Suicide Among Diverse Youth

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Editors

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A Case-Based Guidebook

Springer

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Foreword

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Preface

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

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

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

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

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

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

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

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

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

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

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

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

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

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