue to keep the family together or any positive experiences to motivate them to stay together. **Structured interventions for families** help improve communication, raise cohesion, reduce negative conflict, and repair the structures of families. For adolescent Latinas who are in the cultural transition, family histories that began in another country and culture may have been lost or untold, not storied or converted into rituals.

Communication in families can come through stories and rituals, for they too tell stories about the family. **Restructuring families so that they share stories and rituals** can go a long way in improving communication and bonding. As the therapist hears from the Latino family, the impaired communication and their broken emotional bonds are evident and give the therapist and family a way to **use storytelling** as a means of repairing relationships affected by cultural distance, acculturation and generational gaps, and the stresses of

adaptation. Being together is to have shared moments, all sorts of experiences that create shared memories that may be full of emotional meanings. And these experiences get shared orally, reauthored and reexperienced, and made new with meanings that are part of the family unit (see Imber-Black, Roberts and Whiting 1988).

Rituals are activities that are repeated time and again usually the same way or with many of the same steps. The activities become traditions. These rituals provide predictability and stability, like the schedules and activities by which we place our children to bed every night. Naturally occurring family rituals, according to Barbara Fiese and her collaborators (2002), are symbolic communication that create and are reinforced by the emotional commitment family members have to each other and to their collective. Rituals give family members who participate in them a sense of things being "right," familiar, comfortable, warm. Rituals provide a feeling of belonging. Rituals are not to be mistaken for routines; routines are momentary, utilitarian, require little commitment, and do not hold much affective connection after they are done. They are done and forgotten. Putting the garbage cans at the curb on Tuesday mornings is a routine, not a ritual. However, the making of pancakes every Sunday morning and having breakfast together before going to church services constitute rituals if they are important to family members and are imbued with affection, closeness, attachment, and enjoyment. Important to the rituals in our lives is that after they have been done, we may replay the last time the ritual was performed so as to hold onto the emotional experience and the fulfillment that the ritual and the memory of it gives us. There are three functions of family rituals. Rituals communicate symbolically "this is who we are" as a family; demonstrate commitment to one another; and provide continuity extending across generations (Fiese et al., 2002). By engaging in family rituals, members of the group are communicating an important message that says, "We look forward to this ritual, to being together and doing this ritual together." That affective experience is then learned and emotionally incorporated by younger generations. Research shows that when families follow rituals and storytelling moments, teenagers report higher satisfaction, feel more content, less anxious, and less self-conscious (Eaker & Walters, 2002). Both rituals and stories provide a sense of continuity of "who I am and what I am a part of." Sometimes finding one's way back in the family system through the remembrances of family stories and rituals can be preventive of problems as well as solutions to disruptions.

Chapter 5
When a Suicide Affects the School

Teachers play an important role in helping prevent suicides through the daily contact they have with students. This daily interaction allows teachers to get to know the moods, actions, and words that students present that can lead the teacher to be concerned that the student may be at risk for suicide. In this regard, teachers play an active role in preventing suicide by promoting connectedness and belonging within the school community. School connectedness is the belief by students that adults and peers in the school care about them as individuals as well as about their learning. Connectedness has been shown to improve academic performance, promote healthy behaviors, and reduce suicide ideation and attempts (Whitlock et al., 2014; Marraccini, et al., 2017 as cited in SPRC, 2019).

A study of teachers' roles in the implementation of a district-wide suicide prevention program through focus groups and interviews with middle school teachers, administrators, and other school personnel.[12] Teachers play a critical role in detecting students at risk for suicide. The factors that appear to facilitate teacher participation in a suicide prevention program includes well-defined crisis policies and procedures, communication of these procedures, collaboration across staff, and the presence of on-campus mental health resources. Emphasis must be given to direct teacher training on risk factors for suicide, crisis response, and classroom management. Other strategies for improving suicide prevention efforts included in-school trainings on mental health resources and procedures, regular updates to these trainings, and greater visibility of mental health staff.

But suicide among students happen. A very useful guideline for how schools can respond to a suicide among its students—After a Suicide: A Toolkit for Schools, Second Edition (2018)—is available from the Suicide Prevention Resource Center (https://www.sprc.org/sites/default/files/resource-program/AfteraSuicideToolkitforSchools.pdf).

The toolkit provides guidelines for:

A. Crisis response or the immediate actions necessary after school receives news of an unexpected death of a student by suicide.

B. Helping students cope reduces the emotional trauma among students especially those at suicide risk.

C. Bringing in outside help allows for the school to include professionals who have not been directly involved with the school community.

D. Considering any possibilities of suicide contagion, mentioned earlier, is essential. This means ensuring the wellbeing of vulnerable students who may be at risk of suicide in order to avoid additional suicidal behaviors and deaths.

E. Working with the community involves communicating with organizations in sharing information (i.e. local government, police, health care providers).

F. Working with the media to ensure that the media communicate the appropriate information accurately.

G. Memorialization of the student who died in a dignified manner helps without creating additional trauma among students.

[12] The Role of Teachers in School – Based Suicide Prevention: A Qualitative Study of School Staff Perspectives: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4813810/

H. Knowing and responding to social media is a contemporary issue that must be considered following the suicide of a student. The school's role is to share information accurately with into the community without spreading false information or raising risk of further trauma.

I. Finally, going forward involves implementing a suicide prevention plan for the school and returning to a new normal at the school.

Chapter 6
Postvention Following a Suicide or Suicide Attempt

Given the value that family holds in Hispanic cultures, **the family should play a part in any intervention** that is directed at the individual. In fact, in some instances it may be **family therapy** that is the treatment of choice. Family oriented treatment should encompass as many members of the family as can reasonably be included, whether the suicide attempter is an adolescent or adult. Past research points to the value of family and the expectation that the family will be involved in the treatment during the recovery period.

Postvention is a **comprehensive response** following a suicide in order to (1) facilitate the healing and distress of individuals affected; (2) reduce negative effects that could occur when exposed to suicide; and (3) prevent suicide among individuals who may be at high risk after suicide exposure.[13]

The immediate postvention for family and friends starts with providing **support for normal grief process** to occur and minimize the possibility of complicated grief and guilt reactions. Clinicians and case managers can help **reduce the risk of suicide behaviors** such as by removing firearms from home and lethal medication as well as monitoring family members. As soon as is possible, family and friends need to **be connected with mental health resources** within the community. For those already receiving mental health care, it is essential that they disclose the suicide to their providers.

In a community based postvention program, the organizers must bring together a stakeholder community team is necessary in **developing an effecting postvention plan**. This may include faith-based members of the community, law enforcement, funeral homes, primary care providers, parent associations, social service agencies, school districts, local hospitals. Community organizers should focus on reducing imitative suicide behavior while promoting healthy recovery for the affected community. To do this, the CDC[14] recommends that the community review guidelines and develop responses before an imitative suicide or suicide cluster occurs. There has to be a coordinating committee to deal with day to day response to crisis and community resources must be identified and readied for quick action. One agency or group should be responsible for monitoring the incidence of suicide to collect data that can be studied and used to prevent future suicides or suicide attempts.

[13] U.S National Guidelines developed by the Survivors of Suicide Loss Task Force, 2019
[14] http://www.texassuicideprevention.org/wp-content/uploads/2013/06/TexasSuicidePrevention-2012Toolkit_8-31.pdf

Chapter 7
Case Studies

In this section, we present two cases for discussion of the principles and ideas discussed in this report. Added to each case are topics for discussion.

Case Example: Andrea

Andrea is a 13-year-old adolescent. Her parents came to the US from El Salvador 18 years ago looking for better economic opportunities. She is the older of two children, with an 8- year-old sister. When Andrea was 8 years old, she experienced sexual abuse by her father´s cousin who had come to the US, and briefly lived at the house while looking for employment. Andrea disclosed the abuse a few months later to her mother, who responded in disbelief and despair, asking what she may have done. Andrea felt ashamed, confused and guilty. She felt she has disappointed her mother. She then retracted her disclosure saying she probably dreamt it. Andrea did not receive any psychological or psychiatric service at this point and her father had not been told of this as he was “too busy” with work responsibilities.

After Andrea´s sister turned 8, she started experiencing nightmares, intrusive memories and intense fear and sadness. She had been taking care of many of her sister´s needs as both her parents worked long hours. Her academic performance worsened, and she began to isolate herself from her friends. She showed little interest in activities she previously enjoyed and showed signs of anxiety including tremors. Her parents explained these changes as part of her development and called it a “phase”. She had difficulties communicating with her parents, as they were working more than one job and adhered to practices of their country of origin that were different from what Andrea wanted for herself. She saw herself going to college and living on her own, while her parents´ expectations were that she contribute to the family´s well-being. Her peers seemed to be more independent than she felt she was. When psychological follow up was suggested by a schoolteacher, her mom said it wasn´t necessary, and that when she was growing up “you did what you had to do”, and that her daughter was not “loca”. She added that she had also had difficult experiences and was able to continue with her life by “poniendo de mi parte” (putting in my part) Andrea again felt that she was a disappointment to her mother, and that psychological services would result in a financial burden to her family who was already struggling. Andrea began a pattern of self-harm by cutting herself in order to alleviate her emotional pain. She told a classmate she saw no reason to live and was looking for “a way out”. She feared her family´s reaction and did not want to hurt her parents or sister. She also feared punishment from God for hurting herself. This time, she was referred to emergency services by school personnel.

Case Discussion Areas:

1. Reason for referral:
    - Andrea was referred for assessment of criteria of harmfulness.
2. Cultural factors that may be present:
    - Familism
    - Spirituality
    - Gender roles
    - Acculturation gaps
    - Stigma regarding mental health services
3. Stressors:
    - Financial
    - Sexual abuse history
    - Difficulties in parent-adolescent communication
    - Academic difficulties
4. Evaluation:
    - How was familism expressed in this family?
    - What do you identify as the risk factors for the attempt and the possibility of a re-attempt?
    - What are the protective factors that can prevent re-attempt?
    - What interventions would you use with her and her family?

Case Example: Lorena

Lorena was 14-years-old at the time of her suicide attempt. She was being raised by her maternal aunt and the aunt’s husband. Lorena was a second generation Puerto Rican adolescent whose mother was completing a prison term of more than ten years for a drug-related offense. Her aunt was a first-generation Puerto Rican and the husband a first-generation Dominican man. Lorena’s father had abandoned the family before her birth and Lorena had no contact with him whatsoever. There were no other siblings and the aunt’s children were older and out of the home. Both aunt and uncle (aunt’s husband - tío político) worked outside the home and Lorena had a room of her own in the small apartment they occupied. Lorena thought of her aunt and uncle as parents for they had stepped in when her mother was convicted.

Lorena was referred by the emergency department for outpatient therapy following the suicide attempt which consisted of taking an overdose of acetaminophen with codeine. In Lorena’s first visit to the outpatient therapist, Lorena’s aunt and uncle participated at the therapist’s request. After some initial conversation and pleasantries, the topic turned to what had occurred the day of the attempt.

Lorena stated that her aunt and uncle were engaged in a very heated argument about household finances. Voices were raised and tempers flaring between the aunt and husband. Lorena became upset to see her aunt and uncle “fighting” and stepped in between them and screamed, “Stop fighting, you two!”

“It’s your fault we’re arguing,” replied her aunt in a moment of anger. “We wouldn’t have some of the expenses if it wasn’t for you.”

Lorena ran to her room and stayed there the rest of the day and night. Lorena said that she felt guilty that her aunt and uncle were fighting because of her. Guilt set in and Lorena ruminated through much of the night about how she was causing her aunt’s marriage to start crumbling.

Thinking that they would be better off without her, Lorena swallowed the codeineenhanced acetaminophen. It was only in the morning that the aunt found Lorena in a nearly unconscious and very groggy state.

In the initial family session, Lorena’s aunt described the argument. She agreed that she had spoken in a moment of anger without thought of what she said or what impact it would have on Lorena.

Case Discussion Areas:

1. Reason for referral:
    - Lorena was referred by the emergency department for outpatient services after a suicide attempt.

2. Cultural factors that may be present:
    - Familism
    - Immigrations - family fragmentation and reconstruction
    - Possible acculturation gaps
2. Stressors:
    - Abandonment by father
    - Family financial difficulties
    - Mother in prison
    - Explore communication dynamics
4. Evaluation:
    - How was familism expressed in this family?
    - What do you identify as the risk factors for the attempt and the possibility of a re-attempt?
    - What are the protective factors that can prevent re-attempt?
    - What interventions would you use with her and her family?

Chapter 8

Recommendations for Clinicians Working with Latino Populations

I. Learn about Latino populations
    a. Rates of suicidal behaviors including suicide attempts
    b. Differences in acculturation rates
    c. Possible differences according to country of origin, place of birth and generation

II. Explore risk factors including cultural variables
    a. Family history of suicide
    b. Previous suicide attempts
    c. Major loss
    d. Feelings of hopelessness
    e. History of child maltreatment or neglect
    f. Emotional and behavioral self-regulation difficulties
    g. Acculturation and acculturative stress

III. Explore protective factors including cultural variables
    a. Availability of effective behavioral and mental health care
    b. Useful life skills including coping and problem-solving skills
    c. Self-esteem
    d. Sense of purpose and meaning in life
    e. Spirituality and religion
    f. Familism
    g. Mother-daughter reciprocity

IV. Include a cultural framework as a way of understanding meanings and self for Latino clients

V. Consider family-centered interventions to maximize effectiveness

VI. Include family and community resources congruent with cultural values

References

American Foundation for Suicide Prevention. (2018, January 18). Can a community program reduce suicidal ideation and behavior in Latina adolescents? Retrieved from https://afsp.org/can-communityprogram-reduce-suicidal-ideation-behavior-latina-adolescents/

American Psychiatric Association. (2017). Mental health disparities: Hispanics and Latinos. https://www.psychiatry.org/File Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Hispanic-Latino.pdf

Baumann, A. A., Kuhlberg, J. A., & Zayas, L. H. (2010). Familism, mother-daughter mutuality, and suicide attempts of adolescent Latinas. Journal of Family Psychology, 24(5), 616-624. https://doi.org/10.1037/a0020584

Berman A. L. (2011). Estimating the population of survivors of suicide: seeking an evidence base. Suicide & life-threatening behavior, 41(1), 110–116. https://doi.org/10.1111/j.1943-278X.2010.00009.x

Bridge, J. A., Asti, L., Horowitz, L. M., Greenhouse, J. B., Fontanella, C. A., Sheftall, A. H., Campo, J. V. (2015). Suicide trends among elementary school–aged children in the United States from 1993 to 2012. JAMA Pediatrics, 169(7), 673. https://doi.org/10.1001/jamapediatrics.2015.0465

Carroll, R., Metcalfe, C., & Gunnell, D. (2014). Hospital presenting self-harm and risk of fatal and non-fatal repetition: Systematic review and meta-analysis. PLoS ONE 9(2), e89944. https://doi.org/10.1371/journal.pone.0089944

Cauce, A.M., Domenech-Rodriguez, M., Paradise, M., Cochran, B.N., Shea, J.M., Serbnik, D., & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: A focus on ethnic minority youth. Journal of Consulting and Clinical Psychology, 70(1), 44-55.

Centers for Disease Control and Prevention. (2021). Preventing suicide. https://www.cdc.gov/suicide/pdf/preventing-suicide-factsheet-2021-508.pdf

Centers for Disease Control and Prevention (2021, May 7). Leading Causes of Death in the United States (2018). https://www.nimh.nih.gov/health/statistics/suicide

Centers for Disease Control and Prevention. (2018, April 18). QuickStats: Age-adjusted suicide rates, by race/ethnicity - National Vital Statistics System, United States, 2015-2016. https://www.cdc.gov/mmwr/volumes/67/wr/mm6714a6.htm

Centers for Disease Control and Prevention. (2008). Youth risk behavior surveillance - United States, 2007. https://www.cdc.gov/mmwr/preview/mmwrhtml/ss5704a1.htm

Center for Mental Health Services (US), & Office of the Surgeon General (US). (2001). National Strategy for Suicide Prevention: Goals and Objectives for Action. US Public Health Service.

Cerel, J., Brown, M.M., Maple, M., Singleton, M., van de Venne, J., Moore, M. and Flaherty, C. (2019), How Many People Are Exposed to Suicide? Not Six. Suicide Life Threat Behaviors 49: 529-534. https://doi.org/10.1111/sltb.12450

Crosby, A.E., Ortega, L., & Melanson, C., (2011). Self-directed violence surveillance: uniform definitions and recommended data elements, version 1.0. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Crosby, A. E., & Sacks, J. J. (2002). Exposure to suicide: incidence and association with suicidal ideation and behavior: United States, 1994. Suicide & life-threatening behavior, 32(3), 321–328. https://doi.org/10.1521/suli.32.3.321.22170

Curtin, S.C., Warner, M., & Hedegaard, H. (2016, April). Suicide rates for females and males by race and ethnicity:United States, 1999 and 2014. NCHS Health E-Stat. National Center for Health Statistics.

Data Access and Dissemination Systems (DADS). (2010, October 5). American Fact Finder Results. Retrieved June 15, 2019, from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=kmk

Eaker, D. G., & Walters, L. H. (2002). Adolescent satisfaction in family rituals and psychosocial development: A developmental systems theory perspective. Journal of Family Psychology, 16(4), 406–414. https://doi.org/10.1037/0893-3200.16.4.406

Fiese B. H., Tomcho T. J., Douglas M., Josephs K., Poltrock S., Baker T. (2002). A review of 50 years of research on naturally occurring family routines and rituals: Cause for celebration? Journal of Family Psychology, 16, 381–390. doi:10.1037//0893-3200.16.4.381

Flores, A., & Flores, A. (2018, June 13). Facts on Latinos in America. Retrieved June 4, 2019, from https://www.pewhispanic.org/2017/09/18/facts-on-u-s-latinos/

Garcia, C., Klingbeil, D., Reigstad, K., Houri, A., Lee, C.-Y., Sung, Y., … Klimes-Dougan, B. (2012). Perceptions of suicide risk and coping in Latino and White adolescents and young adults: A pilot study informing suicide prevention efforts. Suicidology Online. https://pdfs.semanticscholar.org/0b4f/82df021fe956624b8640aa5406f62eb33e82.pdf

Goldston, D. B., Molock, S. D., Whitbeck, L. B., Murakami, J. L., Zayas, L. H., & Hall, G. C. (2008). Cultural considerations in adolescent suicide prevention and psychosocial treatment. The American Psychologist, 63(1), 14–31. https://doi.org/10.1037/0003066X.63.1.14

Hausmann-Stabile, C., Gulbas, L., & Zayas, L. H. (2018). Treatment narratives of suicidal Latina teens. Archives of Suicide Research: Official Journal of the International Academy for Suicide Research, 22(1), 165–172. doi:10.1080/13811118.2017.1304305

Imber-Black, E., Roberts, J., & Whiting, R. A. (Eds.). (1988). Rituals in families and family therapy. W W Norton & Co.

Krogstad, J.M., Noe-Bustamante, L. (September 9, 2021). Key facts about U.S. Hispanics for National Hispanic Heritage Month. Washington, DC: Pew Hispanic Center

Kulis, S., Marsiglia, F. F., & Nieri, T. (2009). Perceived ethnic discrimination versus acculturation stress: influences on substance use among Latino youth in the Southwest. Journal of Health and Social Behavior, 50(4), 443–459. https://doi.org/10.1177/002214650905000405

Liddle, H.A. , Rowe, C.L. , Dakof, G.A. , Ungaro, R.A. , & Henderson, C. (2004). Early intervention for adolescent substance abuse: Pretreatment to posttreatment outcomes of a randomized controlled trial comparing multidimensional family therapy and peer group treatment. Journal of Psychoactive Drugs, 36, 2-37.

Lorenzo-Blanco, E. I., Meca, A., Unger, J. B., Romero, A., Gonzales-Backen, M., Piña-Watson, B. Schwartz, S. J. (2016). Latino parent acculturation stress: Longitudinal effects on family functioning and youth emotional and behavioral health. Journal of Family Psychology: JFP: Journal of the Division of Family Psychology of the American Psychological Association (Division 43), 30(8), 966–976. https://doi.org/10.1037/fam0000223

Marraccini, M. E., & Brier, Z. (2017). School connectedness and suicidal thoughts and behaviors: A systematic meta-analysis. School psychology quarterly : the official journal of the Division of School Psychology, American Psychological Association, 32(1), 5–21. https://doi.org/10.1037/spq0000192

Marsiglia, F. F., Parsai, M., Kulis, S., & Southwest Interdisciplinary Research Center (2009). Effects of Familism and Family Cohesion on Problem Behaviors among Adolescents in Mexican Immigrant Families in the Southwest U.S. Journal of ethnic & cultural diversity in social work, 18(3), 203–220. https://doi.org/10.1080/15313200903070965

Nadeem, E., Kataoka, S.H., Chang, V.Y., Vona, P., Wong, M., & Stein, B.D. (2011). The role of teachers in school-based suicide prevention: A qualitative study of school staff perspectives. School Mental Health, 3(4), 209–221. https://doi.org/10.1007/s12310-011-9056-7.

National Hispanic and Latino ATTC. (2013). Cultural elements in treating Hispanic and Latino populations (revision 2013). Bayamón, PR: Universidad Central del Caribe.

Noe-Bustamante, L. (September 16, 2019). Key facts about U.S. Hispanics and their diverse heritage. Washington, DC: Pew Hispanic CenterFlores, A., & Krogstad, J.M. (2019, July 26). Puerto Rico's population declined sharply after hurricanes Maria and Irma. Washington, DC: Pew Hispanic Center. https://www.pewresearch.org/facttank/2019/07/26/puerto-rico-population-2018/

O'Carroll, P. W., Berman, A. L., Maris, R. W., Moscicki, E. K., Tanney, B. L., & Silverman, M.M. (1996). Beyond the Tower of Babel: a nomenclature for suicidology. Suicide & lifethreatening behavior, 26(3), 237–252.

Odafe, Mary & Talavera, David & Cheref, Soumia & Hong, Judy & Walker, Rheeda. (2016). Suicide in Racial and Ethnic Minority Adults: A Review of the Last Decade. Current Psychiatry Reviews. 12. 1-1. 10.2174/1573400512666160530124538.

Pantin H, Coatsworth JD, Feaster DJ, Newman FL, Briones E, Prado G, Schwartz SJ, Szapocznik J. Familias Unidas: the efficacy of an intervention to promote parental investment in Hispanic immigrant families. Prevention Science. 2003;4:189–201.

Perreira, K. M., Marchante, A. N., Schwartz, S. J., Isasi, C. R., Carnethon, M. R., Corliss, H. L., Delamater, A. M. (2018). Stress and Resilience: Key Correlates of Mental Health and Substance Use in the Hispanic Community Health Study of Latino Youth. Journal of Immigrant and Minority Health, 21(1), 4–13. https://doi.org/10.1007/s10903-018-0724-7

Ramirez, A., Gallion, K., Aguilar, R., & Dembeck, E. (2017, September 12). Mental health and Latino kids: A Research Review. https://saludamerica.org/wpcontent/uploads/2017/09/FINAL-mental-health-research-review-9-12-17.pdf

Santisteban, D., & Mena, M. (2009). Culturally informed and flexible family-based treatment for adolescents: A tailored and integrative treatment for Hispanic youth. Family Process, 48, 253– 268. https://doi.org/10.1111/j.1545-5300.2009.01280.x [PubMed: 19579908]

Santisteban, D., Coatsworth, J., Perez-Vidal, A., Kurtines, W., Schwartz, S., Laperriere, A., and Szapocznik, J. (2003). Efficacy of Brief Strategic Family Therapy in Modifying Hispanic Adolescent Behavior Problems and Substance Use. Journal of family psychology : JFP : journal of the Division of Family Psychology of the American Psychological Association (Division 43). 17. 121-33. 10.1037/0893-3200.17.1.121.

Santisteban, D., Suarez-Morales, L., Robbins, M. and Szapocznik, J. (2006). Brief Strategic Family Therapy: Lessons Learned in Efficacy Research and Challenges to Blending Research and Practice. Family process. 45. 259-71. 10.1111/j.1545-5300.2006.00094.x.

Santisteban DA, Mena, M.P., & McCabe, B.E.(2011). Preliminary results for an adaptive family treatment for drug abuse in Hispanic youth. Journal of Family Psychology, 25(4), 610-614. https://doi.org/10.1037/a0024016 [PubMed: 21639636]

Silverman, M.M. (2007), In This Issue. Suicide and Life-Threatening Behavior, 37: iiivi. https://doi.org/10.1521/suli.2007.37.3.iii

Suicide Prevention Resource Center. (2019). Suicide by age. https://www.sprc.org/scope/age

Suicide Prevention Resource Center. (2015). Responding to grief, trauma, and distress after a suicide: U.S. National Guidelines. https://www.sprc.org/resources-programs/responding-grief-trauma-and-distress-after-suicide-us-national-guidelines

Suicide Preventions Resource Center. (2014). Family intervention for suicide prevention (FISP). https://www.sprc.org/resources-programs/family-intervention-suicide-prevention-fisp

Suicide Statistics. (2019, April 16). Retrieved May 21, 2019, from https://afsp.org/about-suicide/suicide-statistics/

Suicide Prevention Resource Center. (n.d.) Provide for immediate and long-term postvention. http://www.sprc.org/comprehensive-approach/postvention

Szapocznik, J., Hervis, O., & Schwartz, S. (2001). Brief Strategic Family Therapy Manual [NIDA Treatment Manual Series]. Rockville, MD: National Institute on Drug Abuse. Mental Health America. A suicide Prevention and Postvention Toolkit for Texas Communities-U.S National Guidelines developed by the Survivors of Suicide Loss Task Force, 2019 http://www.texassuicideprevention.org/wpcontent/uploads/2013/06/TexasSuicidePrevention-2012Toolkit_8-31.pdf

Veterans Affairs. (2013). VA/DoD Clinical practice guideline for assessment and management of patients at risk for suicide. Washington, DC: VA. https://www.healthquality.va.gov/guidelines/MH/srb/VASuicideAssessmentSummary5FINAL.pdf

World Health Organization. (2014). Preventing suicide: A global imperative. https://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

Whitlock JL, Exner-Cortens D, Purington A. Validity and reliability of the non-suicidal selfinjury assessment test (NSSI-AT) Psychol Assess. 2014;26:935–46. doi:10.1037/a0036611

Zayas, L. H. (2011). Latinas Attempting Suicide: When Cultures, Families, and Daughters Collide. Oxford.

Zayas, L. H., & Pilat, A. M. (2008). Suicidal behavior in Latinas: Explanatory cultural factors and implications for intervention. Suicide & Life-threatening Behavior, 38(3), 334–342. https://doi.org/10.1521/suli.2008.38.3.334

Zayas, L. H., Lester, R. J., Cabassa, L. J., & Fortuna, L. R. (2005). Why do so many latina teens attempt suicide? A conceptual model for research. The American journal of orthopsychiatry, 75(2), 275–287. https://doi.org/10.1037/0002-9432.75.2.275

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