



# **Understanding Suicidal Behavior Among Latin Adolescent Girls**

## **Living in the United States**

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## **Abstract**

Suicide in adolescents between the age of 10 and 24 years old is the second cause of death in the United States. This rate differentiates by ethnic and racial groups within the same country; Latino/Hispanic adolescent girls have the highest rate of suicide behavior. Considering that Latino/Hispanic is the fastest growing minority group in the nation, with an expected population of 30% by 2060, this issue should be a public health priority.

This paper answers the following question: what are the conditions operating among Latin adolescent girls living in the United States that cause significantly higher suicidal behavior rates in the U.S. and compared with their peers in Latin American countries? And, how adequate are treatments such as Dialectical Behavioral Therapy and prevention programs in tackling the specific risk factors affecting this population?

The paper is divided into five chapters; the first four are based on a comprehensive literature review of statistics of suicide, risk and protective factors, treatment, and prevention programs. The last chapter offers an analysis of the sociological phenomenon of suicidal behavior in this population and three brief narratives of attempters and non-attempters.

Studies show that subjective distress, familism and immigration issues are the key risk factors of suicidal behavior in Latina adolescent girls. Understanding the risk factors is key in order to design promotion and prevention programs that are culturally relevant and that can have a positive impact in the reduction of this alarming phenomenon.

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## Acknowledgements

My interest in this topic began during the course I took on the fall 2015 semester called “Global Mental Health” in which I learned the meaning of acculturation and idiom of distress; the relevance of adapting treatment and prevention programs to be culturally relevant in order to be efficient; and the importance and uniqueness of culture and the impact it has on mental health. In class we read different cases, including some of Latin people and the difficult mental and physical health issues they face when living in the United States. Additionally, I have always had a particular interest in mental health of children and adolescents. With this background and context of the course I started researching and found this concerning statistic about suicidal behavior in Latina adolescent girls and I decided I wanted to understand what is happening to these girls in order to try to find a way to change the statistics.

I want to thank my supervisor Prof. Edward Tiryakian who guided me through this journey and helped me define the scope of the project. He was always on the lookout for information released in scholarly articles and newspapers so that I could have the most updated data in my paper. He also taught me about Sociology and the relevance of Durkheim’s study *On Suicide* for my paper. I want to thank the professors I had during my master’s degree because they shared with me their passion for research, writing and for doing work that could have a positive impact in the communities in which we live.

Finally, I want to thank my husband, my family and friends for all their support during the time that I was writing this project.

## Introduction

Suicide is a serious health issue around the world. In the United States, suicide is the second cause of death among adolescents between the age of 10 and 24 years old (Center for Disease Control and Prevention, 2014), representing approximately 15% of the deaths within this age range. Suicidal behavior ending in fatality is only part of the problem; it is known that more adolescents survive suicide attempts than actually die (Center for Disease Control and Prevention, 2015), according to the Substance Abuse and Mental Health Service Administration (SAMHSA), there are more than 25 attempted suicides for each suicide death. Each year around 157,000 adolescents receive medical care for self-inflicted injuries at emergency departments across the country (Center for Disease Control and Prevention, 2015) accounting for approximately \$1 billion in treatment for failed attempts and up to \$30 billion in lost productivity (qtd. in Lorenzo-Luaces and Phillips 458).

Suicide mortality and suicidal behavior (ideation and attempts) rates differentiate by gender and by ethnic and racial groups. Sources like the Center for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) confirm in their reports that males are four times more likely to die from suicide than females, but females are much more likely to have suicidal behavior which is associated with hospitalization, possible future attempts and possible future death. Regarding the ethnic and racial groups, Native American and Alaskan Native youth have the highest rates of suicide-related fatalities (Center for Disease Control and Prevention, 2015), while Latin/Hispanic adolescents, and especially females, have the highest suicidal behavior rates. "Adolescent Latinas between the ages of 14 and 18 years



are almost twice as likely to plan or attempt suicide than non-Hispanic White or African American adolescent females” (Center for Disease Control and Prevention, 1996, 2008, 2012).

The Hispanic population in the United States as of July 1<sup>st</sup>, 2014 was of 55 million people, 17% of the country’s total population (United States Census Bureau). By the year 2060, it is expected that the Hispanic population will constitute 28.6% of the nation’s population with a number of 119 million people (United States Census Bureau). Because people of Hispanic origin are the largest ethnic or racial minority in the country and the fastest growing one, the phenomenon of high suicidal behavior in this population should be considered a public health issue.

It is extremely important to note the fact that when talking about the Latin population in the United States we are talking about more than fifteen different subgroups (for example: Cuba, Costa Rica, Dominican Republic, Mexico, Puerto Rico, etc.). It is a limitation to cluster several Hispanic subgroups together and I will try, to the extend possible, to talk about each group independently although for most of the paper they will be considered as one group. It is also important to note that throughout the paper I will refer to Latin adolescent females also as Latin adolescent girls, Latina adolescents, Latina youth, Latin youth girls and/or Latino/Hispanic adolescent girls.

The goal of this paper is to understand the conditions operating among Latin adolescent girls living in the United States that cause significantly higher suicidal behavior rates compared with their peers in the United States and Latin American countries. This goal will be pursued by doing a comprehensive literature review of several topics and ending with an analysis to provide my understanding of the phenomenon of suicidal behavior in this population.

The first chapter presents suicide mortality and suicidal behavior rates that are available for the United States population through the Center for Disease Control and Prevention and the United States Census Bureau. For the comparison rates with Latin American countries, statistics available within each country will be used. The importance of having this data available is to understand the magnitude of the problem and as a consequence, to make a call of action to improve treatment and prevention programs that can inhibit suicidal behavior, themes that will be further discussed in chapters three and four.

The second chapter focuses on understanding the main risk and protective factors that are specific to Latina adolescents towards their suicidal conduct. Studies show that subjective distress, familism and acculturation (terms that will be defined on page 24), and immigration issues are the key risk factors of suicidal behavior in Latina adolescents.

Chapter three explores the available treatments for suicidal adolescents focusing on Dialectical Behavioral Therapy (DBT) and analyzing if this treatment is adapted to be effective in the Latin population. Dialectical Behavioral Therapy is a comprehensive cognitive behavioral treatment that was developed by Marsha Linehan and colleagues for the treatment of suicidal behavior in adults with Borderline Personality Disorder (BPD). Rathus and Miller adapted DBT to adolescents (DBT-A) with BPD with recurrent suicidal behavior and non-suicidal self-injury.

In chapter four I discuss whether prevention programs are effective in protecting adolescents from suicide. The goal is to understand if these school-based programs are built to treat the specific risk factors of the Latin population.

The last chapter offers a discussion, based on the facts examined in the previous sections, of the phenomenon of suicidal behavior in Latina adolescents. For this interpretation and analysis

I use Durkheim's sociological theory on suicide. Émile Durkheim was a pioneer of sociological method and he played a key role in establishing sociology as an academic discipline in France in the late nineteenth century and early twentieth century. Durkheim said that "less psychology and more sociology is required to make any sense of why some groups more than others might kill themselves" (Durkheim xvi). At the end of the chapter, I describe two narratives of attempters and one non-attempter in order to analyze the risk and protective factors that are present in these girl's lives.

# Chapter One

## Statistics of Suicide

### 1.1 Statistics within the United States of America

Suicide is the second highest cause of death among adolescents between the age of 10 and 24 years old in the United States of America (Center for Disease Control and Prevention, 2014), resulting in around 5,500 lives lost each year.

**10 Leading Causes of Death by Age Group, United States – 2014**

Rank	Age Groups										Total
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 4,746	Unintentional Injury 1,216	Unintentional Injury 730	Unintentional Injury 750	Unintentional Injury 11,836	Unintentional Injury 17,357	Unintentional Injury 16,048	Malignant Neoplasms 44,834	Malignant Neoplasms 115,282	Heart Disease 489,722	Heart Disease 614,348
2	Short Gestation 4,173	Congenital Anomalies 399	Malignant Neoplasms 436	Suicide 425	Suicide 5,079	Suicide 6,569	Malignant Neoplasms 11,267	Heart Disease 34,791	Heart Disease 74,473	Malignant Neoplasms 413,885	Malignant Neoplasms 591,699
3	Maternal Pregnancy Comp. 1,574	Homicide 364	Congenital Anomalies 192	Malignant Neoplasms 416	Homicide 4,144	Homicide 4,159	Heart Disease 10,368	Unintentional Injury 20,610	Unintentional Injury 18,030	Chronic Low. Respiratory Disease 124,693	Chronic Low. Respiratory Disease 147,101
4	SIDS 1,545	Malignant Neoplasms 321	Homicide 123	Congenital Anomalies 156	Malignant Neoplasms 1,569	Malignant Neoplasms 3,624	Suicide 6,706	Suicide 8,767	Chronic Low. Respiratory Disease 16,492	Cerebro-vascular 113,308	Unintentional Injury 136,053
5	Unintentional Injury 1,161	Heart Disease 149	Heart Disease 69	Homicide 156	Heart Disease 953	Heart Disease 3,341	Homicide 2,588	Liver Disease 8,627	Diabetes Mellitus 13,342	Alzheimer's Disease 92,604	Cerebro-vascular 133,103
6	Placenta Cord. Membranes 965	Influenza & Pneumonia 109	Chronic Low. Respiratory Disease 68	Heart Disease 122	Congenital Anomalies 377	Liver Disease 725	Liver Disease 2,582	Diabetes Mellitus 6,062	Liver Disease 12,792	Diabetes Mellitus 54,161	Alzheimer's Disease 93,541
7	Bacterial Sepsis 544	Chronic Low Respiratory Disease 53	Influenza & Pneumonia 57	Chronic Low Respiratory Disease 71	Influenza & Pneumonia 199	Diabetes Mellitus 709	Diabetes Mellitus 1,999	Cerebro-vascular 5,349	Cerebro-vascular 11,727	Unintentional Injury 48,295	Diabetes Mellitus 76,488
8	Respiratory Distress 460	Septicemia 53	Cerebro-vascular 45	Cerebro-vascular 43	Diabetes Mellitus 181	HIV 583	Cerebro-vascular 1,745	Chronic Low. Respiratory Disease 4,402	Suicide 7,527	Influenza & Pneumonia 44,836	Influenza & Pneumonia 55,227
9	Circulatory System Disease 444	Benign Neoplasms 38	Benign Neoplasms 36	Influenza & Pneumonia 41	Chronic Low Respiratory Disease 178	Cerebro-vascular 579	HIV 1,174	Influenza & Pneumonia 2,731	Septicemia 5,709	Nephritis 39,957	Nephritis 48,146
10	Neonatal Hemorrhage 441	Perinatal Period 38	Septicemia 33	Benign Neoplasms 38	Cerebro-vascular 177	Influenza & Pneumonia 549	Influenza & Pneumonia 1,125	Septicemia 2,514	Influenza & Pneumonia 5,390	Septicemia 29,124	Suicide 42,773

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC.  
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.



Figure 1: 10 Leading Causes of Death by Age Group, United States – 2014  
Source: National Center for Health Statistics, CDC

The most recent suicide rates published by the National Center for Health Statistics indicate that in 2014, in the age group of 10 to 14, 2.6 boys and in the age group of 5 to 14, 1.5 girls in 100,000 people killed themselves; and in the age group of 15 to 24, 18.2 boys and 4.6 girls in 100,000 people committed suicide. Additionally, the report indicates that suicide rates for females in all age groups under 75 years old have significantly increased since 1999.

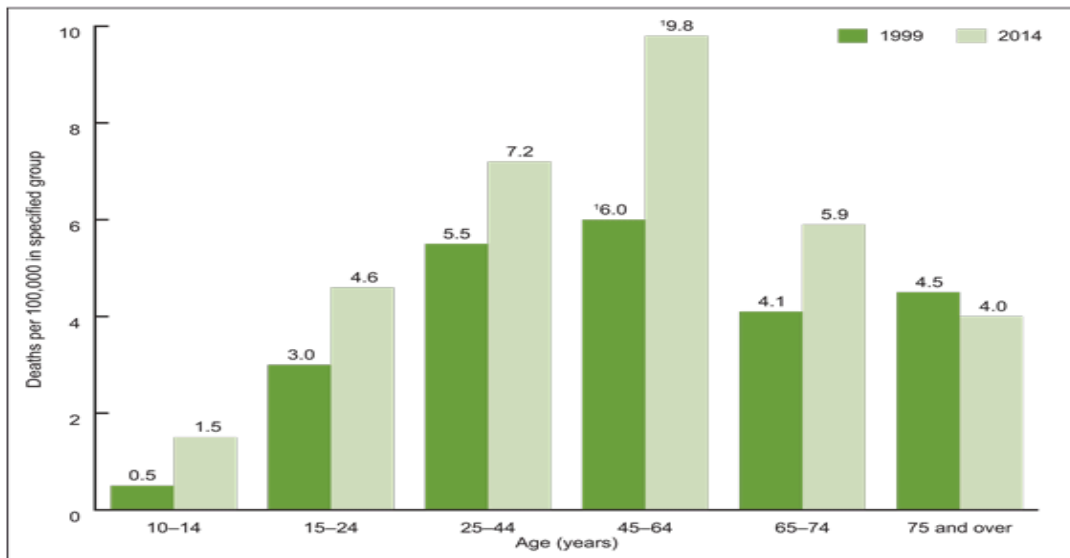


Figure 2: Suicide Rates for Females by age: United States, 1999 and 2014  
 Source: National Center for Health Statistics, National Vital Statistics System, Mortality. CDC

Every two years the Center for Disease Control and Prevention conducts a nationwide survey that uses a representative sample of students from 9<sup>th</sup> to 12<sup>th</sup> grade in public and private schools in order to monitor priority health risk behaviors that contribute to the leading causes of death, disability and social problems among youth. The group of surveys that monitor the health risk behaviors is called the Youth Risk Behavior Surveillance System (YRBSS). The 2013 survey sample size was of 13,583 students. Results reveal that 17% of students reported seriously considering attempting suicide, 13.6% reported creating a plan about how they would attempt

suicide and 8% reported trying to take their own life in the 12 months preceding the survey (Center for Disease Control and Prevention).

Results from the YRBSS survey also show that these rates differentiate by ethnic and racial groups. The percentage of Hispanic students who seriously considered attempting suicide was of 18.9% versus 16.2% of whites and 14.5% of blacks. Almost 16% of Hispanic students made a plan of how they would attempt suicide versus 12.8% of whites and 10.4% of blacks. Eleven percent of Hispanics attempted suicide versus 8.8% of blacks and 6.3% of whites, and lastly 4.1% of Hispanics made a suicide attempt that resulted in an injury, poisoning, or overdose that required medical attention versus 2% of whites and 2.7% of blacks.

Rates also differentiate by gender and even though males take their lives at nearly four times the rate of females (Center for Disease Control and Prevention), females are more likely than men to have suicidal behavior (SAMHSA). Results from the YRBSS survey found that 22.4% of females considered attempting suicide over the past year versus 11.6% of males. According to the Center for Disease Control and Prevention, Latino/Hispanic adolescent girls between the ages of 14 and 18 years old are almost twice as likely to plan or attempt suicide than non-Hispanic White or African American adolescent girls.

It is important to know the location of the students with high suicidal ideation and identify if these locations have a higher concentration of Latin population. The states with the highest population of Hispanic people (1 million or more) according to the United States Census Bureau are: Arizona, California, Colorado, Florida, Illinois, New Jersey, New York and Texas. Results from the YRBSS show that Alabama (4% = 200,664\*), Arizona (30.5% = 2,056,455\*), Arkansas (7% = 208,821\*), Hawaii (10% = 143,239\*), Illinois (16.7% = 2,152,974\*), Louisiana (4.8% = 224,867\*),

Mississippi (3% = 88,937\*), Montana (3.4% = 35,362\*), Nevada (28% = 790,034\*), North Carolina (9% = 894,276\*), Texas (38.6% = 10.4 million\*) and Wyoming (10% = 57,065\*) have the higher percentage of students who seriously considered attempting suicide during the 12 months before the survey in 2013 with a range of 16.7% to 19.2%. When we look at the percentage of students that did attempt suicide, Montana, Texas and Wyoming are not in the highest range and instead we see North Dakota and Rhode Island, additionally, North Carolina did not ask this question.

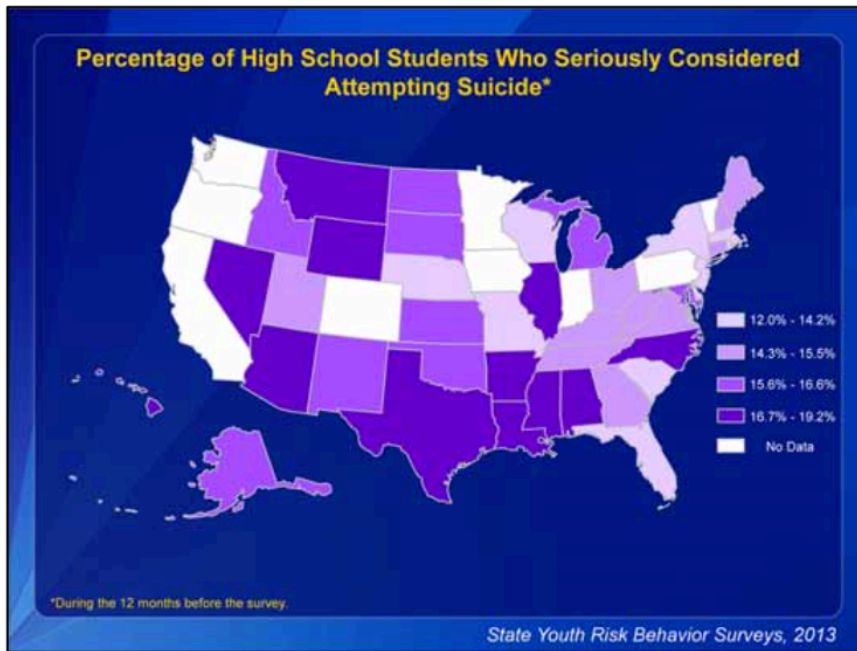


Figure 3: Percentage of High School Students who Seriously Considered Attempting Suicide by State  
Source: Youth Risk Behavior System 2013, CDC

\* Hispanic population (all ages and all sexes) as of July 1st, 2014 according to the United States Census Bureau <http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmm>

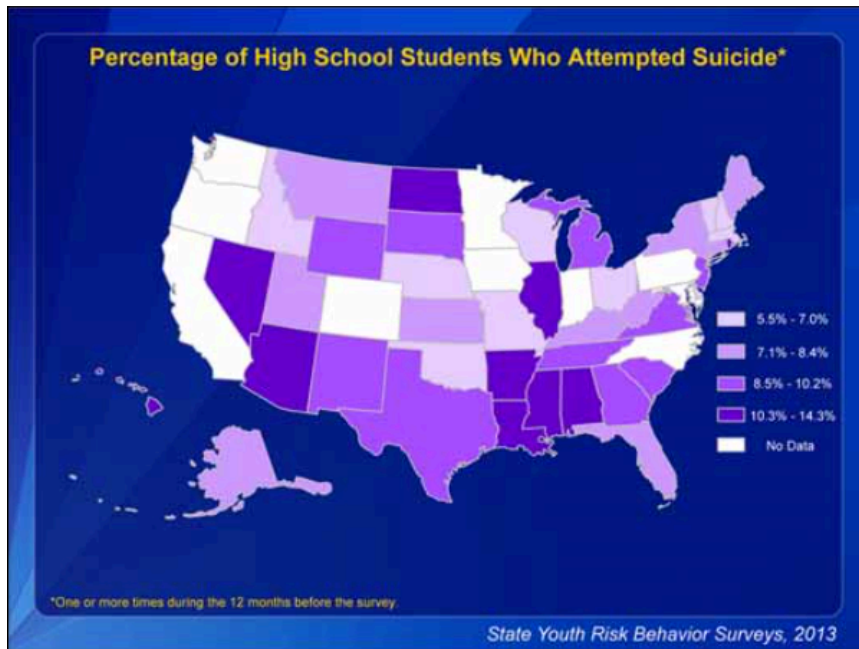


Figure 4: Percentage of High School Students who Attempted Suicide by State  
Source: Youth Risk Behavior System 2013, CDC

Even though we can see different rates of suicidal behavior in different states, Luis Zayas (2011), who has researched Latina adolescent suicide for more than 30 years in the United States, mentions that surveys do not suggest it to be a regional problem:

Like subgroups, regional differences do not appear to account for the higher rates among both young Latinas and Latinos. If that were the case, then Latinas in one region would have to be attempting suicide at a scale that raises the overall levels for all other Hispanic youth.

## 1.2 A diverse ethnicity

When we talk about Hispanic and/or Latino people it is critical to note that we are placing more than fifteen nationalities together. In general terms, it could be wrong to talk about them as a homogenous group because they are actually different in ethnicity, geography, acculturation, migration patterns and socioeconomic status (Fortuna et al. 578). According to the 2010 Population Census in the United States, 50,477,594 million people identified themselves as



Hispanic or Latino (16.3% of the US population); out of this total, 31,798,258 are Mexican (10.3% of total US population – 64% of Latin population), 4,623,716 are Puerto Rican (1.5% of total US population – 9.0% of Latin population) and 1,785,547 are Cuban (3.4% of Latin population). There is also a large group of Dominican (0.5% of total population – 2.8% of Latin population), Central American (1.3% of total US population – 7.6% of Latin population) and South American (0.9% of total population) (Population Census in the United States, American Fact Finder, 2010).

Most studies, like the YRBSS, when talking about suicide and suicidal behavior in adolescents, do not differentiate Latinos into subgroups. Nevertheless, there has been some research done, mainly in adult populations, which looks to find those differences depending on the country of nationality or descent. Enrique Boca-Garcia et al. published a paper in 2010 which goal was to compare the prevalence of suicidal ideation/attempts among Hispanic subgroups in the US in a certain period of time (1991-1992 and 2001-2002) and to identify high-risk groups. They found that Puerto Ricans are the Hispanic ethnic subgroup with the highest rates of suicide attempts and that over the 10-year period between the surveys, the lifetime prevalence of suicide attempts significantly increased among 18 to 24 years old Puerto Rican women. Contrary to Boca-Garcia et al. findings, Lisa R. Fortuna et al. (2007) found that there was no statistically significant group difference in rates of suicidal ideation or attempt among Latino subgroups. Additionally, although the survey and interviews were conducted with people that were 18 years and older, 62% of their sample reported that their attempted suicide occurred when they were under 18 years old.

Zayas states that it is correct to speak of Latino or Hispanic adolescent suicidality across groups without neglecting their diversity, “they may not be [a monolithic group], but it seems that when it comes to adolescent suicidality, we can speak of them as a group” (Zayas, 12).

Because of these mixed findings, I will discuss suicide and suicidal behavior in Latinos as a group, trying to make differences wherever information is available.

### **1.3 Statistics within Latin American countries**

In this section, I will present the suicide rates in adolescents in those Latin American countries that have a higher representation of population living in the United States and in those where the information was available and reliable (Costa Rica, Cuba, Dominican Republic, Mexico, Panama, Puerto Rico) in order to further comprehend the high numbers of suicide and suicidal behavior among Latina adolescents living in the United States versus their country of origin or descent. This is important because for example, Swanson et al. found that “Mexican youth residing in the U.S. had significantly higher rates of suicidal ideation than peers living in Mexico, and that U.S. residency significantly predicted more suicidal thoughts” (qtd. in Smokowski et al. 244). It is also important because The World Health Organization in 2013 stated, “historically, Latin America has had lower suicide rates than the global average, while North America is at an intermediate level” (qtd. in Pan American Health Organization, 1).

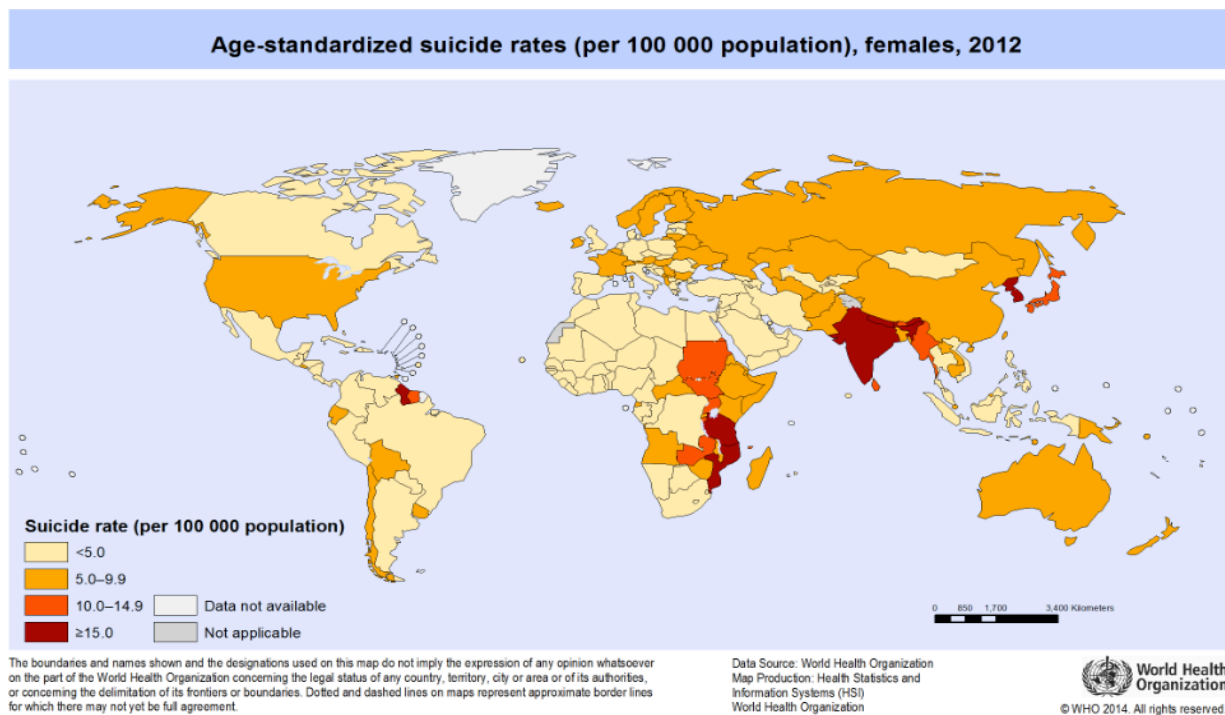


Figure 5: Age-standardized suicide rates (per 100,00 population), females 2012

Source: World Health Organization

Costa Rica, in 2009, reported a suicide rate of 0.5 per 100 thousand in the age group of 5 to 14 years old and 7.0 per 100 thousand in the age group of 15 to 24 years old (who.int).

Additionally, the Costa Rican Health Ministry registered an average of 318 suicides (all ages) per year during the 2010-2013 period (ticotimes.net).

Cuba, in 2008, reported a suicide rate of 0.2 per 100 thousand in the age group of 5 to 14 years old and 4.7 per 100 thousand in the age group of 15 to 24 years old (who.int).

In 2014 in Dominican Republic there were 31 completed suicides of female adolescents and 86 of male adolescents (one.gob.do).

In Mexico, according to a study led in 2011 by the Instituto Nacional de Psiquiatria (National Psychiatric Institute), 5.2% of adolescents between 12 and 14 years old and 7.6% of adolescents between 15 to 17 years old thought about committing suicide. The suicide rate of the

country in 2013 was of 7.5 suicides per 100 thousand adolescents between the ages of 15 to 29 years old. By gender, the suicide rate in males in the same age range was of 12 per 100 thousand males and 3.2 per 100 thousand females (inegi.org.mx).

Panama registered 0.02 per 100 thousand female suicides and 0.12 per 100 thousand male suicides. There is no information specific to age (minsa.gob.pa).

In Puerto Rico in 2014 the suicide rate in the age range between 10-14 years old was 0.83 per 100 thousand inhabitants and in the age range between 15 and 19 of 1.90 per 100 thousand inhabitants. Out of all the committed suicides (all ages) in 2014, 85.5% were male and 14.5% were female (salud.gov.pr).

## Chapter Two

### **Suicide: *Risk and Protective Factors***

#### **2.1 Defining suicide**

As more research becomes available in the field of suicidology, it has become important to define what does suicide and other terms that relate to it mean in order to have a clear understanding of what we are dealing with, especially considering that “Hispanic adolescents are less likely than non-Hispanic whites to have completed suicide but are at higher risk of non-fatal suicide behaviors” (qtd. in Tortolero and Roberts 214).

Suicide has been defined as the intentional behavior or deliberate self-harming resulting in death (Hawton and Van Heeringen 2); it is the deliberate act to end one’s life. Suicide attempt has the same intentional behavior of dying but does not result in death: “attempted suicide is used to describe self-inflicted behaviors for which there is evidence that the person intended ‘at some level’ to kill him/herself” (qtd. in Hawton and Van Heeringen 2). According to Goldsmith et al. “there are between 100 and 200 attempts for every one completed suicide in the 15-24 year age group” (qtd. in Zayas, 24).

Suicidal ideation consists of thoughts about being dead or killing oneself (Miller, Rathus and Linehan, 9). People with suicidal ideation might or might not have a plan; “a suicidal plan involves identifying a specific method, and possibly a given time frame in which the adolescent plans to kill him- or herself” (Miller, Rathus and Linehan, 10). The intent characterizes the level of commitment in carrying out the suicidal plan.

According to Goldston et al. and O'Carroll et al., suicidal behavior can be considered an umbrella term that includes thoughts of killing oneself (suicidal ideation), suicide attempts, and death by suicide (qtd. in Romero, et al. 4).

Non-suicidal self-injurious behavior (NSIB) has been defined as "the deliberate, direct destruction or alteration of body tissue, without conscious suicidal intent but resulting in injury severe enough for tissue damage to occur" (qtd. Miller, Rathus and Linehan, 9).

## **2.2 Risk and Protective Factors**

As it will be further discussed in Chapter Four, it is very hard to predict if an adolescent is going to attempt or complete suicide. Many studies have been made in order to try and predict suicide but researchers have concluded that, "we do not possess any item of information or any combination of items that permits us to identify to a useful degree the particular persons who will commit suicide" (qtd. in Hawton and van Heeringen, 586). Nevertheless, it is important to know the characteristics of subpopulations in which rates of suicide or suicide behavior are higher than the rest of the population. These descriptions can be used to determine if an adolescent is at high risk for suicide (Miller, Rathus and Linehan, 11).

The World Health Organization defines a risk factor as "any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury."

Protective factors are much more than just the opposite of risk factors, according to Romero et al. protective factors are:

Those characteristics that, when present, serve as a buffer between a stressor and the individual's reaction to that stressor. They reduce the impact of the stressor, or chronic adversity, and thus act as a shield that protects the person from the potential negative outcomes and allows for a more adaptive response. Protective factors, according to Dekovic (1999) might be better conceptualized as "compensatory factors", as they appear to be beneficial for all adolescents, regardless of the presence of risk factors.

If we look closely at Figure 2 presented in Chapter One, we can see that the highest increase of suicides happened in girls ages 10-14 (0.5 in 1999 and 1.5 in 2014); this increase raised a lot of questions in researchers who at the moment have the hypothesis that an important risk factor in girls is early puberty, "one hypothesis about what's going on with girls is pretty surprising: early puberty" (Arielle Sheftall qtd. in npr.org). Researchers have found that puberty is associated with the early onset of mental disorders like depression. But, is this the case for Latin adolescent girls attempting suicide? In the next section we will review the specific and most important risk factors affecting them.

### **2.3 Specific risk factors in Latina adolescent suicidal behavior – Systematic Review Results**

Because rates of suicide and suicidal behavior vary among ethnic groups, protective and risk factors affecting each group are also different. In this section I will focus on studying the specific factors portrayed in Latina adolescent suicidal behavior. The information was acquired from a Systematic Review that I worked on at the end of the year 2015.

An initial search on PsycINFO was conducted using the following search terms: "suicide" and "Latinos" and "United States or America or USA or U.S." and "youth or adolescent or teenager". A second search was performed using PubMed database under the following search terms: "suicide" and "Latina". The searches were conducted during the month of October 2015

and the last search was made on October 27<sup>th</sup>, 2015. On April 2016 I performed a new search using the same search terms used last year on PsycINFO and PubMed in order to find newer articles that could be used but no recent publications were found.

The inclusion criteria were determined in order to ensure that the results would show studies conducted in the United States among Latin or Hispanic adolescent population living in the United States. To be included, the articles had to discuss suicide risk factors in male and/or female Latin adolescents. The studies were also selected if they included qualitative or quantitative data. On the contrary, studies were excluded if they did not include subjects living in the United States and were not Latin male and/or female adolescent. Studies were also excluded if they were published before the year 2000 and if they were not in English.

Considering the inclusion and exclusion criteria, 10 studies were included and 17 were excluded. The following table (table 1) describes the key findings in each of the included studies.



**Table 1: Key findings**

<b>Study</b>	<b>Location</b>	<b>Type of Study</b>	<b>Sample</b>	<b>Risk Factors</b>	<b>Results</b>	<b>Limitation</b>
Gulbas, L.E., Zayas, L.H. 2015	New York City	Qualitative interviews	<p>10 Latinas attempters and parents</p> <p>10 Latinas non-attempters and parents</p> <p>Low-income families</p> <p>Average age 15.7 years</p> <p>Colombian, Dominican, Ecuadoran, Mexican, Puerto Rican, Salvadoran and Venezuelan.</p>	<p>Culture, can be a protective factor (familism) or a risk factor (different or oppressive values).</p> <p>Social interactions, lack of social connections.</p>	<p>The convergence of these 3 factors: Subjective distress. Interpersonal discord. Emotional isolation.</p>	<p>Spanish-English open-ended interviews: language depended on participant preference.</p> <p>Linguistic expression of experience.</p>
Baumann, A.A., Kuhlberg, J.A., Zayas, L.H. 2010	New York City	<p>Quantitative data</p> <p>Lugo Steidel and Contreras Scale (Familism)</p> <p>Mutual Psychological Development Questionnaire (Mutuality)</p> <p>Youth Self Report (Internalizing and Externalizing Behaviors)</p> <p>Bidirectional Acculturation Scale (Hispanic and US cultural involvement)</p>	<p>86 mother-daughter pairs of Latinas attempts</p> <p>83 mother-daughter pairs of Latinas non-attempts</p> <p>Average age 15.19 years</p> <p>Puerto Rican, Dominican, Mexican, Colombian, Ecuadoran, Salvadoran, Honduran, Peruvian, Venezuelan.</p>	<p>Gap in familism and less mother-daughter mutuality are risk for externalizing and internalizing behavior and suicide attempts</p>	<p>No significant difference.</p> <p>Effects of mutuality (low) were fully mediated by internalizing and externalizing behaviors.</p> <p>High externalizing behaviors significantly predict suicide attempts.</p>	<p>Fathers not considered for this study.</p> <p>Directionality of the variables from the model.</p>

Guzmán, A., Koons, A., Postolache, T.T. 2009	USA	Systematic- Review		Acculturation issues, family conflict, physical and sexual abuse, low household income. Low support at school.		Literature research between 1980-2008
Peña, J.B., Wymar, P.A., Hendricks Brown, C., Matthieu, M.M., Olivares, T.E., Hartel, D., Zayas, L.H. 2008	USA	National Longitudinal Study of Adolescent Health – Analysis of data from wave 1 –in home interviews 1995.	3,135 adolescents plus a respondent parent  58.6% Mexican descent	Immigrant generation status is a useful and readily measured variable related to acculturation.	Second generation Latinos are 2.87 times more likely to attempt suicide.  Third generations are 3.57 times more likely to attempt suicide.	Data was collected in 1995.
Zayas, L.H., Pilat, A.M. 2008	USA	Integration of knowledge of past research with clinical observations and theoretical accounts	Female adolescent Latinas living in the USA that had suicidal attempts.	Developmental process, social and peer group factors, cultural traditions, bicultural challenges, individual characteristics and family dynamics.	They propose intervention and prevention.	It is not a clinical trial. It is not a qualitative or quantitative research, it is mainly a paper that summarizes the findings they have had through previous research.

<p>Piña-Watson, B., Castillo, L.G., Rodriguez, K..M., Ray, S. 2014</p>	<p>USA</p>	<p>National Longitudinal Study of Adolescent Health – wave 1 Center for Epidemiologic Studies Depressive Symptoms Scale</p>	<p>345 Latina adolescents between 13 and 18 years old</p>	<p>Determine which specific familial factors served as predictors of Latina suicidal ideation.</p>	<p>Full model: nativity, academic interest, depression and parental caring are significant predictors of suicidal ideation.</p>	<p>Suicidal ideation was measured only with 1 item on the questionnaire.  Definition of connectedness with parents might need further clarification for participants.  Data was collected in 1995.</p>
<p>Gulbas, L.E., Hausmann-Stabile, C., De Luca, S.M., Tyler, T.R., Zayas, L.H. 2015</p>	<p>New York City</p>	<p>Qualitative Study (data gathered from a larger quantitative study)</p>	<p>139 adolescent Latinas =73 with history of self-harm and 66 with no history of self-harm  Average age 15 years old  Puerto Rican Dominican Mexican Colombian Ecuadorian</p>	<p>Differentiate risk factor towards suicidal behavior and/or nonsuicidal self-insury (NSSI)</p>	<p>The following risk factors are higher in suicidal behavior than in NSSI: Fragmented family, family conflict, parental criticism, transnational stress, physical/sexual abuse, domestic violence and academic challenges.</p>	<p>Language in which the interview took place, participant could choose English or Spanish.</p>

<p>Kuhlberg, J.A., Peña, J.B., Zayas, L.H. 2010</p>	<p>New York City</p>	<p>Quantitative and ethnographic interviews. Used cross-sectional data from a project on the sociocultural processes in the suicide attempts of adolescent Hispanic females. If attempted suicide in past 6 months they were selected.</p> <p>Self-esteem-Rosenberg Self-Esteem Scale</p> <p>Internalizing behaviors-Youth Self-Report</p> <p>Parent-adolescent conflict-Conflict Behavior Questionnaire</p> <p>Familism – Attitudinal Familism Scale</p>	<p>121 Latina suicide attempters /105 parents</p> <p>105 non-attempters /95 parents</p> <p>M age was 15.47 years</p> <p>Puerto Rican Dominican Mexican Colombian Ecuadorian Peruvian</p>	<p>Influence of family, cultural and individual factors to suicidal attempt.</p>	<p>Attempters have higher levels of parent-conflict and internalizing behaviors.</p> <p>No statistical difference in parent education, adolescent age or familism.</p>	<p>Only half of participants were part of the ethnographic interviews.</p> <p>In the report, parents' perceptions are not included.</p>
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De Luca, S.M, Wyman, P., Warren, K. 2012	USA	National Longitudinal Study of Adolescent Health- Wave 1, school and in-home questionnaires	1,618 Latinas M age=15 years	Fewer positive connectedness with family, peers, and teachers are factors for suicide attempt	High depression, low parental care, low support from parents and low teacher care and support predict attempts.  Having a suicidal friend increases suicide attempt in more than 100%	Self-report questionnaire and parents were not involved. Data collected in 1994-1995
Cervantes, R.C., Goldbach, J.T., Varela, A., Santisteban, D.A. 2014	L.A., Miami, El Paso, Boston.	Quantitative study  Hispanic Stress Inventory – Adolescent  Children Depression Inventory 2	1,651 Hispanic adolescents n=1,254 participants completed all survey protocols and were included in the analysis (46% male, 54% female)  M age= 14.9	Measure cultural stress (acculturation)	Gender differences in causes of suicidal ideation/self-harm  Acculturation gap, immigration stress and family and drug related stress are higher factors for female suicidal ideation/self-harm  Discrimination stress is a predictor in Hispanic male suicidal ideation	Use of cross-sectional design so they were unable to know the direction of causation.

The risk factors for suicidal behavior in Latino adolescents found through the literature review are presented below in three main groups (subjective distress, familism, immigration issues):

## **Subjective distress**

Four out of the ten articles discuss the role that subjective distress plays as a key factor that leads to suicidal behavior. Subjective distress is the experience of distress located in different areas of the adolescent's life.

Two of the articles discuss that academic performance is one of the leading sources of distress among Latina adolescents. In the interviews from the qualitative study by Gulbas and Zayas (2015), they found that academic difficulties signified failure as a family member and the rejection is framed as plural. The stress of academic failure has two sides, on one side they worry about failing as a family member and disappointing their parents and on the other hand they worry that they will not get into college and achieve independence from their parents. One of the articles states, "Latinas who attempted suicide were most likely to interpret academic shortcomings as evidence of their perceived worthlessness" (Gulbas, L.E., Hausmann-Stabile, C., et al., 2015). Additionally, it is known that Hispanics have the highest rates of school drop out (Wagner, B.M., 2009).

Another important cause of distress is abuse. One of the articles specifically states that physical or sexual abuse and witnessing domestic violence leads to suicidal behavior (Gulbas, L.E., Hausmann-Stabile, C., et al., 2015). In this study, teens that reported suicide attempt recounted experiences of violence and abuse and they were most likely to attribute to these experiences feelings of loneliness. For those who witness violence at home, they recount that during school hours they are all the time thinking about coming home and finding their mother hurt. One article discusses the distress this kind of abuse produces in the adolescent's life: "a frequent source of

subjective distress among attempters was abuse, whether it was direct experience of sexual or physical abuse (n=4) or witnessing domestic violence n=1” (Gulbas, L.E., Zayas, L.H., 2015).

### **Familism and Acculturation**

Familism is a very specific phenomenon within Latin culture. Familism is defined as the emphasis on family cohesiveness, interdependence, loyalty and responsibility to care for one another, and of placing the family before one’s personal needs (qtd in Baumann, A.A., et al.).

According to Zayas, a person acculturates when he/she leaves a familiar culture and moves to a culture that is more dominant numerically and culturally, and there is a change in the person during the process (Zayas, 19). Berry (qtd. in Colucci and Lester, 71), states that these changes include physical changes (e.g. housing, urbanization); biological changes (e.g. weight); cultural changes (e.g. language, religion, education); psychological changes and social relations. He also states that there are four things that can happen to the nondominant culture: (i) integration (maintaining relations with dominant culture while maintaining cultural identity); (ii) assimilation (maintaining relations with dominant culture but not maintaining cultural identity); (iii) separation (not maintaining relations with dominant culture and maintaining cultural identity); and (iv) marginalization (not maintaining relations either with dominant culture nor cultural identity), (qtd. in Colucci and Lester, 72).

Although one study did not find any significant difference in familism between girls that attempted suicide and the control group (Baumann, A.A. et al.), the authors do mention that gaps in familism in which mothers have higher familism than their daughters can lead to suicidal behavior.

Seven other studies indicate the role familism plays as a risk factor of suicide behavior. In the process of acculturation, family values cause struggle in the minds of the adolescents; on one hand they have to be loyal to the family and behave under the belief that family comes before the individual and on the other hand, the US culture demands autonomy and individuality. Zayas et al. (2011) mention that, “the acculturation differences US Latino parents and adolescents face influence their interactions and add another layer of complexity to the relational challenges encountered during adolescence.” According to Peña et al. (2008) there is a relationship between acculturation and mental health.

De Luca et al. (2012) found that greater connectedness of the adolescent with her father decreased risk of suicide ideation. This finding is worth analyzing further because most studies only focus on the importance of the mother-daughter relationship.

Additionally, out of the ten studies, only one discusses the influence that having a suicidal friend has on the adolescent’s behavior. De Luca et al. (2012) found that “having a suicidal friend (regardless if friend reported reciprocity) increased the likelihood of attempts by 209%.”

### **Immigration issues**

Four articles specifically discuss the role immigration plays as a risk factor for suicide behavior. Peña, Wyman, et al. (2008), found that immigrant generation status was significantly related to suicide attempts. Their study confirms that first-generation immigrant adolescents have lower rates of suicidal behavior while second- (US-born Latinos with immigrant parents) and third-generation (US-born Latinos with US-born parents) have higher rates. Piña-Watson et al. (2014) also found in their study that being born in the US increased the probability of suicidal ideation.



Cervantes, et al. (2014), found that immigration stress was predictive of self-harm behavior among Hispanic girls. In their study they also included male subjects, but they found that immigration stress does not have a self-harm outcome on them; males suffer more from discrimination stress, an important risk factor for them towards suicidal ideation.

The last study that had findings related to immigration as a risk factor of suicide behavior is by Gulbas, et al. (2013); here, girls who attempted suicide were more likely to report transnational stress, which they define as the “explicit and communicated desire by participants to return to their country of origin as a result of the stress produced by their daily life in the United States” (Gulbas, et al. 2013).

When talking about immigration issues it is important to include identity issues; Latinos growing up in the US grow up with two cultures and instead of integrating them in order to forge a single one, adolescents tend to use one identity (Latin) in certain social contexts like family and the other one (US) in other contexts like school.

#### **2.4 Specific protective factors in Latina adolescent suicidal behavior**

A few of the studies described above, like the Gulbas and Zayas research, mention that there are some factors (like having better or worse familism) that can play both as a risk or as a protective factor. But there are also some factors that are specifically protective and have been proven to be compensatory in Latina’s lives to avoid suicide, in the next paragraphs I will discuss two of the most relevant protective factors that have been found.

Durkheim in his study *On Suicide*, states, “religion, Catholicism in particular, helps protect against suicide” (qtd. in Barranco, 2). Hispanics in Latin America are predominantly Catholic with a

very conservative strain; according to the PEW Research Center (2013), the percentage of Catholics living in Latin America and the Caribbean increased over the last century from 24 to 39 percent (qtd. in Barranco, 6), but it is known (Barranco, 7) that US-born Latinos' affiliation to Catholicism decreases and they are likely to join other non-Catholic denominations. Barranco's study on "Suicide, Religion and Latinos" demonstrated that the presence of religious adherence (to any religion) lowers US-born Latino suicide.

Another protective factor in Latina adolescent suicidal behavior is the parent's level of education. According to Zayas, "with more education and knowledge, parents interact with their children differently, displaying more cognitive flexibility and engaging in verbal exchange that exposes their children to the world of words, abstractions, and logic that, in turn, enhances their children's academic and social-emotional performance" (Zayas, 10). Additionally, he mentions that these educated parents tend to be better equipped to better prepare their daughters (and sons) to confront the challenges of adapting to a new culture in a successful or more adaptable way.

## Chapter Three

### Treatment

#### 3.1 Methods of treating suicidal behaviors

According to Miller, Rathus and Linehan, there are two methods of treating suicidal behaviors in clinical populations: the first method is the model underlying most psychodynamic and biological approaches to treatment; here, one assumes the behaviors are effects of an underlying mental disorder so treatment is focused on treating the mental disorder and as a consequence, the suicidal behavior should decrease. The second focuses directly on the reduction of the suicidal behavior, this method underlies most behavioral and cognitive-behavioral approaches to treatment (Miller, Rathus and Linehan, 28). It has been suggested “that directly targeting suicidal behaviors may prove a more efficient way to decrease suicidal behavior rather than indirectly treating them by targeting associated psychiatric disorders” (qtd. in Hawton and van Heeringen, 503).

The most common example of treating suicidal behavior indirectly is by treating adolescents for depression, “mood disorders are the most common diagnoses related to suicide” (Miller, Rathus and Linehan, 28). A Major Depressive Episode (or Major Depressive Disorder if it lasts at least a year) is characterized by experiencing symptoms like change of mood; biological symptoms like fatigue, disturbances in sleep, appetite or psychomotor activity; affective-cognitive symptoms like intense self-deprecatory thoughts and feelings of guilt and worthlessness; cognitive symptoms like trouble concentrating, remembering or deciding. Suicidal symptoms cut across cognitive, affective and behavioral domains (Curry, 511).

Another example of indirect treatment is through pharmacological intervention, which has been used to treat depression but empirical evidence has not demonstrated success in reducing suicidal behavior. For example, the Treatment for Adolescents with Depression Study (TADS), which evaluates the effectiveness of pharmacological therapy, cognitive behavioral therapy and their combination in adolescents with major depressive disorder, demonstrated that suicidal events were more common in patients receiving fluoxetine therapy (14.7%) than combination therapy (8.4%) or cognitive behavioral therapy (6.3%) (TADS team, 1132). Additionally, the FDA ordered a special label to be included in all antidepressant medications that indicates the potential for increased suicidal ideation and other suicidal behaviors among children and adolescents who use these medications (qtd. in Miller, Rathus and Linehan, 29).

Psychotherapy that targets suicidal behavior directly has not proven to be very successful either and very few of them have been subjected to clinical trials. According to Miller, Rathus and Linehan there are few or no empirical data confirming that standards of care are effective in preventing suicide or reducing frequency of suicide attempts.

### **3.2 Dialectical Behavior Therapy (DBT)**

Dialectics refers to acknowledging that there is more than one way to view a situation and to solve a problem, basically it means that there is no absolute truth and that reality only exists in opposing forces (Miller, Rathus and Linehan, 39). Dialectical Behavior Therapy (DBT) was developed to treat chronically suicidal adult patients. Currently the treatment is used with patients diagnosed with Borderline Personality Disorder (BPD) but because of similarity between BPD and suicidal behavior, DBT also continues to be used with suicidal patients and has been

proven successful. Miller, Rathus and Linehan view suicidal behaviors as learned methods of coping with acute emotional suffering when no other coping options are available, and they conclude (DBT perspective) that suicidal behaviors are a result of two interacting conditions: the first one being the lack of interpersonal distress tolerance skills and the second one being personal and environmental factors that inhibit the use of skills the individual may have (Miller, Rathus and Linehan, 35).

DBT was adapted to adolescents (DBT-A) by making changes like reducing the treatment length, simplifying skills handouts, including skills examples that are more relevant to adolescents, including family therapy sessions and conducting an orientation for adolescents' support network (Miller, Rathus and Linehan, 88). The therapy takes place in four different ways: individual therapy, group skills training, family therapy, and telephone consultation.

Initial outcome data in a 12-week program for adolescents yielded promising results (Miller, Rathus and Linehan, 34); the pilot sample of the program was composed primarily of an ethnic minority (largely Hispanic) population. Their results demonstrated that 13% of adolescents receiving treatment as usual versus 0% using DBT-A were psychiatrically hospitalized and 40% of adolescents receiving treatment as usual versus 62% in DBT-A completed the treatment. There were no significant differences between both groups in number of suicide attempts, 9% for those receiving treatment as usual and 3% for those receiving DBT-A, nevertheless, authors mention that when they examined pre-post change within the DBT group, they found significant reductions in suicidal ideation (Miller, Rathus and Linehan, 34).

Recently (2014) the first randomized control trial to test the efficacy of DBT-A took place in Norway. The primary hypothesis was that "DBT-A would be superior to usual care in reducing self-

harm behavior suicidal ideation and depressive symptoms in self-harming adolescents with Borderline Personality Disorder features” (Mehlum, et al., 1083). Researchers assessed self-harm, suicidal ideation, depression, hopelessness and symptoms of borderline personality at baseline, 9, 15 and 19 weeks as well as frequency of hospitalization and emergency department visits. The participants were 77 adolescents age 12 through 18 years, 87% were female and 79% were of Norwegian ethnicity. There were no completed suicides during the trial. One DBT-A patient and two enhanced usual care (EUC) patients had an emergency department visit for self-harm. The results show that “DBT-A was superior to EUC in reducing frequency of self-harm, severity of suicidal ideation and depressive symptoms, with generally large effect sizes for outcomes in DBT-A condition, but weak or moderate outcomes in the EUC condition” (Mehlum, et al. 1089).

### **3.3 DBT-A for Latina adolescents**

Is DBT-A effective for treating suicidal Latina adolescents? Many authors (Miller, Rathus, Linehan and Zayas) have agreed that it is effective because it targets several specific emotions that Latina adolescents go through when having suicidal behaviors, “DBT addresses several of the issues that are manifest in suicidal Latinas” (Zayas, 166). Specifically, DBT-A helps improve impulse control, frustration tolerance, anger management and management of other emotions by enhancing emotional self-regulation. In therapy, patients learn skills that help them be more effective in regulating their emotions; it teaches them to better cope instead of using suicidal behaviors and it takes away reinforcers of that maladaptive behavior.

Another important factor that makes DBT-A effective is that it includes families in the therapeutic process; considering that in Latina adolescent suicidal behavior familism is one of the

main risk factors it is key to include them in the therapeutic process. This helps the therapist to understand the home environment and family dynamics. Families also undergo the skills training mode where they learn the same skills as their daughters (or sons), which helps to improve the family interaction by having better emotion regulation and communication.

Overall, DBT-A seems like a very suitable treatment for Latina adolescents with suicidal behavior. The only weakness I see is that skills training happens in a multifamily group setting consisting of up to six adolescents and at least one parent. In these sessions adolescents can form bonds and since that De Luca, et al. (2012) in their study found that having a suicidal friend increases suicide attempt in more than 100% it could be counterproductive; it might be better to adapt the skills training to only the adolescent and her/his parents and siblings and/or other family members living under the same roof, considering that Latin people tend to live and have a very close relationship with the extended family (uncles, cousins, grandparents, etc.).

## Chapter Four

### Prevention

#### 4.1 Preventing the unpreventable?

According to Robert D. Goldney (Department of Psychiatry, University of Adelaide, South Australia), suicide and suicide attempts are not predictable:

There has not been any research which has indicated that suicide can be predicted or prevented in any individual. The result of this is that programs designed specifically to prevent suicide, even those which purport to focus upon so-called high-risk groups, have not yet demonstrated a reduction in suicide rates (qtd. in Hawton and van Heeringen, 585 Chapter 33).

Goldney cites different authors that have tried to create statistical methods to predict suicide, like Goldstein in 1991 and Pokorny in 1993, both ending with unsuccessful methods and stating that "...based on present knowledge, it is not possible to predict suicide, even among high-risk group patients" (qtd. in Hawton and van Heeringen, 587). Goldney concludes that the challenge of detecting those who will commit suicide is mainly because of the low base rate and the large number of false positives.

Notwithstanding, suicide and suicidal behavior prevention in adolescents can't be outrun, considering that there are around 5,500 lives lost each year, and that there are more than 100 attempts per completed suicide, it would be a crime against youth public health to avoid attempting to prevent suicide.



## 4.2 World Health Organization and US National Strategy for Suicide Prevention

In 2013 the World Health Organization (WHO) adopted the first Mental Health Action Plan in which suicide prevention is one of the key matters with the goal of reducing the rate of suicide in countries by 10% by 2020. Specifically, the action request from the WHO is that the countries should “develop and implement comprehensive national strategies for the prevention of suicide with special attention to groups identified as at increased risk of suicide, including lesbian, gay, bisexual and transgender persons, youth and other vulnerable groups of all ages based on local context” (World Health Organization Mental Health Action Plan, 29). They propose the following actions to achieve this goal:

- Increase public, political and media awareness of the magnitude of the problem and the availability of effective prevention strategies
- Restrict access to the means of self-harm and suicide (like firearms and pesticides)
- Promote responsible media reporting in relation to cases of suicide
- Promote workplace initiatives for suicide prevention
- Improve health system responses to self-harm and suicide
- Assess and manage self-harm/suicide and associated mental, neurological substance use disorders
- Optimize psychosocial support from available community resources both for those who have attempted suicide as well as for the families of people who have committed suicide

Finally, the World Health Organization recognizes that “there are many risk factors associated with suicide beyond mental disorder, such as chronic pain or acute emotional distress, [therefore] actions to prevent suicide must not only come from the health sector, but also from other sectors simultaneously” (World Health Organization Mental Health Action Plan, 17).

By 2012, the US Government had put in place a National Strategy for Suicide Prevention that intends to guide suicide prevention actions in the country over the next decade. The strategy is made to include population of all ages and not just youth, but it does include specific considerations for them and it also discusses the importance of considering ethnic and racial differences. In general terms, the strategy outlines four strategic directions, 13 goals and 60 objectives that are meant to work together in a synergistic way to prevent suicide (ncbi.nlm.nih.gov). The four strategic directions of the National Strategy for Suicide Prevention will be listed below; I will expand on the prevention one (strategic direction II) because it is the most relevant one for this chapter:

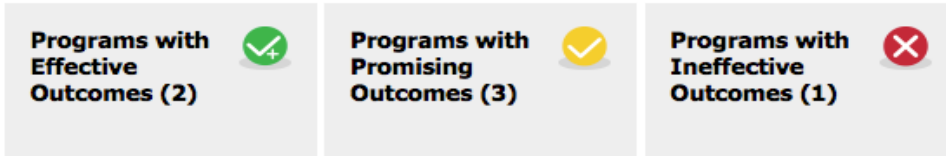
- I. Healthy and empowered individuals, families and communities
- II. Clinical and community preventive services
- III. Treatment and support services
- IV. Surveillance, research and evaluation

#### Clinical and community preventive services

This strategic direction includes three of 13 goals and 12 out of the 60 objectives. The main idea is that support systems, services and resources need to be in place to promote wellness and help individuals to stay alive living a healthy life. In relation to youth at risk, this direction encourages schools, colleges and universities to ensure access to mental health and counseling services and to train school staff to recognize students at risk and to have an appropriate referral program. This point is very important since, as it was discussed in Chapter Two, low teacher support and care are considered risk factors in Latina adolescent suicide behaviors.

The strategy also encourages non-profit, community and faith-based organizations to implement prevention programs that are culturally, linguistically and age appropriate and to educate clergy, parent groups, schools, juvenile justice personnel, rehabilitation centers, and defense and divorce attorneys about the importance of reducing access to lethal means (ncbi.nlm.nih.gov). In line with specific protective factors in Latina adolescent suicidal behavior, like adherence to religion, if clergy and staff from faith-based organizations are trained and prepared to help youth at risk, more suicide attempts could be prevented.

Within this direction, the National Strategy recommends two resources in order to acquire acceptable prevention programs; the first one is the National Registry of Evidence-Based Programs and Practices (NREPP) listed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the second one is the Best Practice Registry (BPR) listed in the Suicide Prevention Resource Center. BPR lists 15 education and training evidence-based prevention programs including SOS (effectiveness will be further discussed) while NREPP lists twelve programs and includes a recent revision of four of these programs (shown in Figure 6 below). This revision, completed in September 2015, demonstrated that the selected programs do not have very effective outcomes in reducing suicidal behaviors.



Title	Evidence Rating (by Outcomes)
Applied Suicide Intervention Skills Training	<ul style="list-style-type: none"> <li>✔ Personal Resilience/Self-concept</li> </ul>
Cognitive Therapy for Suicide Prevention	<ul style="list-style-type: none"> <li>✔ Depression and Depressive Symptoms</li> <li>✔ Suicidal Thoughts and Behaviors</li> <li>✔ Personal Resilience/Self-concept</li> <li>✔ Social Functioning/Competence</li> </ul>
SOS Signs of Suicide Middle School and High School Prevention Programs	<ul style="list-style-type: none"> <li>✔ Suicidal Thoughts and Behaviors</li> <li>✔ Knowledge, attitudes, and beliefs about mental health</li> <li>✘ Receipt of Mental Health and/or Substance Use Treatment</li> <li>✘ Social competence</li> </ul>
STEP UP (Strategies and Tools Embrace Prevention with Upstream Programs)	<ul style="list-style-type: none"> <li>✔ Self-regulation</li> <li>✔ Social competence</li> </ul>

Figure 6: Newly reviewed programs (September 2015)  
Source: SAMHSA, NREPP

### 4.3 School-based prevention

Usually, school-based prevention programs can be divided in two types, those that promote awareness of suicide and those that promote awareness of depression. According to Rachel Jenkins (WHO Collaborating Center, Institute of Psychiatry in London) and Bruce Singh (Department of Psychiatry in the University of Melbourne), “there is evidence suggesting that promoting awareness of suicides may be counterproductive in that although such programs succeed in their primary objective of increasing awareness of suicide, they may have the unfortunate consequence of making it more acceptable for youngsters to contemplate suicide”

(qtd in Hawton and van Heeringen, 605) and they agree that those programs who address awareness of depression seem to work better.

There are four known types of school-based suicide prevention programs. They will be described briefly (Hawton and van Heeringen, 647):

- I. Psycho-educational or curriculum-based programs: designed to enhance awareness of the problem, encourage the identification of students at risk (case-finding), promote help-seeking behaviors, and reduce the stigma attached to obtaining help for mental disorders.
- II. Direct case-finding or screening programs: they apply some form of screening instrument to all or selected students to identify those with important risk factors for suicide. Students are asked directly whether they are experiencing any symptoms of depression, have suicidal ideation or have ever made a suicide attempt and/or have an alcohol- or substance- abuse problem. Instruments like Suicidal Ideation Questionnaire or Columbia Teen Screen are used.
- III. Preventive or therapeutic interventions: educates professional staff in a school-based mental health clinic or school counselors on how best to treat suicidal teens, establishing a school-based suicide hotline or establishing groups to promote coping skills.
- IV. Intervention after suicide: provides intervention after one of the school students has committed suicide. The major goal is to assist in grief process, identify and refer those individuals who may be at risk following the suicide; provide accurate information about suicide, while attempting to minimize suicide contagion.

There is an ambiguous perspective regarding the effectiveness of school-based prevention, so the following general considerations should be taken into account when planning to implement a school-based prevention program (list of considerations qtd. in Hawton and van Heeringen, 646):

Positive considerations:

- a) Adolescents gather conveniently in schools, so that evaluations can be carried out or interventions provided in a cost-effective matter.
- b) Schools are a good place for treatment; teenagers attend school-based clinics more regularly than they do hospital-based clinics (Adelman and Taylor, 1991), and the school environment is often supportive and conducive to frank disclosures and discussion.

Negative considerations:

- a) Suicidality is usually nested in complex psychodynamic and psychosocial influences that do not lend themselves to simple didactic explanations.
- b) Talking openly with an adolescent on the topic of suicide is not necessarily a benign or even neutral process. It may be distressing to some, it may produce attitudes towards suicide that are unhelpful (Shaffer, et al, 1990), and it may induce negative mood state (Overholser et al, 1989).

A systematic review of evidence for two widely marketed and disseminated youth suicide prevention programs concluded, “we cannot recommend that schools and communities implement either the SOS<sup>1</sup> (Signs of Suicide) or YR<sup>2</sup> (Yellow Ribbon) suicide prevention programs” (Wei, Kutchner and LeBlanc, 2015) because neither has been proven to decrease youth suicide rates. The review included research studies that evaluated effectiveness, cost-effectiveness

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<sup>1</sup> School prevention program that helps identify and screen at-risk youth for signs of depression. [Mentalhealthscreening.org](http://Mentalhealthscreening.org)

<sup>2</sup> Community-based model that increases the competence and confidence of youth to recognize suicidal individuals. [Yellowribbon.org](http://Yellowribbon.org)

and/or safety of SOS and YR. One of the studies of SOS (Schilling, et al. 2014) had five suicide attempts in the intervention group versus zero attempts in the control group. Additionally none of the studies evaluated cost versus effectiveness. In spite of these results, SOS continues to be marketed as an effective school-based preventive program. In their website we can find the following statement (mentalhealthscreening.org):

The SOS Signs of Suicide® High School Prevention Program is the only school-based suicide prevention program listed on SAMSHA's National Registry of Evidence-based Programs and Practices that addresses suicide risk and depression, while reducing suicide attempts. In a randomized controlled study, the SOS program showed a reduction in self-reported suicide attempts by 40% (BMC Public Health, July 2007).

#### **4.4 Prevention focused in Latina adolescents**

Because risk factors affecting Latina adolescents are specific to them, prevention programs should be adapted to match their experiences and needs in order to make them culturally relevant. Zayas believes that schools have a major role to play in reducing the despair of young Latinas, in spite of the controversy whether prevention and school-based prevention programs can avoid suicide and suicidal behavior. He proposes the following prevention program that is specifically built for Latin/Hispanic suicidal adolescents.

According to Zayas, schools need to have prevention-oriented groups, psychoeducational groups, and support groups that include both the adolescents and their parents and he mentions that the key to success of these groups is that they (i) need to focus on the adolescent's development considering the context of the culture at home and at school, handling stress and health living, (ii) need to enhance the parent's understanding and communication with their daughters (and sons). The ultimate goal of these groups, according to Zayas, is to build adaptable but cohesive interactions between daughters and parents that will make suicidal behavior

unnecessary (Zayas, 178). Groups should meet every other week for a period of six to eight weeks; sessions should be two hours long and each session should have two to three knowledge messages that the adolescent can take home, and activities related to skills and behaviors. The first session is called “Your Development” and the goal is to inform Latina adolescents of what to expect in regard to language, immigration, acculturation, ethnic identity, family, autonomy, and other age-related issues (Zayas, 178). The second session is called “The Stresses and Strains of Growing up Latina or Latino” and here themes such as peer pressure, parental authority, family tensions, academic demands, depression and self-injurious behaviors are included (Zayas, 179). Third and fourth sessions are called “Living Happy, Living Healthy with Family” and here individual psychological and family issues and skills are reviewed (Zayas, 179).

These groups should also exist in nonprofit and faith-based organizations and any other communities where Latina adolescents interact in their daily life.



## Chapter Five

### Discussion

#### 5.1 Social Theory

Suicide is generally studied from a psychological perspective because it's perceived as an individual disorder; we see this in both treatment and prevention programs which usually target mood disorders like depression in order to "reduce" suicidal behavior and suicide. Nevertheless, after the research presented in this paper, I can conclude that in order to understand suicidal behavior in Latina adolescents we need to include a sociological perspective. This conclusion goes hand in hand with Durkheim's theory of suicide in which he states that suicide has an important social dimension and that "less psychology and more sociology is required to make any sense of why some groups more than others might kill themselves" (Durkheim, xvi).

Specifically, Durkheim believed that in a pathological society or a society with low levels of integration, suicide attempts would increase (Pickering and Walford, 14); he considered suicide to be "a signal of crisis in a society riven by constant and excessively rapid change, a phenomenon which threatened the existence not only of society but also of the individual" (qtd. in Pickering and Walford, pg. 12). Durkheim categorized suicide into four types: egoistic, altruistic, anomic and fatalistic. The term "anomie" refers to "a societal condition in which preexisting norms no longer control behavior because of rapid societal change... the person is left alone to deal with change..." (qtd. in Wagner, 44). Basically, an anomic suicide happens as a consequence to a crisis to which the person is unable to cope and uses suicide as a solution (Wagner, 44).

Durkheim's social theory of suicide serves as a framework to understand Latina adolescent high suicidal behavior rates:

- (I) People of Latino/Hispanic descent are the fastest growing minority in the United States, as mentioned previously, by 2060 Latino/Hispanics will represent about 30% of the US population. It is important to highlight that this growth is not due to higher immigration in recent years but rather because of high birth rates among women of Latino or Hispanic origin (Zayas, 6 and CDC). Here, it is important to bear in mind that suicidal behavior among Latina adolescents takes place predominantly in second and third generation youth rather than in foreign born first generation. All of these data reaffirms that being a US born girl of Latino/Hispanic descent is a risk factor of having suicidal behaviors, which leads us to agree that there is a social factor contributing to higher suicidal behaviors among these population; Zayas stated that "this may indicate a real social problem for children of immigrants dealing with two cultural traditions..." (Zayas, 13); which brings me to the second point of the social theory;
- (II) There are low levels of integration within the society and Latina adolescents most of the time feel that they do not belong neither to the US community nor to the traditional Latin community, which causes an identity issue; Latinas have "grown up between two cultures, belonging to both and to neither of them" (qtd. in Zayas, 134). Here is where acculturation plays a key role because Latina adolescents must negotiate between the culture lived within their families (familism) and the culture outside their homes, mostly, a culture of independence.

(III) Considering the four types of suicide established by Durkheim (egoistic, altruistic, anomic and fatalistic), anomic suicide is the one that best helps to understand Latina adolescent suicidal behavior; there is not “a clear definition of ‘who I am’ and ‘what I can be’ because of constrains placed by the society” (Zayas, 26). Latina adolescents are undergoing an identity crisis between familism and individualism, between Latin heritage and US culture; being unable to manage and cope with this feelings and situations, they turn to suicidal behaviors.

Latina adolescent suicidal behavior can also be explained as an *idiom of distress*, a term used in cultural psychiatry that refers to “recurrent, locality-specific patterns of aberrant behavior, means for expression that are provided by the indigenous context of the group manifesting the idiom” (qtd. in Zayas, 145, 146). According to Kirmayer and Sartorius (2007), an idiom of distress is a way of communicating psychosomatic experiences (qtd. in Zayas, 146). Nichter (1981) stated that an idiom represents local responses to certain kinds of distress that surface as a result of several psychosocial problems (qtd. in Zayas, 146). This way, suicidal behavior is the communication used by Latina adolescents that represents what is happening to them.

## 5.2 Narratives

In the next pages, I will describe two brief narratives, taken from Zayas’ book “Latinas Attempting Suicide,” of girls that attempted suicide and one that did not; the goal of this is to analyze what factors (risk and protective) are present in each of these Latina adolescent lives.

### Narrative 1

Esmeralda is a 17-year-old that lives with her parents, who are Colombian immigrants, and her younger brother. She got a tattoo and this caused disappointment in her parents, her mother withdrew her companionship for a period of time.

During ten painful days, Esmeralda endured the loneliness resulting from her acting against her parents' authority. Finally, her parents organized a family day trip in order to begin the process of healing, a truce of sorts. Esmeralda joined the family, and while in the car, they discussed the conflict, shared their points of view, and sorted things out...Her parents also moved forward, understanding that with Esmeralda soon to be eighteen, their say in her decisions was becoming increasingly limited...Esmeralda understands that even though she is about to become an adult, she still needs to openly negotiate her choices if she is to expect her parents' support. (Zayas, 48)

Esmeralda is a non-attempter adolescent. In my opinion there is a good family dynamic and high mother-daughter mutuality, which helped as protective factor in this specific case. There could have been a very difficult situation when her mother withdraws affection from Esmeralda for a period of time, but after some days, her parents were ready and open to talk and to understand the developmental process Esmeralda was going through. By planning a family trip, they demonstrated interest in resolving the conflict with a clear and open dialogue. All of these helped Esmeralda to manage her emotions correctly and even though she felt lonely for a period of time, she knows she can always talk to her parents. She also learned from this situation that she needs to negotiate some things with her parents in order to have their support.

### Narrative 2

I cut myself; I don't remember why, but I know that my mother was fighting with me. Then I became full of rage. I couldn't do anything. So, to unburden myself, I began to cut myself. (Zayas, 113)

The girl that narrates the passage above is clearly demonstrating that she does not have emotion regulation and that her coping skills are not adaptive because instead of finding a way to talk with her mother and managing the situation, she cuts herself. There seems to be low mother-daughter mutuality, which is a risk factor for attempting suicide.

### Narrative 3

Zuleika is a 15-year-old born in the U.S. of Dominican parents and now lives with her mother, four siblings, and an aunt who has two young children. Her father is in prison. Zuleika tries to balance her obligations at home by helping her mom and babysitting her cousins, and at school.

School is stressful just because I feel like there's things that I should know for my age that I don't know because when I was in middle school, I looked at school like it's playtime...So it's stressful and I just sit there and feel stupid...Maintain grades, stressful. Coming home to take care of two kids, very stressful...

I was raped by my uncle at 8, and then it stopped-like it was 3 years that it went on. At 12 years old, I told my mother. I expected her to do something; she didn't...

I was frustrated. And then after I did it, like I stopped crying 'cause I didn't feel, I was like numb when the blood was coming out. So after that I felt fine. You don't think. Like me, personally, I didn't think anything... I was just calm, looking at it. (Zayas, 123 and 114)

There are clearly a lot of risk factors going on in Zuleika's life. First of all, her father is not at home; sometimes the father figure helps as a protective factor. Secondly, Zuleika is experiencing subjective distress, on one hand she suffers in school because she does not understand some of the topics, which could be mediated if she had support from the school and especially from her teachers; and on the other hand, she suffered sexual abuse when she was younger and this is also a key risk factor. Finally, it seems that her family has high level of familism in which family comes before the individual; Zuleika has to spend most of her time at home cleaning and taking care of two children. Zuleika needs to learn coping skills that help her regulate her emotions instead of having suicidal behaviors and the family dynamic needs to improve in order to lessen her obligations at home.

## Conclusion

In order to ameliorate the distressful adolescence stage of Latina girls by reducing suicidal behavior, efforts should always consider not only a psychological perspective but also a sociological one. It's only this way that the problem can be solved from the root.

The social environment surrounding Latina girls needs to be enriched in order to improve integration and prevent suicidal behavior. Parents need to be better prepared to understand the developmental changes that their adolescent daughters are going through, they need to have an open dialogue that encourages a clear, trustful, and two-way communication; they need to show support and affection; and they need to break gender stereotypes that cause so much distress in their daughters' life. Change is not easy, and some people even say that you can't change a person, but parents should be able to modify their attitude by undergoing parent training through community-based interventions. Schools need to have better support systems. Teachers should be trained to identify kids who are struggling with grades and propose special after-hours classes where the student that feel behind with any subject can catch-up with the rest of the class. Also, teachers should demonstrate support to all of their students.

Treatment should have a community-based focus and should include the adolescent, her parents and extended family, and school staff like teachers. Most importantly, treatments need to have a focus on teaching coping skills that will help the adolescent use more adaptive behaviors in difficult times. This population needs easy access to treatment options through school referral programs and outpatient clinics located inside their communities with professionals that can speak fluent English and Spanish and that understand the Latin culture. In the same way, prevention programs need to focus not only on mood disorder or suicidal behavior but also on

cultural aspects of the adolescent's life, like acculturation issues, and they should include training for both parents and adolescents on how to improve communication and family dynamics.

For future research, it would be interesting to study youth of different ethnic and racial backgrounds that have also been born in the US (2<sup>nd</sup> or 3<sup>rd</sup> generation) like Asian-American adolescents, in order to understand why they might have more adaptive behaviors and to study the way they cope with acculturation issues.

Finally, in order to continue studying this phenomenon in Latina adolescents, new studies and analysis should be performed with more updated data; for example, the Center for Disease Control and Prevention will be releasing the Youth Risk Behavior Surveillance System report by the end of June 2016. It will be very interesting to read, study and compare these new results and analyze if there have been any changes in the statistics over the past years.

## Bibliography

Baca-Garcia, Enrique, Mercedes M. Perez-Rodriguez, Katherine M. Keyes, Maria A. Oquendo, Deborah S. Hasin, Bridget F. Grant, and Carlos Blanco. "Suicidal Ideation and Suicide Attempts among Hispanic Subgroups in the United States: 1991-1992 and 2001-2002." *Journal of Psychiatric Research*. 45.4 (2011): 512-518.

Barranco, R. E. (2015), "Suicide, Religion and Latinos: a Macrolevel Study of U.S. Latino Suicide Rates." *The Sociological Quarterly*. Early View August 20, 2015.

Baumann, A.A., J.A. Kuhlberg, and Luis H. Zayas. "Familism, Mother-Daughter Mutuality, and Suicide Attempts of Adolescent Latinas." *Journal of Family Psychology*. 24.5 (2010): 616-624.

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. (2015) Suicide Prevention, Youth Suicide. Retrieved from [http://www.cdc.gov/ViolencePrevention/suicide/youth\\_suicide.html](http://www.cdc.gov/ViolencePrevention/suicide/youth_suicide.html) consulted April 1st, 2016

Centers for Disease Control and Prevention. Adolescent and School Health. Youth Risk Behavior Surveillance- United States 2013. Retrieved from <http://www.cdc.gov/healthyyouth/data/yrbs/results.htm>

Centers for Disease Control and Prevention. National Center for Health Statistics. Retrieved from <http://www.cdc.gov/nchs/products/databriefs/db241.htm>

Cervantes, R.C., J.T Goldbach, A. Varela, and D.A. Santisteban. "Self-Harm among Hispanic Adolescents: Investigating the Role of Culture-Related Stressors." *Journal of Adolescent Health*. 55 (2014): 633-639.

Colucci, Erminia and David Lester, eds. *Suicide and Culture, Understanding the Context*. Massachusetts: Hogrefe Publishing, 2013. Print.

Curry, John F. "Future Directions in Research on Psychotherapy for Adolescent Depression." *Journal of Clinical Child and Adolescent Psychology*. 43.3 (2014): 510-526.



De Luca, S.M, P. Wyman, and K. Warren. "Latina Adolescent Suicide Ideations and Attempts: Associations with Connectedness to Parents, Peers and Teachers." *Suicide and Life Threatening Behavior*. 42.6 (2012): 672-683.

Durkheim, Émile. *On Suicide*. 1897. Trans. Robin Buss. New York: Penguin Books, 2006. Print.

Fortuna, Lisa R., Debra Y. Perez, Glorisa Canino, William Sribney, and Margarita Alegria. "Prevalence and Correlates of Lifetime Suicidal Ideation and Suicide Attempts Among Latino Subgroups in the United States." *J Clin Psychiatry*. 68.4 (2007): 572-581.

Gulbas, L.E., C. Hausmann-Stabile, S.M. De Luca, T.R. Tyler, and Luis H. Zayas. "An Exploratory Study of Nonsuicidal Self-Injury and Suicidal Behaviors in Adolescent Latinas." *American Journal of Orthopsychiatry*. 85.4 (2015): 302-314

Gulbas, L.E., and Luis H. Zayas. "Examining the Interplay among Family, Culture and Latina Teen Suicidal Behavior." *Qualitative Health Research*. 25.5 (2015): 689-699.

Hawton, Keith, and Kees van Heeringen, eds. *The International Handbook of Suicide and Attempted Suicide*. England: John Wiley & Sons Ltd, 2000. Print.

Humes, K.A., N.A. Jones, and R.R. Ramirez. Overview of Race and Hispanic Origin: 2010. Census Briefs. Retrieved from <http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf>

<http://www.census.gov/newsroom/facts-for-features/2015/cb15-ff18.html> consulted April 1st, 2016

<http://www.samhsa.gov/suicide-prevention> consulted April 1st, 2016

<http://www.nrepp.samhsa.gov/AdvancedSearch.aspx> consulted May 27th, 2016

<http://www.eluniversal.com.mx/articulo/nacion/sociedad/2015/09/9/suicidio-tercera-causa-de-muerte-entre-los-adolescentes-en-mexico> consulted April 1st, 2016

<http://www.inegi.org.mx/saladeprensa/aproposito/2015/suicidio0.pdf> consulted April 1st, 2016  
Mexico Data

<http://www.salud.gov.pr/Estadisticas-Registros-y-Publicaciones/Estadisticas%20Suicidio/2015/Febrero%202015.pdf#search=suicidio> consulted  
April 1st, 2016 Puerto Rico Data

[http://www.minsa.gob.pa/sites/default/files/publicacion-general/ind.\\_basicos\\_pma\\_2014.pdf](http://www.minsa.gob.pa/sites/default/files/publicacion-general/ind._basicos_pma_2014.pdf)  
consulted April 1st, 2016 Panama Data

<http://www.ticotimes.net/2014/11/04/an-average-of-315-costa-ricans-commit-suicide-every-year-report-says> consulted April 12th, 2016 Costa Rica Data

[http://www.jhsph.edu/research/centers-and-institutes/center-for-adolescent-health/\\_images/\\_pre-redesign/az/US%20Fact%20Sheet\\_FINAL.pdf](http://www.jhsph.edu/research/centers-and-institutes/center-for-adolescent-health/_images/_pre-redesign/az/US%20Fact%20Sheet_FINAL.pdf)

<http://www.one.gob.do/Estadisticas/146/suicidios> consulted April 28th, 2016 Dominican Republic  
Data

<http://www.npr.org/sections/health-shots/2016/04/22/474888854/suicide-rates-climb-in-u-s-especially-among-adolescent-girls> consulted April 29th, 2016

<https://mentalhealthscreening.org/programs/youth> consulted April 29th, 2016

<http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-7-161> consulted April  
29th, 2016

<http://www.ncbi.nlm.nih.gov/pubmed/23136686> consulted May 27th, 2016

<http://www.sprc.org/bpr/section-i-evidence-based-programs> consulted May 27th, 2016

<http://yellowribbon.org/our-work/training/youth/>

- Kuhlberg, J.A., J.B. Peña, and Luis H. Zayas. "Familism, Parent-Adolescent Conflict, Self-Esteem, Internalizing Behaviors and Suicide Attempts Among Adolescent Latinas." *Child Psychiatry and Human Development*. 41.4 (2010): 425-440.
- Lorenzo-Luaces, L., and Julie A. Phillips. "Racial and Ethnic Differences in Risk Factors Associated with Suicidal Behavior among Young Adults in the USA." *Ethnicity & Health*. 19.4 (2014): 458-477.
- March, John S., Susan Silva, Stephen Petrycki, John F. Curry, Karen Wells, John Fairbank, Barbara Burns, Marisa Domino, and Steven McNulty. "The Treatment for Adolescents with Depressive Study (TADS) Long-Term Effectiveness and Safety Outcomes." *Arch Gen Psychiatry* 64.10 (2007): 1132-1142.
- Miller, Alec L., Jill H. Rathus, and Marsha M. Linehan. *Dialectical Behavior Therapy with Suicidal Adolescents*. New York: The Guilford Press, 2007. Print.
- Peña, J.B., P.A. Wyman, C.H. Brown, M.M. Matthieu, T.E. Olivares, D. Hartel, and Luis H. Zayas. "Immigration Generation Status and its Association with Suicide Attempts, Substance Use, and Depressive Symptoms among Latino Adolescents in the USA." *Prevention Science*. 9.4 (2008): 299-310.
- Pickering, W.S.F., and Geoffrey Walford, eds. *Durkheim's Suicide, a Century of Research and Debate*. New York: Routledge, 2000. Print.
- Piña-Watson, B., L.G. Castillo, K.M. Rodriguez, and S. Ray. "Familial Factors Related to Suicidal Ideation of Latina Adolescents in the United States." *Archives of suicide research*. 18.2 (2014): 213-220.
- Smokowski, P.R., C. David-Ferdon, and N. Stroupe. "Acculturation and Violence in Minority Adolescents: a Review of the Empirical Literature." *The journal of primary prevention*. Vol 30.3-4 (2009): 215-263.

Tortolero, Susan R., and Robert E. Roberts. "Differences in Nonfatal Suicide Behaviors among Mexican and European American Middle School Children." *Suicide and Life Threatening Behavior* 31.2 (2001): 214-223.

United States Census Bureau. American Fact Finder. Hispanic or Latino by Type, 2010. Retrieved from [http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC\\_10\\_SF1\\_QTP10&prodType=table](http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_QTP10&prodType=table)

Wagner, Barry, M. *Suicidal Behavior in Children and Adolescents*. New Haven: Yale University Press, 2009. Print.

World Health Organization. Mental Health Action Plan 2013-2020. Retrieved from [http://www.who.int/mental\\_health/publications/action\\_plan/en/](http://www.who.int/mental_health/publications/action_plan/en/)

World Health Organization. Retrieved from [http://www.who.int/mental\\_health/media/cuba.pdf](http://www.who.int/mental_health/media/cuba.pdf) consulted April 12th, 2016 Cuba Data

World Health Organization. Retrieved from [http://www.who.int/mental\\_health/media/cost.pdf](http://www.who.int/mental_health/media/cost.pdf) consulted April 12th, 2016 Costa Rica Data

Zayas, Luis H. *Latinas attempting suicide: when cultures, families, and daughters collide*. New York: Oxford University Press, 2011. Print.

Zayas, L.H., C. Hausmann-Stabile, and J. Kuhlberg. "Can better mother-daughter relations reduce the chance of suicide attempt among Latinas? *Depression Research and Treatment*." Article ID 403602 (2011): 1-7.