Andres J. Pumariega
Neha Sharma
Editors

Suicide Among Diverse Youth

A Case-Based Guidebook

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Foreword

Suicide among adolescents and young adults is a tragedy. A life is ended before it bears full fruit, always leaving emotional devastation in its wake, affecting loved ones, peers, and acquaintances. Suicidal ideation and nonlethal suicide attempts disrupt the sense of safety for the family and present fear, confusion, and the experience of hopelessness. The reality or threat of suicide represents a true emergency and highlights that something serious is wrong with the way things are for the family. Suicidal behavior is also at the intersection of youth, family, mental health, and the mental health system and community.

In twenty-first-century USA, notions of family and community are significantly influenced by diversity that is so prevalent in our society. Diversity requires an understanding of the many cultures present in our communities. While the mental health system and mental health clinicians respond to suicidal threat, cultural diversity challenges the system to react with an understanding of cultural difference and in accord with differing cultural understandings of adolescence, family, and the immediate threat of suicide. At the same time, systems of care often offer an approach to prevention, assessment, and treatment that is monolithic and culturally blind.

While the experience of danger, the sense of the youth of being disconnected and alone, and the highly emotional reaction of caretakers may be similar in suicidal situations, the nature of the youth's problems, the nature of engagement and support, preexisting problems, and preferred solutions vary from culture to culture. This complexity is often absent from clinical approaches, leading to further disconnection and treatment based upon mutual misunderstanding. The solutions that is offered doesn't help, and the hoped-for collaboration between the youth, family, and clinician never occurs. The disruption associated with youth suicidality and experienced by family and community is magnified and produces greater marginalization.

I believe the pain of the suicidal youth is a plea for understanding, connection, and a path to his or her meaningful future. This path leads to an integration of personal agency, meaningful connections, and a competent way of being in the community. Cultural diversity challenges the community (Which? Whose?). Marginalization, discrimination, and xenophobia challenge agency, connections, and competence. A successful resolution of the suicidal impulse includes a connection of the youth to his or her path toward adult competency and meaningful connections. That resolution must be inclusive and respect the multiple identities of that youth and those who care

for and love him/her. The treatment of suicidal youth always is based upon the belief that there is a place for that youth in our community and society. In order to help any young person move from despair and self-destruction to hope and development, we must know and understand that youth, his or her experience, and his or her contexts.

Every adolescent mental health encounter is a dialogue across cultural difference at the intersection of four cultures: the culture of the clinician, the culture of mental health treatment, the culture of the adolescent, and the culture of the family. The clinician needs to be aware of his or her culture and implicit biases and also aware of the biases and influence of the mental health system and clinical practice. Recognizing the culture of the youth and that of his or her family is more complicated and made more emotionally tense under the threat of suicide or the occurrence of a suicide attempt.

To create this dialogue across cultural difference, the clinician must develop an understanding of diverse cultures, an appreciation of current adolescence, and an awareness of the history of the group that adolescent is from. Some minority groups, Native Americans, African Americans, and Latinos, have been in the USA for generations. Their culture has been influenced by historical trauma of genocide, slavery, and discrimination. The horrors and trauma of these experiences are filtered through generations creating poverty, fractured families, substance abuse and addiction, violence, and incarceration, any of which can influence families and vulnerable adolescents. Often, adolescent distress can be a significant challenge for these families. The situation also can be affected by mistrust of institutions, including health-care services, and by cultural stigma toward mental illness and mental health treatment. Trauma, discrimination, and often poverty have influenced family life, form the background of the current crisis, and must be understood and validated to begin resolution and healing.

Immigrants from a variety of regions representing a number of nationalities have come to the USA in recent years. Each family and individual have different immigration stories. Often, they have experienced distinct experiences of trauma, dislocation, and disruption. Immigrants may have experienced war, abuse, and torture prior to leaving their home countries. Passage to the USA may have been difficult and potentially traumatic. Arrival in the USA may have been disconcerting and hard and may have included deprivation. In the USA, in addition to the challenge of language, immigrants often work long hours at low-paying jobs which can be exhausting and at times dangerous. Differences in language, customs, dress, and religion mark the immigrant as an outsider, leading to experiences of discrimination, ridicule, misunderstanding, and aggression. Second-generation children of immigrants may also experience derision, bullying, and extrusion. At the same time, youth are influenced by the culture of school, peers, and the media in the USA. Attempts to fit in may lead to acculturative family distancing leading to significant disconnection from parents, while academic and social challenges may lead to failure, isolation, and worsening helplessness. This can lead some youth to suicidal thoughts and behavior. Mental health care can feel foreign and not acceptable to both parents and youth. The loss of home and disconnection felt by immigrant families only make things worse.

A clinician responding to the threat of suicide or to the reality of a suicide attempt can be lost in the intense emotions that families experience, coupled with the crisis engendered by the threat of suicide. The combination of family stress occurring in association with immigration and conflicts and misunderstandings associated with growing acculturative family distancing can leave the clinician isolated and helpless. Often in these circumstances, the clinician feels for, and takes the side of, the distressed youth, alienating and failing to validate parents and loved ones.

The clinical goal in suicidal situations is to reinstitute safety while building tolerance of emotions and reducing impulsivity and violence. This is while also rebuilding relationships as a source of connection and mutual support. This requires that the clinician be comfortable with emotional intensity, be patient with generational conflict, and possess a relentless belief in the survival and future of the youth and the possibilities of the family for healing. For this healing to occur through the course of treatment, the clinician builds relationships of respect, regard, and hope with parents and youth. At the heart of these relationships is the dialogue across cultural difference. This always requires the cultural curiosity and cultural humility of the clinician.

Pumariega and Sharma's book, *Suicide Among Diverse Youth*, provides pathways through this dialogue across cultural difference, providing the clinician with guides to understanding, information to provoke curiosity, and the grounding to develop relationships to successfully resolve the suicidal crisis and promote long-term healing. Sharma and Pumariega begin with epidemiologic data that highlight that teen suicide is a significant public health crisis and that it is increasing significantly in the minority and immigrant population. They also highlight cultural and religious views on suicide among those highlighted in their volume. This information further challenges the clinician to approach any suicidal youth, especially minority and immigrant youth, with an enhanced curiosity about the role of culture, discrimination, and historical trauma in the suicidal crisis and the family's response. These two authors go on to present an overarching clinical approach, emphasizing the role of the family in healing and recovery. They also present the American Academy of Child and Adolescent Psychiatry's Practice Parameter on Cultural Competence [1] and the American Psychiatric Association's Cultural Formulation Interview with its Supplemental Modules [2] as key tools for appreciating cultural views of mental health problems and mental health clinical encounters. These valuable approaches begin to bridge the cultural divide in clinical encounters and especially in crisis situations.

Subsequent chapters in the book highlight the problem of teen suicide and the challenge of responding to a suicidal crisis in each of the several immigrant and minority cultures in the USA, including the prevalence of suicide and suicidality in sexual minority youth. Each chapter details the stresses and challenges prevalent for each group. Historical trauma, oppression, discrimination, and microaggressions are described in the chapters about minority youth in the USA, while immigration traumas, acculturation, and acculturative family distancing are highlighted in the chapters about recent ethnic minority immigrants. Each chapter contains case examples describing the background of suicidal crises for youth from that culture. Where culturally

adapted evidence-based practices have been developed, they are described, and specific culturally appropriate and clinical responses are also included in the case material. In several instances, though, the authors point out a lack of information about suicidal youth and treatment based upon a lack of specific research for that culture. This is especially true about different regions of Asia, the Middle East, and Eastern Europe, all locations with numbers of immigrants in the USA. The chapter on sexual minority youth points out clearly the protective role of family and community acceptance while pointing out the negative impacts of victimization and isolation.

The final chapter in the book describes a variety of approaches to preventing youth suicide. Structural community-wide prevention programs and services are outlined, clinical treatment programs are described, and culturally based youth development and suicide prevention programs are highlighted. This chapter points out the need for community participation in program design, political leadership to maintain and sustain programs, and publicity to ensure participation. Support for and participation in suicide prevention and reduction of stigma about mental health challenges and treatment remains inadequate, especially in minority and immigrant communities. These efforts will require community commitment and political will to grow to scale.

USA is a diverse country, growing more diverse as time passes. Children and adolescents in minority and immigrant families are expanding the population of diverse communities. Discrimination and microaggressions fueled by traumatic experiences and memories of historical traumas can lead to further stress and marginalization. Cultural differences can continue to magnify stigma. The stress of these experiences will only amplify the challenge of youth suicide among diverse youth. Perhaps we can take the message of Pumariega and Sharma's book, develop welcoming communities for diverse populations and encourage culturally curious and culturally respectful mental health practices. The problem of youth suicide demands inclusive communities, responsive and culturally curious mental health care, and knowledgeable clinicians. Only then will a life filled with hope, acceptance, and opportunity be possible for all youth.

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Preface

Child and adolescent psychiatry and mental health have increasingly focused on the growing mental health challenges faced by culturally diverse populations of children and youth. Non-European-origin youth make up a growing segment of the population of the USA and will become the majority of youth somewhere between the years 2018 and 2020. In many ways, their health and success will determine the future of the USA.

Major disparities in mental health services utilization by these growing populations have been well documented. However, other growing disparities are the gaps in knowledge, evidence-based, in training about the mental health of these populations. The main problem around the adequacy of evidence around mental health services is that the overwhelming majority of research in child and adolescent mental health is based on European-origin children and youth and not necessarily relevant to other ethnic or racial populations.

The American Academy of Child and Adolescent Psychiatry (AACAP) began focusing its efforts toward serving diverse children and youth by forming a workgroup on diversity and culture in 1994. It was first led by Drs. Jean Spurlock and Ian Canino, both pioneers in cross-cultural child and adolescent psychiatry. Andres Pumariega served as one of its founding members along with other pioneers, as well as chair and co-chair from 2007 to 2015. The workgroup, which later became a standing committee – Diversity and Culture Committee – of the academy, focused on enhancing the awareness of how culture impacts adolescent development and mental health needs and the growing disparities in assessment, treatment, research evidence, and service access. The AACAP Diversity and Culture Committee has undergone some evolutions since its inception, though it maintains its original mission. Please see an excerpt of the mission below [1]:

1. To promote and develop mentoring, recruitment and retention systems for trainees of culturally diverse groups.
2. To promote increased diversity in the membership of the AACAP through activities and systems for the recruitment, retention, and leadership development of culturally diverse members.
3. To develop and promote consultation services, curricula, practice parameters, and continuing education geared at addressing the educational needs of all trainees and AACAP members in culturally competent practices and

the special developmental and clinical needs of minority children and adolescents.
4. To review all AACAP publications, including Facts for Families, practice parameters, and policy statements to assure that attention is given to pertinent cultural issues and to solicit/develop materials for AACAP publications; said manuscripts to address culture and diversity in assessment procedures and treatment of children and adolescents and any policy implications.
5. To promote research in the areas of intersection between child and adolescent psychiatry and mental health and culture/race/ethnicity, including research in development, identity development, ethnopsychobiology, cross-cultural epidemiology and services research, efficacy and effectiveness of mainstream treatment interventions, and development of culturally modified interventions.
6. To raise awareness about mental health disparities and developmental needs of diverse children and youth, advise the organization on culture and diversity issues, and identify methods to maintain these issues in the forefront of AACAP advocacy, policy, and activities.

In recent years, it has supported the development of a model curriculum on cultural competence in child and adolescent psychiatry [2], as well as an official Practice Parameter for Cultural Competence in Child and Adolescent Psychiatric Practice [3]. It has also sponsored well over 100 symposia, workshops, and case conferences on diversity and culture in child and adolescent mental health and psychiatry at annual AACAP meetings over the past 20 years.

One of these symposia (a Clinical Perspectives session) on suicidality in diverse youth [4] was inspired by the work of various committee members on the growing challenges on suicidality among non-European-origin diverse youth. Through our affiliation with the committee, we recruited presenters from it and co-chaired and submitted this session to the AACAP program committee for its annual meeting in San Antonio, Texas, in 2015. This session featured presentations by Drs. Cheryl Al-Mateen (present co-chair of the committee), Susan Daly, Zheya Yu, and Lee Carlisle, as well as us. The session was generally well received, but it also came to the attention of Springer Press, who approached us about expanding the session into an edited textbook. We readily accepted the challenge and put together the book proposal in record time, and before we knew it, we were in the writing and editing process, the fruits of which you see in the following pages.

The structure of this book is designed above all to bridge the knowledge and skills gap encountered by most clinicians dealing with youth from diverse cultural backgrounds, particularly those different than that of the clinician. The chapters cover a spectrum of diverse populations, including the underserved and underrepresented ethnic/racial groups in the USA, LGBTQ youth, and various immigrant groups from Eastern Europe and the Middle East. These chapters are framed by two introductory chapters on general principles of suicidal behavior and culture and culturally informed treatment and clinical

approaches of suicidality and, at the end, principles and examples of preventive approaches, general and culturally specific.

The population-specific chapters feature a case report of suicidal behavior of any young person from that ethnic/cultural group. It is then accompanied by a review of the literature, unique characteristics and risk factors associated with suicidality, and both evidence-based practice and practice-based evidence provided by the authors from their considerable experience, striving to cross-reference key findings or issues brought up by the case. The authors are often from the same ethnic/racial/cultural group that they write about, thus providing experiential knowledge where scientific knowledge is lacking.

The first chapter provides an introduction to suicidality and suicide within a cultural context, a review of basic terminology to use in this discussion, and a cross section of religious and cultural beliefs across populations. The second chapter outlines principles for a culturally informed treatment that one can use to care for diverse youth. The following chapters discuss cases that highlight unique risks experienced by youth from different ethnic/racial history. Furthermore, these chapters also suggest evidence-based practices and practice-based evidences that a provider can utilize to provide care to African American, American Indian/Alaskan Native, Latin American, South Asian American, Southeast Asian American, East Asian American, Turkish American, Middle Eastern American, and Eastern European American youth. These chapters provide a historical context to the population that highlights cultural reasons for suicidal behavior in the second-generation immigrant youth. For example, the chapter on African American suicidal youth emphasizes contribution of segregation, discrimination, and racism as it contributes to the mental health stressors. Similarly, in the Latin American chapter, the second generations' struggle of living up to family's values while also accepting their hyphenated identity is stressed. Soviet Jewish Americans also have unique struggles that arise from conflicts of home culture and host culture, such as experience of being discriminated as a Jew in the Soviet Union that is compounded by being different among American Jews. Youth who are minorities because of their sexual orientation or gender identity experience rejection and isolation by their families, their peers, and the larger society. This places providers at a critical position to support families which is discussed at length in Chap. 13. Lastly, Chap. 14 provides an overview of prevention and intervention programs that involve family and community support. This is to engage family and community such that the treatment of the youth has higher chances of being successful since the risk factors of suicide and its alternatives exist in the cultural context.

We wish to thank our many colleagues who accepted our invitation and took on the challenge of contributing their knowledge and insights to this book. Their scholarship, clinical insight, empathy, creativity, and persistence demonstrate their dedication to diverse underserved youth. Springer Press deserves many thanks and kudos for identifying this area as an important one and for supporting and promoting a project that we hope will benefit many youth and their families as well as the clinicians who served them. Special thanks to Stephanie Frost, our indefatigable and ever-supportive editor from Springer, who put incredible work into the details of this book. We also thank

our families for their support of our work, which was mostly done during borrowed personal time. We thank the youth and families we've had the honor of serving and learning from and the mentors and colleagues we have learned from along the way. Finally, we thank our colleagues who are devoted to serving underserved youth and their families and hope that the book both is helpful in their work and does their work justice.

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June 17, 2017

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Cultural Aspects of Suicidality Among Youth

1

Neha Sharma and Andres J. Pumariega

Abbreviations

AA	African-American
AAPI	Asian-American/Pacific Islanders
AIAN	American Indian/Alaskan Native
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders-IV
MDD	Major depressive disorder
MH	Mental health
NCS-A	National Comorbidity Survey Replication-Adolescent Supplement
NHW	Non-Hispanic White
NSDUH	National Survey on Drug Use and Health
ODD	Oppositional defiant disorder
PTSD	Post-traumatic stress disorder
SI	Suicidal ideation

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"I wish it need not have happened in my time," said Frodo.

"So do I," said Gandalf, "and so do all who live to see such times. But that is not for them to decide. All we have to decide is what to do with the time that is given us."

–J.R.R. Tolkien, The Fellowship of the Ring

When people don't express themselves, they die one piece at a time.

–Laurie Halse Anderson, Speak

To be, or not to be: that is the question:

Whether 'tis nobler in the mind to suffer

The slings and arrows of outrageous fortune,

Or to take arms against a sea of troubles,

And by opposing end them? To die: to sleep;

No more; and by a sleep to say we end

The heart-ache and the thousand natural shocks

–William Shakespeare, Hamlet

Introduction

Adolescent suicide is the most tragic experience for any society. The sudden loss of beautiful memories, a bright future, and growth of the individual and family is jarring and appalling. In 2012, suicide became the second leading cause of death in adolescents aged 15–24 years after unintended accidents and followed by homicide.

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In this age group, the deaths caused by suicide alone are greater than the combined deaths caused by cancer, heart disease, influenza, pneumonia, diabetes mellitus, human immunodeficiency virus, and stroke [1]. This is a remarkable increase from 1987 to 1997, when suicide was the third leading cause of death among adolescents 10–19 years old [2]. This increase in the rate of suicide from the third leading cause of death to the second disproportionately impacts youth of ethnic/racial minority background. The rate of suicide increased from 1999 to 2014 in non-Hispanic White (NHW) 15–24 years old increased by 59% and by 17% in females and males, respectively. By comparison, among Hispanics, the increase was 89% and 16% among females and males, respectively. Additionally, there is an alarming rate of 35% increase among Asian males from 1999 to 2014 in the same age group [1]. Figure 1.1 shows suicide deaths among youths as a function of gender and ethnicity [3]. The group with highest risk is American Indian/Alaskan Native (AI/AN) adolescent males, while the lowest risk group is African-American (AA) females.

Due to this demographic shift and steadily increasing suicide rate, there is a need of reassessing the current model of suicide prevention, assessment, and management. The current model is based on Western culture that values individualism and sees the purpose of life from one's individual sense of successes and failures. This core value that guides the current screening tools and assessments may not be relevant when addressing youth from diverse populations, among whom value orientations are more oriented to family and community than to the individual. For example, when working with Asian-American youth, the impact of a family's experience of shame, loss, or dishonor may contribute to suicidal thoughts more than the youth's individual sense of failure. If this factor is not assessed correctly, the mental health (MH) provider is likely to miscalculate the severity of risk factors, miss the opportunity to prevent suicide attempts, or may develop a treatment plan that is not relevant to the youth or the family.

In the light of the changing US population, it is possible that we are approaching a public health crisis because we are not equipped to address the needs of a culturally diverse population.

Since the increase in the rate of suicide is disproportionately higher among minorities, there is a need to understand suicidal behavior through the lens of the cultural context of precipitating factors, risk factors, protective factors, and means of suicide. Furthermore, how the behavior is interpreted, in the cultural context, directly impacts preventive care, intervention, and post-intervention process. Thus, awareness of how cultural elements interact with adolescent suicidal behavior is vital to provide effective care.

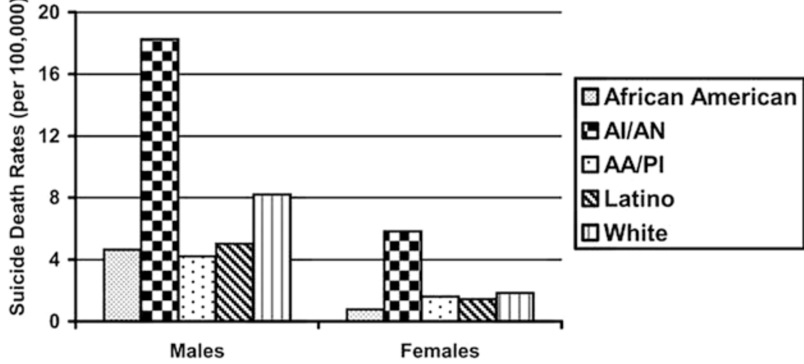

Fig. 1.1 One-year rates of suicide deaths among 10- to 19-year-olds (1999–2004) [3] (Reprinted from Goldston et al. [3], © 2008, with permission from the American Psychological Association)

How Do We Understand Suicidal Behavior Today?

First, some definitions of terms related to suicide need to be reviewed. Suicide is a self-inflicted form of death that occurs predominately in adolescence and from middle age to older age. Suicidal behavior is referred to voluntary action that could result in death. A suicide attempt is an attempt to harm self with an intent to kill himself/herself that could be lethal or nonlethal. Suicidal ideation (SI) is referred to thoughts of killing oneself with or without a plan or an intent to die. (Please see Table 1.2 for definitions and Fig. 1.2 for conceptualization of the relationship of these terms to each other.)

The National Comorbidity Survey Replication-Adolescent Supplement (NCS-A) attempted to identify prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents by surveying 6483 adolescents and parents. Conclusions of this survey estimated that lifetime prevalence of suicide ideation, plan, and attempts among respondents is 12.1%, 4.0%, and 4.1%, respectively, occurring more commonly among females than males. One third (33.4%) of ideators go on to develop a suicide plan and 33.9% make an attempt. The proportion of ideators who go on to make an attempt are 60.8% of those with a plan compared to 20.4% of those without a plan. Thus, when assessing suicide risk, the importance of inquiry about suicide plan and the intent is vital. A majority of adolescents that transition from ideation to plan (63.1%) and from ideation to attempt (86.1%) do that within the first year of onset of ideation [4]. This shows the importance of MH follow-up for during the first year after suicide ideation is identified. Commonly, an adolescent has been experiencing SIs and has vague ideas of a plan. However, in a state of distress and/or impulsivity, an adolescent is more likely to transition from plan to attempt, and a minority of suicide ideators can go on to make attempts impulsively without a plan.

The NCS-A also notes that majority of adolescents with suicidal behavior meet lifetime criteria for at least one Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) diagnosis. (Prior mental disorder is most strongly associated with SI.) The significant positive predictors of suicide attempt are major depressive disorder (MDD), post-traumatic stress disorder (PTSD), eating disorder, bipolar disorder, and oppositional defiant disorder (ODD) in that order [4]. Most importantly, prior history of a suicide attempt is a predictor of future suicidal behavior. Additionally, anxiety disorders, substance abuse, and runaway behavior are associated with increased risk of suicide attempts in both sexes. Runaway behavior is highly associated with a history of abuse. Abuse by itself, regardless of

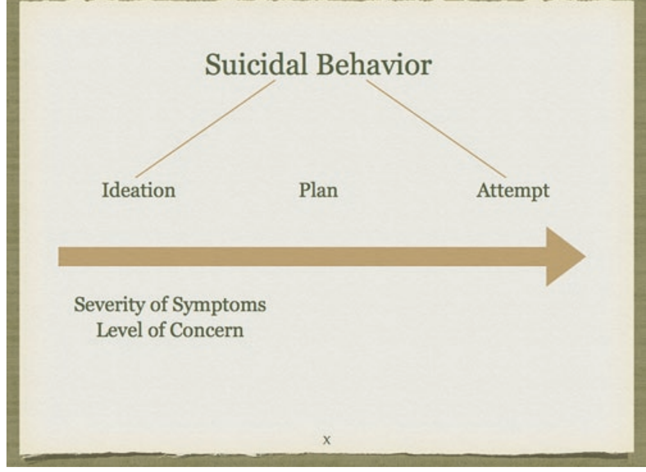

Fig. 1.2 Severity of symptoms and level of concern for suicidal behavior

runaway behavior or substance abuse, significantly increases the risk of suicide. Family history of suicide attempt, psychopathology, and parental substance abuse should increase concern regarding youth's suicidal behavior. Good parent-child communication is associated with a lower prevalence of suicidal thoughts, whereas feeling of not being understood by parents increases the risk significantly [5].

Besides psychiatric and family history, psychosocial stressors further increase the risk of suicidal behavior. Often the ability to cope with stressors is challenged by life events, such as loss of a romantic relationship, disciplinary difficulties, academic failures, or family struggles. Adolescents with significant family disturbance or estranged family dynamics are also more likely to exhibit suicidal behaviors [5]. (See Table 1.1 for more comprehensive list of risk factors for adolescent suicide.)

Generally speaking, female adolescents present more commonly in the acute settings for suicidal behavior. Meanwhile, male adolescents are more likely to complete suicide. This dissonance is likely to be due to three factors – lethality of means of harm, higher male social isolation, and treatment-seeking behavior. Male youth are more likely to use lethal means to attempt suicide, whereas female youth tend to use less lethal means to harm themselves that do not cause severe immediate harm. When harm does not occur immediately, it allows the adolescent to change their mind and seek help. The use of firearms and knives does not allow for this option even if the adolescent changes his mind. Additionally, there is some data that even if male youth fail in their suicide attempt, they are less likely to seek treatment. Female youth seek treatment more often than male youth [5]. The choice of means of self-harm is highly correlated to availability and access. Since access to over-the-counter medications is easier, most adolescents tend to use ingestion of pills as means. However, when there are firearms in the household, it increases the chance of its use to complete suicide. Furthermore, females are typically less individualistic and have a greater value orientation to social connectedness than males. This

Table 1.1 Summary of risk factors for suicide by adolescents [6]

Demographic	Clinical	Family and environment	Mental state
Male	Psychiatric diagnosis	Life stresses, particularly unemployment and legal and school problems	Suicidal thoughts, especially if pervasive and involving planning
Older youth	Recent discharge from psychiatric hospital	Access to lethal means	Homicidal ideation
Nonheterosexual orientation	Past suicide attempt	Lack of social supports	Alcohol and illicit drug intoxication
	Family history of suicide	Non-intact families	Severe depression, anxiety, agitation, hopelessness
	Childhood history of trauma (sexual, emotional, physical)	Parental mental illness	Impulsivity
	Severe insomnia	Impaired relationship with parents	Impaired problem-solving skills
	Poor physical health with functional impairment	Poor communication with parents	
	Personality traits	Perceived excessive control and low care by parents	
	Low self-esteem	Indigenous heritage	
	Poor treatment compliance	Contagion exposure to other suicidal behavior	

Reproduced with permission from Gordon and Melvin [6]. Available at www.racgp.org.au/afp/2014/june/suicidal-adolescents

makes it less likely to follow through on plans for suicide due to greater consideration for the impact on significant others. They are also generally socialized to be less impulsive, adding further protection from impulsive forms of suicide without a plan.

According to NCS-A, which is depending on self-report by adolescents and parents, more than 80% of suicidal adolescents receive some form of MH treatment (MH provider, school, primary care physician, legal), and treatment starts prior to onset of suicidal behavior for more than 55% of the adolescents [4]. This treatment-seeking behavior is lower among minority populations due to MH stigma and cultural perspectives and prohibitions on suicidal behavior and its treatment. Even if an adolescent from an ethnic/racial minority community seeks treatment, it tends to be later in the course of illness and presents with more severe symptoms [7].

Cultural Concepts About Death and Suicide

Definitions

In order to understand the cultural context of suicidal behavior, certain terminologies should be defined. The terms mentioned in Table 1.2, specifically culture, ethnicity, and acculturation, are dynamic descriptions. They are not static because these features are learned and ever changing. Thus, they reflect heterogeneity within each ethnic group.

Religion, Death, and Suicide

Suicide is prohibited as a sin in many religions and is even a crime in some nations and societies. Still, some faith traditions have viewed it as an honorable way to exit some shameful or hopeless situations. Suicide can also be distinguished from martyrdom, which can be characterized as death in the process of self-sacrifice in the service of others in life-threatening emergencies or reckless bravery in battle and usually escape religious or legal prohibition. Though diverse youth are often not directly aware of the beliefs and values of their current religions or faith traditions, these can serve to influence their attitudes and behaviors as well as those of their families and communities.

The diverse views on death and suicide in some faith traditions are presented below.

Buddhism

According to Buddhism, what an individual does in the present moment influences his or her future, in this life or the next life. Karma is the reaction to or repercussion of intentional action by mind, body, or speech and is the reason behind the conditions and differences we come across in the world. For Buddhists, the first precept is to refrain from the destruction of life (including oneself), and suicide is considered a negative form of action. However, in spite of this view, an ancient Asian ideology persists to influence Buddhists to commit the act of "honorable" suicide while under oppression. In modern times, Tibetan monks have used this ideal in order to protest the US involvement in Vietnam in the 1960s and the People's Republic of China's occupation of Tibet and Chinese human rights violations [17].

Christianity

Christianity is traditionally opposed to suicide and even assisted suicide in the face of terminal illness. In Catholicism, suicide is considered a grave and sometimes mortal sin. The chief theological argument is that a person's life is the property of God and to destroy one's life is to wrongly assert dominion over God. Additionally, many Christians believe in the sanctity of human life, a principle whereby all human life is sacred as a creation of God, and every effort must be made to preserve it whenever possible. Even while believing that suicide is generally wrong,

Table 1.2 Definitions [8–16]

Term	Definition
Culture	The belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (language, care taking practices, media, educational systems) and organizations (media, educational systems) [8]
Race	The category to which others assign individuals on the basis of physical characteristics, such as skin color or hair type, and the generalizations and stereotypes made as a result [9, 10]
Ethnicity	The acceptance of the group mores and practices of one's culture of origin and the concomitant sense of belonging [9]. This may derive from the use of common language and sense of shared history, values, and traditions [11]
Immigrant	Someone who intends to reside permanently in another country
Suicide	Self-inflicted death
Suicide attempt	An attempt to inflect death on oneself that could be lethal and nonlethal
Suicide ideation	Thoughts of killing oneself with or without the intent to die
Suicidal behavior	Any action that leads to suicide attempt and/or death by suicide
Communalism	Allegiance to one's ethnic group rather than the wider society
Familismo	Allegiance to one's family above the needs of the individual [12]
Marianismo	Definition of the positive female gender role as emulating the Virgin Mary in all her purity and virtue
Personalismo	Orientation to interpersonal engagement effectiveness over intellectual pursuits
Assimilation	Culture of origin is rejected and the host culture is largely adopted [13]
Separation	Host culture is rejected, and there is a strong adherence toward traditional culture, often exemplified by ethnic enclaves [13]
Marginalization	Separation from both host culture and culture of origin resulting in diffusion of ethnic identity [13]
Integration	Identification with culture of origin, as well as understands infusion of dominate ethnicity into the holistic identity, resulting in "hyphenated" identity [13]
Acculturation	The modification of the culture of a group or individual as a result of contact with the host culture [13]
Enculturation	The process by which knowledge, behavioral expectations, attitudes, and values are acquired and shared by members of a cultural group [14]
Acculturative family distancing	"The distancing that occurs between parents and youth as a result of differential rates of acculturation resulting in communication difficulties and cultural value incongruence" [15]
Refugee	A person who is outside their own country and has a well-founded fear of persecution due to his/her race, religion, and nationality, is a member of a particular social group or political opinion, and is unable or unwilling to return [16]
Discrimination	Based behavior toward, and treatment of, a group or its members on the basis of a specific trait such as age, appearance, race, and ethnicity

liberal Christians often recognize that people who commit suicide are severely distressed and believe that God can forgive such acts within his love for humankind [17].

Hinduism

In Hinduism, suicide is considered murdering one's own body and is considered equally sinful as murdering another person. However, it is considered acceptable to end one's life by fasting under various circumstances. Such suicide, known as prayopavesha, requires time and will power, so there is no danger of acting on impulse. It also allows time for the individual to settle all their worldly affairs, to ponder life, and to draw closer to God [17]. Though Hinduism considers suicide to be sinful, some individuals may interpret the concept of reincarnation to mean end of one body but not the soul that continues after life. Additionally, often suicide is considered to be a better outcome than losing one's honor.

Islam

Islam views suicide as strictly sinful and detrimental to one's spiritual journey. However, human beings are considered to be fallible and to committing mistakes, and God forgives their sins if the individual is true to the causes, truly sincere in repentance, and determined in intention. However, in the Quran, although God is "the Most Merciful, the Most Kind" and forgives all sins, the great sin of unbelief is deemed unforgivable, so those who die unbelieving cannot be forgiven. Some fundamentalist sects have been posited that actions committed in the course of "jihad" (holy war) resulting in one's own death are not considered suicide but are a form of martyrdom, especially if committed against unjust oppressors, if there is absolutely no other option, and if life otherwise would end in death. However, there is Quranic evidence to the contrary stating those involved in the killing of the innocent are wrongdoers and transgressors. Nevertheless, some claim Islam does permit the use of suicide only [17].

Judaism

Judaism views suicide as one of the most serious sins, and it has always been forbidden by Jewish law. There are three exceptions under which suicide would be permissible: if one is being forced by someone to commit murder, forced to commit an act of idolatry, or forced to commit adultery or incest. Outside those cases, suicide is forbidden, and this includes taking part of assisted suicide [17].

Indigenous Religions in North America

Traditional religions among American Indian tribes in North America had prohibitions against suicide in most instances, with beliefs strongly emphasizing the spiritual dimension of life and various beliefs in the afterlife. However, ethnographic archives going back as far as the 1700s have documented tribal exceptions to such prohibitions that go back before Europeans set foot on the continent. These include ritual suicide by widows in the midst of their grief looking to join their dead spouses in the afterlife, suicide by engaging in battle to protect or bring glory to the tribe, suicide by elders looking to reduce burdens to families or communities in the midst of hardship, and even suicide as a method of revenge against enemies (by having them come in contact with the "polluted" body of the completer) [18].

African Religions

Traditional African religions have a wide range of beliefs about life, death, and suicide, even in close geographic proximity. For example, the Yoruba of Western Nigeria (from which many slaves taken to the Caribbean and Southern United States originated) have a concept of "life worth living" that includes being devoid of pain and suffering. They also believe that people determine their own faith as they seem fit. Among the Yoruba, suicide can be respectable and preferable to shame, dishonor, and indignity, including infirmity. On the other hand, the Igbo of Eastern Nigeria do not accept suicide in any form, at any age, or as a solution to any problem regardless of its complexity. The Igbo have a paradigm of resilience and view life as both physical and spiritual and transcendent over human travails [19, 20].

Impact of Cultural Values and Attitudes on Youth Suicide African-Americans

Suicide is the third leading cause of death among AA ages 15–24 [3]. Though the suicidal rate among AA adolescents has decreased from 4.5 to 3.0 per 100,000 in the United States from 1995 to 2004 [3], it doubled in school-age children from 1.78 to 3.47 per million between 1993 and 2012 [21]. The percentage of AA female students reporting suicidal thoughts and plans was similar to that of White female students but higher than

Table 1.3 Youth Risk Behavior Surveillance, United States 2011 [22]

"In the past 12 months, have you":	Black females (%)	Black males (%)	White females (%)	White males (%)
Had serious thoughts of suicide	17.4	9.0	18.4	12.8
Made suicide plans	13.9	8.4	13.7	10.6
Attempted suicide	8.8	7.7	7.9	4.6
Gotten medical attention for a suicide attempt	2.4	2.4	2.2	1.5

that of AA male and NHW male students [22]. See Table 1.3.

The Black church has been traditionally protective for AA youth, as a source of social integration, enculturation to the community's cultural and spiritual values, and support for the AA family. Black ministers have traditionally preached a strict prohibition against suicide, even stricter than against substance abuse and illicit activities (where exemptions resulting from distress or need are at times expressed). This prohibition reflects the emphasis on stoicism and resiliency in AA culture, characterized by the motto "keeping on keeping on." At the same time, such values can serve to reinforce the stigma against mental illness and internal barriers to help seeking and treatment [23].

One of the factors associated with depression in AA youth is perceived racism and discrimination. Racism and discrimination are also correlated to increased substance abuse and hopelessness which are contributing factors to suicidal behavior [24, 25]. Additionally, there is higher density of AA in inner cities where there are less economic opportunities. Such social and economic disadvantage results in higher incidence of poverty, experiencing lower quality of education and greater exposure to community violence. All of these social elements increase the rates of hopelessness, depression, and suicidal behavior, in addition to historical trauma of segregation [26]. Furthermore, these elements reflect a lower protective influence given poor community support and resources. Gibbs [27] noted that social support, cultural cohesion, and extended family members also play a protective role which is less available in inner cities. Nisbet [28] hypothesized that the lower suicide rate among AA females age 18 and older, as compared to AA males, is likely to be due to greater familial connections.

In comparison to NHW youth, among 10- to 24-year-olds, homicide is the leading cause of death for AAs [1]. Wolfgang [29] speculated that due to mental health stigma and avoidance of appearing vulnerable, it is possible that AA youth may instigate others to kill them as an indirect method of suicide. This would allow them to display bravery and defiance, both of which are memorialized at the funeral in the community, especially when the victim is a gang member.

There has been increasing data about middle-income AAs experiencing a higher rate of anxiety, stress, or anger due to higher pressure to assimilate to mainstream America while holding onto their cultural identity. This gravitation toward two opposite directions may result in increased risk of suicidal behavior [30]. With improved socioeconomic status, the AA families may move to neighborhoods where they may not see as many AA adolescents, teachers, coaches, and other models. This may result in increased confusion about self-view and increased experience of both isolation and microaggression.

The lower rate of help-seeking behavior from institutions providing care can also be explained by a history of distrust of societal institutions and historical trauma from the time of slavery and a lack of cultural sensitivity by health and mental health service providers [31]. Additionally, the AA community has a fear of being used for "experiments" due to the Tuskegee Study. This deep laden distrust results in AAs preferring informal sources of help – a clergy, coach, or extended family member.

American Indian/Native Alaskans

American Indian/Alaskan Native (AIAN) have the highest suicide rate of any ethnic group. This occurs more among youth who live in rural areas

on reservations, nearly one third of the total AIAN youth. This higher rate of suicidality is associated with geographical isolation, economic deprivation, limited quality education, and limited opportunities for employment, all of which are likely to increase hopelessness. Due to the high rate of suicide on the reservations, it is likely that AIAN youth are exposed to suicidal behavior more than other ethnic groups, thus, further, traumatizing them [32]. Substance abuse and alcohol abuse are another risk factor that tends to occur earlier and at a higher rate compared to other ethnic groups [33].

The historical trauma of forced relocations that resulted in living on land with limited means to earn a living indicates a systematic disadvantage for AIAN youth. Additionally, the practice of traditional religions was illegal on the reservations which resulted in loss of cultural connections to cope with stressors. Both of these facts increase demoralization and hopelessness for AIAN families while perpetuating intergenerational trauma. Historical trauma has been associated with the overall poorer state of health and higher mortality in the AIAN population, including high rates of accidental or unintentional injuries [34].

Studies have demonstrated that enculturation during adolescence to traditional culture and its values, early involvement in spirituality (including church attendance), learning native languages, and greater tribal autonomy and self-determination with emphasis on cultural continuity are all associated with lower AIAN suicide rates [35, 36]. All these factors are associated with fostering the development of a strong ethnic/racial identity in AIAN youth and mitigating the damage of historical trauma.

Mental health stigma is pervasive in small, isolated, and rural AIAN communities. Concerns about embarrassment and confidentiality result in youth not engaging in treatment. And, if they do seek help, often they are also pursuing traditional healing due to their strong belief in it. Inclusion of traditional healing in the treatment planning can lead to more positive outcomes as it is linked to strong ethnic identity, a protective factor for AIAN youth.

Asian-American

In Asian cultures, an interdependent collectivist identity where the well-being of the family or society comes before that of the individual is a core concept. When an individual's behavior upsets group harmony, the family and even the individual can experience loss of face (social shame). Loss of face is more prominent in East Asians (i.e., Chinese and Japanese) and East Asian-Americans, although it may also exist in other Asian groups (e.g., South Asians) and can persist in spite of assimilation. In Chinese culture, the significance of lien (face) cannot be appreciated without recognizing its close relationship with the concept of ch'ih (shame). There is a parallel and contrast between the Chinese face-shame complex, in contrast with the Western sin-guilt complex. Lien implies the presence of ch'ih, which is one of the fundamental requirements of being human. Losing lien is experienced as wu ch'ih (without a sense of ch'ih). In cases of complete loss of lien, this can be a precipitant to an act of suicide as a final resort to show the presence of ch'ih. On the other hand, if suicide itself is seen as dishonorable by the group, then the youth may be less likely to pursue it so as to prevent further ch'ih [3, 37].

The collectivist orientation of Asian-Americans can be a source of resilience and protection against suicide, as it promotes social integration, seen as key to preventing suicide [36, 38]. On the other hand, a collectivist orientation may be associated, with conformity, clearly defined roles, and the importance of group harmony. This may result in suppression of conflict and the withholding of free expression of feelings within the family. Together with fear of loss of face, this emphasis on interdependence may contribute to concealment of emotional distress in Asian-American/Pacific Islanders (AAPI) adolescents and to a possible lack of awareness by others of suicide risk. AAPI youth may also experience conflicts between the demands of independence, assertion, and role fulfillment on the one hand and the need for conflict reduction on the other, both within the family but also when dealing with social problems with peers, such as

peer rejection, bullying, and being ostracized as too dependent on others. The stereotyping of Asian-Americans as a population being a “model minority” also causes much stress, but it is in conflict with findings that high-achieving Asian-American adolescents without externalizing difficulties exhibit higher rates of depressive symptoms than their peers [39]. Less acculturated Asian-American and Asian immigrant youth can also lead to isolation created by the lack of social support from peers due to their high degree of family and community orientation. To no surprise, such individuals have been found to be at a higher risk for depression [3].

Hwang et al. [15] studied the effect of acculturation on depression in Chinese-American families. Acculturation is described as acquisition of beliefs, behaviors, and values of the majority group upon immigration. It was previously assumed that this acquisition of new values results in relinquishment of values in one’s culture of origin. Now, it is believed that most immigrant families tend to adopt the majority group values while also retaining their own culture, a process known as enculturation. When the parents and the youth acculturate and enculturate, they do it at different rate and in relation to different settings and different needs. For example, the parents may acculturate in relation to their occupational needs. Whereas, youth is more likely to acculturate in relation to language, social, and interpersonal needs. This difference in the rate and quality of adoption is referred to as acculturative family distancing (AFD). AFD impacts the quality of parent-child relationship and their ability to use each other as support during adversity. Thus, it is no surprise that high AFD is strongly associated with depression in second-generation immigrant youth as shown by Hwang et al. [15] in Chinese-American youth. Similarly, the process of acculturation by itself can increase the risk of depression. On the same account, support from families and the ethnic community and strong ethnic identity is protective against depression [40].

The low MH utilization by Asian-Americans could be an attributing factor for low suicide rate in this subpopulation. To be specific, Among Asians, males and females have high probability of being at self-injury risk and not asking for help. Males are also at high probability of suffering from depressed mood but not seeking help. Overall, Asian-Americans are less likely than NHW to mention their MH problems to a friend or relative, MH provider, or physicians [41]. This is likely due to the values of collective community that emphasizes the importance of perception, in return perpetuating MH stigma.

Latinos

Hispanic/Latino Americans are the largest minority population in the United States. It is a heterogeneous group with intergroup differences and variable immigration journeys to the United States. They do have some common aspects of cultural heritage (language, some religious commonalities through Christianity and Catholicism, and diverse yet convergent common ethnic/racial roots from indigenous, European, and African origins). Common to this group is the core value of familismo, which includes a collectivist orientation focused on the well-being and integrity of the family over the individual. Similar to Asian-American families, this expectation of keeping the family as a central factor in all decision-making contrasts with Western/American cultural values of individualism and independence. Another important core value is that of personalismo, which highly prizes interpersonal skills and relationships.

Though family closeness and good relations with parents have been found to be a resiliency factor for suicidality among Latino males and females more than other female groups, Latina gender role promotes the practice of marianismo (aspiration to the purity of the Virgin Mary), while male children are enculturated to expectations of machismo, which presumes fewer restrictions and greater freedom to navigate the extrafamilial world and more assertiveness. For example, the expectations for daughters of being less assertive and worldly, more nurturing, and helping with household chores and family needs may conflict with the need of peer involvement

and desire for autonomy within the Western cultural context [3].

The immigration and acculturation processes also impact the mental health outcomes of Latino youths. Some families have legal status and immigrate through support of extended families. Other families are trying to escape poverty or political or community persecution. For example, the story of a 10-year-old girl highlights the significance of her journey on her mental health. She ran away with her 20-year-old female cousin from a small village in Guatemala to escape her abusive grandfather and to reunite with her mother living in Massachusetts. They took different buses to get to the border of Mexico. Since they were short of cash, they worked at a restaurant for a month to earn sufficient money to pay the "consultants" who would help them cross the Mexican border. To reach the border, they had an arduous journey to the American-Mexican border that included walking for long hours, taking multiple buses, and stopping to work to earn money. Crossing the American border was physically strenuous since it required walking and crossing turbulent Rio Grande in the dark and with limited water and food. All of this while making sure that they were not caught by the border control. Eventually, this girl was detained by the American government, while her cousin had escaped. It took the government an additional month to locate her undocumented mother. When seen at a MH clinic, she was requesting refugee status due to severe PTSD and MDD with suicidal ideations. This story illustrates how a prior history of abuse and adversity of the journey contributed to this child's hopelessness. Additionally, school was challenging for her because she attended school inconsistently in Guatemala and because she was not proficient in English. She was bullied, experienced racism and discrimination, and struggled to acclimate to American culture; her risk of depression and suicide increases multifold. This acculturative process could be different for different subgroups. For example, a Latino youth from Cuba may not experience as much stress in Miami, Florida, due to the high Cuban-American population and the greater similarity and interconnection between mainstream American and Cuban cultures. Meanwhile, as presented in the case, a Guatemalan youth from small town may experience more acculturative stress if she moved to an area where her native community has little representation. This impact of immigration journeys and acculturative stress on MH outcome is also true of Asian-Americans as indicated earlier. Similarly, as with other populations, acculturation stress, and acculturative family distancing, has been associated with increased risk for depression and suicidality among Latino youth [15, 42]. As with other populations, cultural exposure to mainstream American culture has been shown to increase suicidal ideation among Latino youth and loosen the traditional religious and cultural prohibition against suicide [43].

When evaluating Latino youth, it is important to consider cultural expressions of distress. The term nervios (nerves) refers to a culturally based somatic expression of anxiety or other emotional distress, which is differentiated from more severe pathology. Ataque de nervios is a cultural syndrome which includes somatization and dissociation as well as impulsivity, at times appearing like mania. Suicidal attempts can occur in the context of ataque de nervios, particularly among Latina youth experiencing family conflict [44].

Latino youth are more likely to seek help from informal sources, peers, and family, for depression. If they have undocumented status, they may be concerned about being reported. Additionally, a parent's language barrier may prevent or delay the family from seeking help for the suffering youth. They may also be reluctant to seek formal treatment due to unfamiliarity with the mental health system. All of these result in low MH service utilization by Latino youth [3].

Non-hispanic Whites/Caucasian/ European

Individualism, which is a hallmark value of Western societies and culture, has been strongly correlated with subjective well-being and happiness in cross-national studies. However, individualistic societies tend to have higher suicide

rates, suggesting personal freedom which involves trade-offs and can have both desirable and undesirable consequences. People in individualistic societies are free to pursue individual goals; this can be at a cost to social support on which they rely when they encounter challenges. In many ways, this parallels the work by Durkheim [38] that established the social relationship between suicide rates and higher levels of "anomie."

Eckersley [45] studied cultural correlates of youth suicide internationally and found a strong positive correlation between male youth suicide rates and subjective measures of health, optimism, and several indices of individualism, including personal freedom and control. Correlations between female youth suicide and individualism were smaller, attaining significance in only one instance. Correlations between suicide and other relevant cultural variables – tolerance of suicide, belief in God, and national/ethnic pride – were not significant**.** The analysis of socioeconomic variables yielded only one significant but marginal correlation.

The results of this analysis also show significant positive correlations between trust, optimism, and health.

These findings are suggestive of two views of youth suicidality in the West. One of them is the "island of misery" hypothesis, where the psychological costs of being pessimistic and powerless are higher in societies where most people feel optimistic and empowered; in a society of "winners," "losers" are likely to feel even more isolated and alienated than they might otherwise.

The other hypothesis is that of suicide, and other serious forms of psychosocial disorder are "the tip of an iceberg" of suffering. In particular, there is a striking discrepancy between levels of self-reported happiness and life satisfaction and levels of psychological distress and disturbance among young people. As suicide has climbed, measures of overall subjective well-being suggest a decline among young people, not a rise. Additionally, surveys over 50 years have shown higher anxiety and neuroticism (as well as depression and substance abuse) in youth in the United States. Researchers ascribe the increased anxiety to low social connectedness and high environmental threat, both of which are linked to increasing individualism and freedom and fewer sources of social identity and attachment [45]. These findings may also explain the adverse impact of acculturation by diverse youth into Western culture as they loosen their traditional cultural and social identifications before finding substitute ones in the host culture [43, 45, 46].

Racial Ethnic Disparities and Suicide

Demographic Findings

The demographics, correlations of suicidal behavior, presentation of the symptoms, and risk factors mentioned in the introduction section are mostly based on studies where majority of the subjects are Caucasian. Thus, it is predominately based on cultural factors and health beliefs common to Americans with European descent.

We do have some emerging data on suicidality across the main racial ethnic minority groups in the United States. The biannual CDC Youth Risk Behavior Surveillance System [47, 48], which surveys a probability sample of high school youth in the United States, has been tracking risk factors for injury and illness for a number of years. The latest results and recent trends have been demonstrating the following trends:

1. Persistently higher rates of depression, ideation, plans, and suicide attempts among AIAN youth (with the absolute highest rate of serious suicide attempts among males at 9 %)
2. Increasing rates of depression, suicidal ideation, suicidal planning, suicide attempts, and serious suicide attempts (requiring medical intervention) among Latino youth, particularly Latina female adolescents, with this group often being the highest other than AIAN youth
3. Increasing rates of suicide attempts and serious suicide attempts among AA youth, recently rivaling the rates among Latinos and primarily due to increasing rates among AA males [47, 48]

Table 1.4 Suicidal risk variables across US racial ethnic groups [47, 48]

Suicidal risk variable (percent over last year)					
Ethnic group	Depressed mood (≥2 weeks)	Serious suicidal ideation	Suicidal plan	Suicide attempt	Suicidal attempt requiring medical treatment
AIAN	34.9	20.9	17.4	15.0	4.0
Latinos	35.3	18.8	15.7	11.3	3.7
African-Am	25.2	14.5	13.7	8.9	3.8
Asian-Am	22.9	17.7	13.8	7.8	1.5
Caucasian	28.6	17.2	13.9	6.8	2.1

From other data, we know that completed suicide rates are three times higher among AIAN youth than all other groups [3]. These results point to significant and growing disparities in suicidality among youth of ethnic/racial minority background (Table 1.4).

Risk and Diagnostic Factors

When assessing risk factors, the onset of puberty is associated with an increase in depressive symptoms for non-Hispanic White (NHW) girls but not for AA and Hispanic girls. However, early and late pubertal maturation is associated with increased depression for Hispanic adolescents. This indicates that the difference in cultural meaning of "coming of age" impacts depression differently. The higher observed levels of depression among Hispanic adolescent girls could be related to conflicting gender roles prescribed by Latino culture as compared to American culture. Similarly, there is variability in risk and protective factors for suicide depending on racial and ethnic background. AA youth were more likely to endorse a fatalistic view of life and an external locus of control. Both of these attitudes were associated with poorer school achievement, depressive affect, greater risk of hopelessness, and suicidal behavior. Also, less perceived support from family and nonfamily sources was associated with more severe SI and higher levels of depression and substance abuse among AA youth [49]. Thus, when working with ethnic minority youth, comprehensive care requires inclusion of cultural perspectives to assure appropriate assessment and management.

Anderson and Mayes [50] reviewed internalized disorders among youth and noted that the symptom expression varied by race and ethnicity. For example, AA youth reported increased anger, aggression, and irritability with depression. Comparatively, Hispanic youth endorsed diminished pleasure, decreased energy, low self-esteem, crying, and difficulties in concentration with depression. Asian-American youth presented with sad mood more. Among preadolescent school children, the highest rates of somatic symptoms were reported in Hispanic and Asian-American youth. Somatic symptoms may be a culturally acceptable method to express depression for both Hispanic and Asian-American children because it mitigates mental health stigma and protects from family shame. For example, among boys who subscribe to machismo, expression of internalizing symptoms may be a weakness, and expression of somatic symptoms may be more acceptable. Hispanic youth are also taught to place their needs secondary to the needs of the collective group and family; thus, they may be more likely to present with internalizing symptoms.

Treatment and Service Disparities

Cultural views, such as health beliefs about mental illness and stigma toward MH treatment, can influence treatment-seeking behavior. Help-seeking behavior is dependent on what is the cultural meaning of suicidal behavior and to the extent that is tolerated within the cultural group. In some cultural groups, suicidal behavior may be considered a problem, but the utilization of

care is minimal because of the MH stigma [3]. To illustrate, a bright 22-year-old Pakistani-American was referred to MH clinic after an occurrence of dissociative amnesia. Upon further assessment, it became apparent that she was depressed for the last 4 years and experienced suicidal ideations intermittently. The family understood these symptoms to be in reaction to the move to America from Pakistan. Thus, they engaged extended family members, increased yearly visits to Pakistan, and increased involvement in the local mosque to address her symptoms. This example highlights how a culturally influenced meaning of the suicidal behavior resulted in seeking support from family and faith community rather than the formal healthcare system. Additionally, MH stigma may have kept the family from seeking formal treatment.

Disparities in MH treatment in adult ethnic minorities and its utilization in ethnic minority youth have been well documented [51]. To be specific, AA girls received treatment at one third the rate and AA boys at half the rate of NHW boys. In a multiethnic high-risk youth group in public care systems, Hispanic youth's first visits occurred at an older age, and they received about half as many visits as did NHW youth [52]. NHW youth were more likely than AA youth to receive more than two sessions of treatment, suggesting differences in adequacy and retention [53]. The National Survey on Drug Use and Health (NSDUH) conducted a nationally representative cross-sectional survey from 2005 to 2008 on non-institutionalized individuals age 12 and older in 50 states. The survey included questions about MH service utilization, perceived reasons for treatment, sociodemographic characteristics, substance use, and other externalizing behaviors. The results showed that 8.5% of 71,183 adolescents experienced a major depressive episode in the year past. Approximately 50% of them received MH treatment during that year. However, minority groups were less likely to endorse reasons for treatment involving internal emotional distress and more likely for treatment involving externalizing or interpersonal problems. AA participants were more likely to receive MH treatment in a school setting [54].

The type of treatment received depending on racial or ethnic background for major depression episode reflects the level of disparity in MH (See Fig. 1.3). When the data pooled from the NSDUH was narrowed to include only 12- to 17-year-olds and was adjusted for lower family income and private insurance, it showed that AA, Hispanics, and Asians received significantly less MH treatment for a depressive episode than NHW [55]. This was also true for receiving prescription

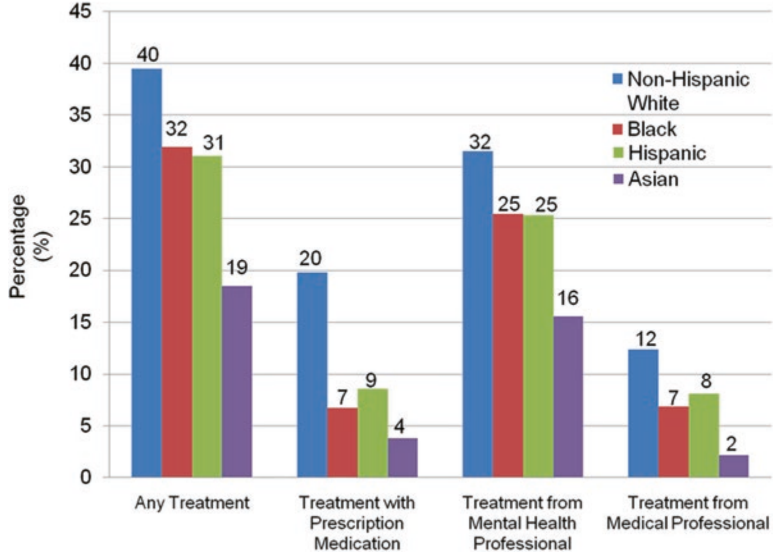

Fig. 1.3 Depression treatment disparities [55] (Reprinted from Cummings and Druss [55], © 2011, with permission from Elsevier)

medication, for receiving treatment from MH specialist or a medical provider, and for receiving any MH treatment in an outpatient setting. Hispanics have approximately 2.8 fewer outpatient visits per year than NHW (13.6 visits per year). Since untreated depression is a risk for suicide, this data is really concerning for minority youth. Stewart et al. [56] suggested that contextual, patient-related, and provider-related factors may explain this disparity.

How Do We Understand These Mental Health Disparities?

Provider variables that are implicated in healthcare disparity among ethnic minority population include referral bias, diagnostic disparities, and differential communication style. Specifically, it has been suggested that AA youth are more likely to be referred to the juvenile justice system rather than MH clinic [57], likely because of cultural differential understanding of the behaviors. In contrast, outpatient treatment is more likely to be recommended for NHW youth. Preconceived ideas and assumptions about MH stigma also result in physicians modifying their approach to minority population. For example, internists and family medicine doctors were more likely to volunteer information about antidepressants to NHW than Hispanic patients. Also, NHW patients received higher-quality technical, interpersonal care, and more positive talk compared with AA and Hispanic patients [58]. Due to the poor rapport, saliently, this may furthermore contribute to medication nonadherence and lack of follow-up by minorities.

Contextual variables that affect the care of ethnic minority youth include economic circumstances, availability of services, and lack of services in native language. Ethnic minority groups are more likely to have low socioeconomic status, which is linked with adolescent depression. Also, when facing poverty, families are likely to prioritize their other basic needs more than MH. Thus, it is likely that there is higher prevalence rate of depression and suicide among this group. Families of ethnic minority youth are more likely to have limited financial resources and thus have limited access to appropriate psychiatric care and healthcare insurance. Even when controlled for health insurance and education, there are discrepancies in the quality of care that they receive. Often there are limited services in areas where minority population are concentrated so, they may have to travel for a longer period incurring the cost of transportation. Knudsen et al. [59] indicated that even if the treatment center were in the minority neighborhood, the quality of service is significantly lower; for example, the availability of selective serotonin reuptake inhibitors in substance abuse treatment centers was inversely associated with percentage of AA and Hispanic patients. This is true even after health insurance and socioeconomic status were controlled. However, this association was not true when parents were able to communicate in English. Unfortunately, involvement of bilingual providers does not correct the low adherence rate among minority population, indicating the presence of other barriers causing low utilization of the services.

Since contextual variable alone cannot explain the low utilization of MH services, Stewart et al. [56] reviewed contribution of patient variables. Ethnic minority youth are more likely to be underdiagnosed because the screening tools and tracking measures have been developed and normed on middle-class NHW samples. These screening tools may overemphasize psychological experience and underemphasize somatic complaints, which are more likely to be the presenting symptoms for non-Western cultures [60]. Ethnic minority groups differ significantly in how they pursue services and even what they perceive as mental health problems [61]. Morrison and Downey [62] found that very low numbers of ethnic minority clients disclosed suicidal ideation prior to an in-depth assessment at a university counseling center.

Fabrega et al. [63] examined intakes in an outpatient clinic over a 7-year period and concluded that NHW youth showed higher levels of pathology except for social aggression. Social aggression was more present with higher levels of symptoms among AA youth. This indicates that

NHW interviewers were better able to elicit internalizing symptoms from NHW adolescents, and they were particularly uncomfortable with interpreting social aggression. Kilgus et al. [64] similarly found diagnostic disparities that suggested AA youth were underdiagnosed with comorbid depression and anxiety, while they had similar levels of diagnosed conduct disturbance as NHW youth. When identifying ethnic differences in adolescents starting treatment of depression, Stein et al. [65] noted that interviewers rated minority youth with more severe behavioral symptoms. This indicates that NHW interviewers had more difficulty interpreting the cultural cues of minority adolescents. Alternatively, it is also possible that minority youth experience more severe symptoms. The underreporting of internalizing symptoms by AA adolescent boys may also confound timely diagnosis, severity of symptoms at initial presentation, and treatment. This underreporting could be related to cultural expectation of AA male youth to not talk about their internal experience. Ethnic minorities reside more in inner city area where exposure to chronic trauma is common, which may not be easily recognized as depression.

Families' cultural beliefs about mental illness, its causes, symptoms, coping styles, avoidance of stigma, treatment, and mistrust of professionals (both from adverse historical experiences and cultural unfamiliarity) impact low MH service utilization. The parents of minority youth were less likely to endorse a biopsychosocial model as an explanation for mental illness, relying on traditional beliefs and explanatory models. When analyzing Hispanic and Asian-American youth, parental acculturation partly mediated the disparities in MH service use [66]. When the parents accept the biopsychosocial model, which may be indicative of level of acculturation, they are more likely to engage in treatment. If they attribute the symptoms to negative influence of peers, there is negative association with MH service use [67]. Additionally, the parents may have higher tolerance for symptoms; for example, the parents of AA adolescents who did not receive adequate care also did not believe that they needed MH treatment for an emotional problem [68]. When adult AA and Hispanic patients were asked about treatment of depression, they were less likely to indicate that antidepressants were acceptable which indicates low acceptability of treatment. They also believed that the antidepressants are addictive and that they were not effective. AA patients also believed that counseling arouses "too many bad feelings like anger and sadness" and that "prayer can heal depression" [69]. Thus, the treatment was not noted to be helpful. Hispanic and AA parents did not prefer active treatment for children; instead, they preferred "watchful waiting" and counseling [70]. And Hispanic families prefer prayers and use of traditional services to treat health conditions; for example, they would prefer self-help groups, peer counseling groups, counseling from clergy, and alternative healers. This indicates that how ethnic minority parents conceptualize severity of MH and appropriateness of treatment directly impacts the utilization of treatment.

Another factor that impacts MH service utilization and its effectiveness in minority population is adherence to treatment. For example, monolingual Hispanic and AA patients had lower medication adherence rates than NHW [71]. This was true even if there were bilingual providers. One of the reasons for low adherence could be low health literacy among minorities. Also, due to genetically mediated polymorphisms for enzyme metabolism of medications, ethnic minority populations may not respond as well to pharmacological treatment and have higher likelihood of adverse effects which can be deterrent to follow through with the treatment [7].

Conclusion

Due to the changing census in US population and rapidly increasing minority group, it is important that the MH clinicians prepare themselves to address diverse youth's suicidal behavior. The diverse youth may present depression and suicidal behavior differently than that of NHW youth. It is likely that the risk factors, protective factors, and expression of distress are influenced by cultural factors. Similarly, assessment, pre-

vention, and intervention will need to be in the cultural context in order for it to be effective. Though there is limited research on suicidal minority youth, this book is to prepare and guide MH clinicians to provide care to seriously troubled diverse youth and families. The next chapter provides a general approach to assessing minority youth. The following chapters are case based and focused on specific subgroups highlighting the unique cultural context, stressors, and needs of the group. These chapters are written by experts and pioneers in the field and present clinical guidelines for treatment. The last chapter focuses on family and community prevention for suicide in diverse youth.

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2 Culturally Informed Treatment of Suicidality with Diverse Youth: General Principles

Neha Sharma and Andres J. Pumariega

Introduction and General Principles

The USA faces rapid demographic changes, with an increasingly multiracial and multiethnic population, especially among its youth. These changes largely result from three main factors: low birth rate and progressive aging of its European-origin population, higher birth rates and lower mean ages in non-European minority groups, and a significant rise in immigration from non-European regions (including Latin America, Asia, and Africa). Somewhere between the years 2042 and 2050, European-origin Americans will no longer be the numerical majority; this will happen before 2020 among children and youth younger than 18 years and is already true among 7- to 8-year-olds [1]. These growing populations of children are very diverse in their racial, ethnic/cultural, national origin, immigration background, and socioeconomic makeup. As a group, they are different from the older, European-origin, Caucasian, and largely higher socioeconomic majority population. These changes and differences are highly significant for child mental health services. First, the acceptability and orientation of mental health (MH) services are informed by cultural attitudes, beliefs, and help-seeking practices. Second, the conceptual basis and the majority of the evidence base for psychiatric diagnosis and treatment have largely excluded diverse populations in their development, with resulting questions about its generalizability. At the same time, these emerging populations face increasing levels of MH needs as a result of significant levels of stressors (such as immigration traumas and stress, acculturation stress, discrimination/xenophobia, community violence, and socioeconomic pressures) and their impact on youth and families [2].

Our healthcare system, including the MH system, has generally not been accessible and effective in addressing the needs of these culturally diverse populations. This has resulted in racial/ethnic disparities in health, including lower access to services and evidence-based treatments, and higher morbidity and possibly mortality, than Euro-Americans [3]. These disparities have already expressed themselves around rates of suicidality among diverse youth. For example, the Youth Risk Behavior Survey (YRBS) of the Centers for Disease Control has demonstrated over the past 6 years that Latino

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and African American (AA) youths have significantly higher rates of suicidal ideation and attempts compared with Euro-Americans [4]. In response to these mounting population MH, clinical, and service delivery challenges, the cultural competence of child and family services has become an increasing focus for both clinicians and policymakers.

Cross and coworkers [5] first conceptualized cultural competence as an important element in children's MH services. They defined cultural competence as a "set of congruent behaviors, attitudes, and policies found in a system, agency, or a group of professionals that enables them to work effectively in a context of cultural difference." Child and adolescent MH assessment and services consider differences in normal development and dysfunction in the context of family and greater community influences. However, cultural differences in normality, dysfunction, and help seeking are often not integrated in these considerations, with possible risks to the acceptability, effectiveness, and quality of clinical care as a result. Even clinicians from the same diverse cultural backgrounds as the emerging populations may not be adequately sensitive or skilled to recognize such factors, given the lack of emphasis in their professional training and their lack of awareness of their own personal acculturation process [6]. However, Cross et al. [5] were clear that there would be insufficient numbers of MH clinicians to provide ethnic and racial matching for diverse youth and families given disparities in education and training. Therefore, the goal they set out is that all clinicians regardless of their racial/ethnic origin should strive to develop the qualities to pursue cultural competent treatment and services as our social responsibility (around access to care) and professional responsibility (around quality of care) for the care of this ever-growing number of diverse youth.

Culturally competent MH services are delivered by culturally competent clinicians within the context of culturally competent MH service organizations. Culturally competent clinicians are not only sensitive to and accepting of cultural differences but also aware of their own cultural background and the biases it may contribute to their clinical judgment. They strive to acquire knowledge about the populations they serve, adapt clinical approaches to the needs of their diverse patients and families, and work to bridge the explanatory models and conceptualization of the behavioral or emotional disorder between the family's traditional culture and Western clinical perspectives. Ideally, culturally competent clinicians should practice within organizations and systems of care that support principles of cultural competence, including valuing and adapting to cultural, ethnic, and religious diversity; understanding and managing the dynamics of cultural differences and power differentials; institutionalizing cultural knowledge through training and education; and adapting policies and procedures to better serve diverse families, accounting for unique characteristics such as their socioeconomic level, level of acculturation, and experience with the service system. Such organizations should develop expertise and policies responsive to the cultural values and needs of the full range of populations and communities they serve [5–8].

Pumariega et al. [9], in the Practice Parameter for Culturally Competent Child Psychiatric Care of the American Academy of Child and Adolescent Psychiatry, applied cultural competence principles to the clinical care of children, youth, and families and outlined detailed recommendations in child and adolescent MH care. This is the first practice parameter in medicine addressing cultural factors in diagnosis and treatment. The key recommendations include:

- Evaluating and addressing barriers (economic, geographic, bureaucratic, insurance, cultural beliefs, stigma, etc.) that may prevent obtaining mental health services
- Evaluating children and families in the language they are proficient in and providing linguistic support services that are objective and professional, not relying on informal

interpreters, family members, and especially not the identified child patient
- Recognizing the impact of dual language competence on the child's adaptation and functioning as a part of the developmental process
- Awareness by clinicians of their own cultural biases to prevent stereotyping or cognitive shortcuts that may interfere with objective clinical judgment
- Awareness by clinicians of cultural differences in developmental progression, idiomatic expressions of distress, or symptomatic presentation and considering these when reaching diagnoses and treatment plans
- Evaluating the history of immigration-related and community trauma (warfare-related or terroristic violence, abuse, domestic violence) experienced by the child and family and approaches to addressing them as part of treatment
- Evaluating the level of acculturation, acculturation stress, and intergenerational acculturation family conflict and addressing these as part of treatment
- Making special efforts to engage family members and key members of traditional extended families (such as grandparents or other elders) and maintain a family contextual focus in assessment, treatment planning, and treatment interventions
- Evaluating and incorporating the family's cultural values, beliefs, and attitudes in treatment interventions to enhance the child's and family's participation in and effectiveness of treatment
- Treating culturally diverse children and their families in familiar settings within their communities and avoiding out-of-home placements whenever possible
- Supporting parents in developing appropriate behavioral management skills consonant with their cultural values and beliefs
- Preferentially using psychological and pharmacological interventions with evidence for the ethnic/racial population the child and family belong to
- Address ethnopharmacological factors (pharmacogenomics, dietary, use of herbal cures) that may influence the child's response to medications or their experience of side effects, as well as providing psychoeducation and culturally appropriate consent (including from elders and family decision-makers) about pharmacotherapeutic interventions

Culturally Informed Assessment of Suicidality

For culturally diverse youth, one must evaluate the cultural context for suicidality as part of the overall evaluation of suicidality. There are two scenarios to be considered: post-suicide attempt and pre-suicide attempt. Regardless of either scenario, it is important to identify the culturally related factors related to suicidal thought or behavior. Precipitating factors can include acute losses related to immigration (such as family separations such as from a parent, inability to return for an ill or dying relative, family conflict over intimate relationships such as a boyfriend or girlfriend, lack of support or validation over ongoing abuse by a family member, and fear of their coming to attention of law enforcement), xenophobic bullying by peers, lack of acceptance or validation over sexual orientation, loss of face over not meeting family expectations for achievement or success, etc. Sustaining culturally related factors can include acculturation stress, family or youth separation margination from mainstream culture, gender role conflicts for females in culturally traditional families [10], immigration trauma, historical trauma (American Indians (AI), AA, and immigrant groups that have undergone genocide or oppression/persecution), and peer culture influences (dissonant form traditional values and upbringing). Berry's model of acculturation and assimilation is further explained in Chap. 3 by Drs. Al-Mateen and Rogers. Clinicians should also evaluate for protective factors, such as cultural taboos about suicidality in traditional culture (usually weakened/questioned; though those can be the source of guilt or shame

and be precipitating factors), and family supports (though those can be weakened due to family acculturation stress, socioeconomic pressures, and impact of trauma on family members). As part of the assessment, it is also important to elicit cultural and religious beliefs about suicidality, death and the afterlife, and spirituality.

Such information can be integrated into the DSM 5 Cultural Formulation [11] as an organizing structure to understand the interaction of suicidality and culture and can guide the clinician on how to develop an effective intervention plan. The DSM Cultural Formulation covers the following domains:

- *Cultural identity of the individual* (racial, ethnic, or cultural groups; involvement with the culture of origin versus host culture, religion, socioeconomic status, migrant background, and sexual orientation)
- *Cultural conceptualization of illness* (influence of cultural beliefs on experience, conceptualization, and expression of symptoms; includes cultural syndromes, idioms of distress, explanatory models of illness, emotional norms, perceived severity, meaning of distressing experiences, and methods of coping)
- *Psychosocial stressors and cultural features of vulnerability and resilience* (key stressors and supports in the sociocultural environment, such as religion, family, and social supports. Modulated by cultural interpretations, family structure, developmental tasks, and social context; level of function, disability, and resilience in the context of the person's cultural group)
- *Cultural features of the relationship between the individual and the clinician* (dynamics of difference based on cultural, socioeconomic, language, and social status that may cause differences in communication and influence diagnosis and treatment. Includes experiences of discrimination and racism that impact on trust within the clinical encounter, problems in eliciting symptoms and misunderstanding their cultural significance, and difficulty in therapeutic alliance)
- Overall cultural assessment summarizing the implications of the above aspects for diagnosis, plan of care, and other clinically relevant issues

The Cultural Formulation Interview and its Child and Adolescent Module [11] can be useful tools to elicit the information necessary to complete the Cultural Formulation for suicidality with diverse youth. Additionally, Arthur Kleinman's explanatory model approach and interview questions can facilitate discussion about suicide and depression with families from different cultures [12]:

- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you?
- How severe is your sickness? Do you think it will last a long time, or will it be better soon in your opinion?
- What are the chief problems your sickness has caused for you?
- What do you fear most about your sickness?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to get from treatment?

A culturally informed safety assessment is critical in working with suicidal diverse youth and their families. The interview process with diverse youth and families for eliciting information or insights about suicidal ideation (SI) or attempt (SA) requires special attention beyond the usual clinical (presence of psychiatric symptomatology) and safety risk assessment, such as with a tool as the Columbia-Suicide Severity Rating Scale (C-SSRS) [13, 14]. Diverse youth are more prone to sharing SI or the motivation for an attempt with the clinician than with family members, especially since they are typically not encumbered by the impact of the stigma of suicidality as their parents or elders are. A nonjudgmental approach as with any suicidal youth is important but also overtly expressing validation for their predicament vis-a-vis their family (especially if they fear rejection or lack of validation

due to stigma). At the same time, open and frank discussion about safety concerns is including where possible a safety contract that includes the family. This is especially important to be able to return the youth to their home if this is clinically feasible for community-based follow-up. It is also important to provide reassurance to the youth that you will support their discussion with their family so that family members do not retaliate negatively against them and can provide them nonintrusive support if they experience the recurrence of SI.

Family members, on the other hand, may interpret suicidality in various nonclinical or safety-related ways, such as rebelliousness by the youth against the traditional family (including limit setting), becoming contaminated by dysfunctional Western ideas and values, or lacking in sufficient devotion to their traditional faith. The clinician needs to be aware of, elicit, and address such perceptions and also investigate family and cultural stigma about suicidality. He/she should also evaluate for associated family dynamics, such as acculturative family distancing (AFD) [15, 16] and their impact on the youth's SI or behavior, and family reactions that can trigger or aggravate such. The clinician also needs to maintain objectivity so as to experience and express empathy toward the family facing such a critical situation as well as the youth, helping them deal with their distress and overwhelming experience, including with the unfamiliar clinical and cultural context of the experience. This may mean dealing with denial; anger at their child; shame over the youth's behavior or ideation; fear of rejection by extended family members, elders, and ethnic community; and sense of isolation in an unfamiliar culture or community. In many traditional cultures, behavioral or emotional challenges experienced by the child are perceived primarily as a failure of parental competence, not as being related to biological vulnerability or psychological conflict. In family-centered cultures, parents and elders carry an expectation that they and other relatives should be able to buffer the child from adverse stressors. Deeply held religious and spiritual beliefs may also proscribe strong prohibitions against even thinking about suicidality, much less acting on those thoughts. The taboo against suicidality is so strong in certain traditional cultures (including in the USA until recently) that family members would never acknowledge attempts or deaths by suicide, using many different excuses or euphemisms, also extending even to changing coroners' rulings. This may mean that family history of suicide and MH may be hard to elicit without attention to these issues. These taboos are weakened by the process of acculturation, where youth adopt the values and beliefs of mainstream culture, where suicidality is romanticized [17].

In the wake of a suicidal crisis (expression of ideation or attempt), the clinician needs to facilitate immediate communication between parents and youth. This may involve starting to build an empathic "bridge" between the family and youth, facilitating discussion around the youth's emotional crisis on the one hand and the family's sense of shame and grief. Cultural values, stigma, and perceptions will likely come into focus even at this early stage, and they need to be put on the table for immediate- and longer-term resolution. This may include appropriate use of community crisis services and access to the clinician vs. the traditional approach of keeping sensitive issues within the family (also building a sufficient alliance for such resources to be allowed into the family space) and youth being able to openly discuss suicidal thoughts and ruminations without recrimination or invalidation. The goal is to establish a contract of open communication with nonjudgmental reaction and support and gradual longer-term trust building around safety (i.e., progressive freedom of independent activity and private space). This contract needs to be the foundation of a youth and family safety plan. If such conditions cannot be reached in the context of serious suicide risk (such as a Level 4 or 5 in the C-SSRS) [12], then serious consideration should be given to a more restrictive level of care (such as inpatient admission).

Part of a culturally informed suicide risk assessment may require appropriate linguistic support, especially when family members are not fluent in English and the clinician is not sufficiently fluent in their language. Since such a

critical evaluation requires a high level of understanding of verbal and nonverbal nuances, clinicians should not be overconfident in their command of the family's language and strongly consider the use of a qualified interpreter (being a native speaker may not even offer enough capacity unless the clinician has occasionally practiced in that language). The use of the family's language, even with limited fluency, can help build the alliance with family members. Introducing the interpreter into the clinical scenario requires extra time and attention as well as reassurances of utmost confidentiality. One should make certain and reassure the family that any interpreter is not personally connected in the least bit with the family or their immediate community. The interpreter and clinician should meet prior to the assessment or interview to strategize goals and critical issues to be covered and then meet afterward to debrief. The interpreter should not only be able to translate linguistically but also interpret nonverbal cues and reactions. She/he and the clinician should address parents and family decision-makers such as elders if necessary. The use of family members or close friends (including siblings, distant relatives, etc.) or especially the identified youth should not be pursued to assure confidentiality. However, if the family wishes such supports be available to them as they go through the clinical assessment process, they can be helpful, but should not be relied on for accurate interpretation. Shame, stigma, sympathy, or other emotions can interfere with their objectivity, and their level of command of either language is not assured. Translated written materials can be useful, but clinicians should be sensitive around illiteracy on the part of family members even in their own language, which could be a source of shame and lack of disclosure [9].

Culturally Informed Treatment of Suicidality

There are general approaches that should be used to address cultural factors related to suicidality in diverse youth. From the outset, it is important to address culture and cultural difference with youth and family members as it relates to the therapeutic relationship, confidentiality, boundaries, and expectations from treatment. Those are likely to be different between youth and parent or elders and negotiated separately and jointly. For example, the issue of confidentiality for sessions and information from youth vis-a-vis the family is important given the frequent expectations for open sharing of information from the youth with parents and elders. On the other hand, the clinician may need to clarify the critical safety situations where safety information around imminent risk does need to be shared. The primary alliance with the youth must be preserved but also respecting generational boundaries and parental authority and hierarchy that is traditional to their culture. The clinician needs to frequently address the issue of stigma of mental illness and suicidality so this does not become a barrier for adherence to treatment and communication. The use of cultural consultants (including healers and religious) and family supports from the ethnic community may be very helpful in helping the family accept and address depression or other mental disorders underlying the suicidality in their child, as well as receive overall support for their distress. Continued psychoeducation is the key to helping to bridge traditional explanatory modes for behaviors, emotional distress, or psychopathology with Western concepts for parents and elders [9].

Pharmacotherapy needs to be targeted to underlying psychiatric disorder (depression, anxiety mood stabilization, etc.) and needs to be presented in a manner that elicits the parent and youth's engagement and active decision-making. Ethnopharmacological principles of population/genetically linked metabolic polymorphisms and enzyme inhibition from dietary preferences or use of traditional herbal remedies must be kept in mind around medication selection and dosing [18]. Culturally adapted evidence-based practices (e.g., various forms of cognitive behavioral therapies) and practices and therapies with evidence with the family's ethnic/racial population are preferable [9].

Individual Psychotherapy

Cognitive-behavioral interventions which are present oriented and problem-solving focused have the most research support with diverse youth. They also have the most congruence with the cultural values of most diverse populations. Some cultural adaptation may contribute to the effectiveness of the intervention and enhancing adherence to treatment. Cultural adaptations may include the incorporation of explanatory models from the culture (such as spiritual or interpersonal causation), cultural values (e.g., family centeredness, deference to elders, interdependence, etc.), the use of culturally related idioms or folk sayings that illustrate concepts behind the intervention, translation of written materials, and delivery by someone from the same cultural ethnic racial group. The latter may be the most challenging adaptation given the dearth of diverse MH professionals. Adaptations also need to be congruent with the explanatory model behind the intervention so that the intervention retains reasonable fidelity [19, 20]. Some culturally specific models may exist for given populations that incorporate traditional cultural and spiritual healing practices. The following chapters in this book will outline a range of evidence-based adaptations to culturally based interventions.

In order to ensure openness and engagement in psychotherapy, clinicians should readily address perceived power differential and differences openly rather than allow those to serve as barriers to an open alliance. They should maintain a value-neutral approach both toward the family and their beliefs and the youth's views of them (and their own emerging beliefs/values). Though the classic approach of psychotherapists is to refrain from expression of personal emotions or information, genuine warmth and empathy in the context of professionalism is important to develop a strong alliance with diverse youth and family members. Judicious use of self-disclosure of experiences and affect can be helpful in developing the alliance and illustrating interpretations or concepts, when these are oriented to serve the youth and family's needs (and not the clinician's need to share). It is also important to address culturally based transference or countertransference on the part of the youth or family. Comas Diaz [21] presents an excellent discussion of the various forms of positive and negative transference and countertransference, based both on the different backgrounds of the clinician and patient/family members and the projection of perceptions and unconscious biases that may originate from either or both.

Psychotherapy addressing suicidality needs to be addressing current as well as past stresses and traumas arising from immigration, acculturation, discrimination/xenophobia and related bullying or abuse, and exposure to family or community violence. Suicidality may be the ultimate expression of distress related from such stresses and trauma, particularly when other forms of expression of distress were not attended to and did not lead to any amelioration or conflict resolution. Lack of earlier response may be related to limited family emotional resources preventing response or even outright conflict avoidance around the key issues. In addition to addressing intergenerational conflict the youth may be facing within the family (such as loyalty conflicts around educational or career decisions, expectations for geographic closeness and lack of emotional separation, gender or other role restrictions, etc.), the clinician should also address internal cultural identity conflicts, where youth may genuinely experience discomfort and distress around the differences between their emerging identity and traditional expectations from them. The goal in psychotherapy should ideally be the development of flexibility in cultural orientation and adaptive biculturality, where the youth can feel free to select aspect of both their traditional cultural beliefs/values and those of the mainstream culture.

Confidentiality concerns that may come up as a barrier in addressing some of these issues, including safety issues, should not interfere with family collaboration. Traditional families may expect that the clinician shares all critical information directly with them. The clinician should maintain confidentiality around material and information that comes up in individual sessions. However they should recruit the youth in the goal

of building a base of support in the family and greater understanding on their part of the stresses and distress they face, preventing potentially dangerous isolation. Therefore, the youth should be strongly encouraged to be the one who shares critical information with parents or family members that is important in maintaining support and safety. Only in cases of imminent danger should the clinician breach confidentiality to share such information with parents.

Family Therapy And Family Involvement

A family focus is essential in culturally competent treatments or interventions. The clinicians should demonstrate genuine respect for culturally established relational lines/boundaries and roles within the family. At the same time, he/she should address (AFD) and work on the development of intergenerational empathy to "bridge" the acculturation divide. AFD is the distancing that occurs between immigrant parents and their children due to their differential exposure to cultural values and language. In many respects, a suicidal crisis serves to bring such intergenerational cultural conflict to a head, so it presents an opportunity to address them rather than the default of conflict avoidance. Family-oriented approaches such as Brief Strategic Family Therapy and various adaptations addressing AFD have high applicability to the treatment of diverse youth and their families [22]. As part of addressing AFD, it is important to address gender role conflicts for female youth in male-dominant cultures as well as the conflicts around Lesbian Gay Bisexual Transgender (LGBT) youth within traditional families. Family therapy can also include psychoeducation about the mainstream culture and navigating its expectations versus the expectations of cultural and family traditions. Education about mental illness (particularly depression) and practical support for addressing its impact on the youth and family may also be practically useful in this context.

Intensive community-based treatment services may be necessary initially to stabilize the youth and ensure family and community support. Intensive community-based interventions such as Multisystemic Therapy (MST) [23], Cognitive Behavioral Intervention for Traumatic Stress (CBITS) [24], and others listed in Chap. 12 are preferable to hospitalization or residential treatment whenever safety can be maintained in the home in the evenings and weekends. There are other approaches that can be used to mobilize culturally based community resources, such as reaching out and collaborating with school-based resources, religious leaders, cultural healers, and culturally based community advocates [22]. Home-based services may also be considered for intensive individual and family therapy, but it is important to ascertain if the family gives permission and consent, since in many cultures having nonfamily members in the home can be considered a significant breach of boundaries. Some communities that have a significant ethnic enclave might have ethnically specific programs to serve youth in crisis. Culturally based case management can also be very effective, with case managers who are from cultural community, are able to provide emotional support for family members, and also identify and connect families with informal community supports. The *Promotora de Salud* model is an example of a lay-based community case manager model which originated in border Latino communities and is now used in many underserved communities, with potential for psychoeducation about suicidality [25].

Conclusions

The treatment needs of diverse youth experiencing suicidal crises are unfortunately growing and becoming more prominent as culturally diverse youth become the majority of youth in the USA. We already see the development of significant disparities around suicidality in particular as well as MH services and outcomes for this growing population. The stressors on diverse youth are only increasing heightened discrimination, xeno-

phobia, and policies that marginalize them socially and socioeconomically as segments of the European origin feel threatened by their growing numbers and also feel underserved and marginalized themselves [2].

These challenges must be met at numerous levels. At the clinical level, it behooves mainstream clinicians to become familiarized with the special MH needs of diverse youth and become reasonably competent in addressing them. At the training and educational level, training programs for all MH disciplines, particularly child and adolescent psychiatrists, should emphasize the above-mentioned elements of culturally informed assessment and treatment in didactic and clinical curricula. The AACAP Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training Culture and Diversity Curriculum [26] can serve as an important resource in implementing such training. Services and treatment research to develop and test interventions and establish evidence with diverse populations of youth is just as essential as neurobiological research. Finally, continued epidemiological surveillance as provided by the YRBS [4] is essential to evaluate the population level impact of our services and interventions and ensure that access to effective care is being pursued and accomplished.

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3 Suicide Among African-American and Other African-Origin Youth

Cheryl S. Al-Mateen and Kenneth M. Rogers

Case

Aaliyah is a 15-year-old biracial girl. Her mother is African-American, and her father is Caucasian. Aaliyah self-identifies as African-American; she states she is the only biracial person in her peer group and feels most comfortable with this group. She presents for treatment with a history of chronic suicidality and self-injury. She has had numerous psychiatric admissions with attempted overdoses, cutting, and attempted drowning. She began cutting in the sixth grade when she was 12. She has a history of ongoing auditory hallucinations telling her to kill herself and, in the past, telling her to kill her mother. A year ago, Aaliyah reported inappropriate touching by her maternal uncle at the age of 8 or 9 years old. She presents with her parents to begin psychotherapy after a discharge from her most recent hospitalization. All agreed that she was not doing well with her last therapist. Parents have participated in therapy.

Aaliyah's medical history is remarkable for obesity. Her family history is remarkable for depression in her father, as well as on her mother's side, and obesity.

Aaliyah lives with her mother and younger brother, who is aged 10. Her mother works evening shift, and Aaliyah helps care for her brother after school. She admits that she argues a lot with her mother. They live in a borderline urban/suburban neighborhood; there are gangs near, but she has not been involved in them. She has two male cousins that were often involved in fights at school. One is in the eleventh grade, and the other dropped out and currently is unemployed. One of her female cousins, aged 14 has also engaged in self-cutting in the past. Reports of touching by her uncle were unfounded by child protective services. She avoids him at family gatherings.

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She is in the tenth grade in regular classes. She had earned As and Bs in middle school, but her grades began to drop last year in the ninth grade. Aaliyah grew up attending church on Sundays and Wednesdays with her family. She attended children's church and then youth church as she reached her teens. There were additional activities for these groups, on Saturdays and during school vacation. She participated in service projects through the church as well. In the past 2 or 3 years, she has gradually decreased these activities. Her closest friends have attended the same church as her family. She is not spending time with these friends currently. She is also less interested in chorus and other musically related after-school activities which she was very active in previously. She likes to watch procedural shows on television and had a dream to become a forensic scientist, but she has been unsure about that lately.

Aaliyah was bullied in middle school because she looked different from her peers because she is biracial. She got into fights in middle school, related to the verbal bullying. This is no longer a significant issue in high school as the bullies stopped. She sees a lot of fights at school, and was shocked at one or two situations that were posted on the internet from her school. She has experimented with alcohol and cigarettes.

Aaliyah develops a good rapport with her new therapist. She is able to get her grades back to Cs. She participates in individual and group psychotherapy. She opens up about being bullied. She has two close friends since elementary school that she regains and maintains contact with. Her parents participate in her therapy, but have difficulty understanding why she has such distress. She starts to participate intermittently in youth group activities at church.

Despite active participation in therapy, Aaliyah continues to have intermittent psychiatric hospitalizations. Ultimately, she is admitted to a residential treatment program and is able to work with therapists to recover further information about her sexual trauma, which was more extensive than she originally recalled. She is able to become closer with her mother, as well as other family members on her mother's side. After some time in a specialized school program, she graduates from high school and attends college about two hours from her home.

Introduction

As with all racial populations in the United States, those who self-identify as Black or African-American [1] are diverse [2]. This group comprised 13.3% of the US population in 2015 [3]. Blacks may be categorized as born in the United States or foreign-born. In 2013, 8.7% of the Black population in the United States were immigrants, and it is anticipated that this will rise to 16.5% by 2060 [4]. In some metropolitan areas, the percentage ranges from 15% to 34%, with most living in the Northeast and the South. In 2013, roughly half of these Blacks were from the Caribbean, with the largest percentage from Jamaica and Haiti. At that time, Africans comprised 36% of the immigrant Black population, with others coming from Central and South America [4]. Children from each of these families may have differences in expected behaviors and/or ethnic traditions related to geography and religious and other beliefs, as well as other historical factors. The literature is scant regarding suicide in the US Black immigrant youth population.

In this chapter, we will use the term "Black" when citing literature that specifically uses this term or when referring to the entire population. We will use the term "African-American" when referring specifically to descendants of African

slaves in the United States or when citing literature which uses this term. We will also describe literature relating to Caribbean-Americans.

Introduction to the Population Group

The eighteenth and nineteenth centuries in America are replete with narratives of brutality toward slaves of African descent. Many deaths occurred during this time, and it was difficult to identify which deaths were related to murder, accidental death, or suicide. However, most scholars have determined that the suicide rate was relatively low in African slaves. Instead, slaves were more likely to display rebellion and outward displays of resistance [5].

Religion has been postulated as a reason for the low suicide rate among enslaved individuals. Many slaves were involved in the traditional religions of West Africa and most were exposed to Christianity in America upon their arrival in America. Both religious traditions view suicide negatively. As a result, religious belief served as a preventive measure against suicide among slaves [6]. The narrative that a loving God would eventually end all suffering encouraged slaves to develop tools to manage extremely difficult situations and confront suffering through hope and enduring religious belief that God would end slavery, protect them physically, and eventually provide eternal life [7]. The belief in God often transcended the belief that God would help them, and many believed that this suffering was able to transform character and make them better individuals [8].

Accurate data on African-American suicide rates following slavery is difficult to obtain. This time period was marked by the aftermath of the civil war, reconstruction, and a governmental infrastructure in the South, where most African-Americans lived, that was in shambles. There are not good birth or death records on African-Americans following slavery. The first reliable information that looked at suicide in the United States was during the 1930s [9]. This early data did not include information that was segregated by race, making comparisons difficult. Based on data from the mid-twentieth century, moving into recent decades, it appears that the suicide rate among African-Americans has remained relatively steady for the years that this data has been reported. Recent data has found that the rate has remained at 5.37/100,000 compared to 12/100,000 in the US population as a whole [10].

In 2014, suicide was the second leading cause of death for all individuals from ages 10 to 24 in the United States [11]. There has been a significant decrease in the suicide rate among all youth over the past two decades [12]. Despite the overall rate decrease, suicide remains the third leading cause of death for African-American youth ages 15–24 years [13, 14]. The rate of suicide in Black individuals in the United States is no longer lower than that of European-Americans [15, 16]. In the 1980s and 1990s, the suicide rate for Black males increased dramatically. The suicide rate for African-Americans aged 10–14 increased by 233% between 1980 and 1995 [17].

The seminal article by Charles Prudhomme [18] provided one of the earliest analyses of suicide among African-American males. He found that suicide rates were lower than those of European-American males and suggested that protective factors (living in the South, religious affiliation, and shared community experiences) helped to prevent suicide among this population. Much of the recent research on African-American male suicide has been based on these early theories.

Bridge et al. [19] found that while the overall suicide rate in children aged 5–11 was unchanged from 1993 to 2012, there was a significant increase in African-American children, with a concurrent decrease in White children. Suicide was the 14th cause of death in African-American children from 1993 to 1997 but the 9th cause of death from 2008 to 2012. The rate of suicide in the Caucasian children was 12th (from 1993 to 1997) and 11th (from 2008 to 2012). The rate of hanging and suffocation increased in African-American boys, while the rate of firearm use in suicide decreased in White boys. Overall, from 1993 to 2014, suicide has increased from being the sixth to the fourth leading cause of death in

African-American 10–14-year-olds. It has remained stable as the third leading cause of death in African-American 14–24-year-olds. The peak age of committing suicide in African-Americans is 25–34 (the fifth leading cause of death) and is 45–54 in the population overall as well as in Caucasians (the fourth leading cause of death) [11, 20].

In 2014, the American Association of Suicidology [21] found that African-American females were more likely to attempt suicide; however, 81% of the completed suicides were by males. The ratio of African-American male to female suicides was 4.25:1. Having a mental disorder is associated with the presence of suicidal ideation; however, the risk of suicide attempt is elevated for females even in the absence of a mental health issue, such as anxiety or depression [22]. It is estimated that 4% of the Black teens and 7% of the Black teen females will attempt suicide. The method of suicide does not appear to differ significantly between African-American and Caucasian youth with the leading cause of completed suicide being firearms, followed by hanging and self-poisoning [14, 20, 23]. The most recent data suggest that the suicide rate is increasing among young African-American males for reasons that are not fully clear, but appear to be associated with depression, same-gender romantic relationships, and unmet basic life needs [24]. One study reviewed the National Violent Death Reporting System data from 2003 to 2012 for 17 states to determine characteristics of Black vs. non-Black children compared to early adolescents who attempted suicide. Children who committed suicide were more likely to have attention deficit hyperactivity disorder (ADHD) than adolescents who did so. They found that Black children and adolescents were more likely to die through hanging, strangulation, or suffocation than non-Black youth. They also found that the Black adolescents in this study who committed suicide were less likely to have boyfriend or girlfriend concerns and less likely to leave a suicide note [25].

Many immigrants of African descent are more likely to live in the Northeastern United States, which tends to have higher rates of youth suicide than the Southern United States [23]. A nationally representative sample of African-American and Caribbean youth of African descent youth demonstrated that having an anxiety disorder and living in the Northeast were highly correlated to suicidal ideation and suicide attempt [22].

Many studies related to mental health in the African-American population have largely been done in urban areas, which may not be representative of the US population of African-American youth as a whole. Youth in urban areas are more likely to be exposed to violence and to have a lower socioeconomic status than youth in suburban or rural areas. Furthermore, youth who had lived in violent settings or had less support from a mother figure were more likely to experience symptoms of depression, including increased suicidality [26, 27]. Available research has focused primarily on the behavioral problems in this population, not on depression or anxiety [17]. It has also been noted that studies of youth suicide often do not have adequate samples of African-Americans to provide a clear picture of this population [28].

“Historical trauma” is a term used to describe a collective experience of complex trauma inflicted upon a group with a specific group identity (ethnicity, nationality, religious affiliation, etc.). It includes cumulative wounding across generations as well as during one’s current life span in a group that shares a specific collective experience [29]. The initial definition is related to the genocide and experiences of Native people that distorted their cultural identity, self-concept, and values. The impact of these traumatic events was felt by individuals who did not directly experience them. Historical trauma has been conceptualized as a second-generation psychological trauma.

Historical trauma has been identified as relevant for children of survivors of the Holocaust as well as the Japanese-American internment in California during World War II. Similarly, historical trauma is relevant for African-American descendants – referring to slavery, racism, and discrimination. Racism is harmful to health, and perceived discrimination is a predictor of future psychological distress among African-Americans [30]. Another example

is the Tuskegee Syphilis Trials, in which 600 African-American men with syphilis were neither told of this diagnosis nor treated, in order to observe the long-term effects of the infection. There was no informed consent. They were, however, given free medical care, meals, and burial insurance. This continued even after penicillin became available to treat syphilis in 1947. The experiment lasted from 1932 to 1972, when it was reported in the news. Mistrust of healthcare providers and medical research is an example of the reaction of later generations to the Tuskegee syphilis experiment [31].

Stigma and mistrust are additional factors that are relevant for the Black population. There is often a stigma related to psychiatric disorders and their treatment in the Black population. This may extend to a refusal to consider the use of psychotropic medications. The underutilization of all levels of care appears to be a major issue [32]. Cuffe and colleagues [33, 34] found that African-American youth were less likely to have identified mental health needs and were less likely to receive services than Caucasian youth. They found that both African Americans and females received less treatment than Caucasian males despite having significant symptoms of depression. Of adolescents and young adults hospitalized for a suicide attempt, Freedenthal [35] found that only 37–52% received mental health treatment in the month before the attempt. Forty-seven percent of Black and Hispanic youth (vs. 30% of White youth) were identified as having unmet need. The precise reasons for this are unclear [33]. Additionally, a lack of mental health literacy may result in a refusal to accept a psychiatric diagnosis or to minimize the seriousness of a suicide attempt because of the mistaken belief that "Black people don't do that." Psychoeducation is needed in these circumstances, and collaboration with clergy should be considered.

There may also be a cultural mistrust of government agencies, including social services, juvenile justice, as well as mental health. This relates to historical trauma, as well as personal experiences with discrimination. An example may be seen in parents who believe "that healthcare professionals cannot and will not accurately diagnose their health problems, which necessitates vigilance toward more proactive and aggressive interactions with health professionals to secure adequate care" for their child [36]. There may also be a concern that the Department of Social Services may become involved with the family, risking loss of child custody [36]. Both Cuffe and Freedenthal [33, 35] identified the need for culturally sensitive services, outreach programs, and treatment programs aimed at meeting the unmet need.

Ongoing surveillance provides additional information. The Youth Risk Behavior Survey (YRBS) is conducted every two years among high school students throughout the United States. It includes the following four questions relating to the 12 months before the survey: (1) Have you seriously considered suicide? (2) Have you made a plan about how you would attempt suicide? (3) Have you attempted suicide? (4) Have you attempted suicide that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse? YRBS data confirm that Black or African-American male youth had the highest rate for suicide attempts and attempts that require medical attention [37, 38]. Although there was an overall decrease in considering suicide from 1991 to 2015, there was an increase from 2009 to 2015. The highest rates of planning suicide remain among females. Reports of actual suicide attempts have increased from 7.3% to 8.6% overall and from 6.6% to 8.9% in Blacks. The number of attempts that required medical treatment remained about the same as the previous year's survey in the general population (1.7–2.8%) but increased to 3.8% for Blacks [38].

Pena et al. [39] reviewed 5 years of YRBS data and found that extreme levels of substance abuse and violent behaviors were most correlated with suicide attempts in the past year. In this sample, they noted an overrepresentation of African-American and Latino students in the *low* substance abuse and violent behavior groups. Their conclusion was that this may relate to significant psychosocial stressors such as discrimination, racism, poverty, mental health stigma, and community violence. They also cited the existence of disparities in access to mental

healthcare and cultural perspectives regarding treatment as potential factors. Garlow also found African-American youth less likely to test positive for cocaine or alcohol at autopsy after suicide [40]. Increased substance use may not be a major precursor of suicidality in African-American youth as it is for other populations.

Anderson et al. [41] reviewed 2011 YRBS data to determine whether ethnic minority teens had answered the questions related to suicidality. The concern was that perhaps those who were really thinking about suicide might not share that information, despite the apparent confidentiality of the information, thus resulting in underestimation of suicidality. This concern was valid. About 19% of African-American teens did not answer the question about whether a suicide attempt had been made in the last 12 months [41]. This was significantly more than all other groups and more than the overall rate of 12.3% of students skipping that question. At least 98.6% of all teens answered the question about developing a suicide plan. The authors called for more research in this area, noting the need to be able to guide assessment and interventions. Studies of college students also show that African-Americans are less likely to disclose even imminent existing suicidal ideation [42]. It may be necessary to follow up negative responses to risk assessment questions in this population.

There are three major epidemiological studies that provide information about Black adolescents and suicidality. The National Comorbidity Study-Adolescent Supplement (NCS-A) studied teens aged 13–17 and their parents/surrogate and included African-American, European-American, and others to estimate the prevalence and other characteristics of Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) disorders in adolescents in the United States.

The National Survey of American Life (NSAL) is a nationally representative, household survey of African-Americans and Blacks of Caribbean descent, which is the largest group of Black immigrants in the United States. Cultural traditions in those of Caribbean descent vary from the experiences of those who descended from slaves in the United States. The NSAL found that Caribbean Black males had the highest rates of suicide, with the greatest risk within 1 year of the onset of suicidal ideation. Those who were younger, had less education, and were from the Midwest had increased risk of suicide. The largest protective factor was perceived parent and family connectedness [22].

The NSAL-Adolescent Supplement (NSAL-A) is a study solely of Black adolescents in the continental United States designed to estimate prevalence and other characteristics of DSM-IV disorders in African-American and Caribbean adolescents in the United States. From the NSAL households, 810 African-Americans and 360 Caribbean Black teens, ages 13–17, were randomly selected to complete the NSAL-Adolescent Supplement (NSAL-A) survey. In their report of the findings, African-Americans were found to have a 7.5% lifetime prevalence of suicidal ideation and a 12-month prevalence of 3.2%. Lifetime suicide attempts were 2.7%, and 12-month prevalence was 1.4%. Four percent of all adolescents had attempted. African-American youth were five times as likely to attempt as Black youth from the Caribbean [22].

The risk for suicidal ideation in African-American girls increased with the number of comorbid disorders [22]. The teens' responses to questions about suicidal ideation and nonfatal suicide attempts revealed that attempts may occur up to 10–40 times more often than completed suicides and are important risk factors for future suicide [22].

The National Longitudinal Study of Adolescent to Adult Health is studying over 12,000 diverse students including 1038 middle- and upper middle-class African-American youth with college-educated parents from 1994 to 2018; it is still in progress. US students in grades 7–12 in the 1994–1995 school year have participated in five follow-up interviews to understand biological, social, environmental, and behavioral data to discern factors related to health and chronic disease (see Table 3.1). Findings to date show risk factors that have been identified for African-Americans, Hispanic/Latinos, and White females, including somatic symptoms, a friend's

Table 3.1 Epidemiological studies [22, 43, 44]

Study	Subjects	Relevant findings
National Comorbidity Study-Adolescent Supplement (2001–2004)	10,123 adolescents, including 1953 African-Americans	Non-Hispanic Blacks were less likely to make suicide attempts or to have suicidal ideation [44]. Black girls are less likely to complete suicide
National Survey of American Life Adolescent Supplement (2001–2003)	810 African-Americans, 360 Caribbean Black adolescents ages 13–17	Almost half of respondents that reported a past suicide attempt had never met criteria for a DSM-IV disorder. Suicidal behavior should be screened in all, especially females. Caribbean female subjects had the highest rates of suicidal ideation. Caribbean adolescent males had lowest rates [22]
National Longitudinal Study of Adolescent to Adult Health (1994–2018)	Oversampled middle- and upper middle-class AA youth with college-educated parents. 1038 interviewed from 1994 to 2018 to follow chronic disease	Risk factors for suicide in girls include somatic symptoms, a friend's attempt or completed suicide, and a history of mental health treatment. Risk factors for boys include weapon-carrying and same-sex attraction. Protective factors for both are parent and family protectiveness as well as emotional well-being for girls and a high GPA for boys [43]

suicide attempt or completion, and a history of mental health treatment. Risk factors for all males to attempt suicide included weapon-carrying at school and same-sex romantic attraction [43]. Protective factors against suicide for African-Americans, Hispanic/Latinos, and European-Americans were perceived parent and family protectiveness. Emotional well-being was protective for all females, and a high grade point average was helpful for males. If there were at least three protective factors, there was a 70–85% reduction in risk [43].

Risk Factors

Many of the known risk factors for suicide in adolescents are from studies of generally White, non-Hispanic adolescents [45, 46]. Early adverse events have both a direct and indirect impact on individuals, which contribute to suicidality [47, 48]. Risk factors for all youth include suicide of a friend, history of mental health treatment, somatic symptoms, and being lesbian, gay, bisexual, or transgender (LGBT). Several authors have reported additional risk factors for suicide in African-American youth. These may be societal, familial or individual (see Table 3.2).

African-American adolescents are disproportionately exposed to environmental stressors compared to their European-American peers. These stressors include disadvantaged neighborhoods and exposure to community violence with trauma-related loss of family members and peers. Adolescent African-American males are at increased risk of being educated in poor-performing schools, experiencing family dysfunction, increased poverty, and lack of positive male role models [59]; this disconnection from society increases the risk of psychological distress and suicidality among African-American youth [58]. The negative outcomes associated with these risk factors include suicide, homicide, delinquent activity, and school dropout. Such adverse experiences in childhood are known to lead to chronic physical and mental disorders [60–62]. The societal impact is consistent with the literature on historical trauma. Anthropologists have documented the link between the lowered aspiration to achieve and the self-destructive

Table 3.2 Risk factors for suicide in Black youth [28, 45, 49–58]

Biological	Psychological	Social
May not have a history of depression [28]	Diagnosis of conduct disorder [49, 50]	Racism/discrimination as related? [50, 51]
LGBT [52–56]	Acculturation stress [55]	Acculturation stress [57]
		History of stealing [45]
		History of beating someone up [45]
		Lack of urban societal cohesion [58]

behaviors that is witnessed among too many young African-American males [63, 64].

Willis et al. [58] noted the increase in completed suicides in African-American males aged 15–19 and postulated that this was related to changes in "postmodern society" in urban communities with less social cohesiveness or support and more vulnerabilities: to depression, a sense of helplessness, increased risk of substance abuse, and more accessible firearms. African-Americans are more likely to die from suicide in urban areas [65].

Racism and discrimination are noted as additional significant stressors for African-Americans and related to depression, substance use, and hopelessness, which are all associated with suicidality [51]. Authors have also noted the impact of perceived discrimination as an environmental factor contributing to suicidal ideation in youth [50, 66]. These topics are not typically addressed in the literature [17, 51]. The relationship between experiencing racism and the mental health of African-American youth is evident at as young as three years old [67]. These youth have both internalizing and externalizing behaviors, decreased self-esteem, and increased hopelessness and tobacco and alcohol use [68]. Parents' experiences with racism can cause increased anxiety, depression, and substance use in their adolescents [69]. Racism is more likely to be perceived by children who are from families of higher socioeconomic status [50]. Recently, a study [28] of 722 African-American boys and girls (mean age 10.56 years) assessed experiences with racism, stressful life events, psychiatric diagnoses, and thoughts of death. Each participant was assessed twice over a two-year period. They identified that perceived racism had direct and indirect effect on suicidal ideation as well as thoughts of death. These were related to anxiety as well as depression two years later for both girls and boys. In addition, girls experienced anxiety, although boys did not [28].

Acculturation

Acculturation refers to "the extent to which ethnic-cultural minorities participate in the cultural traditions, values, beliefs and practices of their own culture versus those of the dominant… society" [70]. This concept occurs on a continuum, with "Traditional individuals participating primarily in the practices and beliefs of their culture of origin, and Bicultural or acculturated individuals participating in practices of both their own and the dominant cultures." A person who is assimilated has beliefs and practices primarily of the dominant culture. This person may have gradually changed over time or may never have participated in their own culture. An individual may also feel marginalized from both the culture of origin and the dominant cultures (see Table 3.3). Berry [71] notes that acculturation occurs both on an individual and a group level. Individuals establish an identity as part of society as a whole, as well as to smaller groups within the society. The larger society may be open/inclusive, or closed/exclusive, which impacts the individual's or group's ability to acculturate. Acculturative stress has been defined as "the stress that is associated with cultural adaptation" [72]. Acculturative stress includes the environment surrounding the individual who is acculturating. It is increased by the magnitude of difference between the cultures, additional stressors, and if the society is more exclusive, with

Table 3.3 Cultural identification

Identification/connection with larger society	Identification/connection with cultural group	
	Strong	Weak
Strong	Acculturated Bicultural Integrated	Assimilated
Weak	Separated Dissociated Traditional	Marginalized

Adapted from Berry [71]. © 1998. Reproduced by permission of Taylor and Francis Group, LLC, a division of Informa plc

more engrained prejudice and discrimination. It includes conflicts between language and values of the family and the dominant culture.

Emerging adulthood or transitional age youth ranges from 15 to 26. These youth are in a critical stage of development and have a "heightened risk for excess emotionality, reward seeking, and poor judgment" [73]. A study of youth ages 18–25 [16] identified perceived discrimination and acculturative stress as predictors of suicide attempt history. In a diverse sample of college students, Asian and Black students reported more experiences of discrimination, and Blacks were more likely to have attempted suicide related to acculturative stress. Familial acculturative stress was associated with twice the likelihood of a history of suicide attempt overall. However, Blacks were four times as likely to have a past suicide attempt if there was familial acculturative stress. A study of 969 young adults aged 18–25 found that familial acculturative stress and perceived discrimination resulted in higher rates of past suicide attempts in Blacks compared to Asians, Latinos, and European-Americans [16].

There is a very strong association of suicidality and depressive symptoms in African-American college students who report high symptoms of both depression and acculturative stress, which suggests a potential for increased suicidal behavior [16]. Acculturative stress is noted to occur at a higher level in a state university than in a historically black college and university (HBCU) [74]. Walker notes that typically African-American male college students have higher acculturative stress than female students [57]. This gender difference could be because women are more likely to utilize social supports than men as noted by Utsey et al. [75]. This outcome of acculturation is not seen in European-Americans [72].

Bullying, including cyberbullying, has become a more acute issue in recent years in all populations. Both scientific studies and anecdotal cases seen on the evening news and local periodicals point to a rise in this phenomenon and its impact on suicidal ideation and attempts among teens [76]. In a sample of low-income, African-American youth in grades 5–12, bullying had an impact on depressive symptomatology [77]. Recent studies suggest that there may be more traumatic experiences when the bullying is intergroup [77].

Several studies point to a problematic parent-child relationship as a major risk factor for teen suicide [78, 79]. This may manifest as lack of parental oversight, lack of emotional support, and/or child maltreatment [80]. Parental lack of support has been cited as a major risk factor in numerous studies and may be related to a number of issues, including parental mental illness (e.g., maternal depression), family burden (e.g., caring for an ill child, having multiple jobs), and conflict with the child (e.g., LGBT issues, behavioral issues). Parental conflict that spills over into the parent-child relationship is also a source of significant tension. Each of these issues, whether real or perceived, can have an impact on a vulnerable teen. Predictors of suicide attempt in African-American adolescents include a threat of separation from the parent (parent may threaten to put the child out of the home), insomnia,

neglect, substance abuse, suicidal ideation, and failing grades [81].

Parental mental illness, especially when it culminates with a suicide attempt, increases the risk of suicide in the offspring [82]. Although a significant amount is known about the method of transmission of depression from parent to offspring, less is known about the transfer of suicidal ideation. Much of the family discord that may exist within a family system may be related to mental illness among parents. Because the rates of untreated mental illness may be higher among urban and minority populations, the impact of a mentally ill parent may be higher than for a Caucasian or suburban youth.

The rate of child maltreatment (physical, sexual, emotional abuse, or neglect) in the United States is 9.4 per 1000 [83]. The number of African-American youth experiencing child maltreatment is 14.2 per 1000. This increased rate of maltreatment likely places these youth at increased risk for negative outcomes, such as suicide. These stressors are further complicated when the situation is layered with additional stressors, such as high-crime neighborhoods, poor-performing schools, and poverty. In a study that included a 55% African-American population [80], Miller and colleagues found a strong association between child maltreatment and suicidal ideation.

A 1999-2000 cohort of urban economically disadvantaged African-American and Latino adolescents had risk factors for suicidal ideation of "being female, having basic needs unmet, engaging in same-gender sex, and depression" [78]. The number of youth who had attempted suicide was higher than the general population, with 6.7% of African-American youth in the 1999 YRBS. [84]. Of the African-American study subjects, 8.1% attempted suicide versus only 3.4% of youth in the local area (New York City). (The overall YRBS report was 8.3%.)

A small study of urban, disadvantaged African-American youth aged 12–16 found that girls and boys had the same likelihood of attempting suicide [45]. They also found an increase in suicide attempts in those who had stolen from a store in the past year (2.4 times more likely), hit or beat someone up (5.7 times more likely), or did not get along with their parents (6.4 times more likely). Those who felt that they did not have at least two adults that they enjoyed spending time with were 2.6 times more likely to have attempted suicide. Another study found that depression and conduct disorder were associated with suicide attempts in a sample of African-American adolescent girls [49].

Youth with psychotic disorders are at greater risk of suicide. In a 2012 study of more than 9000 youth with schizophrenia spectrum disorders (SSD), there was an increase in suicide attempts [85]. Further, the risk of suicide attempts was higher in those with psychiatric comorbidities, particularly attention deficit hyperactivity disorder (ADHD), depression, and bipolar disorder [86, 87]. Rates of ADHD are higher in children than in adolescents who commit suicide [25]. Nugent et al. found a higher rate of SSD diagnosis in African-American and Latino children [50], and opined that this may be related to difficulty in differential diagnosis, resulting in overdiagnosis of psychosis, as has been seen in adult populations [88]. Characteristics of providers were not noted in either study.

LGBT Youth

The impact of suicide on lesbian, gay, bisexual, and transgender (LGBT) youth has been the source of increasing interest [52, 53]. While much of the negative social environment that exists for these youth is in the school or community setting, a significant number of youth experience similar levels of stress at home as well. This issue is even more acute in the African-American community where homosexuality is viewed more negatively than within the Caucasian community [54, 55]. O'Donnell et al. [89] found rates of suicidality to be increased in Black and Latino LGBT adults compared to Caucasians in a study including transitional age youth. Thoma and Huebner [56] studied a sample of 276 African-American or biracial LGBT adolescents and found that they had experienced both racial and anti-LGBT discrimination that increased levels

of suicidality. Although Lyon et al. [81] did not assess any correlation to sexual orientation, they did find that parental threats to put the child out of the home were a predictor of suicide attempt. Furthermore, institutions such as the church, which are beneficial in increasing the protective nature of the risk factors in other settings, may increase the negative pressure that many youth feel [54].

Protective Factors

Protective factors may also be societal, familial, or individual. Historically, spirituality, family cohesion, social supports, and religious activities have been considered protective factors for African-Americans against suicide [18, 46, 57, 90–92]. Washington and Teague [93] identified a relationship between spirituality and an unfavorable attitude toward drug use in preadolescent African-American males in an extremely high-risk neighborhood, suggesting that this may be protective against suicide. Orthodoxy, defined as a commitment to core religious beliefs, was identified as the strongest religious protective factor for a sample of over 1000 African-American and European-American teens [94]. Additional protective factors that have been identified include stronger religious beliefs, cultural disapproval, a large support network, and lower alcohol intake [92].

Matlin et al. [46] studied African-American adolescents and determined that family and peer supports were protective against suicide. Family support was most helpful for high levels of depression, and peer support was most helpful at lower levels of depression. Nurturing parents and prosocial peer support are protective factors against the effects of racism, which can contribute to suicide [50, 95]. Feeling connected to the community trended toward helpfulness and was most important at higher levels of depression. Family closeness has also been identified as a strong protective factor [78]. Risk is decreased when the youth experienced and maintained high-quality, positive interpersonal relationships with peers [80]. Price et al. defined developmental assets, "resources that support growing into a responsible health adult," as a protective factor. These internal or external resources include values, attitudes, skills, and supports from individuals or the environment [45]. An example is that strong academic performance is also a protective factor [50].

It has been suggested that ethnic and racial identification is associated with positive self-esteem in Black college students [96]. Although there is not an established relationship between ethnic identity formation and suicidality, it may be protective against suicidality [78]. Strong ethnic identity development may be an important protective factor in more integrated environments [78]. Simply understanding how the adolescent manages environmental stressors is relevant. Passive coping (relying on others to solve the problem) is related to depression and suicidal behaviors [78]. We need to understand more about the implementation and effectiveness of coping strategies, such as active vs. passive styles.

Recommendations for suicide prevention include the use of multiple community resources. In the African-American community, the utilization of the church seems practical, given the long-term importance of this institution [97]. Prevention programs have been developed utilizing the church as a resource, training clergy and lay helpers to identify need and make referrals to community mental health resources [98]. In many cases the faith community and ethnic identity are inextricably linked. African-Americans are more likely to engage with and identify with faith communities than the general population of Americans [99].

Culturally Specific Presentations

African-Americans who complete suicide are more likely to be under the age of 35 and less likely to have a high school diploma than European-Americans [65, 100]. Additionally, African-Americans attended church, exercised, and talked on the phone regularly. These subjects did not verbalize worthlessness, but endorsed a

wish to die [65]. Groves et al. found an increased risk of attempting if a friend had attempted was most pronounced for girls [92]. Available literature identifies that African-Americans who commit suicide are younger and may not have major depression as may be seen in other groups [28, 72].

Pilgrim and Blum [101] reviewed the literature regarding adolescent mental and physical health in English-speaking Caribbean countries (Antigua, Bahamas, Barbados, British Virgin Islands, Dominica, Grenada, Guyana, Jamaica, Trinidad and Tobago, and Saint Lucia) from January 1998 through July 2011. They noted prevalence rates of 50% of adolescents with depression and 15–18% with suicidal thoughts.

Studies of Caribbean youth have found similar risk factors as African-American youth [101–106]. Jamaican youth had a lower rate of suicidality, which correlated with being in a rural area and also with thoughts of harming others [107]. Higher maternal education was noted to be protective against suicidality [108]. Youth with a history of self-directed violence and access to an effective weapon are more likely to attempt [104]. Those with a history of suicide in family or friends are at higher risk [105]. Knowledge of these similarities to African-American youth helps ensure that we are gathering appropriate information in working with diverse Black populations in the United States. Knowledge of differences is also important for the same reason.

African-American youth in urban areas are more likely to come into contact with the child welfare and juvenile justice systems. Many neighborhoods that are experiencing the highest unmet need for mental health services have the least access to services [109]. Therefore, many of the youth that have the risk factors described above never have the opportunity for a thorough assessment by a trained mental health professional. The relative mistrust that many of these youth, especially males, have toward mental health professionals and those associated with the child welfare system, makes assessment and obtaining accurate date more difficult [110]. Even when mental health services are present in many urban neighborhoods with large ethnic minority populations, there are increasing challenges with accurately evaluating, diagnosing, and treating mental health issues [111]. Without adequate treatment for the underlying issues, preventing suicide in this population becomes increasingly difficult.

Diagnostic Considerations

Every youth presenting with the above presentation should have a comprehensive psychiatric evaluation which consists of eight to nine areas [112]:

1. Description of present problems and symptoms
2. Information about health, illness, and treatment (both physical and psychiatric), including current medications
3. Parent and family health and psychiatric histories
4. Information about the child’s development
5. Information about school and friends
6. Information about family relationships
7. Interview of parents/guardians
8. If needed, laboratory studies such as blood tests, x-rays, or special assessments (e.g., psychological, educational, speech, and language evaluations)

In the case of Aaliyah, there are several diagnostic considerations that should be addressed. Unlike many youth, she presents with a stated history of suicidality and self-injury. However, she continues to have numerous suicide attempts which are escalating in lethality. It is important to assess the triggers for her suicidal thoughts/actions and whether these are acute or chronic.

Aaliyah has a family history of depression. It would be important to explore whether there was a family history of suicide attempt or completed attempt. Exploration of parental physical or emotional availability because of the history of depression and obesity, as well as parents living apart, would be important in assessing her risk of suicide. Given that many individuals with mental illness may have family conflict or poor interper-

sonal relations, these areas would need to be explored with her parents.

Like many youth with a history of suicidal thoughts and behaviors, Aaliyah has a history of sexual abuse and being bullied. There is no additional data on emotional abuse or neglect. Given the information that is available, the risk of these incidents is higher than in the general population. It would be important to her for us to look for additional risk factors that place her at risk for harm, including the level of dangerousness in her neighborhood, any added history of being bullied, and the continued use of substances. Her obesity would also be a risk factor and should be explored in the context being depressed and psychotic. Protective factors, such as having a positive peer group or being in a supportive school, should also be explored and optimized.

The presence of depression as well as acute psychosis is a source of risk for Aaliyah. The severity of her depressive symptoms as well as auditory command hallucinations places her at high risk for suicide. It is unclear whether she has been treated with psychotherapy or psychotropic medications. Her treatment history, including a response to these treatments, would be critical in this young lady. Additional clinical concerns would include her known experimentation with alcohol and cigarettes which would need to be addressed as part of a comprehensive treatment plan. The literature stresses the need for a thorough assessment of the nature and quality of parental relationships, abuse history, peer interactions, as well as the presence of depression and other mental health issues [80].

Evidence on Intervention Approaches

A number of promising interventions have been developed to prevent teenage suicide in African-American youth. The need for culturally sensitive and community-based interventions is critical to achieving positive outcomes in this population. Culture significantly impacts help-seeking behaviors and determines the level of engagement with the treatment interventions that are offered [113]. The manner in which the suicidal behavior is perceived will have a significant impact on services that are offered as well as the ones which will be accepted. African-American youth are underrepresented in outpatient mental health services [83]. The reason for this underutilization of services has been a source of speculation with the most prominent explanations being distrust of mental health professionals and cultural insensitivity of providers. The former is driven by a long history of interventions, such as the Tuskegee Syphilis Trials [31, 114]. While many of the youth referred for services have little firsthand knowledge of many of these experiments, many have family members who are more familiar and share knowledge within families and communities.

Many individuals seeking mental healthcare are more adherent with treatment and have better outcomes when being treated by a provider from the same culture or a provider from a different culture who is culturally sensitive [115]. However, many outpatient mental health facilities have a paucity of African-American providers and frequently have providers from different cultures. This is further compounded by the stigma associated with seeking mental healthcare in minority communities [116].

An awareness of, and adapting to, these factors goes a long way in improving the efficacy of treatment. While extensive discussion is beyond the scope of this chapter, the authors recommend the use of the *Practice Parameter for Cultural Competence in Child and Adolescent Psychiatric Practice* [117].

Interventions to address suicidality in the youth have fallen largely into two primary areas: Those focused specifically on suicidality and interventions focused more broadly, but having decreased suicidality as one of the outcomes. Among those focused more broadly is multisystemic therapy (MST), which focuses primarily on delinquency and mood symptoms, but also on suicide in a predominantly African-American population of youth [118]. MST is based on the premise that youth and families can learn to better manage impulsive and delinquent behaviors if provided with a therapist/role model that can help

them work through challenging situations. The MST therapist is provided to the family for several months and is available around the clock to help to deal with issues. Examples include coming to a home to de-escalate a conflict between a youth and family, going to a police station with the parents of a recently arrested youth, and attending a parent-teacher conference with a family to learn better skills for aiding in school success. MST was found to be more successful than emergency hospitalization at treating attempted suicide at a 1-year follow-up [118].

Interventions such as dialectical behavior therapy, mentalization-based therapy, and cognitive behavior therapy have all been used to address mood disorders and suicide in adolescents. A meta-analysis by Ougrin and colleagues [119] was not able to independently verify the effectiveness of these three generalized modalities in decreasing suicide attempts among African-American teens.

The Substance Abuse and Mental Health Services Administration (SAMHSA) developed the National Registry of Evidence-Based Programs and Practices (NREPP) as a repository of evidence-based repository and review system designed to provide the public with reliable information on mental health and substance abuse interventions [120]. The NREPP ratings include the rigor of evaluation studies, the program's impact and size on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework [120]. The original methodology was in place from 2008 to September 2015. In October 2016, a revised system was put in place. Under the new system, each outcome examined by the system is assigned one of the three scores (effective outcomes , promising outcomes , or ineffective outcomes). Three programs were rated using the current criteria. These programs all included a large enough population of African-American youth to determine the effectiveness of the intervention in this population. The outcomes for each of these programs and their outcomes are shown in Table 3.4.

Conclusions

While there are many studies and reports, there is replication primarily in regard to risk factors for suicide in African-American youth. We do not fully understand why there has been an increase in suicide in these youth. While many of the risk factors for suicide are similar between African-American, European-American, and other youth, the unique psychosocial stressors identified include the impact of discrimination, acculturative stress, and other community-related factors. The key protective factors are useful for all youth: parental support, community support, and peer support. The heterogeneity of Black youth has only minimally been addressed in the existing literature. The open questions are complex, including:

1. Precisely, why has the rate of suicides increased?
2. Most race-specific studies on mental illness and suicide have focused on low-income African-American urban youth. Do the suicide risk profiles for suburban or rural African-American youth appear more similar to urban African-American youth or suburban/rural Caucasian youth?
3. Much of the research on protective factors for suicide has been done in the Caucasian population. There are institutions, such as the church, that have shown mixed benefit, but mostly positive for African-American adults. What is the overall effect of the factors in teens?
4. The current bullying literature does not identify racial/ethnic descriptors for the bullies or the victims – what, if any, are the additional factors related to intragroup or intergroup bullying?
5. As we reviewed the YRBS data, we found that numbers are often statistically higher for multiracial children in regard to risky behaviors related to suicide. When will this be explored and addressed?
6. Is there a need for further preventive work, which is difficult without very clear causes?

We look forward to the work that is to come.

Table 3.4 Evidence-based therapies [120]

Program title	Evidence rating (by outcomes)	Program description
Cognitive Therapy for Suicide Prevention	Depression/depressive symptoms	This brief therapy (10–16 sessions) intervention is a cognitive–behavioral psychotherapy program designed for patients who have previously attempted or thought of suicide. It is designed to be provided by individual therapists on a one-to-one basis
	Suicidal thoughts and behaviors	
	Personal resilience/self-concept	
	Social functioning/competence	
SOS Signs of Suicide Middle School and High School Prevention Programs	Suicidal thoughts and behaviors	This intervention is a school-based depression awareness and suicide prevention program for middle school or high school students. The goals are to decrease suicide and suicide attempts by increasing student knowledge and adaptive attitudes, encourage personal help-seeking, reduce the stigma of mental illness and encourage schools to develop community-based partnerships to support student mental health
	Knowledge, attitudes, and beliefs about mental health	
	Receipt of mental health and/or substance use treatment	
	Social competence	
STEP UP (Strategies & Tools to Embrace Prevention with Upstream Programs)	Self-regulation	This intervention is a social and emotional learning-based curriculum for middle school students, ages 11–14, aimed at promoting positive mental health, building emotional competence, and creating a safe school climate
	Social competence	

From SAMHSA [120]

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4 Suicide Among American Indian, Alaskan Native, and Native Hawaiian Pacific Islander Youth: An Unrealized Future

L. Lee Carlisle and Rebecca Susan Daily

Abbreviations

AI	American Indian
AIAN	American Indian Alaskan Native
AIAN/NHPI	American Indian Alaskan Native/ Native Hawaiian Pacific Islander
AN	Alaskan Native
ASD	Autism spectrum disorder
CPS	Child protective services
DSM5	Diagnostic Statistical Manual 5
FC	Foster care
IHS	Indian health service
MH	Mental health
MHP	Mental health provider
NH	Native Hawaiian
NHPI	Native Hawaiian Pacific Islander
PI	Pacific Islander
SA	Suicide attempt
SB	Suicidal behavior
SI	Suicidal ideation
UNESCO	United Nations Educational, Scientific and Cultural Organization
US	United States

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Case

Joey, a 10-year-old American Indian (AI) and member of his local tribe, attempted suicide by hanging. After a brief, acute hospitalization, his tribal school encouraged his mother to have him attend a day treatment mental health (MH) program with integrated school.

Joey presents as an only child of AI parents. His mother found great comfort in her tribal connections, especially when Joey's father died of suicide after suffering from depression, chronic alcoholism, and intermittent unemployment. Mother, a high school graduate who worked in food preparation in the tribal casino, met father in HS but left school to work construction to help support his birth family when his father, who also suffered from chronic alcoholism, left them. Joey's father was financially overwhelmed by having to support not only his own new family but his mother as well.

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Before his father's death, Joey attended public school. There, his behaviors were considered unusual, and the boy, large for his age, quiet, sensitive, and gentle, complained of chronic bullying. He enjoyed weaving, an activity that, in his culture, is not considered feminine. Joey grew up weaving with artists—both male and female—in his community. During mentorship programs, he weaved and listened for hours, but in school, he was distracted, withdrawn, and had poor eye contact, especially with adults. Because Joey's eye-to-eye gaze was below average, the school psychologist questioned if he might have autism spectrum disorder (ASD).

In the early fall, after his father's death but before his suicide attempt, Joey's mother transferred him to tribal school, where she felt he would fit in better and benefit from more cultural connections. But Joey continued to struggle academically and, even there, was withdrawn. Mother knew he was grieving his father's death and considered that normal. Then he started sleeping more, and she had difficulty getting him to school at all. Once there, he would sit quietly or sleep and not participate. He even isolated during recess breaks and struggled to make friends. He did relate well to the teachers when talking of cultural issues, especially when discussing his weaving activities with the elders. This was new for him, since, in the public school, these cultural needs had not been addressed.

Joey and his mother were quite close, and he was rarely alone. While she worked at the casino, he stayed with his mother's friend. After work, around 10–11 PM, she would take him home to sleep. His mother's friend was also AI and married to a European American who supported their children being raised in the AI culture. His mother reported the children in that home were much younger than Joey and looked up to him. Joey helped in the kitchen and in caring for the toddlers.

Joey used to accompany his mother on shopping outings but grew anxious in crowds of strangers and began staying home alone when she went out on short errands. One time, when she returned and called for him, he did not answer. She eventually found him in the bathroom, barely conscious, with one of his father's old belts around his neck and tied to the shower head. When she got him down, he was "talking out of his head" with no explanation for what had happened. His mother, frightened, called 911. She never expected a child, however sad he might be, to attempt suicide. He was admitted to an inpatient unit for 7 days, placed on fluoxetine, and sent home. When his mother refused MH services prescribed as part of his aftercare, Child Protective Services (CPS) were notified and mandated her to engage him in MH counseling. Mother was reluctant. Her reservations regarding MH counseling stemmed from previous experience, in that MH providers never really understood or helped her husband. The outpatient MH provider attempted to develop a safety plan so Joey could return to school, but the tribal school felt they did not have the resources to keep him safe and referred him to a local, elementary age, day treatment program for school and MH services.

Introduction to Population Groups

AIAN youth of the twenty-first century are among the first generations in over 500 years to see their numbers increasing as a percentage of the overall population. At 2% of the United States (US) population, they make up 8.4% of foster children, are arrested at three times the national average, and account for 79% of federal incarcerated youth [1]. Fifteen percent are involved in

gangs, and they rank third in rate of victimization. With over 1.6 million AIAN youth under the age of 18, suicide has become a leading cause of death, and awareness of its risk factors has become a critical concern [2].

In contrast, NHPI youth have a more mixed history. The Pacific Islands include over 7500 islands, of which about 500 are inhabited, with 22 countries or territories covering approximately 15% of the world's surface. Topography ranges from mountainous with highly diverse natural resources to flat, 1–2 ft above sea level with a minimal variety of resources. With only 0.1% of the world's population yet one-third of the world's languages, this is an exceptionally diverse cultural region [3, 4]. Population density varies dramatically from nation to nation and island to island with some islands (Ebeye of Marshall Islands, 9614/sq. mile) [5] having extreme density and others (Pitcairn, 25/sq. mile) extremely low density [6]. Over 54% of the growing population is under 24 years, most living in extreme poverty with few economic or social prospects [7]. Adoption and fostering of children is a tradition among many of the PI nations, which provides for population and resource management as well as broadening the genetic pool [8, 9]. The larger islands have active foster care (FC) with the same drop in the number of NHPI children in care in the USA (down 33.9% as of 2012) as seen with other FC ethnicities over the past decade [10]. While larger islands such as New Zealand and Hawaii have juvenile justice systems and CPS, most of the island nations have little to no youth specific services. PI accounted for 6% of juvenile justice contacts in Hawaii in 2011 [11]. When youth from small Pacific Islands are sent to further their educations off island (USA, Australia, New Zealand, etc.), they frequently move from close-knit communities with strict traditional approaches to discipline and high expectations of success to fairly unsupervised societies where they often struggle with drugs, alcohol, and legal infractions. This leads to shame for the whole family, sometimes with physical punishment, blame for failing, and shunning of the youth. Tokelau territory reviewed suicides over 25 years and found 83% were under 25 and 67% had been punished by elders prior to the event [7, 12].

NH youth have unique characteristics within their growing population with almost half living off island. The fourth largest ethnic group on their home island, at least 35%, is under 18 and account for over 41.6% of juvenile arrests from 2000 to 2010 in Hawaii [13]. NH youth account for 50% of completed suicides in the state of Hawaii, and almost 40% of those survived known suicide attempts. Seventeen percent of NH high school students seriously consider suicide. The Hawaii Youth Risk Behavior Survey revealed the highest risk among youth in poverty with minimally educated parents, parents on welfare/disability, and/or unemployed [14].

Suicide is the second leading cause of death for American Indian/Alaskan Native (AIAN) and Native Hawaiian Pacific Islander (NHPI) youth ages 15–24 years, sixth leading cause of death for AIAN males [15], and third for all NHPI youth age 10–14 years [16].

Historical Trauma Review

Historical trauma, the cumulative and pervasive emotional and psychological damage from repeated traumatic experiences by a defined group, over generations, resulting in trauma-associated behavior and thinking patterns, is the root of multiple risk factors for self-annihilation among the AIAN/NHPI diaspora and is of particular importance when considering youth suicide. Accumulated traumas and losses contribute to feelings of helplessness, anger, grief, apathy, and a loss of hope or expectation of a better life [17]. A brief review of AIAN/NHPI trauma history follows.

Prior to the arrival of Europeans, the AIAN population was estimated between 54 and 100 million. Within 100 years of European arrival and initiation of colonization in 1492, this number dwindled by approximately 50%. Some tribes disappeared completely (e.g., Island Arawak). Reasons for the dramatic decrease are directly tied to European contact with Europeans using the usual colonization techniques of vio-

lence, deprivation, and displacement with a few twists, including epidemics of diseases to which the Native population had no immunity, enslavement, and forced assimilation [18–20]. Genetic analyses show a dramatic drop in females of reproductive age among AI at the time of European invasion, believed primarily disease related. This combination of events decimated the Native population and disrupted the social structures of their communities [21]. Population continued to decline over the next 400 years until about 1900 when it began to grow again to the current level of about three million. Including all individuals of mixed race no matter the percentage of AI, the number is closer to six million [22, 23].

Europeans used a variety of methodologies to further their expansion and colonization. Alcohol, almost unknown in North American prior to the arrival of the Europeans, was used as a bartering tool and weapon to decrease the sensibilities of the AIAN population, devastating tribal communities with high rates of addiction and violent behavior. European groups formed alliances with some tribes encouraging increased intertribal violence and violence against other Europeans with the introduction of firearms and bounty for scalps. Episodes of genocide (1599, Acoma; 1637, Pequot; 1704, Apalachee; 1837, Miwok; 1864, Sand Creek; and 1890, Wounded Knee) occurred throughout colonization and the westward migration period. Removal from traditional lands (e.g., 1836–1839 Trail of Tears) and resources through treaty, warfare, and massacre were common. Treaties tribes were told were forever lasted only a few years before they were broken or revised. The moral fiber of tribal communities was shredded, leaving a lack of structure, sense of belonging, and a constant sense of loss [24, 25].

Tahiti's first contact with Europeans in 1767 eventually led to becoming a French colony with Tahitian culture falling to the French policy of assimilation [26]. New Zealand was home of the Maori, who had a highly developed culture. First contact in 1642 ended in the retreat of Europeans with the next known contact 127 years later, in 1769, with increasing contact and trade. The Maori became British subjects in 1840 with the Waitangi Treaty and, despite multiple assaults, have managed to retain their cultural identity, traditions, and language [27–29]. The NHPI experienced similar disease introduction, violence, warfare, broken treaties, and loss of traditional rights, lands, and resources. By the late 1800s, annexation as territories was common to many island nations as other countries made land and territory grabs. By the late 1900s, many had gained independence with democratic governments working beside traditional social structures [30].

Ethnocide

"Kill the Indian, save the man:" Colonel Richard Henry Pratt, Carlisle Indian Industrial School [31]. Indian (AIAN) boarding schools were founded by the Bureau of Indian Affairs in 1860 with the purpose of assimilating and civilizing native children to European-based American culture and eradication of traditional ways of life. Children were taken (often forcibly) to boarding schools where they were immediately stripped of everything related to their past life, given a uniform and an English name, and forbidden to speak their native language. Their religious practices were forbidden, and only Christian practices allowed. Disobedience resulted in severe punishment. Lessons included the inferiority of the AIAN culture. By the 1880s, there were 60 schools in the USA [31–33]. These schools were extremely destructive to AIAN culture and were known sites of appalling levels of physical and sexual abuse and high death rates. Children who survived carried these experiences back to their communities, contributing their trauma to the transgenerational load [34].

Assimilation for NHPI varied due to many factors: which other countries laid claim to the islands, existence of plantations or industrial interests on the islands, experiences and results of world wars with subsequent territory changes, etc. As these are islands, land group ownership and use are core to social structure. Within now independent Pacific Island nations, over 90% of

land is still traditionally owned, and cultural traditions of oral histories, land transfer, and social structure are respected. However, on the larger islands with more desired resources, traditional ownership has greatly diminished or been almost eradicated, contributing to the dissolution of traditional social structure. Christian missionaries built churches and missionary schools and converted the majority of the population. Missionaries were core to replacing traditional spiritual practices, mode of dress, social practices, and language with their own Christian versions [30]. Divided by Europeans into three regions, Polynesia, Micronesia, and Melanesia, the 2016 estimated population for PI in the South Pacific is 11.3 million (1.2 million NHPI in the USA) with over 20 distinct cultures, including Samoan, Tongan, Marshallese, and others [35, 36].

Disenfranchised grief is the feeling that no one of the dominant culture acknowledges the loss or need to grieve and, in the case of a conquered culture upon which ethnocide has been inflicted, there is no allowance for grief. Unresolved grief, over time and generations, becomes a palpable sense of shame within the community expressed in anger and depression.

Six Phases of Historical Unresolved Grief for Native Americans

1. Initial Contact—awareness of event shock, genocide events, colonization, new ideas/diseases/substances
2. Economic—loss of resources, loss of place, loss of sustainable living
3. Invasion/War—genocide events, refugee status, loss of leaders/warriors/population
4. Subjugation—confinement, forced relocation, starvation, forced dependence, insecurity, loss of self-determination
5. Ethnocide—forced acculturation, boarding schools, forced religious conversion, destruction of core family values and system, loss of language, loss of cultural knowledge, invasion of person (cut hair, clothing taken, rape, beatings, confinement), discrimination
6. Marginalization—shrinking of reserves, prohibition of religion, acculturative stress, racism/discrimination, loss/diminution of self-government, lack of recognition as victim [37]

Ethnocide, or cultural genocide, was declared in 1981 by the United Nations Educational, Scientific and Cultural Organization (UNESCO) to be denial of the right of ethnic communities to maintain their own enjoyment, development, and transmission of both their culture and their language. In 2004, UNESCO released the “Indigenous Peoples and Cultural Diversity: A Conceptual Outline and Proposals” which gave definitions, scope, policy, and objective recommendations, rights and obligations of governments, and ways to utilize international cooperation and assistance and how to implement recommendations made by the Convention on Cultural Diversity [38]. AIAN/NHPI communities have borne the full brunt of cultural genocide for over 500 years, living with the historical trauma sequelae on a daily basis.

Cultural integrity is the complex whole of language, customs, beliefs, history, and other traditions of a group living with and for each other working toward common goals. A healthy sense of cultural integrity provides a safe environment for an individual within that culture to develop a sense of self, or cultural identity, which is adaptable and flexible. A healthy culture provides the environment an individual need to become a competent individual within the culture [39]. Losing cultural integrity means losing the integral sense of belonging within a culture and of a safe environment within which to grow and exist. The individual’s sense of identity becomes fragile and the community fragmented. As the adolescent begins to perceive this lack, both intellectually and emotionally, they become more at risk of suicide [40].

Within historical trauma occur numerous losses including physical resources (land, minerals, food sources, shelter) and members of the community (leaders, healers, teachers, elders, skilled individuals, historians). Loss of physical resources occurring through forced relocation

leads to poverty (25% of AIAN and 19% of NHPI children live in poverty compared to 13% US nationwide) [41, 42], an inability to sustain/develop community services, decreased nutritional resources with risk of malnutrition, increased chronic disease, inadequate housing/utilities, and, consequentially, increased morbidity and mortality [43]. Leaders and role models died due to war, starvation, and assassination. Forced assimilation through boarding schools fractured the family. Inadequate health and educational resources removed mentors and holders of cultural knowledge in communities where most cultures utilized oral history and social interaction as the traditional method of passing on cultural knowledge. Children lost the holders of their culture's accumulated knowledge and were unable to gain their sense of community pride, language, and cultural identity [44].

The ability of a community to be self-sustaining and perpetuate common beliefs and traditions is the core to community self-esteem. Relocation caused customary farming, hunting, fishing, and other subsistence living activities to dramatically decrease. Employment away from the tribal community has led to families living off the reservations and traditional lands and unable to participate in traditional activities. Community and individual responsibilities to others have decreased, while substance abuse, alcohol use, and domestic violence have increased [45]. This modification of social dynamics and processes has led to intergenerational recreations of loss and low self-esteem [46]. Historical trauma has wreaked havoc on the AIAN/NHPI adolescent's ability to develop a self-identity.

An overview of Maori experience with colonization gives an understanding of this process. Maori traditional society was based on belonging to the land and kinship groups and the giving and redistribution of "wealth" with reciprocal obligation, which literally spread the wealth so the many benefited over the individual. Individual European concepts of individual ownership undermined the social construct with loss of land leading to being disconnected not just from place but from kin, being unable to meet reciprocal obligations and loss of *mana* (spiritual authority, power, influence, validity legal) [47]. Maori had a higher standard of living and life expectancy (about 30 years) than the average European at the time of first contact. Within 130 years, life expectancy dropped to 25 for males and 23 for females, and now they are more likely to have chronic disease and average 9 years less life than Europeans in New Zealand. Assimilation included the Native Schools Act of 1867, compulsory English with Maori language forbidden, and the Tohunga Suppression Act of 1907 targeting traditional medicine practitioners and holders of traditional knowledge [48]. Currently, more than 50% of Maori have a diagnosed mental illness, 25% a lifetime occurrence of substance abuse, and the highest rate for suicide deaths of all ethnicities in New Zealand with 21.74/100,000 in 2015 [49]. Maori trauma with loss of cultural integrity, ethnocide, loss of social and physical resources, and the resultant sense of disenfranchised grief have been devastating to subsequent Maori generations [48].

Risk Factors

The dawn of the twenty-first century has brought into focus the desperate plight of AIAN/NHPI populations where suicide has become a terrible plague. During 2015–2016, multiple Native suicide clusters made headlines. From Standing Rock Sioux Reservation to Bethel, Alaska to Attawapiskat, Ontario, Canada, Native youth are choosing death over life. AIAN/NHPI youth have the highest rate of suicide among all racial and ethnic groups in the USA and Canada. Among the Nunavut (Inuit), 27% of all deaths since 1999 have been suicides [15].

The earliest publications in North America noting the suicide rate among AIAN/NHPI communities appeared in the 1960s [50–52]. By 1974, a wide variety of causes of death, including firearms, strangulation, poisonings, and suffocations (many of which had been listed as accidents), were reported regarding the increased rate of deaths among AIAN tribes [53]. Among NHPI, strangulation was most frequent and drowning least frequent [54]. Researchers have

noted a tendency for young age of suicides, variability of rate of suicide over time [55, 56], and a variance between community settings [57]. The variation has been a focus of interest and appears to be related to several factors, including level of community cohesiveness, integration of individuals into the culture of origin, and level of tribal or ethnic identity and mainstream acculturation [58]. Data collected over the past 116 years has revealed the suicide rate from 1900 to 1955 for 15–24 years old AIAN youth was stable—and equivalent to about half that of all American age groups combined. To become the second leading cause of death in this age group by 1988. Among PI the rate of suicide began to rise in the 1950s with a rapid increase tracking with the breakdown of traditional social structures with the most common precursor intergenerational conflict [59]. This dramatic and devastating increase has researchers seeking risk factors for suicide among AIAN/ NHPI youth.

Demographics

Multiple risk factors are involved in any suicide. A review of basic demographics and history of AIAN/NHPI communities reveals causes for a majority of the stressors facing these youth and their families. The AIAN population in 2014 (US Census) was 2% of the total population or 5.4 million people of either single or mixed race. This percentage is expected to increase to 2.4% by 2060. The majority of AIAN tribal members lived in 15 states with the highest populations in Alaska, Oklahoma, New Mexico, South Dakota, and Montana. The median age was 31.4 years, 6.3 years younger than the median age for the US population overall. Within the 566 tribes recognized in 2015, there were almost two million households, of which 37.8 % represented married-couple settings. Of these, 6% had at least one grandparent living in the home. 84.4% of the Native population 25 years and older had a high school level of education. Upper-level education fell far behind the general population with 18.5% of single-race AIANs holding a bachelor's degree or higher, compared to 30.1% of the general population. Poverty is a significant burden among AIAN communities. The median income overall is $37,227 compared to $53,657 for the general population. 28.3% of AIAN households were living in poverty, the highest rate for any racial group in the USA (poverty rate 15.5%). Unemployment is a major contributor with minimal work opportunities in the majority of reservation settings [60]. Health disparities are abysmally high with death rates for tuberculosis 600% higher, alcoholism 510% higher, and diabetes 189% higher than the general population. Vehicle crashes are 229% higher, injuries 152% higher, and suicide 62% higher. Violence rates are also higher with 1:10 annually above age 12 being victims of violent crime and the rate of aggravated assault about twice the overall rate nationwide [61].

As of 2014, 1.5 million or 0.5% of the US population was of NHPI alone or in combination with another ethnicity. The majority reside in their home state/territory/associated country (Guam, Northern Mariana Islands, Palau, Marshall Islands, Federated States of Micronesia, American Samoa) [62, 63] with a significant portion in California, Oregon, Washington, Utah, Nevada, Texas, and Florida. Over 33% were under age 18 years. Educationally, 88% have completed high school or higher with about 21% having bachelor's degrees or higher and 6.6% graduate degrees. Average income was $55,296 with 18.4% living at poverty level. Over a third of the homes were at least bilingual [64]. NH have the highest infant mortality rate of any US ethnic group, tuberculosis is 15 times higher, and there is a 4.7 times mortality rate from heart disease as compared to all other races in Hawaii [65]. NHPI have a rate of 75% for overweight or obese [66]. Cancer is the fastest-growing killer in the Samoan population and NH having the highest cancer rates among NHPI [67].

Common stressors found in suicidal individuals, i.e., relationship breakups, mental disorders, and addiction, are also present among AIAN/ NHPI youth. Substance abuse starts early and progresses rapidly with a 2014 report showing 8% of 8th grade and 35% of 12th grade AIAN youth regularly using marijuana, while heroin

and oxycodone use were two to three times the national average for the same age range [68, 69]. Substance abuse rates are higher and age of onset younger in NH youth with high levels of associated violence and victimization [70]. Surveyed Maori who had used substances reported about 30% had begun by age 14 or earlier [71]. Subsequent problems with school (truancy, falling grades, failing peer relationships, dropout), legal issues (criminal activity, arrests, detention, violence), and home life (domestic violence, runaway, teen pregnancy, etc.) assist in perpetuating intergenerational trauma. The lack of cultural competency within mental health and substance abuse treatment communities, along with lack of funding, leads to a dearth of appropriate treatment resources for AIAN /NHPI youth.

Culturally Specific Presentations and Symptoms

The idiomatic expressions of distress and unique symptom presentations inherent to Joey's culture had to be considered when forming a therapeutic alliance and plan [72]. *Wounded Spirits, Ailing Hearts* [73], a manual used by the Veterans Affairs for patients with post-traumatic stress disorder (PTSD), is helpful for understanding some of the shared beliefs of AIAN cultures. In Joey's case, the cultural values and beliefs included (1) placing his family and tribe's needs before his own; (2) focusing on today rather than preparing for tomorrow; (3) valuing age over youth; (4) a cooperative rather than competitive stance in groups; (5) valuing humility and patience over assertiveness; (6) having more flexible, overarching rules rather than a rule for every situation; (7) living life less time driven, trusting it will unfold in a way and at a time that are "right"; and (8) honoring intuition and the mysterious with less skepticism.

Studies show that perceived discrimination is a sentinel stressor in the lives of AI youth and a major contributor to drug and alcohol abuse as well as suicide [74]. In public school, both Joey and his family sensed discrimination. His ability to withstand these perceived pressures greatly decreased after his father's death. He became increasingly withdrawn and was transferred to a majority NA school. There, although he received more support, it appeared to be too late. He even withdrew from the weaving classes he used to love. The entire family grieved, expecting to be sad until it was the "right" time for them to move on. In Joey's case they realized, albeit too late, the boy had spiraled downward more than other family members.

Participation in weaving groups led by elders had always been a positive influence on Joey's mood and self-esteem. This type of cultural connection is a common phenomenon in NA youth and is positively correlated with protection against suicidal ideation. When *enculturation*, defined as "the process by which individuals learn about and identify with their traditional ethnic culture," was studied in AI youth, these connections strongly correlated with lower suicidal ideation [74, 75].

Distrust of MH professionals available only through the majority culture inhibited earlier assessment. When studying youth living on reservations, it was found that discrimination and collective trauma were major factors in increased suicide rates [74, 75]. Though Joey did not live on a reservation, we can extrapolate from his experience of living in a closely knit AI family that the memory of historical trauma played a part in his delay of treatment. When CPS were called in, his mother's deeply rooted fears of working with majority-culture professionals kicked in and negatively impacted his treatment. An evaluation of studies that looked at adverse childhood experiences of youth living on reservations, but did not take into account historical trauma and loss, found that the narrow perspective led to a poor understanding of NA youth suicide [76].

Joey's method of suicide is characteristic of AIAN youth, who generally use more violent or lethal methods such as hanging or firearms. Joey's father died of a gunshot wound to the head, and Joey attempted to hang himself. He is also characteristic in that rates of suicide for AIAN are highest among young males. Joey and his father are both in this young male demo-

graphic, for his father was in his early 30s when he passed. AIAN suicides are more commonly alcohol related, and this was the case with Joey's father. Joey, however, was not involved with drugs or alcohol. Tribes undergoing rapid change in their social, economic, and acculturation stress tend to have higher suicide rates [75]. Joey's tribe is in rapid decline, and a large number of European Americans are moving onto their land.

Joey's initial presentation with acute depression and self-harm is a common pattern for AIAN youth. For example, studies with Cherokee youth found they were more likely to receive MH services through the juvenile justice system and acute inpatient facilities as compared with the majority population. This was despite availability of outpatient MH services through Indian Health Services (IHS). Studies of the Northern Plains NA youth show that they rarely used treatment services during their lifetime. The causes are multifaceted, but it has been hypothesized that this is influenced by organizational barriers, bias, and a lower emphasis on MH by the IHS. Difficulty coordinating on suicide prevention between tribal, state, and federal agencies is also thought to also be a major barrier to mounting an effective response to the high rates of suicide in AIAN youth [75]. A study of AN children and adults found that nonfatal cases of suicide were more likely to show warning signs, such as isolation, depression, alcohol use, or a history of suicide deaths in the family. Joey would fit this description due to his signs of isolation, anhedonia, and having had a father who died of suicide. They also found that alcohol use was often a major factor in nonfatal suicide attempts. As younger people were at higher risk for suicide than the older individuals, interventions were recommended to be focused on younger people. They also found a higher rate of suicide among those with a lower level of education. As in many other studies, the need for educational supports to increase academic success and employment is recommended. Joey's educational challenges within the year after his father's death were also signs for his high risk of suicide [77].

Early on in day treatment, Joey was quite shut down emotionally. Suicidal ideation was difficult to assess due to his low verbal output. He never admitted to suicidal ideation but continued to talk about wanting to be with his father. When attempting to fall asleep, he did occasionally talk of visions of seeing his father. He only told his mother and grandmother late in the evenings about his desire to go to his father and help him. These were thoughts he had before his suicide attempt, and mom's intuition was this was part of the grieving process. She explained that, in her culture, this was a common experience. Mother explained that his lack of interest in weaving, increased desire to stay at home, and decreased interest in school work were far more concerning. She felt chastised by the inpatient MH providers, who viewed the visions of his father as key to the boy's diagnosis. Over time, it was born out that she was correct. He still experienced the visions after discharge from the day treatment MH program, though at a lower frequency. The team agreed that his improvement was indicated by an increase in once pleasurable activities like weaving, helping mom around the house, going on errands with mom in the community, and even a gradual increase in academic effort with external rewards of cultural activities he desired. These were consistent with mother's views of what would signal improvement, thinking it would be independent of the visions of his father.

Beliefs in influence between the human and spirit worlds (reciprocity) and that the dead can interact with the living are common beliefs across many AIAN tribes. In Joey's case, he communicated with his father after death, a cultural experience that would not have raised concerns of depression in his family or community. After his suicide attempt, Joey expressed feeling drawn to be with his father and to help him in his reincarnation process. MH providers in his public school were aware of the death of his father and his gradual social and academic withdrawal but likely were not well versed in the cultural cognitions commonly experienced during the grief process. Since there is a belief in reincarnation and that those living can influence what becomes of a loved one's spirit, AIAN youth may perceive a high burden of responsibility for the future of the deceased family member's spirit. This feeling

of responsibility may interact with situational stressors of the living world in a detrimental manner. However, with any cognition there are also protective beliefs to guard against suicide. Many members of the AIAN community fear the spirit world and see life as a gift not to be squandered. Control over one's actions and impulses is a highly valued cultural influence as well [78]. During Joey's hospitalization, the (dominate culture) psychiatrist thought he was having a psychotic process and needed quetiapine. This baffled his mother, further fueling her distrust of the MH system.

Diagnostic Considerations

After the death of Joey's father, his level of isolation, lower academic interest, and eventual lack of production at school supported a diagnosis of depression and a complicated grief reaction. During Joey's treatment, it became obvious he had a high level of cultural identification and, in light of recent research on affective styles and depressive styles in AIAN youth, would require additional evaluation. A study completed of the North American Plains Tribes supported that youth with strong cultural identity have affective styles that are less reactive. The results also support that seeking individual success in a collectivist cultural context of placing the wants of others above one's personal desires increases depressive symptoms [79]. In Joey's situation, even before his father's death, academic goals were secondary to his passion for learning from tribal mentors.

Joey attended a public school where there were no other children who identified with AI culture. For many AIAN youth in urban settings, this is a factor to consider when evaluating depression or ASD, both diagnoses given to Joey. The Diagnostic Statistical Manual 5 (DSM5) criteria, researched and developed primarily with the majority culture in mind, will fall short. In Joey's case, his lack of socialization within the majority culture school, monotone speech, limited range of emotion, and low eye-to-eye gaze appear to be the major reasons he was thought to have ASD. When observed in a group led by the elder weavers, he presented similar to other youth.

Although frequently bullied at school—usually with some allusion to what the other children thought of as "war hoops" or requests to perform an "Indian" dance—he rarely complained, even to his family. In the AI community, he was considered a shy and thoughtful child. After his father's death, Joey became isolated and appeared to others emotionally shutdown. These behavioral changes brought him to the attention of the school psychologist who began an evaluation. The assessment, however, did not begin until Joey was already suffering the effects of a complicated grief reaction, which is not a good time for diagnosing developmental disorders such as ASD. During his psychiatric day treatment program, he improved and was prepared to transition back to the AI school. During that time, no signs or symptoms of ASD were observed. As part of the assessment, he was observed during learning activities, such as the weaving classes, where instruction was in the context of his cultural values, and evaluators could compare him to youth of similar cultural backgrounds [80]. This is a necessary part of a culturally competent evaluation, and as a MH provider, one must be creative in finding the best ways to accomplish this evaluation, especially when the provider belongs to the majority culture. This is also an opportunity for self-evaluation of the provider's own bias, which is a lifelong process [81].

During Joey's acute hospitalization, there were concerns of possible psychotic features as part of a major depressive episode, but as more was learned about his tribal belief system, it became clear that this was a common experience after the death of a loved one. Those left behind are to participate in ceremonies (potlatches), while the life soul is in the land of the dead waiting for reincarnation to reenter the world of the living. The family honored these celebrations, but due to financial stressors and busy work schedules, there was little time to devote to them. Joey was not able to discuss this with his therapist, but after sessions with the mother, grandmother, and/or baby sitter in

attendance, Joey was reassured that he had done everything he could to help his father be reincarnated. This seemed a comfort to the boy. Over time, the dreams/visions of his father occurred less often, and he was less likely to express seeing his father in distress and feeling the need to help him. A better understanding of his culture helped his providers see these experiences from his point of view, and not as a psychotic process. His mother, who allowed antidepressants but not antipsychotic medication, felt validated. Many AIAN tribes, including Joey's, have a history of contact with Christian and Catholic missionaries, which led to suppression of the culture, and potlatch was banned in the USA until 1934. Much of the oral history and many traditions were lost. Those that were preserved were passed down from the elders, and there was a resurgence of interest in the ancient culture in the 1960s. In 1974, a landmark civil rights decision, the Boldt Decision of the US Supreme Court, gave tribes 50% of the fishing rights in accordance with previous treaties dating back to the mid-nineteenth century. For Joey's tribe, like many other AI tribes, this was a part of reclaiming their rightful traditions and identity [82].

Evidence on Intervention Approaches

Barriers to treatment which ultimately resulted in the coercive, CPS-ordered attendance in a day treatment program were assessed. Minority families are not as prone to seek MH treatment and, once in therapy, are less likely to complete the prescribed course [72, 83–85]. In Joey's case, the barriers were understood to be primarily cultural. The mother reported a bad experience with MH and substance abuse providers when they did not meet her husband's needs before he died of suicide. His court-ordered services seemed tailored for Caucasian families, and she did not feel the providers truly understood how important the father's AI identity was, that it needed to be central in his treatment. She had the same concern for Joey. After his mother called 911, Joey was admitted to a psychiatric hospital in which he was the only AI youth. She feared that, like his father, he was headed for treatment that would not consider his cultural needs. She did not follow up with MH services. Instead, wanting to be a better AI mom by giving him more exposure to his tribal heritage, she sought tribal supports to get help for Joey. When the tribal school did not feel they could support his psychological needs, CPS became involved, and, once again, Joey was forced into a program where he was the only AI youth.

Logistical and economic barriers required accommodations on the times of treatment planning meetings and therapy. Special efforts were made to accommodate family members, including key traditional extended family, in treatment [72]. Arrangements were made for the grandmother, mother, and the AI daycare provider/friend to attend as many sessions as possible. The mother and grandmother moved in with each other while he was in the day treatment program, so they would not have to work extra shifts in order to make ends meet. They worked low-wage jobs at the casino in food preparation and housekeeping, working opposite shifts as much as possible. The friend who provided daycare stayed involved and allowed Joey to come when needed so he was never alone. Joey continued to enjoy being a role model for the toddlers in her home. All of these arrangements for Joey's supervision, decided in early treatment team reviews, were crucial.

Mother knew the resources for her husband were culturally inadequate and feared this would happen again with Joey. Aware that this is a common difficulty for patients from underrepresented minorities [86], the treatment team validated mothers' cultural concerns and worked with her, the grandmother, and the daycare provider—all AIs and willing to provide cultural information—to find culturally appropriate treatment goals for Joey. Joey was shy and far less talkative than his family in team meetings, therapy groups, and sessions. He was a quiet participant, but the team could see he was listening. After each meeting, he talked to his mother, grandmother, or daycare provider about the ideas that were suggested.

Once the treatment team earned the trust of his family, they found the answer to the major treatment intervention. Joey's anhedonia, a prominent symptom for the boy, was discussed, and his family put together a culturally relevant activity—weaving—that previously brought him joy and for which he lost interest after his father died. He was encouraged to bring examples of his weaving to school and to share them at show-and-tell. At first, for fear of being made fun of, he did not. He was, however, willing to share his weaving and the work of his mentors with his teacher. She responded with enthusiasm and even met Joey and his family at the art museum to see the weaving of his mentors on display. He returned to his weaving groups but had to complete his in-class school work and homework to earn the classes. The teacher made reasonable accommodations in his work based on his depressive symptoms and gradually increased the amount and difficulty of the work as his depression improved. Eventually, he could share his love of weaving with interested and supportive peers on a one-to-one basis. This is an excellent example of community-based participatory research models for engagement of AIAN youth to improve MH services. Recent research with the Lumbee Tribe of North Carolina, funded by the National Institute of Mental Health, developed a Lumbee rite of passage for suicide prevention model for AIAN youth that was found to be successful. As in the case of Joey, the success of this program hinged on enhanced cultural education rather than specifically targeting suicide. Cultural activities like drumming, dancing, singing, and beadwork promoted enculturation. They found that improvement of self-esteem and social support in a culturally sensitive context led to suicide prevention. The classes were run by Lumbee elders who were considered role models and confidants. Joey gained this support from the elder weavers of his tribe. Additionally, in the Lumbee study, families were engaged in learning the cultural and MH programming provided for the youth. In Joey's case, his mother and grandmother were an integral part of all interventions in the day treatment program and supported his weaving participation [87]. In other research on AIAN youth, interventions that are hoped to be generalizable across communities had limited utility. Many programs have been initiated but have had significant problems with translation, adaptation, and sustainability in AIAN youth populations. The most promising programs at this time are those that collaborate between the indigenous communities and researchers, with a focus on community priorities. It is thought that this collaborative model, engaging both communities, may be a significant part of the effectiveness of the intervention [88]. While there were no such programs in Joey's community, his treatment team, family, and elders created an individualized enculturation plan for the boy. The AI school to which he transferred after day treatment also provided enculturation not just for Joey but for all the youth.

Joey asked for stories about his father. His grandmother and mother came up with many funny stories about him, which Joey liked hearing over and over. Joey never spoke of his father, but in school he journaled about him almost every day. He was happy for the teacher to read them but did not want them read aloud. His teacher gave him academic credit for journaling the stories, an accommodation for his MH and cultural needs. Joey and his mother made a therapeutic goal of making a closer connection to their tribal community central to their lives and honoring the memory of the father through storytelling. A crucial point in Joey's case is that, though he gained benefits from the specialized therapeutic interventions of day treatment, he made little progress until his passion for weaving was discovered—and weaved into his treatment plan.

Joey transitioned back to tribal school where he will be able to attend the rest of his education with peers from his and other regional tribes in a place where Master Weaver classes are a fixture.

Cultural continuity was found to be a protective factor, and promotion of this construct is part of an effective suicide prevention effort. Markers were found that demonstrate a community is making efforts to preserve and promote indigenous cultures. These markers include land claims, health services, self-government, police, fire protection services, education, and cultural facilities. In Joey's case, after the suicide death

of his father, his family was drawn closer to their AI community where many of these markers are present. As he improved, Joey identified with his AI weaver groups and gained comfort from the elder weavers [89].

Assessing risk of suicide is crucial to prevention. In a study of AIAN youth risk and protective factors, death of a friend to suicide carried the highest risk. Somatic complaints, including headaches, breathing problems, stomachaches, anxiety, and concerns about their health, have also been found to be risk factors for attempting suicide in AIAN youth. Research shows that we could do a better job of prevention if those in health care and schools saw these warning signs and screened for suicidal ideation and previous suicidal ideation. Many youth within this group present to a primary care physician or school nurse with a pattern of chronic physical symptoms, especially symptoms for which an organic disease is not found. Joey had a history of going to the school nurse in the public school after his father died and had seen his primary care provider for chronic fatigue and feeling keyed up, especially around school attendance. Additionally, studies show that having a family member who died of suicide is also a significant risk factor for suicide, even when making adjustments for family psychiatric history. By itself, this would have been a reason to identify Joey's increased risk for suicide and to screen and think of adding interventions to increase resilience. Screening for substance use/abuse is also important since this too increases the risk for suicide, even when other factors are taken into account. Joey was only 10 years old and not involved in substance abuse. However, as a youth moves into adolescence, this factor takes on more significance, and screening with interventions when needed will lower suicide risk. Assessing for protective factors is important as well, weighing the risks and protective factors and finding the appropriate level of treatment to prevent suicide. The following protective factors were found to be particularly helpful in AIAN youth: talking out "problems with friends or family, emotional health, and family connectedness." The interventions for Joey focused on finding ways to express his feelings toward others in ways comfortable for him, which were journaling and spending time with his family, friends, and mentors in his weaving group [90].

A concept program for Native Hawaiian youth and young adults based on *kuleana* (responsibility) was put forward. The program would be youth led with participants as the change agents. The goal is for the youth to be part of problem-solving for their community in a "collective action." The program is a derivative of several AINA tribal reculturation-based interventions. It promotes a paradigm shift in perceptions of youth to strength-based, problem-solving that builds on the assets of the existing community. By empowering youth with an ability to critique structures that led to oppression and inequality, the program hopes to lessen the destructive behaviors (interpersonal violence, disruptive behaviors, substance abuse, and suicide) that were bred. The *kuleana* program strived to increase the collective consciousness around decolonization and conscientization. *Conscientization* is defined here as a process in which youth develop the ability to think critically about issues of power in relationship to privilege and oppression in the social structures in the lives of the group members. Further incorporation of community epistemology for NH youth is to create a sense of place within the history of their community, striving to create an understanding of the cultural history and the history of exclusion. This process broadens the youth's view of how the culture and history affect each youth individually and the community at large and moves toward a collective level of knowledge. An understanding of *malama 'aina*—the concept of caring for the land so it can give back all that is needed to sustain ourselves and future generations—helps youth critically think about the structures that created the unhealthy behaviors they seek to leave behind. Seeking *mana* (power) on a spiritual level leads to increased *kuleana* (responsibility) to the land and each other. While this concept/program has much promise, and significant effort was put into developing the framework for it, it has yet to be implemented [91].

There were similar findings in youth suicide within the Inuit of Northwest Alaska, who have

one of the highest rates in the world. To illuminate interventions needed to address the problem, Wexler, through a participatory action research design, studied the Inupiaq culture from the voice of its people. It is felt that by revealing modern colonialism, its forms now more subtle than before, the Inuit may be able to “marshal agency to withstand oppressive structures.” In order to accomplish this, however, they will need to develop a collective identity of the young and old through a “recreation” process. Ideally, this process of forming a collective unity would allow the Inuit youth to better resist oppression and work to prevent youth suicide [91]. This process is similar to the enculturation that was so helpful in Joey’s case and the proposed decolonization in the NH program, *kuleana* [91].

A community-based model of suicide prevention was implemented in a circumpolar indigenous community of rural Yup’ik youth in Southwestern Alaska in which suicide and alcohol were targeted. They used the *Elluam Tungiinun* (Toward Wellness) prevention program. Research in these small, isolated, geographically dispersed communities is difficult because the sample size is too small to have much power. And yet, community-based programs are thought to be promising because, in studies, community-level influences have emerged as having a greater influence on a person’s desire to live than individual characteristics. This is not surprising given the increased value placed on collectivism in this population. The study used three key informants: school, tribe, and city government leader. The intervention revealed an increase in community readiness scores which indicated the community had moved to a more advanced stage on the continuum toward addressing youth suicide and alcohol abuse. Research in these remote communities is challenging, but the need for community-based programs is evident, and results are hopeful [92].

In 2011, Hawaii’s Caring Communities Initiative (HCCI) responded to the disproportionately high suicide rate for its indigenous youth in rural communities and initiated a youth-led, youth suicide prevention program. The program, derived from the evidence-based connect suicide prevention program, strives to adapt to each community’s needs and makes efforts toward cultural confidence. The youth leaders train together and develop leadership roles within their communities, which is beneficial for them as well. This program suggests that evidence-based programs can be effective when grounded in the strengths and needs of the specific ethnic community. Research supports community-based prevention programs for youth that use a youth leadership approach, especially in ethnic minority and marginalized communities [93].

Due to ease of operation and availability of subjects, much research concerning AI youth has been completed on reservations. Joey, however, lives in a small urban area on tribal lands now populated primarily by the dominant culture. Suicide research shows that populations on or off the reservation differ in important ways that could affect the utility of these studies when treating youth from an urban area. There was a significantly lower rate of suicidal ideation and lower rates of psychosocial problems in urban AIAN youth, yet the rates of suicide attempts were not significantly different between reservation and urban living AIAN youth. They had the same rate of depression, sexual and physical abuse, and exposure to suicidal behavior. Reservation youth had higher rates of substance abuse and conduct disorders. In ascertaining the best intervention program to prevent a suicidal attempt, or when treating youth after an attempt, a program must take these differing risk factors into consideration. AI youth on the reservation may need a heavier emphasis on substance abuse prevention and disruptive behavior disorders than urban youth. Joey fit into these statistics well as he had mostly internalizing symptoms and fewer disruptive symptoms [94].

A systemic review of suicide prevention programs for indigenous peoples in the USA, Canada, Australia, and New Zealand revealed that, though key lessons were learned, there is a need for more rigorous research methodology. At this time, it is difficult to recommend which programs are most effective. Future research will more likely give us this answer when the following agencies effectively collaborate and foster a reciprocal process

with free exchange of ideas, knowledge, and practices throughout the process: government, research agencies, health-care providers, and indigenous health-care services. Community-wide interventions targeting risk factors for suicide and similar MH disorders such as alcohol abuse and history of prior suicide attempts need to be designed and implemented in collaboration with indigenous communities. And, finally, research is needed to ensure that data is accurate and culturally relevant by using definitions of health and well-being from the view of indigenous peoples' perspective. The authors stress the importance of using new, experimental designs and warn that using less expensive, more standard types of interventions is unlikely to provide effective suicide prevention. Given what many consider a worldwide epidemic of suicide among indigenous peoples, new, effective prevention interventions are needed now [95].

Conclusion

Suicide among American Indian/Alaska native and native Hawaiian Pacific Islander youth is epidemic. Suicide prevention for this vulnerable group is and will continue to be a major challenge for mental health providers. For the present, as demonstrated in the case study, a better understanding of the specific risk factors for these populations, the cultural and historical contributions to those risk factors, and an awareness that current protocols for evidence-based care regarding youth suicide in general may be insufficient for these indigenous populations. In other words, more research is needed specific to these vulnerable groups to provide the knowledge necessary to be able to clinically target their unique needs. A more culture-specific knowledge base may better help mental health providers care more effectively for this vulnerable group of patients. For the future, cooperation among the varying agencies and governments will be needed to perform the necessary studies and acquire necessary data in order to provide more specific and effective evidence-based care for these specific populations.

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Suicide Among Latino Youth

5

Eugenio M. Rothe and Andres J. Pumariega

Introduction to the Population

Latinos are the largest ethnic group in the United States. Latinos are a very diverse ethnic group within themselves, with indigenous, European, and African origins (stemming from the African diaspora) and many specific nationalities and cultural groups of origin. Latinos primarily speak Spanish, though Latinos originating from Brazil speak Portuguese and many from Central America, Mexico, and some South American nations speak multiple indigenous languages and dialects.

There are currently over 54 million Latinos in the United States (including the Commonwealth of Puerto Rico), comprising almost 18% of the total US population, with 40% of these are foreign-born. Of these, 34.6 million are of Mexican origin, 5.1 million are of Puerto Rican origin, 2.0 million are of Cuban origin, 1.7 million are of Dominican origin, 4.9 million are of Central American origin, and 3.3 million are of South American origin. There are over 42 million immigrants in the United States, comprising 13% of the total population, of which 16.1 million are from Latin America, with 47% of the total foreign-born persons in the United States being Latino [1]. In fact, the United States has the third largest Latino population in the Western Hemisphere, after Brazil and Mexico, and the second largest Hispanic origin population in the Western Hemisphere.

The growth rate of Latinos in the United States (24.3%) from the 2000 to 2010 census was more than three times the growth rate of the total US population (6.1%). In the United States, today, 24% of all children under the age of 18 years are of Latino origin, totaling 16 million, and this number will grow to 36% by the year 2050. Latinos have the youngest age and highest birth rate of all US ethnicities [1]. This means that the health and mental health of the Latino population are extremely important to the overall welfare of the United States.

Epidemiological data focusing on suicide among Latinos appears complex and sometimes contradictory. One and a half decades ago, public health epidemiological literature showed that Latinos appeared to be protected against suicide when compared to White, non-Latinos, and African-Americans, but most of these studies had been done on adults [2, 3]. Surprisingly, also a decade ago, the literature

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suggested a significant acceleration in the rate of suicide among Latino youth, approaching the higher rates traditionally seen among White youth [2–4]. In addition, Latinos age 18 and over are also more likely than non-Latino Whites to exhibit feelings of sadness, hopelessness, worthlessness, or feelings that everything requires an effort [5]. Suicide is the 12th leading cause of death for Latinos of all ages and the third leading cause of death for Latino males ages 15–34. The lifetime prevalence of suicidal ideation and suicide attempts of Latinos of both sexes has been placed at 11.35% and 5.11%, respectively [6]. Among Latino ethnic subgroups in the United States, Puerto Rican adults had the highest rates of suicide attempts. During the decade between 1992 and 2001, the lifetime prevalence of suicide attempts increased significantly among 18- to 24-year-old Puerto Rican women and Cuban men, and among Latinos who reported having attempted suicide at any point in their lifetime, most attempts occurred before age 18.

Suicidality Among Latino Youth

Recent data supports the concern that suicidality is a significant and growing mental health and public health challenge among Latino youth. Over the past few years, the results from the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System (YRBSS) [7, 8] have pointed to a growing risk of suicidality among Latino youth and particularly Latinas. This biennial survey study of US high school youth has demonstrated that Latino youths have the highest rates of depression, suicidal ideation, suicidal ideation with a plan, suicide attempts, and serious suicide attempts (requiring medical attention) than non-Hispanic Whites and African-Americans (except for serious attempts being equal to African-American this year and all exceeded by Native American-American Indian youth). In the 2011 YRBSS, Latinas that had the highest rate of suicidality indicators of all the ethnic and gender subgroups except Native Americans (see Table 5.1 below) who were born in the United States have higher rates of suicidal ideation and suicide attempts than Latino immigrants. Studies have consistently shown that since 1995, Latino adolescent females have higher rates of suicidal thoughts and behavior (but not deaths) than Black or White females [9, 10]. However, a recent study reveals that Latino adolescent girls in the United States currently have the highest rates of suicide attempts in this age group [5].

Latino immigrants who came to the United States as children have higher suicide rates than those who came as adolescents and adults. One study found that US-born Latino adolescents whose parents were also born in the United States have higher rates of suicide attempts than US-born Latino adolescents with immigrant parents [11]. (Also, see section on "Acculturation Stress.")

This chapter will attempt to interpret and explain these complex, and sometimes contradictory findings, and will discuss the risk factors and protective factors, the influence of cultural factors, the diagnostic considerations and the evidenced-based treatment approaches to the problem of suicide among Latino youth. Case material will also be presented to illustrate these points.

Risk Factors

Family dysfunction and lower socioeconomic status have been associated with increased risk for suicide among Latinos [12–17], as well as being a victim of physical and sexual abuse [16, 17]. The use of alcohol and drugs has also been found to increase the risk of suicide among

Table 5.1 Suicidality among Latina youth [6]

Items on the YRBS	Latina females	Non-Hispanic females	Latino males
Serious thoughts	21.0%	18.4%	12.6%
Plans	17.6%	13.7%	11.1%
Attempts	13.5%	7.9%	6.9%
Serious attempt	4.1%	2.2%	2.2%

YRBS, 2011 [6]

Latinos [18, 19], and substance abuse that is comorbid with depression [14] and being a Latino homosexual male also increases the risk [20].

Other factors that may contribute to higher suicide rates among Latino youth may be related to cultural factors, including the fact that in the traditional Latino families, the family needs are placed above individual needs, leaving the adolescent feeling that he or she is without a voice or that deeper personal feelings are not considered. Also, there may be higher levels of stress due to the heavier burden placed on Latino girls to conform to more traditional gender roles and the sense of duty they experience in having to meet their family obligations. In contrast, the family closeness that is often found in traditional Latino families has been found to be a resiliency factor for both, male and female adolescents. Traditional Latino families may avoid seeking the necessary help with a mental health professional, believing that suicide is an issue that should be dealt with in the family or through a faith-based community approach. In addition, language and cultural barriers have been found to prevent Latino families from accessing the necessary mental health services [21].

Acculturation Stress as Risk Factor

Acculturation refers to the process that occurs when groups of individuals of different cultures come into continuous firsthand contact, which changes the original culture patterns of either or both groups. The encounter causes cultural diffusion of varying degrees and may have one of three possible outcomes: (1) acceptance, when there is assimilation of one group into the other; (2) adaptation, when there is a merger of the two cultures; and (3) reaction, which results in antagonistic counter-acculturative movements. Acculturation is a concept that applies to individuals living in communities other than where they were born, such as immigrants, refugees, and asylum seekers [22].

Studies conducted on Latinos support the idea that, for many second-generation Latino adolescents, the acculturative process and associated stress may have negative effects on their mental health. For example, as was mentioned earlier, Latinos born in the United States have higher rates of suicidal ideation and suicide attempts than Latino immigrants. Also, immigrants who came to the United States as children have higher rates than those who came as adolescents and adults [11]. In addition, US-born Latino adolescents with US-born parents have higher rates of suicide attempts than US-born Latino adolescents with immigrant parents [23]. In terms of possible etiological factors that contribute to suicidal ideation and suicidal attempts, a study [24] reported a vulnerability to depression and low self-esteem in Latino adolescents who complained of perceived discrimination. Another study comparing Latino, African-American, non-Latino, and White adolescents [18] found higher levels of suicide attempts among drug using Latino adolescents who experienced more acculturative stress, which included perceived discrimination, perceived poor life choices, language, and acculturation conflicts. A study focusing on suicidal ideation on immigrant adolescents [25] found that 25% of immigrant Latino adolescent high school students in their sample had positive symptoms of suicidal ideation and depression and that these were significantly related to acculturative stress. These adolescents also experienced more family dysfunction and negative expectations for the future.

Pumariega et al. [26] published a comparative study conducted with 4,000 Mexican origin youth who lived on the Mexican ($N = 2{,}000$) and American ($N = 2{,}000$) sides of the US-Mexico border along the lower Rio Grande Valley. That study highlights the powerful influence of acculturation on increasing the risk of suicide. Mexican-born youth with two Mexican-born parents had the lowest rates of past week suicidal ideation (11.3%), followed (in increasing progression) by Mexican-born youth with one US-born parent (15.8%), US-born Latino youth with one Mexican-born parent (22.5%), and US-born Latino youth with US-born Latino parents (24.8%). These results appear to illustrate a continuum of cultural influence on suicidality

which increases with progressive acculturation (see Fig. 5.1) [26].

Additionally, the study found that Mexican adolescents on the Mexican side of the border spent more time supervised by adults and that in the absence of parents, extended family members and other caring adults, such as neighbors and family friends, were always available to them for supervision and support. In turn, Mexican adolescents on the American side of the border spent more time alone at home, watching television, while waiting for their parents to return from work and most of the time did not have access to other adults or extended family members that could assume a supervisory or mentoring role for them. So, this study revealed that cultural variables associated with more mainstream American culture, particularly more independence from the family and greater exposure to the popular media, are associated with higher levels of suicidal ideation, and possibly with increased risk for suicide. These variables maintained their significance while controlling for the level of depression, loneliness, and substance use. In addition, this study also demonstrated that actual suicide attempts were influenced by other more traditional variables including depression, substance abuse, and father absence, with only independence from family remaining as a culturally related variable [26].

More recent studies have continued to highlight the role of acculturation in the increased risk for suicide among Latino youth. Acculturation stress appears to affect particularly Latino girls, who place a high value on family and suffer more tension resulting from the cultural differences they encounter between the traditional family values to which they are exposed at home and those of the mainstream society, and these factors were found to be an important causal factor in suicide attempts by Latino adolescent girls [10, 27].

Acculturation stress also plays out within the Latino family unit. Investigators have identified a pattern recently termed acculturative family distancing (AFD) [28] that results from conflictual interaction between Latino youth and their less assimilated and traditional Latino parents (usually immigrants). These conflicts are results of youth adopting the more liberal value system from the mainstream culture and youth culture, including around sexuality, independence, and individualistic value, as opposed to *familism* and collectivism of traditional Latino cultures. On the other hand, parents retain the values of their traditional cultures and have limited contact with the mainstream culture which increases contrast between school life and home life for Latino youth. Another contributing factor is the limited Spanish proficiency of the younger generation versus the older generation, contributing to linguistic problems in communication. In earlier generations, studies associated AFD with conduct disturbance and substance abuse [29]. However, in recent years, AFD has been found to be associated with depression and suicidality in Latino youth [30, 31].

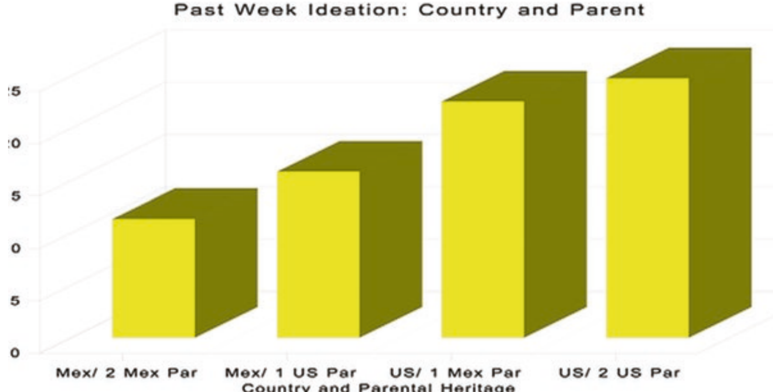

Fig. 5.1 Country and parental heritage and suicide ideation [26] (Reprinted from Immigration and Mental Health [26]. © 2010, with permission from Nova Science Publishers, Inc.)

Other Risk Factors

Perceived discrimination has been found to play an important role in acculturation stress and was identified as a risk factor for suicide among Latino college students [32], and an analysis of suicide notes among Latinos and feelings of alienation from the family, from the society, and from the person's culture has also been identified as a risk factor [33]. In a 4-year analysis of a nationally representative sample, Latino adolescents and young adults had the highest rates of hopelessness and fatalism among all racial/ethnic groups, which may also contribute to helplessness and the contemplation of suicide as a way out [34].

In addition to the culturally related risk factors affecting Latinos, some of the most significant risk factors for suicide across adolescent populations include:

1. Having had a prior suicide attempt
2. Having history of alcohol and drug abuse
3. Having history of mood and anxiety disorders
4. Having access to a lethal weapon or lethal means
5. For individuals already at risk, having had a "triggering factor," such as an event that causes profound shame, relationship problems and breakups, financial hardships, or health problems [23]

In a study conducted by the National Violent Death Reporting System (2003–2009), of the four racial/ethnic minority groups studied, Latinos had the second highest rate of alcohol use during an attempt, with 28% having been legally intoxicated at the time of death [35].

Lack of access to care represents an additional risk factor for suicide among Latinos. Compared to non-Latino Whites, Latinos underutilize mental health services, are less likely to receive care that follows recommended guidelines, and are more likely to rely on informal supports, such as family, friends, and primary care providers, than on mental health specialists for mental health services and advice [36]. In a large national survey, Latino adults who reported suicidal thoughts were less likely to receive mental health services [37] and less likely than other ethnic groups to call a suicide crisis line during a suicide crisis [38].

Protective Factors

Research has shown the following to be among the most significant protective factors against suicide in Latino populations:

1. *Familism*: refers to the strong feelings of commitment, loyalty, and obligation to family members that extend beyond the nuclear family. The interdependent nature of family includes making family needs a priority as well as being able to turn to family for support. Latinos in the United States score high in measures of familism. And, youths who report strong, supportive relationships with their parents are less likely to attempt suicide [39, 40]. However, as pointed out previously, familism can also become a risk factor in the face of acculturation family distancing and parental inflexibility around family cohesion.
2. *Ethnic affiliation*: A greater sense of affiliation to the culture of the parents decreases cultural distancing between Latino children and parents, given that cultural distancing has been identified as a risk factor for adverse mental health outcomes in Latino adolescents. Latino adolescent girls with greater involvement in Latino culture have more positive relationships with their mothers and fewer withdrawn-depressive behaviors and suicide attempts [41]. In addition, a strong sense of ethnic identity is positively associated with positive self-esteem among Latino adolescents of both sexes and has been shown to moderate the relationship between perceived discrimination and depression [24].
3. *Religiosity and moral objections to suicide*: Individuals identifying themselves as Latino report higher scores on measures of moral objections to suicide and on measures of religiosity compared to people who are not Latino

Table 5.2 Culturally specific risk and protective factors for suicidality in Latino youth

Risk factors	Protective factors
Acculturation stress	*Familismo* (family focus with collectivism)
Acculturative family distancing	Ethnic identity/affiliation
Gender role conflicts (esp. Latinas)	Religiosity and spirituality
Immigration stresses and family separation	Moral objections to suicide
Loosening or loss of extended family support	Personalismo

[42]. Latinos are also more likely than other racial or ethnic groups to belong to religious denominations that have strong beliefs prohibiting suicidal thoughts and behaviors [43] and the perception that one is cared for by teachers: One recent national study found that perceived caring from teachers was associated with a decreased risk of suicide attempts by Latino adolescent girls [44].

4. *Personalismo*: is the valuing and building of interpersonal relationships. Personalismo encourages the development of warm and friendly relationships, as opposed to impersonal or overly formal relationships [45]. This cultural value is protective against social isolation, and Latino families emphasize this value early in a child's development. This is also a value that needs to be demonstrated by health and mental health professionals to gain the youth and family's trust (Table 5.2).

We present and discuss two cases of suicidal behavior among Latino adolescents, with focus on risk and protective factors illustrated by them.

Case I

Hector, an 18-year-old Latino-Puerto Rican adolescent, had a diagnosis of major depression, recurrent with psychosis and attention deficit hyperactivity disorder (ADHD) (inattentive type). He was an only child who was being raised by his paternal grandmother and his father, who was a Vietnam veteran that worked odd jobs as a handyman. His mother had been diagnosed with schizoaffective disorder and had been unable to care for Hector. The parents had been separated since Hector was 11 years old, but despite this, the mother maintained a close relationship with Hector. She would sometimes be the one to take him to his psychiatric appointments. The father continued to have a caring and parental role toward Hector's mother, who lived in an apartment on her own, and neither one of the parents had remarried. Hector was sometimes allowed, by his father, to spend several days at a time in his mother's apartment when her mental health condition was stable. Hector was an outpatient in a Community Mental Health Center (CMHC) situated in a Latino ethnic enclave of a large city. His mother received psychiatric services in the adult department of the same CMHC, where the staff was closely acquainted with the family. Hector was very stable on medication, and the parents were very enthusiastic with his upcoming high school graduation date. During the second part of his senior year of high school, Hector began dating his first girlfriend and became sexually active. Soon thereafter, a confrontation ensued between Hector and his mother after he was caught several times being sexually intimate with his girlfriend at the mother's apartment. The mother then called on the father to take Hector back into his home, where the father and the paternal grandmother were better able to set limits on Hector. A few days later, Hector's girlfriend announced to him that she no longer wanted to date him. Soon after, Hector and his father presented to the clinic for the monthly medication management visit, and this time Hector appeared agitated and oppositional. The psychiatrist immediately ordered that

individual and family therapy, as well as case management, be restarted to address the crisis and to explore other possible reasons for his unusual behavior. The following weekend, the psychiatrist received a call that Hector had committed suicide by jumping off the fifth story of an empty building. He left a suicide note thanking his father, grandmother, and mother for their love, forgiving the girlfriend for the breakup, and bequeathing all his possessions to his friends. It was later discovered, unbeknownst to his parents and his psychiatrist, that Hector's girlfriend's brother was dealing drugs and supplying them to Hector and to his own sister and that Hector had most likely been using drugs sometime before and during the suicide.

This case illustrates what could be conceptualized as a "perfect storm." A vulnerable adolescent boy, with the pre-existing psychiatric conditions of depression and ADHD and a home environment with a low level of family cohesion, was faced with the stressor caused by the breakup of his first adolescent romantic relationship. In addition, his pre-existing psychiatric problems were exacerbated using drugs, which probably accounted for the impulsivity of his act, very likely affected his cognitive functioning, and could have even produced a psychotic state at the time of the suicide. Hector was cared for primarily by his elderly paternal grandmother, and even though his father was very involved in his life, he was busy at work. In turn, his mother tried her best to care for him, but she was severely handicapped by her mental illness. Neither one of Hector's three caretakers was in the position to become intimately familiar with his adolescent culture, his daily routine outside of the home, and the quality of his peer group. Cultural distancing among well-acculturated Latino youth and their parental caretakers causes an overreliance in the adolescent peer group and a decrease in parental supervision and is known to be an important risk factor for adverse mental health outcomes [11, 26]. In contrast, family involvement helps maintain a sense of connectedness and emotional support, and family cohesion serves as a buffer against depression in Latino youth [47, 46]. In the case of Hector, despite having three loving parents who deeply cared for him, he found himself facing the adolescent developmental challenges of negotiating his first romantic relationship and surviving his first romantic breakup. The risk of experimenting with drugs became even more dangerous given his pre-existing psychiatric vulnerabilities. In addition, the low level of family cohesion in his family constellation contributed to his isolation and the lack of understanding by his parents of his adolescent cultural milieu, a knowledge that could have played an important protective role in averting Hector's suicide.

Case II

Carmen, a 15-year-old adolescent Latino-Cuban girl, arrived in the emergency room at the pediatric hospital after she took an overdose of about a dozen aspirin tablets. After undergoing a gastric lavage, she was seen by the psychiatric fellow who admitted her to the inpatient unit. Carmen attended a predominantly Latino Catholic school for girls from lower-middle-income families and lived with her mother and stepfather. Her biological father worked as a long-distance truck driver and was an absent figure in the girl's life. Carmen had a polite but distant relationship with her stepfather and a tense relationship with her mother. She complained that her mother was too strict, critical, and unloving. She stated that "my mother thinks that everything I do is bad, she never sees anything positive in me, she wants me to behave like a nun and all I want is for her to listen to me and to understand me. I feel that I am always falling behind my girlfriends in everything they do, because I am not allowed to go out anywhere or do anything."

Carmen was a good student, and she did not have any history of behavioral problems. Once family therapy was started on the inpatient unit, it was revealed that Carmen's mother had lost her own mother at the age of 9 and had been raised by relatives that made her feel unloved. Carmen's mother became pregnant; married Carmen's father at the age of 16, "to get out of the house"; and later realized that she had made a mistake. She did not want her daughter to repeat the same pattern. When Carmen was questioned about her suicide attempt, she stated: "I don't know what took over me. I wasn't thinking. I just did something crazy because I felt like I didn't know what else to do."

Suicidal behaviors are often impulsive, sudden means of escaping a stressful situation, and, in the case of Latino adolescent girls, they are often related to arguments or conflicts with their mothers. In the traditional Latino culture, the progression into adulthood for girls is primarily interpreted in the socialization process as readying a person for parenthood, which reinforces the obligation to family. In contrast, in the United States and in most Western countries, adulthood is defined in terms of the accomplishment of personal achievements and occupational roles. In the case of the traditional Latino family, *familism* is passed down from one generation to another, and cultural traditions dictate that women maintain closeness and obligation to the family while limiting any attempt at adolescent individuation and limiting in the way that anger can be expressed [10]. In these cases, suicidal behavior appears following an argument with the mother or the breakup of a romantic relationship, which is also related to the attainment of individuation. In these cases, the desires for autonomy and relatedness are met with the prohibitions based on firm cultural traditions that imply strict expectations of traditional female behavior, and they constrain the adolescent girl's developmental needs. These often occur in the context of conflictual and unsupportive home environments that may have left the adolescent with poor coping capacities, which further increases the risk for suicidal behavior. In these situations, the adolescent is neither thinking about death nor even aware of her own thoughts. Instead, these events represent a moment of dissociation that can be conceptualized as a culture-bound syndrome. For example, the *ataque de nervios* is a cultural syndrome that involves screaming, fainting, crying, trembling, becoming verbally or physically aggressive, feeling a loss of control, and, sometimes, suicidal acts [47] that is seen in some working-class Latino adolescents and adults, especially female. It allows them to ventilate anger and frustration and to relieve tension in a way that does not present the woman as assertive and direct and does not challenge the traditional and culturally defined gender roles. The *ataque de nervios*, like suicidal behavior, is a psychocultural response to a perceived threat to the stability of the woman's social world and of her family. For many older Latino women, suicidal behavior is correlated to issues of family disruption, such as divorce, sudden deaths or loses of family members [48]. For adolescent Latino girls, they tend to revolve around issues of individuation, coupled with family conflict [10]. In the case of Carmen, the early death of her maternal grandmother left her mother an orphan resulting in a childhood of emotional deprivation. Thus, while she was desperately searching for affection, she entered impulsively into a premature and failed marriage. This caused a transgenerational dynamic that thwarted Carmen's attempts at individuation and identification with her adolescent peer group. These attempts at individuation were further complicated by her mother's embracing of the traditional gender roles assigned to Latino women and her choice of sending Carmen to an all-girls Catholic school, which supported these values. Carmen's physically and emotionally absent biological father and her distant relationship with her stepfather, both of whom could have potentially mediated between Carmen and her mother, to facilitate her individuation, were not available to help her in her struggle. In desperation, feeling completely alone and

misunderstood, and not yet having developed more mature and adaptive coping skills to deal with her distress, Carmen impulsively attempted suicide in an episode of quasi-dissociation. Later, when she was seen in individual and family therapy, Carmen expressed regret, shame and surprise at the intensity and danger involved in her own impulsive actions. Carmen's treatment involved a combination of antidepressant medication, cognitive behavioral therapy for Carmen, individual psychotherapy for her mother, and a combination of strategic and structural family therapy to help Carmen's mother identify and separate her own individuation issues from her daughter's. Also, to foster Carmen's developmentally appropriate individuation, an attempt was made to involve her stepfather as an active figure in the family, with a role as a mediator in the conflict between mother and daughter and as an available supportive male adult figure, given the absence of the biological father.

General Clinical Approach

Successful suicide intervention strategies with Latino youth always need to involve the family, with parents and adolescents working together and alternating with individual therapy for the parent and the adolescent, usually the mother and the daughter [10, 41]. In the traditional Latino culture, not only do the parents expect the adolescent to become involved in treatment, but the adolescent daughters also expect the mother to participate [49, 50]. The effectiveness of psychosocial treatments for youth suicide is difficult to assess, given the fact that suicide has a multifactorial etiology, so each of the underlying causes, such as depression, substance abuse, violence, and acculturation problems, may need to be addressed either conjointly or separately.

As to the overall clinical approach to working with suicidal Latino youth, the AACAP Practice Parameter on Culturally Competent Care [51] provides useful guidance and structure. In the diagnostic evaluation, special attention should be paid to culturally specific symptom expression. Suicidal verbalization and action as presented in the previous cases will be expressed "in the moment" of distress or heightened conflict but later suppressed and difficult to discuss due to cultural and familial shame and stigma (latter related to perceived disloyalty to the family). In fact, Latino families may attempt to maintain some denial and minimization of suicidal ideation or behavior in their child in reaction to such stigma. Latino children and adolescents often avoid eye contact with adults in authority, and this can be misinterpreted as despondency or distress. On the other hand, presentation with comorbid somatic complaints, anger, anxiety, substance use, and post-traumatic stress symptoms is frequently seen. Hence, depression should be also considered in youth presenting with such symptoms. Using rating scales in Spanish that have been validated with Latino youth should be considered, including the Children's Depression Inventory (CDI), Beck Depression Inventory (BDI), Child Behavior Checklist (CBCL) with the two versions of Youth Self-Report (YSR) and Teacher's Report Form (TRF), and Strengths and Difficulties Questionnaire (SDQ). Part of the diagnostic evaluation needs to include the potential contribution of acculturation stress, gender role conflicts, immigration stressors and traumas, domestic violence, and grief/loss inherent in the acculturation process.

Individual psychotherapy needs to be practical and problem-oriented. It should address the impact of immigration traumas, acculturation stress, and ethnic identity conflicts (internal or generational). The therapist needs to be careful with boundaries and balance the alliance with the youth and the whole family without appearing to be more partial to either and needs to demonstrate respect for cultural norms. The therapist also needs to be emotionally accessible and warm, expressing the values of *personalismo*. Family involvement is critical, both in the diagnostic and treatment phases. Family permission for the youth to fully explore the context and factors contributing to suicidality is essential. Family therapy needs to focus on intergenerational conflicts, bridging the generational acculturation gap, mobilizing family supports, promoting

respect for the traditional family structure, and promoting cultural flexibility on the part of parents and elders with their children. Family intervention should also be oriented toward facilitating the negotiation of gender roles and confidentiality, so that youth can have some autonomy and privacy but remain engaged with their families. Interventions should focus on the intergenerational relationship, as it is a predictor of the youths' outcome. Family-based intervention, where intergenerational and intercultural conflicts are explored and the value of communication within cultural expectations is underscored, is effective when working with Latino adolescents.

Clinicians should promote and utilize family strengths and community natural supports. As much as possible, they should avoid institutionalizing youth or removing them from their families and communities, except if there is significant continued suicidal risk. If available, ethnically specific programs may be particularly effective. Case managers from the Latino community are needed, so that they can mobilize such community supports and serve as trusted intermediaries between the family and mainstream community agencies (schools, courts, child welfare, juvenile justice, and mental health) as well as culturally specific community organizations and faith communities.

Linguistic support is critical for effective service delivery for newer Latino immigrant families who are not English fluent. This should be provided through trained and certified interpreters or (preferably) clinicians who are fluent in Spanish and familiar with the culture (or in the case of indigenous people from the Americas, the family's native language). The use of family members, especially children, as interpreters should be avoided at all costs, especially around such a sensitive issue as suicidality. There should even be caution about using interpreters from the same community as the family, to prevent a breach of confidentiality if the interpreter happens to know the family [51].

Evidence-Based Treatment

Prevention strategies are the only logical treatment for suicide, in addition to the crisis intervention that occurs around a suicide threat or a suicide attempt. In a review of the literature of psychosocial treatments of youth suicide [52], ten empirical studies were evaluated, and the findings can be summarized as follows:

1. Developmental group psychotherapy was significantly superior to the comparison group in reducing self-harm in adolescents.
2. Family communication and problem-solving strategies were effective in reducing suicidal ideation but only among a sample of adolescents without major depression.
3. Family interventions did not reduce the suicidality in youth with major depression, indicating that major depression is an important risk factor that needs to be addressed separately.
4. Short-term outpatient treatments were effective in reducing suicide attempts or deliberate attempts at self-harm among suicide attempters.
5. Outpatient treatment was found to be a safe and acceptable alternative to hospitalization in two of the ten studies, and these findings are also supported by other studies [53, 54].
6. Cognitive behavioral therapy (CBT) was found to be effective in reducing the direct and indirect risk factors of suicide, including depression and other suicide risk behaviors, such as substance abuse.
7. Dialectical behavioral therapy (DBT) was found to be effective in reducing several indirect markers of suicidality, especially in females with a diagnosis of borderline personality disorder.
8. Short-term interventions that included families were found to be effective in increasing retention and patient compliance with treatment, given that retention and compliance

problems are common among youth that have attempted suicide.

Many of these findings are relevant to working with Latino youth dealing with suicidality.

Some studies have examined the identification and help-seeking patterns of suicidal Latino youth. In a study within a large community school district, Latino youths were least likely to be identified as suicidal and receive crisis intervention compared with other ethnic groups, despite their high rates of suicide attempts [55]. Latina adolescents seek help for such problems as depression, family, and relationship problems from informal sources such as peers and family rather than formal mental health services [56]. Latino families are unlikely to seek mental health services as a first option in help-seeking behavior and may turn to family first [57], and many prefer to seek treatments from family physicians rather than mental health specialists [58]. Lack of familiarity with the service system, fear of being reported as undocumented, and language barriers reduce service utilization among newly arrived Latinos, especially families. Suicidal Latino youths tend to be English fluent, making language differences with providers less of a problem, but youths often want (and need) parental involvement in their treatment, necessitating bilingual clinicians or trained interpreters especially to avoid having the adolescent or another family member serve as the interpreter [59].

There are very few studies of treatment or preventive interventions for suicide designed exclusively in Latinos. However, there have been adaptations of other therapies for other disorders (e.g., depression, substance abuse) associated with suicidality. Rosselló and Bernal [49, 50] adapted cognitive behavioral and interpersonal therapies for depressed Puerto Rican adolescents to include parental involvement. This approach was consistent with the cultural values of *familism* and *personalismo*, the expectations of Latino youth to include their parents, and provided opportunities for parents to better understand their adolescent's socio-emotional needs within the context of their cultural expectations versus the social context for their child. In the manualized protocols for such evidence-based therapies, cultural adaptations have been made that reflect cultural values and idioms (Puerto Rican version) as well as family-centered examples [60].

As already emphasized, engagement of families of suicidal youths is particularly important for Latino youths. Rotheram-Borus et al. [61] developed a cost-effective intervention geared to engaging the parents of Latina youth suicide attempters in emergency room (ER) settings. It included (1) a staff training program to enhance ER staff's sensitivity to Latino parents' reactions; (2) a "telenovela"-style videotape (filmed in Spanish and dubbed in English) to educate families and youth about the service process, demonstrate adaptive coping strategies to the attempter and her family, and provide a strong rationale for follow-up treatment; and (3) a structured family therapy session with the Latina attempter and her family by a bilingual therapist, who also served as a liaison to community treatment resources. They compared the intervention across 65 youths and families who received the intervention versus 75 receiving services as usual. Attempters receiving the specialized program were more likely to attend one treatment session (95.4% versus 82.7%) and were somewhat more likely to attend more sessions (5.7 versus 4.7); however, their mothers were less likely to complete treatment. In addition, participants receiving the specialized program reported reduced psychiatric symptoms, and mothers reported more positive attitudes toward treatment and perceptions of family interactions. Strategic structural systems engagement (SSSE), an approach for bringing hard-to-reach families into treatment, has also shown effectiveness with Latino families [62]. In a study conducted with youth at risk for drug abuse, SSSE improved overall family engagement in therapy. The results differed depending on the Latino group studied, with non-Cuban Latino families responding much better than families of Cuban origin. The authors pointed out that Cuban Latinos differed from other Latinos in several key respects, including higher levels of assimilation, individualism, and orientation to the values of the mainstream culture. Brief Strategic Family Therapy (BSFT), an intervention originally

developed with Latino youth to address AFD in families of youth at risk of substance abuse and conduct disturbance, has also been found to be highly effective at engaging families in treatment, as well as its inherent value in addressing AFD itself, which can be a major risk factor [63]. Cardemil et al. [64] demonstrated the effectiveness of a school-based cognitive intervention for depression as far out as 2 years. Kataoka et al. [65] demonstrated the effectiveness of a school-based cognitive behavioral therapy for trauma-related depression or post-traumatic stress with Latino children and youth.

Insofar as pharmacotherapy, no racial/ethnic differences have been found in antidepressant response among adolescents, particularly in the Treatment for Adolescents with Depression Study (TADS) [66]. However, it is important to keep ethnopharmacological factors when prescribing antidepressants to Latino youth. For example, grapefruit juice may increase serum concentrations of nefazodone, antivirals and alprazolam by affecting CYP (3A4), and corn affects CPY (2D6), thus affecting antidepressant levels. These enzyme inhibitions can disproportionately impact adolescents from Caribbean origin (high-critic diets) and Mexican and Central American origin (high-corn diets). Additionally, Latino youth from indigenous backgrounds can have higher prevalence of slower metabolizing CPY polymorphisms, so dosing should be lower initially so as to prevent akathisia or other side effects resulting from higher blood levels [67].

Conclusions

Suicide among Latino youth, especially among adolescent Latino girls, remains a very serious public health problem in the United States. Treatment interventions for suicide prevention in this population are challenging due to the multifactorial etiology of suicide. In the future, treatment efforts also need to address underlying issues such as depression, violence, and substance abuse. Mental health professionals who treat Latino and other minority youths should become familiar with the patient's culture and can provide culturally competent interventions that address the needs of the adolescent and his or her family [51]. In addition, issues related to acculturation, such as perceived discrimination, feelings of alienation, and the generational differences between parents and children, which result from this acculturation process, should also be addressed in the treatment. At this time, the number of evidence-based interventions is limited but is growing and offers hope for treating this important public health problem among Latino youth [68].

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6 Suicide Among South Asian Youth in America

Neha Sharma and Deepika Shaligram

Case History

Sanya, a previously well-adjusted, healthy, 16-year-old Bangladeshi-American girl in 11th grade, was admitted to the adolescent inpatient unit for attempting suicide. She endorsed low mood, decreased energy, loss of interest, and low self-esteem. She admitted to wishing she was dead and experiencing poor sleep and appetite for the past few months. Previously an academic overachiever, her grades had slipped paralleling a decline in concentration due to headaches in the past 1–2 months. She denied self-injurious behavior or the use of recreational substances.

She was the second of four siblings born to immigrant parents who arrived in the USA 19 years ago. The family lived in a two-bedroom apartment in the local Bangladeshi community and closely followed their cultural values. Her father ran a convenience store, despite holding master's degree in economics, and her mother helped at her father's store. Her father had migrated to the USA (with the help of his maternal uncle who lives in the next town over) because it was difficult to gain employment in Bangladesh. Both of Sanya's parents were raised in large extended families that lived under one roof. The move to the USA was particularly difficult for her mother who spoke only Bengali which limited her employment opportunities and resulted in social isolation. She was often lonely and homesick, but she made this sacrifice because she was determined to give her children a better future. She hoped that her children would appreciate her dedication to them and would take care of her in her older age.

Over time, the family established friendships with others in the community who were in similar circumstances and were thus able to create a second home for themselves. In her community, her mother was

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idealized as a nurturing, kind-hearted, good mother who had raised God-fearing children. Bangladeshi roots emphasized working hard at school while drawing strength from spirituality. Sanya and her siblings were not allowed to attend parties or listen to pop music in an effort to instill and maintain cultural values. Sanya did well academically and she was well-liked by peers and teachers. She had Bangladeshi friends in her neighborhood and American friends at school. She kept her home and school life separate, relaying limited experiences to her parents as she knew that her parents preferred that she had more Bangladeshi or South Asian connections. She had learned that if she wanted to do something that they disapproved of, she could cloak it in the disguise of educational value. For example, when she wanted to go to her non-Bangladeshi best friend's birthday party, she told her parents that she needed to do a group project that required field work in the evening.

In the past, she had been teased for being "brown-skinned" and a peer had asked her "Aren't you Indians bored of being good at math?" When she tearfully relayed these experiences to her mother, she was advised to ignore it to avoid conflict with other "white" families. Even though, they were legal residents, they were afraid of persecution and deportation especially since 9/11.

Sanya's 19-year-old sister had recently had an arranged marriage, aligning with cultural expectations, and it was expected that Sanya follow suit upon completing school. Sanya, however, was frequently the target of her extended family's displeasure for not complying with the wishes of elders in the family (for instance, in the choice of clothing that they found to be immodest). She herself felt that her upbringing was overly restrictive and that there was a disconnect between her parents' expectations (which was different from that of her friends' parents) and her need for autonomy. Meanwhile, her parents felt that they have been very lenient in comparison to their upbringing in Bangladesh where boys and girls were segregated and attended separate schools. Their opposite perspectives had been an ongoing source of stress.

About a month ago her primary care provider had concerns for depression during a routine annual well visit when Sanya complained about persistent headaches that forced her to withdraw to her room, but parents disagreed with the formulation. They wondered if the headaches, along with declining grades and reports of tiredness indicated an underlying medical issue which had not been detected so far. The family denied any past signs of mental illness in Sanya and the family. They expressed surprise and consternation at the suggestion of mental illness. According to them, Sanya had everything a girl could possibly want and has no reason for her to be depressed. When they felt that they were not getting help from the pediatrician, they relied on a traditional healer to address her symptoms.

On the day of the admission, her younger brother had stumbled across some of Sanya's text messages to her boyfriend that he shared with their parents. Sanya's involvement with a non-Hispanic White (NHW) boy, a sign of her deviation from their expectation of a good Bangladeshi daughter, meant that the family would be shunned by their extended family in Bangladesh and the local community. Sanya's acknowledgment of the relationship led to her mother feeling betrayed, feeling humiliated, and feeling that she had failed as a mother. The thought of defamation in the community led her mother to threaten suicide. Her mother's displeasure triggered her father's anger and he forbade Sanya from meeting the boyfriend. He

broke her phone to prevent further contact and did not allow her to go to school (where her boyfriend was also a student). She was told that her "promiscuous behavior" had destroyed the family's reputation, and consequently no one would want to marry her or her younger sister. During this chaos, Sanya felt responsible for her parent's suffering and for the "dishonor" she had brought to the family. The trapped and helpless feeling led her to attempt suicide by hanging herself. Fortunately, the sounds of loud argument caused a neighbor to call 911.

The police arrived on the scene where they found her mother wailing and Sanya crying after a failed attempt. Noting her injuries, the police brought her to the hospital where she was medically treated for her wounds. Admission to psychiatry inpatient unit for safety and stabilization was recommended, but the parents were agitated and refused to give consent for admission as their daughter was not "crazy!" They felt that she did not need to be admitted to a "mental" institution. Doctors were unable to convince the parents that Sanya's behavior was concerning, so they admitted her on an involuntary basis and filed a case with the Department of Children and Families (DCF) based on medical neglect. Her parents were informed that "in America, we hospitalize a teenager who hurts herself."

On the inpatient unit, it was initially difficult to engage family in treatment because they believed that the team was against them and had a goal of "Americanizing" Sanya. They felt that this hospitalization was not going to help Sanya, but they reluctantly complied with the team's requests out of fear that their daughter would be "taken away" from them by the DCF. Though Sanya was more willing to engage, she felt very guilty about causing her parents a lot of pain. The inpatient unit team worked hard to establish rapport with the family by inviting extended family and family friends to be a part of treatment planning. This helped with building trust and with initiation of the pharmacological treatment (initially delayed because parents were not in agreement with the formulation). Outpatient providers were identified early on, and they began to develop an alliance with the family, while Sanya was on the inpatient unit to allow for a successful transition to outpatient care and continued adherence to treatment. Her symptoms gradually improved, with intensive therapy and pharmacological treatment over a 15-day stay.

Introduction to the Population

Immigration History

Asian Americans are the fastest growing minority population in the USA. SA comprising Bangladeshis, Burmese, Indians, Nepalis, Pakistanis, and Sri Lankans form the third largest subgroup of Asians in America, after the Chinese and Filipinos. From a sociological perspective, the main factor influencing immigration from SA is a dearth of opportunities for people to make a living or fulfill personal aspirations in their country of origin like Sanya's family. There are significant differences in earning potential and educational resources between SA countries and the United States of America (USA).

On the macro level, trade investment and political ties between the USA and Asia initiated and sustained immigration to the USA [1]. The US immigration policies during preindustrial (before 1943) and postindustrial age (after 1965) reflected the shifting demands for inexpensive labor and thus influenced the flow of SA immigrants. This set the stage for micro level interpersonal connections that motivate people to

migrate, especially, to reunite with family members who have settled abroad.

The first SA immigrants from India arrived in the first decade of the twentieth century to work as agricultural laborers mainly in California [2]. Yet, others came as traders or jumped from British ships to New York City [3] and settled along the east coast. The Immigration Act of 1917 served to ban all immigration from Asia [4]. Following this the Johnson-Reed Act of 1924 (also known as the Asian Exclusion Act) precluded Asians already living in the USA from becoming eligible for citizenship while favoring immigrants from Western and Northern Europe. Thus, the definition of Asian Americans as "aliens ineligible for citizenship" feeds the notion of Asian Americans as "forever foreign" [5] and as "not belonging to the USA," which has shaped experiences of successive generations, whether US born or naturalized as citizens.

In 1946, the Luce-Celler Act reversed the exclusions defined in the Immigration Act of 1917 and allowed a small quota of SA immigrants to enter the USA and those already in the USA to become naturalized as citizens. Another milestone in immigration was the Hart-Celler Act or the Immigration and Nationality Act of 1965 which favored the admission of highly skilled health professionals and scientists. Hence between 1966 and 1977, of the Indian Americans who migrated to the USA, 83% entered under the occupational category of professional and technical workers [6]. It was during this time that there was a shift in the racialization and characterization of SA in particular and Asian Americans in general as "model minorities" who then became proof of the US system of meritocracy. However, they continued to be denied full representation in institutions of higher education and were exploited as low-wage laborers. To illustrate, the US Census Bureau in 1993 noted that 80% of Indian immigrants had completed high school, but 20% lived below the poverty line and 9% were unemployed [7].

Later, the 1990 Immigration Act expanded opportunities for temporary employment-based and investor migration, which led to SA contributing to emergent industries like information technology and software development. But, it only provided limited opportunities for settlement. During this time, India and Pakistan had the largest numbers of people emigrating, but immigration from Bangladesh slowly increased (in 1996, 8,221 Bangladeshis came to the USA) over time.

Identity Salience and Role Conflict in South Asian Children

SA children are raised with values of respecting others, obedience to parental authority, and prioritizing the family's needs over the individual's. If financially feasible, the children are exposed to their parent's country of origin via transnational traveling. This could be secondary to transnational marriages of their parents, with one parent being born or raised in the USA and the other parent coming to the USA after marriage from SA. Additionally, there is an increasing diaspora from Asian countries that allows for ties to culture, such as food, film, music, fashion, etc. The level of assimilation to American culture depends on the pre-immigration values, the age of the parents at the time of immigration (older generation is more likely to hold onto their own cultural values), availability of SA community connections post-immigration, openness of the immigrant to be flexible and acclimate to the new culture, and level of exposure to American culture in the USA (living in ethnic enclave vs. rural area with limited ethnic mirroring). Depending on the families' level of assimilation, they may hold these values that vary on a spectrum. Youth may have assimilated in some measures and not in other. For example, some youth are comfortable dating but refrain from premarital sex and alcohol consumption. Every individual defines their values depending on family and social expectations.

SA American children often participate in ethnic/language specific schools, music and dance lessons, and other organized activities which may be associated with places of worship, where no one will question their legitimacy or

"Americaness" [8–10]. These social organizations become a place for the second generation to develop their unique identities, strengthen ethnic ties, and start dating within the construct of what is acceptable to their parents [11]. Thus, youth develop their ethnic identity and integrate American culture in their life, allowing them to make the "best of both worlds."

The different rates of acculturation influence widening of the generational value system within the family, which can often lead to parent-child conflict as was seen in the case of Sanya [12, 13]. Sanya's mother believed that making sacrifices for her children would pave the way for her children's success. The definition of success for Sanya's mother includes practicing Bangladeshi cultural values in USA. Meanwhile, Sanya held the individualistic perspective that her mother was responsible for her own happiness and it should not depend on Sanya's choices.

Notably, the acculturative process also differs as a function of gender, given the strong gender-based cultural customs and expectations [14]. Daughters of conservative parents, like Sanya, can be particularly resentful of double standard, where sons are allowed more freedom to express and daughters are expected to follow the cultural expectations. This is especially true of expression of sexuality [15]. The burden of continuing cultural customs was expected to be imparted by Sanya's mother to her daughter more than sons. Such expectation can be experienced as oppressive and sexist by teenage girls who are trying to assert their sense of self in the community. Additionally, parental expectations, driven by the pressure to instill the values of their home country on social connections of children, fuel the parent-child conflict [16]. Depending on the youth's personality and expectations of self, they may view parent's expectations with ambivalence. Youth may experience this parental expectation as a divisive force that separates them from their peers or as something that brings them closer to the family. Such widening dissonance can result in youth's involvement in truancy, runaway behavior, substance abuse, violence, and teenage pregnancy. With Sanya, her dating life and preference for "Western clothing" was a sign of her assimilation to the American culture, but it conflicted with her parents' conservative values and that of the Bangladeshi community. This dissonance in their values, experiences, and lack of acceptance separated her from her family and contributed to acculturative family distancing. Acculturative family distancing has been found to be associated with increased risk of depression in Chinese American youth [17]. It is likely that Sanya's suicide attempt was the direct result of gradual distancing between Sanya and her family.

Sexuality

Ancient Indian temple art (e.g., Khajuraho temple, Madhya Pradesh) and the Kama Sutra bear testament to the freedom of sexual expression and the exploration of sexuality in SA history. However, contemporary SA societies are seen as conservative, sexually repressed, and prone to sexual violence. In actuality, the expression of sexuality is likely to be on a spectrum. On one end, Islam-influenced laws in countries like Bangladesh, Pakistan, and regions of India are likely to be restrictive; meanwhile, secular societies in India and Nepal have more liberal laws. While SA women have the freedom of expression in the USA, this could be a double-edged sword, as SA American women may be seen as exotic and/or objectified. On the other hand, SA males may be viewed as patriarchal, unattractive, and/or not as well-endowed as noted by Azis Ansari in television series "Master of None."

As for the SA LGBTQ population, there is insufficient data; thus, the information gap can be filled by extrapolating data about Asian Americans. The persistent theme is that "People feel that they must choose between their race and sexuality, a pressing dilemma that divides the self" [18]. There are a few SA community-oriented organizations in major cities; for example, SALGA-NYC serves the Desi Queer Community of New York and Trikone, a non-

profit organization pioneered the path of empowering South Asian LGBTQ population since 1986.

Factors Contributing to Weak Ethnic Identities

Weak ethnic identities are associated with increased parent-child conflict, which is a risk factor for youth suicidal behavior [19]. Thus, it is important to discuss factors that weaken ethnic identity. As individuals assimilate and become more "American," they may not be able to sustain the cultural elements. They may prefer connecting to other second-generation peers through social organizations rather than learning more about their culture from the local temple or cultural centers. The temple could be too "authentic" and not representative of them, and they may also feel judged and criticized for being "Americanized" by people at these cultural centers [20].

Besides weakened ethnic ties in America, transnational ties also weaken over time as second generation visit homeland less and speak in English rather than their native language and as familiar relatives abroad pass away. Visits to homeland can make people more aware of how Americanized they are, increasing the distance from their peers in homeland and affirming their ethnic hyphenated identity in the USA [21]. Sanya may experience her extended family in Bangladesh as people who do not understand her, as too conservative with antiquated values, and as people whose critical views hold her parents from assimilating. Thus, she is less likely to see them as important or make the effort to stay connected with them over time.

Another cause of weakened interest in ethnic boundaries could be because second generation are highly assimilated and may have developed interests that are unrelated to ethnicity. Since second generation is likely to be more educated than the first, they have other associations to fulfill their need for advice, belongingness, information, etc., for example, alumni associations especially since maintaining ethnic identity takes motivation and effort. The desire to develop this ethnic identity may not rise until they have children of their own [20].

Individuals respond to their multiple identities differently when they experience "role conflict." Some abandon the identity of one for another. "For instance, if one self-defines as a feminist yet feels one's ethnic social identity expects women to be submissive, one may reject the ethnic identity [11]." Another way to respond to "role conflict" is to segregate one's identities such that the individual chooses different identities in different settings depending on what the individual wants to portray and what the environment expects [22]. To be specific, one can wear ethnic attire, speak ethnic language, and play ethnic music at home but not at school or work [23]. Switching between these identities may increase stress of deception to parents to avoid confrontation, parental disappointment, or being seen as "Americanized," for some youth, all of which would increase the risk of mental health disorder. This was notable in Sanya's clandestine dating life, which resulted in guilt upon discovery by parents. For adolescents, the pressure to keep the "two worlds" separate is an additional stressor to developmentally appropriate exploration of sexuality and identity.

While switching between identities, one may also have to struggle between switching values. For example, individualism and self-assertion is valued in mainstream American culture; meanwhile, maintaining allegiance to the cultural group and obeying authority is encouraged in Asian households. Dhingra [11] poses that individuals overcome the segregation of identities by bridging their identities to live "hybrid" lives. This requires flexibility and openness from parents and significant adaptation on the youth's part. In Sanya's case, this flexibility may have been lacking as parents had firm expectations of Sanya following cultural values and Sanya appeared to have a limited understanding of her parents' sacrifices for the family. Thus, the treatment providers need to have a vision for this family where the parents can be flexible with their values and Sanya could appreciate the parent's journey. Keeping this goal in mind will guide providers toward the next steps.

Experiences with Racism

"South Asian Americans have a distinct phenotype, set of stereotypes, religion, dietary preferences, and more from those of most East Asian Americans. They also are not categorized as Asian Americans by others. The racism most commonly experienced takes the form of accusations of being terrorists, of practicing 'pagan' religions, of being passive or exotic, and the like, rather than as 'slanty-eyed'. Post 9/11, the South Asian ethnic divide from other Asian Americans has only increased" [20] due to being seen as brown-skinned terrorists or turban-wearing Sikhs being misperceived as fundamental Islamists. For SA community the experience of discrimination and being treated like "foreigners" solidifies the notion that their identity is first Asian and second American. (This is beautifully displayed in HBO's new series *The Night Of*.) Thus, "racism guides Asian Americans to move closer to their ethnic group and to recognize ties to other Asian Americans but does not necessarily lead to identification with the people of color" [20]. The SA approach to the experience of racism is to see it as arising from ignorance, and the remedy is deemed to be education rather than a need to address structural racism. This could be the psychological reaction to being seen as the "model minority." For instance, when Sanya shared her subtle racial micro-aggressive experiences in school, her mother told her to "ignore it," so she can continue to be seen as a pleasant, agreeable, and well-adjusted teenager.

Due to the model minority stereotype, SA Americans may be seen as a threat to educational and employment opportunities for other groups [24]. For youth in particular, the model minority stereotype can contribute to the stress of performing academically and occupationally at a level that feels unattainable and to a lack of recognition of mental health concerns in these communities [25]. For example, at school, when Sanya was struggling with depression, her low grades were seen by the teacher as lack of effort rather than sign of depression.

While both foreign-born and US-born immigrant-origin adolescents have been shown to experience racial and ethnic discrimination by adults and peers at schools, when considering nativity, US-born immigrant-origin adolescents (second or later generations) appear to be more vulnerable to depressive symptoms because of perceived discrimination [26]. This is consistent with the immigrant paradox seen in Latino population. This study also found that adolescent girls, like Sanya, reported higher levels of depressive symptoms than boys even after controlling for discrimination, ethnic identity, social support, and nativity status [26]. They suggest that foreign-born immigrant-origin youth may be less identified with racial hierarchy and dynamics of US society and their mental health may be less influenced by stereotyping and discrimination as compared to later generations. On the other hand, US-born immigrant-origin adolescents may experience discrimination in the form of rejection by peers at school, diminishing a sense of belonging, which is particularly critical to forming multiple cultural identifications across home and school [27]. Racial and ethnic discrimination by adults at school can further pose challenges to youth's sense of safety in the school environment. However, strong ethnic identity mitigated the negative effects of this perceived discrimination from adults on depressive symptoms. Interestingly, a strong ethnic identity did not protect against the negative effects of peer discrimination as seen in Sanya's case. Other researchers have suggested that social support may not have a positive effect on psychological distress or offset stress related to everyday discrimination [28, 29].

Issues Within the Family: Violence

To understand SA family issues, it is imperative to first understand the viewpoint of parents on violence and their stressors. The lack of assimilation plays an important role in SA family domestic challenges. Studies of SA immigrant women showed that 25–40% reported domestic violence in their homes [30–32]. SA women who immigrate to the USA after marriage, like Sanya's mother, may lose power in the marital relationship due to language differences, cultural differences, and isolation. Additionally legal issues

and ineligibility to work can result in further losses including economic control and put them at risk for coercion, intimidation, and intimate partner abuse [33, 34].

Many SA women do not report abuse whether physical, emotional, or sexual because of associated shame, fear of being shunned by the community and family, a negative view of divorce, and a lack of awareness of their rights. Additionally, the awareness of meaning of maltreatment or abuse varies for people. One study showed that SA women understood the concept of physical abuse but not sexual abuse as they believed that husbands had a right to have sex whenever they wished [33]. This notion aligns with the idea that women are asexual beings and do not have sexual desires of their own. One can imagine how Sanya's exploration of her sexuality and experience of dating could be jarring to her parent's understanding of young women, especially if her virginity is seen as sign of family honor. It directly challenges their expectations of obedience, silence, and modesty from young women while also impacting their social status. Thus, it is not a surprise that Sanya's family experienced shame and anger upon learning of her dating life.

The "model minority" stereotype further perpetuates this cultural silence about abuse. Speaking up threatens the image of "well-behaved immigrants" [35] and, thus, the unintended acceptance of being a "model." Despite abuse, SA American women often want to maintain their relationship and wish to seek equality rather than end the relationship [36]. When they do seek help, they typically turn to family and friends [37]. Such community connection has led to ethnic-specific shelters (e.g., Manavi in New Jersey) [38]. Another common domestic issue is corporal punishment which is not seen as child abuse even if it is harsh [39].

When treating first-, 1.5-, or second-generation SA for perpetuating abuse or violence, it is important to keep in mind that it is likely that they have witnessed domestic violence in their families [33, 40] which can conflict with their understanding of abuse from American culture perspective. Besides domestic violence and corporal punishment, youth's exposure to violence could be due to their family's journey from war-torn countries where violence may be a part of daily life [41].

Risk Factors

SA students often have stable households, close-knit families, and values that emphasize academic success. However, SA students often feel ashamed if they have academic, emotional, or relationship problems. They may view seeking help for these issues as a sign of weakness. For SA students, as with other students, positive family history of suicide, lack of relational attachments, feelings of worthlessness, and hopelessness have been correlated with thoughts of suicide. Problems related to school and academic performance also have been shown to be correlated with students who complete suicide. Being female gender is an independent risk factor for the SA community. According to a British study, where SA are the largest minority, SA female youth are five to seven times more likely to self-harm than SA male youth. They were also twice as likely to self-harm as native British female youth. As youth begin dating, the interplay of cultural issues surrounding sexual freedom (especially for girls and for sexual minority youth) and acculturative stress (marginalization versus assimilation) can precipitate suicidal thoughts and behaviors [19]. Thus, proximity to the transitional age where autonomy is highlighted in Western culture is a risk factor for SA youth [19, 42]. Please see Fig. 6.1 which conceptualizes factors that contribute to self-harm in SA youth [43].

Common Presentation Among Suicidal South Asian Youth [44]

- Initial presentation: lack of prior psychiatric history, less likely to be using recreational drugs, likely to be impulsive, often

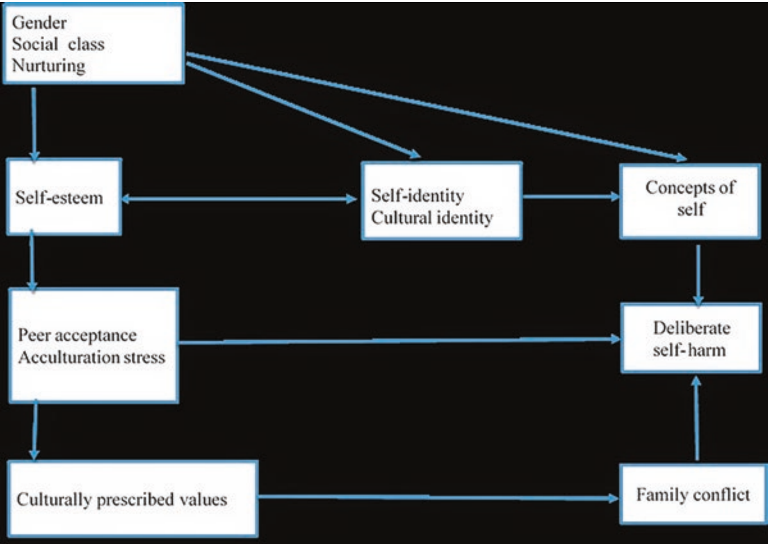

Fig. 6.1 Factors contributing to deliberate self-harm [43] (Reproduced with permission from Crisis 2002; Volume 23 (3): 108–113. © 2002 Hogrefe & Huber Publishers. www.hogrefe.com DOI: https://doi.org/10.1027//0227-5910.23.3.108)

in a state of crisis, prior history of somatic complaints [45]

- Academic concerns: inattention in class, missed classes, failing to complete assignments, falling grades, failed exams and courses
- Relationship problems: conflicts with parents and siblings is more likely than roommates, friends, or partners; social and/or spiritual isolation
- Domestic violence: likely to have witnessed or experienced physical or verbal abuse
- Risky behaviors: violent or aggressive behavior, unprotected sexual practices, alcohol and other drug abuse, driving under the influence
- Physical symptoms: muscular tension, insomnia, headaches stomach aches, other physical complaints

Academic concerns, relationship problems, social withdrawal, and physical symptoms were all issues in the case of Sanya. Of these, social withdrawal may be missed initially as it may be attributed to longer hours needed to study or to somatic symptoms. In addition to conflicts with parents regarding sexual expression, SA youth may also experience conflicts with parents regarding academics (choice of major), level of autonomy (extracurricular activities and socialization), decision about colleges (commute from home versus staying on campus), choice of clothing (specifically for girls), and career choice (pressure of being financially successful). For youth practicing Sikhism, desire to remove facial and body hair to assimilate into American culture could be a contentious topic as Sikhism sees hair as a gift of God. This cultural expectation could put them at risk for bullying and being undesirable to the opposite sex. These stressors combined with lack of access to and/or lack of acceptance of mental health interventions and ease of access to lethal forms of self-harm can have tragic consequences among these youth.

Protective Factors

Some factors that are protective for SA students who may be suicidal include the availability of social and familial support, specifically inclusion of family members in mental health treatment, and a positive acculturation experience (or bicultural identification), which can also be aided by good English-speaking skills. Cultural focus on educational achievements may allow for positive relationships with adults outside of home (i.e., teachers, coaches), and positive peer relationships among other talented children (i.e., Math club, Chess club) may allow for stronger sense of competency, of confidence, and of being accepted.

Culturally Specific Presentations and Expressions

Few epidemiological studies have examined culturally specific symptoms and illness presentations among SA, primarily because research has focused on the Asian community as a whole rather than specific subgroups and low rates of help-seeking behavior due to need for privacy and perceived stigma. The notion that mental illness is a sign of weakness of character and arises from a lack of self-control contributes to stigma which extends to the entire family.

SA, like the larger Asian community, tend to report more physical symptoms, and somatization may be the presenting manifestation of depressive and anxiety disorders [46, 47]. Somatosensory amplification, attribution styles, explanatory models of illness, illness behavior, and perceived stigma interact with cultural influences to account for the heightened somatization in this population as it is socially acceptable [48–50].

Given the collectivism of SA cultures (versus individualism in Western cultures), the core focus of fear in social anxiety disorder tends to be a fear of offending others rather than perceived inadequacy [51]. A study of 299 female SA British youth aged 16–24 years showed that this group was less likely to report depressive symptoms than their NHW counterparts. They were also less likely to be offered specialist mental health services and more likely to be referred to their primary care providers [42]. As for substance use disorders, a study of second-generation Asian Indian adolescents in the USA found low rates of substance use (cannabis 2.5%, nicotine 16.5%, and alcohol 28%) [52]. And first-generation Indian Americans had lower rates of alcohol use than other Asian immigrants and lesser binge drinking than the second generation [53]. It has been suggested that cultural differences in family values and beliefs regarding substance use and differences in metabolism of these substances may account for the differences in patterns of substance use [54]. Individual case studies postulate that substance use, especially in the second-generation Indian Americans, is likely a coping measure used to deal with acculturative stress [55]. It may also be a means to assimilate with peers by reducing differences in a social context.

Asian Americans aged 15–24 years have been found to die from suicide more often than any other cause of death [56]. Indian Americans, in particular, have lower rates of suicide attempts and completed suicides, but inability to meet high parental expectations can precipitate depression and suicidality [57, 58]. Plus, delay of seeking treatment amplifies the problem [59, 60], resulting in a complex initial presentation. Another cause for lower rates of suicide attempts could be due to religious values. Islam denounces suicidal behavior which may be another reason to present with somatic complaints rather than psychiatric complaints, whereas Hinduism professes reincarnation and basis of next birth on current karma (duties). This can result in overvaluing current failures as affecting the future and deserving of negative experiences, increasing both guilt and shame. In keeping with this theory, a study of immigrants from Bangladesh, India, Pakistan, and Sri Lanka showed a higher rate of suicide among Hindus [61].

Suicide rates among young Asian Indian women in the United Kingdom (UK) are higher than Asian Indian women and men from India [61, 62]. Interestingly, among Asian Indian immigrants, the association between duration of time spent in the USA and suicidal ideation was stronger when compared to immigrants from other Asian countries [57]. Putative mechanisms for the increased rates of suicidality include family conflicts, depression, anxiety, and domestic violence [61]. Acculturative stress and intergenerational conflict, especially in the context of relational issues, have been highlighted as key factors leading to suicidality in young SA women in the UK [43, 63]. This is in keeping with a study on gifted Asian Indian college students which showed that acculturative stress mediated by attitudes of separation and marginalization was strongly associated with depression and suicidal ideation in this group [57].

Diagnostic Considerations

Certain cultural factors that providers should keep in mind while working with SA youth and their families include:

- The salience of the experience of prejudice and racial discrimination
- Pressure to sacrifice an individual's wishes to that of the family and community
- A man's need to wield authority over his wife and children
- A need to conceal family conflicts and present an ideal face to the outside world
- A need to minimize mental health concerns due to cultural mental health stigma
- A need to minimize parent-child conflict to avoid shame and display idealized "model minority" perspective
- A lack of eye contact and silence to communicate shame and guilt
- Politeness and affirmative answers even when a question is not understood arising from a need to please [64]
- Increased pressure on the eldest child to fulfill filial duty [65]
- Taboo surrounding discussion of sexuality especially with a mental health professional of the opposite gender among individuals of the first generation
- Increased chances of exposure to domestic violence and/or violence in the country of origin

Since spirituality is an integral part of life for SA, an important aspect of evaluation and treatment planning for SA would be investigating the religious beliefs of the patient and family. For instance, Buddhist beliefs in Nepal and Sri Lanka link mental illness to deviation from right living and excessive ambitions or desire. Similarly, Hindus of India, Nepal, and Sri Lanka may believe that suffering arises from previous misconduct (bad karma) or evil spirits and acts of penance and religious rites to ward off evil spirits may be necessary for healing. Thus, it may be helpful to understand how the spiritual life of the patient influences symptoms, psychosocial impairment, and treatment.

Evidence on Intervention Approaches

Currently, there is limited research on best interventions for SA American suicidal youth. The recommendations discussed here are suggestions of mental health experts on this population. Pursuing engagement with the family from the stance of openness and curiosity is crucial to treatment engagement and good outcomes. The collective cultural stance may appear to be oppressive for an adolescent growing up in an individualistic (and capitalistic) society. However, most families have experienced immense amount of personal loss, in their pursuit of overall amelioration of the family's situation that can make them appear insensitive to the youth's pain. Developing alliance with families over their pursuit for progress would increase a MH clinician's rapport and effectiveness. This may require, at times, validating parent's experience of adversity and trauma. In Sanya's case, the outpatient team attempted to build alliance with the family by meeting them on the inpatient unit at admission and again prior to discharge.

The outpatient team held an accepting stance by agreeing to focus on only three goals for the family: (1) Sanya's safety, (2) Sanya's academic decline, and (3) family's return to the outpatient clinic. They identified a natural support system – Sanya's sister and brother-in-law – for the family. The treatment plan for Sanya's safety included regular check-ins by her sister and brother-in-law whom Sanya and parents trusted. She would also see the school guidance counselor regularly to affirm her wellbeing and academic support. By the time Sanya was discharged from the unit, parents had already removed or locked all potentially harmful objects – i.e., sharp objects and over-the-counter pills. These goals were less intrusive and less shameful to the family. The team was able to use the trusted sister and brother-in-law to convey their concerns about Sanya's isolation as she was struggling to balance two

opposing sets of expectations. By sharing their own struggles with maintaining the cultural expectations at home while maintaining expectations of independence in school, they could get Sanya's parents to listen to her side of the story. Sanya's sister was also able to impress her parent's perspective onto the team. Once the team could empathize with the parents, there was sufficient trust developed that they could start pursuing more difficult conversations. The team created environment of safety that allowed the parents to mourn over their loss of connections, validations, support system, and memories. They were also able to applaud the families' resilience that helped them overcome adversity of social isolation and financial hardships. Furthermore, the team could start discussing the parents' unique position to prevent one more loss – that of their daughter.

To sum up, once the family is engaged in treatment, following suggestions may guide MH clinicians' assessment and treatment. First, it may help to use a medical *model of illness* focusing on somatic aspects of mental illness as this is more likely to be acceptable to SA families particularly in the initial stages of treatment. This approach may reduce the perceived stigma surrounding seeking treatment. Once the youth and family have established a rapport with the health-care provider, they are more likely to be receptive to psychological aspects of illness. Second, given the reservations of the SA community toward seeking mental health treatment, it is often a crisis that precipitates a visit to a psychiatrist or therapist. A description of patterns of help-seeking behavior in second-generation SA notes that a family friend usually initiates a referral and the clinician is often viewed in the light of a guru or expert [66]. Additionally, there is a preference to seeing a physician who is familiar to the community, who has been recommended by other member's in the community, and who is known as an expert in the field. Thus, it is important for the psychiatrist/therapist to convey a sense of expertise and an appreciation of the patient's cultural background [67] to establish a rapport with the patient and the family. Third, the collectivist nature of the community and the risk factors of intergenerational value conflicts superimposed on acculturation stress make family-based interventions an important component of treatment, per Rastogi and Wadhwa's [55] study. The provider must be open to inviting respected members of the community, if family allows, while being mindful of shame associated with mental illness. Psychoeducation to the key family members about the illness and tools reduce severity and relapse. When developing the treatment plan, it is vital to invite these key extended family members with nuclear family's permission.

Fourth, the families may respond well to culturally sensitive interpersonal problem-solving approach, specifically when working with youth struggling with self-harm [42]. There is some data that a few sessions of psychodynamic and cognitive behavioral therapy are effective. Meanwhile, the safety planning is done in detail with youth that includes emergency contact services. Again, it is possible that extended family members or individuals from the community may play a vital role here. If the family members are not fluent in English, the value of a skilled interpreter who can also be used as a cultural consultant cannot be overstated.

Fifth, since SA families are reticent about psychiatric settings, meeting with a clinician does not guarantee treatment adherence in second-generation SA patients [66]. Hence, it is imperative that assertive outreach is done when the youth "no-shows." Sixth, many SA tend to consider using herbal or indigenous systems of medicine (like Ayurveda and Unani), psychic healers, spiritual leaders, meditation, yoga, and other forms of complementary or alternative medicine before seeking "Western" medicine. They will often continue with these treatments while using psychotropic medications and/or psychotherapy. Hence it is important to inquire about these practices. Seventh, ethnicity of the clinician can have positive or negative impact on the relationship depending on the expectations of the family. Belonging to the same ethnic group may result in over identification, and it is possible that the family anticipates loss of confidentiality in the community. It is important to discuss what to expect if they may run into the clinician in other settings.

On the other hand, being of same ethnicity may strengthen a sense of acceptance and understanding between the provider and the family. Similarly, the clinician of different ethnicity may benefit from a strong rapport if they practice a stance of curiosity, openness, and respect. The fear of confidentiality violation may be less. Counterpoint of the clinician of different ethnicity is that the family may anticipate the provider to have more Western healing perspective and critical or even intolerant of their culture and concerns and thereby reinforce the youth's "Americanness." Thus, it is vital to be mindful of how one's ethnicity is playing a role in the relationship. It is important to clarify potential assumptions that the family may be making. Lastly, it is highly recommended that providers working in areas with a large SA community raise mental health awareness at local schools and in community centers [68, 69].

Conclusion

In summary, SA youth have high rates of deliberate self-harm due to their struggles with acculturation, intergenerational conflict, racial discrimination, and cultural values. SA female youth are especially vulnerable to deliberate self-harm due to a complex interplay of gender related sociocultural, family, and biological factors. The second-generation SA youth manage the above-mentioned stressors in different ways – picking one cultural value over the other, rejecting both values, or mixing the values depending on personal preference. Thus, SA may present to mental health clinic in variety of ways. Mental health stigma and model minority stereotype are major reasons for low help-seeking behavior. However, we believe that increasing education about mental health in the community will reduce the stigma. Also, the culturally sensitive clinician can skillfully navigate these complexities, harness their considerable strengths, and help youth in distress and their families. Further research focused on SA and perhaps training of student clinicians in cultural issues will help in a deeper understanding of the mental health challenges faced by this community and inform treatment.

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Resources

Domestic Violence: Manavi (New York City); Saheli (New England).

LGBTQ: SALGA (New York City), Trikone- Hotline (Founded in San Francisco, chapters in many cities and countries), Khush (Washington DC), Trevor Project- Hotline.

Mental Health: New York Coalition for Asian American Mental Health; Asian American Suicide Prevention and Education; My Sahana: A Nonprofit Serving South Asians; The American Foundation for Suicide Prevention; The Jed Foundation (college students).

7 Suicide Among Southeast Asian Youth

Consuelo C. Cagande and Kalvin Foo

Case

Sue was a 17-year-old Filipino senior high school student who immigrated with her mother when she was 5 years old. The past year had been a struggle for Sue with a slight decline in grades and more participation in partying. Her friends noticed her Facebook postings were "always sad" and "dark" and pictures on Snapchat were not her usual "upbeat" pictures, with comments about being alone. Despite this, she joked around with them about it and they did not think of it as a concern. One of her friends mentioned that she would drink to feel relaxed and to be happy around her friends. Another friend recalled she once talked about dying, "What would it be like to be dead?" but ignored it because Sue was laughing when she said it. On the day of her suicide, her mother confronted her about her declining grades and increased partying. She warned Sue that her father knew about these and was angry. He told her that he would not support her pursuit of nursing school if she continued the behavior. Her mother was a nurse, but Sue was never sure she wanted to be a nurse. Sue was afraid to face her father. He was considered strict and education was always priority in order to get a good job. Fearing her father's reaction and scolding, hours later Sue went to the bathroom and took 20 pills of acetaminophen. She was admitted to pediatric intensive care unit.

Sue has no prior history of psychiatric illness but was described as a perfectionist and anxious about her academic performance as well as getting into a top nursing school. When she immigrated to the United States (USA), she was teased about her accent and did not make friends easily. Her father came to the USA 2 years after Sue and her mother did. He had difficulty acculturating to American culture given that he had to work in an under-qualified position. He was an engineer and managed a 20-person team in the Philippines; meanwhile in the USA, he was a restaurant manager. She has one older brother and one older sister who came to the USA with her father. The sister had recently been accepted to one of

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the best nursing schools in the area. In terms of relationships and support system, Sue was closest to her mother since they immigrated together. But now, her mother "always took my father's side."

Introduction

Since the turn of the millennium, suicide among Southeast Asian diverse youth has increased. It has become one of the leading causes of mortality in young people globally. Therefore, it has become a public health concern in developing countries such as those in Southeast Asia (SEA). . Suicide was identified to be one of the five leading causes of death in people aged 15–29 years [1]. There appears to be specific predisposing and risk factors, psychiatric diagnoses, and access to means of self-harm among youth who either thought of suicide, attempt suicide, or complete suicide in the majority of these countries. Fortunately, some countries have taken steps towards prevention and intervention. In other countries the stigma of mental illness is still profound. This stigma can translate into their adopted countries such as the USA, where there are profound differences in Asian-American mental healthcare utilization [2]. In the past decades, suicide has become one of the leading causes of mortality in young people globally and thus a major focus of research. It is the third leading cause of death among adolescents and youth in the USA [4]. In the USA, SEAs were found to have a higher prevalence of overall psychiatric disorders compared to East Asians and South Asians, mostly due to a high prevalence of drug use disorder (16.7%) which is a risk factor for suicide [5].

Some SEA countries underwent hardship or suffering due to suppressive leadership. There were some studies on Cambodian refugees in the USA who were young during the Khmer Rouge regime. They experienced and survived extreme conditions of death and destruction such as deprivation, physical injury or torture, incarceration or reeducation camps, and witnessing killing or torture brought about by the Khmer Rouge regime from 1975 to 1979 [6]. These youth are parents now and their experiences as refugees may affect their parenting style.

Alliances among Asian countries with Western countries had major impact on acculturation and discrimination against immigrants in the USA. For example, until recent years where most Asian countries have a respectable relationship with the western world, the Philippines had a stronger relationship with the USA than Vietnam did, especially during the war [3]. Western culture was evident in many areas of the Philippines, especially in urban cities. In addition to being under the US, the presence of the US military bases in the Philippines strengthened the relationship, providing jobs for the local people. Therefore, Filipino immigrants, especially those immigrating at a younger age, may have a better understanding and acceptance of American culture and can easily identify with certain attitudes and behaviors such as autonomy than other countries. The parents on the other hand may have more challenging experiences acculturating. This challenge can prove to be too stressful for their children also.

There has been a paucity of research on suicide in many Asian countries such as those in the Southeast Asian region, but since the turn of the century, it has become a public health concern among countries such as Cambodia, Malaysia, the Philippines, Thailand, and Vietnam. We found minimal literature, but it provided important data on predisposing and risk factors and cultural aspects and insights on suicidal behavior among youth from these countries and cultures in the USA.

It is important to understand suicide in these specific ethnic populations in their native country as well as in their adopted country such as the USA. This chapter will focus on looking into SEA-American youth who struggle with suicide and mental health in the USA.

Epidemiology

Asian-Americans are the fastest growing minority population in the USA. Among the diverse groups in the USA, a study on ethnic identity and major depression (MDD) in Asian-American subgroups (Chinese, Filipinos, Vietnamese) found that Filipinos (4.33%) and Vietnamese (3.27%) subgroups were among the top three after Chinese subgroups to most likely suffer from MDD [3]. As prior research has shown cultural attitudes to affect immigrants and first-generation attitudes toward mental health and subsequent utilization, cultural attitudes in mother countries bear weight in Asian-American populations in America [5]. Epidemiologic findings can be used to formulate a comprehensive understanding of SEA immigrants and/or descents in America.

A study on Asian-American college students and adolescents showed that this population was most likely to seriously consider suicide in the previous year compared to European-Americans. Furthermore, in this study, SEA (e.g., Hmong, Cambodia, Laotian) who are more likely to be mixed in the pan-ethnically Asian population were more likely to report suicidal thoughts in the previous 30 days and SEA older adolescent boys were more likely to attempt suicide than girls. Interestingly, the gender generalization of suicide attempts where girls are reportedly to attempt more than boys does not necessarily translate across ethnic groups [7]. The gender difference was also not the same in their country of origin.

Historically, suicide was very rare in the SEA region relative to other regions, and subsequently, SEA-Americans were thought of as a low-risk population for mental illness and suicide. To the contrary, World Health Organization (WHO) Health Statistics 2016 data reported the SEA region as having the highest suicide rate (17.1/100,000) compared to the rest of the world (11.4) [8]. It is the leading cause of death for 15–19-year-old males and females in the Southeast Asia Region, the rates being slightly higher for females than males (28 and 21 per 100,000 population, respectively) [9].

Outside of SEA, descendants of emigrants of this population have also been found to have increased rates of suicidal thoughts. The SEA region ranks third after the African and Eastern Mediterranean Regions in disability-adjusted life years (DALYs), with an indication that affective disorders are the highest-ranked causes of years lost. Trending between 2010 and 2012 has shown a 21% decrease in DALYs potentially because of recent public health focus [10]. Additionally, a significant focus is placed on school-aged students as a focal population for suicide, but this does not capture the full scope of youth. To appreciate a more comprehensive perspective, cultural epidemiology that may impact these youth immigrants must be assessed.

In terms of Southeast Asian factors that may compound Southeast Asian-American youth's emotional state, studies involving Cambodia, Malaysia, the Philippines, and Vietnam reported the most vulnerable age group for suicidal behavior was between 15 and 24 years old [11–14]. This is consistent with the systematic analysis of population health data on global patterns of mortality in young people which showed suicide increase in both sexes in people aged 15–24 years and was overall the second most common cause of death [1]. Our case subject, Sue, falls into this age group.

Brunei seemed to have the lowest suicide rate among youth ages 10–19 years [15]. However, this Brunei study did not specify the factors that protect this age group from suicide risk.

In Cambodia, youth who had conflicts in their academic or filial lives are at risk for suicide. A youth risk behavior survey revealed 19% of 11–18 years old expressed suicidal thoughts and 14% made suicidal plans. Among those who had suicidal thoughts, 39.5% had attempted suicide once and 12.4% more than three times [13].

Data that may help clinicians with Vietnamese-Americans is that overall prevalence of suicidal ideation in the last 12 months was lowest in Hanoi (2.3%) compared to 8.1% in Shanghai and 17% in Taipei. Consistent with most countries females were more likely to report suicidal ideation and attempt. A 1998 data from the Ministry of Health estimated the national prevalence in Vietnam to be 0.98 per 100, 000 [12].

In Thailand, a survey of the transgender youth population revealed that 49% had attempted suicide in the past. In another study of 55 Thai transgender youth aged 15–21, 45% had seriously consider suicide and 26% had suicidal behavior [16]. In another Thai study on fatal firearm injuries, autopsy reports found suicide as the second most common manner of death, consisting of 29 males and 3 females [17]. This gender difference in lethal means is consistent with the US means of suicide.

Malaysia has a heterogenous population of Malays, Chinese, Indians, and indigenous people. The Indian ethnic group has the highest attempt and completed suicide rates. It is thought that the Hindu faith appears to permit suicide for a noble cause. Malay Muslims, on the other hand, consider it to be a taboo. The Malaysian Psychiatric Association estimated that seven people, mostly comprised of youth and young adults, are killing themselves daily. According to the 2011 National Health and Morbidity Survey done by the Ministry of Health Malaysia, 6.3% reported having suicidal ideation. Females were found to have reported higher suicidal ideation. Unlike developing countries, there was no difference between urban and rural population [18]. The prevalence of suicidal *ideation* in 2012 seemed to increase to 7.9% which was higher compared to Cambodia (6.2%) but lower compared to that of Vietnam (16.9%), the Philippines (16.3%), and Thailand (8.8%) [14]. There did not seem to be a specific factor for this increase, but a heterogenous group can be a factor in terms of identity crisis or the stress of maintaining one's cultural values and challenges of acculturation. The past-year prevalence rate of suicidal ideation in a systematic review by Armitage et al. ranged between 6% and 8%, consistent with the other studies [19].

In the Philippines, a study using the Global School Health Surveys (GSHS) found 17.1% of students reporting seriously considering attempting suicide in the past 12 months. This is close to the US high school 2003 Youth Risk Behavior Survey (YRBS) of 16.9% and higher than China's GSHS result of 15.8%. Unfortunately, the GSHS did not inquire about suicide attempt [20]. Another study analyzed the suicide death trend from 1974 to 2005. It revealed an increased incidence of suicide in both males and females. Consistent with most countries, more women than men attempt suicide and case fatality is higher in males (3.3:1). Overall, the increases in incidence occurred in adolescents and young adults [11]. In a small and very rural island called Palawan, a survey was conducted due to an increase in suicide rates there. They found the suicide rate to be ten times more than in the USA, Canada, and many European countries. Similar to other studies, the suicide rate in ages between 15 and 24 years was high (56.25%) [21]. One theory for the high rate is limited access to modern technological support, higher education, and employment opportunities. But this is a theory that is not fully proven among most Asian-Americans like Sue, where social media via technology can be a vehicle to both more stress and a cry for help. Furthermore, Sue had access to higher education with nursing school and employment opportunities as a nurse. One would think these as protective.

Descendants from these countries in the USA are showing similar age patterns; therefore, screening is vital for prevention and intervention for Southeast Asian youth like our 17-year-old Sue. What are the other factors then that pushed Sue to take her own life?

Risk Factors/Culturally Specific Presentations and Symptoms/Expressions

Experiencing developmental changes in the context of psychosocial struggles cause youth to be very vulnerable for high-risk behaviors such as suicide. It is well known that having a mental illness and history of prior suicide attempt are major risk factors for future suicide attempts. Asian-American youth with longer histories in the USA, i.e., Filipinos and Chinese, will have less stress than Koreans and Vietnamese, who would more likely to be recent immigrants and

refugees [22]. Integration and cultural assimilation of a particular Asian subgroup has thought to be an alleviating factor to the stresses of multiculturalism of Asian-American youth, in terms of adaptation to culture and American views of the subgroups. Compared to children of US-born non-Hispanic White families, American children of foreign-born Asian families were at greater risk of poor physical health, depression and anxiety (by parent report), and inadequate interpersonal relationships. Children of US-born Asian parents did not differ in physical health or internalizing problems. Physical and mental health was worse in SEAs, due to higher likelihood of disadvantaged living situations. Furthermore, Huang and his group reported the "model minority" concept of Asian-American children compared to other ethnic backgrounds seemed to have added perpetuating pressure of academic achievements in this age group [23]. Sue's parents like most Asian parents place a high value on educational achievement. Sue was described to be a perfectionist and seemed to value academic performance as expected of an Asian child.

Willgerodt reported that family bonds and peer behavior exert significant influences on psychological and behavioral outcomes in Asian-American youth, similar with White adolescents [24]. Social connection and support in the USA is vital for their mental health. Sue seemed to have friends, but social media has also substituted friendship in terms of posting vague or encrypted messages that seem to be a cry for help despite "sugarcoating it." Clinicians should take into consideration social media activity and value of friendship as part of their mental health assessment of all SEA youth.

There are other risk factors discussed below in individual SEA countries that can impact their mental well-being when attempting to acculturate in the USA. They can also directly and indirectly impact mental health and risk for suicide in these youth. Clinical implications of the following factors and findings from studies are important for a culturally informed mental illness assessment of SEA-American youth.

Malaysia

In Malaysia, it was found that the commonly reported suicide attempts were due to personal illness issues, family illness, bereavement issues, interpersonal issues, work issues, and other life event issues in descending order. Base on a review of psychological autopsies, interpersonal issues contributed to 94% of total cases of suicide attempts. Malaysian-American youth may struggle themselves with interpersonal relationships.

The presence of generalized anxiety disorder (GAD), major depressive disorder (MDD), and a past lifetime history of major depressive disorder greatly increased the risk. One study found depression as the only predictor for suicidal ideation which is consistent with other countries. Other precipitating factors found among Malaysian adolescents were being bullied and being abused at home, either physically or verbally. Sue was bullied for her accent as a child. There seemed to be no other form of abuse which is protective. Consistent with other countries, alcohol dependence was associated with suicide risk [14, 18, 19].

Understanding how faith is valued among youth can help mental health providers formulate religion as precipitating or protective factor. The Hindu faith reportedly has less deterrents with respect to suicidal behavior. General attitude though varies with some Hindu scriptures condemning it and others condoning it. Researcher Adityanjee in India reported that "Hindu religion has given sanction to altruistic suicides." In contrast, Malay Muslims endorse it as taboo. In fact, attempting suicide is a crime in Malaysian law which might explain the low rate of reported suicidal ideation in one study [25].

Means of suicide is also important to explore in this population. Hanging was the most common means of suicide in the urban regions, while ingestion of agricultural poisons was more common on rural areas. Though, more recently, there have been increasing reports of jumping from tall buildings. This can be attributed to Kuala Lumpur's boom in high-rise constructions [15, 19]. Having

close friends and married parents were strongly protective against suicidal ideation [19, 25].

Cambodia

There is a paucity of studies involving Cambodian youth in the USA, but more recent articles have studied refugees who were young during the Khmer Rouge regime. In addition to experiencing extreme conditions of death and destruction, the Cambodian refugees in the USA also endured racial discrimination and "severe antagonism." Shirley McSharry and Robert Blair studied a cohort of Cambodian refugees in Utah, where the largest number of Cambodians settled. Their findings resulted similar findings with earlier studies where post-traumatic stress disorder (PTSD) and major depressive disorder (MDD) were ubiquitous among this population. Risk factors included greater number of war traumas experienced (average of 20.1), greater number of resettlement stressors, loss of more immediate family members, and financial stress. Given there were more men killed during the Khmer Rouge regime, there were more women among the refugees. A protective factor was living with immediate family or extended family while in the camps [6].

Thailand

Thailand ranks the highest rate of civilian gun possession among regional countries. Access to a lethal weapon is a well-known risk factor for suicide. In Thailand, suicide is the second most common manner of death (21.5%) using a firearm. Men are more likely to commit suicide, consistent with global data trend [17]. In the USA, gun control may have more restrictions than Thailand. Therefore, suicide by guns may occur depending on the availability of guns.

A report on Thai transgender youth identified depression, substance abuse, underage sexual activities, feelings of insecurity at school, cigarette smoking, and a lack of social support as the most common risk factors affecting LGBT and non-LGBT population. It also observed that loneliness was a high-risk factor and predictor for depression, suicidal behavior, and sexual risk behavior among Thai transgender youth. Furthermore, those with higher level of education reported greater loneliness (feeling isolated from the general population), contrary to most literature reporting lower levels of education are more frequently to report loneliness. Using the Positive and Negative Suicide Ideation Inventory (PANSI), Yadegarfard et al. found Thai transgender adolescents aged 15–19 years to have higher suicidal ideation than non-transgender adolescents [16]. The outward appearance and higher visibility of transgender people are more evident in Thailand than in most Asian countries, but there is still high prevalence of hostility and prejudice toward LGBT people, as well as institutional discrimination [26]. Thai transgender youth in the USA would have similar factors mentioned earlier in addition to the stigma of being transgender and being in the minority population. These are factors that can lead to suicide. It is possible that stigma of being trans in the Thai community can isolate the youth from his family and community, thus, potentially stripping him/her of a support system.

Vietnam

Like the Cambodian immigrants, earlier Vietnamese settlers arrived as refugees. They also left their homeland under frequently violent and traumatic circumstances of the Vietnam War. Fifty two percent of Vietnamese-American children who were US born were under 18 years as of 1990. Although they may have not experienced the trauma of war, they were still deeply affected by family histories and quasi-mythical accounts of life in the host country [27]. The study on ethnic identity in Asian-American subgroups by Amy Ai et al. reported that racial and ethnic identity and level of acculturation stress were the highest in the Vietnamese subgroup [3]. This stress can impact the youth of refugees.

Like most Asian countries, Vietnam has experienced an economic transformation and increas-

ing influence of more developed countries that challenge their traditional values. These can have an impact on Vietnamese-American youth. Blum studied the impact of this influence of social change on the rates of adolescent suicide and risk factors among youth in Hanoi. Younger age groups, female gender, family structure (i.e., single parent), immigrant status, family history of suicide, adverse relationships with mother and father, and alcohol use were all associated with suicidal ideation. Smoking cigarettes in the past month appeared to be almost two times at risk for suicidal ideation. Migrants from rural to urban had almost twice the likelihood of suicidal ideation compared to their urban native peers. These youth were the least likely to seek help if they were experiencing suicidal thoughts compared to youth in Shanghai and Taipei, but they are most likely to turn to peers, followed by partners and, then, parents. Interestingly, males were more likely to turn to parents. Comparatively, females were more likely to turn to health professionals and peers. A higher positive maternal relationship was a protective factor for youth in Hanoi [12]. Religious involvement and social support supplied protection of mental health in Vietnamese subgroup as well as having the highest level of racial and ethnic identity [3]. Immigrant parents with these behavioral patterns can also have an impact on Vietnamese-American youth.

The relationship between length of residence in America and depression in Vietnamese-Americans was reported to be significant. The first decade of resettlement had higher levels of psychiatric problems. However, after approximately 12.5 years, depression levels decrease. Age, family income, and gender had no effect. Protective factors included being married, higher education, employment, and good health [28].

Parenting style seemed to be a significant risk factor for Vietnamese-American youth mental health issues that can lead to suicide. Vietnamese-American adolescent immigrants who perceived their fathers as using the authoritarian parenting style reported lower levels of self-esteem and higher depression scores when compared with those who perceived their fathers as using the authoritative parenting style [29]. A limitation of this study is that it did not explore suicide. It would enhance a clinician's knowledge about Sue's relationship with her father and her perception of her father's parenting style. Sue seemed to be closer with her mother but at the same time felt betrayed. "My mother always took my father's side." The mother herself seems to be caught in the middle.

The Philippines

Factors that impact Filipino-American youth tend to be rooted from their country of origin. In the Philippines, the most commonly used methods of suicide were hanging, shooting, and organophosphate ingestion. Common precipitants were family and relationship problems. The most common diagnosis was adjustment disorder. In an indigenous tribal group in Palawan, poisoning by a plant *Derris elliptica* (tuba) followed by hanging were the most common means. In this group, called Kulbi, reasons for suicide among the younger and middle-aged adults were anger, jealousy, "love problems," and grief over the death of a loved one. Other characteristics such as impulsivity, violence, childhood abuse, and substance use are risk factors as well [11, 21].

In a study by Page et al., suicide ideation was associated with substance use, physical activity, feelings of loneliness, hopelessness/sadness, and worrying. Sadness or hopelessness almost every day for 2 weeks or more consecutively that limits functioning was the overall strongest predictor of suicide ideation. Interestingly, this study found that obesity and sedentary lifestyle (sitting activities more than or equal to 3 h per day) was protective for Philippine adolescents compared to Chinese adolescents. The explanatory theory was that the overweight Philippine adolescents who have access to electronic devices represent those with adequate family income. Therefore, the economic advantage is indicative of emotional well-being in this population. Filipino-American youth of immigrant parents may not have this economic advantage in the USA, thus it can have a psychosocial impact.

In terms of economy and financial factors, for Sue's case, it seems the family income may have decreased. The father achieved higher status in the Philippines but forced to acquire a more middle socioeconomic status in America. Furthermore, he was not employed for what he studied for, an engineer. There are many SEA families with similar situations. This can have an impact on SEA youth. They may feel the pressure of achieving higher education. Their parents only "want the best" for their children, not necessarily what the children may aspire for themselves. They want for their children what they never had in their country of origin or even in their adopted country.

Alcohol use, ever being drunk, using drugs, current smoking behavior, being in a physical fight, having no close friends, and been bullied were other risk factors for suicidal behaviors. Page also identified that there was higher risk for suicide in the least populated and more rural regions [20]. Living in an urban community where there are other similar ethnic groups tends to be psychologically protective among Filipino-Americans. Major cities such as Honolulu and in the west and east coasts such as Los Angeles, San Francisco, New York, and Jersey City/Newark areas have large Filipino communities among other Asian cultures.

Filipino culture is predominantly Roman Catholic. Religion has been found to be protective when suicides were barred from receiving religious burial sites. In 1983 this ban was removed from the canon law and seems to correlate with the increase in reported mortality rates in the Philippines and other predominantly Catholic countries. Nevertheless, the strong Roman Catholic culture could also be protective, which is consistent with low suicide rates in other predominantly Catholic countries [11].

Unlike with Vietnamese-American, ethnic identity and level of acculturation stress were lowest in Filipinos. The Filipino subgroup reportedly experienced the highest level of discrimination, but it also reported the highest levels of social support. Social identity theory may explain this discrepancy since "when facing collective stressors, the targeted group can rally around its identity to collectively resist adversity." In the same study, although immigration and cultural experiences were different from Chinese and Filipinos (they experienced more overt racism and discrimination early in their immigration status), the acculturation stress experienced by Vietnamese was found to be related to elevated diagnosis of MDD. The Philippines' alliance with the USA against North Vietnam may have contributed to a low level of perceived discrimination. Furthermore, Filipinos may be more acculturated because of their exposure to Western culture through the three-century colonization by Spain and the USA [3].

Although Sue was not a refugee and did not seem to experience physical or sexual abuse, being teased for her accent and not having friends during her early childhood may be traumatic enough as an immigrant child. Her onset of depressive episode was during her adolescent years which can portray resiliency until internal conflict develops. The nature of the parent-child relationship must be explored. She wants to be successful and make her parents proud but at the same time she wants to be independent, making her own career choice instead of what her parents want, with the risk of losing their support. Filipino-American students were less willing to openly disagree with their parents [24].

In summary, a good support system and faith appear to be the most common protective factor among Malaysian, Cambodian, Vietnamese, and Filipino-American youth. The degree or perception of the support system should be explored, though a SEA-American youth may vary based on their own personal family history, coping mechanism, and economic status like Sue.

Diagnostic Considerations

Asians are likely to be more comfortable talking about somatic as opposed to psychological complaints. Internalizing symptoms and depressive symptoms were related to an elevated risk for suicidal presentation among Asian-American youth [30]. The *model minority* myth that depicts Asian-Americans in better psychological health than the general population has been refuted. In

one study, ethnicity was not significantly associated with somatic symptoms. But other studies on Asian-American college students consistently revealed more somatic complaints, isolation, and anxiety. Another study reported Asian-American adolescents aged 12–17 to score lower on depressed mood scales compared to Latinos, Euro-Americans, and African-Americans. In a nationally representative study of immigrant youth, it was found that Filipino and other Asian adolescents were more likely to report depressive symptoms compared to non-Hispanic Whites [31]. Hopelessness was a major psychological symptom that preceded suicidal thoughts among Asian-American adolescents in general [30]. Sue had signs and symptoms of depression with suicidal behavior. She seemed to internalize symptoms compounded by her ambivalence about becoming a nurse but at the same time displaying signs of depression through social media.

Using the DSM-IV criteria among Asian-American adults compared to European-Americans, which may also reflect youth, a study reported that there was no overreport of somatic symptoms (i.e., appetite changes, sleep disturbances, loss of energy). This is contrary to what is more widely known of people of Asian descent reporting primarily somatic symptoms and endorsing affective symptoms (i.e., sad mood, anhedonia) more rarely, which may explain the low rates of depression reported in some Asian countries. But the study did reflect a high rate of a variety of depressive symptoms, including depressed mood, discouragement, insomnia, loss of energy, trouble concentrating, loss of self-confidence, and decreased talkativeness. Asian-Americans endorsed feeling worthless and appetite disturbances more easily [32]. Psychological autopsy of Sue's suicide attempt and the emotions and events leading to it would reveal many of these symptoms, including discouragement. She may be discouraged by her mother who she perceived to be close to her or discouraged about herself not being able to disagree with her parent's aspiration of her.

SEA-American engaged in substance use may also be a risk factor to suicidal behavior. For example, cigarette smoking was related to depression among Chinese, Korean, and Filipino females [30]. Another study found substance use to be the highest prevalence rate (16.7%) among SEA-Americans compared to other Asian-Americans in the study (East Asians 13.1%, South Asians 11.1%). In the same study, SEA-Americans had a higher prevalence of any DSM-IV psychiatric disorders (34.6%) compared to East Asians (22.5%) and South Asians (24.5%). Furthermore, SEA-Americans were found to have the highest point prevalence of any mood disorder and any anxiety disorder. Although the latter finding was not found to be statistically significant [5], psychiatric disorders among SEA-Americans play a major role in suicide. Another study reported that Filipino-American adolescents engaged more in delinquent acts that moderately correlated with substance use compared to Euro-American adolescents. The reason was unclear [31]. Sue's substance use seemed to spiral and seems to impact her academic performance. This can further impact her status for nursing school. She may have been self-medicating herself. It is well studied that substances altering the mind predisposes a person to suicide. Sue may have not been using drugs at the time of her suicide, but the chronicity of use has a major impact on the mood, impulse control, and judgment.

Evidence on Intervention Approaches

On a regional level, Suicide Prevention International's (SPI) Strategies to Prevent Suicide (STOPS) project approaches suicide prevention through increasing public awareness and knowledge, educating gatekeepers, increasing identification of at-risk individuals, improving treatment for suicide-risk conditions, reducing access to lethal means of self-harm, and protecting survivors of suicide [33]. The overlapping countries between this project and countries of focus in this chapter include Malaysia, Thailand, and Vietnam. While it employed novel strategies and examples of implementation in the countries, the report acknowledges the infeasibility of finding statistical significant

reduction of suicide and evaluates programs through changes in identification of at-risk individuals and ability to provide help to them.

In terms of improving public awareness and improving media portrayal, the Malaysian Ministry of Health, in conjunction with the Malaysian Psychiatric Association and the Befrienders Worldwide organizations, has released posters and radio and television broadcasts and run public forums. Furthermore, they released national guidelines for media presentation of suicide, leading to news frequently detailing the method of death and acknowledging related mental disorders. On the other hand, the Ministry of Public Health in Thailand has held multiple seminars on how to sensitively present suicide news, and strong public efforts have not been made in Vietnam. With regard to awareness and portrayal, there is frequent failure to acknowledge mental disorders related to suicides and little exposure of suicide-related stories. Unfortunately, there has been weak evaluation for these programs.

Gatekeepers are nonmedical workers who have regular and widespread contact with individual in distress and have been a target by the STOPS project to better identify and facilitate guidance to mental healthcare. Teachers, social workers, religious leaders, and policemen are all examples of gatekeepers that participating countries have targeted. While there have been local efforts in all STOPs participants, only Thailand has nationally approached gatekeeper education, as the Ministry of Public Health has trained community leaders on how to recognize depression and developed referral networks. Utilizing a cultural resource, there has also been work with Buddhist monks to educate and counsel suicidal individuals using Buddhist dharma, although both programs have not been evaluated.

In a culture with limited help-seeking behavior, novel identification strategies of high-risk individuals have operated at the community level, through non-health sectors, and implementation of screening and detection. Examples in the region have enhanced screening for high schoolers, military personnel, gamblers, and welfare recipients, but multiple participants have reinforced suicide screening for people with existent mental health issues.

Restricting means of self-harm works through a multifactorial theory, one of which is by minimizing the role of impulsiveness in suicide due to access barriers. As such, members of the STOPs project have aimed at reducing access to poisons, restricting firearms, and securing jumping sites. Pesticides, as a primary means of poisoning in rural areas, have encountered provisions such as warning labels, lockboxes, and other small-scale projects pending evaluation. This may hold true still in youth living in rural areas where migrant Asian families are. Finally, the STOPs notes a lack of support for survivors of suicide, as support groups, professional support, and psychiatric consultation were not readily accessible for these individuals. For the support services that were found, they were noted to be isolated major urban areas. This was found to be an area that is a culmination of social and political factors that have been strongly affected, and that with the existing knowledge of increased risk of suicide for individuals with prior attempts, it needs to be properly addressed.

While the STOPs program has been a collaborative international effort, there have been concurrent studies and interventions at different, nongovernmental levels. For example, in studies targeted at school-aged and university-aged youth in Cambodia and Malaysia, respectively, deficit in life skills and problem-solving schools have been linked to suicidal ideation [9]. School-based interventions to build psychological hardiness have been employed in an effort to improve mental health profiles.

Asian-Americans have a low rate of help-seeking behavior [2]. They are among the least to utilize mental health services. Stigma, cultural beliefs and practices, and barriers to services may affect their motivation to stay in treatment. Studies have shown that patients who engage in treatment have better health outcomes than those who dropped out of treatment [34].

A culturally sensitive school-based mental health program seems to be an important model for early detection, intervention, and preventive strategy for SEA youth. A study looked at the

effectiveness of such a program for SEA refugee children. The program included a collaboration among bilingual/bicultural teachers and nurses in schools implementing a cognitive-behavioral school-based program. The cognitive-behavioral interaction emphasized coping skills building and homework assignments. The latter were designed to foster parent-child interaction. The Children's Depression Inventory was used 1 month prior the intervention, at 4 weeks and 8 weeks and 1 month following the intervention. This may improve and meet the needs of the youth. The study demonstrated a successful decrease in depressive symptoms among these children. It also reportedly diminished any social stigmas that may have been associated with attending an after-school activity [35].

Sue would benefit from psychopharmacology and psychotherapy given the severity of her depression. Careful dosing of psychotropic medications should be considered for SEA youth. Medications should start at a lower than recommended dose given Asians have reduced cytochrome P450 enzyme activity [36].

Psychotherapy should focus on improving her coping mechanisms, self-seeking behavior, and interpersonal skills. The parents will require a lot of psychoeducation about Sue's diagnosis, especially signs, symptoms, and course of depression. Specifically, highlighting that depression occurs insidiously, and that it is not a sign of weakness. Family therapy should also be considered since, for Filipino adolescents, family support was an important protective factor against academic, behavioral, and emotional difficulties [37]. The father may have difficulty accepting the mental illness and engage in family therapy. He may also have the burden of guilt which he may not endorse right away. Addressing expressed emotions may also be a good strategy. Although Sue is a Filipina, there was a study on the perceptions of Vietnamese fathers' acculturation level, parenting style, and mental health outcomes in Vietnamese-American adolescent immigrants. Results revealed most of the adolescents perceived that their fathers have not acculturated to the US culture and continue to practice the traditional authoritarian parenting style, regardless of the amount of time spent in the USA. Furthermore, the adolescents who perceived their fathers as using the authoritarian parenting style reported lower levels of self-esteem and higher depression scores when compared with those who perceived their fathers as using the authoritative parenting style [29].

In terms of psychotherapy, the idea of ethnic match between therapist and patient remains to be studied more as an effective treatment. A study did illustrate ethnic matching as a significant predictor for success of treatment [22]. It may help develop a stronger therapeutic alliance but more for the parents rather than the youth. The parents may expect the therapist and psychiatrist to be "on their side." Countertransference and transference issues need to be addressed if it will affect the alliance. Developing rapport involves a trusting, predictable relationship that often develops gradually [6]. A benefit for the youth may be that the therapist's and psychiatrist's recommendations will be taken seriously given their high professional status. Medical professionals are highly respected in Asia, especially in the Philippines. Engagement is key to success of treatment [35]. Good rapport always has an impact on outcome. The challenge is dissecting through the stigma and guilt a family member may be feeling and not being open to treatment. Given interpersonal issues are a major factor, starting with a focus on the positive aspects of the relationship and person may help as a start. The model of behavior therapy can be applied in the early psychotherapy stage.

Conclusion

There is a paucity of literature and studies on the increasing trend of suicide rates among SEA youth. But the literature we found and discussed in this chapter has data that provided insight and foundation to further researching the risk factors, prevention, and intervention in the SEA. There were a few studies done in Malaysia and the Philippines.

Hanging and ingestion of poisons were the most common means of method to suicide. In a

high firearm possession country or region, preventive measures must be implemented.

Psychological and interpersonal relationship problems were the most common predisposing factors. Religion seems to still have a protective purpose, but interestingly in certain religions such as Hindu and Catholic practices, it has allowed this population to accept suicide as a ways of coping with stress or as a "saving face" behavior. More research into religion as a protective versus precipitant factor should be done. Additionally, regional cultural beliefs and practices also need to be considered and explored more as risk factors as exemplified by the subgroup in a remote region in the Philippines.

Social media was not studied or mentioned in the literature we found for this specific region. Globally the Internet has brought youth closer across the oceans, and it should play a big factor especially when cyberbullying has been known to precipitate suicidal behavior. On the other hand, social media can act as a "big brother" that can help alert family and friends to intervene. In our case, social media did not protect Sue. Her friends did not alert her parents or other adults despite their perception that Sue was not serious.

The SEA region of the world should be able to collaborate and share data to better understand what the driving forces are that have propelled an increase in suicide rate in the youth. One of the goals should be to educate and destigmatize mental illness and suicide in this region which can be carried with those who immigrate to the USA. Furthermore, a level of support that is safe to talk about their feelings and not feel alone should be available to youth in this region. There are programs that have been implemented already, but more efforts should take place within the family unit as well. Preservation of family and social support appears to be a strong protective factor among SEA-American youth.

The content discussed in this chapter has valuable implications for mental health professionals and primary care physicians who provide care to SEA-American youth. The youth's cultural and ethnic background should be considered as part of the assessment, cultural formulation, and treatment plan for mental illness among SEA-American youth.

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8 Suicide Among East Asian Youth

Steven Sust, Lea Hecht, and Zheya Jenny Yu

Case

John (pseudonym) is a 15-year-old East Asian American male with no significant past psychiatric history who lives with his parents and a younger sister. John's father and mother work at the same salon as full-time hair stylist and part-time manicurist, respectively. His parents were born and raised in Saigon, Vietnam, where they met and married. They immigrated to Northern California in their 20s in 2001, shortly after which John was born. Two years later, they had his younger sister. His parents stated that they are ethnically Chinese and that they fluently speak Mandarin Chinese as well as Vietnamese at home. John initially presented after school counselor contacted his parents about John's chronic suicidal ideation with recent aborted suicide attempt by stepping in front of a train. John stated that he was in his usual state of health until transitioning into high school where John felt lonelier because his closest friend from middle school moved away. John always struggled with making new friends because of his shy temperament. Notably, John reported a significant lifelong preoccupation with being the center of attention in class discussions or peer interactions due to his fear of being judged or humiliated and socially rejected. Thus, John remained relatively silent and socially reclusive from school peers for the entirety of freshman year while seeking out social support from his 13-year-old sister or fellow Internet gamers. Although John's grades were superior in all classes, his parents grew increasingly concerned about his social reclusion and video game overindulgence. In the autumn of sophomore year, his parents tried restricting his access to his smartphone and video games in order

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to promote more pro-social behavior, but his parents noted that this became an increasingly volatile point of contention with John that contributed to daily arguments. In hindsight, John stated that the loss of his phone and video games led to loss of contact with "Clash of Clan" peers and John's primary stress reliever. So, he frequently complained and commiserated with his younger sister.

In the 6 months preceding the aborted suicide attempt, John reported gradually worsening social isolation, low mood, irritability, and hopelessness. He began to believe that no one cared about him. On the day of John's aborted suicide attempt, upon returning from school, he reported an argument with his father about John's phone usage. Subsequently, another argument ensued with his sister when trying to share her tablet. Feeling invalidated, rejected, and aggravated by his parents and sister, John left home without parental permission and walked around the neighborhood and then went to the train station. John walked up to the walkway adjoining the train tracks to stand with other passengers waiting for the coming train so that he could jump in front of it. However, he hesitated because the train was moving too slowly for a successful suicide, and he feared that it would instead only lead to permanent disability. Once the train pulled away, John stayed at the station for another few minutes before deciding to return home. John confided in his sister about his suicidal intent at the train station. He made her promise not to disclose this secret to their parents to avoid further scrutiny by them. John's sister reportedly was distraught and subsequently discussed this with her friends at school the next day, which led to the school counselor contacting John and his parents for formal recommendation of mental health treatment. The parents first contacted John's primary care doctor, who then made an urgent referral to an integrated behavioral health clinician.

Formal psychiatric evaluation revealed no significant past medical or psychiatric history, and no current or prior medications. John denied past or present alcohol and substance abuse. His parents initially denied prior family history of significant mental illness, but when specifically asked about any ostracized family members, John stated that his parents often talked about John's maternal cousin who was depressed, playing too many video games, and socially isolated. Developmentally, John's parents denied gestational complications, exposure to substances in utero, and reported normal standard delivery. Parents reported that John met milestones appropriately except for speech impediment (slurring) that benefitted from speech therapy in early years of elementary school. In school, John's grades were always superior to his peers. He had a select few classmate friends to whom he was extremely close and frequently played video games with them. However, these friendships dissipated when his last friend moved away during summer transitioning from middle school to high school. At home, John reported that he was closest with his sister and older female maternal cousins. His parents reported in confidence that they had typical relationship with John. Interestingly, John listed talking to his parents as an item on his hierarchy of feared events. John attributed their strained relationship to a long history of arguments over John's "laziness" and incomplete chores. The parents blamed his excessive involvement with video games for his behavior. John admitted that he liked to play video games online after arriving home. He felt that he could play while simultaneously completing homework and performing activities of daily living.

Furthermore, he clarified that he only played when he was bored or when he felt uncomfortable. For example, when he spent time with his sister or cousins outside home, he did not play video games because they made him feel comfortable to be himself.

Initial treatment planning included a safety evaluation yielding no acute safety concerns and concluded with John jointly completing Crisis Safety Plan [1] and then explaining this plan to his parents. Afterward, they all received several photocopies, which were regularly reviewed in subsequent sessions since both John and his parents frequently lost or forgot elements of the Crisis Safety Plan. Not so surprisingly, treatment planning also consisted of conflicting elements whereby parents were interested in reducing John's excessive video game play while John showed more interest in decreasing anxiety related to social interactions with a goal toward having closer social supports. Thus, the clinician and John as well as family agreed to start weekly individual cognitive behavioral therapy targeting John's social anxiety and family therapy targeting their disagreements. Cognitive behavioral therapy sessions started with psycho-education regarding social anxiety, cognitive distortions, and safety behaviors followed by weekly hierarchy revision and either imaginary or in vivo exposure. By the end of week 8, John still reported significant social anxiety but was able to connect with a new friend who shared John's interest in "Clash of Clans" and played basketball outside with John on a weekly basis. Although limited to ten sessions, John reported some improvement in anxiety and denied experiencing significant stress leading to suicidal ideation despite ongoing arguments with his mother.

Introduction to East Asians

Asian immigration into the United States (US) came in ebbs and flows. The first major wave of Asian immigration happened in the 1830s when Japanese farm workers migrated to Hawaii, but subsequent immigration patterns from all parts of Asia changed for multiple reasons. Geopolitical events such as World War II and the Vietnam War and shifting US polices such as The Chinese Exclusion Act of 1882 and the Immigration and Nationality Act of 1965 significantly shaped Asian immigration into the United States during their respective time periods [2]. More recently, review of US census data plus multiple other sources shows that immigration into the United States came primarily from China, Vietnam, India, the Philippines, and South Korea [3].

The Asian population of the United States is a growing demographic which the US census bureau defined as "original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam" [4]. Previous US census reports showed that the Asian population between 2000 and 2010 increased by 43 % and grew faster than any other US minority population. In a 2010 US census report, over 17 million out of 308 million respondents self-identified as Asian and represented approximately 5.6% of the US population [4]. More recent 2015 estimates by the US census report nearly 21 million out of 330 million self-identified as Asian and represented 6.3% of the US population [5].

On average, Asian immigrants entered into the United States through legal means that were related to work, family, or political status, but unstable socioeconomic circumstances in some Asian countries created surges of undocumented immigrants who endured harrowing conditions in hopes of better opportunities. Previous accounts of Vietnamese refugees after the Vietnam War depicted the hazards of piracy, extortion/theft, and murder which traumatized families as they fled the invading Northern Vietnamese armies [6]. A 2013 New York Times article about

Chinese undocumented immigrants described high costs to be smuggled into the United States only to encounter long hours with cramped lodgings in hopes of paying off debts and obtaining legal residence [7]. Currently, there are an estimated 1.5 million unauthorized immigrants from Asia living in the United States, and many continue to avoid government programs such as Medicaid and Deferred Action for Childhood Arrivals (DACA) due to distrust of American institutions [8]. Though the term "Asia" covers a large area in the world, in this chapter, the focus will be East Asians—specifically, individuals from China, Japan, Vietnam, and North and South Korea. Since the research studies do not always delineate between Asians and East Asians, the information provided here is as distilled as possible from multiple overarching studies.

Confucianism

Confucianism originated nearly 2,000 years ago, and its cultural influence spread so deeply throughout East Asia (e.g., China, Korea, Japan, Vietnam) that its reach is evident in modern East Asian immigrant families. The first major principle of Confucianism refers to benevolence (仁) and ascribes great importance to virtues such as kindness, generosity, and, particularly, filial piety (孝), which emphasizes strong respect toward family elders. The second major principle of Confucianism refers to education and places scholars at the highest social class compared to farmers, workers, and businessman. The third major principle of Confucianism refers to family harmony which emphasizes further family needs rather than individual needs especially with respect to educational aspirations. Thus, Confucianism can influence parents to adopt a more active role in their children's educations and influence their children to seek out high educational goals as a pathway toward families' upward social mobility. (For more extensive discussion, please see the book chapter by Huang and Gove (2015) [9].)

A mixture of Tao and Buddhist philosophies as well as ancestor worship forms the basis of Chinese beliefs. The holistic theory of body and mind in Chinese beliefs suggests that mental health depends largely on physical health, as mental activities are as a result of somatic activities. Physical and mental health are reflected by one's emotional state, which is regulated by circulation of air (氣) that is maintained by a combination of an innate quality and intake of food and drink. Therefore, unbalanced emotion (through 氣) is considered as the primary reason for any kind of illness [10].

Survey Statistics

The overall suicide rate in the United States has been increasing over time. According to the National Center for Health Statistics, there has been a 24% increased suicide rate from 1999 to 2014 with higher percentage increase in females (45%) than males (16%) for age-adjusted suicide in the general US population [11].

A review of the US youth survey data has revealed significant concerns about suicidal ideation among Asian high school students. According to the CDC's High School Youth Risk Behavior Survey (YRBS) in 2015 [12], 17.7% of Asian high school students indicated that they had seriously considered attempting suicide during the 12 months before the survey was administered (Table 8.1).

Similarly, California Healthy Kids Survey showed 18.3% of Asian high school students had endorsed suicidal ideation in the past 12 months [13]. Work from Vander Stoep et al. in 2009 [14] showed that African-American and Asian American participants were two times more likely to be classified in a group experiencing a higher probability of endorsement of thoughts of death or suicide compared to European American participants. More recent work from Thapa et al. in 2015 [15] showed that when compared to Whites, young adult Asian Americans perceived suicidal behavior to be more common, perceived a stronger link between depression and suicide, endorsed help-seeking strategies less frequently, and reported more distress after viewing a suicide prevention public service announcement.

Table 8.1 The US high school Youth Risk Behavior Survey, 2015 [12]. Seriously considered attempting suicide (during the 12 months before the survey)

Race	Percent (confidence interval)	Total
Total	17.7 (16.7–18.8)	15,434
AIAN (American Indian/ Alaska Native)	20.9 (13.2–31.4)	161
Asian	17.7 (13.1–23.5)	617
Black	14.5 (12.3–17.1)	1,647
Hispanic	18.8 (17.1–20.7)	5,061
NHOPI (Native Hawaiian or other Pacific Islander (non-Hispanic))	N/A	98
White	17.2 (15.4–19.2)	6,782
Multiple race	26.6 (21.0–33.0)	729

Table 8.2 California Healthy Kids Survey 2011–2013 [13]. Suicidal ideation (student reported) in last 12 months, by race/ethnicity

California	Percent	
Race/ethnicity	Yes	No
African-American/Black	17.1%	82.9%
American Indian/Alaska Native	18.4%	81.6%
Asian	18.3%	81.7%
Hispanic/Latino	18.1%	81.9%
Native Hawaiian/Pacific Islander	22.0%	78.0%
White	17.7%	82.3%
Multiracial	22.1%	77.9%
Other	19.7%	80.3%

Additively, this suggests a potential correlation between culture, ethnicity, and suicide that is gaining greater recognition (Table 8.2).

Risk Factors

Lau et al. [16] studied differences of risk factors for suicidal behaviors between Asian American outpatient youths and majority youths and found that these two groups appear to share some risk factors for suicidality such as age, index of psychopathology, family conflict, depressive disorder, and higher number of internalizing problems. The study also suggested that Asian American youths are at a 30-fold higher risk for suicidal behaviors when they face high levels of intergenerational conflict. Langhinrichsen-Rohling [17] also reported that besides sharing the cross-cultural risk factors for suicidality, Asian American youths exhibit culturally specific risk factors including family conflict, harsh parental discipline, peer rejection, higher rate of depressive symptoms, recent immigration, model minority stereotype, and decreased affective expression (model minority is discussed more in depth in the later section). Chu et al. recognized that Asians Americans may not exhibit the most commonly assessed risk factors found in the general population and identified two distinct groups of Asian Americans experiencing suicidality—those of a "psychiatric" subtype and those of a "nonpsychiatric" subtype [18]. In Chu et al.'s study, individuals were identified as "psychiatric" subtype if their presentation was mostly related to psychopathology, while "nonpsychiatric" individuals were classified as such if their cases were more often associated with nonpsychiatric factors including medical illness, functioning or productivity problems, and/or sociocultural issues. In a group of 191 Asian Americans with a history of serious suicidal ideation or attempts, it was found that 48% were of the "psychiatric" subtype, while 52% were of the nonpsychiatric subtype [18]. These data and the striking prevalence of less commonly recognized risk factors in this population highlight the utility of recognizing culturally specific contributors to suicidality.

Acculturation/Acculturative Stress

Acculturation is defined by Redfield et al. [19] as the "...phenomena which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original cultural patterns of either or both groups." Acculturation stress is an individual's initial psychological response to the

conflict that often coexists with acculturation and may cause compromised mental health but then later improves as a person acculturates [20]. Acculturation gap is the discrepancy in acculturative status between immigrant parents and their children [21].

Moderating Factor in Effect of Parent-Child Conflict

A study of suicidal behaviors in a sample of 285 Asian American youths suggested that the acculturation process coupled with parent-child conflict correlated with suicidality. When under high level of parent-child conflict, less acculturated Asian American youths were at proportionately higher risk for suicidality than their more acculturated counterparts [16]. In a national study of Asian American adults, Wong et al. [22] found that family cohesion was associated with reduced rate of suicidal ideation among Asian American adults with low level of English proficiency; conversely, problematic relationships with their parents in Asian American youths were suggested as a risk factor for suicidality [16, 23].

In *John's* case, even though his parents reported a typical relationship with their son, John listed talking to his parents as one of the feared events as result of ongoing arguments between his parents over his “laziness” and incomplete chores. Furthermore, John's relationship with his parents seemed to be problematic as John isolated himself in his room playing video games because of his fear of talking to his parents. This also exacerbated his parents' wish for John to be more socially outgoing and have more typical peer interactions. Despite their good intentions, John's parents seemed limited in their abilities to provide activities with which to connect with his peers in more meaningful ways other than restricting his video game playing. Therefore, restricting John's access to his online peers (the only social connection at the time) inevitably exacerbated the conflict between John and his parents. This conflict partially stemmed from the acculturation gap between John and his parents since his parents may not have realized that meaningful social interactions come in many different forms besides typical direct personal interactions in adolescents who live in modern countries in the twenty-first century. Not until after John and his parents got help from evidence-based cognitive behavioral psychotherapy for social phobia did John's social interactions with peers start improving. However, treating the conflict between John and his parents would likely benefit further from ongoing family therapy.

Peer Relationship and School Relationship

Using longitudinal data from the National Longitudinal Study of Adolescent Health that included 959 Asian American adolescents, Wong and Maffini [24] identified subgroups of Asian American youth who demonstrated differences in risk and protective factors for suicide attempts. Guided by Joiner's [25] interpersonal-psychological theory that proposes a sense of belongingness to a valued social group as a salient protective factor against suicidality, three subgroups of participants were identified in explaining the association between family, peer, and school relationships and subsequent suicide attempts. The study found that most participants belonged to the subgroup in which family, peer, and school relationships were protective factors; however, stronger peer and school relationships were suggested to be potential risk factors in a small percentage of participants who were less acculturated. This finding suggested that less acculturated Asian American adolescents may have felt culturally marginalized when they spent a lot of time with their close friends [26], possibly due to being less acculturated than their friends yet still more acculturated than their parents. Alternatively, less acculturated groups may have experienced cognitive dissonance because of the different cultural messages they have received from their peers and families [27]. Hence, the awareness of cultural differences was perhaps reinforced when this subgroup of adolescents spent more time with their peers, which then increased their experiences of acculturative stress

and vulnerability to suicidality. Lorenzo et al. [28] also found that Asian youth reported more problems with peers including peer rejection and teasing as well as more depressive and withdrawn behaviors compared to their Caucasian peers.

In *John's* case, his close connection with a select few classmate friends in middle school probably provided him with a sense of belongingness. John started feeling lonelier only when he lost his friendships. Subsequently, John felt too shy to make new friends when transitioning to high school because of his underlying social anxiety. His fear of being humiliated and socially rejected by peers was paralyzing for him. Trying to regain some social connection, John sought out support from fellow Internet gamers—his "Clash of Clan" peers—which were his primary stress reliever. John's perceived peer rejection that resulted in his social isolation may have perpetuated his social anxiety in making meaningful friendships and consequently exacerbating his depression.

The connectedness and sense of belonging that one feels about his/her school includes feeling close to people at one's school, being part of one's school, and happiness being at one's school. It is hard to imagine that John felt connected to his high school. In addition, the author's experiences in working with East Asian youth of immigrant families suggest that parental involvement with school can sometimes be limited to minimal, which further weakens any potential connectedness of this group of youth with his/her school.

Proportion of Life Lived in the United States

Wong et al. [22] examined the relationship between proportion of life lived in the United States (an indicator of acculturation) and lifetime suicidal ideation in six different ethnic groups of Asian Americans (Chinese Americans, Filipino Americans, Indian Americans, Japanese Americans, Korean Americans, and Vietnamese Americans) using the National Epidemiologic Survey of Alcohol and Related Conditions (NESARC). As anticipated, the study found the longer the proportion of life the Asian Americans lived in the United States, the greater the odds of suicidal ideation. Possible explanations for this association may be disruption of traditional community and family support or increased exposure to racial discrimination over time [29]. When examining the interaction between acculturation (i.e., proportion of life in the United States) and ethnicity, acculturation was more strongly associated with suicidal ideation for non-Chinese Americans vs. Chinese Americans (odds ratio, OR = 1.84), non-Japanese Americans vs. Japanese Americans (OR = 1.60), non-Korean Americans vs. Korean Americans (OR = 1.31), and non-Vietnamese Americans vs. Vietnamese Americans (OR = 4.42). The result suggests that more acculturated East Asians have less of a risk factor for suicidal ideation. In contrast, proportion of life was more strongly associated with suicidal ideation for Indian Americans vs. non-Indian Americans (OR = 1.20), whereas proportion of life was not significantly associated with suicidal ideation between Filipino Americans and non-Filipino Americans [22]. A possible reason for East Asians Americans' acculturation being less of a risk factor for suicidal ideation is perhaps their ability in better preserving ethnic cultural values over time, which may serve as a buffer against the adverse consequence of living in the United States over time.

Family Relationships

Family relationships appear to play a major role in predicting suicidal behaviors within Asian Americans. In general, Asian Americans, especially immigrant parents, tend to adhere to a collectivist orientation [30] in contrast to Asian American youths, who often have more individualistic attitude as they assimilate in mainstream cultural beliefs and behaviors [31]. Family conflict often causes these youths to be distressed when they feel torn between their role in fulfilling collectivist parental expectations and their own desires in establishing an independent identity [32]. Thus, family conflict could be a

significant predictor for suicidal behaviors in Asian Americans overall, regardless of depression, low income, or gender [24, 33, 34].

Parenting Styles

Asian culture places strong emphasis on family unity and harmony. Poor family dynamics is one of the most powerful and consistent predictors of suicide among Asian Americans [35]. A qualitative study by Hahm et al. [36] explored the concept of fractured identity from daughters of immigrants who experienced disempowering parenting styles and reported a history of self-harm and/or suicidal behaviors. Participants reported feeling caught in an internal struggle between a deep desire to satisfy parental expectations and a wish to simultaneously rebel against the pressure to fulfill the duty of being a "perfect Asian woman." This fractured identity led to a sense of low self-worth and use of unsafe coping strategies. Hwang [21] reported that Asian parents sometimes use strategies such as guilt inducement and social comparison to manage child behaviors. On the one hand, it is culturally normal and even effective for youth in Asia. On the other hand, the same strategies may not be effective and can be counterproductive when applied to more acculturated Asian American youth. Fung [37] found that use of shaming techniques is widespread among Chinese and Chinese American parents, and Kim and Ge [38] showed that harsh disciplinary practices by Chinese American parents were significantly associated with depressive symptoms in adolescents.

The inherent parenting styles of *John's* parents seemed to fit typical Asian parents who expected their children to achieve good grades in school while also obeying the parents. When John's parents requested that he do chores and stop playing so many video games, they might not have paid special attention to their way of communicating with John to make him feel comforted and/or supported; as a result, John may have interpreted their good intention as criticism, and over time this interaction generated fear in him. Though it was not clear whether John's parents used guilt-inducing strategies with their son, many Chinese parents tell their children that "We have worked so hard so that we can give everything you wanted, and why you are still not happy or getting good grades, etc.?" or "When would you be happy or getting better grades again, etc., so we can be happy?" If Asian youths constantly experience blame and feel responsible for not only their own happiness but also the happiness of their parents, they start internalizing guilty feelings about not being able to meet their family's expectations. This further discourages them from seeking appropriate help, in fear of either burdening their parents or feeling further blamed by them. Additionally, in their efforts to be adequate, the process of help-seeking may be too burdensome. It would be most helpful for John's parents to be aware and utilize family therapy to adjust their own parenting communication styles toward John who may be emotionally more sensitive during his adolescent years. Ultimately, the hope was that John's fear of talking to his parents could diminish over the time.

Intergenerational Conflict

Lau et al. [16] reported that Asian American youths have a 30-fold increase in risk for suicidal behaviors when they experience high levels of intergenerational conflict. Acculturative Family Distancing (AFD), a theory and construct that was first coined by Hwang [21], is defined as "the problematic distancing that occurs between immigrant parents and children that is a consequence of differences in acculturative process and cultural changes that become more salient over time." AFD covers two dimensions: communication breakdown and incongruent cultural values as a consequence of different rates of acculturation resulting in acculturation gap. These two dimensions are believed to directly increase the risk of potential problems through emotional, cognitive, and behavioral distancing. As AFD increases, immigrants tend to experience more risk for family conflict, which in turn mediates the relationship between AFD and psychopathology.

There is some evidence suggesting that Asian American youth have difficulties communicating with their parents effectively, which lead to a breakdown in family cohesion [39]. Verbally, although some Asian youths can speak fluent native language for pragmatic needs and concrete activities, they may not be able to communicate emotional and affective needs nor are they able to discuss issues of greater complexity. Nonverbal communication styles include proxemics (interpersonal space), kinesics (body movements and facial expressions), paralanguage (vocal cues), and high-low context communication (the degree to which the explicit language is used vs. implied) [40]. Using proxemics and kinesics as examples, Asian youth may misinterpret their parents as being emotionally distant when parents have more reserved or controlled facial and physical expressions [41]. On the other hand, parents may perceive their children as being too needy, as lacking emotional control, or being sexually promiscuous when they show more physically liberal expressions. For example, a pause in Asian culture may suggest that one should not interrupt, whereas a pause in American culture is to indicate change of flow in conversation. When more acculturated children speak after a parent's pause, Asian parents may feel disrespected as they experience it as "talking back." To further complicate the communication between parents and adolescents, what seems to be a culturally direct and appropriate method of communication to the parents is felt as indirect and confusing to acculturated youth, since in Asian culture, adults tend to be more verbally indirect and restrained.

Different cultural orientations (collectivistic vs. individualistic) can involve different views of self. In collectivistic Asian culture, people have an interdependent self-construal [42]. They are expected to sacrifice individual needs for their family needs [43]. Those who deviate from the norm may face culturally acceptable disciplinary strategies such as guilt induction and scolding. Immigrant Asian youth who are raised in mixed individualistic and collectivistic environments are less likely to retain an interdependent self-construal than their immigrant Asian parents who were raised in collectivistic cultural environments. Change in ethnic identity can occur when children are continuously exposed to mainstream American values and traditions [44]. Interrupted cultural transmissions and the choices children make in keeping, changing, or surrendering cultural values can place them at risk for developing relational difficulties with their parents, especially if youth choose to give up all native cultural values [45]. On the other hand, parents' flexibility in adapting their parenting styles and value systems for their children could also influence parent-child relations. In addition, children of immigrants often undergo a more complicated individuation process as they are raised in two cultural environments that can pose different or even opposite value systems. These cultural differences can result in identity confusion [46].

It is believed that AFD has fewer consequences during a child's formative years [47]. When children enter adolescence, the process of individuation and separation from their parents begins such that children of immigrants start making choices in cultural retention, ethnic identity, and social group affiliation [46]. During this period, the extent to which AFD affects family relations is dependent on how much ethnic youth affiliate themselves with their culture of origin as well as how strongly parents retain and pass on cultural traditions. By the time adolescents reach young adulthood, their cultural identities become more consolidated, and they start making many important life choices such as choosing a romantic partner [46] or a career path. During this period, AFD has potential for further accentuating normal individuation along with demographic relocation to lead to even greater separation and distance from parents. Additionally, AFD could bring cumulative untoward effects for immigrant families if left unaddressed. It is suggested that Asian American college students experience more intergenerational family conflict than Hispanic and European students, possibly because of greater AFD [48]. AFD between immigrant parent generation and their children has been positively correlated with greater depressive symptomatology. Higher levels of AFD are associated with higher psychological distress and greater risk for clinical depression,

which is mediated by family conflict. Perceived acculturation gaps and intergenerational cultural dissonance have been linked to reports of family conflicts and less supportive parenting styles among Chinese American youth and adults [49]. Thus, it is not a surprise that some studies indicate that Asian American youth have higher level of depressive symptoms than Caucasian youth [50–52]. In addition, older Asian Americans, especially women, were found to have highest rate of suicide compared to all other groups [53].

In *John's* case, although his parents encouraged John to be involved in pro-social activities, communicating and guiding John to overcome his social anxiety may have been a difficult task due to their language barrier as well as John's own social isolation. John, as the child of first-generation immigrants, naturally underwent a more complicated individuation process as he was raised in two cultural environments that potentially pose different value systems. Under those two value systems, potential conflicts could arise regarding preferred language spoken at home, the content and style of the communication between John and his parents, and the balance between dependence on parents' support and complete self-reliance. John's mental illness might have been worsened by generational and cultural conflicts. Working with other East Asian adolescents of first-generation immigrants, the author also witnessed significant intergenerational conflict similar to John's. One particular adolescent's conflict became much more prominent after she lost her grandmother who was the main caregiver, on whom she relied for comfort and support while parents worked for long hours. Hopefully, John's parents will work with mental health professionals to address the generational conflict and work toward a more favorable outcome in John's individuation process as well as the family relationship dynamic.

Perceived Discrimination

Previous studies have shown perceived discrimination is associated with poor mental health [54] and decreased use of mental health services [55] among Chinese Americans as well as underutilization of medical and mental health services among Southeast Asian Americans [56]. Results from the National Latino and Asian American Study (NLAAS) suggested that self-reported racial discrimination was associated with higher rates of DSM-IV diagnosable disorders including depressive and anxiety disorders within the past 12 months, as authors believed that perceived discrimination possibly leads to sadness, decreased feelings of control, effects on self-esteem, and internalized negative stereotypes [54]. In a study of US mental health service equity and the perceived needs of Asian American women, participants indicated a lack of culturally appropriate interventions [57]. A national survey revealed that Asian American children aged 18 and younger were less likely than Whites, Blacks, and Hispanics to receive mental health services [58]. Language barriers or lack of language-matched mental health professions have contributed to nearly half of Asian Americans having difficulty accessing mental health services [59].

Using the data from Health Behaviors in School-Aged Children (HBSC), Sen [60] attempted to understand whether there were race and gender differences of help-seeking behaviors among participants who suffered from depression. Results suggested that adolescent males were less likely than females to ask for help for their depression; Blacks (of both genders) were especially prone to not asking for help. The possible explanations included racial differences in attitudes and a certain degree of stigma associated with mental health problems as well as lack of racially matched healthcare professionals. In addition, religion might have influenced help-seeking behaviors and suicidality among Asian Americans [32].

Shame is described as a debilitating, painful experience that involves the negative evaluation of the self [61]. It includes feelings of inadequacy and a core motivational desire to hide or escape [62]. Shame has been moderately related to depressive symptoms, and it may also be attributable to suicide-related outcomes [63]. Shame could be internal (one's negative evaluation of self) or interpersonal. The interpersonal aspect of

shame may be culturally more relevant to Asian and Asian Americans, compared to internal shame, because of the cultural emphasis on collectivism [64]. Interpersonal shame has two dimensions: external shame (perceived negative evaluation of self through others' eyes) [64] and family shame (the perception of one having brought the shame to one's family). A study that examined the association between shame and personality among university students in the United States and Japan found Japanese undergraduates reported higher level of external shame [65]. Additionally, there are two specific terms in Chinese that describe shame: 慚愧 (*Can Kui*, similar to external shame) that often involves one's feeling of failure to meet other's standards, whereas 羞愧 (*Xiu Kui*, includes family shame) extends to an acknowledgment that one has harmed others or brought shame to others. Wong et al. [22] demonstrated that external shame was significantly associated with depressive symptoms, generic state shame (a subscale of the State Shame and Guilt Scale), self-esteem, self-face concerns (individuals' motivation to maintain their own face or social persona), and other-face concerns (individuals' motivation to maintain others' face), whereas family shame was significantly related to suicide ideation. This finding is consistent with the previous research that identified family-related problems as a salient antecedent for suicide ideation between Asian and Asian American college students [66]. In addition, the study also suggested that family shame might be a more proximal antecedent of suicide ideation than other two negative interpersonal states (thwarted belongingness and perceived burdensomeness) in Asian Americans. It is common practice for East Asian children to bring parents only good news but not bad news (the idiom of報喜不報憂Bao Xi Bu Bao You) when children feel *Can Kui* and are afraid of bringing parents worries. This shows how cultural perspective on shame impacts the behaviors and experiences of Asian American youth.

Stigma has been reported as one of the barriers for Asian American people to seek mental health help. Augsberger et al. [57] studied 17 young adults, representing 8 different Asian American groups, and found that in Asian culture there is a negative perception of people seeking counseling. Additionally, these individuals were worried that their parents would be in denial of their mental health needs or may see them as "crazy." Without any specific questions on stigma on a survey, 47% of interview participants discussed family contributions to mental health stigma, whereas 30% reported community contributions to mental health stigma. The Asian American community views mental health problems as a taboo subject and disapproves of burdening others with problems [57]. Overall, stigma associated with mental health conditions and services influenced participants' utilization of mental health services, regardless of their generation [57].

In *John's* case, his parents sought help for John's excessive video game playing behaviors only after he contemplated suicide, suggesting possible shame and/or lack of knowledge about mental health issues among first-generation immigrants. Even after treatment was recommended to them, John's parents had difficulties in accepting the necessity of their own involvement in John's recovery. Working with East Asian immigrant children as well as children of immigrants, this author has recognized significant shame in these adolescents when they suffer anxiety and depression resulting in academic decline. For them to bring up the struggles to their parents is almost unimaginable as they are fearful of further burdening their hardworking parents as well as their parents' loss of face in the eyes of extended families and the local community. Shame, as one of the contributing factors, has often delayed these adolescents getting help until their symptoms are severe (e.g., suicidality).

Internalization of Model Minority Stereotype

The popular image of Asian Americans as the model minority often suggests that Asian Americans are more successful than any other racial minority group academically, economically, and socially [67]. As the model minority, Asian Americans are often perceived to have less

social and psychological problems in adjusting to the American culture. Contrary to this perception, internalization of the model minority myth may have negative consequences for Asian Americans' ethnic identity development [68]. Asian American youth are preferentially treated with higher expectations by their teachers, more likely racially harassed by their peers, and teased for being too successful as "nerds" and "geeks." These experiences may, in turn, become a threat to one's social identity, which could lead to further deceased identification, pride, and engagement toward one's ethnic group membership [68]. Serving as a stressor, internalization of model minority can lead to unrealistic expectations and pressure to succeed and subsequently result in greater psychological distress [69], lower academic performance [70], and higher risk of suicide. In addition, Asian Americans who internalize the model minority myth may also mask their personal problems and hinder their help-seeking behaviors [71]. Lee [72] conducted interview of high- and low-achieving Asian high school students and found the latter would not reach out for either educational or psychological support while experiencing mental health difficulties. They may have struggled through academic and mental health difficulties to avoid the embarrassment or shame of not living up to the model minority myth [73]. Using 2001 YRBS response data of Asian American and African-American high school students, Whaley and Noel examined the relationship between academic performance and behavioral health measurements [74]. Contrary to findings from previous studies, they reported that Asian American students had similar distributions as compared to African-American students across categories of suicide risk, substance abuse, and significant higher scores on violent or dangerous behaviors. These findings did not support the model minority assumption of ethnic/racial differences in academic achievements in adolescents. Based on the stereotype threat theory [75], a situational predicament in which individuals are at risk of confirming the negative stereotypes behind the model minority perspective can lead to performance decrements in Asian Americans.

In *John's* case, one may suspect he internalized model minority stereotype of achieving high grades but may have avoided mental health help for the cost of embarrassment or shame of not living up to the model minority myth. This stereotype may have also influenced the way John viewed himself, subsequently contributing to losing his identity and social anxiety.

Unique Risk Factors

Sexual Orientation

Asian American lesbians and gay males are considered as a "double minority" population, which signifies the importance of both ethnic development and sexual development in the psychological well-being of sexual minority of Asian American youth. It is believed that these two critical processes are both parallel and interactive [76]. Using YRBS data from 2005 to 2007, Bostwick et al. [77] examined the relationships among sexual minority status, gender, and mental health and suicidality in racially/ethnically diverse adolescent populations. Compared with non-Hispanic White sexual minority youths, Asian and Black youths were at significantly lower odds of suicidal ideation, suicide planning, and self-harm. Compared with non-Hispanic White sexual minority females, Asian and Black sexual minority females had lower prevalence of 1-year suicidal ideation and self-harm [77].

Age and Gender

Using the data from Adolescent Health to assess the relationship between timing of adolescent development in 9th and 11th grades and risk factors for suicide, Fried et al. [78] found being of "other" ethnicity (mainly Asians or Native American) was a risk factor for 11th graders but not 9th graders. Lau [16] reported older youths were at greater risk of suicidal behaviors; however, gender was not associated with higher risk of suicidal behaviors. Using a large sample of 346 adolescents in grades 7–12 and of different

ethnic backgrounds, Supple et al. found a significant interaction among Southeast Asian ethnicity with gender and with age, specifically, regarding the incidence of suicidal thoughts—suicidal thoughts were higher among boys and older respondents [79].

Protective Factors

Perceived Parental Support

Cho and Haslam [23] reported that Korean students who came to study in the United States without family vs. those who immigrated with both parents had twice the level of suicidal ideation compared to the immigrant group (both had been in the United States less than 4 years). In these groups, perceived support from non-family significant others and same- and different-ethnicity friends were of lesser importance than perceived support within the family environment; however, this effect may be secondary to living with both parents and perceiving support from them.

Other Protective Factors

Other protective factors against suicide among Asian American and Pacific Islanders include proficiency in English language, orientation toward present rather than past times, and social support from families and ethnic communities [80]. A study by Zhang and Jin [81] comparing US and Chinese college students found that religiosity and family cohesion were protective factors for suicidal thoughts.

In *John's* case, his strong relationship with his sister served as the protective factor, and it was his sister who brought John's suffering to the forefront. In this author's clinical experience, it is not unusual for older siblings of East Asian adolescents to act as surrogate parents especially when parents may also suffer from mental health issues and/or have significant culture or language barriers. These siblings have certainly added a layer of comfort and support to suffering adolescents. On the other hand, these siblings may also be perceived as "mean and abusive" when the suffering adolescents feel disciplined or criticized.

Comorbidities

Lau reported Asian American youth with major depression or dysthymia were four times more likely to exhibit suicidal behaviors when compared with youths without depression [16]. Asian American youth self-reported higher test anxiety and stronger efforts directed to pleasing their parents compared to European American youth [82]. In exploring the roles of anxiety, depression, and hopelessness as mediators for suicidal behaviors among different ethnic youth, Thompson et al. [83] hypothesized that anxiety did not directly influence suicidal behaviors. Rather, anxiety exerted effects indirectly through hopelessness and depression. In *John's* case, social anxiety played a role in worsening his hopelessness and depression, leading to his suicidal gesture. This author's experiences of working with East Asian youth indicate that a high percentage of youth experience high levels of anxiety in meeting the expectation of their parents as well as in burdening their parents when they recognized the need for more support and help.

With regard to substance use and other health risk behaviors, the data from National YRBS (1991–1997) [84] found that Asian American/Pacific Islander (AAPI) students were less likely to have drunk alcohol or smoked marijuana compared to Black, Hispanic, or White students; however, AAPI students were reported as likely as other groups to have attempted suicide. There is limited research available in examining the ethnic differences in the relationship between alcohol use and suicidal behaviors in adolescents across different ethnicities [85]. Exploring other health risk behaviors including sexual behaviors, unintentional injury (e.g., drunk driving), or intentional injury (e.g., carrying a weapon) suggested that AAPI students were also significantly less likely than White, Black, or Hispanic students to have had sexual activity or have carried a

weapon or fought. However, once sexually active, AAPI students were as likely as other race/ethnic youths to engage in risky sexual behaviors. Lau reported that externalizing behaviors (such as impulsive, antisocial, and under-controlled behaviors) were not related to risk of suicidality [16]. Instead, these behaviors were found to be protective from suicidality, consistent with a previous study of suicidal behaviors in young adolescents conducted by Garrison et al. [16, 86, 87]. The possible explanation of this phenomenon is either a methodological issue or alternatively the individuals may have exhibited externalization problems due to at least a portion of their emotional distress, thereby decreasing the risk of suicidal behaviors. Individuals with internalizing problems were more likely to exhibit suicidal behaviors [16].

In *John's* case, there was no clear indication that he was displaying any externalizing behaviors, which could serve as a protective factor. In the authors' work with many East Asian youth, externalizing problems were rarely the reason for referral.

Culturally Specific Symptom Expressions and Related Beliefs

Choi and Park [87] explored the depressive and anxiety symptom expression among different ethnic middle school children in a large city. Symptom expression in depression was found to be varied; for example, Asian American youth were more likely to report sad mood, whereas African-American youth reported increased anger, aggression, and irritability.

Somatic Presentation of Psychological Problems

Choi and Park [87] found the most consistent between-group difference to be somatic symptom presentation; additionally, Latino American and Asian American preadolescent school children reported the highest rate of somatic symptoms. Belief in mind and body harmony and the tendency of Asians to not express emotions openly could have led to the presentation of somatic complaints and subsequent under-reporting of psychological symptoms [88]. Due to the somatic manifestation of psychological distress, Asian Americans were considered to be "hidden ideators" in regard to disclosing suicidal ideation [89].

Somatization also plays an important role in influencing the diagnosis of depression in the Chinese population [90]. From a linguistic perspective, expression of somatic distress is much richer in Chinese words than are descriptions of one's dysphoric emotional state [91]. Tseng also provided several other reasons why Chinese present with somatic complaints in place of psychological ones. First, based on traditional Chinese medicine, just like body organs, human emotions were believed to correspond to various elements in nature. For example, angry feelings are derived from the liver, which is connected to fire; other emotions are also derived from corresponding organs, which are connected to water, earth, wood, and metal, for example. Second, because of the medical belief system, it is much more socially acceptable to have physical complaints than emotional complaints. Third, Chinese prefer more subtle ways of communication to expressing emotions openly especially related to sexual or negative feelings. Fourth, due to the shame associated with revealing one's weakness if psychological problems are presented instead of bodily symptoms, concerns for bodily symptoms are reinforced socially. Besides headache and chest tightness, sighing is also a frequent somatic presentation in Asian patients in expressing their emotional distress, especially in adult patients. Additionally, in this study, depressed Chinese and Japanese groups had more gastrointestinal disturbances (poor appetite, indigestion, and gas) compared to the depressed Whites [62].

Internalization

Lau [16] reported that individuals with internalizing problems such as withdrawing, crying, sleeping disturbances, and anxiety were more

likely to exhibit suicidal behaviors than those with externalizing behaviors. This aligns with *John's* situation, in which he displayed internalized behaviors due to his social isolation.

Behavioral Addiction

Messias et al. [92] investigated the association between excessive video game and Internet use and youth suicidality using the data from the 2007 to 2009 YRBS. They found that high school students who reported 5 h or more of video game or Internet daily use had a significantly higher risk for sadness, suicidal ideation, and suicidal planning in both 2009 and 2007 surveys. Although race was not an outcome variable in the analysis, it was a variable for which the outcome was adjusted.

With Internet addiction as a disorder in DSM-5 gaining more attention, studies have been underway examining the potential influences of variables such as shyness and locus of control, online experiences, and demographics on Internet addiction [93]. Wong and Lam [94] examined adolescent gaming behavior and addiction at an Internet café in Hong Kong as well as benefits and harm potentially associated with this activity. They found that the psychological factors associated with gaming addiction included low self-esteem, a strong desire for aggressive and exciting experiences, reliance on gaming to pass time and to obtain satisfaction, coping with problems and negative emotions, and obsession with achieving higher rankings in games. Li et al. [95] examined the roles of temperament variables in problematic Internet use (PIU) among 2,758 adolescents in Southern China and found that sensation seeking, anger/frustration, and shyness positively predicted PIU. Effortful control was negatively associated with PIU. However, at this time, there is no data on impact of excessive video game and Internet use on psychological and family relationship problems in Asian American youth. In *John's* case, though he did not complain about somatic symptoms, his excessive gaming activity may have served the dual purpose of coping with his distress while also avoiding his challenges.

Diagnostic Considerations

The DSM (Diagnostic and Statistical Manual) is a product of the Western view, which is based on an individualistic value system as a person is generally viewed as a self-centered and self-conscious identity, whereas the Asian way of life recognizes an individual as a member of a larger group guided by a set of conservative ideas, philosophies, and religions [10]. Diagnosing Asian Americans may be challenging to clinicians unfamiliar with this culture. Clinicians should apply the five aspects of cultural formulations outlined in the DSM-IV-TR (2000) during assessments as these may explain behaviors of an individual from Asian background. The first aspect of cultural formulation is the cultural identity of the individual. In that regard, Asian youth may display unique attitude and affective expressiveness when being examined by clinicians, such as avoiding direct eye contact as a sign of respect to elders or subdued or even incongruent affect when feeling uncomfortable. Additionally, Asian American youth may present with psychiatric symptoms differently from the general population. Asian American youth may express depression and anxiety with somatic symptoms such as headache, fatigue, and insomnia, which could lead to misdiagnosis [44]. The threshold of distress in East Asian Americans seemed to be low as they show heightened reactivity when depressed compared to Caucasians [96]. Due to emphasis on the moral model, Asians may view mental illness as a result of poor morals, laziness, and selfishness. Thus, they may be more motivated to improve these moral deficiencies rather than seeking mental health treatment. Furthermore, in the religious model of supernatural factors and the medical model of imbalance of diet, Chi and Yin-Yang play important roles in Asians' view of physical and mental illness. In traditional Chinese

medicine, the energy in each human being interrelates with the energy of the universe. *Chi* (energy) and *Jing* (sexual energy) are both viewed as vital life elements that are kept in balance by *Yin* and *Yang*. The Yin-Yang balance is commonly achieved by eating a certain type of diet and controlling other environmental factors such as room temperature. Cultural factors related to the psychosocial environment and levels of functioning should be assessed for Asian American youth. Asians, in general, tend to adhere to their traditional beliefs and values; thus, it is important to find out the patient's view on how deviation from those beliefs and values has influenced their thinking, emotions, anxiety, or self-esteem. In addition, it is also important to inquire about the supportive roles of extended family, social-cultural networks, and religious organizations [10]. Lastly, since cultural matching between the clinicians and the individual may not always be possible, the use of cultural interpreters would facilitate the diagnostic process.

Chu et al. [97] have developed a specific diagnostic tool to address the abovementioned lack of culturally competent measures of suicide risk. The Cultural Assessment of Risk for Suicide (CARS) guides researchers or clinicians to incorporate cultural factors into risk assessments with questions based around constructs identified in Chu et al.'s 2010 Cultural Model of Suicide [98]. CARS includes an assessment of the model's four cultural risk categories: cultural sanctions, idioms of distress, minority stress, and social discord. Each item is rated on a Likert scale, with higher CARS scores indicating higher suicide risk. In an efficacy assessment of CARS, researchers found convergent associations with previously validated measures of suicidality, including the Beck Depression Inventory, the Beck Hopelessness Scale, and the Suicidal Ideation Scale. Authors also found predictive value in CARS, regardless of whether an individual self-identified as a culturally minority or not [97]. Clinicians working with minority youth should consider utilization of such a tool to aid in the identification of individuals at risk in order to account for culturally specific presentations of suicidality.

Evidence on Intervention Approaches

Traditional treatments such as dietary control, local herbs, and acupuncture tend to be the initial choice of treatment for Asian Americans. Clinicians should be mindful of these common practices and incorporate them into overall treatment options. In a therapeutic relationship between clinicians and Asian adolescents, the latter sometimes expect clinicians to play an authoritative role; otherwise, the clinician may be regarded as incompetent or indifferent [10]. In the beginning of a therapeutic relationship with Asian adolescents, clinicians may experience a lot of "I don't know" answers, which usually stem from adolescents' uncertainty about their autonomy and how much they should assert themselves in front of a clinician. As the therapeutic relationship progresses, with clinicians' encouragement and facilitation, these adolescents could adapt and express their emotions with more certainty, especially when they are aware that their parents are simultaneously making efforts to improve their relationship. Clinicians should be aware that Asian youth are more likely to respond to please the clinician, in the same way as they appease their parents, and avoid overburdening the clinicians.

Thus far, there are limited studies available as regards to which specific treatment model is effective for East Asian American youth. Shen et al. [99] implemented cognitive behavioral therapy (CBT) using Cantonese language to treat depressed Hong Kong immigrants in Canada, and results showed that the CBT group had a significant reduction of depressive symptoms than the treatment-as-usual group. Several models have been developed in attempts to guide culturally competent services including the Cultural Accommodation Model (CAM) developed by Leong and Lee [100] and Formative Method for the Adapting Psychotherapy (FMAP) [101]. The FMAP has been utilized to create a culturally adapted CBT manual for Chinese Americans by Hwang [101] and an evidenced-based problem-solving therapy for depression in older Chinese adults by Chu et al. [102]. In addition, Okazaki

and Ling [103] stated that factors that could influence clinical outcome include clinician credibility (ascribed vs. achieved) as described in Sue and Zane [104], which is an important consideration in rapport building. Additionally, ethnic and language matching between patients and therapists was associated with length of treatment (though evidence of effect on treatment outcome not clear at this time). There is some evidence to indicate positive outcomes for ethnic matching and ethnic treatment centers. They also suggest that therapists could establish credibility and rapport through other connections to clients such as common values, attitudes, and personality characteristics.

At the present time, no program for suicide prevention, evaluation, or treatment approaches specifically for East Asian youth or AAPI has been rigorously validated in randomized controlled trials. Nevertheless, Garrett Lee Smith Memorial Suicide Prevention Program (GLS program) provides grants for suicide prevention activities that are awarded to states, tribal communities, and college campuses throughout the United States. In the study of effects of the GLS program on suicide attempts among youth, participating youth including "non-Hispanic Asians" from 2095 counties between 2000 and 2006 were analyzed. Results indicated a decrease in the rates of suicide attempts among youth 16–23 years of age following implementation of GLS program [105]. However, studies that specifically examine the correlation between ethnicity and GLS program are currently unavailable.

Conclusion

In summary, mental health issues among East Asian youth present unique challenges to themselves, their families, and their community including schools and the mental health professionals striving to help these individuals. As the nation faces the sobering statistics of an increased suicide rate and growing population of East Asian youth in the United States, mental health professionals have to be more prepared than ever to provide culturally competent care and help this underserved East Asian group deal with potential suicide risk factors that could lead to adverse outcomes such as self-injurious behaviors or suicide attempts. More research in this special population group is needed in order to develop effective suicide prevention programs.

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9 Suicide Among Turkish American Youth

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Case

Selin, a 12-year-old Turkish American female, presented with self-harming behaviors and suicidal ideations. She cut both her forearms superficially by razor multiple times over a year. She had frequent intermittent suicidal ideations without any specific plan or intent for the last 6 months. She began to struggle with depression 3 years ago, soon after she immigrated to the USA with her biological parents. She reports that she felt "down, depressed, and lonely." She complained of constant headaches, stomachaches, and fatigue. It was difficult for her to stay awake during classes. She endorsed poor motivation and concentration, increased appetite, loss of interest in her hobbies, and social isolation. Since she had difficulty making friends in the USA, she felt that isolation was imposed on her. She did not have any close friends in her neighborhood, and she felt, in general, that her classmates were not friendly to her. They made fun of her because she never had a boyfriend, while other peers called her "terrorist," because she was a Muslim and because she wore a headscarf.

She did not have any significant medical problems. She was born full term by normal vaginal delivery and was not exposed to drugs, alcohol, or any medications in utero. *She reached her developmental milestones as expected. She completed kindergarten through third grade of school in Turkey, before moving to the USA with her parents. Her 19-year-old sister and 18-year-old brother, whom she described as her biggest supports, were not able to immigrate with the family. The family moved to the USA for a future of better opportunities when her father obtained a faculty job at a university. Though her mother was working as an elementary school teacher in Turkey, her difficulty with English made it impossible for her to find an equitable job in the USA. The parents decided to leave their older children with their grandparents in Turkey to protect them from adaptation problems and even cultural shock. They planned to bring them to the USA after they finished college in Turkey so they would not ignore their cultural and religious values.*

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Selin stated that separating from all of her loved ones, especially, from her siblings and grandparents, was very traumatic for her. Since she was the youngest child in the family, she was getting a lot of care and love from extended family members in addition to her immediate family. Her parents used to spend more time with her in Turkey where they were financially affluent. In contrast, her father had to work for longer hours in the USA. Although her mother stayed home, she was not as engaged with her leading Selin to believe that her mother was depressed.

Her parents described her as an outgoing and popular girl when she was in Turkey. She had serious adjustment problems after the immigration, including selective mutism in the school setting during her first year in the USA. The parents initially did not want to accept that Selin's self-harm behaviors were related to depression. They believed that Selin was harming herself to get more attention and that her faith was not strong enough. They reached out to a Muslim chaplain, known as the "Hodja (Imam)" in a local Turkish American community. After talking to the parents and Selin, the Imam convinced the parents that Selin's challenges were not related to poor faith and recommended that they see a psychiatrist.

The parents were open and accepting of both therapy and medication as they were already convinced by the Imam about seeking help from a professional mental health provider. Her depressive symptoms, self-harming behaviors, and suicidal ideations were significantly diminished with fluoxetine 20 mg daily and cognitive behavioral individual therapy and family therapy sessions over a 6-month period. The parents developed a better understanding about depression and self-harming behaviors. They learned more about the dynamics of the relationships among family members and the importance of unification of the family. Eventually, they brought the older siblings to the USA, who contributed significantly to Selin's recovery.

Cultural Factors

Geographically, Turkey is located at the junction of Europe, Asia, and North Africa. It is considered a regional power because of its strong military, geographic location, historical background, and cultural and economic influence in the Middle East and surrounding areas. According to the 2015 data of the Turkish Statistics Institute, the population of Turkey is 78 million, with 23.4% under the 15-year age group and 67.3% in the 15–64-year age group [1].

Turks dominated the Balkans, Middle East, Northern Africa, the Caucasus, and large arches of Eastern Europe for about 500 years under the Ottoman Empire. Today there are 47 independent national states established in the lands once controlled by the Ottoman Empire. Turkish is the seventh most commonly used language in the world, and around 150 million people speak Turkish globally, including about three million people of Turkish descent living in Europe and the USA [2].

According to the Turkish Department of State, there are about 300,000 Turkish citizens living in the USA. However, the number of Turkish-speaking residents is estimated at around one million when Turkish-speaking ethnic groups who immigrated to the USA from former Ottoman Empire lands are included [2]. Turkey has a heterogeneous and multicultural society, partially because of its unique geographical location where Europe, Asia, and North Africa meet and historical trade routes cross. Istanbul connects Europe and Asia with bridges across the Bosphorus. It has been a melting pot of Eastern and Western cultures for centuries, historically as the capital of the East Roman (Byzantine) Empire and Ottoman Empire, and later as the economic and cultural capital of the Republic of Turkey

since 1923. As the capital city of the two longest living empires in history, Istanbul has been a sought-after destination for tourists, businessmen, scholars, artists, writers, and diplomats. It has tolerated and nursed diverse communities with various languages, cultures, and religions throughout history.

As such, Turkish people in the USA come from many different sections of Turkish cultural background. Although all of them are considered Turkish Americans, they may have significant variety in terms of social, educational, cultural, and religious presentations. While there are no statistics about religious demographics of Turkish descent people living in USA, one can predict that more than 90% of them are Muslims based on the fact that about 99% of people living in Turkey are Muslims. However, the degree of adherence to Islamic practices shows large variance among Turkish Americans due to the secular nature of education since 1923 and religious plurality of society since Ottoman times.

Immigrants from Turkey might have had various motivations for coming to the USA. Many Turks come to pursue undergraduate or graduate degrees from US universities, and some settle down here upon the completion of their education. The students who come to study at college are mostly from upper-middle class families. Graduate and postgraduate students represent a cross section of an emerging Turkish educated class, as the Turkish government has provided scholarships for graduate education at major countries of the world since the mid-1980s. Turkey ranks among the top 10 countries sending students to the USA for college or postgraduate education. The second most common motivation for Turkish people to come to the USA is for economic reasons. Some, in this group, may come directly to the USA from their small towns through sponsorship from their relatives or through the USA's annual residency diversity lottery. It is likely that this group never had exposure to urban culture even in Turkey.

There is limited research available about the Turkish American population in the USA. Burakgazi-Yilmaz et al. [2] categorized Turkish American family structures in three groups:

1. *Traditional Family Structure*: Traditional families have a hierarchical structure. The father or the grandfather is considered the head of the household, and the oldest son comes after the grandfather/father in hierarchy. Mothers usually play a moderating role between the children and the father. While mothers are encouraged to stay home and are responsible for the children's moral and academic education, the father is responsible for finances. Both parents mostly have a lower level of education; however they encourage their daughters and sons to get the best education they can [3]. Although they encourage their daughters to get higher education, those within the traditional family structure are stricter and more protective toward their daughters than their sons.
2. *Educated, Moderately Religious Family Structure*: In this family structure, at least one parent or both are commonly college graduates, and they come to the USA for postgraduate education. They usually set higher educational goals for their children, because they aim to raise their children as "model minorities" with Turkish and Islamic values. They encourage their children to attend to the best US universities. Their children may face pressure from home to overachieve and may face challenges in practicing their cultural and religious values because of conflicts between their family and traditional cultural values and American culture.
3. *Educated, Secular Family Structure*: In this family group, both parents are usually highly educated, and they come to the USA for postgraduate education. They tend to adjust to the American culture easily because they often do not follow religious restrictions, such as not consuming alcohol. On the other hand, their children may be more likely to be assimilated to Western culture and forget their cultural background, and this may later create tension in extended family circles.

The majority of Turkish Americans live in and around major metropolitan areas such as New York City (NYC), Los Angeles, Chicago, Houston, and Philadelphia. The Northern Jersey-NYC area is home to the largest Turkish American community and also Muslim Americans living in the USA. All of these areas and other large cities host blue-collar, traditional families and white-collar, educated, religious, and secular families of Turkish descent. They interact and spend time with each other in ethnic markets, restaurants, cafes, mosques, and other community centers at various social, cultural, religious, political, and sports activities.

Most Turkish American families, like other immigrants, take pride in their home culture, traditions, cuisine, and history. They work hard to pursue the American dream and provide the best social, economic, and educational opportunities for their children. The importance of extended family in some ways is similar to Italian American and Asian American cultures, especially among traditional and religious families. However, strong extended family connections rarely reach beyond secondary relatives among second- and third-generation immigrants.

The mental health stigma, in general, decreases as the education level of family members increases, regardless of being religious or secular, and is lower among the children and grandchildren of the immigrating generation. The traditional, less educated families are more likely to postpone or avoid seeking mental health care and first seek help from the religious leaders of their community. Educating Imams and other community leaders about mental health problems should help to diminish mental health stigma and improve seeking timely medical and mental health care.

Risk Factors

Suicide is a major public health problem in the USA, including immigrant populations. The results from an annual survey of a representative sample of high school students in the USA indicated that 17.7% of students had seriously considered a suicide attempt over the prior 12 months [4]. There are no studies on Turkish Americans, but the authors of this chapter believe that besides the risk factors below, conditions related to being an immigrant youth from a Muslim country such as acculturation stress, limited family support and resources, and victimization via school, media, or social media bullying (e.g., accusation of being a terrorist) should be considered while assessing and treating mental health problems of Muslim minorities, including Turkish American youth. Positive history of suicide attempts, history of depression or other mental illness, alcohol or drug abuse, stressful life events or losses, easy access to lethal methods like guns, exposure to the suicidal behavior of others, incarceration, and family history of completed suicide increase the suicide risk in any culture [5].

Dalkilic et al. conducted a survey among more than 30,000 high school students, representing about two-thirds of all high school students in Istanbul, Turkey, to assess the risk factors for suicide. They found that almost 26% of the students reported having suicidal ideation. Depression, anxiety, low self-esteem, anomie, irritability, antisocial behavior, peer influence, and illicit substance use were identified as significant risk factors for suicidal ideation. Interestingly, among younger students, higher parental education, lower anxiety, higher parental involvement, and lack of illicit drug use were associated with lower suicidality. Urban immigration status (being born in Istanbul versus moving later), religiosity, time spent with family, family history of substance abuse, and perceived family affluence were not significant factors according to this study [6]. In a similar, but smaller, study, Toros et al. investigated the prevalence of suicide attempts and risk factors among more than 4,000 Turkish students. The prevalence of suicide attempts was 1.93%. Relationship problems with parents, use of illicit drugs, and having a mental illness were the most common risk factors in their sample [7]. Also, in traditional Turkish culture, females might experience a more difficult separation process for independence, as compared to males.

Table 9.1 Common risk factors of suicidality in Turkish descent immigrant youth

Common risk factors
Personal history of psychiatric illness, low self-esteem
Previous suicide attempt
Family history of suicide and mental disorder
Family connectedness
Friends and social support
Religiosity
Alcohol and substance abuse
Immigration

When we consider Selin's history and presentation, the following factors are likely to have played a role in her suicidal ideation: presence of depression, low self-esteem, high anomie (due to school, environment, and cultural change), self-harming behavior (as an expression of high irritability and anxiety), decreased quality time with parents (the father had less time, the mother was possibly depressed), and loss of support from her other family members (siblings and relatives were left behind in Turkey) (Table 9.1).

Personal History of Psychiatric Illness and Low Self-Esteem

Many psychiatric disorders, and particularly depression, are considered high risk for suicidal ideations or behaviors. Pessimism, low coping skills, negative perception of body weight, and low self-esteem are correlated with a higher risk of suicidal ideation, as well. Eskin et al. investigated the risk factors of suicidal behaviors among 805 high school students in Turkey. They concluded that depression and low self-esteem were the most consistent and independent predictors of suicidal thoughts, attempts, and high score on suicide probability scale [8]. Ozdel et al. examined 144 patients admitted to an emergency room in Turkey for suicide attempt. The majority of the patients (74.6%) met DSM-IV criteria for at least one psychiatric illness, and almost 30% of the patients met criteria for major depressive disorder [9]. Selin's demographics and symptoms fit into the findings of these studies.

Previous Suicide Attempt

A previous suicide attempt is a proven risk factor for future suicidal behaviors in all cultures and nations [10]. Although there are no studies on this area yet, this is likely to be the case with Turkish American youth, too. Borowsky et al. examined a representative sample of 13,110 black, Latino, and white students in the USA between 1995 and 1996. They concluded that previous suicide attempts were a risk factor for future suicide attempts, particularly for boys and across ethnic groups [11]. Although there was no suicide attempt in Selin's history yet, she had suicidal thoughts and self-harming behavior over the last 3 years.

Family History of Suicide and Mental Disorders

Exposure to suicide and mental health disorders through family members may increase the risk of suicide among youth. Besides sharing the genetic makeup with biological parents and relatives, youth may also consider suicide as an option in difficult life situations if they have already witnessed or became aware of completed suicide in their family. Toros et al. investigated a sample of 4,256 Turkish students and found that suicide attempts among relatives are an important risk factor in children and adolescents with suicide attempts [7]. Selin has not lost anyone biologically related to her to suicide, but her mother possibly might have been suffering from an undiagnosed depression.

Family Connectedness

Poor communication within the family is associated with an increased risk of suicide in youth. In a national representative sample of 13,110 American students, Borowsky et al. demonstrated that family and parent connectedness was a major protective factor against suicide attempts for black, Latino, and white students in grades 7 through 12 [11]. Though there is no data available

for Turkish American immigrants, the authors who have worked with many Turkish American youths and families believe that family connectedness is a protective factor. Selin has had concerned, educated, and caring parents, but due to their migration to the USA, their time and attention were pulled away from her.

Van Bergen et al. investigated suicidal ideations across several ethnic groups versus ethnic majority adolescents in Utrecht, Netherlands. Turkish youth demonstrated a significantly higher risk of suicidal ideations (38.1%) compared to the average Dutch youth (17.9%) and other minority populations, including Moroccans (12.8%) [12]. Although having a good relationship with parents is a protective factor against suicide, more Turkish adolescents reported not enjoying being at home and discussing problems with their parents, which would explain the increased risk of suicidality in Turkish adolescents in this study. Interestingly, Moroccan adolescents, who have nearly similar socioeconomic and immigration status as Turkish youth, did not demonstrate increased vulnerability for suicidal ideations [12]. It is hypothesized that Turkish youth might have been relatively more westernized compared to Moroccan youth. Thus, they may have been more comfortable with the disclosure of suicidal ideations compared to the Moroccan youth. Another possible reason for very high rate of 38.1% suicidal ideation among Turkish descent youth in this study could be that second- and third-generation Turkish immigrants in Europe predominantly work in blue-collar jobs. They have had significant difficulty in integration into mainstream European community, because most of them were from uneducated traditional families as opposed to educated families.

Friends and Social Support

Being in a tightly connected and supportive social environment, with access to, would likely be a protective factor against suicide in many cultures and nations. Bearman et al. investigated friendship data on 13,465 American adolescents from the National Longitudinal Survey of Adolescent Health to explore the relationship between friendship and suicidal ideation and suicide attempts. Both boys and girls were found to be at a greater risk of suicide if they had a friend who committed suicide. Girls search for more social connectedness and peer support in their relationships, and as such, socially isolated females have a higher risk of suicide [13]. In Selin's case, significant social isolation and bullying likely have contributed to her suicidal thoughts, self-harming behavior, and depression.

Religiosity

Between 96% and 99% of Turkish citizens are reported to be Muslim [14]. However, no data are available about the religious demographics of Turkish Americans. One can assume that Turkish American immigrants continue to follow their familiar cultural and religious practices after they move to the USA.

As with most religious traditions, suicide is strongly forbidden in Islam. Difficult life situations are considered a test from God and showing patience, seeking logical and feasible solutions, and enduring difficulties are strongly encouraged. Suicide is one of the most forbidden sins in Islam. Committing suicide would result in eternal punishment in hell according to Islamic scriptures and almost all scholars, unless the person committing suicide lacks the mental capacity to make reasonable decisions.

Religion, however, is considered a coping and protective factor against depression and suicide. Zuraida et al. conducted a study among 51 depressed patients from different religious faiths including Buddhists, Hindus, Christians, and Muslims. The patients who had significantly lower suicidal ideation scores reported higher levels of faith and considered religion an important domain in their lives. The significance of the findings was even more pronounced among Muslims [15]. Selin's parents' approach to the Imam signified the importance of religious values, which would be a protective factor for Selin.

Eskin conducted a survey in a group of students (N: 206) undergoing religious education and a group of students (N: 214) undergoing

secular education. The survey results indicated that suicide was more acceptable among the secular group. However, the religious group was found to be more accepting of suicidal friends as close friends than secular group [16].

Alcohol and Substance Abuse

Alcohol and substance abuse are associated with increased psychiatric illness and suicidality. Alcohol and substance use may lead to suicidality by disinhibiting brain activity, increasing impulsivity, and impairing judgment. People may drink alcohol or use drugs prior to a suicide attempt in order to ease the distress associated with committing the act of suicide [17].

Singh et al. reviewed autopsy and field reports for all pediatric suicide cases referred to the New Mexico Office of the Medical Investigator from 1979 to 2005. The age-adjusted suicide rate was 4.8 per 100,000. In 26% of the cases, alcohol or other drugs were detected in postmortem tests. Boys were 2.7 times more likely to have an alcohol use disorder than girls, and they were more often intoxicated at the time of suicide than girls. Individuals with alcohol use disorders were more likely to shoot themselves [18]. According to a study consisting of 20% of the total high school student population in Istanbul, illicit drug use was one of the most significant risk factors for suicidality [8]. In the presented case, alcohol or illicit drug use has not been reported, but substance use problems should be ruled out in minorities including Turkish American youth.

Immigration

Existing literature does not include any studies on immigration and suicide in Turkish American youth. Hopefully, this book will generate more interest to conduct research on suicide and mental health among minority Americans by showcasing suffering youth like Selin. Current research has yielded conflicting data, as to whether immigrant status is generally a risk or protective factor for suicidal behaviors in youth likely because immigration status and suicidal behaviors may vary by ethnicity and country of settlement.

Pena et al. investigated the relationship between immigration generational status and suicidal behavior in a US National Survey of more than 20,000 Latino American adolescents and found that suicide attempts were least likely among first-generation immigrants. Suicide attempt rate was higher in second-generation immigrants and highest among third-generation Latino Americans [19]. Similar findings of lower rates of suicide in first generation immigrants have been found in studies examining Korean Americans, Latin Americans, Russian Israelis, and Moroccan Dutch adolescents. The exception is Turkish female adolescents in the Netherlands, who experienced a higher rate of suicide attempts than nonimmigrant Dutch adolescents and Moroccan immigrant adolescents [12, 20].

Culturally Specific Presentations and Symptom Expression

The presentation of psychiatric illness may vary in patients depending on their backgrounds, even among those within the same culture. The clinicians seeing Turkish American patients need to be knowledgeable about basic Turkish cultural and religious values and core beliefs. They should be aware that the Turkish American population is a heterogeneous group and may have a variety of clinical presentations. Assumptions about presentation of illness that do not account for cultural and socioeconomic nuances, even within a culturally homogenous group, can be misleading [2].

Inquiry and discussion about suicide with the individual and family are essential for psychiatric evaluation. The clinician needs to be thorough, yet delicate, while conducting a suicide risk assessment. It is painful, and, at the same time, it can be shameful to talk about suicidal behavior and family history of suicide. In Turkish culture, suicide is considered an unforgivable sin and a very shameful event for the entire family. Suicide is deemed so sinful that individuals who have committed suicide may

not be allowed a religious funeral ceremony. Hence, the clinician needs to revisit suicide assessment in each visit and talk about a suicide safety plan in detail. Based on the above information, one may better understand the suppressing effect of religious and Turkish cultural values on suicidality and the reasons why self-harming behavior and depression were relatively easier to talk about in Selin's case.

The presentation of depressive symptoms may differ according to socioeconomic status in Turkish American patients. Patients in lower socioeconomic groups may present with more physical ailments rather than psychological symptoms of depression. It is common to hear from an uneducated patient complaining of "numbness or pain starting from the head, traveling through the body, and exiting from the tip of the big toe." In the case of a mental illness, common physical complaints vary from neurological symptoms, such as headache, numbness, dizziness, and electrical shock feelings, to gastrointestinal symptoms including nausea, stomachache, "knot in the stomach," distention, and even more vague symptoms like being possessed by the devil, etc. It may be difficult to make a clear assessment because some patients may have difficulty expressing their feelings. Some patients from higher socioeconomic status, however, may present with well-expressed depressive symptoms as clear as a textbook presentation of a typical American patient.

Clinicians should be cautious, delicate, but thorough when assessing substance or alcohol use in the Turkish American population. Alcohol and substance use are prohibited in Islam. People from religious backgrounds may feel offended when they are questioned about alcohol or substance use. On the other hand, clinicians should not assume that Muslim patients do not use alcohol or illicit drugs solely because they are prohibited by their religion. Like other faiths, there are many Muslims who do not follow all of the religious rules and doctrines prescribed by their faith. Family traditions, as well as the social networks of the individual, play a significant role in the decision to consume alcohol, use illicit drugs, and experimentation.

Selin's parents have been well educated and care about the well-being of their daughter. Yet, they sought help from a mental health professional only after being recommended by a religious leader. On the other hand, once they have been provided with needed psychoeducation about her condition, they adhered to treatment recommendations of the psychiatrist despite a 2-h commute for therapy sessions. They felt it has been important for them and their daughter to see a Turkish American clinician who understands their cultural values and norms rather than another psychiatrist.

Diagnostic Considerations

Suicidal ideations, at any age group, should be taken very seriously. Careful attention should be paid to both the intensity and the context. The case description provided in this chapter clearly depicts the impact of immigration and psychosocial aspects on an adolescent female's mental health needs that were not acknowledged and addressed for more than 2 years until her parents were recommended to see a psychiatrist by a Muslim chaplain. It is imperative to identify the key factors that require added attention during psychiatric assessments. Collateral information from family members, including relatives in the home country whenever possible, school teachers, primary care providers or pediatricians, as well as peers at school, and in the community, should be included in the very first assessment. Every attempt should be made to obtain collateral from other mental health providers if the youth is in therapy, and medical records should be requested in a timely manner.

Immigration and acculturation processes appeared to play a remarkable role in Selin's crisis. Burakgazi-Yilmaz et al. reported that adolescent female Turkish immigrants were found at a high risk for suicide, possibly representing the role of cultural and immigration specific factors in suicidality [2]. As mentioned before, Selin was a very outgoing and popular girl while living in Turkey, and her current presentation has been significantly different from her baseline

behavior prior to immigration. Clinically, similar changes should raise a red flag. Prompt identification and attendance to these changes can be of great help to the youth and can potentially prevent grave consequences.

Also, loneliness has presented a serious problem in Selin's life. In Turkish and many Eastern cultures, the social structure of family and socialization and learning from siblings play a significant role while growing up. Both of Selin's older adolescent siblings were left behind in Turkey, creating a disconnect from her usual support system. Her loneliness was also compounded by the rejection she experienced from her peers at school and not having friends in the neighborhood. Initial signs of feeling rejected and isolation from social interactions should be carefully monitored by family members. Any changes in behavior including, but not limited to, feeling tired all the time; feeling weak while playing sports or avoiding activities which the adolescent previously enjoyed; numerous somatic complaints like frequent headaches, belly pain, leg pain, etc.; any remarkable drop in school grades; and changes in likes and dislikes should be monitored and noted carefully. Since depression in youth can show various presentations, irritable mood and change in social interactions should also be investigated.

Adolescent males are more likely to die from suicide attempts due to their tendency to choose more lethal methods for suicide. Though adolescent females tend to have more suicide attempts, they use less lethal methods such as medication overdose or self-injurious behaviors [5]. Although this has not been studied yet in Turkish American youth, the authors think it is likely the case. For example, Selin engaged in multiple self-injurious behaviors in part as "a cry for help," suggesting that this generalization could be valid for Turkish American youth, too.

There are several scales available to adequately assess the risk for suicide in youth. Posner et al. have demonstrated the utility of Columbia Suicide Severity Rating Scale (C-SSRS) in children and adolescents [21]. Extensive research shows inter-rater reliability and predictability with the C-SSRS, and hospital-wide screening implications also have notable value [22]. However, while administering the C-SSRS, adolescents often do not clearly report safety-compromising behaviors during direct clinical interviews. In these instances, other collateral information and other self-reporting measures can be useful. Timely assessments, or at least screenings for affective disorders like depression and bipolar disorder, as well as anxiety and substance use disorders, should be employed to ensure effective interventions. Physical or physiological complaints including changes in sleep, appetite, energy level, or interests in hobbies or activities should be given due importance. The clinical scenario described in this chapter depicts how inadequately diagnosed and unmanaged immigration-related stress may have perpetuated the development of a major depressive episode.

Intolerable anxiety in children and adolescents can present with noticeable clinical consequences. In this age group, somatic complaints like belly pain, frequent headaches, or as seen in Selin's case "selective mutism" might be commonly encountered. The fact that this adolescent was selectively mute during her first school year in the USA clearly suggests internalized conflictual circumstances, which she could not resolve and led to a mind-body disconnect.

Intervention Approaches

The best approach to an adolescent in crisis depends upon multiple factors. The geographic location, precipitating circumstances, underlying psychopathology, family dynamics, and support systems must all be taken into consideration. The social, cultural, and economic factors fueling the crisis should always be kept in mind. Intervention begins at the initial assessment and should be adjusted according to actionable data gathered during first assessment, which frequently is the first psychiatric encounter for patient and family. Direct inquiry about the factors leading to and contributing toward suicidal ideation or self-injurious behavior often sheds light on issues which youth and family might not have otherwise

thought about. The interview should be conducted in a calm milieu, taking into consideration the individual and family's fluid emotional state after the crisis. Asking the youth's choice on whether the interview should be conducted individually or with family helps to empower them. The effectiveness of any intervention largely depends upon building a good therapeutic rapport with the youth and the family.

Cultural differences especially language barrier and religious symbols or values might cause difficulties in establishing therapeutic rapport with immigrants including Turkish American youth and families. Limited education of parents, lack of knowledge, and experience with the complicated American mental health system might even result in loss of trust and withholding crucial information from the clinicians. Keeping a nonjudgmental approach and giving the youth and parents an option to call or invite a trusted family friend or relative besides using trained translators would usually resolve potential misunderstandings and set a good foundation for assessment. Whenever possible, having clinicians from Turkish or Muslim American or similar cultural backgrounds with the ability to speak the native language of the family should be preferred.

Rarely the parents or youth might have negative assumptions or prejudices against providers from countries with historical political animosity with Turkey, especially if they were not exposed to people from such countries before. This could be addressed by assuring them that healthcare providers treat all patients ethically based on professional standards and without any discrimination based on religion, gender, country of origin, etc.

Interventions can be grouped into individual, family, or system categories. The individual approaches can further be divided into those addressing current or past factors. Current factors may include recent trauma or microtrauma, such as a breakup, poor school grades, peer group interactions, bullying, recent immigration and poor acculturation, parental or sibling conflicts, and ongoing medical and/or psychiatric illness. Past factors that could be targeted for intervention might include past family conflicts, history of abuse, and history of mental illness. Several interventions addressing some factors specifically pertaining to Selin's case and Turkish American youth are reviewed below.

Treatment in Crisis in Office, School, or Emergency Room

A youth in crisis is often in a fluid state of mind, wherein motivational interventions could effectively be started via meaningful conversation by a professional. Pertinent contributing factors should be considered in deciding to hospitalize, referring to partial hospital or intensive outpatient, or arranging outpatient community follow-up. Recent research shows post-discharge community follow-up could prevent hospitalization [23].

School counselors or psychologists could play a pivotal role in recognizing emotionally struggling immigrant students and referring them to culturally competent therapists and/or psychiatrists for further evaluation and treatment. In Selin's case, her symptoms, especially selective mutism and social isolation, had been noticeable, and her parents might have been advised to seek help from a professional during her first school year in the USA.

Suicide Hotline and Suicide Text Line

National and local hotlines have been established to help young people who are thinking about or planning suicide. Toll-free numbers like 1-800-SUICIDE (1-800- 784-2433) or 1-800- 273-TALK (1-800- 273-8255) are nationally available in USA for 24 h a day and 365 days a year. Providing these resources to youth and family in need could potentially prevent suicide attempts and provide a timely intervention. Hotlines could be especially helpful for patients like Selin, where the young person's social network could be very limited secondary to immigration factors. Having culturally competent and bi- or multilingual counselors available on hotlines as an option would improve engagement and follow-up with recommendations among minorities and immigrants.

Research shows beneficial outcomes of brief telephone therapy via suicide hotline [24].

There has been a significant rise in text-message communication among youth since the spread of smartphones. Texting has become a predominant method of communication, especially among young people, and continues to gain more popularity. There are free 24-h crisis text lines, for example, www.crisistextline.org has been increasingly popular and can be provided as a resource [25]. Crisis hotlines for hearing and speech impaired youth such as 1-800- 799-4TTY (4889) are also available.

Treating Underlying Illness

Underlying psychopathology, if diagnosed, should be explored and treated adequately. In immigrant youth, common mental disorders such as depression, anxiety, bipolar, substance use, trauma and stressor related, learning disorders, and attention deficit hyperactivity disorder should be screened in schools. In case of any serious psychiatric or medical illness, having a culturally competent mental health professional in a consulting role could minimize crises and complications through early diagnosis and intervention. For minorities including Turkish American youth, a strong follow-up plan and reaching out and tapping into resources in the local immigrant community are likely to improve adherence and outcome significantly.

List of Emergency Contacts

Asking and helping the youth to develop a contact information list for at least three reliable support people to reach out in case of crisis could be of great help, especially, for socially isolated Turkish immigrant youth. If the youth is connected to one of the parents, then efforts should be made to include supportive parent on the list of contacts. If possible, having an immigrant peer or trusted adult from the country of origin as a support would be helpful, but whether support persons would be available at a time of crisis (being far away or in a different time zone) or not should be explored carefully. In Turkish culture, friends and relatives play a significant buffering and supportive role through relationships in case of emotional challenges and crises.

Working with Family and Other Supportive Measures

Young people often carry a high threshold of mistrust toward family members or healthcare providers, depending upon their circumstances of presentation. It is very important to establish a strong rapport initially with the youth. In Turkish culture involving immediate family members, whenever possible such as Selin's case, could be a crucial step for a successful outcome. In native Turkish culture, research depicts preponderance of impulsivity and the unplanned nature of suicide attempts, especially by Turkish females [26]. Usually, supportive relationships with friends, siblings, and relatives balance culture-based emotional impulsive behaviors, but Selin was separated from her siblings, who were a main support to her while in Turkey, and she had since been struggling with loneliness.

The acculturation process sometimes leads to a "lost identity" of an immigrant youth, who cannot assimilate with the host culture. Immigrant families usually bring their native values and practices with them, and those values might clash with the values of the host culture. The tension resulting from conflicts between home and host cultural values might overwhelm young immigrants. The struggle in balancing conflicting values possibly has played a trigger role in Selin's depression. All efforts to educate family about these dynamics and available resources such as referring to a culturally competent clinician should be provided.

School support is another essential avenue in preventing and treating suicidal behavior in immigrant adolescents. Selin's long and lonely struggle with the acculturation process, accompanying frustration from lack of progress, and limited support might have significantly contributed to her self-criticism, self-harming behaviors,

and suicidal symptoms. In addition, immigration challenges, pressure from parents for better school performance, and transitioning to a new education system should be considered in Selin's case, as well. Mental health professionals should approach the school and utilize the services therein to provide ongoing support in that environment. When necessary, more educational support like individualized education planning, tutoring, or extra coaching should be considered besides mental health treatment.

Several programs providing support to immigrant families in the acculturation process have been designed and implemented which provides services to youth and their family members. For example, refugee support services provided by the Dallas Independent School District (DISD) and Children of Refugees' Education, Acculturation Teaching and Empowerment (CREATE) are specifically directed toward refugee families [27, 28]. Tool kits designed by the National Child Traumatic Stress Network (NCTSN) help the providers to understand what services refugee families need, to identify needs for mental health services referral, and to ensure connectivity to appropriate interventions [29].

Obviously, extensive knowledge about home cultures of immigrant youth should not be expected from clinicians treating them, but an empathic, nonjudgmental approach and an interested and curious attitude could be enough for a strong therapeutic rapport and initial successful assessment and interventions. Hopefully the information presented in this chapter would be useful for clinicians in the treatment of young Turkish immigrants who may be struggling with suicidality in the USA, Europe, and other host countries.

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Suicide Among Youth of Middle Eastern Origin

10

Fayez El-Gabalawi, Karim Sedky, and Racha Nazir

Introduction

The Middle East (ME) is generally defined as the area from East of Libya to Afghanistan, usually including Egypt, Sudan, Israel, Jordan, Lebanon, Syria, Turkey, Iraq, Iran, Saudi Arabia, and the other countries of the Arabian Peninsula. North African Arab countries, Libya, Tunisia, Algeria, and Morocco, are also commonly associated with the Middle East. Although each country of the ME has its own historical, linguistic, and cultural individuality, they seem to share common cultural characteristics that emphasize the role of religion in all aspects of life (predominantly Islam, followed by Christianity and Judaism), the role of the extended family and the presence of the authoritarian patriarchal figures, and the gender inequality that values males and restricts expression of sexuality. The main wave of immigrants from the ME occurred after the Immigration Act of 1965 that allowed people from all countries to immigrate to the United States (USA) regardless of their ethnicity or religious affiliation. Recently, more immigrants and refugees are trying to flee the Middle East that has been embroiled in brutal civil wars, extreme religious fundamentalism, and oppressive autocratic regimes. Many millions, especially from Syria and Iraq, have been uprooted and stranded in refugee camps, while others, including large number of children, desperately tried to cross dangerous seas and walk through precarious state borders to reach European countries. The current temporary American ban on refugees and immigrants from several majority Muslim countries in the ME, intended to protect against terrorism, has instead affected multitudes of innocent people and the most vulnerable of children and women who were trying to reunite with their families. Contrary to the spirit of the immigration act, it can create an additional adversarial and hostile attitude toward new immigrants.

Historically, mental illness has long been described in old Egyptian transcriptions, and the first mental hospital developed in Iraq followed by Egypt and Syria [1]. However, over the years, there has been less focus on psychiatric disorders, till recent years when a dramatic increase in the incidence of mental illness was noticed. Although this might be partially explained by increased awareness, other factors such as civil wars and economical unrest have also led to elevated

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emotional complications. Additionally, increased internet use, globalization, and easy access to illicit substances without full awareness of their deleterious effects have led to even more serious consequences. Moreover, easy access to guns and increased trauma caused by wars and extremist activities have led to high incidence of post-traumatic stress disorder (PTSD).

Cultural background, education, gender, religion, and socioeconomic status can all affect acceptance of mental health treatment. For example, gender difference between treating clinician and patients at times might pose a challenge (i.e., a male clinician treating a female patient might provoke jealousy in the male partner) so as the age difference (i.e., a young female clinician treating an older ME male, which might pose a differential power struggle). It is important to note that many recent immigrants to the USA from the Middle East provide care for a relative with mental illness [2]. However, many immigrants avoid seeking psychiatric services because of cultural beliefs, language barrier, and lack of knowledge of resources, in addition to the fear that the mentally ill relative may be taken away from them [2]. It is the sense of obligation of keeping family together and the duty to care for the mentally ill that lead to their continuation of care.

Cultural difference between the ME and Western countries can create significant dilemma, especially for the younger population. The demand of parents of absolute obedience by children may hinder treatment. Additionally, the male-dominated family structure characteristic of the Middle East may change dramatically with immigration. In the USA, immigrants from the Middle East may congregate into their group of ethnic origin or religious affiliation such as Arab Americans, Iranian Americans, and Muslim Americans (although not all Arabs are Muslims and not all Muslims are Arabs). There is no accurate census of the number of Middle Eastern immigrants in the USA; however, the suggested range is from one to three million, mostly children and adolescents, due to the tendency of having large families, and parents are usually working as professionals [3]. Most recent ME immigrants come from Iraq, Egypt, Lebanon, and Syria, and they reside mostly in California, New York, Michigan, Texas, and New Jersey. The largest concentrated Arab American population today in the USA lives in Dearborn, Michigan.

Case Presentation

T.A. is a 16-year-old Iraqi adolescent female who presented to the inpatient adolescent unit after overdosing on several acetaminophen pills. In addition to her depressive symptoms, she expressed vegetative symptoms including decreased appetite, weight loss, fatigue, and insomnia. She struggled with flashbacks associated with intrusive traumatic memories. She has immigrated with her mother, 11-year-old brother, and a 9-year-old sister, to the USA about 6 months prior. They were fleeing from the war-torn country in order to join the maternal uncle and aunt, who have been residing in the USA with their two young children for the last 4 years. She has experienced multiple losses and traumatic experiences including the death of her father during the civil war when she was 9 years old. At age 11, she witnessed a car explosion in the neighborhood that destroyed part of their house, killing her 19-year-old brother. For 4 consecutive years, the family had to stay in the partially destroyed home, without running utilities for most of the time. She became withdrawn and lost interest in her schoolwork, barely passing her grades, despite her previous academic excellence. She lost significant weight and was having thoughts about dying to join her father and older brother. She struggled with flashbacks associated with these intrusive traumatic memories. T.A. then began to suffer bouts of major depression as well as post-traumatic stress disorder (PTSD) symptoms. Despite her mother's efforts to seek help while in Iraq, there were no adequate mental health services for children or even adults in that respect. Her mother had resorted to her extended family members and local Mosque for support and help, they provided some

relief and spiritual healing for a while, but the symptoms continued to increase without significant alleviation of her daughter's sufferings.

Six months prior to admission, with the help of the maternal uncle, the family successfully immigrated to the USA. However due to the stigma and sense of shame, the family did not seek the school's help in counseling services to aid the patient and hid her struggles. Additionally, because of her English language barrier, she was enrolled in the neighborhood high school at the tenth grade, a level lower than her expected grade. Despite the safety and comfort of her uncle's small home, she felt uprooted, socially isolated, and intensely missing her home country. She was overwhelmed by the school's academic demands and the need to learn a new language. The adjustment to a new culture and different social norms and relationships, in addition to the specter of failing the academic year, began to aggravate and perpetuate her symptoms, which eventually led to her experiencing recurrent suicidal thoughts. Being a moderately religious person, T.A. began to suffer pangs of guilt since her Muslim religion forbids suicide, she began to isolate herself and pray excessively to ward off the negative thoughts, yet for a couple of weeks, the suicidal thoughts were intensifying and developing into a plan to overdose on acetaminophen (her medication for menstrual cramps) in a suicide attempt to end her mental agony. The day of the incident, she refused to go to school and told her mother that she was having headaches and stomach pain. When entering T.A.'s room, the mother found her holding her abdomen in pain and noticed the open medication bottle. T.A. told her mother that she felt hopeless and a failure and had been thinking seriously about killing herself for a while, and this morning she overdosed on a handful of over-the-counter pain medication pills. The mother was distraught, although she knew that her daughter had experienced periodic suicidal thoughts, yet she never knew that they are that serious or that T.A. will ever act on them. The mother started calling the uncle at work, who suggested that they call the ambulance immediately, and she was then transferred to the emergency room (ER).

Her routine investigative tests, including liver function, were negative on admission. Her urine pregnancy test and urine toxicology were negative as she was not sexually active and had not used drugs. Due to the language barrier, the help of an interpreter was utilized during the emergency room evaluation. When the decision was made to admit her to a psychiatric unit due to the severe depressive symptoms and the high suicidal risk, the family was very reluctant and insisting on taking her home instead. The ER team spared no efforts to gain their trust and explain the seriousness of the condition including the urgent need for psychiatric treatment in an inpatient adolescent unit. The family was concerned about several issues. First, they were afraid that T.A. will be taken away from them because of her mental problems. The team explained that she will not be taken away and that the family will be involved in all steps of the treatment and participating in family meetings and treatment decisions and also the family is allowed to visit daily if necessary. The second concern was about the cultural and religious issues; the family was concerned about adhering to her dress code and dietary restrictions (wearing a scarf and not eating pork). They were concerned about T.A. mingling closely with male adolescents and associating with a male doctor or therapist. The team explained that all cultural and religious preferences are respected and observed in hospitals to a great extent. Though they could not promise only female

unit, they affirmed that she will be safe and protected since the unit milieu is highly supervised and monitored at all hours of the day and the night. The family was also assured that she can keep her holy book with her and be allowed visitors from the Mosque for religious support. The third concern was about the nature of the inpatient treatment and if she will be given medication against her will. The team explained that treatment and medication will be discussed in details with the family and not imposed on the patient with the exception of this admission. Finally, the family agreed to transfer T.A. to an inpatient unit and continue the discussion with the hospital team. A cornerstone aspect of assessment was the cultural evaluation to carefully address ethnic issues and specifically war trauma. The family's financial constraints, limited social and medical support, and cultural adjustments were some of the hindering factors. Although parents agreed to hospitalize the patient after the medication overdose, the family struggled with the admission of mental health issues the patient had been experiencing. Both the patient and her family were educated about the benefits of an antidepressant medication; yet, they refused medication initially due to strong objections related to religion and stigma. After several discussions and culturally sensitive educational sessions that lasted more than a week, they both consented to a medication trial on fluoxetine 10 mg, which was titrated up to 20 mg in the following week. T.A.'s depressive symptoms and suicidal ideation persisted for about 2–3 weeks because of the comorbidity of major depression and post-traumatic stress disorder (PTSD) combined with the complicated grief and the stress of immigration. The patient and family were grieving the death of the father and brother which was superimposed on other stressors. She eventually responded to treatment, with the resolution of the suicidal thoughts. Both insomnia and nightmares significantly subsided, with increase in appetite and improved mood. Her affect also brightened. In addition to providing outpatient therapist and psychiatrist, the family was also referred to services for new immigrants to help the family adjust to their transition and acculturation. School was contacted to involve the counselor in the process of transitioning back to school and address the particular issues related to her adjustment and language difficulty.

Prevalence and Cultural Factors

There are few epidemiological studies about the prevalence of mental illness among adults in the Middle Eastern countries; even less is known about the exact prevalence among the adolescent population immigrating to the USA. The incidence and prevalence of mental illness in the ME are not uniform, and they depend on the specific population and country, in addition to the war being a contributing factor. In a systemic review on mental illness in Middle Eastern countries struggling with civil war, child and adolescent individuals in Israel had 5–8% PTSD [4], and 25–35% had some form of subclinical depression, of which 3.3% with major depression. About 3% had attention deficit hyperactivity disorder (ADHD), while 2.5% had specific phobia, and 1.4% suffered from generalized anxiety disorder (GAD), and higher percentage was reported to be found in the Palestinian population living in occupied territories: 23–70% had PTSD, while 11.3% had depression, 10% had ADHD, and anxiety ranged from 40% to 100%. In Iraq, 10–30% struggled with PTSD, 4.3% with separation anxiety, and 3.3% with specific phobia [4].

It is with no doubt that wars had exposed this young population to starvation, loss of parents, disease, poor education, truancy, and exploitation. Kuwait had up to 70% PTSD risk after its Iraq

invasion in the 1990s [5]. In a study conducted in Baghdad following the Iraq war, 14% satisfied criteria for PTSD and up to 30% in Mosul [6]. Among youngsters attending primary care, mental illness was found in 37.4% of children and adolescents. PTSD represented 10.5% of the group, followed by separation anxiety in 4.3% and depression in 1.5%. A 15% high rate of ADHD was found in school children [7]. It is important to note the lower rate of depression compared to the PTSD in the latter study during the time of war. This might highlight Durkheim's "social integration theory" discussed later in the chapter.

In 2000, it was reported that suicide represented the 25th leading cause of death in the ME [8]; this rather very low incidence compared to other countries was thought to be due to the traditional belief that dominant religions (i.e., Christianity and Islam) condemn taking one's own life [9]. A Swedish study evaluating the rate of suicide in the first- and second-generation ME immigrants to the country during the period from 1990 to 1998 found a lower suicide rate in both parents and their children of ME origin compared to other ethnicities [10]. Male youth had a higher rate compared to female counterparts (0.08% in youth males compared to 0% in female, with slightly higher suicide rate of 0.14 if one of the parents was Swedish). Compared to the Swedish-born population, an odd ratio of 0.5 for suicide was found, and the odd ratio increases to 0.9 if one of the parents was Swedish. Similarly, another study investigated the prevalence of nonfatal suicidal behavior, and examined risk factors in non-Western female immigrant adolescents compared to majority female adolescents in the city of Rotterdam, Netherlands, including 4,527 adolescents of Dutch, South Asian-Surinamese, Moroccan (557 girls), and Turkish origin [11]. It was found that rates of attempted suicide among Turkish and South Asian-Surinamese young women were higher than of Dutch females, while Moroccan females had lower rates (6.1%) than Dutch female adolescents. Physical and sexual abuse, and an impaired family environment, as well as parental psychopathology or parental substance abuse contributed to nonfatal suicidal behavior of females across ethnicities.

However, many have challenged the notion of low suicide rate and attributed it, at least partly, to underreporting. Others have even suggested a high suicide prevalence and dramatic increase in the recent years. This increase in both depression and suicide is thought to differentially affect young females in the ME. In a study conducted in Egypt involving 602 adolescent females, depression rate was 13–15%, with fatigue being the most common complaint [12]. Subsyndromal depression and major depressive disorder (MDD) were present in 5%, while 3% had dysthymic disorder. Suicidal ideation was present in 20% of the population with 2.5% having serious attempts. GAD was present in 32.5% of depressed individuals and was one of the commonest comorbidities. Social phobia followed at 20% and substance abuse in 8.8%. Obsessive-compulsive disorder (OCD) was reported to be 2.5% in this cohort [13]. In yet another study conducted in Alexandria, Egypt, 30% of high school adolescents exhibited strong suicidal ideation in the previous year [14]. It is suggested that denial and minimization of mental illness, blaming the victim, and externalization of the cause to be related to Western influence and drug addiction are some of the psychological defense mechanisms commonly used by the ME communities.

Less is known about methods of suicide in adolescents, due to its low incidence. However, in adults, methods of suicide in the Middle Eastern countries may differ dramatically from Western countries. Although suicide by immolation is extremely rare in the West, it is one of the common causes of fatal suicide in the Middle East. Perhaps, due to its availability and frequent domestic utility, individuals use kerosene to set themselves on fire. In an Egyptian study spanning 20 months, 3% of the patients in the burn unit had attempted suicide. Out of these 23 individuals, 21 were females [15]. In a meta-analysis including 19 studies from the ME, suicide by hanging occurred in 39.7%, by poisoning in 20.3%, and by self-immolation in 17.4% [8]. Methods of suicide in males compared to females were different: hanging was in 38.8% versus 26.3%, compared to those dying from both poisoning (19.0% versus 32.0%) and self-immolation

(11.3% and 29.4%). Other methods used were firearms (7.0%), drug overdose (2.5%), drowning (3.1%), and jumping from high-rise building (0.8%). In the ME suicidal females resort to drinking cleansing liquids (organophosphorus), which is also one of the common causes of poisoning and still has high suicide fatality between 10% and 20% compared to overdose on medicines 0.5% [16].

In some studies, it was suggested that suicide in females between the ages of 15 and 29 was even higher than suicide in elderly males [9]. The level of urbanization and education has also affected suicidal rates and gender ratios. This was observed in an adolescent population admitted to the burn unit (of which 85% were female) in a rural town in Iran, with 74% of them attempting suicide [17]. Parental and sibling conflict occurred in 47.5% compared to marital conflict in only 17.5%. It is important to note that a relatively lower rate of suicide by immolation was found in other urban parts in Iran: 41.3% of females committed suicide by immolation compared to 10.3% among men [18]. The higher female suicide rates by immolation have been attributed to a lower educational status and increased family conflict in Kurdistan, Iran. On the other hand, higher male suicide completers were found in an analysis study involving 1,901 individuals in a Westernized Iranian city. Females, younger population, and those from urban locations tended to die by self-immolation (a relative ratio of 13.3) and drug overdose, compared to men by firearms [19]. Among this cohort, hanging was the most common method of suicide (41.7%), followed by self-immolation (25.9%) then drug overdose (12.5%). Children between 10 and 19 years of age, who committed suicide in this study population, showed equal tendency between hanging as method of suicide and immolation (98 vs 90, respectively). This was much higher than those using drug overdose and firearms (36 vs 34, respectively). In Saudi Arabia, most of those who commit suicide were females [20, 21], and in Turkey, suicide in females is 3.8 times those of males [22].

T.A. case is an example of the increasing prevalence of mental illness especially depression, PTSD, and suicide among Middle Eastern adolescents especially females from the war-torn countries such as Iraq. When evaluating or screening ME young immigrants, it is important to inquire about PTSD symptoms due to the prevalent experience of trauma, separation, and loss caused by the war. It is crucial as well to inquire carefully and tactfully about suicidal thoughts since most Middle Easterners are religious and tend to deny the existence of such thoughts because they contradict their religious beliefs. A good strategy is to be direct and open about the issue with clear psychiatric explanation. When T.A. was asked initially "do you have thoughts about dying or killing yourself?," her answer was "no, I took the pills because I only wanted to relieve my headaches." When she was approached with a more culturally appropriate question such as "when a religious person suffers from severe depression and trauma for a long time without getting help or relief, she may start having thoughts about wanting to die. That does not mean that she is becoming less religious, but it means that depression is getting worse and negatively coloring her thoughts. Has this ever happened to you?," her answer was reflective of her situation. It is also important for the interviewer when evaluating a suicidal new immigrant from the ME, especially young females, to ask if the person has had thoughts about setting self on fire (immolation), which is a common method of suicide in the ME.

Risk and Protective Factors

Table 10.1 discusses the risk and protective factors for suicide.

Immigration: Parental Acculturation, First and Second Generation

Many immigrants, including those from ME countries, escape political and financial struggles seeking better life for themselves and their chil-

Table 10.1 Protective and risk factors for suicide in the ME population

	Protective factors	Risk factors
Age	Preadolescent age	Adolescent age
Gender	Male	Female
Socioeconomic status (SES)	High	Low
Lack of family and friends' support		Yes
Generation	First-generation immigrants. However, language barriers and social and economic constraints increase risk	Second-generation immigrants
Religiosity	Yes	
High cognitive function	Yes	
Legal and criminal consequences		Yes
Substances and smoking cigarettes		Yes

dren. However, adjustments have four types of acculturation: assimilation (individuals adopt the host culture and abandon the traditional culture), separation (individuals maintain the traditional culture only), integration (adopting both cultures), and marginalization (separation from both cultures). Difficulty in bringing their extended family to the USA and lack of people with similar ethnicity in the local community can lead to alienation. Language barriers contribute to already existing social and economic strains that frequently worsen challenges to assimilate [23]. In addition, for illegal immigrants, the process of immigration may lead to unexpected period of detention, which can lead to difficulty in rebuilding their life [24]. Moreover, discrimination and violence complicate cultural adjustments [23]. Thus, although pre-immigration trauma leads to PTSD and other psychiatric complications, post-immigration struggles may lead to persistence or exacerbation of these issues.

While first-generation immigrants struggle with social and economic challenges, second-generation adolescents face identity crisis: the conflicting expectations from the parental culture versus American culture. Parental high achievement expectation is usually a source of conflict [25]. First-generation adolescent immigrants are usually enmeshed with their parents, because they tend to adhere strongly to their parents' cultural values and expectations that emphasize close and protective relationships especially between mothers and daughters, while allowing male adolescents to be gradually more independent. Second-generation adolescents usually seek more independence from their parents and are more inclined to engage in dating and premarital sex, contrary to their parent's expectations, and are less willing to follow the strict adherence and practices of their parent's religion. The generational gap between parents and adolescents among immigrant families may be accentuated by the increasing difference in acculturation, language acquisition, and religiosity between parents and children [26].

War, Traumatic Experience, and Suicide

The political and religious wars that have been ravaging the ME recently have contributed to a very disturbing phenomenon of children and teenagers being used as soldiers and suicide bombers. Those children were victims of indoctrination by an extreme religious ideology. Some authors have suggested that the suicide bombers share a chaotic childhood, low self-esteem, and personal crises that might increase their vulnerability and make them susceptible to exploitation. Living in an oppressive environment without employment opportunity or ability to be successful, and having anger toward corrupt systems that leads to seeking revenge and/or glory are added

factors [27]. This latter is flourished by cultural endorsement such as promise of eternal life and/or financial rewards. It is important to note the relatively new shift from these bombers being strictly males to gradual increase among the female population [27]. This later phenomenon, however, is still under investigation, and the information is limited due to the difficulty in gathering accurate statistics and conducting accurate assessment.

Both severity and the number of exposure to traumatic experiences have contributed to PTSD, depression, anxiety, and behavioral problems [4]. Some studies suggest that a cognitive and emotional experience following the trauma is a strong predictor of a later mental illness [4]. Increasing age and male gender increase the risk of PTSD; this is probably related to increased risk to trauma occurrence with both these factors. However, females tend to exhibit internalizing symptoms such as depression and anxiety, while males exhibit externalizing disorders (i.e., anger problems and hyperactivity) [28]. The trauma-related symptoms in mothers could precipitate mental illness in children. Additionally, abuse history predicted higher risk for depression in adolescent population. Poor parental relationship affected females more than males; this might be explained by the males trying to establish independent friendships outside the family, compared to the more isolated females in their ME homeland [29].

Several international studies suggested a lower suicide rate during major and minor wars in individuals in their home country [30, 31]. This has been observed across age groups including adolescent population, due to a shift from internal focus to external threat. “Social integration theory” highlights the need for social cohesion during major wars among ethnicities that lead to decrease in suicide. Other studies, however, had challenged this theory, with some focusing on the increase in suicide before and after the war being due to social exclusion [32]. However, it is not clear if this phenomenon also occurs in immigrants, with their original homeland struggling with wars.

Country

Although there is a paucity of studies on suicide in the children and adolescent population in the ME, there are some performed on adults. Methods of suicide are dependent on the country; for example, hanging was the most common suicide method in Bahrain (92.8%), poisoning by pesticide was the highest in Pakistan, and immolation in Iran in 50% and up to 82% in some areas [8]. However, suicide in the Western countries among the ME population appears to be the same as that from the Western countries (i.e., overdose especially among women). Pesticide and immolation are rarely reported in the Western countries.

Gender

In a study to investigate the differences between adolescent boys and girls, the rates of depression and associated factors were determined for adolescents in 2 different samples, 552 in South Sharqiya, Oman, and 1,577 in Alexandria, Egypt. In Alexandria, the rate of having depressive symptoms in girls was, as expected, almost double that in boys. In Oman, however, there was unexpectedly no significant difference [29]. This led researchers to conclude that gender differences in rates or correlates of depression exist but may differ according to the country in the ME.

The increasing female suicide in the Middle East has been attributed to the unequal position that females culturally find themselves in comparison to their male counterparts. The role of marriage in the causation or prevention of mental illness is rather unique to the ME; while marriage is generally a protective factor against mental illness in Western countries, it may contribute to mental illness, especially among vulnerable females in the male-dominated societies of the ME. This is probably attributed to a high incidence of spousal abuse (34%) [33]; a large age difference between partners, forced marriages, polygamy, or poorly matched arranged marriages may accentuate this phenomenon, especially if arranged and forced marriages involve females in

the adolescent age when they first get married [32]. In some situations, where poverty is common, adolescents or young females are forced to marry rich older males by their families. They often become overwhelmed by the demands of domineering husbands and often mistreated by controlling in-laws and view suicide as a way of escape from feeling trapped in an abusive marriage.

The double standard of morality toward women in the Middle East is highlighted in a Moroccan study [28]. It showed that male infidelity is usually tolerated, while female infidelity, even when it is not confirmed, is usually condemned and frequently leads to honor killing. Infertility is considered a "tragedy" for females from ME countries, in which women often being blamed for it, and men often divorce the infertile women or resort to polygamy, which is permitted for men by Muslim culture.

Age

Suicide is rare in preadolescent children; it has been estimated to be at 1–2 deaths/100,000 compared to that of youth, 11/100,000. Regarding depression, a direct correlation between the increasing age of girls and severity of depression has been suggested [34].

In a study performed in Iran during a span of 10 years, 6,414 children and adolescents were admitted to inpatient psychiatric hospital with suicidal attempts or parasuicidal behavior [35]. In inpatient children up to age 12, suicidal attempts occurred in 6.2% of the population.

Incarceration and Other Psychiatric Disorders

Among the incarcerated adolescents in the Islamic Republic of Iran, a cross-sectional analysis of 100 adolescent individuals, 70% had at least one psychiatric disorder: 55% had conduct disorder, 48% had oppositional defiant disorder, and 33% had ADHD [36]. Up to 50% of them had attempted suicide in the past.

Cigarette Smoking and Substance Misuse

Depression in adolescents was associated with nicotine initiation, continuation, increased frequency [21], and difficulty quitting.

The prevalence of tobacco smoking in the Middle East is one of the highest in the world with Egypt being the highest [37]. Up to 50% of students were found to smoke, with 25% starting nicotine use between 10 and 15 years of age. Prevalence of shisha (Hookah), a single- or multi-stemmed instrument for vaporizing and smoking flavored tobacco whose vapor or smoke is passed through a water basin—often glass based—before inhalation, was found to be 53% in Syrian individuals and 31% in Jordan. However, in an Iraqi study, nicotine smoking was in 10.5% of the population, and shisha in 4.4% in a population aged 18–23 years [37]. In another World Health Organization (WHO) study conducted in northern Iraq, tobacco use was 33.2% among males and 10.9% among females aged 13–15 years.

Although cigarette smoking appears to be low in immigrants from the ME, a high prevalence in Hookah is observed. In an analysis of 1,671 Arab American adolescents, 6.9% smoked cigarette in the past 30 days, with 1% at age 14 increasing to 14% ever use at age 18 [38]. These later numbers appear much lower compared to nonimmigrants. The Global Youth Tobacco Survey estimated 35% of males aged 13–15 years versus 4% in females living in the Middle East are smokers [38]. Lebanon has one of the highest smoking rates reaching 45.5% of boys who are smokers versus 39.6% of girls. Experimentation with Hookah in either gender was 27% ranging from 23% at 14 years of age to 40% at 18; this later method has been increasing in both mainland and immigrant population. The strongest predictor of smoking cigarettes or Hookah was if friends or family were smoking [38].

There has been a steady rise of substance abuse among youngsters in the ME. In a study performed in several districts in Egypt, 7.9% of the subjects aged 15–24 had used alcohol or substances [39]. Of those 3,852 individuals, 19.4% tried substances between the ages 8 and 15, and 29.3% had used substances for the first time between the ages 16 and 19 [39]. A male predominance of 13.2% was found among the whole population compared to only 1.1% in females, with cannabis being the most commonly used drug. Although substance misuse has been clearly linked to increased suicide risk in the Western countries, less is known in the ME population.

The risk of alcohol-related disorders in first- and second-generation immigrants in Sweden were investigated and compared with the Swedish majority population to assess how alcohol habits are modified over generations in a new society. First- and second-generation immigrants from Finland had higher relative risks (RRs) for hospital admission because of an alcohol-related disorder compared to the Swedish majority population (socioeconomic adjusted RRs 2.1 and 1.9, respectively), while first-generation immigrants born in southern Europe, the Middle East, and other non-European countries had lower risks. Second-generation immigrants with heritage in southern Europe, the Middle East, and other non-European countries had socioeconomic adjusted RRs that were higher relative to the first-generation immigrants but lower relative to the Swedish majority population [26]. However, a much higher relative risk was observed, especially in female admission if one parent is Sweden born (1.0).

Socioeconomic Status

Studies suggest that less mental illness is observed in those with higher socioeconomic status [4]. Children who financially supported their families or had unemployed parents were at more risk for mental illness. Low socioeconomic status had a negative effect on the access to psychiatric services. A study in Egypt investigating pathways to child mental health services concluded that the delayed psychiatric services were primarily dependent on the patient belonging to the middle or low socioeconomic class [40].

Social Support, Religiosity, and High Cognitive Capacity

The social support, religion, and high cognitive functions are protective factors against the development of depression in the adolescent population. In a study involving 1,577 adolescents, relationship to parents had a protective value and was inversely related to mental illness especially among females [41]. Parenting styles can vary from authoritarian type (i.e., a parenting type in which the parent gain control over the child's behavior without explanation or reasoning) to permissive type (i.e., in which parents do not interfere with the child's behavior and foster their choices). In a study examining the effects of different parenting styles on children, children of the authoritarian parents (i.e., parents who force tasks and choices onto their children including career and sexual partner) exhibited more depression, low self-esteem, addiction, and difficulty making decisions [42]. Meanwhile, poor social skills, selfishness, and low self-esteem characterized children of permissive parents. The style of parenting which used a mixture of both usually helped foster the child's healthy development. Some studies suggested that poor relationship with parents affects girls more than boys [21]. When college students don't feel safe or nurtured by their parents due to insecure attachment, suicide was highly correlated [43].

Most of the ME population practice Christianity and Islam; both religions prohibit suicide and thus are protective against killing oneself. In a study conducted among Muslim immigrants to the United Kingdom, a negative correlation was found between adherence to religion and suicide [44]. In a review of seven studies, five showed a decrease in suicide in religious population [45]. Religion and spirituality were also linked to lower alcohol and drug misuse (89% of nine studies), decreased depression (76% of 17 studies), and anxiety (48% of 33

investigations) [45]. However, industrialization (for both Middle Eastern countries and those who immigrated to the West) can sometimes lead to decreased religiosity as a protective factor. Disinhibition secondary to substance misuse can lead to promiscuity, giving up on self and higher powers. The associated stress and lack of religious support can lead to further deterioration and increased suicide.

Although less is known about the comparison between Muslim and Christian ME adolescents' mental illness, some studies suggested that Christian Arabs are more successful in adapting to the American culture [46]. Religious prosecution in homeland and sharing the same religion as the majority of Americans were suggested as a reason. Discrimination of Muslims, their less satisfaction in living in a foreign country, and continuation of their cultural retention were suggested as a cause of lower adaptation by Muslim Arabs and may be a risk factor for suicidal behavior.

Applying the above analysis of the risk and protective factors of suicide to the case of T.A. will help elucidate the complexity of this case and assist in managing treatment and better predict prognosis. On the one hand, T.A. seemed to struggle with multiple risk factors, a recent adolescent immigrant who had a language barrier that significantly hindered her communication and school performance. She came from Iraq, a Middle Eastern country that is mired in a violent civil war. As a result she sustained a traumatic loss of father and brother, the partial loss of her house, and a drop of her socioeconomic status. She became very susceptible to PTSD, depression, and suicidal ideations. She is a young female, first-generation immigrant, who came from a conservative religious society that poses a challenge for her adjustment and acculturation to a more liberal society that encourages gender equality and individual expression. An integration of her native culture and the American culture would reduce the overall risk, while failure of integration could lead to marginalization and alienation from her new country that could further increase her risk of mental illness. On the other hand, T.A. seemed to have some protective factors—a close knit supportive family, academic excellence, lack of history of cigarette smoking or substance abuse, lack of legal problems, and presence of moderate religious practices. She seemed resilient and receptive to treatment as shown by her positive response to treatment in the hospital.

Immigration and Mental Health

While children are resilient, a direct child involvement in pre-immigration trauma or an ongoing stress after immigration might negatively affect the long-term mental health. A study involving 131 children and young adolescents, predominantly of Iraqi descent, assessed predictors of development and maintenance of psychological complications after 8–9 years of immigration to Denmark. Discrimination in foreign country and lower maternal education predicted both externalizing (i.e., defiance, aggression, impulsivity, and hyperactivity) and internalizing disorders (i.e., anxiety and depression) in the younger population. In contrast, the higher number of traumatic events before and after immigration and social isolation as evidenced by lack of Danish language proficiency predicted higher internalizing disorders [47].

In yet another study, 50 Iranian preschool children who had immigrated to Sweden 3 years prior showed that the individual's strong premorbid function prior to trauma, strong child-parent relationship, and positive peer relationship predicted a healthier outcome [48]. These studies highlighted the importance and need for integrative programs to aid parents, for example, programs that provide classes to teach them the countries' language and support employment rehabilitation while improving tolerance and diversity in the community.

Although the relationship between PTSD and suicidality has not been well studied in the ME adolescent population, in a study involving 149 adult refugees, of which 52% were of ME origin, a high incidence of PTSD diagnosis was found to

have positive correlation to suicidality [49]. It would also be expected that parental suicidality might increase the risk in their offspring.

Although in ME countries adult males tend to be the income earners and decision-makers for the family, equitability of both genders in Western countries can be experienced as loss of power by ME men. This change of family structure, although empowers women, might pose stress to both genders in which men feel low self-esteem and women struggle between their families' needs and fulfillment of their career demands. Also, in ME countries, men and women associate and socialize with the same gender. However, when in Western countries, ME youth's cross-gender relationships can increase, leading to conflicts within the families. Dating is usually not permitted in the ME countries.

In a Swedish study, therapists working with ME immigrants were surveyed. Communication was a major hindering problem for therapist treating immigrants. Miscommunication, distraction from nonverbal effects, indirect use of language (i.e., they might say one thing but mean another), and lack of specific terms of what they want to express in the new language were cited [50]. In addition, younger females struggled with forming therapeutic relationship with older male therapists. Cultural view that family problems should be dealt internally would hinder therapy as well.

T.A. case illustrates clearly the effect of pre-immigration trauma and the ongoing stress after immigration on the risk of mental illness. She was subjected to severe trauma of war such as the tragic death of her father and brother and the partial destruction of her home. PTSD in her case, being a recent immigrant, may predispose her to a higher suicidal risk. The ongoing stress is represented by her difficulty in communication due to the language barrier that affected her academic performance, social competency, and the deep emotional expression in therapy that is mostly accessible by the primary language. T.A.'s prognosis could change depending on the changes in the political climate toward integrating and respecting immigrants.

Diagnostic Considerations

Some studies highlight the reluctance of Arabic-speaking population to utilize mental health services compared to other ethnicities, unless it is associated with out-of-control behavior [51]. The fear of reputation of having mental illness and the view that mental illness is a form of weakness have been suspected as a cultural denial of mental illness [2]. In addition, understanding each individual's preconceptions about their problems before starting therapy is important, in the context of cultural and religious beliefs that might hinder treatment. One of the cultural traditions is that parents of mentally ill insist on keeping the care in the family rather than institutionalization or getting outpatient psychiatric care. In addition, adolescent individuals, so as the adults, might express their psychiatric symptoms as physical complaints [25].

In a description of a 17-year-old male emigrating from Iraq, he was misdiagnosed as having psychotic disorder secondary to his perceived regressive tendencies [25]. The authors noted that he was misdiagnosed since overdependence and enmeshment are common characteristics of the relationships between parents and their adolescents in the ME, which is usually intensified during periods of illness or stress and may present as severe regression. In addition, although the American psychiatrist diagnosed him with possible catatonia (he was mute when attempted to speak to in English), he was later completely conversant when spoken to in Arabic. This case highlights how enmeshment very often can lead to misdiagnosis and inaccurate interpretations of the psychological problems.

In diagnosing depression, anxiety, and PTSD in immigrants from war countries like Iraq (the Iraq war started in 2003), it is important to realize that many young people either have been born or raised during the war and the symptoms and signs of mental disorders may seem regular feelings to them, such as recurrent nightmares or numbness to loud noises or a chronic degree of anxiety and depression.

The initial negative reaction of T.A.'s family to the recommendation of admitting her to an

inpatient unit and their insistence on helping her at home were culturally expected and needed to be handled with understanding and sensitivity. The presenting symptoms and signs that reflect vegetative and somatic complaints in the case of T.A. such as fatigue, weight loss, insomnia, and recurrent headaches and abdominal pains rather than psychological symptoms are more characteristic of the manifestation of depression in the ME and other non-Western cultures. T.A. did not understand in the beginning the question about “flashbacks” and considered the frequent reexperiencing of the traumatic events as normal occurrences that may have special religious meaning. It is important to realize that some people from the ME may not accept the diagnosis of mental illness, even in case of overt psychosis or severe depression, because they perceive mental illness as a punishment or a test from God, and may resist treatment, and consider it against their religion.

Treatment and Suggested Intervention Approaches

Treatment Settings

Throughout Egyptian history, it was traditionally acceptable for most patients with psychiatric disorders to be treated in general medical setting. Although several, freestanding psychiatric hospitals exist, most of individuals struggling with mental illness are treated in an outpatient setting. Thus, reluctance by the Middle Eastern communities to inpatient psychiatric admission might pose a struggle to treating providers. Family integration and rehabilitation are likely to lend positive disease outcome [52].

Culturally Specific Practices

One of the culturally bound healing practices in Egypt is the Zar (a whirling dervish-like dance) that induces a state of trance in patients. This is based on the belief that mental problems are caused by an evil eye or magic inflicted on the person. Others view mental illness as punishment from God [2]. This nonreligious act, although does not have scientific support, is still practiced in which a “possessed” person would hire a healer and engage in the Zar performance to expel the bad spirits. This Zar cult involves a whirling, dervish-like dancing to the beat of large drums, and loud repetitive singing till the person get exhausted and fall. Involvement of religious figures might sometimes facilitate the individual’s understanding of mental illness and increased acceptance to mental health providers, compared to those referred by “regular and nonreligious” individuals.

Intervention Approaches

Evidence of intervention is significantly lacking, especially in the child and adolescent population. Although there is an increase in the awareness of treating mental illness in the ME, it has not translated into treatment or intervention approaches yet. Most medical schools in the Arab world have a rudimentary programs or intervention programs. Since most immigrants to the West still need to overcome the barriers of stigma and shame of mental illness, a successful intervention program should design culturally sensitive approaches that deal effectively with these specific problems. This might include a provider that speaks the same language to facilitate understanding, without lost information during interpretation [23], and, if possible, practices the same religion. The provider should understand the dynamics of a nuclear family from the ME. In that the father is often the one who works and involved in disciplining the children, while the mother plays the role of the shield and a bridge between the father and the children. Another major conflict may ensue between immigrant parents and their children when choosing a career; thus, understanding this conflict and working through it with the family become very important. While in many cases parental conflict leads to divorce in the Western countries, this is less acceptable in the ME immigrants since religious authority strongly discourages it.

The gender and religion of the therapist have been also debated regarding the compliance of treatment. For example, some studies suggested that some Muslim women patients are reluctant to be in the same room alone with a male therapist [53]. A more debatable issue is the therapist's religion and the outcome of treatment. Most of the studies suggest that Muslim therapist treating Muslim females yields the best outcome. The fear of breaching confidentiality and/or religious difference of the therapist are attributed to be detractors from the treatment [54]. Cultural sensitivity and understanding, undoubtedly, will aid the progress in therapy [55]. Some even suggested that the visibility of the religious books in the office might give patients comfort [56]. Physical contact, including hand shaking, is better avoided unless clued by patient [49]. For example, some Muslim women and men might avoid shaking hands with the opposite sex therapist.

Cultural complexity can also include differing perception of acceptable boundaries. For example, inviting the treating provider to their home or offer food is a common sign of gratitude. In Western mental health practice, this would be considered a boundary crossing. Thus, explaining the reasons for declining such an invitation should be clearly communicated to the patients. Professional interpreters are required when there is a language barrier [49]. They are preferred to be of the same sex and culture. The use of family members is strongly discouraged due to the risk of maintaining family power and avoidance of filtering effects. Perception of the Western medications being strong or that they might act quickly has been suggested by some studies [45]. Thus, while medications are not condemned by religion, open discussion about the meaning for medication usage and expectation are important. In some cases, Muslim women might relegate discussions of youth's treatment to their husbands [49]. Encouragement of parents to seek social treatments, such as the involvement in non-therapy groups, and learning local language among immigrated population might help with adjustments [45] to the community while strengthening the rapport.

The difference between Middle Eastern and Western culture can create significant dilemma, especially for the younger population. The demand of parents of absolute obedience by children may hinder treatment [57, 58]. Enhancing parental and adolescent acculturation might be an initial focus, leading to increasing trust and therapeutic alliance [27]. In first-generation adolescent immigrants, encouraging autonomy and/or separation from parents might contradict the family's belief and lead to further conflict. Thus, tactful management of addressing this issue could be achieved through assuring and educating parents about the developmental task of adolescence that requires a degree of a healthy separation and autonomy, while still preserving and maintaining the cultural values and the family unit. The relationship between the adolescent individual and parents might be further complicated by financial restraints resulting in long work hours that are perceived as emotional unavailability by their children. Controversy exists regarding the use of a directive approach by therapists toward patients; some suggest that paternalistic relationship with the therapist is commonly expected by the patients [59]. This largely depends on the level of acculturation of the patient with variability in each individual [45]. In addition, discussing repressed "taboos" is not advised, and it may further complicate the outcome. Other supportive social factors, for example, women seeking marriage or trying to find suitable husbands, should be openly discussed. In many cases, invitation of parents for brief discussions about adolescent-parent conflict might increase communication between them. However, some suggested that this should not be more than five sessions [58]. It is important to highlight that direct inquiry about suicide, by asking about death wishes rather than suicide, is essential even though religion might condemn it [60].

Several studies suggested the effectiveness of religiously based cognitive behavioral therapy (R-CBT) in adults struggling from depression [55, 61] and/or anxiety disorders [62]. From 51 studies, 69% documented significant benefit of R-CBT compared to traditional CBT [45, 63]. It

is essential to understand the patients' preconceptions of their problems before starting therapy; this includes feeling possessed and depression is a punishment or a test by God [64]. Thus, some might deny management based on their faith that treatment is against religion. Others seek religious figures and spiritual healers as the only acceptable modality of treatment [64]. Thus, working with religious leaders, in addition to education and open discussion before and during treatment, is an integral part of a successful outcome.

Among Middle Easterners, mental illness is commonly associated with fear and shame, which is further accentuated by difficulty in acculturation. Culturally orientated programs, using native languages and dialects, and development of programs geared toward involvement of both parents and their newly immigrated children are thus needed. Since religion plays a major role in the ME, thus, churches and mosques ought to help with the cultural transition of newly immigrated families. This might include educating newcomers on the country's system and services, encouraging socialization and attendance to religious activities, as well as helping to refer them appropriately to health services (including mental health) when needed. Both imams (religious figures for Muslims) and priests can help tremendously in detection, offering support and appropriate referrals for treatment, especially if there is a lack of insurance.

The severity of depression and PTSD in T.A. case reflected the lack of early intervention in their homeland. During the hospital treatment, T.A. and her family struggled with the feelings of stigma, shame, and fear of mental illness. The treating team was very perceptive to their needs and made extra efforts to explain that T.A.'s emotional difficulties are not uncommon and sometimes expected given the magnitude of the stress and trauma the family had suffered. Upon the family's request, the team invited respected members from the local Mosque to participate in the discussions regarding the need to start medication for depression. This involvement of religious figures led to acceptance of medication as part of the treatment plan by the family. The family's relationship with the team became of mutual respect. Upon discharge from the hospital, the family requested a female outpatient therapist preferably from the same religious background for their daughter. The case manager made conscious efforts and successfully referred her and the family to the preferred therapist. Finally, consideration of the cultural aspects of the patient's history and the clinical presentation enhanced and refined the diagnostic assessment, optimized the treatment, and significantly improved her prognosis.

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11 Suicide Among Eastern European Immigrant Youth

Aida Spahic-Mihajlovic, Alekhya Buddhavarapu, and Neha Sharma

Case

Milan was 14 years old in 1994 during the war in Bosnia. His father provided for the family as a physician. They had a stable life together. Suddenly one day, Milan's father was arrested by local militants and placed in a concentration camp. The family was never given an official reason for the imprisonment. Milan's mother was concerned for the safety of her two sons. She was able to send the younger son to Norway as a refugee. Milan was to follow shortly after. However, just before fleeing, Milan was arrested and placed in a separate camp from his father. He was never given an official sentence and had no contact with his mother.

During his time at the camp, he was forced to perform manual labor along with enduring physical and psychological torture. He was surrounded by death and despair. He was unable to find solace by mingling with the other children in the camp since they were irritable and depressed themselves. He prayed for the day he would rejoin his family and hoped they were all safe wherever they were. After months of imprisonment, Milan was being pushed beyond his breaking point. He would sometimes take refuge in alcohol with the older prisoners. At one point, he heard of news that the war might be stretching for another decade due to mounting political uncertainty in the region. He abandoned all hope and decided to take his life with a plan to hang himself using bedsheets. When an opportunity to carry out the plan presented itself, he tied his sheet to the beam of the ceiling and attempted suicide. Luckily for Milan, another prisoner interrupted the attempt and saved Milan. The prisoner urged Milan he needed to stay strong and persevere for his family.

The message got through to Milan, but he continued indulging in self-harm behaviors after that. He was regularly requesting the other inmates for more share of their

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stash of alcohol and cigarettes and would try to beg the nurse for sleeping pills.

He endured several more months in the concentration camp before the International Red Cross managed to negotiate his release. When he was freed, he discovered that his father had been released just a month prior to that. His family then fled Bosnia and joined his brother in Norway temporarily. The family lived in Oslo at the refugee resettlement camps of the organization Caritas. After 3 months there, with further attempts by Caritas, they were accepted into the USA as refugees where they moved for resettlement. They came to New Haven CT.

Despite being a physician in his home country, Milan's father was not certified for medical practice in the USA. This led him to seek jobs as a research assistant at a pharmaceutical company. The family found a small apartment in the city and enrolled the two boys into the local school after they lost about four valuable school years. The boys were accepted into classes they were about three years too old for. Milan's father's initially worked at a grocery store in the evenings but later bought a pre-owned car and worked as a driver in a ride-sharing service to make up for his low income. Milan's mother was a homemaker before the war. In the USA, she contributed to the family income by taking up a job as a vendor at a deli. The boys missed their father greatly due to his multiple jobs. They missed their mother since her job had more of evening hours, making her unavailable to the kids after school. They lived in a neighborhood with hardly any recreational activities or sports centers, and the cold weather added to their feeling of being cooped up in the house during evenings and weekends. The boys reportedly had a couple of incidents at school where they were teased about their poor English. This further added to their hesitation to try and mingle and make friends. The brothers tried to fetch some pocket money by running errands at stores or shoveling driveways. Eventually, they got accustomed to the routine of their new life, but not without frequent memories of the good old life they led in Bosnia with a large family of relatives, in their family home. They missed all the friends they grew up with and often wondered where everybody was dispersed to. They hoped that all their friends survived the war.

Milan's father became a very different man after the years of turmoil he went through. He was not the confident and boisterous physician, but a worrying head of a family in a new and strange country. He had been weakened by the years as a camp detainee, and leaving his professional passions led him to become a silent, morose man that his family could hardly recognize. He took solace from the demons of his mind by having a couple of drinks now and then. Milan, on the other hand, had started leading a secret life after school with few acquaintances he made at his local community center. He would regularly sneak out of his home to have a smoke. His brother was aware of Milan's increasing dependence on these habits but hesitated to tell on his hard-working parents to spare them additional worries.

One night, the family received a call that Milan along with another boy had been apprehended while driving rashly under influence. The parents rushed to salvage him from the situation. They could not believe that the obedient son, they once had, brought them this shame. Enquiring further into his behavior had given them hints that he was taking drugs regularly. Milan's mother wailed in grief for days. His father panicked and tried to counsel his son about the dangerous effects of these habits on his young body. Unfortunately, Milan did not respond with reassurance that he would refrain from the habits. Milan continued to sneak out at night with

friends while avoiding his brother. The money he was earning on his petty jobs meant he had no need to ask his parents for money, thus evading suspicion. The parents worked hard to make ends meet and had no family in the area to share their grief with. All they could do was pray or lament over the phone to relatives back home. Milan started arriving home late or sleeping away from home. He missed school few times when he did not return the previous evening. This finally led the parents to seek professional help for their child.

Introduction to the Population

Geography

The region of Eastern Europe has a wide mix of cultures in the form of the following constituent countries—Estonia, Latvia, Lithuania, Belarus, Poland, Ukraine, Belarus, Moldova, Slovakia, Hungary, Slovenia, Croatia, Bulgaria, Bosnia and Herzegovina, Macedonia, Serbia, Kosovo, Montenegro, Albania, and Greece.

The northern Baltic nations of Estonia, Latvia, and Lithuania have generally thriving economies, with good per-capita incomes. Greece is a major economy which has been suffering only in the last decade due to the global recession. Poland and Ukraine are post-Soviet states still reeling from the collapse of the Soviet Republic and the Eastern Bloc. These countries are still plagued by hegemony from Russia, conflicts with Russian forces, and human right violations of many kinds [1].

The Balkans occupy the major fraction of Eastern Europe. Most of the region was under the rule of the ancient Ottoman Empire for centuries until the end of monarchy after World War I. The parts of the Balkans which were not under the Ottomans or the Russian Czar were ruled by the Austro-Hungarian Empire. After many years of having fluctuant borders during the world wars, the Slav territories finally formed the unified nation of Yugoslavia under the leadership of Marshal Josip Broz Tito, who served as the head of the socio-communist state of Yugoslavia until his death in 1980. The multiethnic region had multiple civil wars after his time and split into many smaller nations [2, 3].

Ethnicities

For centuries, the Slav region had a mix of ethnicities like Serbs, Croats, Bosniak Muslims, Slovenians, Jews, Romanis, Albanians, and other minorities. Religiously speaking, these were people of many faiths such as Orthodox Christians (majority in Serbs, Greeks, Polish, Ukrainians), Roman Catholics (majority in Croatia, the Baltics, and Albania), and Muslims (Bosniak Muslims) living together for many centuries, unified under monarchies, or communist regimes.

The end of Marshal Tito’s communist regime, followed by the fall of the USSR led to a rise in religious identity and fervor. There arose ultranationalist sentiments and separatist movements based on religion and ethnicity. Nations were formed only after very bloody civil wars that have scarred generations of families [4].

The Muslims in this region are moderate followers of Islam compared to those in the Middle East or the Caucasus region. They have lived in harmony with other groups until politically motivated cries for separation led to clashes with the other sects in the 1990s. Muslim migrants to the USA from these regions have often been found saying that they faced discrimination and threats like other Muslims in the USA after the 9/11 attacks of 2001.

There is also a large fraction of the population who have mixed ethnicity due to the common practice of marriages into other ethnicities throughout the years. These people faced a peculiar identity crisis amidst the ethnic conflicts of the region [5].

Recent Political Background

The most war-torn section of Eastern Europe is the mountainous Balkan region of the for-

mer Yugoslavia, famously once called the "Yugosphere" for its dominance on the political map of the world. "Yugonostalgia" is a term locals commonly use to talk about the glorious period post World War II when Yugoslavia had a major dominance under Tito as a politically neutral "non-aligned" state in the Cold War era between the Western and Eastern Blocs. Yugoslavia had a large temporary and some longer-term workforce migrating to countries in Western Europe and the USA. Tito's leadership focused on the common good for Yugoslavia with his revised form of Communism. His government exercised control over religious and ethnic divisions in the land. The nation functioned well under a socialist system and a sense of social security prevailed for years. After the death of Tito in 1980, and the fall of the Iron Curtain in 1991, there have been many political shockwaves throughout the region. There was a shift from the centrally planned communist economy to market-based economy. This led to drastic changes in the socioeconomic order, including a rise in poverty and unemployment, with simultaneous declines in education and health care. The seat of government in Belgrade was destabilized by these multiple challenges. Politically influenced ethnic conflicts in the region led to mass migration and fleeing of refugees to Western Europe and the USA [6].

The period between 1990 and 2009 has witnessed multiple Yugoslav wars at different timelines and for different durations. Few were short and successful military mutinies or coups by those who wished to secede as separate democratic states, while others were long and bloody wars fought with major resistance. Human right violations and atrocities were rampant in the form of concentration camps, ethnic cleansing of towns, genocide, and rape. Families living in this region experienced multiple bloody and gruesome battles [7].

The politicians of the opponent Serbs and Bosniaks or Serbs and Croats used these conflicts as political currency. The opposing factions mutually reinforced one another for political mileage during the wars until the intervention of the United Nations (UN) and North Atlantic Treaty Organization (NATO) to end the wars with the US-brokered Washington Peace Agreement and the Dayton Peace Agreement [8, 9]. Many believe that a genuine lack of political will to resolve crises and relieve them of the limbo had greatly extended the duration, suffering, and damage of the wars. All the carnage has left a lasting impact on the stability of this region. The two war-torn decades have redrawn all the political boundaries based on ethnic majority and saw the birth of Serbia, Croatia, Bosnia and Herzegovina, Slovenia, Macedonia, Kosovo, and Montenegro as successor states of the former Republic of Yugoslavia. However, most families have relatives on one or the other sides of boundaries due to constantly changing borders over time, making it difficult to decide which country, nationality, or identity they belong to.

Risk Factors and Protective Factors

Migration

The migration of Eastern Europeans can be broadly classified into primary migration to the USA or secondary migration (i.e., migration to Western Europe followed by migration to the USA). For decades, the most common destinations for workforce migration for Eastern Europeans have been Germany and Switzerland, due to their relatively more lenient immigration laws and policies. Many immigrants took low-paying and blue-collar jobs upon their emigration.

However, the wartime flight as refugees under traumatic circumstances had been very unlike the previous waves of migration, including undocumented immigration and asylum seeking by victims of the civil wars. Few displaced persons traveled first to the neighboring countries like Germany, Hungary, and Switzerland to take support from relatives living there. But most others had rougher roads, with no support and no certainty, and many bureaucratic barriers for entry into safe territories. Their distribution and resettlement into the Western world (Sweden, the UK, Brazil, the

USA, etc.) happened in stages monitored by organizations like the United Nations, Caritas Europa, Caritas Internationalis, the International Red Cross, etc. [10]. Their exodus was a pitiable trek across continents. Milan's family had faced a similar plight with them taking refuge in Oslo for few months before being resettled in the USA with the efforts of International Red Cross and Caritas Internationalis [11].

Immigrants to the USA were mostly legal asylum seekers and refugees, with a smaller number of them being undocumented immigrants. Eastern Europeans moved either as families, as individuals, or as orphans adopted by new families after losing their loved ones in the war and genocide. When the whole family has migrated together, youth have better transition as opposed to individuals immigrating to the USA alone.

Upon immigration, youth and families settle in areas that are affordable. Often those towns and cities are in impoverished areas with limited resources, entailing areas of high unemployment rates, more blue-collar occupations, more school systems with limited resources, and higher community violence. The families struggle to make ends meet; thus, the focus on youth's education is limited. Due to missed years in school in Eastern Europe, academic progress can be much more challenging for youth. Many regret the way the chaos led to delayed educational milestones, resulting in more barriers to get into college (key to getting out of poverty.) While families are acculturating, it is challenging for them to navigate the application and financial aid processes for colleges. Youth have limited guidance since parents are not experienced in this; thus, finding themselves to be lost. Like in any immigrant population, building a life in the USA leads to changes in parental attention and the quality of parenting. Both parents work to provide for the family, which might make the young miss their presence. The support system at home is perceived as failing. Few parents fled from the homeland without proper documents in hand and hence could be overqualified workers here working in menial jobs. Occupational stress, economic uncertainty, lack of suitable employment, and housing tenure difficulties among parents indirectly lead to issues in the young.

Acculturation to American culture can be quite challenging for families, at times resulting in them wanting to return to their homeland. It has been reported that the years after the wars have seen a rise in the number of earlier migrants returning to Eastern Europe. However, these families often find themselves to not be able to relate to the newer Eastern Europe nor US culture, thus often feeling stuck in the middle and frequently traveling back and forth looking for a home that they can identify with. Such search for identity and home can be unsettling for the youth being raised in the USA and can intensify their own sense of loss. Additionally, Dr. John Sargent, who worked with Eastern Europeans in their homeland and in the USA, specified that because of their Caucasian appearance, the Eastern Europeans' traumatic journeys can be dismissed. For example, the individuals may be expected to function as if they had privilege of resources and stability, making it easy to attribute their struggles to character flaw rather than to MH or historical losses. In contrast, Balkan refugees had better PTSD recovery when compared to Cambodian victims of ethnic cleansing 1 year after immigration, suggesting that identity confusion does not always result in poor outcome for this group [12]. To highlight the group's resilience, many people live in close vicinity to the ethnic groups they had fought with in the past. Few find it awkward, while others find it ironic and even a part of life's humor. Most migrant groups have learned to live in harmony with one another. There are typically no altercations noted, except for the occasional loud and animated discussions about past and current matters of their land.

Loss

Families from these regions take pride in their ethnic identities, familial heritage, and linguistic roots. The Slav wars led to loss of their land and property that was probably in their family for generations causing a seething sense of loss and

injustice. The wars changed the narrative of the countries, communities, and individuals. Tales of past glory are often told by elders to the young which frequently brings an air of gloom to the family gatherings. The context of war is very commonly brought up in the media, in classrooms, at family dinner tables, at places of worship, or at community gatherings.

Many Eastern European refugees have been unable to return to their homeland due to various factors. It is alleged that the new governments in the ethnically divided regions have made sure their ethnic opponents' valuable symbols of roots and culture are eradicated slowly and systematically. Those who do visit are shaken by the way the war transformed their homeland beyond recognition. The region is still suffocated by political gridlock and economic stagnation. They say, "The war is being fought even now by other means." Their old homeland is no longer hospitable to them. The ghosts of war haunt them to this day, and they insist upon making the younger generations aware of their past. "We should never forget and never let others forget" is what they proclaim. They believe the children are to be made aware of the ordeals and suffering of their parents or grandparents [13, 14].

Individual Factors

People who migrate alone leaving everyone and everything they knew behind in their homeland have a very difficult time coping with their new life in the USA. Those who have been orphaned by the wars have been moved to communities in the USA through churches and parishes. Many have been adopted into new homes with the coordinated efforts of bodies like the United Nations, the International Red Cross, and Caritas Internationalis [10, 11]. These individuals are often found to be still dealing with traumatic memories of the past. They struggle with a lack of closure on many fronts. Thousands are deemed missing from the war period, and people who lost relatives have not found answers yet about their whereabouts due to geographical dispersion, unacknowledged deaths, and unmarked graves.

Table 11.1 Traumatic childhood experiences and their impact on suicide [15]

Number of adverse childhood events reported	Percentage that attempted suicide
0	0.7%
1	2.2%
2	5.2%
3	8.7%
<3	23.6%

Those who lived in concentration camps and labor camps, or in extreme wartime poverty, are affected by having experienced chronic malnutrition and are unable to lead healthy lives now due to the long-term sequelae. Individuals who witnessed torturous or inhumane acts as victims or as soldiers have led a life of disability—emotional and/or physical. Recent statistics from the Slav nations state that there are thousands of past soldiers and civilians living with post-traumatic stress disorder (PTSD), poverty, and unemployment in the present [14]. See Table 11.1 that indicates association of suicide as it related to the adverse childhood events.

A sense of nihilism prevails in few who have been affected by the futile wars and bloodshed. This leads to more behavioral disturbances associated with grave pessimism, hopelessness, recklessness, and substance abuse. Many others have found from their tragic past a resilience to start a new life from scratch in the new land "and that life should go on" and that it is important to focus on "the now." Hence, there are many variations in coping, internalizing, and externalizing among these immigrants. Few are forever displaced members of an older society, while others have moved on from the old reactionary viewpoints by seeking new ideologies and identities in the new homeland.

Family Factors

Family is the epicenter of one's life for Eastern Europeans. They are used to closely knit multigenerational households, with grandparents playing an important role in the upbringing of the young. Migration many times involves sep-

aration from grandparents and relatives causing changes in the family dynamics. This is a common source of sadness and a sense of latent loss in the young. Language is an essential tool for families to make sure their culture thrives through the generations. Attitudes toward the maintenance and loss of heritage language cause differences between parents and children. The language of their motherland is spoken at home. Children are sent to community-organized classes to learn reading and writing their language.

Ethnic identity is preserved in the form of books and stories told at home. Tradition is remembered passionately while celebrating holidays. Eastern European art and literature are considered to be dark and mystic representing its history. Those who are exposed to songs and other forms of art are enamored by the sorrow hidden between the lines. Religious identity has seen a spike since "the war has made them more aware of their faith." Hence parents insist that the younger generations keep their faith and pray. These various fervent sentiments imposed by elders may hinder acculturation of the young in the USA. There is still an undercurrent of a vicious fight for ethnic superiority, political power play, and a dominant narrative of the past. This social dynamic chiefly aims to shape the attitudes of the young through various modes, though most of these youths were not even born at the time of said tragedies.

American schools encourage the young to be assertive individuals. But assertive behavior can sometimes be considered rude and inappropriate by the elders at home in these families. This leads to conflict of values. Culturally, the needs of the family are prioritized over the needs of the individual. In some households, there are gender-based role differences, especially in the upbringing and liberties given to the young. Growing up, females are told at home to "act feminine," "behave gracefully," and "talk softly" especially in the presence of males. Habits like smoking and drinking alcohol are often labeled as masculine.

Socioeconomic and Health Factors

In their homeland, Eastern European families were used to a sense of camaraderie in the air, with close links to neighbors, friends, family, relatives, and colleagues. They banked on this "social capital" in the form of social networks during times of stress. Such connections are often absent in the USA. Lack of support and challenges with acculturation lead families from these communities to be at a disadvantage. Families are also not equipped with good health insurance, thus making good MH care inaccessible. Physical health needs are also chronically neglected, with a lack of understanding about how to navigate a complex healthcare system, which badly affects quality of life [16].

Youth are often exposed to health-harming behaviors such as smoking, alcoholism, and substance abuse. Eastern European immigrants often have a long history of usage for generations in families. Statistics have generally shown a higher risk for substance abuse than actual suicidal behaviors when coping with stress [17].

Attitudes Toward Mental Health

The concepts of MH and mental illness are mostly nonexistent in the Eastern European region. This could be due to years of Soviet and other suppression of the science of psychology in universities. Additionally, focus on surviving the wars caused other necessities to be less important by comparison. A cultural mistrust of MH professionals has been bred over the years due to the communist governments of the region never validating psychology as a science. This mistrust is many a time compounded by religious factors like Islam, especially in those who faced discrimination post 9/11 [10]. It has been widely reported that people of this region have a propensity to terminate therapy prematurely due to their impatience with the therapeutic process and their ignorance of the gravity of mental illnesses. When faced with situations of mental distress in the young, elders often use phrases like "just get a grip and go on with life"

"eat well, breathe deep, exercise, and it will pass." One is expected to pick oneself up, pull oneself together, and move forward. They are also more likely to seek advice with family and their community or from religious heads instead of seeking professional help [18, 19].

Admitting to a MH problem is seen as loss of face or shame to the family and community. Fear of MH stigma leads to gross underreporting. Some families deem it a sin to consider suicide since for them, faith is a mode of healing, strength, and survival in crises. The problem is attributed to lack of faith, bad spirit possession, the "evil eye," and other spiritual or supernatural beliefs. The patients are viewed as those who "lost their faith or their way." Eastern European women are less likely to internalize MH stigma and are more open to asking for help and receiving assistance. This could probably be due to men coping with their stress through indulgence in alcohol or other substances [18, 19].

Patterns of Suicidality Among Eastern Europeans

Prevalence of Suicide and Suicidality

We have no reliable data on suicidality among Eastern European immigrant youth in the USA. However, looking at all age groups, the Eastern Europe region has a very high rate of suicide in the world. Historically, this has not always been the case. Over the past few decades, suicide rates have seen sharp increases that are not seen anywhere else in the world. Currently, the region contains 6% of the total world population, but it accounts for one-eighth of the world's suicide attempts. The current leading hypothesis postulates the collapse of the Soviet Union and sudden incorporation of a market economy throughout the region as causes for widespread fear and uncertainty. Looking at recent suicide trends in a country like Hungary, which has witnessed an increase in suicide rates similar with Russia, helps to pinpoint specific social conditions that could be responsible for the increase. Like Russia, Hungary has experienced socioeconomic instability over the past several decades leading to greater unemployment, less security and control over work, and a significant destabilization of the family unit. These social stressors combined with maladaptive coping skills and a lack of strong social support lead to a feeling of hopelessness. Durkheim's theory of suicide postulates that suicide attempts will actively decrease during wartime and subsequently increase after resolution. Active wartime brings with it increased cohesion and deepened societal bonds. This would provide a sense of belonging to those who otherwise might contemplate suicide. After the resolution of wartime, the social integration lessens along with a postwar economic strain on the countries involved [20].

By contrast, suicide rates in the region appear to be decreasing after the wars that impacted the region in the 1990s. To study this phenomenon, youth suicide rates were compared in Bosnia and Herzegovina before and after the Bosnian war (see Table 11.2). With respect to methods of suicidality, sex, age, and prevalence, the statistics on suicide were not kept during the actual war. The prewar period included suicide data for children (aged 10–14) and adolescents (aged 15–19) from 1986 to 1990. Of the 135 recorded suicides, 54% were boys and 20% were classified as children. The male-to-female ratio of suicide rates was 1.2:1. Hanging was the most common modality in both boys and girls. See Table 11.3. However, greater discrepancies were observed with regard to method between children and adolescents. Hanging was the suicide method in 70.4% of child attempts, but only 48.1% of adolescent attempts. Adolescents had a much higher incidence of suicide by firearm when compared to children. The postwar period looked at suicide

Table 11.2 Effect of war on prevalence of suicide in Eastern Europe [21]

	Pre-Bosnian war (89–90)	Post-Bosnian war (02–06)
Suicide attempts per 100,000		
Ages 10–19	3.6	2.4
Ages 10–14	1.4	1.1
Ages 15–19	5.7	3.6

Table 11.3 Incidence of types of modes of suicide in Eastern Europe [23]

Suicide modality percentage	Pre-Bosnian war	Post-Bosnian war
Firearms	17%	4
Hanging	52.64%	32.3%
Jumping	3%	16.9%
Other	19.3%	7.74%
Poisoning	8.1%	3.1%

data from 2002 to 2006. As compared to the 135 suicides from 1986 to 1990, they were only 65 child and adolescent suicides from 2002 to 2006. 69.2% were boys and 23.1% were children. From the prewar to postwar period, child and adolescent suicide as a whole dropped by 33%. Suicide rates in both child aged and adolescent girls dropped by 45.5%. Rates for adolescent boys dropped 27%. Although contrary to the overall trends, suicide rates in child aged boys increased 22%. In comparison to the 1.2:1 male-to-female ratio of the prewar period, a male-to-female ratio of 2.2:1 was witnessed in the postwar period. A shift in suicide method was also witnessed from the pre- to postwar periods. Postwar saw firearms as the most common method for boys and hanging the most common method for girls [21].

There are several key findings demonstrated in this study that could help further understanding of suicide trends during times of conflict. First, contrary to Durkheim's theory, suicides rates appeared to decrease in the postwar period. Significant shifts in societal norms require appropriate coping mechanisms in order to adapt to a new postwar life. The sudden shift would likely cause significant discord throughout the population, resulting in a new and powerful cause of suicidality [20].

It is difficult to identify individual factors that contributed to the overall decrease in suicide rates. There are many current theories, such as increased religious influences stabilizing social instability in the postwar period. The only outlier observed in the data is an increase in suicide rates for boys 14 or younger. Upon further investigation, there was a reported increase in child sexual abuse in postwar Bosnia and Herzegovina which could have contributed to this increased suicidal behavior [20].

Although the raw data indicates suicide rates decreased for children and adolescents from prewar to postwar, one aspect of the data that must be taken into account is a change in state procedure with regard to reporting suicide. The change occurred in the postwar period and cannot definitively be ruled out as a possible cause of underreporting of suicides in the postwar period [20, 22].

Modes of Suicide

There are no accurate records to signify predominance of any mode in this population, but studies suggest hanging to be a common mode in females and residents of concentration camps or refugee camps. As shown by Table 11.3, jumping is another mode of suicide that has been observed among people from this region. Postwar Slav nations have reported war veterans burning themselves to end their life [23].

A new mode of suicide postwar is firearms. Males have been shown to be more likely to use a firearm than females. During prewar communist regimes, there was a good amount of control on firearm use in Eastern Europe. But the end of the war was followed by illegal firearm sales and families possessing firearms as a mode of security.

The War Veteran Associations in the former Slav nations of Eastern Europe have released statistics that about 4,000+ soldiers have committed suicides in the last 16 years. Psychological trauma and PTSD are commonly seen in those who served on the forces. There is also a hypothesis that this region is afflicted by an endemic of "Vietnam syndrome." This syndrome is reported to be seen predominantly in Serbs and can appear like bipolar disorder with anger, depression, and suicides in war veterans when they see that they are forgotten in peacetime, the media is not on their side, and all the support from the community has stopped. Many are buried in poverty owing to unemployment. There have been dreadful

modes of suicides like burning as their reaction to current society [23].

Repetition of Attempted Suicide Among Immigrants in Europe

Statistics on suicidal repetition were analyzed and compared among seven European countries. The countries studied are Switzerland, Belgium, Israel, the Netherlands, Sweden, Estonia, and Germany. The countries chosen would present a snapshot of Europe as a whole and allow for differing socioeconomic landscapes to be compared and contrasted. In addition, immigrant populations were compared to local populations to determine if a statistical difference existed between those born in a specific region versus those forced to into a foreign environment in terms of suicide repetition. The study followed European citizens who attempted suicide for 12 months after their initial attempt [24].

One of the strongest predictors of a future suicide attempt is a past suicide attempt. It was found that one in three patients who attempted suicide will repeat their attempt in the next 30 days, 50% will repeat their attempt in 3 months, and almost 66% will repeat their attempt in 6 months. The risk factors associated with suicide repetition are very similar to risk factors for an initial suicide attempt, leading to difficulty in identifying those at risk for repetition. Extensive analysis of suicide repetition data throughout Europe yielded two populations that showed a significantly lower risk of suicide repetition when compared to other populations, non-European immigrants and Eastern European [24]. In Western Europe, both locals and immigrants report more previous suicidal attempts when compared to Eastern European locals and non-European immigrants as shown in Table 11.4. In addition, when immigrant groups are broken down and analyzed by their country of origin, Eastern European immigrants were half as likely to repeat a suicide attempt as the locals they coexist with. Both Eastern European men and women both display lower rates of repetition. The timing of suicidal repetition was found to be similar in immigrant and local populations. Of those who go on to attempt suicidal repetition, 32% will repeat their attempt within 30 days of their initial attempt. The only statistical difference observed between populations with respect to timing comes between locals and Eastern European immigrants occupying the same region. Eastern European immigrants were found to be much less likely to attempt repetition within 30 days [24].

Table 11.4 Statistics on repeat attempts of suicide based on geography and time between attempts [24]

	Western Europeans	*Eastern Europeans*
Repeat suicide attempts	45.7%	31.3%
	Within 30 days of first suicide attempt	*After 30 days of first suicide attempt*
Timeframe of repeat suicide attempts (all regions)	32%	68%

The key point demonstrated through this study is that while Eastern Europeans are statistically at an increased risk for attempting suicide, they are much less likely to repeat after a failed attempt than their counterparts in other regions of Europe. Also, if an Eastern European repeats a suicide attempt, it is more likely to be after the initial 30 days of their previous attempt. This leads to questions about whether the first attempt and the repetition are provoked by different, unrelated stressors. The data presented in the study can lead one to the conclusion that the suicidal crisis leading to an attempt in Eastern Europeans populations is precipitated by acute situational stress factors that tend to diffuse over time. This correlation has a direct impact on treatment and long-term prognosis [24].

Combined data for research on child suicide around the Bosnian war, suicide repetition rates by geographic region, timeframe of suicide repeats, and the link between adverse childhood events and suicide attempts indicates that acute stressors and ease of access to various suicide modalities lead to increased suicide rates in Eastern Europeans, but lower rates of repetition once the stressor is removed [21].

Diagnostic Considerations

Life for children like Milan had been cruel and unfair. He was lucky enough to survive and eventually escape, but was scarred deeply by his traumatic experiences. One must look at the physical and emotional trauma he suffered to address stressors related to suicide attempts of youths from this region. Milan was faced with severe stress as his family members got dispersed and he was forced to witness atrocities one should not be exposed to. The circumstances surrounding this period in the family's life will greatly increase the risk of suicide attempts in both the sons. It is important to understand the nature of stressors during and after war in this kind of youth to prevent a likely progression to suicide attempts. Eastern Europeans have been shown to have high rates of primary suicide attempts but a lower rate of repeat suicide attempts. This emphasizes that acute issues are more of a concern with this demographic than prolonged illness. A greater understanding of the cultural contexts around suicide in this population may help in improving access and preventing barriers to treatment [10, 18].

Discriminatory stress and migratory stress often cause low self-esteem in immigrant youth. In addition, those like Milan have been through unthinkable atrocities. Camp detainees and other victims like Milan indulge in various self-harm behaviors as a result of chronic depression and emotional numbness. Many unmet chronic MH needs in immigrants often increase social isolation and marginalization in the new land and thus hinder acculturation. A lot of content about this population comes from elaborate accounts from the host nations in Western Europe [25].

Primary stressors are social isolation, marginalization, and discrimination based on talking style and social manners. Reactions to stress in these immigrants tend to manifest as health-harming behaviors more than actual suicidal ideation. It is very important to note that many physical complaints could be sequelae to substance abuse that masks MH issues. Many with a history as camp detainees show long-term malnutrition. Depression in these sects is commonly a result of trauma, longing, identity confusion, loneliness, and culture shock. Depressive symptoms and suicidal thoughts can occur in isolation or as part of other issues like mood disorders, bipolar disorder, anxiety and panic disorders, post-traumatic stress disorder, etc. [25].

"Bullycide" is a growing cause of concern with the young in these populations. Surveys among schools in the UK, Sweden, and Germany have shown an alarming number of students admitting to having suicidal thoughts. Bullying at the hands of peers due to their accent is a common stressor. Other factors are social isolation, low self-esteem, identity issues, lost school years, or the challenges of adapting to the academic demands [26].

There is also a section of youth who owe their morose predicament to the mood at home. Many of the parents in these families are haunted by the ghosts of their traumatic pasts and have unhealed wounds themselves. Emotional numbness in few sometimes leads to impaired parenting. Cultural baggage, migratory stress, and rough acculturation contribute to mood disorders in few. It is crucial to remember that many of the elders in these families could be suffering from MH issues themselves, which could be making their families dysfunctional. Most parents have been either witness to atrocities or have been disabled permanently as civilian victims or when they fought as soldiers for their respective factions [25].

Economic stagnation in the region since the end of the war has led to high rates of unemployment. There has been rise in crime rates, with various groups indulging in illegal firearm trades, drug trafficking, child and adult sex trafficking, etc.

The civilian population has former camp detainees and victims of sexual abuse reeling under the atrocities they have been subjected to. There is an anger especially in Serbs toward the North Atlantic Treaty Organization's (NATO's) taking of sides in the war that shows as mood disorders or resentful behavior in current host nations [7].

Another important indicator is that the former Slav states have seen an unsettling rise in teenage and underage delinquency rates in the postwar

period. Many youth have been failing to finish school, indulging in dangerous habits and hooliganism. Some estimates say that nearly 60% of the population suffer from PTSD [25].

Valuable resources are available from Sweden, since it has been the country that granted asylum to the highest number of refugees from the Slav region. One of Sweden's major observations has been that there is a grossly higher incidence of schizophrenia and other forms of non-affective psychoses in the refugee population compared to the regular population. They have supported their statements with ample research on this high-risk population. While refugees from sub-Saharan Africa have shown the highest predisposition toward these conditions, those from Eastern Europe have been observed to be greatly affected as well. Sweden asserts the need for awareness among host countries about this psychosomatic vulnerability in addition to other social, physical, and MH needs. Psychosocial adversity and trauma before, during, or after wars influence the appearance of psychosis [25].

An air of nihilism is seen in few, with an apparent recklessness, pessimism, and robotic way of going about their lives. Risks of self-injurious behavior are a comorbid psychiatric condition, feelings of hopelessness, emotional numbness, clouded judgment, and acute stress [25].

Evidence-Based Interventions

The migrants and refugees from the Eastern European region are increasingly being considered an overlooked demographic in terms of MH. There is a need for changes in the social support services and healthcare services in the USA to suit the needs of this immigrant group. A culturally sensitive approach is crucial. These services should include foster care or resident treatment centers, prevention-based programs, and programs to support unaccompanied minors from another country. We should look to the work done in this regard by the host countries of the European Union and take from their experience some important pointers [25].

There is poor self-reporting of MH issues. Schools are often a channel through which parents become aware of behavioral problems. Due to negative attitudes and cultural mistrust, they tend to seek counselors of the same ethnicity and are known for the propensity to terminate therapy prematurely [10, 18, 19].

Firearm safety has been proposed as one of the needed routes of intervention for prevention of suicide in this population. Many families are devoid of proper information regarding the risks posed by the possession of firearm in a house. It is recommended that they are educated about the increased likelihood of firearm suicide in a house that has a firearm. Removal of firearms from the home is the greatest deterrent to suicide by firearm. The next effective measures are to create awareness about proper storage of firearms, i.e., unloading and locking the firearms before storage. Use of barricades in likely spots for jumping is said to help with curtailing this form of suicide [23].

The UK government has conducted surveys and studies in its efforts to come of better use to young Eastern European immigrants in their schools. Questionnaires distributed among a sample of students gave about 16.5% stating that they had suicidal thoughts in the past year. This sample was then divided into three groups and exposed to three different forms of interventions to address the issue. One group had teachers and school staff offering to be of use in times of need as counselors. The second group was made to participate in MH screening procedures by local psychotherapists. The third group was involved in a hands-on awareness and education drive with students participating in plays that talk about the ill effects of depression and suicide on society at different levels [26].

After a year of the earlier survey, these three groups answered a new survey asking about suicidal thoughts. It was observed that the first two groups had hardly shown any change in the incidence of suicidal ideation, but the third group showed nearly 70% fall in the number of students who reported to have had any suicidal thoughts during the year. This study has helped UK communities and schools design educational programs

to spread awareness about mental illness and the services and help available for those in need [26].

Sweden has done major studies and experimented with various interventions regarding psychoses in migrants with a traumatic past. Their reports lay emphasis on early interventions in the vulnerable populations. For traumatic stress in children, Sweden and other host countries are mostly adapting the culturally sensitive "Multiphase Model of Psychotherapy (MPM)" among various types of Trauma Systems Therapy. Multiphase Model of Psychotherapy involves a five-layered, culturally sensitive approach to their client's care. These include family therapy, community engagement, culturally and politically relevant knowledgebase, social justice advocates, and human rights groups [25].

It is essential that therapists understand the premigration situation of the family, transition into the new life, adjustment, and acculturation. They should be able to accept various worldviews and acknowledge various attitudes and beliefs toward child rearing. It helps to be sensitive of any biases or prejudices or privileges on their part when dealing with such clients. They need to step out of their usual comfort zones at times to ensure enabling the normal development of these children [25].

Linguistically and culturally relevant therapists can prove highly effective for this population. Sometimes, it even helps to take help of community heads, religious guides, or social workers while working with these families, if the family permits of course.

Family therapy and family-integrated models can help deal with the typical attitudes of elders of this region in matters of MH. It is crucial to have able translators or interpreters when speaking to these families. There are many languages in this region which sound very alike, with common words among them. It is important to ensure that the communication is conveyed to the family in their actual language and not some dialect that is similar.

The MH practitioners need to expand the traditional role and function as skilled multicultural practitioners ready to collaborate with social workers, community cohesion engagers/networkers, or consultants. It is advantageous to be informed about the client's sociopolitical background to ensure quality treatment suitable for each client [25].

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12 Suicide Among Youth of Soviet-Jewish Origin

Dina Goldstein Silverman

"Russia is a riddle, wrapped in a mystery, inside an enigma"

– Winston Churchill

Case

"Marina," a 17-year-old Caucasian Jewish student originally from the Former Soviet Union, was referred to a university counseling center for treatment of depression and test anxiety and a declining academic performance. At intake, she reported depressed mood, tearfulness, hopelessness, anhedonia, constant anxiety and worry, early and middle insomnia, and feelings of worthlessness. She noted significant preoccupation with her academic performance which had steadily declined over the course of the academic year. She reported significant problems with attention and concentration and with internalizing learned material. Marina described struggling to focus and described sitting in front of the same chapter or article for hours, reading and rereading the same sentence. She said that she would not be able to recall what she had read and that she would find herself becoming distracted with other thoughts, most of them judgmental and self-deprecating thoughts of her own shortcomings. She noted several instances of panic attacks that had occurred during exams; she would freeze and not be able to recall material. She also endorsed tachycardia, racing thoughts, and marked gastrointestinal distress, including stomach pains, nausea, and diarrhea that would accompany these episodes of panic and her overall anxiety. One episode that she described took place during a major Biology test. Marina became so overwhelmed with panic that she ran out of the room and proceeded to cry, shake, and vomit in the hallway bathroom outside the lecture hall. When she had returned to the classroom to finish the exam, she only had 20 min left on the test and ended up failing the exam, as she had felt too humiliated by her panic attack to explain to her instructor what had happened and ask for an extension or a retest. She also noted that her parents would frequently rely on Marina to travel back to her hometown to help out with her aging, ailing grandparents' numerous medical appointments, as well as to help them parent her younger teenage

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brother, further exacerbating her stress. She reported that she missed her family, but also felt resentful toward them for asking her to come home, as she would miss out on social events taking place on campus at the weekend. Marina experienced a lot of pressure from her family to live at home and commute to campus in order to save money and spend more time with her family.

Marina was born in Moscow to an educated, middle-class Jewish family. Her father was an engineer, and her mother was a physician. The couple lived with Marina's maternal grandparents, as was typical for the living standards of Moscow during the early 1990s, in a three-room apartment. Marina loved her childhood, but was also aware that her family expected her to perform well academically. She denied abuse and had a particularly tender relationship with her grandparents. Marina was 5 years old when her brother was born; she would begin primary school the following year. As a young child, she had shared a bedroom with her parents, but upon her brother's birth, she would be moved to the pullout sofa in the main room. She felt resentful of the attention that her brother was getting while also being fascinated with the baby. She was encouraged to hold him and attend to him. As Marina and her brother grew older, she would be asked to watch out for him, and Marina would be expected to walk with her brother to and from school, help him with his homework, and keep an eye on him when the two would play with their peers outside. When she began primary school, she was encouraged to study hard and was taught that as a Jew, she would have to outperform her Russian peers academically to achieve the same positions in life. Her initial encounters with anti-Semitism occurred during primary school – a group of her classmates chased Marina and another Jewish student. They called them "kikes" and yelled at them to "go back to Israel." She was told that Jews make matzos out of the blood of Russian infants by another classmate, and another boy pelted her with rocks on a walk home from school. However, the same peers spoke to her and engaged with her in the classroom at other times.

Marina was 9 when her parents began the emigration process, and along with her family, she would be awarded religious and political refugee status. At age 14, along with her family, she relocated to the United States, settling initially in a working-class neighborhood of a major northeastern city. The city boasted a large Soviet-Jewish immigrant community, and her parents enrolled her in a local middle school with a sizeable Russian-speaking immigrant population. Marina remembered that as someone from Moscow, she was seen as spoiled and rich by peers who had immigrated from more peripheral cities and towns. She also recalled a fair amount of segregation at her middle school, noting that the school had a large, diverse immigrant population, and students would mostly keep to their own ethnic and immigrant social groups. At that time, Marina had felt particularly lonely, as her parents were too busy working to spend time with her. Her mother worked as a laboratory technician and, then, as a pharmacy technician, all the while studying for her United States Medical Licensing Exam to become qualified to practice medicine in the United States. When her mother matched to a medical residency program, her long work hours precluded her from spending much time with Marina. Marina's father struggled to find an engineering job, working several menial jobs delivering pizza, and installing carpet until he secured his first professional position. Marina noted that her parents were fairly lucky, as both had

been reasonably fluent in English upon immigration and found professional employment fairly quickly. She recalled her mother's sadness and worries over the possibility of becoming credentialed as a physician in the United States and noted admiring her mother's determination. Her parents placed a lot of responsibility on her for taking care of her brother. Busy with work and their studies, they would send Marina to parent-teacher conferences at his school, as her grandparents did not speak enough English. When her grandparents' health began to deteriorate, Marina was expected to accompany them to medical appointments and interpret her grandparents' concerns for their providers. Nonetheless, Marina excelled academically and joined her high school swim team. Her parents were skeptical about her extracurricular involvement but encouraged her once they learned that extracurricular activities would make her a compelling college candidate. They also encouraged her to become involved with a Jewish youth organization in the area. Marina felt awkward joining this particular group, as most other participants were American-born residents of affluent neighboring suburbs. She felt marginalized as an immigrant from a relatively poor and urban immigrant background. She assumed that it would be easy to make friends in this group, but was snubbed by other Jewish teenagers. She felt self-conscious about not having the right kinds of clothes, of speaking with a slight Russian accent, and of living in an apartment in a working-class urban neighborhood as opposed to a single-family home in the suburbs. Most of her peers from this group attended high schools in the suburbs that were academically more competitive than her urban high school. Despite these differences, she developed a particularly strong friendship with one young woman in that group.

Marina was accepted to a top-tier university 2 h away from her family home and accrued considerable financial aid through grants, scholarships, and loans, enabling her to live on campus. Her parents and grandparents expressed their reservations about her going away to college as opposed to living at home and attending university in her home city, which was the norm in their immigrant community. Her decision to move away to college and take the opportunity to live away from home was a source of many arguments, exacerbated by dating a classmate who was neither Jewish nor of Russian decent. Her parents' work schedules would prevented them from accompanying her to some of the orientation activities at her college. Her parents, however, helped her move into her residence hall, and purchased a used car for her, allowing her to travel home on the weekends.

Marina's parents and grandparents encouraged Marina to pursue the sciences, engineering, or business as a major, urging her to pick a practical field that would ensure her with a steady income and a good quality of life. She half-heartedly declared Chemistry major with a premed concentration, although she noted interest in the arts and humanities, including creative writing. Since beginning her freshman "weed-out" courses, she has struggled academically, to her great anxiety and worry. She felt fearful of letting down her parents due to the tremendous sacrifices they had made to bring her and her brother to this country. She also felt disloyal to her parents for disliking her science courses. She thought that she lacked the study skills that other students had accrued at more competitive institutions and procrastinated, engaging in the phobic avoidance. She experienced immense amount of guilt if she chose to stay on campus to socialize with her peers instead of traveling to her

hometown to help her brother with his homework and assist her parents with caring for her grandparents. The end of her high school relationship further exacerbated her symptoms of anxiety and depression. With the end of her first semester of college approaching, Marina felt increasingly more desperate with her worsening grades. She had begun to skip classes and linger in bed, sleeping through the morning. She would skip meals and began losing weight, prompting concerns from her family and friends. In the afternoons, she would attempt to study to catch up on the work she had missed, only to engage in experiential avoidance through playing games on her phone, perusing social media, or watching television shows and noted that she would have problems with falling asleep and would frequently awaken in the middle of the night. She pursued counseling at the insistence of her roommate who was troubled by Marina isolating and becoming reclusive. At her initial evaluation, she denied suicidal ideation, but endorsed hopelessness. However, as her therapeutic alliance with her therapist strengthened, she disclosed that she had experienced passive suicidal ideation without intent or plan. Simultaneously, she had found herself struggling with feelings of shame, guilt, and anxiety over experiencing suicidality while holding on to hopelessness, sadness, and a belief that she was a failure. She indicated that she was letting her family down by her worsening academic performance and also disappointing them by experiencing suicidal ideation. She believed that her suicidal ideation was indicative of her lack of resiliency and not measuring up to her parents' persistence, perseverance, and achievement in the aftermath of immigration. She was engaged in an integrative therapeutic treatment, which included traditional cognitive behavioral therapy, including such techniques as Socratic questioning, cognitive restructuring, and relaxation training and a mindfulness-based approach that taught her to practice nonjudgmental self-compassion, present-moment awareness, and cognitive defusion. She responded well to a combination of both CBT and ACT. After 15 sessions of therapy (intake took place over a span of two sessions), she developed increased self-efficacy and hope and experienced a softening of her categorical perfectionistic thinking, and she began developing increasing flexibility. Most importantly, she was able to acquire and practice self-compassion that allowed her to experience empathy rather than shame at her past suicidal ideation. As Marina's self-efficacy increased, so did her comfort with her bicultural, bilingual, 1.5 generation identity. She realized that she had the liberty to move flexibly across both cultural paradigms and neither lose her Russian-Jewish identity and become subsumed in American culture nor reject the American collegiate culture of her peers in favor of upholding the cultural mores and values of a bygone society. She returned for maintenance psychotherapy six times the following academic semester and no longer endorsed symptoms of depression, anxiety, or suicidal ideation. Her academic performance improved, and she changed her major to Journalism. She became more comfortable setting healthy boundaries with her parents and peers in the service of living according to her unique values, one of which included maintaining healthy, balanced relationships.

Introduction to the Population Group

It should be noted that for the sake of brevity, in this manuscript, Russian-speaking, predominantly Jewish immigrants from the Former Soviet Union are referred to as Russian-Jewish. Whereas the majority of this émigré population identifies as Jewish (and the complexity of Jewish ethnic, religious, and cultural identity in itself is far too complex to be explored fully in this brief scholarly discussion), and whereas most immigrants from the Soviet Union to the United States have Russian as their first language, many of them are in fact Ukrainian-Jewish, Moldovan-Jewish, etc. Also, Russian-Jewish and Soviet-Jewish are used interchangeably in this text, due to the lengthy cultural precedence of first, Imperial Russia and following the October Revolution of 1917, Soviet Russia, engaging in the Russification of Soviet culture in the Former Soviet Union [1]. Although historical scholars would divide the process of Russification in three distinct processes – Russification, Russianization, and Sovietization [1], the particular vicissitudes of these unique phenomena are beyond the scope of this manuscript.

The history of the Russian-Jewish immigrant community in the United States cannot be examined without considering the traumatic history of the Russian-Jewish community in Russia and the circumstances surrounding the arrival of this group in the United States. Over the course of the modern era, Jews had been systematically massacred and expelled from every single European country [2]. Jews were expelled from the countries of Czarist Russia multiple times, from the 1495 expulsion from Lithuania to the 1727 expulsion from Russia proper to the 1843 expulsion from Southern Russia [2]. In 1772, all Jews within the Russian empire, including Poland, Baltic Republics, Russia, Ukraine, and Belarus, were deported to the Pale of Settlement, the few territories where Jews were permitted to reside within the Russian empire [2]. The initial immigration of Jews from the Russian Empire to the United States took place following the upswing in violent pogroms of the 1800s, and the majority of the modern-day American Ashkenazi Jewish community is comprised of descendants of this group of Jews [2]. Sixty percent of Ukrainian Jews, 65% of Belorussian Jews, 90% of Jews from the Baltic Republics, and 40% of Jews from Russia proper were exterminated during the Holocaust [2]. In the Soviet Union, between systematic persecution by Stalin's regime in the 1930s and subsequent state discrimination against Jews in the workforce and education, including limits on how many Jews could be admitted to universities, the Russian-Jewish community and other religious minorities and political dissidents often had to contend with the threat of forced psychiatric hospitalization and forced psychiatric medication, torture, and imprisonment in labor camps [2]. Although a trickle of Soviet Jews managed to escape to Israel and the United States during the 1970s, the beginning of *Perestroika*, the era of government reform that would eventually lead to the demise of the Soviet Union, and the demise itself, respectively, brought a large number of Soviet immigrant Jews to Israel and the United States. From the mid-1980s and until 2008, more than a million immigrants from countries of the Former Soviet Union (FSU) were admitted to the United States, with the majority of those immigrants emerging from the three Slavic republics of the FSU, including the Russian Federation, Ukraine, and the Republic of Belarus [3]. Between 1995 and 2005, 450,000 immigrants from the Commonwealth of Independent States, a conglomerate of countries that had in their previous incarnations been Republics of the Soviet Union, have been documented by the Immigration and Naturalization Service [4]. Additionally, an additional 250,000 undocumented immigrants had arrived around the same time, bringing the total number to 700,000 [4]. At present, 44% of all European-origin emigrants to the United States hail from Russia and countries of the Former Soviet Union, including Ukraine [5], and the majority of this population are native Russian speakers.

Some studies indicate that as many as 67% of this group have been Jewish religious and political refugees escaping persecution by the Soviet state, as well as the pervasive institutional oppression and culturally sanctioned anti-Semitism

[2, 6, 7], although due to systemic repression of religious and cultural expression by the Soviet state, many remain secularized and religiously nonobservant [3]. Among Jewish refugees from the FSU, their lack of knowledge of religious rituals and Hebrew or modern Jewish culture may serve as a barrier for their acculturation into the American Jewish community [2]. Limited English-speaking ability may isolate them from the American community at large upon arrival into the United States, contributing to feelings of worthlessness and depression [8–11] which are further worsened by the disruption of extensive, multigenerational friendship networks, loss of professional identity, and economic uncertainty [10, 11]. Many Russian-Jewish immigrants retain somatic symptoms of anxiety and depression after as many as 6 years in the United States [9]. Research also supports higher rates of alcohol abuse in the Russian-speaking population (e.g., [12]).

Other Russian-speaking and non-Jewish immigrants from the FSU include Muslim refugees escaping sectarian violence, the war with Chechnya, and political disintegration in the wake of the dissolution of the FSU and Slavic origin immigrants who immigrate to the United States for economic reasons. Some of these immigrants escaping sectarian violence may be struggling with the additional stress of anti-Muslim prejudice and racism from the general American population [13] while simultaneously feeling isolated from their Russian-Jewish peers due to marked religious and cultural differences. At the same time, they may flounder in acculturating in a Western country after emerging from a conservative Muslim surrounding. The trauma of fleeing a war-torn country and disintegration of immediate and extended family networks may further complicate their acculturation process [13].

Due to the systemic enforcement of collectivist Soviet norms, most Russian-origin immigrants have been raised with a more collectivist mindset than their Western counterparts. In Russian-origin families, child-raising practices place importance on serving the welfare of the whole family unit and society at large rather than the individual [14]. Soviet child-rearing literature recommends parental withdrawal or love and privileges as methods of punishment and discipline, and immigrant parents from the FSU to Israel report restrictive methods of isolating or ignoring the child to counteract disobedience [15]. Some studies suggest that Soviet parenting styles have assimilated the emphasis on high behavioral control and harsh punishment evocative of the Soviet regime's style of education [16, 17]. Thusly, Soviet immigrant parenting tends to advocate for harsher punishment and less positive reinforcement than Western parenting [16, 17]. Studies comparing Russian immigrant youth with their Israeli-born peers found that Russian-origin youth perceive their parents as less warm and less supportive than their native-born counterparts and as less emotionally expressive [15, 16, 18, 19]. Another study demonstrated a relationship between harsh, punitive parenting and aggression and conduct disorder in Russian-origin adolescents [16]. In a seminal study examining the suicidal ideation of Israeli adolescents, Ponizovsky, Ritsner, and colleagues found that Jewish immigrants from the FSU were comparatively more distressed and prone to suicidality than their Israeli-born peers [20]. They also established that the risk for suicidal thoughts was highest among those adolescents experiencing family discord, strained relationships with parents, hostile peers, difficulties with language barrier, and heightened anxiety and depression [20]. This finding echoes research coming out of Russia that suggests that strained relationships with parents, single-parent households, and anxiety and depression factored significantly in the rates of youth suicide in Siberia [21, 22].

Marina was born and raised in intact family and noted loving relationships between her family members. She was also relatively privileged, as her parents' education afforded her with a higher quality of life in terms of economic stability and cultural and educational learning opportunities than someone her age raised in a more rural setting or in a working-class environment. Having grown up in a middle-class family in a city with one of the largest Jewish populations in the FSU but also high incidences of anti-Semitism, she

self-identified as Jewish since childhood and reported being keenly aware of her being different from her non-Jewish Russian peers. She cited several instances of anti-Semitism directed specifically at her, and she also remembered her parents encouraging her to outperform her non-Jewish peers academically, as they had been keenly aware of the double standards applied to Jews and non-Jews in terms of exam scores, admissions to universities, and professional advancement. Upon immigration, she was given increasingly more responsibility caring for her younger brother and translating for her grandparents. This is in line with research that has indicated a higher prevalence of parentification in Soviet immigrant families [23, 24]. Researchers posit that parentification in immigrant families enhances family interdependence and relatedness and allows immigrant children more autonomy [23, 24]. In immigrant families, parentification is indicative of a positive relationship with parents and increased positive coping with stressful life events [23, 24]. As Marina spends more time in the United States and becomes more acculturated into American teenage norms, however, she begins to chafe at the spousal role taking and parentification that her parents impose upon her, which is consistent with research in this area [25]. While parentification contributes to her having more self-efficacy, she still feels put upon and exhausted, as she struggles to manage the academic responsibilities of college and the social demands of ordinary American student life, contributing to her feelings of distress.

Community psychologist Dina Birman has extensively examined the acculturation process in Soviet-Jewish immigrant adolescents and their parents. She has found that typically, acculturation progresses in a linear pattern, with behavioral acculturation and evolving cultural identity over time increasing for both immigrant adolescents and their parent group, while Russian language competence remains intact regardless of length of residence for the parent group [26]. However, she observed that Russian-born adolescents maintained their identification with Russian culture over time more than their parents [26], and she also observed that Russian-born peers supported their fellow Soviet immigrant adolescents' acculturation to Russian cultural norms [27]. She also found that high levels of acculturation to American culture were predictive of support from American peers and higher grades [27]. Both adolescents who had successfully adapted to American cultural norms and those who had remained aligned to Russian culture, reported having their parents' support and scored low on measures of loneliness [27]. However, successful acculturation to American culture directly influenced distress [26, 27], whereas acculturation to Russian culture predicted less distress only if high levels of perceived parental support were also present [26–28]. In Marina's case, she perceived her parents as supportive of her education but hesitant to support activities that were more typical of an American adolescent, such as non-academic extracurricular activities or dating someone outside of her cultural group, mitigating her adjustment.

Russian cultural norms of behavior include a collectivist ideation and imposed social support, including unsolicited encouragement, information and care [29, 30], and genuine expression of emotion, including value placed on experiencing both strong positive and strong negative emotions in the service of growth and authentic living [31]. While Russians tend to report being less happy than Westerners [31], it is plausible that expression of negative emotion is simply more culturally sanctioned in Russian respondents than in the Anglo-oriented culture of the United States. Russian society also demonstrates unique gender norms, as men have the power in patriarchal decision-making, such as an expectation of men proposing marriage, providing financially for their family, and showing gallantry toward women [31]. However, women are expected to maintain the paradoxical dichotomy of balancing both meaningful careers and managing family, children, and household finances [31, 32]. Women are also expected to maintain their appearance and femininity [32], including remaining slender, wearing makeup, having their hair done, and wearing fitted, ultrafeminine attire.

Table 12.1 Risk factors and protective factors for suicidality in Russian-origin youth

Risk factors	Protective factors
Peri-migration and migration stress	Family support around migration and acculturation stress
Parental trauma or distress stemming from exposure to the Chernobyl nuclear disaster	Limited exposure or lack of distress to the Chernobyl nuclear disaster
Family discord/conflict/sense of estrangement[a]	Parental and family unity/support
Secular upbringing/lack of a strong Jewish identity	Knowledge of Jewish religious traditions and a level of religious observance
Social isolation/loss of multigenerational familial and social support networks	Parental support of acculturation efforts and developing a bicultural identity and encouragement of bicultural social engagement
Difficulties with learning a new language/language barrier[a]	English language competency
Identity crises	Bilingual/bicultural identity
Strained and hostile relationships with peers[a]	Peer acceptance
Use of alcohol and other drugs/parental use of alcohol and other drugs	Resiliency/healthy psychological functioning/ lack of using harmful substances
Anxiety/depression/hopelessness[a]	Resiliency/healthy psychological functioning/ lack of using harmful substances/lack of parental use of harmful substances
Academic difficulties and social difficulties at school	Parental support at school and parental school involvement and teacher support
Poverty/parental underemployment	Financial stability
Parental mental health problems	Parental mental wellness and stability

[a] Indicates highest risk for suicidal ideation as indicated by the Ponizovsky et al. 1999 study [20]

Risk Factors

The stress of immigration constitutes one of the most comprehensive and pervasive disruptions in family life (see Table 12.1). Prior to immigration to the United States, Russian-origin immigrants may have incurred dissident experiences, religious prejudice, cultural discrimination, and institutional racism, as well as exposure to the Chernobyl nuclear disaster and its aftermath and the political unrest secondary to the collapse of the FSU. During migration, immigrants may suffer loss of material possessions, status, and employment and disruption of social networks. Finally, during settlement in the United States, immigrants have to cope with re-settlement stress, including limited employment opportunities and subsequent financial problems; increased care-taking responsibility for ailing, aging elderly and young children; and language problems, impacting their psychological health [10, 11, 33, 34]. Research has consistently demonstrated that adolescent perception of parental attitude and support predicts adolescent functioning [19, 23, 26–28, 35]. However, immigration weakens family roles and disrupts boundaries, creating financial concerns and instability, problems in familial relationships and communication, a reduction in family resources, an increase in the number of single-parent households, and increased responsibility being placed on the adolescent, while, simultaneously, linguistic boundaries and financial concerns limit the ability of many parents to be involved in their children's learning process and functioning [16, 18, 35, 36]. This is similar to Marina's experience of becoming parentified, while her parents were less involved in her educational journey due to the challenges of their own studies and work. The culture shock of transitioning from countries of the FSU to the United States often leads to depression and demoralization in recent immigrants, exacerbating existing mental health problems [2]. Simultaneously, Russian-origin parents desire to maintain a separate social identity, and culture may contradict

the social pressure for immigrant adolescents to acculturate to a new identity [37, 38]. Birman and colleagues have found that over time, Russian teenagers in the suburbs of Baltimore acculturate to American culture similarly to the Russian immigrant adolescents in Israel acquiring Israeli cultural norms [26, 39, 40]. However, she noted that they tend to hold on to their Russian identity in an effort to find or maintain their own sense of identity [26]. She postulates that for the parents of immigrant adolescents, Russian identity has to do with shared history, friendships, Russian language and literature, music and food, and a mutual understanding that comes from noticing others of the same culture, while, for adolescents, many of whom may be quite young at the time of immigration, being Russian may simply mean belonging to a particular group [26]. It is possible that in some instances, the use of this label is used pejoratively by faculty or other students as referring to those immigrant students who have been identified as troublemakers or having a particularly difficult time with adjustment. In comparing the experiences of Soviet adolescents in a concentrated community, a community where many Russian-Jewish immigrants reside in close geographic proximity to one another, vs. in a dispersed community, where Russian-Jewish immigrants are relatively spread out and have more contact with Americans, she has found the notion of acculturative press at work [41], where Soviet adolescents in the concentrated community hung on to their Russian identity in response to discriminatory experiences and negative perceptions of themselves as Russian [41]. This, in turn, may lead them to underperform, academically as well as socially. Marina came of age in such a concentrated community and experienced some discriminatory experiences, both from peers hailing from the Former Soviet Union but more provincial cities and towns and from American teenagers and immigrant teenagers from other immigrant groups.

Other research has repeatedly pointed to the increased incidences of bullying and peer aggression and violence in first-generation immigrant adolescents [42]. However, still other studies postulate that second-generation immigrant youth are at a higher risk than first-generation immigrants for behavioral problems, including conduct disorders, substance abuse, and eating disorders [43–45]. Pumariega et al. suggest that experiences of poverty, racism, and marginalization without the secure identity and traditional values of their parents impact the second-generation adolescent who has not yet developed a secure bicultural identity and skills [46]. It may be possible that points of crisis occur at different times for first-generation FSU immigrant adolescents vs. second-generation immigrant adolescents; for first-generation immigrant adolescents, they might be caught between the stress of immigration, pressure from their parents to maintain the values and behaviors of their home country, and the struggle to form social relationships and fit into American educational and social norms. They might revert to the norms of their home country for comfort and experience homesickness for friends and loved ones left behind, and they may struggle to learn a new language and acclimate to new educational and professional goals. Therefore, crisis points may occur shortly after migration or within a few years of immigration to the United States. For 1.5 generation adolescents who become acculturated into American values, or for-second generation adolescents, born into American culture, the crisis might occur when their newly assumed American values clash with their parents' more traditional upbringing, such as when they might decide to live outside of the family home while attending college or date someone of a different ethnic, religious, or racial background, as in the case of Marina.

Further, it is also plausible that in terms of religious identity, how a particular adolescent sees him or herself may be disrupted by the process of immigration. In the FSU, Jews were seen as a distinct ethnic and religious minority and were targets of significant anti-Semitism, racism, and institutional oppression. They were not viewed as ethnically Russian and registered in their passports as having a Jewish nationality. In the United States, Jews are often viewed as a predominantly White, assimilated non-minority, and many non-Jews tend to view Jews as insular and

economically privileged [2]. Birman and Trickett document that both the American Jewish community, largely responsible for bringing Soviet Jews to the United States, and the American society at large would expect that Soviet Jews would assimilate easily into American society, as they tend to be highly educated, employed in professional occupations and White [26]. However, Soviet Jews tend to retain a strongly Russian cultural identity and a secular religious observance, which often isolates them from the American Jewish community [47]. Many scholarly discussions of multiculturalism, oppression, and privilege exclude Jews. Noted feminist scholar, sociologist, and writer Melanie Kaye/Kantrowitz has posited that Jewish oppression "does not fit previously established analyses" (1991, p. 270, as cited in 2). Evelyn Torton Beck, another renowned author, psychologist and scholar posited:

> If the concept 'Jew' does not fit the categories we have created, then I suggest we need to rethink our categories. This is what feminists have said to the builders of patriarchal theories into which women do not fit, and it is what lesbians have said to feminist theorists who excluded lesbian identity – 'not *we*, but your theories are inadequate'. The unwillingness to rethink the adequacy of our categories... suggests a refusal to consider the politics behind our namings and a refusal to face the implications of our questioning (1991b, p. 193, as cited in 2).

Immigrant adolescents from the FSU may not find themselves represented either in position of power, prestige, and privilege or among the underprivileged minorities. A distressed adolescent may not find a space or a voice to address his or her particular concerns. Raised in largely secularized homes, many lack the knowledge of Jewish rituals and may find their lack of familiarity a barrier to integrating into the American Jewish community [2]. In analyzing factors contributing to suicidal ideation in Jewish adolescents, literature has repeatedly documented that religious observance has shown to be a protective factor [48], although in comparison to Jewish teens of other ethnic origins, immigrant teens from the FSU are at an increased risk for suicidality [48], as many of them hail from a relatively secular upbringing in the FSU. Particularly in newer immigrants, lower levels of religious observance, a sense of social isolation, loss of familial and social support networks, identity crises, difficulties with learning a new language, a sense of estrangement, and family conflict have been shown to contribute to suicidal ideation [48]. In comparing a US sample of Jewish adolescents to an older, community sample, Kakhnovets and Wolf found that for a younger population, mean age 18.98, Jewish affiliation was not a moderator between ethnic identity and spirituality [49]. The authors proposed that younger people might have competing activities that occur on the Jewish Sabbath, whereas for older adults, attending services might serve as a means of social contact. This may be particularly salient in examining the susceptibility of immigrant youth to suicidal ideation, as secular immigrant adolescents residing in more diverse environments may be even less likely to pursue religious engagement in the service of identity development, further predisposing them to psychological complications. Regardless of level of religious observance, however, research has shown that Jewish adolescents will identify as Jewish [49], and other research has demonstrated that a strong Jewish ethnic identity is predictive of a higher self-esteem and tends to moderate the relationship between perceived discrimination and depressive symptoms in Jewish Americans [50]. In fact, Jewish adolescents rate themselves as consistently higher on measures of ethnic identity than White Americans, but not as high as ethnic minorities [50]. Interestingly, in a survey examining Jewish identity in Soviet-Jewish immigrants vs. American Jews of Eastern European descent, Rosner, Gardner, and Hong found that Soviet Jews felt that their Jewish identity could be a bridge between American and Eastern European ethnic identities, indicative of a kinship with other Jews regardless of their national origin [51]. However, for American-born Jews, their Jewish identity did not bridge the gap between American and Eastern European ethnic identities [51]. This finding further corroborates the notion that for recent Soviet-Jewish immigrant adolescents coming from a more secular and less religiously observant background, their perception of their own

Jewish identity may be strikingly different than that of American-born Jewish teenagers who may be more well versed in religious ritual but have less cultural and ethnic affinity to their Jewish culture than their Soviet-Jewish counterparts. In fact, in order to address the unique needs of the Soviet-Jewish adolescent immigrant community, Young Judaea, a national Zionist youth movement, has begun a program called "Havurah," Hebrew for "Fellowship" specifically for Russian-speaking immigrant adolescents in grades 8–11. The aim of this nationally recognized program, the first of its kind in the United States, is "to strengthen their Russian-Jewish identity, culture and heritage... allow them to build a community. [The Hevurah program at] Camp Tel Yehudah is the perfect environment for teens to be in a balanced environment that allows them to focus on their Russian-Jewish background, while being part of the greater Jewish community in North America" (http://www.telyehudah.org/program/havurah/) [52].

The use of alcohol or other drugs, parental alcohol and drug addiction, smoking, and poverty were also shown to predict suicidality and suicide attempts in the Russian adolescent population [21, 22]. In the Russian immigrant community, somatic complaints are more socially acceptable expressions of psychological distress than reporting depression or anxiety directly [20]. Post-traumatic stress may also be responsible for somatic complaints [9–11, 53, 54]. Forced psychiatric hospitalization of Jewish dissidents and political prisoners in the Soviet Union and cultural norms that enforce the separation of public and private personae in the group may make it difficult for immigrants from the FSU to seek psychiatric or psychological services, which results in recasting psychological phenomena as physical illness and increased somatization [2, 8, 53].

Moreover, in the collectivist Russian culture, friendship networks tend to be multigenerational and span the whole family [53, 55, 56]. Those networks are broken by immigration, and in the process of immigration and resettlement in another country, priorities of new immigrants tend to shift to more pragmatic matters, such as securing a dwelling and finding employment. Whereas the immigrant community may bond together to assist new immigrants in situating themselves in the United States, it is less likely that complex and richly intimate multigenerational friendship networks formed in Russia would be established in a new country over the course of just a few years, with issues of resettlement taking precedence. A small study found that many Russian-speaking immigrants reported significant practical social support from fellow immigrants, such as bringing food to a bereaved family after a loved one's death or coming together to celebrate a child's wedding, but few reported feeling true relational intimacy and mutuality, the feeling of being heard, understood, validated, and connected to another fellow being [8]. School adjustment, including feeling great internal and external demands to succeed academically and adjusting to new social norms and practices, may likewise worsen immigration stress for adolescent immigrants [57]. The level of school environment, including parental support at school, such as monitoring and school involvement, as well as teacher support and peer relationships, including perceived peer acceptance and peer rejection, have shown to be significant predictors of immigrant adolescent mental health outcomes and risk behaviors [58].

More recent research has extensively explored the concept of resilience and its relationship to psychological functioning, specifically in immigrant and refugee populations. While additional investigations are needed to examine the various causal mechanisms managing the complex relationship between stress, resilience, and psychological outcomes (e.g., [59]), compelling research has demonstrated that while immigration may be a particularly stressful event, not all immigrants are likely to experience lasting psychological distress or functional impairment as a result of migration [60]. In a study of 450 Russian-origin immigrants to Israel, Aroian and Norris found that resilience significantly increased the likelihood of not being depressed [61]. In their sample, immigrants who were older, female, and less resilient and those who experienced greater immigration demands were more likely to be depressed [61]. In a study that utilized epidemiological data

and multivariate statistical analysis and incorporated a comparison group of Jews still residing in Russia, Ritsner and Ponizovsky found that distress, hopelessness, depression, and anxiety were predictive of strikingly higher suicidal ideation in recent Russian-Jewish immigrants to Israel [40]. A sense of identity confusion, powerlessness, and loss and lack of social support were also predictors of suicidal ideation [40].

This seems to support the Perez-Foster hypothesis of multiple domains of migration stress, pre-, peri-, and post-migration, impacting immigrant functioning [10, 11]. Interestingly, national origin seemed particularly predictive of suicidal ideation in that more urban immigrants from regions with traditionally elevated rates of suicide, such as Moscow and the Baltic Republics of the FSU, demonstrated markedly more suicidality than those from less industrial, more rural, and more traditional Caucasian and Middle Asian republics (2000). Ponizovsky et al. suggest that increased religiosity, strong national traditions, and more stable intergenerational family networks are predictive of less suicidality in those populations [20]. Hailing from a secular, urbane, and highly educated family environment in Moscow, Marina appears at a higher risk for suicide although her risk is mediated by a warm and supportive relationship with her parents. Having a rich social life with both American- and Russian-born peers in her hometown and in college is also a protective factor for Marina's risk of suicide.

In comparison with examining prevalence and risk factors for suicidal ideation in Russian-Jewish immigrants, Ponizovsky and Ritsner compared Russian-born Jewish immigrants to Israel, aged 18–74 to indigenous Jews in Russia. They had found that a 1-month prevalence rate of suicidal ideation in the immigrant sample (15.1%) was significantly higher than that in their Russian-based controls (6.6%) [40]. Being younger, living without a spouse, low levels of perceived social support, being a physician or a teacher, a history of immigration from the Baltic countries or Moscow, and duration of stay in Israel from 2 to 3 years are risk factors for suicidal ideation. Of note, physicians and teachers probably experienced higher rates of suicidal ideation due to the lengthy, costly, and challenging journeys those professionals would have to undertake in order to be qualified in their respective professions in the Former Soviet Union. The authors extrapolated that young people must have felt particularly vulnerable and more prone to suicidality due to the identify confusion, dislocation, powerlessness, and multiple losses engendered by immigration and associated rapid cultural change [40]. Also, the researchers had found that suicidal ideation in recent immigrants peaked among those who had spent 2–3 years in the country, suggesting that persistent resettlement difficulties, hardships that remain unsolvable, and ongoing adjustment difficulties may have contributed to the development of suicidal ideation [40]. Finally, high levels of psychological distress, including anxiety, depression, and hopelessness, also contributed to suicidal ideation among immigrants [40]. Other studies, examining the long-term impact of the 1986 Chernobyl nuclear reactor on the population of immigrants from the FSU, found that having lived in close proximity to the damaged nuclear reactor and cognitive belief in exposure to radiation predicted current psychological distress, including depression, anxiety, and trauma in immigrant populations [34, 62]. It is plausible that those adolescents, whose parents have experienced ongoing trauma symptoms and psychological distress stemming from the Chernobyl nuclear disaster, might be at higher risk for developing suicidal ideation. This finding is particularly relevant for those communities with large amounts of immigrants from the Ukraine and Belarus, which were particularly affected by the Chernobyl disaster.

Cultural Specific Symptoms and Expressions

In a comparison study of immigrant adolescents with native-born Israeli adolescents, Ponizovsky and his colleagues at the Ministry of Health found a high rate of acculturation in immigrant children and adolescents, particularly those that moved to Israel from the FSU before the age of 5 and

between the ages of 6 and 10, suggesting that they had adopted Israeli ways of coping and cultural approaches to problem-solving [39]. This confirms other research on acculturation of immigrant youth and expressions of psychological distress [60, 63]. Researchers have found a higher rate of suicide attempts among recent immigrants than either Israel-born adolescents or those Jewish teens that were still residing in Russia [20].

It has been documented that Russian-Jewish adult immigrants tend to overutilize medical services and somaticize symptoms of psychological distress [7, 54, 64, 65]. A qualitative study that examined health service utilization by Russian-Jewish immigrants in the Boston area found high levels of depression and somatization in the population [53]. One immigrant described the stress caused by immigration:

> The whole process of immigration...the preparations, the expectations, the waiting and then coming here and dealing with all the problems... is very difficult. This translates into major depression. People abandoned jobs they loved, miss their family and relatives, the places they used to like. They even miss their language [53].

Another immigrant explained:

> When you have bad moods, you start feeling physical aches and pains. You don't feel well. You feel fatigued. You can't find anything to distract you from these thoughts [53].

A provider alluded to the tendency of immigrants from the FSU to somaticize emotional distress:

> Somatization is a feature of these people. They won't complain like Americans about feeling depressed. They complain about a pain over there, a pain over here.

Other studies of Russian-Jewish immigrant adults have confirmed the finding that physical manifestations of anxiety and depression presented as heart or chest pain, feelings of weakness in various body parts, and nausea, as well as headaches, backaches, and a variety of other physical symptoms, are quite common in this population [7, 65]. In an examination of the levels of psychological distress in Russian-Jewish immigrants in a primary care setting, 82.5% experienced psychological distress and 43.9% experienced clinically significant symptoms of depression [66]. Hopelessness, anhedonia, lack of optimism, and a dysfunctional attributional style, as contributing to psychological distress, were endorsed by Russian-Jewish immigrants [66]. Ponizovsky has demonstrated that levels of distress in immigrant populations may peak immediately after immigration, as well as several years later [39]. The emergence or exacerbation of family difficulties and underemployment in later stages of acculturation are factors unique to this immigrant population that seem to worsen adjustment and predict psychological distress at later stages in acculturation [39]. While Ponizovsky in Israel [39] and Birman in the United States (e.g., [26–28]) found that in many ways Russian-Jewish immigrant successfully acculturate to their host countries and express their psychological distress similar to native-born adolescents, perceived levels of parental support and parental functioning mitigate how immigrant parents and immigrant adolescents might express their distress. Consequently, this impacts where and how the adolescents might seek mental health services. Based on this data, it seems prudent to conclude that medical providers should pay close attention to somatic manifestations of psychological distress among Russian immigrants, as they are often on the front lines in terms of diagnosis and treatment of anxiety and depression.

Further complicating Russian immigrants' psychological presentations, research has found that adolescents raised by a single or divorced mother have been shown to underutilize mental health services [39, 67]. A recent study found that divorced mothers of immigrants were four times less likely than mothers of Israel-born adolescents to consult someone for emotional or behavioral concerns regarding their child [67]. Also, the same study, examining the prevalence of mental disorder and service utilization in immigrant vs. native-born adolescents in Israel, found that immigrant mothers perceived their children as engaging in less prosocial behaviors and more conduct and hyperactivity-inattention

problems than mothers of Israeli-born adolescents [67]. It seems that parents, particularly single parents, may struggle with their own acculturative difficulties and their teenage children's functioning. This may include developmentally appropriate separation and individuation, acculturation to the host country, and emerging psychopathology. A recent study described Russian immigrants in treatment as a "paradoxical mix of modern and traditional values" referring to expressions of psychological distress, collectivism, gender norms, social support, and parenting styles. Researchers suggested that Russian immigrants constitute a unique amalgam of Western and non-Western, religious and secular, and culturally and ethnically laden beliefs, values, behaviors, and expressions of distress [31]. Based on this often contradictory information, it seems plausible that Russian immigrant parents might hesitate to seek out mental health services for their children, resorting instead to pursuing traditional medical settings for treatment of somatic complaints. However, acculturated immigrant adolescents might behave similar to their native-born peers in seeking psychotherapy or medication. In Marina's case, she was encouraged to seek counseling by her roommate, and she was amenable to pursuing services but hesitant about disclosing that she was in therapy to her parents. She believed that her parents would judge her as deviant or exceptionally troubled or that they would deem her unable to cope if they knew that she was in treatment. On the contrary, once she did disclose to her family that she was pursuing therapy and antidepressant medication, they expressed their full support, although they were understandably concerned about her prognosis. They did note puzzlement at how therapy might help her cope with her worsening academic performance, and they continued to encourage Marina to work hard, as they tended to conceptualize her academic difficulties as stemming from poor work ethic rather than psychological distress. Marina would often find it burdensome to educate them about her symptomatology, which would continue to remain a source of contention between her and her parents.

Diagnostic Considerations

Ponizovsky and Ritsner found that among those immigrants with suicidal ideation, psychological distress, particularly anxiety and depression, was endorsed most prominently, and the prevalence rate of suicidal ideation for highly distressed immigrants was ten times that of their non-distressed counterparts (38.8% vs. 3.6%, $p < 0.001$) [20]. Marina endorsed symptoms of depression and anxiety, and she met DSM-V criteria for major depressive disorder, including depressed mood and sadness, anhedonia, sleep problems, including early and middle insomnia and hypersomnia, psychomotor agitation, loss of energy, disproportionate feelings of guilt, and problems with concentration [68]. At the time of her presentation to the counseling center, she was in considerable distress, and she also endorsed marked gastrointestinal problems including nausea, upset stomach, diarrhea, and vomiting, as well as other somatic symptoms, such as bruxism and chest tightness, in line with the somatization that is exhibited frequently by Russian-Jewish immigrants, including adolescents and adults [7, 9, 10, 20, 53, 54]. She also reported symptoms in line with diagnosis of generalized anxiety disorder, including apprehensive expectation, particularly in regard to school work, difficulty controlling worry, irritability, poor sleep quality, restlessness, and concentration problems [68]. Her interpersonal functioning, as regards to her academic work, social life, and family relationships with her parents, brother, and grandparents, was disrupted by both her anxiety and depressive symptoms. Upon further query, she had admitted passive suicidal ideation without intent or plan. Of note, she would also meet criteria for a panic attack specifier, as she would experience panic attacks in the context of exams [68]. Marina would report that she had been diagnosed with bruxism and irritable bowel syndrome (IBS) by her primary care doctor, conditions that have a significant association with anxiety disorders [69, 70]. In line with the somatization observed in Russian-origin immigrants, Marina had been diagnosed with bruxism and IBS by a medical doctor earlier than receiving diagnosis of major

depressive disorder and generalized anxiety disorder by a mental health specialist.

While Marina did not struggle with externalizing behavioral problems, such as conduct issues or hyperactivity, research has documented a higher rate of those conditions in Russian-Jewish immigrant adolescents [67] than native-born adolescents. She also did not endorse substance use or abuse, although elevated rates of substance abuse have been well documented in the Soviet-Jewish immigrant population [12, 71]. Marina's confluence of psychiatric symptomatology, Russian-Jewish immigrant status, and current distress necessitated a thorough interviewing for suicidal ideation and close monitoring. The convergence of her challenging adaptation to college, recent termination of a romantic relationship, tension in her relationships with her parents, and academic stress, coupled with precipitating stress of immigration, rapid culture change, identity confusion, and powerlessness, made her a high risk for a suicide attempt.

Intervention Approaches and Evidence

Jurcik et al. [31] recommend a framework of adapting services to Russian immigrant patients that would adapt more Westernized psychotherapies to the paradoxical Russian amalgam of Eastern, Western, and uniquely Russian values and mores. They suggest examining pre-migration, peri-migration, and post-migration discrimination and trauma experiences along with assessing the levels of acculturation to American vs. native Russian culture including English language proficiency, education, employment, housing and sources, and quality of social support [31]. In Russian culture, stoicism when dealing with suffering, avoidance of disclosure for the benefit of the collective at large, and not asking for advice directly are common social norms. Thus, a clinician may have to take a more active and directive approach [31, 72] while respecting the family's beliefs.

In formulating treatment for adolescents and their families, it is also important to honor the interdependent relationships between Russian-origin parents and their children, as opposed to individualistic, Western relationships [30]. Russians value and expect parentified and mutually obligatory relationships [23, 24]. They expect their children to be submissive to parental authority figures and often provide them with direct, unsolicited social support [29, 30], while also encouraging them to achieve self-sufficiency [31]. For adolescents acculturated to individualistic, Western culture that values less intrusive, more indirect, and more individualistic Western relationships, the mixed message about submissive obedience and resilient independence may be perceived as controlling, confusing, and oppressive. To a clinician unfamiliar with Russian cultural norms, such parenting may seem enmeshed, boundary-less, and intrusive. In Marina's case, as she acculturated more to the norms of a Caucasian American university student, she chafed at her parents' expectations that she maintains her filial obligations to help them parent her younger brother and assist them in caretaking her aging grandparents. She also felt enormous guilt at potentially letting down her parents, both in terms of not living up to these cultural expectations and also in disappointing them with her lackluster academic performance. Thus, she perceived herself as weaker and inferior to them since she could not maintain strong performance in the face of the stress and trauma of immigration.

Russian society demonstrates unique gender norms in patriarchal decision-making powers that rest with men, including an expectation of men proposing marriage, providing for their family, and showing gallantry toward women [31], while women are expected to maintain the paradoxical dichotomy of leading meaningful careers as well as managing family, children, and household finances and all the while maintaining their appearance and femininity [32]. In Marina's case, she admired her mother enormously and hoped to emulate her. Her mother's resiliency and persistence in relaunching her career as a physician and her ability to continue to direct the household while practicing her own challenging career were qualities that she admired, and

Marina noted worrying that she did not have her mother's dogged stoicism and endurance and, thus, lacked a fundamental character quality necessary to succeed in life.

Cognitive Behavior Therapy for Suicide Prevention (CBT-SP) is a manualized approach theoretically grounded in cognitive behavioral therapy, dialectical behavioral therapy, and targeted approaches for suicidal, depressed youth [73]. While it has not been validated specifically on Russian-Jewish youth, it has been studied on several multicultural populations, and its pragmatic approach and focus on creating self-efficacy may be particularly beneficial to Russian-Jewish adolescents. This approach is predicated upon the diathesis-stress theory of suicide that suggests that situational stressors, such as school- or work-related difficulties, may trigger suicidal ideation in an individual that possesses the diathesis, a predisposition to suicidality garnered from genetic, cultural, and religious components, psychosocial stressors, and childhood experiences [73].

A chain analysis of vulnerability factors, activating events associated with the crisis that predicated the suicide attempts and adolescent emotions, thoughts, and behaviors around these events, is conducted in order to select intervention strategies and give the opportunity to the patient to feel understood and, also, to help the provider to conceptualize the biopsychosocial framework of patient's a suicidality and assessment of future risk [73]. The next step in this treatment protocol involves safety planning, including steps that the adolescent can take behaviorally to manage suicidal urges until the next therapy appointment, including internal strategies and external strategies, such as reaching out for social support from family and friends. The therapist would also work with the client to develop a Hope Kit, a concrete implementation of the reasons that the teenager might want to stay alive, including events and activities that he or she may look forward to, people that may care about the client or interests that the adolescent cares about; this kit helps provide the client with a sense of purpose and gives him or her another practical, concrete tool that can be used in a crisis situation [73]. Assessing the client's strength and involving the adolescent in behavioral activation, mood monitoring, emotion regulation and distress tolerance techniques, cognitive restructuring, assertiveness training, and functional problem-solving, among other skills, can be tailored to the individual's problem-solving style and based on the case conceptualization and chain analysis conducted in the earlier phase of treatment [73]. Strategies for relapse prevention are then addressed in treatment [73] in order to help the client develop further hope and self-efficacy, and in vivo imagery is used to help him or her practice applying the skills learned in therapy to his or her symptoms [73]. A culturally sensitive version of this approach, incorporating work with a suicidal adolescent's family, could be utilized to help a suicidal Russian-Jewish immigrant adolescent.

In Marina's case, she was engaged in a more integrated approach, as she did not have a suicide attempt at the time she had presented for treatment, to manage her depressive and anxious symptoms and passive suicidal ideation. She was introduced to the cognitive model and engaged in developing a biopsychosocial formulation of her anxiety and depression, incorporating a review of her and her family's peri-migration and migration stressors and the difficulties that they had faced adjusting to the United States. She successfully implemented cognitive restructuring to her distorted thoughts and was able to utilize cognitive restructuring and relaxation techniques to cope with her test anxiety, contributing to an improvement in academic performance. She was also encouraged to share her therapy homework with her parents during her visits at home, which served to engage her parents in intimacy-building conversations with her and helped bolster their support of her. Further, she was engaged in behavior activation, including regular exercise, and encouraged to join a Jewish student group on campus. Eventually, she would become involved in an effort to organize a Russian house on her college campus, a student group interested in promoting immersion in Russian language and culture, with the support from the faculty in the

Russian studies department. A pivotal conversation between Marina and her parents regarding her choice of major helped her vocalize her passion for writing and change her major to journalism, nurturing her love for the written word.

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13 Suicide and Self-Harm Among Sexual and Gender Minority Youth: Resilience, Coping, and Despair

Peter T. Daniolos, Eric N. Boyum, and Cynthia J. Telingator

The Case of Sam

Sam is a 14-year-old Latino trans-boy – assigned female at birth and named Sally – who yearns to be allowed to start testosterone before his 16th birthday when it is typically offered. He hopes to have a body that better matches his gender identity and looks more like other boys his age who are going through puberty. Sam also hopes to be allowed to undergo a mastectomy before he is 18 when it is typically offered. He is binding his breasts daily which causes much discomfort. When asked about gender-nonconforming or nonbinary identities, he firmly rejects either, stating he is a boy. Sam presents with a clearly male gender identity, in addition to a male gender role/expression. His sexuality is "heterosexual," based on his male gender identity, as he is attracted to girls. Sam attempted to take on a "butch lesbian" identity and a tomboy identity; however, neither fits as he attempted to understand and differentiate his sexual and gender identity. Sam clearly states that for much of his life, he has deeply thought of himself as a boy. He dreams of himself as a boy and is so much happier as a boy.

Amazingly, his peers in his small Midwestern town have treated him quite well, even though they initially knew of Sam as Sally, a masculine tomboy. He is very well liked at school, both by peers and staff, and he is a star on the boy's lacrosse team. He socially transitioned to being a boy at the age of 11, and the school teachers and administrators have been wonderful in providing accommodations. These accommodations include being allowed to change in the nurse's station for gym, using the gender neutral bathroom in the nursing station, and registering him as a boy even

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though his legal documentation still said female. Gendered bathrooms have been very stressful to Sam, as he constantly scans the environment to find a gender-neutral bathroom. The recent North Carolina's so-called Bathroom Bill seeking to limit the ability of transindividuals to use the bathroom allied with their gender identity has only worsened his angst. Mother states that recently Sam used a male restroom in a rest area for the very first time and was quite anxious about this but "made it through it okay."

His mother marvels at Sam's progress. He is thriving in lacrosse and is particularly drawn to the Teen Wolf remake, possibly due to the transformation that the teen wolf character undergoes. When he is asked about that, he states the teen wolf's experiences remind him of the difficult things and challenges he has had in his life, including the rejection he faced by his beloved father.

When he was 10.5 (shortly before his gender transition), he attempted to jump from a moving car, which led to a psychiatric hospitalization. He did have subsequent episodes of self-injurious urges and some cutting when he was struggling to tolerate his ongoing pubertal bodily changes shortly after he was placed on a puberty blocking agent Lupron. He was tormented by his body developing along the entirely "wrong" gender line, and he felt a sense of despair that he would never have the chance of having a body that aligns with his gender identity. Sam states that this social gender transition has been difficult overall, adding "people don't understand how hard it is and how hard it is to stand up in public," referring to the social stigma. In spite of this, his identity remained firmly a "guy" or "trans-guy."

When asked about his self-harming behaviors, he states "I didn't think that I belonged in the world and was so confused. I thought I had to be better than what other people thought of me." Fortunately, however, he states that this pressure has decreased. He feels much more accepting of himself and happier since he feels supported in the world. Although his father is far more accepting then he initially was, he continues to struggle with his child's transition. Nevertheless, he is trying to use male pronouns and will jokingly slap his mouth if he slips. Mother has fully accepted that she now has a son.

Sam first presented for an evaluation in a university-based Midwestern gender evaluation program as Sally when she was 12, requesting that she be offered pubertal blockade in the form of Lupron. Her mother shared that she has had a firmly male gender identity and gender role/expression that dated back to at least the age of 5. Sally struggled with her (female pronouns will be used for times in his life when his gender identity was less clear, and the name Sally will be used during the time that he did not ask to be called Sam) identity as she grew older. Sally would only wear boy-like clothing, liked to play with boy things, and preferred to play with boys. Indeed, Sally was thought of as one of the boys in their small town, although individuals knew of her natal female gender. Her mother struggled with this, as did her father; however, with time her mother realized it was best to allow Sally to dress more like a boy. Her father, however, insisted that her clothing all come from the girl's section of the store. At the age of 10½, Sally started to steal her father's boxers and cologne and wear them. Due to her father's deep conservative religious convictions (he is a Pentecostal church member, as the whole family used to be), he tried hard to convince Sally that she had to be a girl, as "God does not make mistakes." He would say things such as her gender was just a matter of feelings and choices but that she

needed to honor her body and since she was "born female," she had to be female. He believed that "the body is the truth and God gave you the body, so your mind is simply messed up." He also suggested to Sally that if she does not shift her path in life, she will end up going "to hell." This clearly caused tensions between her parents, negatively impacting their marriage.

Prior to her gender clinic evaluation, Sally's behavior steadily worsened, and she became more defiant, oppositional, and aggressive. She became more depressed and withdrew from others. It became clear to her mother that her struggles with gender identity were clearly getting in her way and causing her great difficulty, amplified by the lack of parental support. She was ultimately hospitalized after she tried to jump out of the family's moving car, but her treatment for underlying depression, anxiety, and ADHD did not go well. Sam's treatment shifted when one of the inpatient psychiatrists suggested that many of his difficulties seemed directly related to his gender identity issues and that the best thing for the family would be to affirm and support his gender. Following his hospitalization he continued in outpatient psychotherapy working on better integrating his gender identity, which led to improvement in his behavior and mood-related issues. His mother allowed Sam to don a short crew cut and purchase clothing from the boys' section, important components of socially transitioning to being a boy. Sam binds his breasts with a slimming waistline neoprene $6 binder, which is very uncomfortable but was what they could afford. His mother was tearful when talking about the first time she needed to help "wrap" Sam. She admits this has been a very difficult shift for her; however, she wonders if this could be God's way of bringing a boy to her life as she has always wanted a son. She feels some guilt that this wish might have led to some of her child's issues. She had to leave the Pentecostal church, and she and her husband did ultimately separate.

Introduction

Gender and sexual identity are central components of adolescent identity development. Adolescents commonly question and examine all aspects of their identity, including their sexuality, gender role, and expression. The latter terms refer to the expression of culturally determined facets of being male versus female (including clothing, toy, play preferences, etc.) and are distinct from gender identity which refers to a pervasive sense of *being* male or female [1], not just wishing for some attributes culturally allowed for the other gender. Children and adolescents sometimes articulate not quite fitting into binary gendered boxes (gender nonconforming) or having aspects of both genders (nonbinary). Society clings to gendered boxes, and tension erupts when children are unable to neatly reside within dictated gender parameters. The stigma experienced by gender-nonconforming, nonbinary, and trans-youth can be tremendous. However, as reflected in Sam's case, many families are able to make this transition along with their child, allowing for healthier psychological outcomes.

For most youth, their gender identity is consistent with their gender assigned at birth or natal gender, with such children or adolescents designated as cisgender. For a minority, however, a transgender or nonbinary gender identity emerges, which can lead to personal, familial, and societal turbulence as captured in the case of Sam and in the latter example of Marcos. The terminology and pronoun use can be bewildering, so they are summarized in Table 13.1. In general, providers need to use the pronouns that the adolescent requests, to allow for the emergence of a therapeutic alliance. Some youth prefer that the pronoun "they" be used, allowing room for

Table 13.1 Terminology and definitions

Gender identity	One's basic sense of being male, female, or another gender	[3]
Gender expression/role	External manifestations of behavior, appearance, or personality culturally defined as masculine or feminine. This can include clothing, hairstyle, and play interests	[3]
Transgender	Individuals who cross or transcend culturally defined gender categories. Trans* is an all-inclusive term that covers all youth with an internal gender identity differing from sex assigned at birth (natal gender)	[3]
Cisgender	Individuals whose gender identity and expression are consistent with their assigned or presumed gender at birth	
Transition	The time when an individual begins undergoing a process to change gender expression to align with the gender with which one identifies, with the option of physical changes/medical interventions (including hormonal and surgical). Social gender transitions involve a shift in gender expression, pronoun use, name choice, etc. with no medical interventions	
Gender dysphoria	A DSM5 diagnosis which "refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term gender identity disorder and focuses on dysphoria as the clinical problem, not identity per se"	[4]
Identity	One's abstract sense of self within a cultural and social matrix. This broader meaning (equivalent to ego identity) is distinct from gender identity and usually consolidated in adolescence	
Sexual orientation	Refers to the sex of the person to whom an individual is erotically attracted. It comprises several components, including sexual fantasy, patterns of physiological arousal, sexual behavior, sexual identity, and social role	

nonbinary gender identities. Others prefer that pronouns matching their gender identity be used, and still others might request novel pronouns such as Ze and Zer. Facebook currently has over 50 options for gender [2].

Sexual feelings, desires, fantasies, and preferences are a key part of adolescent development, as is one's formation of an identity as a romantic and sexual being. The rich variation among these facets of sexuality in adolescence is underpinned by biological, psychological, and sociocultural factors that are not fully understood. The term *sexual minority youth* has been used to identify those young people whose sexual preferences, behaviors, or relationships are not exclusively heterosexual. Historically, many sexual minority youth have chosen to identify themselves as sexual minorities by using common terms such as "lesbian," "gay," or "bisexual," in order to find community and solidarity with other youth for support when facing similar developmental and social challenges. There is a continuum of sexual feelings, identities, and experiences that adolescents may choose to self-label or identify at different times in their lives. This can include asexual, pansexual, and polysexual amidst many other identities. Recently, with a general trend toward greater societal acceptance of sexual minorities, youth have begun to resist the older, rigid constructs of gender and sexual identity, describing what likely has always been a great diversity of one's own individually experienced identity in new and creative ways.

Orientation and Identity as Fluid Constructs

Adolescence is a life stage characterized by being and becoming. Erikson, in his classical work *Childhood and Society*, described the adolescent stage as one in which youth struggle to understand who they are as individuals and who they will be in society through later life stages [5]. Adolescence is a time of development and fluidity with respect to sexuality. While gender expression and identity can be thought of – in general – as being stable by adolescence, room exists for variation as well. Early theorists such as Troiden and Cass recognized that even among those who would eventually settle into an exclusively homosexual identity, adolescence was a period of questioning one's previously culturally assumed heterosexual identity in the face of incongruent sexual orientations [6, 7]. Later theorists like Diamond, Savin-Williams, and Klein [8, 9] brought to light that multiple aspects of orientation (e.g., sexual object choice, fantasies, lifestyle, romantic interests) can be fluid, each having its own trajectory throughout one's life history.

Gender is multidimensional, similar to sexuality. For many young people, gender identity and expression correspond to natal gender and are fixed from early childhood onward [10]. For others, aspects of gender expression such as masculine or feminine personality characteristics, traits, or interests can be fluid over middle childhood and adolescence, probably related to social and biological factors [11].

Several large national studies have sought to estimate the number of sexual minority youth in the population. The National Health and Nutrition Examination Surveys (NHANES), National Survey on Family Growth (NSFG), and Youth Risk Behavior Survey (YRBS) have all included questions aimed at identifying aspects of sexual orientation and identity in young people. Generally, the rate of same-sex sexual behavior in teenagers is found to be around 2–4% for males and 10–11% for females [12, 13]. Among teenagers, the concordance between sexual behavior and sexual identity is low, possibly related to teenagers still consolidating this part of their identity during these years [14, 15].

We currently do not have reliable estimates for trans-youth in this country, in part due to the breadth of individuals this term encompasses. A recent survey utilizing data from the CDC's Behavior Risk Factor Surveillance System (BRFSS) to estimate the number of adults who identify as transgender nationally and in all 50 states was conducted by UCLA's Williams Institute, finding that 0.6% of US adults or 1.4 million adults identify as transgender. The youngest age group of 18–24-year-olds was more likely than the older age groups to identify as transgender [16].

Unfortunately, sexual minority and gender minority youth face many social and cultural challenges that can lead to negative health outcomes. In 2011, the Institute of Medicine (IOM) reported significant health disparities between sexual minority and transgender youth in comparison to exclusively heterosexual, cisgender teenagers [3]. After reviewing a decade of publications examining data from 20 years of school, state, and national youth surveys, the workgroup concluded sexual minority youth were more depressed and more likely to consider or attempt suicide than exclusively heterosexual peers [3]. The IOM noted at that time that extant data regarding transgender youth were limited to small convenience samples, limiting the generalizability of their conclusion that transgender youth also *may* face an increased risk of depression and suicide [3]. Unfortunately, in the intervening years, the Youth Risk Behavior Survey (YRBS), a large national sample of middle- and high school-aged students in the United States, first convincingly demonstrated the degree to which both sexual minority *and* transgender youth think about and attempt suicide [17]. The IOM also found that sexual minority youth were more likely to have other negative health outcomes such as high use of tobacco, alcohol, or other drugs, engaging in risky sexual behavior, and/or higher rates of contracting HIV; data for transgender youth regarding these other health outcomes were lacking [3]. High rates of homelessness has also been found for sexual and

gender minority youth, leading some to describe these individuals as "throwaway" youth [18]. Clearly, each of these negative health outcomes is associated with suicidality and self-injurious behaviors.

Most sexual and gender minority youth will navigate their social-cultural milieu successfully without experiencing mental health symptoms or being at risk of self-directed violence. However, stigma and shame will lead a significant minority of these youth to struggle, and clinicians working with them will need to explore their risk, resilience, and social-cultural milieu. More than a decade ago, the *minority stress* paradigm for understanding health disparities among sexual minority youth was proposed by Ilan Meyer [19]; it has since been adapted to explain disparities among transgender individuals as well [20]. Meyer proposed that sexual minority youth can face, individually, negative health outcomes due to overarching societal prejudices and discrimination against sexual minorities as a whole [19]. Robin Lewis and colleagues demonstrated that *stigma consciousness*, an individual's expectation of prejudice or discrimination, was correlated to individual stress and negative mood – at least among lesbians [21]. Stigma consciousness is related to another construct that ties sexual minority and transgender youth to society's attitudes – *internalized homophobia* or *transphobia*, a complex internalization of society's negative attitudes toward sexual or gender minorities [22]. The more youth regard their identity as likely to attract victimization or discrimination or are ashamed of their identity, the more vigilant they become, and the more likely they are to attempt to conceal this aspect of their identity from others [19]. To do so, teens often engage in *impression management*, a term coined by Goffman [23], including consciously altering mannerisms, voice, or appearance in order to avoid being "found out" as sexual or gender minorities. This stigma-driven stress can lead to higher rates of psychopathology for some. Despite these many forms of risk, the story of most sexual and gender minority youth is a story of resiliency. For most, these will be stories of finding a sense of belonging in their family, their peer group, their school [24]. Efforts to destigmatize sexual and gender minorities and provide safe, inclusive spaces for sexual minority and transgender youth, regardless of self-labels they might use, are imperative. GLAAD (Gay & Lesbian Alliance Against Defamation), GLSEN (Gay, Lesbian, and Straight Education Network), HRC (Human Rights Campaign), PFLAG (Parents and Friends of Lesbians and Gays), and other LGBT advocacy organizations are paramount to ensure the lasting physical and mental health of sexual minority and transgender youth.

The Case of Devon

Devon presented as a 13-year-old girl for an evaluation secondary to experiencing significant anxiety. She had been in and out of therapy since she was 8. Her prior therapy was primarily play therapy, and the psychiatrist had prescribed fluoxetine starting at age 10 to help Devon deal with her overwhelming anxiety. She stopped taking it after 6 months stating that she did not want medication. At age 12 she was taken to see a therapist for CBT but did not find that treatment helpful. She lived in the suburbs of a major city and had an older brother. Her mother and father are both professionals. She reentered therapy when she was 13 years old with a new therapist with expertise in working with kids around gender and sexuality. Her family sought treatment to help her with her somatization and ongoing anxiety around death. Her parents also wondered if she was questioning her gender identity.

She presented as a cisgender female, with a medium build. She often wore jeans and a tee shirt, but the tee shirt style would periodically shift into what she perceived as more feminine or masculine, with her

hairstyle also shifting to match her gender expression of that day. Her hair was often closely cropped, and she did not wear jewelry and makeup or have any tattoos or piercings. She was bright and did well in school, but was planning on switching to a private school which would address her learning issues from a strength-based platform. She hoped that therapy would help her with this transition.

At the time that she transitioned to the private school, she felt that she would need to find people who were similar to her. She felt different but could not identify the ways in which she was different. Her father was African-American and her mother Caucasian. Her mother and her father's relationship was tense as her mother would become very controlling at times. Her mother had a history of a mood disorder and alcoholism. Devon was very close to her father and felt that she could speak openly to him about most things. She did not speak to either parent about issues of gender or sexuality.

Devon remained in this treatment from the age of 13 years old until she went to college at age 18. Over the course of treatment, she dealt with family issues, identity issues, and sexuality. The school that she had transitioned to had a poorly attended gay/straight alliance (GSA). Devon felt that she could not relate to many of the kids in the school or in the GSA. She began to wonder if she was a trans-boy. The clinician stayed curious about her experience as Devon continued to focus on school and home stressors. Devon did not want to discuss her experience of her gender with her parents, and they did not ask her about it.

While in her sophomore year of high school, her parent's marriage began to fall apart. She believed that she had always been the person to hold the family together. She would take responsibility for intervening when the family was in crisis. She felt guilty that she could no longer hold the family together and began to superficially cut her inner thighs where it was less visible to others. She steadily began to dress and appear more masculine and began to speak about transitioning to living as a boy. She was unable to discuss this with her parents as she feared their disapproval and rejection. She became increasingly despondent and suicidal. Her family began family therapy to address the family issues and ultimately help with the parents' separation. It was in this forum that Devon began to share with her parents her experience of her gender and sexuality, and she was surprised to find them relatively accepting over time.

Devon's suicidal and self-harming behaviors abated over the time she was in family therapy and working in her individual therapy. One important aspect of this change in coping style and decrease in self-harming behaviors was that she began to be able to verbalize in therapy her experience of her identity confusion and feelings of being "bad." She joined a community support center, which was a youth-led, adult-supported program for LGBTQ youth in high school. Her relationships with both the facilitating adults and the other youth in the support group helped her to find a safe space where she could be more fully herself, and her cutting ceased. This group was significant in allowing her to explore her identity without labeling. She moved from feeling that there was a rigid paradigm of how she needed to express her gender or sexuality in order to feel accepted. The focus of her therapy shifted during her junior year to her experience of her gender and sexuality. She met a female transfer student at school the beginning of junior year and developed emotional and sexual feelings toward her. Over the course of time, they became involved in an intimate relationship. Devon continued her work in

therapy on understanding her experience of her gender and sexuality. She would feel excited when people called her by male pronouns; however, in therapy, she wanted female pronouns and her birth name to be used. As she started thinking about college, she began to wonder how she would want to present in college in terms of gender, leading to deeper work on her experience of her gender and sexuality. She began to understand that she felt more comfortable identifying as gender queer as that felt more appropriate to her experience of gender. She felt more comfortable wearing what is considered more "masculine" clothing and being in what is considered the more "masculine" role in a relationship. She gained clarity over time that she did not want to be male – in fact she preferred others using female pronouns and maintaining her name given at birth.

As she explored her sexuality in college, she became involved with both transwomen and cisgendered women. She found herself ultimately attracted to "feminine" women who were cisgendered, and Devon began to self-identify as a lesbian. Over time Devon shared her lesbian identity with her parents and her brother who were ultimately very supportive of her.

Devon also worked on issues of the intersectionality of her multiple identities. This included understanding and integrating all aspects of herself without taking on a single identity in order to "fit in" or negating aspects of herself to "simplify" who she was. She worked in therapy on understanding her experience of herself across race, gender, religion, ethnicity, and sexual identity without having any one "peer group" with whom she specifically identified. The idea of intersectionality was used to help allay her anxieties about her identity. Her suicidal thoughts and her self-harming behaviors were understood to tie into her feelings of alienation and self-hatred and reduced over the course of treatment. Despite her family's travails and ultimate separation, finding people with whom and places in which she could be "real" allowed her to do the ongoing internal work that she needed to do in order to be self-accepting.

The Case of Margarita/Marcos

Margarita is a 16-year-old natal female, who presented for evaluation with their mother at a Midwestern university medical center-based gender evaluation clinic. Margarita presented as a warm, mature, and thoughtful teenager, dressed in loose-fitting androgynous clothing with a very short haircut and no makeup. They described their gender identity as "gender fluid/nonbinary – I have not bothered to define it more than that," dating back to at least the seventh grade. They prefer to go by the name Marcos, due to its androgynous quality, and prefer the pronouns they or them but would rather not be called she or her. Interestingly, they are comfortable with their mother referring to them as Margarita, adding: "That is what I am – her daughter. My birth name, Margarita, is kind of like an attachment between us. It would be weird for her to use any other name." Regarding therapy, Marcos confides that "my personal goal is to become more comfortable with myself and not have to change things about myself, maybe even becoming comfortable with my birth name and female pronouns."

During our first evaluation, Marcos declared that they are not interested in surgical interventions or hormonal interventions, stating "I am not uncomfortable with my body." They did not have difficulty, for example, when they went through puberty, although at times they will bind their breasts

when they feel like looking more male. They also worry that because of their nonbinary/gender fluid identity, if they were to transition or do anything irreversible, they might later regret it.

Marcos is currently a junior at an excellent Midwestern public high school, where they are thriving, taking many advanced placement and honors classes, with a high GPA and high PSAT scores. They are popular and celebrated in school, with peers and teachers supportive of and interested in learning about their nonbinary identity. The school newspaper interviewed them regarding how to best use pronouns and labels for gender variant youth. They have found much support at their school's GLOW group, "Gay, Lesbian, or Whatever!" Their family is from Colombia and impoverished; their father was deported due to domestic violence, including beating their mother in their presence and threatening to rape his daughters. Their mother works as a cook in a Mexican diner and speaks only Spanish.

Marcos has had a nonconforming gender role and gender expression for their entire life. As a child, they always disliked dresses but did play with both girl and boy toys. Their mother states that in retrospect she suspected that her child was not comfortable with her gender (mother uses female pronouns for her child), as she always rejected more feminine things and seemed to prefer masculine and boy-like things. Marcos states that fortunately their mother did not force them to wear dresses. Mother hopes to better understand what has caused this desire in her daughter to not be a girl and how she should respond as a mother.

In approximately the seventh grade, Marcos noticed that they yearned for things that were more typically boy or male and wished that girls would be allowed to enjoy such things. These feelings intensified, and in their sophomore year, they started "examining gender more." It is at that time that they decided that they "sometimes feel more like a boy, but I am not a boy, and sometimes I feel more like a girl, but I am also not entirely a girl." This led to the realization that the gender label that seemed to make the most sense for them was nonbinary or "gender fluid."

Marcos describes themselves as "pansexual," defining this as not being attracted to any specific gender but rather a person. When they first "came out" to mother during a therapy session as pansexual approximately a year ago, their mother started to cry, wondering if it was a genetic predisposition, since they have a gay uncle. Marcos replied: "why are you crying about who I am?" Prior to that session, Marcos had become increasingly depressed and anxious with periods of suicidal ideation. The onset of their depression and anxious preoccupation was in their sophomore year when they started to examine sexuality and gender, coming to the conclusion that they were pansexual. They started to define themselves as nonbinary after making friends with a nonbinary peer and learning of the existence of this category. However, they became increasingly saddened about losing their experience of growing up as a strong girl, wondering "Can I not be a feminist anymore, and is my childhood experience worthless, if I'm a guy or nonbinary?" This led to an existential crisis with worsening mood and anxiety symptoms and intensifying suicidal ideation, ultimately being placed on a selective serotonin reuptake inhibitor trial along with starting supportive therapy with a bilingual therapist. Marcos now states that their angst came from "within." Although no longer depressed, they continue to wonder: "Who am I, and who am I going to be in life? There have been strong independent women who have helped me and raised me, like my

mother, and if I am not a woman or girl, then who am I?" They continue to worry that by transitioning to a male or nonbinary gender, they might be betraying the strong women who have helped them such as their mother, and they struggle with any identification that could put them closer to the neglectful and abusive men in their lives, such as their father. "The guys in my life have been crappy, so I don't want to be like them at all."

Over time their mood brightened, and the self-destructive urges subsided. Their nonbinary gender identity has solidified, and they have felt less ashamed of themselves and more able to share this aspect of their identity with their mother. When Marcos decided to share with mother their gender fluid identity, "I eased mom into it. I have been starting to wear more guy stuff so that she would not be so surprised." However, they also "Sometimes still wonder where did I come from, and I start to feel useless. I will never hurt myself because I never want to hurt my mother, but then mom worries if she is not around, I won't have anything to live for." Mom became quite tearful when hearing this, admitting that it terrifies her to be the sole reason that her daughter will not act on their suicidal urges. Both mother and daughter admit that they survived their abusive husband/father by reaching out to each other, leaving them intertwined and scarred by their shared past trauma, and very much in need of mother-daughter family therapy.

A parent-child psychotherapy session was conducted at a follow-up session with the help of an interpreter. Marcos' mother was able to warmly and at times tearfully share with her daughter her many worries. She repeated that she loves her daughter more than anything on earth, that she loves her unconditionally, and that she will always love her. She voiced her pride for how intelligent her child is and her belief that her child will do great things. Her daughter shared how meaningful it was to hear this unconditional support. Marcos' mother voiced that she feels so thankful that they are living in the United States, as this is a far more accepting and tolerant society versus *the country they left behind. She has worked hard to overcome her tradition-bound cultural biases, in order to see her child as who they are.*

Following this session, the coauthor received the following note from Marcos: "I'm sorry it took us so long to send back the signed [consent for chapter publication] sheet; hopefully it's not too late, and you can still use it – I'd love to read the chapter when you're done with it! I'd also like to apologize for canceling our last appointment. Recently my mom and I discovered I could no longer have insurance, and we can't afford seeing doctors so I've been canceling any appointments I had. Meeting with you was amazing, though, I hope we can talk again. Thank you so much for all your help, both with my mom – so she can accept me – and also with myself, so I can, too, accept myself. By the way, my mom wants me to let you know she is extremely grateful as well. Take Care! Much Love and appreciation, Marcos."

Risk Factors from Within and Without

Sexual and gender minority youth, like Devon, Sam, and Marcos, develop within a family system and community and are buffeted by stigmatizing and shaming forces both within and surrounding them. Unfortunately, even in modern American society, most sexual minority youth will experience at least some degree of victimization or discrimination, sometimes at the hands of those closest to them. The Gay, Lesbian, and Straight Education Network (GLSEN) conducted a survey

of 7,898 sexual and gender minority middle and high school students in 2013 [25]. Over half (55.5%) of students indicated they felt unsafe at school because of their sexual orientation and 37.8% because of their gender identity or expression. In the past year, almost 75% had been verbally harassed, 36.2% had been physically harassed, and 16.5% had been physically assaulted (i.e., punched, kicked, or hurt with a weapon). Most students never reported these incidents to the school staff, and of those who did report, around two-thirds of the time, there was no response by school personnel. Students also reported that school personnel had limited them from identifying themselves publicly as a sexual minority (9.2%), writing about LGBT topics in school (17.5%), or attending a dance or similar function with someone of the same gender (18.1%). Transgender students similarly faced high rates of victimization and discrimination at school. Both Sam and Marcos have been very fortunate to be in school communities characterized by acceptance, progressiveness, and flexibility, celebrating the diversity among their students.

Marcos had struggled greatly in their home life at the hands of their abusive father, who threatened to sexually assault his gender-nonconforming daughter. Sexual and gender minority youth are more likely than heterosexual peers to experience adversity at home [26, 27]. Such adversity can include family rejection of one's sexual or gender identity accompanied by increased parent-child conflict [28], abuse or neglect [29], and in extreme cases expulsion from the family unit and youth homelessness [30]. In addition to adversity directly related to a youth's disclosed sexual orientation or gender identity, sexual minority adults generally report a more tumultuous childhood home environment. Adverse childhood experiences (ACEs) are a standardized set of childhood experiences that, in addition to childhood victimization, are predictive of a number of negative health outcomes later in life. ACEs include household mental illness or substance abuse, parental incarceration, parental divorce or separation, or exposure to domestic violence. Judith Andersen and colleagues [29, 31] have reported a higher overall burden of ACEs reported by sexual minority adults. The chaos and fighting between Devon's parents, which was exacerbated by her mother's alcohol use, contributed to Devon's feelings of isolation and fear and a sense of inner chaos that paralleled her external experience. She was at an increased risk for self-harming behaviors due to these stressors and her parents' separation and ultimate divorce.

Although data on all the ACEs are lacking, preliminary studies suggests that transgender adults experienced more abuse as children compared with matched cisgender peers [32, 33]. Marcos and Sam both endured significant adverse events in childhood, including domestic violence and threatened rape by Marcos' father, who was ultimately deported, and emotional abuse and neglect sustained by Sam in his biological family before he was adopted and emotional harassment for his gender identity by his father. While, in one sense, this put Marcos at risk for the development of a number of negative health outcomes over the course of their life, this tumultuous shared experience also strengthened the mother-child dyad, which ultimately has served a protective function for Marcos. Since early childhood, Marcos and their mother have enjoyed a strong bond despite Marcos's revelations to their mother about their minority sexual and gender identities. Marcos's revelation of their sexual orientation and gender identity to their mother was an emotional time for both of them, as *both* feared the loss of their treasured mother-daughter relationship, with Marcos stating that they will *always* be their mother's daughter Margarita in spite of their nonbinary gender identity and regardless of their pansexual orientation. Fields has written about her experience leading a support group for parents with sexual minority children. "Most parents came to their first … meetings seeking some way to recover from the loss they felt when their children told them they were lesbian or gay" (p. 170) [34]. The ability of Devon's parents to have a space in family therapy to speak directly with Devon as she worked on her internal experience of her gender and sexuality was essential for the family to better understand their dynamics and for Devon to step out of the position of being the

identified patient within the family. These discussions included the fear and sadness that Devon may be transgender. Later in the treatment, Devon's mother was able to speak to her disillusionment and disappointment that she was not the "feminine" daughter she had hoped for, but both her parents ultimately accepted her identity and supported her.

Dierckx et al. expanded on parents' experiences of coming to terms with their transgender children, which included strong emotions such as shock, loss, grief, shame, and guilt [35]. Marcos' mother did share that at first she felt as if she was losing her cherished daughter. The validation that Marcos's mother ultimately provided to them after coming out as pansexual (before they disclosed their nonbinary gender identity) was touching, reaffirming her unconditional love for her child and her commitment to accept Marcos for who they are. Despite the higher rates of parent-child conflict, such positive outcomes seem to be the rule rather than the exception. As the parents in Field's study talked with each other about their children, they became more accepting and reached a new sense of normalcy for themselves as parents of sexual minority children. "What started out to be such a dismaying and stressful situation in my life has turned out to be one of the most enlightening and positive things that has happened in my life" (p. 179) [34]. Parents of gender variant children had similar reactions over time: "Parents expressed a wide range of benefits from their experience in raising a gender-variant child. This most often related to being humbled by their child's courage, being aware of the need to be nonjudgmental and open minded, and being challenged in their preconceived assumptions regarding gender" (p. 190) [36].

On a larger scale, sexual [19] and gender [20] minority youth tend to be sensitive to stigma and shame that is largely communicated indirectly through social-cultural stereotypes, assumptions, and prejudices. Nonwhite sexual minority youth in the United States can find it difficult to integrate their sexual and racial identities due to what seems to be irreconcilable incongruence between the two. These are complicated issues as all aspects of identity development are lifelong, but they are especially pronounced in adolescence. Devon was able to use her therapy to create the therapeutic space to explore these issues, diminishing her fear that she would be experienced as "disloyal" to either parent and allowing her to be curious about all aspects of her identity, including race, sexuality, and gender.

Among some racial groups, the stigmatization of nonheterosexual people leads some youth to assume a heterosexual identity despite a nonheterosexual orientation and behavior [37, 38]. For others, a sexual minority identity may be adopted loosely but poorly integrated with other aspects of one's identity. Margaret Rosario and colleagues found that a sample of African-American and Latino youth reported limited disclosure of their identity, limited involvement in the larger sexual minority community, and lingering negative personal attitudes toward homosexuality [39]. Youth members of relatively heterosexist social institutions such as conservative religious groups can also face difficulty consolidating their sexual minority identities due to experiencing stigma and shame. Crowell and colleagues [40] found that a sample of 658 Mormon sexual minorities experienced significant stress when attempting to integrate their sexual and religious identities. While holding on to their cultural and racial identity, Marcos and Devon have been able to begin to consolidate their minority sexual and gender identities.

Sexual and gender minority immigrants often face challenges due to changing social, legal, and cultural climates as they navigate the transition from their country of origin to the United States. Seventy-five countries worldwide still criminalize same-sex sexual activity; some others have "propaganda laws" aimed at limiting public disclosure of one's minority sexual identity; certain cultures even condone the practice of "corrective rape" – in which an individual is raped in an effort to change their sexual orientation or gender identity [41]. While advances have been made in transgender rights around the world, significant challenges still exist, according to the most recent report by international watchdog organization Human Rights Watch [42]. International law has

sought to protect sexual minority youth from unfair treatment due to their sexual minority status. The 1989 *Convention on the Rights of the Child* was updated in 2011 to include a nonbinding addendum that basic human rights should not be withheld from children/adolescents based on sexual or gender identity [41]. Despite this, when a sample of 26 immigrants from 16 countries were interviewed by Alessi and colleagues [41], they reported instances in their native countries of stoning, caning, and public shaming, frequently reporting that they had nowhere to turn for help because their families, neighbors, teachers, and religious leaders were at times involved in the abuse. Because Marcos was very young when their family left Colombia, their mother is relieved that they will grow up in the United States where they will face far less torment for their pansexual nonbinary gender identity than they would have in their native country.

Not all of the developmental challenges faced by sexual and gender minority youth come from without. As Marcos clearly stated, their angst "comes from within." Sexual minority youth, in an effort to avoid shame or victimization, may try to hide their identity from others, sometimes for prolonged periods of time, due to internal conflict about their identity. The very process of socialization and adolescent identity consolidation is distorted, as the façade projected to others is based on deception, impacting all of their relationships including those within their families. These efforts tend to come at a psychological cost, with increased stress and fear of being found out, and higher rates of associated psychopathology [43]. Internalized homophobia, the phenomenon of reducing one's own sexual identity to stigmatized aspects, also tends to limit the degree to which teenagers are able to successfully integrate their emerging sexual identity with other core aspects of their identity. The incongruence between these mandated sociocultural and sexual aspects of identity and individual core identity, if persistent, can put youth at risk for what Erikson classically described as the psychosocial crisis of adolescence, identity versus role confusion, nicely captured in the case of Devon [5].

Loss, or the anticipation of loss, can also play a significant role in the distress experienced by gender and sexual minorities [44]. The majority of research has been regarding tangible loss, such as the loss of friends or family members due to rejection or financial loss due to employment discrimination, but a secondary form of loss in this group is "related to the shattering of assumptions, hopes, and worldview" [44]. As Fields writes, this often is the case for parents of sexual minority youth, as well as for youth themselves [34]. While unwavering in the face of the external stressors, Marcos found this anticipation of loss linked to feared maternal rejection due to their sexuality (and gender identity) highly significant with respect to their depression and self-injurious urges. Marcos was also worried that they would lose cherished aspects of their identity and possibilities for their future and betray the powerful and sustaining women in their life if they were gender nonbinary or trans, asking "Can I still be a feminist?" The resulting angst certainly fueled their "existential crisis" that led to significant depression, hopelessness, feelings of worthlessness, self-injurious behaviors, and consideration of suicide, as also captured in Devon's story (Table 13.2).

Sexual/Gender Minority Youth, Depression, and Suicide

Despite all of these potential stressors, most sexual and gender minority youth will navigate these developmental challenges successfully, growing into healthy young adults that are virtually indis-

Table 13.2 Summary of possible risk factors for sexual minority and trans*-youth suicide

Victimization	Abuse/neglect	Stigma/shame
Internalized homo-/transphobia	Family rejection	Homelessness
Substance abuse	Impression management	Depression
Gender discordant puberty	Gender dysphoria	Peer rejection

tinguishable from their peers [45–47]. For some, however, the challenges faced in adolescence will overwhelm their capacity for resilience, leading to emotional problems and self-directed violence. Shortly after Marcos, Devon, and Sam began to question their sexual and gender identities, fears about their future led to distress, depression, feelings of worthlessness, and despair. Devon became suicidal and began cutting herself as she felt that not being a "typical" cisgender, "feminine" heterosexual adolescent was causing further distress in her parent's marriage. Sam tried to jump from a moving vehicle when his parents refused to recognize him as a boy, and Margarita started to engage in non-suicidal self-injury and was seriously considering suicide but did not attempt it due to not wanting to hurt their beloved mother. It was at this point of crisis that Marcos, then going by their birth name Margarita, came to clinical attention for treatment of their depression. By maintaining a nonjudgmental and curious atmosphere, the child psychiatry fellow made Marcos comfortable enough to share their underlying angst fueling the depression. Marcos was ultimately diagnosed with gender dysphoria (GD) and major depressive disorder and treated with pharmacotherapy and psychotherapy.

Depression, anxiety, and substance abuse are all general risk factors for suicidal behavior in teenagers, and all occur with higher frequency among sexual minority youth compared to their heterosexual counterparts [3, 48, 49]. While depression and anxiety disorders are clearly more common among transgender youth compared to cisgender peers [47, 50], sparse data exists regarding disparities in substance use disorders between these groups [3]. Almeida and colleagues [51] administered a brief depression assessment measure to 1,253 high school students in Boston, MA. Of the students surveyed, those identifying as LGBT reported significantly higher average depression scores at assessment than their heterosexual peers. A meta-analysis of existing studies regarding disparities in depression rates indicated a significant effect of sexual orientation on depression symptoms [52]. Birkett, Newcomb, and Mustanski assessed a sample of 231 LGBTQ adolescents aged 16–20 using the Brief Symptom Inventory and found that psychological distress remained fairly high during the teenage years and decreased significantly by the early to mid-twenties [53].

The first large-scale report of the high rate of suicide among sexual minority youth was in 1989 when the US Secretary of Health and Human Services commissioned a task force on youth suicide. In it, the task force indicated that "they [sexual minority youth] may comprise up to 30 percent of completed youth suicides annually" [54]. This rate was challenged by prominent researchers who worked with this population due to concerns about population and measurement issues [55]. While this number might be an overestimate, further research has borne out that sexual minority youth remain at risk of suicide. An Institute of Medicine report in 2011 summarized the extant medical literature on sexual minority youth suicide as such:

> Over the past decade, an increasing number of studies based on large probability samples have consistently found that LGB youth and youth who report same-sex romantic attraction are at increased risk of suicidal ideation and attempts, as well as depressive symptoms, in comparison with their heterosexual counterparts (p. 147) [3].

Most recently, the 2015 Youth Risk Behavior Survey (YRBS) data for heterosexual and non-heterosexual students in grades 9–12 has yielded alarmingly high rates of suicidal ideation, planning, and attempts in lesbian/gay/bisexual youth in the 12 months prior to the survey (Table 13.3), leading to a flurry of media coverage [17].

Over 15,000 students across the country, aged 14–17, took the YRBS survey. The survey found

Table 13.3 Rates of suicidal thoughts, planning, and attempts in the 12 months prior to the 2015 Youth Risk Behavior Survey [17]

	Suicidal thoughts (%)	Suicide plan (%)	Suicide attempts (%)
Heterosexual	14.8	11.9	6.4
Lesbian-gay-bisexual	42.8	38.2	29.4
Not sure	31.9	27.9	13.7

that about 8% of the high school population described themselves as gay, lesbian, or bisexual, which would be about 1.3 million students. This was the first nationwide study to ask high school students about their sexuality, finding that LGB teens were at far greater risk for depression, bullying, and many types of violence than heterosexual peers. A Centers of Disease Control and Prevention (CDC) official was quoted as saying "I found the numbers heartbreaking." This survey did not include transgender youth, but the CDC and other federal health agencies are developing questions on gender identity to reliably survey transgender teens, which might be ready for a pilot test in 2017. A poignant *New York Times* review of the study notes:

> These adolescents were three times more likely than straight students to have been raped. They skipped school far more often because they did not feel safe; at least a third had been bullied on school property. And they were twice as likely as heterosexual students to have been threatened or injured with a weapon on school property.
>
> More than 40 percent of these students reported that they had seriously considered suicide, and 29 percent had made attempts to do so in the year before they took the survey. The percentage of those who used illegal drugs was many times greater than their heterosexual peers. While 1.3 percent of straight students said they had used heroin, for example, 6 percent of the gay, lesbian, and bisexual students reported having done so.
>
> "Nations are judged by the health and well-being of their children," said Dr. Mermin, who is the director of the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention at the CDC. "Many would find these levels of physical and sexual violence unacceptable, and something we should act on quickly" [56].

Estimating the prevalence of suicide death among sexual minority teens has been problematic because sexual orientation is not included on death records, and psychological autopsy studies are limited to identifying adolescents who may have self-disclosed a sexual minority identity prior to death [57]. In Denmark, where same-sex unions are documented, a study of all suicide deaths among people in registered same-sex domestic partnerships indicated a suicide rate around 3–4 times that of the general Danish population, indicating that there may be a truly increased rate of suicide deaths as well as suicide precursors among sexual minority adults [58].

Interventions

While there are no evidence-based interventions for prevention of depression and suicide among sexual minority youth, a compassionate, affirming approach to the assessment and therapy is recommended. A Practice Parameter is available from the American Academy of Child and Adolescent Psychiatry (AACAP) to guide the assessment of LGBT children and adolescents [59]. Assessment of sexual minority youth should include assessment for depression, anxiety, substance abuse, and signs of self-injurious behavior, suicidal thinking, planning, or behavior. Inquiring about risk and protective factors is crucial, including school climate; victimization; abuse; other adverse childhood experiences; strength of the family unit, peer, school, and community supports; and experiences of homophobia within their sociocultural milieu. It is also crucial to examine whether they are needing to hide a stigmatized identity and the psychological impact of this, which could include "impression management" (presenting a non-stigmatizing facade [23]) and "hiding" [43]. Clinicians need to assess the degree of internalized homophobia and the intensity of loss felt regarding heteronormative fantasies about their future. A safe space should be created allowing parents to voice their concerns regarding their child's sexual identity, their fears for their child, and their own sense of loss related to the child they thought they knew and the future they had imagined for their child. Evaluating the parent/s and child together facilitates an assessment of the parent-child relationship and helps to build a therapeutic alliance with both parents and children while guiding initial therapeutic interventions.

Peer support and support by school personnel have been shown to be correlated with better mental health outcomes [3]. Marcos' involve-

ment in their school's GLOW program for sexual minority youth not only allowed them to find support from others facing similar struggles but also allowed them to advocate for a more accepting school environment. Devon found similar support not in her school but in a community-based organization offering a support run by adults.

Larger societal support of the rights of sexual and gender minorities clearly plays a role in reducing the shame, dysphoria, and self-directed violence within the LGBT community. Raifman and colleagues found a 14% relative risk reduction in the proportion of adolescents who were sexual minorities reporting suicide attempts in the past year in states that had implemented policies affirming same-sex marriage [60]. Whether it was the policies themselves or the prevailing tolerance that allowed such policies to be adopted in the first place, this study demonstrates the positive impact of larger social attitudes on the well-being of youth in those states. This study also highlights the crucial role that mental health providers have in informing policymakers at the community, state, and national level that such policies will have a positive impact on individual children and adolescents. Marshall Forstein, M.D., president of the APA Assembly Caucus of Lesbian, Gay, Bisexual, Transgender and Questioning/Queer Psychiatrists, notes that marriage equality laws are reflective of social factors that lead to greater tolerance for sexual minority youth, in turn diminishing stigma and reducing stigma-driven psychopathology including suicide. "Marriage equality is a proxy for many changes in attitudes that create a matrix of social support for LGBT young people…. Increasing social tolerance creates the environment for increasing self-esteem" [61].

Caitlyn Ryan and her colleagues at the Family Acceptance Project have developed a family-based intervention for sexual minority youth with the aim of increasing support felt by the child from their family while simultaneously leading parents to accept their child's sexual identity [62]. While data are incomplete regarding the success of the intervention in treatment or prevention of poor mental health outcomes, there has been a great deal of data to suggest that family acceptance and support, in the absence of intervention, reduces the number of negative health risk behaviors and improves both physical and mental health outcomes [63–65]. Gently moving parents to a more accepting stance, in order to protect their child from negative health outcomes, is vital to provide this much needed support so that youth have somewhere to turn when faced with internal or external stress. In this spirit, therapy was pursued not only with Marcos but also with their mother, who continues to work on getting past cultural and personal biases so that she might better see her treasured child as *they* are. Extensive therapeutic work was done with Devon and her family. Her mother's alcoholism had not been validated by either of her parents as having had an impact on the family. The children felt as if the anger and disappointment their mother would express toward them when she was drinking was due to their behavior. They were bewildered by her shifting moods. Devon internalized her mother's anger, misattributing these painful feelings as stemming from her mothers' disappointment of who she was. She was "different" than she imagined her mother wanted her to be. However, she did not know how to be anything other than what she was coming to know as her "self." When the drinking was addressed in therapy, Devon recognized the origins of her distorted understanding of her mother's communications. Having a context for her mother's mood shifts was healing. But, her mother also needed to work on retrieving her projections within the family therapy, rather than externalizing her issues onto her daughter which in turn fueled Devon's despair and damaged her fragile self-esteem.

Evidence supports the powerful impact of gender transitioning as being correlated with a decrease in the rates of psychopathology in gender minority youth, including adolescent youth with persisting GD and transgender youth [66]. DeVries and colleagues conducted a longitudinal study of subjects with GD before medical interventions, after pubertal blockade, and following hormonal and/or surgical gender-affirming interventions; their findings included decreased rates of psychopathology at each stage of intervention,

such that post-intervention levels of psychological functioning were similar to cisgender controls [66]. In keeping with this literature, when Sam was allowed to transition to a boy, his impulsive, defiant, and risk-taking externalizing behaviors all dramatically decreased, and his depression remitted. His anxiety also significantly decreased without any psychopharmacological interventions. The literature has indeed found that psychopathology dramatically drops when transgendered children [67] and adolescents [66] are allowed to socially transition into their affirmed gender identity. The literature also supports that youth with persisting GD who go on to become transgendered adolescents tend to worsen in terms of their gender dysphoria during puberty as their body develops along the "wrong" gender line, as has clearly been the case for Sam [68]. Some exposure to puberty is diagnostically helpful in the identification of the children who have "persisting" or enduring gender dysphoria, as those youth tend to develop into transgender adolescents/adults. In such cases, offering medical interventions when indicated to assist with this transition to the affirmed gender – including pubertal blockade, cross-natal gender hormonal interventions, and gender-affirming surgical interventions such as mastectomies – can be in the best interest of the child. In particular, pubertal blockade is a reversible intervention that "buys time" (and minimizes the stress of pubertal bodily changes) to allow for gender identity consolidation. A full discussion of these interventions is beyond the scope of this article, but the evidence does suggest that when appropriately used, rates of suicide, self-injury, and psychopathology drop as the adolescent is supported in affirming his/her/their gender identity.

Edwards-Leeper et al. [69] review the affirmative practice literature for working with transgender and gender-nonconforming youth and suggest an expanded model to better serve this vulnerable population. Clinicians must consider the many complex variables that impact adolescent identity, including developmental, psychosocial, familial, and psychiatric factors. The authors state: "To be affirming of an individual's identity at one point in development, yet take into account the various unknown factors shaping that individual's identity, requires an approach that neither over- nor under-emphasizes the potential complexities involved in determining how gender fits into the larger picture for a given youth" (p. 166) [69]. Practitioners can help schools and families realize that only the individual child or adolescent can determine over time their gender identity and that we must follow their lead and avoid premature foreclosure as illustrated in the case of Devon. Devon had to contextualize her experience of her gendered self as she came to understand and verbalize her needs, wants, attractions, and feelings about her own body. This led to a deepening of her understanding of her sexual self. The intersectionality of race, religion, gender, and sexuality was worked and reworked as she worked to integrate these aspects of her identity with other parts of her identity.

There are many barriers to treatment, including the lack of providers trained in working with this population and insurance denials of coverage (including gender-affirming medical interventions) for transgender/gender-nonconforming/nonbinary youth or those with gender dysphoria, as captured in the case of Marcos. Clinicians are best served by supporting whatever gender or genders the child embraces and allowing the child to take the lead. It is crucial however that mental health providers and/or parents not foreclose gender options in either direction, for example, presuming that a gender-questioning child early in their social transition will remain on that same path, as it is not uncommon for younger children to shift course. For many children, especially younger ones, gender identity is still fluid, with many adolescents also clarifying aspects of their identity, including their gender identity. Devon's understanding of her gendered self evolved as she developed emotionally, cognitively, physically, and intellectually, gaining a better understanding of her gender and sexual identity. Clinicians must take a balanced approach so that the child does not feel trapped to be a certain gender and that gender identity is not foreclosed in an arbitrary manner. Many parents and providers struggle with nonbinary and gender fluid concepts, which might lead to the adolescent

feeling trapped to either revert to their natal gender or remain in a transitioned gender even if they start to question this. Adolescence is also a time of impulsivity and limited capacity to imagine life in the future, so a thoughtful mental health assessment for all gender-questioning teens is crucial, in order to identify best interventions and make certain that the central issues are related to gender identity. Adolescents are impacted by their environment and might feel pressure to remain in their natal gender or take on a transgender identity due to peer group influence as a way of connecting with others rather than stemming from underlying gender identity issues [69].

Conclusions

Affirming treatment interventions for sexual and gender minority youth include school-based interventions, psychotherapy for parents and their children, psychoeducation and support groups, psychopharmacological interventions to treat psychiatric issues, and medical gender-affirming interventions when indicated as guided by pediatric specialists. It is crucial that clinicians carefully examine their own biases and presumptions about gender and sexuality, lest these harm the children and adolescents under their care. Parents and providers are not the authors of their patient's and/or children's gender or sexual identities. Only the child or adolescent knows – or will know with support over time – who he/she is. It cannot be imposed. As child psychiatrist and urologist William Reiner, MD, eloquently stated earlier this century, regarding his work with children with disorders of sexual development and presaging the ongoing debate about gender:

> …[gender] identity is individual, unique and intuitive and…the only person who really knows what it is is the person themselves. If we as physicians or scientists want to know about a person's sexual identity, we have to ask them…..[70] In the end it is only the children themselves who can and must identify who and what they are. It is for us as clinicians and researchers to listen and to learn (p. 225) [71].

Understanding individual development and the various factors – which support and hinder it – is essential to developing a comprehensive formulation of children and adolescents presenting with concerns around sexuality and gender. Many children and adolescents will traverse development without seeking treatment, reflecting the resilience and support that many such youth have. However, clinicians must keep in mind that those who present for therapy are often struggling with issues at home, school, and in their communities, as well as struggling internally, leading to their distress. Due to the confusing and stigmatized nature of sexuality and gender, these children may present with self-harming behaviors as they deal with feelings of shame, anger, fear, and confusion. The clinician must thoroughly assess all sexual and gender minority youth for suicidality and self-harm. Furthermore, the clinician's role does not end at the office door – they must reach out to the family, school, and community to enable struggling youth to form life-sustaining connections with important adults and peers in their lives.

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14 Family and Community Intervention in Suicide Prevention and Management

Neha Sharma and John Sargent

"You can't help but slip into the system of competitive insanity … We are not teenagers. We are lifeless bodies in a system that breeds competition, hatred, and discourages teamwork and genuine learning. We lack sincere passion. We are sick … Why is that not getting through to this community? Why does this insanity that is our school district continue?"

Carolyn Walworth – reflection on suicide contagion by a student in Palo Alto

Introduction

Prevention of adolescent suicide is a challenge for any community. But, suicide in diverse youth is even more difficult to prevent. Minority youth have more risk factors in addition to a history of mental health disorders and substance abuse. Previous chapters have reported that stressful life events, such as acculturative stress, microaggression, discrimination, financial limitation, family stressors, and living in neighborhoods with limited resources, further contribute to suicidal behavior in diverse youth. Loss of cultural identity, experiences of intergenerational and generational trauma, and cultural distancing between family members from each other increase the chances of suicidal behavior. To add to it, mental health stigma and lack of culturally sensitive care deter families from receiving care in a timely manner. Furthermore, one of the major challenges of preventing suicide is the challenge to identify any suicidal youth. A suicidal youth is withdrawn and silent in their suicidal rumination over an extended period of time; thus, his or her behavior may not be as alarming for families and providers [1].

The previous chapters have indicated that suicide in diverse youth is closely related to community and family influences in addition to individual risk factors. This is largely due to the collectivist value orientation of the traditional cultures and families of origin. For example, the community's and family's attitude toward alcohol use and abuse directly impacts youth's peer relations and risk of abuse. Youth and family's probability to engage and adhere to treatment is influenced by their culturally influenced explanatory models and formulations of the cause of mental health issues [2]. Thus, appreciating treatment from the family's perspective is vital in order for it to be acceptable and successful. Additionally, often, diverse youth are members of collective communities. The current approach to prevent suicide is predominantly focused on individual intervention as indicated in Fig. 14.1 [3]. This rendition of the figure is

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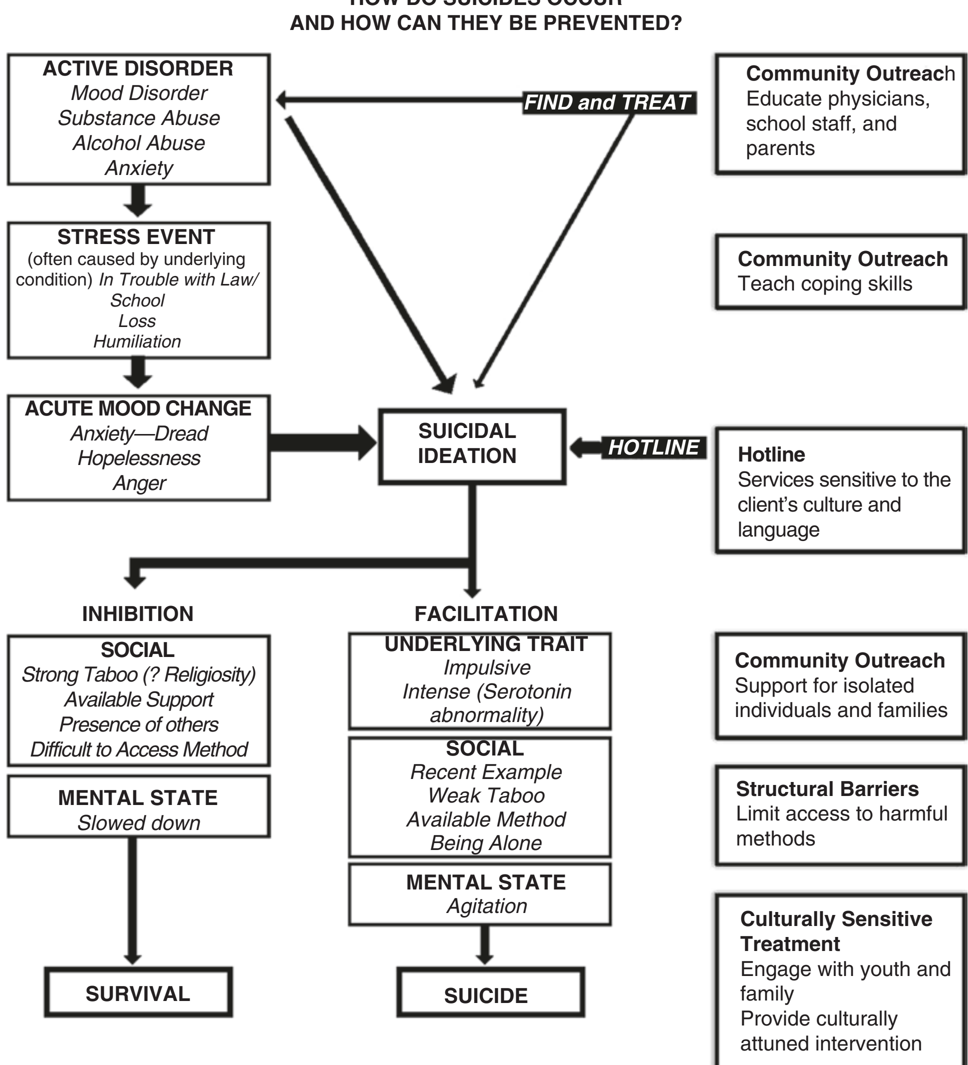

Fig. 14.1 American Academy of Child and Adolescent Psychiatry's suicide prevention model [3] (Reprinted from Shaffer and Pfeffer [3], © 2001, with permission from Elsevier)

modified to illustrate the role of culturally related predisposing, precipitating, and sustaining factors. Current research indicates that the use of generic treatments for ethnic minority youth has not been successful due to its irrelevancy and inaccessibility [4]. Furthermore, challenges of families of minority groups in implementing safety measures include:

1. Lack of economic resources in order to afford the safety measures
2. Higher chance of access to weapons due to positive correlation between rates of gun violence and low-income communities
3. More opportunities for self-harm due to these risks in the community (i.e., suicide by cop, public transport conveyance, and dangerous traffic)
4. Low public spending in minority community by city government
5. Lower level of outreach from suicide prevention interventions to involve minority communities to promote safety measures

To address the unique barriers suggested above and in the previous chapters, this chapter will be focused on family and community interventions to prevent suicide and manage youth suicidal behavior. Likewise, the core goal of suicide prevention is to reduce denial of suicide and attend to contributing mental health and psychosocial stressors. Similarly, reduction in discrimination and the experience of being disfranchised should result in decreased suicidal behavior.

There are many approaches to suicide prevention. To cover all the approaches comprehensively, suggestions for acute cases are discussed first. Then, specific treatments that have been known to reduce suicide are reviewed. Finally, mainstream and culturally based programs that increase awareness and decrease mental health stigma are discussed. In that order, this chapter is organized from the perspective of prevention addressed to the indicated population, the selective population, and then the general population.

Approaches for Acute Instances

The most important approach to address the acute instances of suicide is unrelated to race, ethnicity, gender, or class. The main goal at the critical time of suicide is to decrease access to the means of committing suicide and to ensure that methods are not lethal. Since it is challenging to predict when one would act on their suicidal thoughts, this approach is applied to all potential instances and means. An example of this is gun locks that prevent youth from triggering it impulsively, intentionally, or accidentally. Enhanced background checks and monitoring gun owners can result in a decreased misuse of guns in the hands of underage youth. It is important that gun owners receive education on gun locks and locations to keep guns safely that would limit access for youth and statistics around unintended deaths by gunshots. These educational programs should involve the youth as well since most children who survive gunshot suicide attempts often regret their decision later.

Additionally, sites that are potentially dangerous should have structural barriers to prevent suicide. For example, fences or physical barriers should be placed on roofs, bridges, and train tracks. Similarly, nets should be placed under bridges, school windows, roofs, and apartment buildings. Having bridge patrol teams 24 hours a day can also prevent youth suicide. These teams are often the first ones at the scene and can interfere with potential jumpers. Active verbal intervention of 15–20 minutes often is sufficient to change a youth's decision to end life. The prime example of suicide prevention is the Golden Gate Bridge Patrol that has been able to successfully intervene 84% of the time with a decline in confirmed suicides. The Patrol team also walks the sidewalks and looks for nonverbal signs of the individual contemplating suicide. Additionally, the team has a BOL "be on the lookout" phone number that family members or coworkers can call ahead when they suspect that an individual is headed to the bridge. Due to the growing number of attempts by individuals 34 and younger, a text crisis line has been added to the prevention model. The text crisis line is run by crisis counselor volunteers who have been trained. This service has been able to provide privacy and is able to reach large number of youth (80% of the users of this service are younger than age 25). The text line uses an algorithm that selects for terms correlated with acuity of text content. High-risk texts are responded within average of 1.8 min. For when there is concern about imminent risk or when de-escalation has failed, the location is sent to the dispatch services. This has resulted in average of eight active rescues per day [5].

Another example of a successful crisis and suicide prevention organization is the Trevor Project. It is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, and questioning youth. It is a perfect example of how an organization that started with giving voice to a minority youth, through the medium of a short film, turned into a national organization and spread from managing hotlines to creating meaningful changes in schools and college campuses. Currently, the Trevor Project provides several modes of communication for individuals who are in crisis – Trevor Lifeline (24/7 hotline),

TrevorChat, and TrevorText [6]. In addition, there is a plethora of training workshops for supporting youths and adults, such as free online learning modules, in-person workshops, suicide prevention training (CARE model – Connect, Accept, Respond, Empower), and training to introduce individuals to LGBTQ youths' needs. Additionally, Kognito Interactive has partnered with the Trevor Project to further influence college campuses by providing online and interactive training for students and faculty in higher education. Their partnership has also used the same model to impact students and faculty in 6th to 12th grade. In collaboration with American Foundation for Suicide Prevention, the American School Counselor Association, and the National Association of School Psychologists, the Trevor Project has created a roadmap to help school leaders establish or modify their suicide prevention policies. Community groups (TrevorSpace) consisting of local youth volunteers (Trevor Ambassadors) and leaders (Trevor NextGen) are spread across major US cities, providing social networking opportunities for youths up to 24 years old to advocate for LGBTQ youth mental health and suicide prevention. Furthermore, the advocacy for the cause and promoting policy change is supported by Trevor Youth Advisory Council and Trevor Advocacy Network.

Currently, suicide hotline numbers are provided in the community as a preventive measure to engage help-seekers. However, not all of the hotlines have multilingual counselors who can support a minority youth with the exception of major cities and states with higher diversity. According to the California Suicide Prevention Hotline Survey Report of 2011, six out of ten crisis centers report need for bilingual staff, and four out of ten centers reported need for more outreach and marketing efforts to better engage diverse communities, particularly those of LGBTQ and communities that are predominantly racial/ethnic minorities. The report also acknowledges the need for different outreach methods specific to the target community. For example, an Asian American community will require different outreach techniques compared to an African American or Hispanic community [7].

In more rural areas and less diverse regions, these hotlines are predominantly advertised to target the non-Hispanic white (NHW) youth. They are not found in areas where a minority youth or family visit frequently, such as ethnic food or clothing stores, places of worship, community centers, or other common places in ethnic enclaves. When they are found in an ethnic community, they are often not culturally sensitive or inviting for 1.5 or second-generation immigrants. Additionally, the multilingual counselors are usually Spanish speaking. For hotlines targeted to the Asian population, such as the Asian American Suicide Prevention and Education or the AASPE, the counselors may speak Cantonese and Mandarin but are less likely to speak other Asian languages such as Vietnamese, Tagalog, and Hindi [8]. Thus, due to the failure to target the minority audience and the presence of mental health stigma, minority youth are not able to utilize this already existing service effectively. To increase its effectiveness, suicide hotline services additionally need to be promoted in the language of the local community and in places that are frequently visited by minority youth and families. Additionally, these hotlines should be promoted in locations that are likely to be used for suicides – bridges, train tracks, building roofs, etc.

Furthermore, since one predictor of future suicide is a history of previous attempts and ideations, it is imperative that to prevent suicide, every troubled youth should have an identified clinician or a member in the community that they can speak to when contemplating. This also means that the responsible party – namely, the clinician or the community member – must respond and engage with the youth with support immediately. Lack of follow through at a critical time could lead to an increase in suicidal behavior. Similarly, hospitals and schools can identify an individual who could be contacted by youth at a time of crisis. All of these individuals need to be trained on how to manage such critical situations. It is recommended that after the initial contact, the youth is engaged in person and connected to a mental health clinician. This mental health clinician should be trained in dialectical behavioral therapy that focuses on emotional

regulation as an alternative to self-harm. In order for this preventive approach to be effective, involved community members and clinicians need to communicate well with each other. Needless to say, a dedicated team approach by community members could be successful in preventing youth suicide. Challenges to implementing higher engagement of key community members in preventing suicide include lack of resources to providing mental health training and funding the extra effort of these members to take on the additional role as a mental health counselor. For example, school counselors in schools with a high number of students of minority are often low in number and have poor funding that often fail to adequately fund the bare minimum of academic guidance, let alone personal and mental health guidance for their students.

Approach for High-Risk Individuals

Since previous suicide attempts can predict future suicide, the youth who have been identified as adolescents with suicidal ideation at school or in the emergency room should be connected to a mental health provider. Often, even when a family is connected, the youth or the family does not follow up. Thus, it is imperative that phone calls, home visits, or check-in by school staff is done to affirm and encourage follow-up. The most important reason to affirm follow-up is because adequate treatment is effective in reducing suicidal behavior. Wolk et al. [9] proved that anxious youth who responded to cognitive behavioral therapy (CBT) were less likely to experience suicidal ideation even 1 year after the treatment. Similarly, dialectical behavioral therapy (DBT) adapted for adolescents was found to be effective in reducing suicidal behavior for 1 year after the treatment [10]. Stanley et al. [11] combined elements of CBT and DBT to increase coping skills, reduce suicide risk factors, and prevent suicidal behavior in youth who had attempted suicide in the previous 90 days. CBT for suicide prevention (CBT-SP) was noted to be helpful to all the youth who were interviewed. See Table 14.1 for specifics of different phases of CBT-SP that can be further modified to be more culturally relevant to minority families.

The engagement with high-risk youth and family needs to be in culturally sensitive manner as discussed in Chap. 2. Cultures that promote collective values tend to encourage interdependent relationships. Thus, while considering prevention and intervention for ethnic minority youth suicide, it is vital that family members are engaged. However, feelings of guilt, concerns about privacy, and fear of shame need to be considered closely before full involvement of the family. Additionally, when working with second-generation immigrant, the level of family cohesion and interdependence can be difficult to assess. Thus, it is important to be open to the family and youth's preference for level of involvement while having family cohesion and establishing strong sense of identity as the ultimate goal.

Diamond et al. [12] endorse attachment-based family therapy (ABFT) as an approach to support families through their damaged trust and hurtful experiences to secure and meaningful relationships. The treatment is manualized such that incidents of abuse, trauma, and criticism that can occur in intergenerational immigrant families are uncovered and processed while maintaining a safe environment. Additionally, ABFT has been validated for adolescents with different mental health issues, such as eating disorder, anxiety, trauma, depression, substance abuse, and struggles of youth with sexual identity.

ABFT is based on theories of attachment, structural family therapy, and emotion-focused therapies. It asserts that parent-child attachment can be disrupted at a challenging time of mental health issues and related suicidal behavior. Since attachment is dynamic and ever-changing, the work of the therapist is to support it to become more secure. Improved attachment can be attained by focusing on the following five tasks: (1) relational reframe, (2) adolescent alliance task, (3) parent alliance task, (4) repairing attachment task, and (5) autonomy-promoting task [13]. Table 14.2 reviews the goal of each task.

In Task 1, the therapist joins the family members in their framework of the problem, validates

Table 14.1 Phases of CBT-SP [11]

Phase	Sessions	Summary of phase
Acute treatment		
Initial phase	1–3	Family members are involved in all of these initial sessions
		Chain analysis: within the first two sessions
		Development of a detailed chain analysis of events associated with the index suicide attempt or crisis. This is crucial to selecting intervention methods in later steps of treatment
		Safety planning: within the first two sessions
		Provides specific set of coping strategies and sources of support that can be used during a suicidal crisis based on the chain analysis. Includes means restriction
		Therapist and patient review each step of the plan and problem-solves obstacles to implementation of the plan
		Psychoeducation: within the first two sessions
		Educating the patient and family in areas of the initial phase of treatment, including discussing the nature of suicidal behavior, role of depression, and basic principles of CBT-SP
		Developing reasons for living and hope: third session
		Instilling a sense of hope by discussing personal reasons for living
		This is helpful to precede "coping with suicidal behavior" as this gives the intervention a personal context of "living"
		A concrete implementation of reasons to stay alive is also called a "Hope Kit," which serves as a memory aid in times of crisis
		Case conceptualization: third session
		At the end of the initial phase, a case conceptualization is developed based on the specific problems identified during the chain analysis and the corresponding strategies to address the problems
Middle phase	4–9	This phase is after the immediate suicidal crisis has resolved. Primary area of intervention in the middle phase of acute treatment is behavioral and/or cognitive skill training involving the individual and/or family. Different skill modules are chosen by:
		1. Review of the chain analysis and subsequent case conceptualization
		2. Assessment of the patient's strengths
		3. Identification of skills that are most likely to yield the quickest and effective results
		Individual skill modules
		Behavioral activation and increasing pleasurable activities
		Mood monitoring
		Emotion regulation and distress tolerance techniques
		Cognitive restructuring
		Problem-solving
		Goal setting
		Mobilizing social support
		Assertiveness skills

		Family skill modules: goal is to reduce risk by encouraging support and improve the family's problem-solving skills and modify communication patterns
		Family behavioral activation
		Family emotion regulation
		Family problem-solving
		Family communication
		Family cognitive restructuring
		Session structure for the middle phase: sessions are typically 1 hour in duration except for the first two sessions which are 1.5 hours due to the added family component. A usual session starts with the patient and therapist setting the agenda for the session and going through strategies from the previous session to check if they have been used in the meantime
End of acute treatment		
Relapse prevention task	10–12	"Relapse prevention task" marks the end of the acute phase treatment
		Preparation
		Review of the indexed attempt of suicidal crisis
		Review of the attempt or suicidal crisis using skills
		Review of a future high-risk scenario
		Debriefing and follow-up
Continuation phase	+10–12 sessions	Therapist may introduce new skills or continue to help the patient or family to learn and implement the skills introduced in the acute phase
		Termination:
		Explicit discussions of reactions to the conclusion of treatment
		Review of successful strategies that were learned in the therapy
		Goals that were accomplished as well as a discussion of whether treatment is needed for other problems the adolescent may be experiencing

Table 14.2 ABFT process and outcome goals for each task [12]

Task	Relational reframe	Adolescent alliance	Parent alliance	Repairing attachment	Promoting autonomy
Typical duration	1 session	2–4 sessions	2–4 sessions	1–3 sessions	4–8 sessions
Process goal	Attributional shift in how family members view the problem and solution	Better understanding of attachment narrative (i.e., thoughts, feelings, memories)	Shift in the parent's working model of the adolescent and their parenting role	Engagement in conversations that work through attachment ruptures	Parents effectively help adolescents resolve non-family-based problems (i.e., school, job, depression)
Outcome goal	Agreement to participate in relational focused therapy	Revived valuing of attachment and willingness to renegotiate it	Revived caregiving motivation Acquisition of emotion coaching parenting skills	Revised view of self and other and renewed interpersonal trust	Resumed negotiation of more normative issues related to adolescent development

the struggles of the adolescent, and then shifts the conversation to how the members can be part of the solution (and the problem not being the adolescent's alone). The family's love for each other and commitment to each other are highlighted as the vehicle to gain more a trusting relationship. The following two tasks – adolescent alliance and parent alliance – can occur simultaneously. During the adolescent alliance task, the goal is to connect with the youth while increasing their awareness of the impact of disappointments on their feelings. Once the adolescent has a better understanding of their needs, the goal is to support the adolescent to assert himself and ask for his needs to be met by the parents. During the parent alliance task, the therapist joins with the parents about their worries and concerns about their child. This task results in increased empathy from the parents while reemphasizing their caregiver role. Since parents can feel guilty about not seeing the "red flags" of suicidal behavior, the therapist takes a stance of compassion and reduces self-blame by highlighting the broader context of their individual struggles (i.e., marital, occupational, mental). Once the adolescent and the parents are in agreement about their relational difficulties, the therapist helps them rebuild their relationship in the repairing attachment task. This task is more skilled based where the therapist coaches the parents to respond in empathetic and supportive manner to their child. Practicing with therapist results in increased parental confidence such that it becomes easier to practice the skills at home. The last task, autonomy promoting, is for the family to problem-solve collaboratively to resolve their concerns. In this task, the family experiences competency in being able to resolve an issue without it becoming a tumultuous experience.

ABFT may also be culturally adapted to integrate traditional cultural values of minority groups, such as collectivism, and to build cultural congruence in therapy interventions for diverse at-risk youth populations. An example of this is a 1996 study by Santisteban et al. [14], which incorporates the strategic structural-systems engagement (SSSE) technique with the widely used brief strategic family therapy (BSFT) on 193 Hispanic families. SSSE is a specialized intervention targeted toward hard-to-reach minority youths who may be at risk for drug abuse. It is a planned and purposeful way of joining and diagnosing the family as one entity, from the first contact to the final therapy interview. In this study, 81% of the families successfully engaged in the treatment plan and had significantly improved outcomes compared to the two control groups, which did not include SSSE into their interventions [14].

Similar to ABFT and SSSE, Familias Unidas is an intervention that aims to prevent drug abuse and antisocial behavior in the Hispanic immigrant community by combining three parent-centered interventions to facilitate parent-adolescent bonding, familiarize parents with their children's extra-familial activities, and increase parent-parent bonding within the Hispanic immigrant community [15]. Though all three of these programs have not been proven to prevent suicide, they all address factors that increase suicidal behavior, and, in that regard, they can be considered suicide prevention programs.

Youth/Family Educational Approach

Educational programs that target specific populations with the purpose of destigmatizing mental health would also increase the chances of acceptability of interventions. The goal of these educational programs would be to demarginalize individuals with mental health issues by increasing health literacy of parents and youth in culturally sensitive ways through their preferred language. Thus, educational programs for all adults who come in contact with minority youth can be effective in preventing adolescent suicide. Specifically, healthcare providers, educators, religious leaders, community leaders, and police officers should be provided with programs about risk factors to suicide and about resources for challenging moments.

When healthcare providers – such as pediatricians, adolescent medicine doctors, nurse practitioners, and school nurse – are educated about the differential presentation and risk factors for suicide, they can identify mental health disorders. Often primary care providers have long-lasting relationships with families, placing them in unique position to educate families, to use culturally attuned screening tools, and to promote help-seeking behavior. It is often thought that educating large number of clinicians and staff members in rural area is a costly venture. To the contrary, Haggarty [16] showed significant increases in knowledge and improvements in knowledge and confidence in how to identify individuals at risk of suicide by providing education and training through multimedia. In the age of information, one can consider using videos and internet to educate providers in isolated regions.

Providers in the community can increase their awareness of the needs of the community members by engaging them early on. Establishing connections with the community cannot be overstated. Strong connections will allow providers to understand the cultural conceptualization of medical and psychiatric illness. When there is a shared understanding of causes of the illness, the approach to treatment and the approach to barriers can be established in a way that is acceptable to families. Primary physicians are in unique position to address mental health stigma and shame, motivate minority families to follow through with mental health services, and provide referrals to culturally competent services. Needless to say, this requires the provider to shed their own medicalized and American cultural approach. Additionally, it requires them to be open to different viewpoints and to be flexible with prevention and intervention approaches. To be more specific, please see Table 14.3 that specifies the goals of every provider and clinic working with minority youth**.**

The Massachusetts Child Psychiatry Access Project (MCPAP) [17] is a consultation model that incorporates a team of child and adolescent psychiatrists (CAP), care coordinators, and social workers who consult to pediatricians regarding mental health and behavioral care for the youth. The participating CAP educate the pediatrician about mental health interventions, guide them to

Table 14.3 Goals of providers and clinics that are in contact with minority youth

1.	Be aware of diagnostic bias (e.g., overdiagnosis of disruptive behavior in minority boys)
2.	Be aware of clinical assumptions
3.	Make the clinic, office, and process of engagement more culturally sensitive
4.	Be aware of common presentations
5.	Be aware of alternate explanation of the illness
6.	Address barriers to engagement and treatment
7.	Engage families as partners in the process

support the family, and refer to specialists when needed. This is critical for minority youth due to their low access to MH services and higher prevalence of cultural stigma. The MCPAP, since its pilot in 2005, has been largely successful in their ability to increase child psychiatry access for families. The success of this program in Massachusetts has led 30 other states, such as New Jersey [18], to adapt the program in their states. Of note, MCPAP has not been studied to reduce suicidal behavior, but it addresses risk factors that are associated with suicidal behavior.

Furthermore, the use of screening tools that have been validated for minority youth is vital to confirm that minority youth receive best quality care. Meanwhile, providers should educate parents on developmental milestones, appropriateness of self-discovery, and need for autonomy. Having conversations with families about how that may play out within the family culture can allow for a conversation that the adolescent may not be equipped for by themselves. Likewise, providers can discuss the importance of exercising, good sleep hygiene, and nutrition in the overall well-being of the adolescent. All of these factors have been known to impact mental health disorders significantly. History of poor sleep is highly correlated with the presence of suicidal behavior.

Model Approaches to Community Outreach and Prevention

Community outreach has many faces – discussions at churches, mosques, schools, temples, community centers, shopping centers, and local hospitals. All the preventive approaches for suicide in minority youth have one aspect in common – focus on general well-being and not just on suicide. This allows program developers to address multiple sources of suicide since it often occurs in the context of tumultuous relationships, low self-esteem, poor supervision, limited access to care, lack of family cohesion, and/or lack of a purposeful or meaningful role in the community. The focus on well-being requires paying attention to both protective and risk factors in youths' surroundings. Thus, the ideal approach to outreach to the community is multifold. First, there need to be more community clinics and youth centers in the local community that are prepared for suicidal behaviors and community incidents/disasters. It is vital for the providers to understand the minority paradox and in process work to decrease stigma among all minority communities. Community support requires advocacy for women who can impart their strengths to the children as role models. Additionally, enhancing the well-being of the community by stimulating jobs, creating youth programs, and supporting art programs results in improved mental health and more resilience in vulnerable youth. Readers must be aware that healthy youth are more likely to utilize community resources than at-risk youth. In order to engage withdrawn and isolated youth, community members have to be aware of and connected to all youths. Such outreach programs require dedication to the cause, time commitment, financial resources, and willingness to overcome inevitable pitfalls and barriers. It also requires that committed individuals are flexible with their role, structure and setting, and treatment approaches. Similarly, individual providers and community leaders have to become comfortable with mental health paradigms, so there is an increased acceptance of the program by the community and so that all work together.

Unique stressors faced by the youth include but are not limited to immigrant trauma, culture shock, and acculturation stress. Acculturative family distancing (AFD), substance use disorder, and bullying also occur at higher rates in immigrant populations [19]. Because of this, minority community education of suicidality via local media and community organization outreach, such as church programs, is necessary and beneficial to reduce suicides in minority communities. Examples of such community-specific models include Project SHIFA in Boston, which is a gateway provider model that begins broadly with community outreach and school education programs to identify at-risk refugee youths to engage them in group interventions, and finally individual trauma systems therapy [20]. Project Tam An [21] is another example which is an education program for the Vietnamese immigrant population utilizing local media resources to broadly spread awareness about youth suicide. Finally,

Ford-Paz's culturally tailored community-based participatory research (CBPR) model aims to raise awareness about depression in a culturally meaningful way and promote social connection and cultural enrichment activities for Latino youth [22].

In the process of addressing youth suicide, it is vital to address underlying causes and contributing factors in programs. May et al. [23] presented a collaborative program between Indian Health Services in New Mexico and Rutgers University to address the high adolescent suicide rate. The program was developed for 10–19 year olds who have self-destructive symptoms. The goal was to reduce adolescent suicidal behavior while increasing awareness about its risk factors. The program was developed with the focus to apply universal, selective, and targeted prevention methods. More specific goals included identifying risk factors specific to youth of the community, identifying youth and families at high risk for suicide and violence, implementing the program with high-risk youth and families, including treatment with mental health providers when appropriate, and providing education to increase awareness at the community level. The outreach to the community engaged key leaders in the community as well as elders and parents by conducting over 50 interactive workgroup sessions. The sessions were organized to elicit responses to the following questions: "What are the problems and issues in the community? What are the barriers to resolving these problems? What can be done to solve problems and overcome barriers?" [23]. The community members identified alcoholism, domestic violence, child abuse, and unemployment to be underlying causes of suicide. The engagement resulted in the development of a community mobilization project, which was started by Indian Health Services and Rutgers University, but sustained even after the project ended. Please see Fig. 14.2 to see the stepwise process of the Adolescent Suicide Prevention Project.

The lessons that were learned by the team are the following:

1. Underlying causes or contributing factors to suicide must be addressed in order to address the suicidal behavior.
2. In order for a prevention program to be successful, it must engage the local community early on, so the program is culturally adept to the community.
3. Additionally, the program must be flexible to allow for evaluations, feedback, and related modifications to align the program with the needs of the community.

The Adolescent Suicide Prevention Project was successful in reducing suicidal behavior in the local American Indian/Alaskan Native community, as shown in the data points taken from 1988 to 2002 in the Western Athabaskan Tribal Nation. The number of incidents of three different suicidal behaviors (gestures, attempts, and completions) and the number of total suicidal behavior in three different age groups (ages 11–18, 19–24, and ≥25) were measured. From 1988 to 2002, the number of suicide attempts decreased from 40 to less than 5 per year, and the number of suicidal gestures decreased from 30 to less than 10 per year across all age groups. Age-specific data shows the number of any suicidal behavior sharply decreased in children from ages 11 to 18 within the first 3 years of the implementation of the project, from 30 to less than 5 incidents per year. Overall decrease in the number of suicidal behaviors was also shown in the 19–24 and ≥25 age groups throughout the study period [23].

Despite its success, The Adolescent Suicide Prevent Project ended due to funding and change in leaderships' views. Sustainable funding is persistently one of the main reasons for suicide prevention programs to either not start or end prematurely. To address this, the American Foundation of Suicide Prevention raises money through its Out of the Darkness Walks. It is also known as "Overnight Walks" and is described by the following narrative: "As you walk over 16 miles through the night, you'll feel safe and cared-for in a community where everyone supports each other. It's a place to laugh, to cry, and

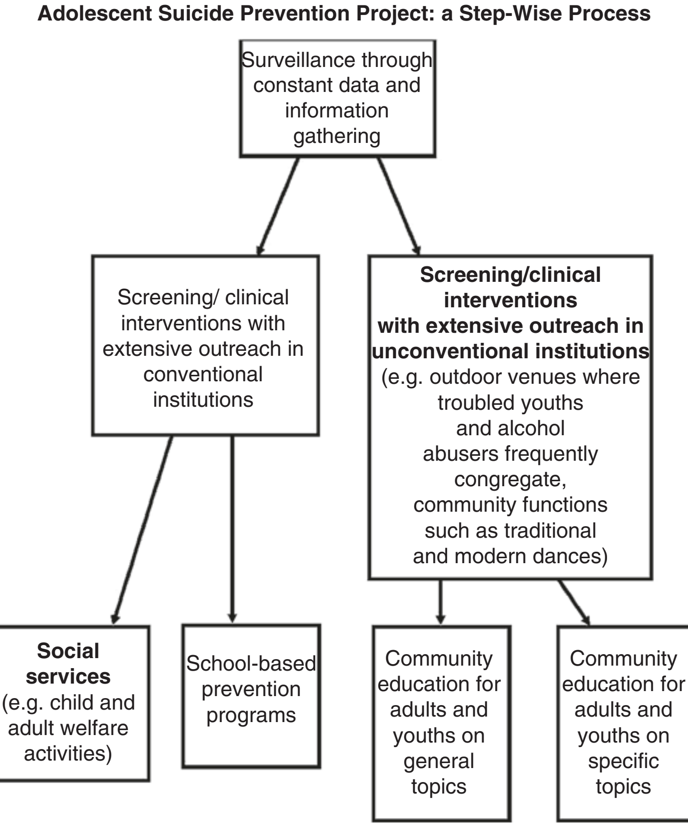

Fig. 14.2 Adolescent Suicide Prevention Project: a stepwise process [23]

to heal – to honor the past and embrace a future that your work will change for the better" [24]. Religion, being an integral part of many individuals and communities, has been stipulated to have both positive and negative mental health outcomes. However, it has been hypothesized to be a protective factor among African American youth because African American culture is deeply rooted in religion. Since religiosity and its practice are complex in nature, it has been difficult to validate hypotheses about its relevance in suicidal youth.

Connection with a Black church can overcome the impact of mental health stigma, lack of service availability in rural areas, lack of health insurance, and distrust toward mental health organizations that have been noted in African American community [25]. Molock et al. [26] tried to identify the connection between different types of religious practices and its effect on hopelessness in African American youth. He found that the youth who were active in church tended to report feeling less depressed and hopeless. Additionally, adolescents who coped by seeing God as an equal partner in their situations reported having more reasons for living. Thus, it is recommended that clinicians inquire about role of religion in a youth's life. Depending on the adolescent's acceptance of religion in their life, it may be valuable to connect with the youth's place of worship. Religious leaders often play an important role in the community. Thus, connection with them and consulting them as cultural interpreters could be meaningful in working with minority youth and families. Furthermore, providing education on risk factors for suicide to church leaders could result in early prevention and intervention of adolescent suicide.

A Gatekeeper Approach to Community Outreach

One community outreach approach is to educate traditional healers and community leaders in nonmental health settings, essentially individuals who can be "gatekeepers" in the community. These individuals are more likely to be in contact with vulnerable minority youth. Capp et al. [27] used a community gatekeeper training program to address high rate of suicide in the aboriginal communities in Australia. The training program focused on identifying key individuals of the community who were in a position to recognize youth at risk and make referrals. The first stage of the gatekeeper training program was in-depth consultation with minority youth and parents about appropriate strategies for suicide prevention in their community. The second stage involved the development of a training program which included eight free workshops in the local community. These workshops were delivered in ways that were engaging and relevant to the participants. As per Capp et al. [27] "The aim of the workshops was to increase the ability of the local community to identify individuals at risk of suicide, mobilize local informal helping networks and, where necessary, facilitate help-seeking behaviors." The workshops provided information about suicidal behavior, including early signs, ways to help, individuals in the community who agreed to be helpful, and how help can be provided. The goal here was to reduce barriers to help-seeking behavior. Additionally, the role of the mental health provider was clarified to reduce stigma. By the end of the workshops, participants had individualized "survival maps" that they could keep with them for future use. Pre- and post- training evaluations completed by the participants showed that the workshops resulted in significant increases ($P < 0.05$) in knowledge about suicidal behavior and confidence to identify at-risk youth. It was also noted that barriers to seeking treatment and referral were identified to be about trust, privacy, and confidentiality.

It is recommended that such gatekeeper approaches should be considered in culturally specific manners to prevent minority youth suicide. Molock [28] suggested that educating clergy and church members of Black churches may result in preventing suicides in African American communities. He believed that the religious and spiritual component of the community is protective and is more accessible to the youth [28]. Similarly, engagement of religions and non-religious leaders in the community by the gatekeeper programs can result in early intervention for youth suicide.

Community Outreach with Focus on Community Strengths

Allen et al. [29] developed a cultural suicide prevention program for Yup'ik youth in rural Alaska where high suicide rate was a concern. The program was named Elluam Tungiinun, which translates to toward wellness, by the local community planning group. Their study recognized that, as a component of this prevention program, they also had to assess safety and enforcement of alcohol prohibitions while also supporting community role models, supports, and opportunities for youth. The key aspect of this approach is that it acculturated the diverse youth to the protective values and belief of their traditional culture while strengthening their ethnic identity. The motivation for the community members to participate in this program was their identity, their pride in the cultural heritage, and their desire to address the issue of suicide. They created Qungasvik, a community toolbox, which suggests ways to adapt activities to reflect their customs and to support community ownership of the program. Over the 12 months, 26 prevention activities were delivered in 32 sessions which were 1–3 hours long. These modules were about suicide but also focused on increasing alcohol control, developing monthly prayer walks, and facilitating weekly meetings for the suicide crisis response team.

The depth of engagement that strengthened identity is exemplified by the following description:

> For example, in Murilkelluku Cikuq (Watch the Ice), youth travel out on the river ice with their families. Elder experts teach them how to

monitor the safety of the ice using visual cues and a tool called an ayaruk, a long, steel-tipped staff. A hook at the opposing end of the ayaruk allows a person to pull her/himself out of the water if the ice underneath gives way. This activity teaches the protective factor of ellangneq, of always being aware, in this case through specific awareness of the changing environment, one's relationship to it and actions in response. Following this activity, the group returned to the Qasgiq. Here Elders and parents discussed through personal narratives to discuss the connection of ellangneq to the lessons of ice safety, and implications regarding high-risk behaviour and valuing one's own life. In a follow-up session as part of this activity, each youth built her/his own ayaruk, which became a symbol of what they learned about ellangneq and of protection from suicide [29].

Additionally, to be supportive of the community, the elders in the community were encouraged to speak Yup'ik as their first language despite the youth's preference for English primarily. Again, this is to help the youth connect with their community and heritage while developing their individual identity. Allen et al. [29] culturally and linguistically adapted the community readiness assessment (CRA) tool to assess the community's response to this program. It evaluates different dimensions that include community efforts, community knowledge of the efforts, leadership, community climate, community knowledge about the issue, and resources related to the issue as listed in Table 14.4. A CRA was done pre-intervention and post-intervention by different community members, 1 year apart. By the end of the study, the CRA scores increased in community knowledge and leadership, indicating growth from developmental stage of vague awareness of the problem to the stage of preparation (see Table 14.5). The process of this study also resulted in an increase in adult protective factor behaviors and youth perception of community protective factors. The adult protective behaviors include talking to youth about excessive alcohol use resulting in loss of control, providing advice to the youth, keeping youth busy with activities, and volunteering for community youth activities. One limitation of this study was that the sample size was small.

Table 14.4 Dimensions of community readiness assessment [29]

Dimension A	Community efforts: to what extent are the efforts, programs, and policies that address the issue?
Dimension B	Community knowledge of the efforts: to what extent do community members know about local efforts and their effectiveness and are the efforts accessible to all segments of the community?
Dimension C	Leadership: to what extent are appointed leaders and influential community members supportive of the issue?
Dimension D	Community climate: what is the prevailing attitude of the community toward the issue?
Dimension E	Community knowledge about the issue: to what extent do community members know about the causes of the problem, consequences, and how it impacts the community?
Dimension F	Resources related to the issue: to what extent are local resources – people, time, money, space — available to support efforts?

Reprinted from Allen et al. [29], published by Taylor & Francis

Prevention Programs

Suicide prevention always starts with addressing underlying contributing factors and protective factors. This entails building and supporting relationships among youth and peers, parents, and community. Supporting relationships while increasing individual purpose would increase youth's self-esteem. Having a meaningful role and tasks in the community results in feeling valued. Furthermore, family activities that increase family and community cohesion are needed to make sure that the family and community can support vulnerable youth and supervise them when needed.

One such exceptional school program that balanced the individuality of the community while integrating an effective prevention program is American Indian Life Skills Development Curriculum (AILSDC) [30]. It is a derivative of the Zuni Life Skills Development Program that was established to address the high rate of suicide

Table 14.5 Stages of community readiness [29]

1. No awareness	Issue not recognized as a problem
2. Denial/resistance	Issue recognized but not as occurring locally
3. Vague awareness	Local concern recognized, but no immediate motivation to confront
4. Preplanning	Recognition of concern but efforts unfocused
5. Preparation	Active planning and modest community support
6. Initiation	Effort justified by community and activities underway
7. Stabilization	Activities supported by leadership with trained and experienced staff
8. Confirmation/expansion	Efforts in place, community support expansion, local evaluation
9. High level of community ownership	Sophisticated knowledge, evaluation, application of model to other issues

Reprinted from Allen et al. [29], published by Taylor & Francis

in the Zuni tribe. The program was a partnership between the Zuni Public School District and the faculty from Stanford University. This program was developed over 3 years during which Zuni community leaders would consult on the applicability of the program to their youth. The tribe specifically wanted to address risk factors associated with adolescent suicide. Thus, the curriculum focused on building self-esteem, identifying emotions and stress, increasing communication and problem-solving skills, recognizing and eliminating self-destructive behaviors, and learning about warning signs of suicide. The program provided suicide crisis intervention training and engaged in individual and collective goal setting.

The program was developed by culturally adapting the interventions. Its success was largely dependent on the partnership in curriculum delivery by a Zuni teacher and a non-Zuni person. When topics that were related to community integrity or issues of privacy came up, the Zuni teacher communicated only in Zuni language with the students. The content of these conversations were rarely shared with the non-Zuni team. This allowed for a level of respect such that confidential customs of the community were not revealed to the outside community. Additionally, the curriculum was started by the Zuni leader – by focusing on Zuni values of community cohesion, knowledge of one's history, fortitude, and resistance [30].

After discussing community values, the students discussed how members of the tribe overcame community-specific struggles. This phase of the curriculum also emphasized how psychological stress manifests itself in culture-specific manners. The next part of the curriculum was focused on a skill-building activity that supported social emotional regulation. For the treatment phase, effective and relevant components of cognitive behavioral strategies were identified. These strategies were further modified with the help of the community members to make them culturally relevant. For example, in the goal setting component, community goals were added to the personal goals.

This curriculum was conducted three times a week during language arts classes during the first year of the intervention. Booster sessions took place during the third year of the intervention. Multiple evaluations, including self-report, behavioral observation, and peer rating, showed that the intervention resulted in decreased suicidal thoughts and feeling of hopelessness and increased problem-solving skills and suicide intervention skills.

Despite its success, this program was terminated due to multiple factors. Often such culturally oriented programs need to be supported at many levels – politically, locally, and by the school. Additionally, the success of the program

resulted in misperception that the problem of suicide was solved. Advocacy for continued treatment was limited and resulted in stakeholders pulling out. Lastly, despite the program's best efforts to protect privacy, in a small community, it was difficult to maintain privacy. Additionally, in incidents where family dysfunction was believed to be the contributing factor to youth suicide, the families felt blamed. Their guilt was a barrier to utilizing the program effectively.

Role of Media in Adolescent Suicide

When specifically addressing youth, the additional goal is to deromanticize suicide. To the contrary, media's portrayal of a celebrity's suicide tends to be sensational and overdramatic in nature. The glorification of the celebrity results in increase in suicide within 3-week period after coverage of a celebrity's suicide [31]. It is believed that overidentification with the celebrity results in creating a meaningful connection increasing suicidal impulses. Thus, glorification of the suicide can result in an imitation effect, specifically among individuals with prior history of suicidal ideation or behavior. Repeated and explicit coverage with extensive details can lead to suicide contagion. In the Internet era, one does not have to search far for news on suicide. Youth, who often communicate through social media, have news alerts sent to them through multiple mediums. Therefore, media has a higher responsibility to disseminate information in socially responsible ways. Besides not glorifying the victim, media must also emphasize levels of distress experienced by him or her and the family. Resources about suicide prevention must be provided simultaneously.

Adolescent suicide can be "contagious" as it can occur in clusters due to shared expression of hopelessness, and it presents suicide as an option to the youth. When the suicides occur in clusters, defined as three or more suicides that occur in geographical and temporal proximity by US Centers for Disease Control and Prevention (CDC) [32], media pays more attention which further romanticizes suicide. Media's excessive attention creates a sensation of victims being heroes or martyrs. Furthermore, availability of social media and access to news in seconds result in vulnerable youth having an excessive amount of details of the incidents that they may not be able to process. Thus, when at-risk students overidentify with victims, they are more likely to harm themselves. An example of this occurred in Palo Alto, California, in 2009 and 2010 and again in 2014 and 2015. During 2009–2010 period, five Henry M Gunn High School students committed suicide. In 2014–2015, four students from Gunn and one from Palo Alto High School committed suicide. Two of them walked in front of a Caltrain train which peers often used to commute to school. Of note, these teenagers were from affluent communities and attended a school with a plethora of resources. (This only exemplifies that mental health concerns and teen suicide occur among all classes.) Three of these adolescents were of Asian heritage. Though heritage may have less to do with this occurrence and more with the level of competition that exists in the school of the affluent community, it is not difficult to imagine the contagious experience of emotional pressures when 42 Gunn students were treated or hospitalized for suicidal behavior in less than a year in 2015. Additionally, since 2011, federal agencies have conducted similar suicide cluster inquiries in Fairfax County, Virginia, and two Denver counties [33].

In contrast to media's response to clusters of suicides, individual suicides are rarely covered in news. The lack of coverage results in community members not challenging stigma and silence concerning suicide. This is a lost opportunity to educate the community, to demarginalize the high-risk youth, to engage the parents, and to raise awareness among health providers and the school system. A pilot project named Tam An attempted to take on this lost opportunity. They used media in the Vietnamese American community to raise mental health awareness by engaging community resources and by following the community readiness model. Messages to destigmatize mental health and promote initiation of mental health treatment

were spread throughout the community via local ethnically and culturally accepted media sources.

Conclusion

In conclusion, suicide prevention is challenging. It is difficult to identify who will commit suicide and who will not. When we discuss suicide, we are truly discussing an intricate interface between different perspectives: feeling of belongingness, feeling worthy, mental health disorders, and support of the family and community. To add to that, since family and community is a vital channel of acceptance, suicide prevention also entails efforts to be just and inclusive. Thus, suicide prevention is essentially about creating a just, inclusive, rewarding, and humane society. All the programs and organizations suggested above do exactly that – create a path of acceptance while making individuals feel desired. Needless to say, suicide prevention is not solely a medical objective. Rather it is a political, social, and family goal that focuses on well-being. And, in the process, it is about integrity. To prevent teen suicide, communities, families, and youth must promote the value of every teen's life honestly and consistently.

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Resources

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American Foundation for Suicide Prevention.
Trevor Project.
Familias Unidas.
Massachusetts Child and Adolescent Provider Access Program.
Asian American Suicide Prevention and Education.
Tam An Project.

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