

# **Suicide Prevention Among Culturally Varied Populations**

A Project of  
The Greater Boston Coalition for Suicide Prevention

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## Introduction

The mission of the Massachusetts Coalition for Suicide Prevention (MCSP) is to prevent suicide through statewide collaboration and advocacy. The Greater Boston Coalition for Suicide Prevention is a subgroup of the MCSP that serves the Greater Boston area. In 2014 the Greater Boston regional coalition was awarded a grant to conduct a series of focus groups with a variety of cultural groups in order to 1) better understand the prevention needs of particular communities, 2) establish and strengthen connections with diverse organizations, 3) expand and diversify membership in the coalition, and 4) learn how to better serve diverse communities. This report presents the results of six focus groups carried out during 2015 and provides a series of recommendations for steps that the coalition and/or other organizations can take to strengthen suicide prevention for culturally diverse populations in the Greater Boston area.

### How to use this report

The findings in this report are divided into four sections. First are cross-cultural findings that are relevant to all of the cultural communities that we talked to throughout this process. Next are sections specific to each group.

Please begin by reading the General and Ethical considerations and the cross-cultural findings. If you do not wish to read the full report you can then read only the sections relevant to populations that you serve or intend to serve.

## Methodology

### Recruitment and Participation

The Greater Boston Coalition for Suicide Prevention conducted six focus groups, ranging in size from 5 to 22 participants. To begin, the coalition asked members who serve unique cultural groups to volunteer to organize focus groups with their constituents. Three initial cultural communities were identified to participate in the first round of focus groups:

- **Asian** (including both Asian-born and Asian-American)
- **Haitian** (including both Haitian-born and Haitian-American)
- **Latino** (born in Spanish-speaking countries or identifying as Latino or Hispanic)

The focus groups were planned by organizations that belong to the coalition, but some groups were hosted by other organizations. In total, 53 people participated in focus groups and one person provided input by email.

## Structure

For each cultural community, two separate focus groups were convened. One group brought together individual community members, some of whom had personal experience with mental illness and/or suicide. A second group convened service providers who work with members of the community of interest. Although some participants in each group spoke from their personal and professional experiences, “peers” and “providers” were separated in order to make community members feel more comfortable speaking more freely than they might if there had been providers in the room. Despite this structure, it was difficult to maintain an even power balance and equal participation during each conversation, particularly in the larger groups. An attempt was made to limit the size of each focus group to no more than nine participants.

Only the Haitian “peer” group was translated. Introductions and questions were in English, and an interpreter translated them into Haitian Creole. If respondents contributed in English their comments were translated into Creole and if they responded in Creole their comments were translated into English.

A question guide and consent forms were developed by Amy Helburn in consultation with the co-chairs of the coalition (see appendix for a copy of the question guide). Amy facilitated the first focus group. Emily Bhargava of Connection Lab LLC facilitated subsequent focus groups.

Before each conversation began, the facilitator verbally reviewed an informed consent form, describing how identities and content of the conversations would be kept confidential. Each participant signed this consent form. Any participants under age 18 also brought a signed consent form from their parents. All conversations were audio-recorded, and one or two note-takers typed notes as the conversation progressed. Each participant was offered a \$25 gift card as compensation for his or her time. One group chose to receive lunch for each participant instead of gift cards.

Following the conversation, each participant received an email thanking him or her for participating. The email included a link to an online survey. The survey contained a prompt for them to share anything that they had not felt comfortable sharing during the conversation or that they had thought of in the weeks since their focus group met and provided a free response space. While almost no one responded to the survey, sending it served as an opportunity to thank participants and to respectfully offer them another opportunity to contribute.

## Data Analysis

Emily Bhargava of Connection Lab LLC conducted the analysis. Typed notes that had been written during the focus groups were clarified and supplemented by listening to relevant sections of the audio recordings. The notes were then edited to correct spelling mistakes. The cleaned notes served as the data that was analyzed to generate this report. A theme list was generated from the reading of three sets of notes. During the coding of subsequent transcripts, themes that had not appeared in the previous transcripts were added to the theme list. All data were coded by theme. Each theme was then analyzed and summarized, maintaining illustrative direct quotes whenever possible.

## General and Ethical Considerations

**“Not everyone fits the same shoe. At the same time we have a common thread that’s suffering and wanting to be connected.”**

**- Focus group participant**

Every person is an individual. And yet many of the ideas, values, approaches and practices that make us who we are come in part from our families, friends and the other people around us. The term “culture” has many definitions<sup>i</sup>, but all of them attempt to explain that there are commonalities between people that can define and distinguish groups. One definition reads: "Culture is the collective programming of the mind which distinguishes the members of one category of people from another" (p. 51).<sup>ii</sup> Another reads: "Culture is the shared knowledge and schemes created by a set of people for perceiving, interpreting, expressing, and responding to the social realities around them" (p. 9).<sup>iii</sup> These schemes and shared knowledge can include religion, language, food, dress, historical oppression, current oppression and a host of other experiences and practices that we share.

As we consider cultural issue that may affect suicide prevention, we must walk a fine line between recognizing and acknowledging cultural differences in order to make services and information linguistically appropriate and to present messaging and support in a way that will be acceptable and useful to particular groups and creating or reinforcing stereotypes. We hope that this report can walk that line, serving to increase our awareness of cultural considerations **without reinforcing stereotypes.**

This dilemma about how to be knowledgeable without making generalizations exists not only in suicide prevention, but also in treatment. One provider talked about the idea of cultural competence for providers and explained that cultural competence should not be about knowing about a culture, but about being open to the individual in front of them. He explained,

“It’s not so much about being culturally competent. [It’s] about providers not making assumptions and having an open mind and...whoever that provider is shouldn't have a set of assumptions of what this population is or isn't. They should be thinking about themselves more critically.”

We must ask questions at a high level about differences in needs and interests between groups. Then, as organizations and individuals we can use these generalizations as background information to help us understand a small part of the context within which people might be approaching us. Once we’re face-to-face with an individual, we have to put aside our generalizations and be ready to listen to that person’s unique beliefs, needs, experiences and requests.

## Cross-Cultural Findings

All three of the cultural communities that we talked to in this first round of focus groups are identified by their place of origin. While Haiti is a small country, Asia and Latin America are extremely large regions. The three areas are in different parts of the world geographically and include many different language groups. Despite these differences between the three groups, there were a number of areas of commonality in their responses. The common threads were:

- Challenges in comparing the suffering of one generation to that of another
- Experiences of being marginalized by institutions
- Requests for non-judgmental service providers who can build trust and long-term relationships
- Difficulty discussing mental health openly

### “Here isn’t as bad, why are you suffering?”

Some focus group participants immigrated to the United States themselves. Others were born and raised here. Each of these experiences comes with challenges. In all three cultural groups people mentioned that difficult or traumatic experiences in someone’s country of origin can affect the way that parents respect or understand their children’s experiences with depression or suicidality. These differences played out in two ways. First, some parents who experienced difficult lives are not able to understand why their children who have more stability or opportunities might not feel fully well. Second, knowledge of their parents’ trauma can make children feel hesitant to disclose their own mental health concerns because they feel insignificant compared to what their parents experienced.

Young people recognized that their parents have a different view of depression and a different frame for their emotions based on their own experiences. One young person explained, “I think it’s because our parents went through their own struggles, and they wanted to give us this life, but [then they think]...I gave you what I didn’t have, why are you still depressed?” another person shared that “They grew up in a different time, so their struggles are different from what it is now...they think you’re just being bratty or spoiled and want more than what you are given.”

### “What does it mean to be marginalized?”

One provider asked, “What does it mean to be marginalized, to have a set of institutions that have failed them?” In asking this question he echoed comments made by each of the cultural groups about how difficult it can be to figure out a complex medical bureaucracy and how hard it can be that once you have actually accessed the system, there might not be providers and programs that are right for you and are offered in your language. Even beyond the language that is being spoken there is a divide between “medical” language and lay language. All three groups referred to a need for psycho-education, or information about what therapy is and how it works. One provider who has worked as an interpreter explains, “we can use the clinical language but it creates more of a barrier. They start to get confused. I end up using three or four sentences to a

provider's sentence." Being marginalized linguistically and culturally can have significant implications for access to quality care, and exacerbates the challenges that many groups have in interacting with medical establishments.

### **"Make them feel comfortable"**

One group explored in depth the question of what brings someone into a clinical setting, what makes someone feel comfortable in therapy, and what keeps them there. On all counts, the answer was personal relationships with someone. One of the key themes that emerged in describing providers who are helpful was trust. One provider noted, "they're coming not because you're a mental health clinician but because 'they told me you can help me'" Focus group participants talked about how it is hard to establish trust between a provider and a patient, and when a provider leaves or breaks the trust in another way the patient may never return to therapy. This theme was mentioned in all three of the cultural groups. One provider noted that it's important to work hard to "Make them feel comfortable, like you care, like you're being compassionate and empathetic". Another provider described that treatment has to be not only appropriate, but also unhurried. If people feel that they are being rushed, they will not continue.

### **"Pretend everything is okay"**

All three cultural groups described how difficult it can be to talk about mental health and to discuss suicide. While the specific reasons for the difficulty varied, many centered on stigma related to mental illness. All three groups discussed a need to normalize mental health concerns and to create space for them to be discussed openly. This may be universal, but one provider implied that the issue is more pronounced in communities of color, saying, "With Caucasian patients, maybe they're more easily able to talk to people about their issues. For clients of color it's traumatizing". Two different cultural groups mentioned that it can be hard to talk about concerns because their community is small, so they feel like their stories will become too public or they will be judged by the broader community if they speak out.

## 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 and Services

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 and social opportunities. One person had joined a group for young people that included community service activities, job opportunities, wellness workshops and socializing. All participants had been to individual therapy, some with Asian therapists, some with non-Asian therapists, and some with both. One woman had also been part of Alcoholics Anonymous for many years. Another is part of a cancer-survivor support group.

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, but that in some cases parents and other family members bring their loved ones in for treatment. For at least one person, family has been a tremendous support. He explains, “I am actually connecting with my parents...they are very humble and they came to therapy from me. I learned from my parents and they learn from me... my problems became their problems. It is a family effort.”

Participants mentioned a few organizations that provide culturally appropriate care. These include South Cove, North Quincy Mental Health and South Shore Mental Health, but they mentioned that many of these places only have one or two providers who speak languages other than English and they do not accept all insurances.

### 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’.

### Stigma

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. One woman described her difficulty in seeking treatment:

“Before I found therapy, I told myself that I am not going because I am not crazy. People who go are crazy, are not normal. I don’t want to say that I am sad, crazy, upset or anything like that. It’s too crazy too say.

Pretend everything is okay. On the outside I look happy but inside myself is not okay. I think going for help is too much. Before I find my therapy, it was hard.”

Another explained that after someone’s suicide or attempted suicide there can be stigma attached to the family because they haven’t sufficiently supported their loved one.

## **Fear**

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 woman explained, “I am very scared of medication. From growing up, medication is terrifying. Even vitamins.” Another described, “Any pain that I can tolerate, I don’t take medicine.” For one woman, the difficulty of medication is that her mother does not approve of them. She described:

“I think it is going to take a long time for my mother to kind of understand the mental disorder concept or paradigm. I find myself to be very patient with her. She still texts me that “are you off your meds yet?” She is worried about the synthetic chemicals. She says that the best way to fix it is through prayer. I think this might have to do with my mom’s personality. She told her bible study group and her peers. She asks them what happens if you take medication and she gets colored feedback. She tells me that I should pray, everyone goes through hard stuff.”

## **Family**

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. Additionally, one young man described the complexity of his relationship with his parents:

“They feel that [mental illness] is a character flaw. They think you are supposed to be successful and more. [They say] ‘I give you everything’... This whole time they were trying to give me the best. Things were also lost in translation. I realized that they have very good intentions. They went through a lot of stuff. They went through war and that carries with them.”

Another person explained that the trauma of one generation passes to the next. “A lot of second generation inherit that trauma because the parents don’t know how to deal with that.”

Many traditional dynamics between parents and children remain in place between first- and second-generation immigrants. One woman described, “The child has no choice and no word. If say you do this, you do that.” Another describes, “within my family it was like we are all cogs within the family machine. No one could tell anything was wrong with me. I ate. I didn’t even have the sense of individualism in eating. My mom would give out the food and we eat and then disperse.” And another explained, “My parents can’t even say I love you and you don’t get that. Just like that is a big thing.” Another shared that “they are not telling me that I am lazy or weak but I myself fill that in.” These dynamics are one of the things that some people explore in therapy. One young man described how his relationship with his parents has changed. “I didn’t like my parents but now we are better...through family therapy, we learned that we care about

each other... In a way mental illness is helpful because it raises awareness that something is wrong. It gathered people together.”

It can be difficult to compare the situation here to the older generations’ experience. One woman describes, “I actually see a lot of mental health issues in my mom’s generation but they are not going to therapy which makes me feel bad about myself. They went through worse stuff, war and stuff and if they don't need therapy, what is wrong with me?”

## **Gender**

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. She said,

“I personally know that many of the Asian women when they experience stress, they don’t really go see providers because of the stigma and also just culturally we are taught to hold everything to ourselves. We don’t let everyone know that we are suffering and also we think that to see a psychiatrist is only for people who are crazy, but we are not crazy. So stress and distress does not fit into the Asian conception of mental health.”

Gender expectations run deeper than simply affecting whether someone seeks support. One provider shared the difficulty that she had in her own treatment and linked it to a cultural expectation that Asian women will not make decisions. She shared,

“Asian women were trained to not make decisions. We were just trained to follow instructions, work hard, be caring and never argue. When I had a Western male therapist in my early 30s, he asked me "So, what have you decided?" He assumed that decision-making was already developed... It is only until I met a therapist in NY who specialized in Chinese population...that he asked, "Do you know what it feels like to make the right decision?" I was already 37 then and I had had a career as a professional having to make rational decisions for my clients, but my answer was still "no." It's a learning curve for some Asian women, or women who had been through very traditional male-dominated cultures to know what decision making for themselves is about.”

## **Cultural expectations**

One person explained that there is a difference between sympathy and understanding. She said,

“My experience with Korean culture is that it is very emotive. There is a lot of sympathy. A lot of times there is a lot of focus on the situational aspect, like financial loss...I think within the Asian community, there is lack of ...understanding of mental illness...There is a lot of sympathy for it but that’s it.”

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 explained, “You are weak, you are lazy. They don’t see you as depressed. They see you as weak. You are supposed to brush it off.”

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. She says, “In India, when you ask “how are you”, you are not expected to tell your true feeling.”

Media portrayals of suicide can affect popular conceptions. One woman explained, “In Korea, there are a lot of celebrities that commit suicide. In the media, the narrative goes like ‘oh she suffered financial loss and lost celebrity status and thus committed suicide’.”

Participants who moved to the United States described differences between expectations set by their parents’ generation and expectations of their own. Participants who were born in the United States also described differences between their parents’ expectations and experiences and their own. 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.

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. One clinician described that, “language appropriate words were not there to help explain jargon words of clinical practice.” For this reason providers pointed out that “you cannot just translate the US material into other languages. It won’t work”

### High-risk populations

Focus group participants identified a few 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.

### What would help?

A variety of suggestions were made about what could be created or expanded to address the challenges that were raised during the conversation. They are listed below, along with clarifications and examples provided by participants.

- **Trust relationships with clinical providers**
  - In describing how she can tell whether a provider is someone she can trust, one woman explained that she looks for “basic eye to eye contact. I look into their eyes and see if they pause.”
- **Peer support groups/ conversations**
- **More Asian mental health providers**
  - Referencing the many cultural nuances involved in her experience, one woman explains, “When I am with an Asian therapist, I know that I can deal with “this stuff” but when I am with a non-Asian therapist, I don't talk about “this stuff””.
- **More therapists who speak Asian languages**
  - Particularly to serve the older generation.
- **Non-Asian providers who have some understanding of Asian upbringing.**
  - One provider hopes that it could “generate more understanding and empathy for the need for validation and the decision making process.”
- **Education or messaging for parents**
  - About raising kids in what one focus group participant described as “a loving and caring way”. One woman explained, “It is hard always to be put down. I mean to this day, I still feel like I didn't live up to my parents' expectation.” Another woman says that “conversations about parenting would be very helpful and healing”
- **Community education initiatives to normalize help seeking.**
  - One provider says, “We don't have the concept that if we are sad or depressed, we need to go see a provider. We need to have more peers and consumers come forward and share their story. I guess the message would be if you have physical pain, you go see a doctor. If you have mental health problems, you need to see a psychiatrist. Normalize it. If you have mental health issues, you are not crazy. You need to restore the balance. I guess in the Asian culture, we really value face. We can create a more accepting environment and normalize the action to seek help [and provide] more education about the effects of medication to take stigma away.”
- **Strong provider-patient relationships**
  - “Where the provider should be listening for solutions to come from the patient...and can find ways to help the patient feel empowered and valued”
- **Inter-generational conversations**
  - Between adults and people their parent's age, but not with their own parents “to talk about mental health and wellbeing. One woman explained, “It is really helpful to hear the struggles and experiences that [people like] our parents have been through”
- **Diversity training**
- **More research on ethnic subpopulations**
  - Including Asian, Latino and African American to see what the needs are in each community.
- **More community workshops**
  - Because seeking help within a complex bureaucracy is difficult
- **Peers telling their stories**
- **Messages coming from sector leaders like spiritual leaders**

- **Welcoming, culturally-appropriate centers**
  - Like one in Seattle where people can come for prevention and treatment
- **Ways to engage people in conversations about culture**
  - Humorously or seriously, including Tai-chi and squats, respecting their expertise and cultural knowledge
- **More relaxed catchment areas for service provision**
  - In order to connect people more quickly to mental health services that are linguistically and culturally appropriate.

## 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 and Services

Church was the support mentioned most frequently by Haitian community members. Haitian providers also discussed the church community as a significant support. The church and its pastors have an opportunity to discuss mental illness and to create openings for people to share their own experiences. One community member shared that, “having someone commit suicide or be suicidal ...many think a demon was sent to you and they don’t want to share, but if the ministers talk about it it’s better.” Another person explained that, “if the pastor says it’s OK to seek mental services... my experience leads me to believe people will do it.”

Neither providers nor community members discussed clinical or medical support extensively. However, individuals in both groups mentioned that it can be valuable for someone to talk to their doctor or to be referred to a specialist. They mentioned primary care doctors as the best first point of contact. One person explained, “My primary care doctor is my friend. They are the one who can see the changes.” They mentioned the value of seeking treatment, particularly for people who feel comfortable talking about how they’re feeling, for teenagers, and when there are clinical symptoms. 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 to someone with a Master’s degree. They also described helping them to find a counselor or family counseling programs in the church.

Local Haitian organizations were mentioned, including an association of Haitian women that addresses domestic violence and elder services, but providers felt that these organizations are not prepared to support someone who is feeling stressed or depressed. One provider explained, “they should know about it. If you don’t educate them, they will not find out...sometimes they communicate [about mental health] but the message isn’t clear.”

Community support is also available. Someone explained that in addition to the hospital, someone who is feeling depressed could turn to their family or their friends. Many focus group participants felt that even if someone is not feeling well, suicide can be prevented. Many people described ways to support their friends, including moral support, asking the person to see a doctor, family counseling programs, and simply sharing their friend’s experience.

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.” Someone else explains,

“There are ways we do deal with it. Humor, we joke around a lot. The other is just little cultural things like when I was a kid in Haiti everyone had a massage, ask a family member to give you a massage. It could be like

that, there are ways to cope with it there and ways to cope it here but if you grow up in a certain system like they did have someone to give you a massage but you come here when everyone is busy you may not have that, you have to adjust with how you deal.”

## 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 it was mentioned that people aren't all aware of them. One woman admitted that she is afraid of seeing a doctor, and others talked about their worries that their stories will not be kept confidential if they talk to anyone in the community.

While there was general agreement that people can go to church or pray when they are feeling stress or depression, individuals also described a number of reasons why someone might hesitate to approach their pastor. First, people try to hide their challenges and don't want them shared with the community and the pastor is connected to the whole community. Focus group participants described the church community and the Haitian community in general as very close-knit, with people sharing information about their friends and family members openly. They explained that this can make it hard for people to share their challenges. One woman explained, “we go to churches but...everything is done privately. We find it hard to articulate the issues and the community is small”

Second, some churches are not accepting of suicide. Pastors participating in the focus groups mentioned that they each have to decide whether their church will conduct services for people who die by suicide, and individuals and families sometimes feel that they won't be welcomed in the church if they or their family is experiencing mental illness. One woman explained that mental illness shouldn't happen to someone who is devout. She stated, “Since I belong to church, things like that should not come to mind.”

Some outreach efforts are not appropriate to the population. For example, one man explained that “half of the Haitian community needs help through online but 50% of the Haitians don't have Internet. We say we can do this in Creole but half of the population don't read Creole but read in English. It's a complicated issue”. Additionally, the Haitian community is diverse. As one provider explains, “Depending on what Haitian community you are addressing, there are multiple segments, Haitian immigrants, Haitian American, young Haitian immigrants, and older Haitians. This all means different things.”

A number of people believe that suicide doesn't happen very much in the Haitian community. One explained that it's because “we are very resilient. We go to church, we pray, we try to feel better. It could happen, but not often.”

## Family

Suicidal ideation can be a sign of challenges for the person considering suicide and can also cause grief for family members and loved ones. This grief can sometimes be heard as judgment. The responses of loved ones to suicidal ideation are varied. One parent described frustration at

her daughter's consideration of suicide, saying that she had been through a lot raising her, and that having her daughter consider suicide wasn't what she deserved.

### **Conception of mental illness**

One person said that people in Haiti think of depression as an illness, but others described it as demons. One described it as the devil: "there's an open door – let the devil in, and then they are possessed. They let the devil in, and that does damage." One person explained that, "some think its spell on the family, that's why the kid committed suicide they didn't recognize it as an illness to seek help" and someone else explained that mental illness can be seen at two levels: "1) when people can use voodoo to make someone do something like that to themselves, 2) when you feel hopeless – seek a job but can't find, want to go to school [but] can't, [you have] no options".

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."

### **Stigma**

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. Someone else explained that "If somebody committed suicide, no one will want to marry a member of that family, to isolate that curse." Churches vary in the way that they will or will not support a family that has experienced a suicide. One pastor who thinks it is important to support the family of the person who died by suicide explained that there's a fine line to walk: You cannot say as a pastor, this person is going to hell, but you also cannot say that this person will be with God." Even during the focus groups, one person referred to suicide as an "evil act".

Suicide remains a taboo subject, which makes it difficult to discuss openly. It also makes it difficult for people to ask for help for themselves and their families. One woman shared her experience with suicide in the family:

“The question is how do we make them talk about it? My cousin lost his son, 30 years of age and was sick, his mother never informed me what was going on, he is here, then left. He was sick. She goes to church for prayer but did not ask about the sickness that her son is suffering. I learned about this when he ended up in the psychiatric hospital. How can we make the people to use the information, its very taboo. That what we discuss that, we can extract the situation, when you hear so and so died from suicide but after the fact, but you know what can we do in the front end to make them talk about it and disclose it so we can direct them or guide them. I see this happen”

## **Gender and class**

There are gender and class issues that also influence whether it’s acceptable to complain about feeling depressed. One person explained, “The culture is very macho, women work and still should have four pots on the stove well coordinated, you are in the culture where everyone struggles and you don’t want to stick out as a complaining”. Another added, “For the women, they only seek help for physical violence but not for anything else.” Someone else explained,

“If it gets to a point where things are too much you feel like the minority and the only person complaining when in fact many people may be stressed.” “Someone who was upper middle class, there is guilt and shame or even say they are stressed, if they say they are stressed or depressed and they would have to lay out why”

Things are different here than they are in Haiti. Accordingly, rates of suicide are different. One person described that,

“I rarely hear about anyone committing suicide, no matter what the situation is. They may have five or more and one loaf of a bread and the thought of taking their lives its unheard of, I have yet to know any family or friends in Haiti to commit suicide but here, I know so many of them I can’t take it anymore”

## **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.

## **What would help?**

Many ideas were shared for ways to improve the current resources. These included:

- **Real life stories**
  - A way for people who have dealt with those situations and then feel better to share their story and then let other people learn from it.

- **Education through the radio and through live TV shows in Creole**
- **Conversations with or through the church**
  - “Not so much about what the word stress means but more about [what they’re] feeling lately”
- **Educating kids to educate parents**
  - Education and communication through church, school and organizations within the school
- **Re-establishment of peer leadership programs**
  - “Youth enrichment services [used to] have an afterschool programs for Haitian students. The grant was used to organize info sessions in churches in the neighborhood and to meet with the pastors”
- **Addressing suicide as a long-term initiative**
  - In a culturally –appropriate way that builds on the long-term personal relationships that are fundamental to Haitian culture. One provider explains, “calling them and keeping them alive that one day doesn’t mean the work is done...the Haitian culture [requires] constant people contact, that interaction with that person doesn’t mean the end.”
- **Ask pastors to discuss mental health**
  - And encourage their congregants to seek services if they need them
- **Church retreats**
- **Recognize diversity within the culture**
  - One provider explained, “you have to sit with the them, talk to them, look at them, but you can see with 20 Haitians and each one is different, that is the diversity we have to identify and we can make a big difference” another added, “also religion is diverse so it’s delicate, the seventh day Adventists may think they are better than the Protestants and so on”
- **A center where people could come to discuss issues**

## 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. For the purposes of this report we will refer to the cultural community as Latino, although we did not include Latino speakers of languages other than Spanish.

### Supports and Services

Youth were aware of various clinical and organizational supports. These included the BEST mental health crisis team, therapists, and partial programs. They knew that parents, school or a therapist could make referrals. Providers described that 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. When asked about resources outside of health centers, providers agreed that most people go to the emergency room if they need care, but that they have to be really sick to take that step. They said people go to Boson Medical Center, Whittier Street Community Health Center, Dimock, Southern Jamaica Plain Health Center and Martha Elliot Health Center.

Clinicians agreed that a variety of factors drive people's choices about where to go, including proximity to home and availability of Spanish speaking clinicians, but that personal referrals from friends and families about where they or their loved ones are going for help are even more powerful. They said that many people who come in have family members who have already been through treatment and explained that many young people, particularly girls between 13 and 25, come in with their mothers or their grandmothers. This family support at appointments is not limited to daughters and mothers. Clinicians described that many Latino clients bring cousins or other family members to appointments and to support groups.

Youth explained that talking and communicating can be helpful, and that friends and family can be good people to talk to. However, they also explained that 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. Clinicians noted that because of this sense of responsibility, those within the community who are 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.

For some people, having someone else be dependent on them can be a significant protective factor. One person explained that her 4 year-old sister is the reason that she's hung on. "A few

times this school year, she would cry, saying kids were mean to her at school...I was like, I'm going to be the person that helps you, not just because of my own selfish needs."

Youth programs can be a tremendous support for teens. One young woman described that Teen Empowerment (a youth organizing and social change program) has taught her:

"We're the future generation and we're going to be the ones listening to people's problems and we'll be understanding because we're the ones we went through it... we can't change anything, unless it's a positive change we do ourselves. In order to change someone else, you need to change yourself first. You have to be selfish to be selfless."

### **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. One person explained that the Department of Children and Families (DCF) can be a barrier to reaching out for help because if DCF knows that you're self-harming they can deem your home unfit. Another described that it can be difficult not knowing that other people feel the same way or not wanting to feel like a misfit.

Another barrier to help seeking is the fear of being reprimanded. One young person explained, "You think you're going to get in trouble. People yell at you about it. They reprimand you about it, self-harm, depression. I got yelled at by my dad, by my teachers, by a whole bunch of people. People are afraid to get in trouble." 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. One young woman explained that the threshold for being accepted into different levels of services is too high. In her case, her mother wanted to move her from a partial to a residential program and was told that she could only do that if she actually caught her attempting suicide.

An issue that can keep people from continuing treatment once they have begun is that they have tremendous respect for the clinician, and if they have not taken medication as prescribed or have not understood recommendations, they may decide not to come back.

### **Religion**

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, and sometimes priests tell the family that they should be worried. While they acknowledged that there can be similar dynamics within other religious cultures, clinicians said that for Catholic Latinos there seems to be less discussion of forgiveness from God.

## Family

Young people recognize that their parents have a different view of depression and a different frame for their emotions based on their own experiences. One young person explained “I think it’s because our parents went through their own struggles, and they wanted to give us this life, but [then they think]...I gave you what I didn’t have, why are you still depressed?” Another person shared that, “They grew up in a different time, so their struggles are different from what it is now...they think you’re just being bratty or spoiled and want more than what you are given.” Providers noted that these intergenerational struggles are not unique to Latinos.

Some young people described language barriers between parents and children. Providers noted that tension within a family can arise from struggles about how much of the family’s traditional culture to retain and from the unusual dynamics of children acting as interpreters for their parents.

## Gender

There’s a Latino masculine identity that providers described as making it hard for men to seek treatment. They explained that it’s about being a tough guy, without feelings and emotions. In addition to differences in help-seeking, one clinician noted that there is a gender difference in the ability to get a gun, making it more likely that men than women will be able to carry out a suicide using a gun.

## Stigma

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”.

## 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), people who are isolated (particularly those who came from tropical countries and feel isolated due to the cold weather).

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 described their understanding of depression as, “When a kid feels ‘there’s no way out’, they feel completely alone. I have no friends, I can’t talk to anyone about anything, no one would care about anything. I think that’s what depression is, a lonely kid, who doesn’t think their life is necessary” or “like diabetes, it’s constantly there, [you’re] always going to have it, but some days it’s worse than others. I think of depression as a constant leech. It’s something that leeches onto you but you can’t get rid of”, Another young person described it as, “When you’ve lost all control, especially your emotions, to the point where you just feel numb . . .and you’d rather feel numb for the rest of your life” and another said “for me depression is kind of hiding reality, making your own fairy tale, saying you’re ok but you’re really not. Kind of having a mask over yourself..”

Teens are at high risk for suicide. One young woman explained the difficult cultural dichotomy of adolescence in the United States and how challenging it can be to be treated like an adult and a child at the same time. She said, “they want us to make decisions about college, careers, but they still make us raise our hands to go to the bathroom. They don’t understand that we have problems, that we’re not children. . .we’re not adults either but we’re not children.”

Teens had a variety of explanations for why someone might attempt suicide, including feeling like it’s their only choice to be happy, feeling like they have no part in anyone’s lives, and “They’re just tired. They can’t go on anymore. They’re tired of trying and trying.”

Youth mentioned that status posts on Facebook about not feeling good or feeling sad can be warning signs for suicide because that’s a good place to reach out for help. 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.

## What would help?

Many suggestions were raised for new interventions, and many best practices were mentioned that could be expanded or replicated. These included:

- **The “right kind of communication”**
  - When teens post online about feeling bad they want to hear responses like “I saw your status, I’m here for you.” Or they want someone to reach out and ask them to spend time together. They want to feel genuine care from someone.
- **Communication from adults that's not judgmental**

- As one young person notes: “adults – some of them will just look at you, be judgmental. One young person described, “When you’re dealing with kids that are depressed...ease them into it, tell a couple of jokes, get them comfortable...try to relate to them, have some positive communication, keep some positive vibes...eventually they’ll ease up, because that’s what they really want. Someone to vent to.”
- **Connecting people to other activities**
  - One young person explains, “If you know that person well and know their interests, you can talk to them about clubs, to connect to other people and meet people who might care about them, or something that could just keep them busy, keep their mind off things.”
- **Spanish-language support groups**
  - Having an interpreter doesn’t work in a support group setting
- **Normalize discussion of mental health and suicide by asking about it**
- **Make sure that mothers know what resources are available**
  - Because parents (particularly mothers), are often the ones who bring their children in for treatment
- **Reach out to people who might be more open to treatment**
  - Include people whose mental illness is interfering with their ability to work and people whose family members have completed treatment.
- **Partial program with Spanish language capacity**
  - Because similar programs have recently closed
- **Education for parents about mental illness**
  - Including youth experiences of mental illness
- **Support groups that aren’t medicalized**
  - “Bring people in a room and everyone expressed what they’re going through – like AA, but not for alcoholics. Like, depression anonymous.”
- **Examples from other people who have been through similar experiences**
  - “I’ve never found a person that’s gone through what I’ve gone through...if I found that person, I would say thank you, I would give the greatest gratitude to that person” “I want someone to be like, I’ve gone through what you’ve been through, and this is where I am now.”
- **Concrete steps and actions to take to survive depression**
  - “What’s the next step? What can I do to not fall back into it really quickly?” one young person explains, “it should be focused more on now, not necessarily on later.”
- **More wrap-around services**
- **More clinicians able to handle dual-diagnosis with substance abuse**
- **Less immediate discharge of patients from the hospital**
- **Care that can be provided regardless of insurance coverage**
- **Information about mental health at community health centers and at health center events to normalize service-seeking**
- **Messaging like “even counselors can use a counselor”**
  - To help reduce the stigma around seeking services.
- **Clinicians that listen closely to their patients and don’t make assumptions**

- **Begin clinical conversations “gently”**
  - With a discussion of “changes in appetite, sleep, energy levels, concentration... then go into mood, then shift more to emotional”
- **Use of non- judgmental, non-clinical language**
- **Less professional turn-over**
  - Providers agreed that the human relationship between provider and patient is the key to successful treatment and once a trusting connection was established, there is a strong bond and a low no-show rate, regardless of whether the provider speaks Spanish. Patients feel like the trust is broken when a provider leaves.

## Conclusion and Recommendations

While it is possible to identify certain general characteristics of each cultural community that participated in focus groups and there were some unique recommendations made by each group, many of the suggestions for what would help improve the situation are universal.

Three suggestions for services that were mentioned frequently and by all three cultural groups are:

- **Personal stories from people like me about their experiences with depression, suicidality, help-seeking and treatment**
- **Education for parents about mental health and mental illness in children**
- **Conversations and support groups**

By making some of the changes that were raised by focus group participants we have an opportunity to improve suicide prevention for everyone.

Moving forward from this report, the coalition may choose to identify action areas based on the recommendations, and may also choose to conduct further focus groups with additional identity groups.

Below are most of the recommendations raised during the focus groups, organized by type of intervention. For further detail about any one idea, refer back to the population-specific sections titled “what would help?”

### **Recommendations:**

#### **Increase communication about mental health**

- Conversations with or through the church about what people are feeling lately
- Inter-generational conversations about mental health and wellbeing
- Educating kids to educate parents
- Peer leadership programs to organize info sessions in churches in the neighborhood
- Yearly church retreats
- More community workshops
- Ask pastors to discuss mental health and encourage their congregants to seek services if they need them
- Support groups
- Spanish-language support groups
- Concrete steps and actions to take to survive depression focused more on now
- Education for parents about youth experiences of mental illness and about raising kids
- Education through the radio and through live TV shows
- The “right kind of communication” to feel genuine care from someone
- Communication from adults that's not judgmental
- Engage people in conversations about culture, respecting their expertise and cultural knowledge

### **Normalize help-seeking/ reduce stigma**

- Real life stories, to share their story and then let other people learn from it
- Public messages such as “even counselors can use a counselor”
- Information about mental health at community health centers
- Examples from other people who have been through similar experiences
- Peers telling their stories
- Messages coming from sector leaders like spiritual leaders
- Have more peers and consumers come forward and share their story
- Normalize discussion of mental health and suicide by asking about it

### **Make clinical institutions more welcoming**

- Less professional turn-over
- Use of non- judgmental, non-clinical language
- Clinicians that listen closely to their patients and don’t make assumptions
- Begin clinical conversations “gently”
- More Asian mental health providers
- Non-Asian providers who have some understanding of Asian upbringing
- Strong provider-patient relationships
- Diversity training
- Welcoming, culturally-appropriate centers

### **Make clinical services more accessible**

- More wrap-around services
- More clinicians able to handle dual-diagnosis with substance abuse
- Less immediate discharge of patients from the hospital
- Care that can be provided regardless of insurance coverage
- A center where people could come to discuss issues
- Partial program with Spanish language capacity
- Reach out to people who might be more open to treatment
- More therapists who speak Asian languages
- Make sure that mothers know what resources are available
- More relaxed catchment areas for service provision so that people can be sent to other towns where they can be connected more quickly to mental health services that are linguistically and culturally appropriate

### **Research**

- More research on ethnic subpopulations

### **Additional ideas were:**

- Address suicide as a long-term initiative
- Recognize diversity within the culture
- Connect people to other activities

## **Acknowledgements**

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## Appendix A: Focus Group Question Guide

### Greater Boston Regional Suicide Prevention Coalition Community Focus Groups Discussion Guide 2014 - 2015

#### Introduction:

Welcome

Introduce self and note-taker

*Review the following:*

- Who GBRSPC Coalition is and what they are trying to do (1 of 9 in MA, a regional coalition working to reduce suicide through education, training, referral, etc. working in coordination with the MA DPH MCSP and area providers and agencies) Gathering information and identifying priorities pertaining to suicide prevention.
- What will be done with this information (Identify suicide and depression beliefs, needs, and resources)
- Why they were asked to participate (Ask if anyone has participated in a focus group before?)

#### Consent Process:

*Thank you for agreeing to participate. We are very interested to hear your opinion on how the GBSP Coalition can better understand beliefs about suicide, communicate effective prevention strategies, and connect individuals and communities to important resources.*

- *The purpose of these discussions is to; 1) learn how different populations and communities in Greater Boston think and talk about suicide, 2) learn how to best tailor suicide prevention outreach, 3) learn what existing resources are helpful and what more is needed to prevent suicide.*
- *The information you give us is completely confidential, and we will not associate your name with anything you say in this focus group.*
- *We would like to tape-record (audio-record) the focus groups so that we capture the thoughts, opinions, and ideas we hear from the group. No names will be attached to the focus groups and the recording will be destroyed as soon as they are transcribed.*
- *You may refuse to answer any question or withdraw from participating at anytime.*
- *We understand how important it is that this information is kept private and confidential. We will ask participants to respect each other's confidentiality.*

- *If you have any questions now or after you have completed the questionnaire, you can contact the GBRSP Coalition leadership whose names and phone numbers are on the consent form.*
- *Please sign the form to indicate that you consent to participate in this focus group.*

**Logistics:**

- Focus group will last about an hour and a half
- Bathroom location
- Refreshments
- Incentives to be distributed at the end \$25 gift cards

**Ground Rules:**

Ask the group to suggest some ground rules, and add as needed;

- Everyone should participate
  - Information provided in the focus group must be kept confidential
  - Stay with the group and please don't have side conversations
  - Turn off cell phones
- ✓ Any questions before we get started?  
 ✓ Introductions by first name

**Questions:**

1. Let's start the discussion by talking about stress and depression; Where can people go for help? How is seeking help viewed or perceived?
2. How is depression described among Haitians? Haitian-Americans? How do people talk about this?  
*Probe: Depression viewed as an illness?*
3. Now let's talk about death by suicide, killing one's self – how is it viewed in the Haitian-American community? In Haitian culture? How is it described?  
*Probe: Is this a difficult subject to talk about?*
4. What are some clues, or warning signs, that a person is considering suicide? (\*Group brainstorm)  
*Probe: verbal, behavioral, situational clues – list of signs/clues (show the group the brainstorm and established/accepted lists side by side, briefly discuss appropriate vocabulary)*

5. Why do you think people consider suicide? Why do they attempt suicide? What are some of the reasons?  
*Probe:* ideation
6. Do you think that you can stop someone who is considering suicide? Is suicide preventable?
7. Where could a Haitian-American person go (in Greater Boston) to get help for depression? suicide?  
*Probe:* Available services and resources? (Medical, Mental Health, Faith/Spiritual Community)
8. What is needed to help prevent suicide in the Haitian-American community? To help individuals?  
*Probe:* What could professionals (counselors, doctors, clergy, etc.) offer? What could community members (family, friends, etc.) offer? Alternatives?
9. What could prevent people from seeking help?

This concludes our focus group. Thank you for sharing your thoughts and opinions with us.

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<sup>i</sup> Accessed 6/9/15 from: <http://www.carla.umn.edu/culture/definitions.html>

<sup>ii</sup> Hofstede, G. (1984). National cultures and corporate cultures. In L.A. Samovar & R.E. Porter (Eds.), *Communication Between Cultures*. Belmont, CA: Wadsworth.

<sup>iii</sup> Lederach, J.P. (1995). *Preparing for peace: Conflict transformation across cultures*. Syracuse, NY: Syracuse University Press.