

Suicide Prevention
Among Culturally Varied Populations
A Project of The Greater Boston Coalition for Suicide Prevention
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**Summary of Findings
by Cultural Group**

Please refer to the full report for context, methodology, and recommendations.

To access the full report or to discuss activities or projects related to the recommendations please contact the co-chairs of the Greater Boston Coalition for Suicide Prevention, Ron White of Samaritans (rwhite@samaritanshope.org) and Tony Dellovo of Screening for Mental Health (tdellovo@mentalhealthscreening.org).

Summary of Findings: Asian Community



Two Asian community focus groups were held on the same day. The first was with community members who are Asian-born or Asian American, and the second was with mental health service providers who identify as Asian. Various language groups were included and the groups were conducted in English.

Supports, Services and Protective Factors

Participants in the focus groups found a variety of supports as they dealt with their own mental health concerns, ranging from clinical mental health treatment to community-based programs, support groups and social opportunities. All participants had been to individual therapy, some with Asian therapists, some with non-Asian therapists, and some with both.

One participant explained that people seek alternatives to clinical treatment, including family support, worship, friends, yoga or meditation. Providers described that Asian patients often seek treatment quietly, and family can be an important source of support.

Why is it hard to get help?

Many different factors make it difficult to access services. One person mentioned that primary care doctors are not an easy entry point to the system for people who do not speak English. Another person described a fear within some families that have experienced trauma of being ‘found out’. Additionally, many places that provide culturally appropriate care only have one or two providers who speak languages other than English and they do not accept all insurances.

The stigma surrounding mental illness affects people’s individual understanding of their own needs, affects their help-seeking behaviors and can also affect their family. After someone’s suicide or attempted suicide there can be stigma attached to the family because they haven’t sufficiently supported their loved one.

Among community members who participated in the conversation, many described a longstanding fear of medication, which influenced their decisions about whether to take medication for depression or anxiety. One young person explained that as his parents tried to help him, things were lost in translation. In a clinical setting as well, language barriers can affect

the ability of providers to help. Providers pointed out that “you cannot just translate the US material into other languages. It won’t work”

One provider explained that some second-generation immigrants have difficulty integrating US culture with their family’s culture and their parent’s experiences. They know the expectations that their parents have of them and they know the expectations that are put on them in the United States, but they do not always align. It can be difficult to compare the situation here to the older generations’ experience, but the trauma of one generation also passes to the next.

Gender expectations are strong within some facets of the Asian community and this can affect mental health and help seeking in a number of ways. One participant mentioned that men do not discuss depression. Another described the way that expectations of women have made it hard for her to seek treatment.

One woman described that mental illness is not part of the Asian ‘model’. Another described her sense that rather than considering it to be an illness, mental illness is considered a character flaw. More than one person explained that mental health challenges are viewed as a weakness.

One provider describes that there are deep-seated differences between Asian and American cultures and that it can be very difficult to replace one set of behaviors with another. She described differences in cultural approaches to child-rearing, differences in expectations about corporal punishment, different dietary restrictions, and also described how difficult it is for her to say “I’m stressed” while it seems easy for Americans to say it. She described that despite her clinical training, in conversations with friends and family the cultural norms that have been instilled from childhood are powerful. Media portrayals of suicide also affect popular conceptions of suicide.

It is difficult to separate the influence of migration, the passage of time, and the influence of the United States’ norms on each persons’ perceptions and beliefs. There was general agreement among focus group participants that there is tension between American culture and family culture, and that there needs to be a place and a way for people to speak comfortably about their feelings.

High-risk populations

Focus group participants identified sub-populations of particularly high need. These were international students who are here in the country alone, immigrants who are far from family and men who are not performing well at work.

Community members mentioned isolation, being less communicative, feeling spiritually drained, guilt, shame and finding friends to say goodbye as warning signs for suicide. They also point out that some people give no signs. One woman shared that before her own suicide attempt she gave money to her sister, but that it was not an unusual thing to do.

Summary of Findings: Haitian Community

Two Haitian groups were convened, one composed of Haitian service providers and one of Haitian community members. The Haitian community group included interpretation between English and Haitian Creole.



Supports, Services and Protective Factors

Local Haitian organizations exist, but providers felt that these organizations are not prepared to support someone who is feeling stressed or depressed.

Church was the support mentioned most frequently by Haitian community members. The church and its pastors have an opportunity to discuss mental illness and to create openings for people to share their own experiences. They mentioned primary care doctors as the best first point of contact. Once a person is not feeling well, community members mentioned a number of ways to support the person: first through individual moral support, then, if needed, with a referral. They also described helping them to find a counselor or family counseling programs in the church.

There are many examples of resilience and cultural practices that help people to handle stress and depression. One focus group participant described, “We have terms like “face is long” or “your head feels hot” ... When we express them it’s with courage. When you mention it people will say things to lift their moods.”

Why is it hard to get help?

According to focus group participants there are numerous barriers to service. One is that people don't know what is available. Some organizations exist, but people aren't all aware of them. Some people are afraid to see a doctor and other people are afraid that their stories will not be kept confidential if they talk to anyone in the community.

Some outreach efforts are not appropriate to the population. Many Haitians don't have access to the internet, making internet-based outreach less effective, and language is also challenging. Much of the populations speaks Creole most fluently but only reads in English.

There are a variety of terms that Haitian community members used to describe feeling depressed or stressed. These include “not feeling good”, “crazy”, “face is long” or “your head feels hot”.

There are differences in terminology by age and by generation. One person explained, “A kid in high school or college they will say I’m stressed. The parents will respond you have a home, food, so what do you have to be depressed or stressed about?” One person says that he is “too Americanized to find the right words” in Creole or French, meaning that he wasn’t raised with the deep familiarity of Creole or French that he would need to be able to describe complex emotional issues.

Another provider explained that although teenagers and the younger generation use the terms depression and stress, there’s not widespread understanding that that can be disconnected from the things and opportunities that the person has, that they might feel that way despite not having anything visibly wrong. Another provider elaborated, “When you tell a Haitian about stress its common word but they don’t understand the meaning of it. They don’t understand what causes it.”

There is a high level of stigma attached to mental illness and to suicide. Many people mentioned that mental illness is not discussed publicly, it is kept within the family in order to protect the family as whole from being ostracized from the community or from the church. In order to keep the concern private many people go to church to pray for the person instead of looking for support from a counselor or a friend. One person described that if someone does die of suicide, people will not get too close to the body.

Some Haitians described depression as an illness, others described it as demons and one described it as the devil. Because of its associations with evil, churches vary in the way that they will or will not support a family that has experienced a suicide.

There are gender and class issues that also influence whether it’s acceptable to complain about feeling depressed. One person explained that women only seek help for physical violence but not for anything else.

High-risk populations

Groups of particular concern that were mentioned by community members include teenagers, parents, and people who are home alone. Providers mentioned veterans as another high-risk group.

Many different warning signs for suicide were mentioned. Community members mentioned increases in smoking, drinking or moving. They described teenagers staying in bed longer, not eating as much, fighting and feeling unsafe. Providers described additional signs, including self-imposed isolation from church and family events, changing routines, having shifting moods, abusive language or fighting.

Summary of Findings: Latino Community

Two focus groups were convened for the Latino community. One group brought together young community members who identify as Latino and the other convened mental health service providers who work with Latino clients as part of their caseload.



Supports, Services and Protective Factors

Youth were aware of various clinical and organizational supports. They knew that parents, school or a therapist could make referrals. In many cases people enter mental health treatment after coming to a health center for a physical symptom and then being referred to a counselor. Most people who do not access counseling go to the emergency room if they need care, but that they have to be really sick to take that step. A variety of factors drive people's choices about where to go, including proximity to home and availability of Spanish speaking clinicians, but personal referrals from friends and families are most powerful.

Youth explained that talking and communicating can be helpful, and that friends and family can be good people to talk to. However, the usefulness of talking to family depends on the parent's experience and perception of depression. Some young people described having parents who come from other countries where they struggled and who don't understand why they, in the United States, with all of the opportunities that they have, could be depressed.

While clinicians noted quite a bit of passive suicidal ideation by their Latino clients (statements like 'I want to die'), they also noted that because of religiosity and concerns about hurting their loved ones, people wouldn't follow through on those ideas. Because of strong sense of responsibility to family, many Latino people would not consider suicide because of the burden that it could place on their families.

Why is it hard to get help?

Young people explained that one of the things keeping them from seeking services is feeling like their problems are not significant enough to warrant help. They also sometimes feel embarrassed to ask for help. People don't want to seem like they're looking for attention by looking for help, and they don't want other people to feel responsible for them. The Department of Children and Families (DCF)'s regulations about what constitutes an unfit home can also be a barrier to reaching out for help. Some young people described language barriers between parents and children

Another barrier to help seeking is the fear of being reprimanded. Providers identified a host of other barriers to service. These included shame, lack of interpreters, inability to read and write, feeling like the whole family unit has failed, high co-pays, lack of familiarity with neighborhoods beyond where the family lives and fear related to immigration status.

Providers noted that for people who are religious, having a suicide or suicidal ideation in the family can be more challenging than for other Latinos. The family can worry about whether the person they love is going to hell.

The level of stigma attached to mental illness and mental health treatment varies within the Latino culture. Providers described that the level of stigma depends more on the culture of each family than on Latino culture as a whole. While young people who participated in the focus group did not refer to stigma in the same way that providers did, they did describe feelings of embarrassment or feeling like there might be something wrong with them if they needed treatment. Also, one person explained that the community is small, and having someone in the family take their own life can make people feel ostracized and judged for being “crazy”. There’s a Latino masculine identity that providers described as making it hard for men to seek treatment.

High-risk populations

Groups that were mentioned as being at higher risk for suicide were people struggling with housing, people immigrating from countries with histories of trauma, people who are undocumented (particularly those who feel like things should be better here but they aren’t), and people who are isolated (particularly those who came from tropical countries and feel isolated due to the cold weather). Latino teens are at high risk for suicide.

Depression is described or referenced in many different ways. Some people might describe their symptoms by saying “I’m having a bad day, or I’m feeling down, or I’m just really tired”. Others might say that they are experiencing *nervios* (nerves), or sometimes *ansiedad* (anxiety). However, one clinician explained that the term *ansiedad* often refer to nervous behaviors, like eating too much, and not to clinical anxiety. The primary phrase that providers listen for as they watch for warning signs of depression or suicide is “*falta de animo*” (lack of animation). One provider described *animo* as “combination of energy and motivation, and *falta de animo* is when you “just can’t mobilize to do anything.”. They explained that in general, the term is used to explain what daily tasks or responsibilities someone doesn’t have the energy for, like not having the motivation to cook or to care for the children.

Youth mentioned that status posts on Facebook about not feeling good or feeling sad can be warning signs for suicide. They also mentioned that people might self-harm, might get touchy or angry, might not sleep as well, might start to smoke or start losing interest in things they used to enjoy.

Providers were not as specific about warning signs, saying that their greatest concern in terms of suicide within the Latino population is for people who also use and abuse substances. They noted that because of a sense of familial responsibility, those at greatest risk for suicide are people who are using opioids or alcohol, for whom substance use has dissolved the connections with their families either temporarily or permanently.