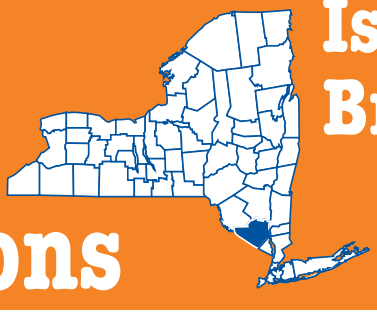
Culturally and Linguistically Diverse Populations



Issue Brief 9

ORANGE COUNTY • NEW YORK

Suicide rates, and beliefs and attitudes about suicide and suicidal behavior have historically varied across cultures, and it is critical that schools have mental health plans in place that serve several different populations, especially those populations that are represented in the school. For culturally and linguistically diverse students, school climate plays an increasingly important role in suicide prevention. Research has shown that students who feel connected to their school (e.g., felt teachers treated them fairly, felt close to people at school) are less likely to experience suicidal thoughts and emotional distress (13, 14). Research has also shown that school problems can be a risk factor for suicide in adolescents (14), and many teenagers in one psychological autopsy study were found to have died by suicide after an acute disciplinary crisis or rejection or humiliation (9).

A comprehensive suicide prevention program will plan for the provision of translation and interpretation services whenever necessary. Community partners, such as local colleges and universities or specific ethnic/cultural organizations, as well as national organizations, can be instrumental in developing a culturally and linguistically competent prevention program.

Much research has found that individuals of color, or who do not identify as white, have less access to and are less likely to receive quality mental health services (2, 6, 7). Mental health and mental illness are shaped by age, gender, race, and culture as well as other distinctions of diversity that can be found within all of these population groups— for example, physical disability, socio-economics, or a person's sexual orientation or gender identity. The consequences of not understanding these influences can result in unintended and negative effects, including death by suicide. With minority youth more likely to express feelings of alienation, cultural and societal conflicts, academic anxieties, and feelings of victimization, it has become clear that careful attention must be paid to the needs of minority youth and their families within the context of their culture (2, 12, 18).

For the purpose of this Issue Brief, culture can be broadly defined as the shared learned behavior, belief systems, and value orientations that influence customs, norms, and social institutions of a group of people (1). The term race typically is used to describe a person's physical characteristics, including skin color and facial features, although the biological basis of race has been debated (1, 37). Ethnicity is used to refer to people who have common cultural traits, such as language, place of origin, sense of history, or common traditions (1). The concept of ethnicity has similarly been debated (1). Given this more broadened consideration of culture, many students may consider themselves to have multiple cultural identities (2). Following are some unique issues facing some of a variety of cultural groups that are represented in the United States school system regarding suicide and suicide prevention.

Youth Suicide Prevention School-Based Guide ©
Orange County, New York

ORANGE-ULSTER BOCES

Orange-Ulster BOCES
845 291-0100
www.ouboces.org

Orange County Department of Mental Health
845 291-2600
www.orangecountygov.com

Suggested Citation: LeBlanc, A., Roggenbaum, S., & Lazear, K.J., (2014). *Youth suicide prevention school-based guide: Orange County, New York—Issue brief 9: Culturally and linguistically diverse populations.* Tampa, FL: University of South Florida, College of Behavioral and Community Sciences, Louis de la Parte Florida Mental Health Institute (FMHI Series Publication #255-9-rev).

This publication is also available on-line as an Adobe Acrobat PDF file: http://www.ouboces.org and http://www.orangecountygov.com

Select County Departments, Department of Mental Health

Populations

Latino/Latina Youth

Latinos represent the largest "minority" group in the United States, and yet are an extremely diverse population, including people from Mexico, the Caribbean, and Central and South America (5, 30). One can identify as another race and Hispanic (3, 4), and indeed terms "Latino" and Hispanic" are often used interchangeably, as they are by the U.S. Census Bureau (30). Suicide is the third leading cause of death for youth of Hispanic descent, although it is important to note that 11% of Latina females attempted suicide at least once within a year before taking the 2009 Youth Risk Behavior Surveillance System [YRBSS] (3). The percent of Latina females attempting suicide (11.1%) is higher than most other female racial groups: Black (10.4%), White (6.5%), and Asian (3.7%) and over twice as high as compared to their Latino male peers (5%). Although the Latina female percentage for non fatal suicide attempts is lower than females of multiple races (13.7%), it's higher than the U.S. average (8.1%). Additionally, 40% of Latina females reported feeling sad or hopeless within the last year (3). Unlike many other ethnic groups Latino youth are at an increased risk of dying by suicide than Latinos overall (4, 30).

While Hispanic and Latino cultures can be quite diverse, many Latino populations place high importance on family and interdependence over individualism and independence (12, 43, 45). One study found that Latina females who felt that their mothers were interested and involved in their lives were significantly less likely to make a suicide attempt (44). Similarly, researchers reviewing the literature on Latina suicide found that prevention and intervention needs to be family-oriented (45).

Language barriers are also a unique issue facing suicide prevention efforts in this population. Latinos are less likely to receive formal mental health services, and one study found that adult Latinos are even less likely than other ethnic minority groups to receive quality care for depression (10), possibly because of language barriers (2, 12, 30). While adolescent Latino suicide attempters living in the United States tend to be U.S.-born English speakers, because of the importance placed on family, they tend to want to involve non-English speaking family, potentially causing further barriers if few or no bi-lingual services are available (12, 42).

Feelings of distress may be expressed uniquely by different cultures, and one way that Latino youth, particularly females, tend to express mental health problems is somatization, or the expression of distress through physical symptoms, such as stomach disturbances, chest pain, dizziness, or a burning sensation in the hands and feet (2, 12, 30). This is sometimes referred to "nervios," (nerves) and sometimes Latina females express "ataques de nervios," (dissociative loss of control and sometimes self-injurious behavior) during stressful events (45).

African American Youth

As of 2007, suicide was the third leading cause of death for African Americans ages 15-19, and it is important to note that between the years 1981 and 1995, there was a 133% increase in death by suicide of African American 10 to 19 year-olds (4). While this group has relatively lower rates of death by suicide compared to their white peers, this fact sometimes leads to the myth that African Americans do not die by suicide and is not a group needing special emphasis for prevention (6, 8). Results of the 2009 YRBSS show that about 13% of African American high school students had considered attempting suicide at least once within the past year, and about 8% made at least one attempt (3).

African American youth have a few unique factors influencing their mental well-being, including racial discrimination. Research has shown that systematic discrimination prejudice has been linked with physiological and psychological problems throughout the African American population (2, 37). These difficulties can lead to depression, substance abuse, and hopelessness, which are all risk factors for youth suicide (14, 38).

African American youth have been found to have some unique symptoms and warning signs of suicidal behavior, including extreme anger, acting out, and high-risk behaviors, making it more difficult for clinicians to assess suicidal intent (11, 12). Additionally, suicidal male African American youth may be at higher risk for finding ways to die that do not at first appear to be suicide, including the death-by-police method (12).

As with other ethnic minorities, African Americans have less access to formal mental health services than their white peers, and African American youth seek formal mental health services at lower rates as well (6, 7, 8, 39). Currently there appear to be no published studies of effective suicide prevention programs specifically for African American youth (7). Some research suggests, however, that suicide interventions for these youth may be coupled with religion and spirituality, as, compared to their white peers, African American youth report more involvement in religious activity, and tend to seek mental health services and help through the more informal avenues provided by church members and clergy (6, 7, 39). Family support, coupled with church involvement, have been suggested as protective factors for African American suicidality, although the leading researchers in the field agree that more work needs to be done on this population (6, 7, 11, 38, 39).

American Indian/Alaska Native Youth

Suicide continues to be the second leading cause of death for young American Indian/Alaska Natives [AI/AN], and remains at that rank until their mid-thirties (4). Suicide accounts for the death of almost 20% of AI/AN youth, and in 2009, 19% had seriously considered suicide within the last year, with 10% actually making an attempt

(3). AI/AN teen females die by suicide at three times the rate of their peers in different cultural populations (4), making suicide prevention in these communities vital. It is important to note there is much heterogeneity across AI/AN tribes and communities, with unique circumstances, histories, and suicide rates for each group (7, 12, 32, 34). Approximately two thirds of American Indian children live in urban areas (12, 40) and suicide research on AI/AN groups tend to focus on those who live on reservations, where AI/AN suicide rates are higher (7).

As with the African American community, an important issue to note is the historical trauma experienced by the AI/AN population by the American government (2, 7, 12, 32). Abuses against AI/AN tribes include the forced relocation of entire communities onto reservations, the removal of AI/AN children into boarding schools where they would be prohibited from speaking native languages or performing cultural traditions, and the outlawing of traditional religious practices (7, 12).

Some specific suicide risk factors for AI/AN youth include feeling that one is disconnected from the family or the community, and/or that one is a burden to the community (12, 34, 35). Additionally, these groups are at a higher risk than others for suicide contagion (where exposure to suicide or reports of suicide influence others to attempt suicide), possibly because of the small, intense social systems among youth on reservations (12, 33).

Another important risk factor for many AI/AN populations, including youth, is an elevated rate of alcohol abuse (7, 12). One study that followed American teenagers from 1976 to 2000 found that almost 25% of AI middle school students reported drinking five or more alcoholic drinks in one sitting within the past two weeks (41). As substance abuse is a risk factor for youth suicidal behavior for all youth, and is unfortunately a specific problem in AI/AN populations, it is critical that suicide prevention efforts be integrated into and presented with substance abuse prevention programs.

Some targeted prevention efforts in tribal and public schools have taken into account culture-specific risk factors, such as lack of cultural and spiritual development, loss of ethnic identity, cultural confusion, and acculturation (the socialization process by which minority groups gradually learn and adopt selective elements of the dominant culture) (2, 12), notably the best-practice Zuni Life Skills Development Curriculum, which has shown positive gains (32, 34). A culturally tailored intervention program for the Zuni Pueblo, the curriculum was developed in collaboration with the Zuni community, and has since been adapted for other tribes, and is now known as the American Indian Life Skills Develoment Curriculum (34).

Another significant program utilizing a public health approach and gathering extensive suicide related data is the White Mountain Apache Tribally Mandated Suicide Surveillance System. As a community-wide and community-based system utilizing a participatory research process, the White Mountain Apache Suicide Surveillance System is informing the design and evaluation of the tribe's suicide prevention interventions (31).

Asian American and Pacific Islander Youth

Suicide is the second leading cause of death among Asian American and Pacific Island [AA/PI] youth between the ages of 15 and 19 (4). Like other ethnic minority groups in the United States, this classification is made up of people across Asia, and each group has its unique intergroup cultural differences, as well as suicide rates. Similar to many Latino populations, many Asian ethnicities, including Chinese and Japanese cultures, value interdependence over individualism (20). Therefore a specific risk factor for AA/PI youth suicide is feeling that one has disrupted family or community harmony (12, 20). Another risk factor is being in a family that came to the U.S. as refugees, particularly from South East Asia (12, 28). As with Latino youth, AA/PI youth in mental health crises tend to focus on the somatic symptoms (12).

Lesbian, Gay, Bisexual, Transgender, Transsexual, and Questioning (LGBTQ) Youth

Unlike the classifications for race and ethnicity, there is no formal tracking of suicide statistics for youth who identify as lesbian, gay, bisexual, or transgender/sexual. Additionally, research in this area does not always use the same criteria when identifying gay, lesbian, bisexual, transgender, transsexual, or questioning youth. Some research, including the subsets of the Youth Risk Behavior Surveillance System (YRBSS) (54) and the National Longitudinal Study of Adolescent Health [Add Health Study], use two ways to identify LGBQ adolescents: their self-identity as gay, lesbian, bisexual, or unsure, and the sex/gender of their sexual contacts. Some discuss "unsure" as questioning (Q) in research findings including research citing the YRBSS (18, 54).

Studies using data from regional YRBSs have found that LGBQ youth are at higher risk for victimization (18, 22, 55), and were more likely to have suicidal thoughts and attempts than their peers who identified as heterosexual and/or did not engage in same-sex sexual behaviors (14, 19, 23, 55).

Other research uses only respondent's self-identity when categorizing LGBQ youth. One study found that over half of surveyed youth who identified as LGB had been verbally harassed at school, and half of those students had been threatened with violence (56). A recent study that asked Oregon high school students how they self-identify (heterosexual, gay, lesbian, bisexual, or unsure) found that youth who identified as LGBQ were

more likely to have attempted suicide in the past year compared to their peers who identified as heterosexual (53).

For sexual minority students, research has shown sexual orientation to be correlated with identified risk factors for suicide and is less of a factor after controlling for these risk factors (14, 25, 26, 27). That is, being LGBQ alone does not put an adolescent at higher risk for suicide, but living "in the closet," being "outed" by someone else, or being ridiculed are specific stressors for this population (18, 19). African American and Latino youth who engage in same-gender sex or identify as LGB, may also be at increased risk as they are less likely than Whites to "come out" to family and friends (48).

The term transgender is used to classify those who do not identify with the gender or sex that they were assigned at birth (15). This could include those who have altered their sexual organs, or those who superficially alter their appearance through dress, hairstyle, or accessories. There is an unfortunate paucity of research on the suicide risk of transgender adolescents, as they are a relatively "hidden" population (22, 57, 58). Transgender youth may be at higher risk for victimization because of gender non-conformity, possibly leading to depression and low self-worth (15). One study using a small sample of self-identified transgender adolescents (55 respondents) found that half of the respondents had thought seriously about taking their lives with half of these youth who reported that those thoughts were related to their trans identity (58). This study also found that one quarter of all 55 respondents had actually made a suicide attempt (58).

Research has shown that supportive communities are a protective factor for LGBQ students (53), specifically with the presence of a Gay/Straight Alliance [GSA] or a similar school-based support group for sexual minority students and heterosexual allies (55). One study found that LGB students who attended schools with GSAs or similar groups were less than half as likely to report feeling victimized, and less than one-third as likely to report making a suicide attempt in the past year than those LBG students from schools with no such support groups (55). In order to make a more inclusionary and supportive school, the Human Rights Watch (22) recommends that faculty, staff, administrators, and volunteers be educated and trained about LGBTQ issues, and additionally, that faculty and staff who are "out" as LGBT be supported institutionally (22). The Suicide Prevention Resource Center also recommends including sexual minority students in LGBTQ program and education development (57). In order to serve the needs of transgender and questioning students, it is recommended that they be able to define themselves in a way that is most appropriate for them and where dress codes are enforced, that they are done so in a gender-neutral manner (22). For developing a safe school environment, the CDC and leading researchers recommend that schools train their staff how to identify harassing behavior, effectively intervene in bullying situations, and include the needs of LGBTQ students in mental health campaigns (21, 22, 29, 54, 57).

Other Risk Factors

Geographic diversity is also a factor in developing effective suicide prevention strategies. For example, research suggests that in inner city areas, African American youth suicide attempts occur at about twice the national rate (46). Another study suggests that tribal communities located within urban areas had substantially lower rates of suicide than did those for which the "lights of the city" were only on the horizon (47). Additionally, one study revealed that the risk of suicidal ideation is higher for urban African American and Latino youth when basic needs are unmet (48). While much attention has been given lately to the bullying and victimization of LGBTQ students, research shows that in fact any student who doesn't "fit in" or those who differ from the majority of their classmates in regards to race, religion, or ethnicity are also at risk for bullying, which may increase certain risk factors for suicide. Subsequently, bullied adolescents may be at increased risk for suicide attempts and death by suicide (7, 16, 17, 19, 24).

Protective Factors

The role of protective factors (factors and experiences that appear to reduce risks for suicide) is an important focal point in any youth suicide prevention strategy, and especially for culturally and linguistically diverse youth. Addressing protective factors (i.e., success at school, interpersonal connectedness and belonging, and supportive family dynamics) can help to identify and build upon youths' strengths and assets. The role of the family cannot be overstated. For LGBT youth, family acceptance predicts greater self-esteem, social support, and general health status; it also protects against depression, substance abuse, and suicidal ideation and behaviors (49). During the complex developmental period of adolescence, the formation of strong cultural and ethnic identity may protect against suicidal and other risk behaviors as youth may feel less isolated and alone (50, 51, 52).

While most of the research literature about LGB youth has historically focused on risk factors and problem behaviors as well as socio-cultural and psychological challenges that LGB youth experience, research on protective factors and resilience for LGB youth is starting to emerge and shows early promise for approaches that will enhance the care and well-being of LGBT youth and their families (36).

Resources

The following are some resources that may be helpful for gathering additional information:

The Suicide Prevention Resource Center (SPRC) has several links and resources for special populations on its website, including: http://www.sprc.org/links/spoplinks.asp http://www2.sprc.org/aian/index - for AI/AN suicide prevention

The Gay, Lesbian and Straight Education Network (GLSEN) The Gay, Lesbian and Straight Education Network strives to assure that each member of every school community is valued and respected regardless of sexual orientation or gender identity/expression. GLSEN brings together students, educators, families and other community members to reform America's educational system. http://www.glsen.org

To Live to See the Great Day that Dawns is a comprehensive US Department of Health and Human Services resource about preventing American Indian and Alaska Native youth suicide. Free PDF at http://www.sprc.org/library/Suicide_Prevention_Guide.pdf

Indian Health Service Injury Prevention Program Website seeks to raise the health status of American Indians and Alaska Natives to the highest possible level by decreasing the incidence of severe injuries and death to the lowest possible level and increasing the ability of tribes to address their injury problems. http://www.ihs.gov/MedicalPrograms/InjuryPrevention/index.cfm

Suicide Prevention Links in Spanish lists links to public information materials in Spanish language on mental health and suicide, including two specific to suicide among adolescents: Understanding Suicide: The Basics and Suicide Prevention: A Parent and Teen Guide to Recognizing Suicide Warning Signs. http://www.helppromotehope.com/documents/Spanish_Materials.pdf

Communities that Care is a coalition-based community prevention operating system that uses a public health approach to prevent youth problem behaviors such as violence, delinquency, school drop out and substance abuse. http://www.sdrg.org/CTCInterventions.asp

Mental Health: Culture, Race, and Ethnicity— A Supplement to Mental Health: A Report of the Surgeon General (2001) lists the following national multicultural resources:

Association for Multicultural Counseling and Development
(703) 823-9800 or
(800) 347-6647
www.counseling.org

DiversityRx
www.diversityRx.org

National Center for Cultural Competence
(202) 687-5387 or
(800) 788-2066
www.gencd.georgetown.edu/nccc

National Minority AIDS Council
(202) 483-6622
www.nmac.org

Search Institute
(800) 888-7828
www.search-institute.org

The Society for the Psychological Study of Ethnic Minority Issues
www.apa.org/divisions/div45

Transcultural & Multicultural Health Links
www.lib.iun.indiana.edu/trannurs.htm

References

1. American Psychological Association. (2002). *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists.* Washington DC: Author.
2. U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD.
3. U.S. Department of Health and Human Services. (2010). Youth Risk Behavior Surveillance-United States, 2009. *MMWR, 59*(SS-5).
4. Centers for Disease Control and Prevention (CDC), WISQARS. (2011). *Leading Causes of Death.* Retrieved from http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html
5. Flores G., Fuentes-Afflick E., Barbot O., Carter-Pokras O., Claudio L., Lara M, … Gomez, F. J. (2002). The health of Latino children: Urgent priorities, unanswered questions, and a research agenda. *JAMA, 288,* 82–90. doi:10.1001/jama.288.1.82
6. Barnes, D.H. (2010). Suicide. In R.L. Hampton, T.P. Gullotta, & R.L. Crowel (Eds.), *The Handbook of African American Health* (pp. 444-460). New York: Guilford Press.
7. Goldston, D.B., Molock, S.D., Whitbeck, L.B., Murakami, J.L., Zayas, L.H., & Hall, G.N. (2008). Cultural considerations in adolescent suicide prevention and psychosocial treatment. *American Psychologist, 63*(1), 14-31.

References continued

Culturally & Linguistically Diverse Populations

8. Garlow, S. J., Purselle, D., & Heninger, M. (2005). Ethnic differences in patterns of suicide across the life cycle. *American Journal of Psychiatry, 162*(2), 319-323.

9. Shaffer, D. (1988). Preventing teenage suicide: A critical review. *Journal of the American Academy of Child and Adolescent Psychiatry, 27,* 675–687.

10. Schoenbaum, M., Miranda, J., Sherbourne, C., Duan, N., & Wells, K. (2004). Cost effectiveness of interventions for depressed Latinos. *Journal of Mental Health Policy Economics, 7,* 69-76.

11. Gibbs, J. T. (1988). Conceptual, methodological and sociological issues in black youth suicide: Implications for assessment and early intervention. *Suicide and Life-Threatening Behavior, 18*(1), 73–89.

12. U.S. Department of Health and Human Services. (2010). *To live to see the great day that dawns: Preventing suicide by American Indian and Alaska Native youth and young adults.* DHHS Publication SMA (10)-4480, CMHS-NSPL-0196. Center for Mental Health Services, Substance Abuse and Mental Health Service Administration.

13. King, K. A. (2001). Developing a comprehensive school suicide prevention program. *The Journal of School Health, 71*(4), 132–137.

14. Borosky, I. W., Ireland, M., & Resnick, M. D. (2001). Adolescent suicide attempts: Risks and protectors. *Pediatrics, 107*(3), 485–493.

15. Transgender Suicide Prevention Working Group. (2008). *Preventing Transgender Suicide: An Introduction for Providers.* Boston, MA: Massachusetts Department of Public Health. Retrieved from www.masstpc.org/publications/suicideprevention.shtml

16. Klomek, A. B., Sourander, A., Neimela, S., Kumpulainen, K., Pila, J., Tamminen, T, . . . Gould, M.S. (2009). Childhood bullying behaviors as a risk for suicide attempts and completed suicides: A population-based birth cohort study. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(3), 254-261.

17. Klomek, A. B., Marrocco, F., Kleinman, M., Schonfeld, I. S., & Gould, M. S. (2007). Bullying, depression, and suicidality in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(1), 40-49.

18. Bontempo, D. E., & D'Augelli, A. R. (2002). Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *Journal of Adolescent Health, 30*(5), 364–374.

19. Russell, S.T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health, 91,* 1276-1281.

20. Oyserman, D., Coon, H., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of the theoretical assumptions and meta-analysis. *Psychological Bulletin, 128*(1), 3-72.

21. Klomek, A.B., Sourander, A., Kumpulainen, K., Piha, J., Tamminem, Moilen, I, … Gould, M. S. (2008). Childhood bullying as a risk for later depression and suicidal ideation among Finnish males. *Journal of Affective Disorders, 109,* 47-55.

22. Durant, R.H., Krowchuk, D.P., & Sinal, S.H. (1998). Victimization, use of violence, and drug use at school among male adolescents who engage in same-sex sexual behavior. *Journal of Pediatrics, 132,* 113-118.

23. Russel, S. T., Franz, B. T., & Driscoll, A. K. (2001). Same-sex romantic attraction and experiences of violence in adolescence. *American Journal of Public Health, 91*, 903–906.

24. Nansel, T. R., Overpeck, M., Pilla, R. S., Ruan, W. J., Simons-Morton, B., & Scheidt, P. (2001). Bullying behaviors among US youth: Prevalence and association with psychological adjustment. *Journal of the American Medical Association, 285,* 2094–2100.

25. Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth suicide risk and prevention interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 33,* 1080–1086.

26. Moscicki, E. (1999). Epidemiology of suicide. In D. G. Jacobs (Ed.), *The Harvard Medical School guide to suicide assessment and intervention* (pp. 40–51). San Francisco: Jossey-Bass Publishing.

27. Shaffer, D., Gould, M., & Fisher, P. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry, 53,* 339–348.

28. Nidorf, J. (2001). Mental health and refugee youths: A model for diagnostic training. In J. T. Gibbs & L. N. Huang (Eds.), *Children of color, Psychological interventions with culturally diverse youth.* Jossey-Bass Publishers, San Francisco, CA.

References continued

Culturally & Linguistically Diverse Populations

29. Davidson, L., & Marshall, M. (2003). *School-based suicide prevention: A guide for the students, families, and communities they serve.* American Association of Suicidology: The Task Force for Child Survival and Development.

30. National Council of La Raza, Institute for Hispanic Health. (2005). *Critical disparities in Latino mental health: Transforming Research into action.* Retrieved from http://depressionisreal.org/pdfs/file_WP_Latino_Mental_Health_FNL.pdf

31. Mullany, B., Barlow, A., Goklish, N., Larzelere-Hinton, F., Cwik, M., Craig, M., & Walkup, J.T. (2009). Toward understanding suicide among youths: Results from the White Mountain Apache Tribally Mandated Suicide Surveillance System, 2001-2006. *American Journal of Public Health, 99*(10), 1840-1848. doi:10.2105/AJPH.2008.154880

32. LaFromboise, T. D., & Lewis, H. A. (2008). The Zuni Life Skills Development Program: A school/community-based suicide prevention intervention. *Suicide and Life-Threatening Behavior, 38*(3), 343-353.

33. Wissow, L., Walkup, J., Barlow, Reid, R., & Kane, S. (2001). Cluster and regional influences on suicide in a Southwestern American Indian tribe. *Social Science and Medecine, 53*(9), 1115-1124.

34. LaFromboise, T. (2006). American Indian youth suicide prevention. *The Prevention Researcher, 13*(3), 16-18.

35. Borowsky, I. W., Resnick, M. D., Ireland, M., & Blum, R. W. (1999). Suicide attempts among American Indian and Alaska Native youth: Risk and protective factors. *Archives of Pediatric Adolescent Medicine, 153,* 573-580.

36. Lazear, K.J., & Gamach, P.E. (in press). The resilience u-turn: Understanding risks and strengths to effectively support LGBT youth and families in systems of care. In C. Ryan, S. Fisher, G. Blau, & J. Poirier (Eds.), *Addressing the needs of youth who are LGBT and their families: A system of care approach.* Brooks Publishing Co.

37. Clark, R., Anderson, N., Clark, V., & Williams, D. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54*(10), 805-816.

38. Gibbons, F., Gerard, M., Cleveland, M., Wills, T., & Brody, G. (2004). Perceived discrimination and substance use in African American parents and their children: A panel study. *Journal of Personality and Social Psychology, 86,* 517-529.

39. Molock, S. D., Matlin, S., Barksdale, C., & Lyles, J. (2008). Developing suicide prevention programs for African American youth in African American churches. *Suicide and Life-Threatening Behavior, 38*(3), 323-333.

40. Snipp, C. M., (2005) *American Indian and Alaska Native children: Results from the 2000 census.* Washington DC: Population Reference Bureau.

41. Wallace, J., Backman, J., O'Malley, P., Schulenberg, J., Cooper, S., & Johnston, L. (2003). Gender and ethnic differences in smoking, drinking, and illicit drug use among American 8th, 10th, and 12th grade students, 1976-2000. *Addiction, 98*(2), 225-234.

42. Cabassa, L., Lester, R., & Zayas, L. (2007). "It's like being in a labyrinth:" Hispanic immigrants' perceptions of depression and attitudes towards treatments. *Journal of Immigrant Health, 9*(1), 1-16.

43. Zayas, L., Lester, R., Cabassa, L., & Fortuna, L. (2005). "Why do so many Latina teens attempt suicide?:" A conceptual model for research. *American Journal of Orthopsychiatry, 75*(2), 275-287.

44. Turner, S., Kaplan, C.P., Zayas, L., & Ross, R. (2002). Suicide attempts by adolescent Latinas: An explanatory study of individual and family correlates. *Child and Adolescent Social Work Journal, 19*(5), 357-373.

45. Zayas, L. H., & Allyson, M. P. (2008). Suicidal behavior in Latinas: Explanatory cultural factors and implications for intervention. *Suicide and Life-Threatening Behavior, 32*(3), 334-342.

46. Price, J. H., Drake, J. A., & Kucharewski, R. (2001). Assests as predictors of suicide attempts in African American inner-city youths. *American Journal of Health Behavior, 25,* 367-375.

47. Chandler, J. M., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry, 35*(2), 191-219.

48. O'Donnell, L., O'Donnell, C., Wardlaw, D. M., & Stueve, A. (2004). Risk factors influencing suicidality among urban African American and Latino youth. *American Journal of Community Psychology, 33*(1/2), 37-49.

49. Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2009). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23*(4), 205–213.

50. French, S. E., Seidman, E., Allen, L., & Aber, J. L. (2000). Racial/ethnic identity, congruence with the social context, and the

References continued

Culturally & Linguistically Diverse Populations

transition to high school. *Journal of Adolescent Research, 15*(5), 587-602.

51. Phinney, J. S. (1992). The multigroup ethnic identity measure: A new scale for use with diverse groups. *Journal of Adolescent Research, 7,* 156-176.
52. Oyserman, D., Brickman, D., & Rhodes, M. (2007). Racial ethnic identity: Content and consequences for African American and Latino youth. In A. Fuligni (Ed.), *Contesting stereotypes and creating identities: Social categories, social identities and educational participation* (pp. 91-114). New York: Russell Sage Foundation.
53. Hatzenbuehler, M.L. (2011). The social environment and suicide attempts in lesbian, gay, and bisexual youth. *Pediatrics, 127*(5), 895-903.
54. U.S. Department of Health and Human Services. (2011). *Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12-Youth Risk Behavior Surveillance, selected sites, United States, 2001-2009.* MMWR, 6 [Early Release]. Retrieved from http://www.cdc.gov/mmwr/pdf/ss/ss60e0606.pdf
55. Goodenow, C., Szalacha, L., & Westheimer, K. (2006). School support groups, other school factors, and the safety of sexual minority adolescents. *Psychology in the Schools, 43*(5), 573-589.
56. D'Augelli, A.R., Pilkington, N.W., & Hershberger, S.L. (2002). Incidence and mental health impact of sexual orientation victimization of lesbian, gay, and bisexual youths in high school. *School Psychology Quarterly, 17*(2), 148-167.
57. Suicide Prevention Resource Center. (2008). *Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth.* Newton, MA: Education Development Center, Inc. Retrieved from http://www.sprc.org/library/SPRC_LGBT_Youth.pdf
58. Grossman, A., & D'Augelli, A.R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life-Threatening Behavior, 37*(5), 527-537.

Youth Suicide Prevention School-Based Guide
Orange County, New York

Prepared by

Amanda LeBlanc
Stephen Roggenbaum
Katherine J. Lazear

Developed by

The Louis de la Parte Florida Mental Health Institute in the College of Behavioral and Community Sciences at the University of South Florida. Funded in part by the Orange County Department of Mental Health and Orange-Ulster BOCES. Originally funded by the Institute for Child Health Policy at Nova Southeastern University through a Florida Drug Free Communities Program Award.

Design & Page Layout Dawn Khalil

Contact for USF Guide: Stephen Roggenbaum
roggenba@usf.edu
813-974-6149 (voice)

USF UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES